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VOICES FROM THE FIELD -
Public Policies and the Prevention of Early Childhood Aggression

Patricia Bégin, Director, Policy & Research
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(Published online July 5, 2004)

Policy perspective

Aggression and violence are linked to a range of serious and costly psycho-social problems that present significant challenges for individuals, families, teachers, peers, communities and mental-health and criminal-justice practitioners.

CEECD authors have made an important contribution to our understanding of the origins of aggression, its physical and social developmental trajectory and promising approaches to preventing and reducing aggressive behaviour. Their research shows that infants engage in aggressive behaviour, which intensifies during the first two and a half years after birth. Significantly, such aggression occurs even in the absence of observed aggressive behaviour models. Through the process of socialization, aggression steadily declines as children learn to regulate their emotions and resolve conflict without acting out aggressively. Pre-school children who do not “unlearn” aggression in their family environment and interactions during this sensitive period of development are at risk for serious behaviour problems during childhood and early adolescence.

Aggressive behaviour problems that emerge and become stabilized in the pre-school years – a period of dramatic cognitive, linguistic, emotional development – are highly predictive of antisocial behaviours in both adolescence (e.g. violence, delinquency, early school leaving and drug abuse) and adulthood. In fact, aggression is seen to be the best predictor for delinquent behaviour before the age of 13 and a risk factor for heavy illicit drug use and dependence in the late teenage years. From this perspective, unchecked early aggression leads to the accumulation or stacking of additional social and developmental risk factors. This trajectory of antisocial behaviour in turn leads to more serious, multi-problem criminal behaviour, which is more difficult and costly to treat.

Socio-economic factors, especially family environment and poverty, are associated with aggressive conduct problems in children. Family-related risk factors of significance are parents who are young and single, family violence, maternal depression, poor parenting practices and history of familial criminality. Recent Canadian research using data from the National Longitudinal Survey on Children and Youth (NLSCY) examined the effect of witnessing family violence on child aggression. It found that “exposure to violence in the home has a strong association with aggressive behaviour among children.” Hostile parenting practices, coupled with exposure to violence, also increased the odds of
aggression for children. Prenatal substance exposure is also associated with cognitive and social deficits, including aggression.

If we accept that in most cases, it is never too late to effect a change in behaviour,\textsuperscript{17} then effective and accessible intervention should be available to address conduct problems at different developmental stages. However, from a community-safety and cost-effectiveness perspective, it is prudent to direct public policies and resources to approaches with the potential to reduce early aggression. Given the evidence suggesting that human behaviour becomes stabilized during the developmental period occurring before the onset of formal schooling, it is warranted to develop policies and invest public resources in prevention and early intervention measures with at-risk families during the preschool years.

Promising measures to reduce early behaviour problems assessed include quality daycare programs using evidence-based pedagogical approaches in child skills/behaviour development, teacher training focusing on appropriate classroom management techniques, and parent training and support to improve parental functioning, child-rearing techniques and the parent-child relationship. Program interventions focusing on both parent and child behavioural deficits appear to produce better results than those that focus exclusively on the conduct of the child. The CEECD authors also point to approaches to prevent and respond to prenatal substance exposure, including timely medical diagnosis, assessment and planning.\textsuperscript{1-11}

The number of prevention/treatment strategies targeting problem behaviour in pre-school children is woefully inadequate. Most have been developed to meet the clinical requirements of children enrolled in elementary school, a developmental period when treatment of aggression is more difficult and costly. There is a dearth of empirically validated treatment interventions for this age group in Canada.

These facts point to a fundamental need for more research and programming in the area of early childhood aggression, particularly in the Canadian context. At a minimum, interventions for children from birth to age five should be grounded in developmental theory, adequately funded, well executed and target both children and parents at risk and those experiencing aggressive conduct problems. As well, they should be tested with culturally diverse populations and in different environments. Evaluation and replication in high-quality trials, using experimental designs with random assignment to treatment and comparison groups, must be an integral aspect of social programs.

Research has the capacity to indicate which social development approaches have achieved their intended outcomes and, of equal importance, which have produced unanticipated, harmful outcomes.\textsuperscript{18} Canada owes it to the next generation to develop early-childhood development policies that flow from a knowledge base and contribute to the advancement of best social practice.
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VOICES FROM THE FIELD -
A View from One Applied Clinical Setting

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Service perspective

The dissemination and relevance of childhood aggression developmental research to service providers is a complex issue. We will limit our remarks to a few salient areas: “empirically supported” interventions, dissemination, risk factors, gender, the dearth of interventions and a call to address economic and social policies that exacerbate factors associated with childhood aggression.

While Earlscourt Child and Family Centre has endorsed empirically supported interventions for over two decades, we have not attempted to rigorously define “empirically supported.” It is interesting to note that words like “empirically supported,” “empirically validated,” “proven,” “evidence-based” and “promising” appear in several articles, e.g. Webster-Stratton; Domitrovich & Greenberg; and Bierman.6,8,10 A consensus on criteria for describing interventions in this way is not self-evident. Service-providers might be understandably confused despite being prepared to embrace the merits of these kinds of interventions. By explaining their terms, researchers would provide a useful service to those in the field. We note, however, that only Domitrovich & Greenberg and Bierman raise the issue of replication and implementation.8,10

Should service-providers simply purchase treatment packages from a dissemination centre? Are materials sufficient without training? Earlscourt Child and Family Centre has taken the position that we will not proactively market our intervention materials (videos, manuals, parenting booklets) until our interventions meet APA criteria for well established interventions. While hundreds of our manuals were previously distributed without restrictions, we have recently limited their distribution to holders of an Earlscourt SNAP™ (Stop Now and Plan) license, and licensing is only available if a site agrees to receive training and ongoing consultation. Based on observations in replication sites we have supervised, the gap between reading a manual and program implementation can be great without sufficient training and ongoing consultation. Issues related to replication are complex; the field would benefit from researchers giving them more attention. Several authors note various risk factors in the development of childhood aggression.1,3,6,7,8,10 In the early 1980s, we at Earlscourt began to scrutinize our interest in
risk and protective factors for our clinical population of children with conduct disorder and ultimately came to shape our multifaceted interventions for each child and family in part based on our understanding of these factors. As a treatment aid and possible outcome measure, we developed two gender-specific risk assessment devices that bring together the developmental literature under 20 risk factors for boys (EARL-20B) and 21 risk factors for girls. These devices are excellent treatment planning tools and the EARL-20B is showing some predictive validity in independent studies.

Gender issues in early childhood development are important to address and represent a large knowledge gap. Only Keenan and Pepler mention these. Earls court recently launched a gender-specific intervention for girls with severe externalizing problems given their risk of poor outcomes, such as early pregnancy and unemployment, and the lack of established interventions that address their gender-specific issues, such as body image, relational aggression and sexual development. This program, known as the Earls court Girls Connection, is currently being stringently evaluated.

In Canada, provincial/territorial governments are responsible for providing children’s mental health services. Ontario is one of the few provinces with a distinct children’s mental-health sector dating back to the early 1970s. It now represents a $315-million annual expenditure typically allocated to stand-alone, community-based children’s mental-health centres. Nothing of note, however, is allocated for research and none are required to deliver empirically supported interventions. Furthermore, at this level of funding, services are available to only a small fraction of those in need. While governments in Canada have endorsed certain prevention programs, they have not endorsed interventions for aggressive, school-aged children at anywhere near comparable levels.

In fact, given flat base funding for children’s mental health in Ontario over the last decade, numerous government-funded programs have closed. Responding to audit recommendations for improved quality control over these expenditures, the Ontario government now requires its transfer-payment children’s mental-health centres to use the Brief Child and Family Phone Interview and the Child and Adolescent Functional Assessment Scale pre- and post-treatment. This is a small quality-assurance effort with potential, but governments continue to fund theoretically diverse and unsubstantiated interventions. On the other hand, there are risks of governments funding only one or another type of intervention, severely restricting new developments in the field. Applied settings would benefit from something like a consumer’s guide to recommended interventions that compared them based on similar dimensions, such as the rigour of the experimental design, effect size, treatment gains post-treatment and over time, transferability and implementation costs and requirements, such as training, certification or licensing.

Where to go from here? We suggest that researchers promote the advancement in community settings of a scientist-practitioner model of professional practice in several ways. We know from first-hand experience that stringent research designs stretch the limits of community settings and that group design studies have limited applied usefulness. Even with these and other limitations found in community settings,
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researchers might provide leadership in promoting descriptions of client populations, outputs, indicators of success, single-subject designs, descriptions of moderators of outcome and follow-up. These are likely to be within the reach of community settings and have the best potential to influence the refinement of effective and efficient interventions.

Finally, we note the gap between what researchers know about factors that are associated with the development of childhood aggression, such as poverty, social housing and lack of recreational and educational opportunities, and their silence regarding Canada’s economic and social policies that contribute to these factors. Children who present for treatment hungry, afraid to return to their neighbourhood and alienated from community resources will have guarded outcomes regardless of the empirical support for their treatment.
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VOICES FROM THE FIELD
Challenges Faced by Parenting Program Designers

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Service perspective

In designing our “Make the Connection” (MTC) parenting skills programs which aim to strengthen secure attachment in infants and toddlers, we draw upon expertise from a great many bodies of theory, among them - infant and adult attachment, prevention, brain studies, developmental psychopathology, early language development, and others.

Although our MTC programs have not yet undergone randomized controlled trials, we make a carefully-considered claim that the underlying principles are based on solid theories and on previously researched intervention formats. What is sometimes difficult for us is to acknowledge specific research, since over time, one simply “absorbs” the body of knowledge, gets on with the work, and loses track of which authors contributed to which theory. This sometimes catches up with us when we are asked to provide the research basis for specific elements within our programs.

Meta-analyses and overview articles are therefore very helpful to us as they tease out best practices, identify key contributors and confirm theories. However, even experts come to different conclusions which can be confusing. Not to mention that our experience in the field may or may not concur with certain findings.

Implications for the design of parenting programs

Diane Benoit’s recent paper from the Encyclopedia on Early Childhood Development will serve to illustrate the challenges we face in designing and updating our programs. Some findings affirm the strengths of our programs, others force us to question certain assumptions, while others point out the gaps, our work in the field could perhaps help to find some answers.

Benoit’s overview of the Efficacy of Attachment-Based Interventions makes particular reference to the findings of Bakermans-Kranenburg’s meta-analysis “Less is More.” They found that the best interventions are brief, use video feedback, start after infants are six-month old and have an exclusive focus on behavioural training of parental sensitivity. We take this seriously, because Marian Bakermans-Kranenburg and Marinus van IJzendoorn are prolific and respected authors in the field of attachment.

The first finding is that secure attachment is promoted when parents respond sensitively, promptly and appropriately to their infant’s cues.
We adopted this principle because it is a widely-held belief which is referred to in dozens of books and articles going back to Bowlby. Benoit affirms that “Historically ... improving caregiver sensitivity” has been a focus of attachment intervention. This is further substantiated in Bakermans-Kranenburg’s meta-analysis as being one of the essential components of effective attachment-based intervention.

A second finding of Bakermans-Kranenburg’s meta-analysis is that effective intervention should have a “clear and exclusive focus on behavioural training for parent sensitivity” as opposed to a focus on changing “internal representations.”

Our experience however, led us towards designing a program which addressed both parental sensitivity and reflective function (RF) – reflective function being the caregiver’s capacity to interpret and hold the infant’s mental states in mind as well as her own. For example, it is most likely that changes in behaviour facilitate changes in RF and vice versa and both are involved in the transmission of attachment. Van Ijzendoorn found that the “strongest predictor of infant attachment is parental state of mind with regard to attachment.” Other research looks at the contribution of maternal sensitivity to attachment security. Perhaps as stated by Bakermans-Kranenburg it is easier to change parent sensitivity than RF. However, it must be noted that interventions in the meta-analysis mostly benefited low-risk groups while our programs widely assist higher-risk groups.

Another reason comes from the field of adult learning. We base all our parent program curricula on a four-part learning cycle derived from Kolb’s experiential learning theory. For truly integrated learning, parents must engage in reflection, analysis, practice and feedback. Viewed from the adult learning perspective, reflective function cannot only be easily addressed within this learning model, but is also essential to a successful learning outcome. In MTC, for example, through the use of photographs and video feedback, caregivers are encouraged to imagine what their infant might be thinking, feeling or intending. Parents also have repeated opportunities to reflect on their own thoughts and feelings about adult relationships, their parenting past and in current situations with their infant.

A third finding is the recommendation by Bakermans-Kranenburg that effective intervention begins after the age of six months.

We are often asked what we recommend to be the ideal age for babies to start attending the Make the Connection Birth to One program. Our answer based on the developmental nature of attachment is “as soon as the mother feels ready to attend.” Thus, it is counterintuitive to read in Benoit’s review that most effective attachment-based interventions start after six months of age. Prior to six months, there are hundreds of opportunities for the kinds of affective exchanges that build an infant’s expectancy of how a parent will respond, his beginning sense of “self” and “other” and emerging self-regulation. This is not to mention the evidence coming from brain studies.
Until we have a better understanding of this finding, we have to continue our on-the-ground experience of seeing how parents gain confidence, skills, knowledge and social support.

The last finding from Benoit’s review\(^1\) of the Bakermans-Kranenburg\(^2\) meta-analysis that raises a question we struggle with, is that effective attachment-based intervention can be accomplished in fewer than five sessions.

We based our nine-week MTC programs on a researched program, similar in format, and of around the same duration which documented the effectiveness in improving parental responsiveness.\(^16,17\) Moreover, our field experience confirms that nine weeks are long enough to see babies change and grow, for parents to complete projects, and for parents to make connections with other parents.

However, experience from the field also tells us that nine weeks may be too long a commitment for some parents and for some service providers. Therefore having a shorter version of the program would meet various needs. This would require further research to find out what are achievable parenting outcomes for a three or four-session program, what critical parenting skills can be covered in four sessions, and which elements of the learning format should be retained - for example, we agree with Bakermans-Kranenburg\(^2\) that video feedback is an essential tool.

**Gaps between research and practice**

In designing research-based parenting programs, it is a challenge to keep up with the relevant body of literature. Therefore, the research reported on and referred to in the Encyclopedia on Early Childhood Development around attachment intervention is helpful in guiding our design by reinforcing what is widely accepted and by confirming that there are still gaps to be addressed. Day to day, we build on what we know and hope that our innovations will some day be corroborated by research.

Specifically, we have questions regarding the contribution of reflective function to secure attachment, self regulation and the intergenerational transmission of attachment. What are reasonable parenting skills outcomes for a short-term prevention program of nine or even four weeks? Should interventions that focus on behavioural training really supersede interventions that focus on mental states or internal working models? And how might this be different in the way we support lower-risk vs. higher-risk families?

These are some of the questions we hope to see addressed by the experts in the years to come.
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VOICES FROM THE FIELD -
A Parental View on Autism

Frances Mallon, Parent and Resource Teacher, Ontario

(Published online September 16, 2005)

Parental perspective

As the parent of an 11-year-old child with severe autism, I try to review as much of the current literature on autism as I can, especially the papers outlining specific practical interventions and strategies that can help me deal with the many daily struggles surrounding autism. It is also important to be familiar with any information around new services, sources of funding and/or support that may become available. As both a parent and a teacher, I am always interested in the latest etiological articles; however, they are less useful to me in surviving my daily work and home life.

Charman discusses Autism and Its Impact on Child Development, clearly presenting the problems associated with raising a child with autism, the physical, social and societal issues a child will face, and the cost to the family and to society. He reviews the most popular interventions and points out that improvement is now being observed with early intervention. For a parent, this was a good review, short and to the point. The language was not too technical, and it ended on a positive note.

As a resource teacher, I find the information presented by the CEECD succinctly put and feel it would be excellent to distribute to school boards’ Autism Intervention teams (such as the team at the Durham Catholic District School Board) and to other school resource teams. Two key things stand out for me:

1. Charman gives professionals a look into the lives of families living with autism, reminding those on “the outside” that these families experience the high stress of finding financial resources to support their child, and that in many ways, the future looks bleak and hopeless for these children and of course, for their families.

2. The author closes by essentially saying that greater societal acceptance of differences in social engagement and behaviour is required. To me, this serves as a reminder to professionals that these children, mostly boys, are still children. It is incumbent upon us as teachers and resource teams to help these autistic children communicate (for example, by finding voice output devices that speak for them), and to recognize that each child can be reached and we cannot give up looking for an appropriate educational plan for any child.

Stone and Turner’s article Autism and Its Impact on Child Development: Early Effects on Social Development discusses the early symptoms of autism, those present before the
usual age of two years plus at which the diagnosis is made. The authors indicate that early diagnoses can present implications for services of “at-risk” children.

I agree that more services are needed for “at-risk” children, and in fact, families who receive the shocking diagnosis of autism need greater access to information.

I have experienced with my son all the symptoms mentioned in the articles. Having to deal with the lack of sleep (for child and parents alike) and fear of the future hinders the average family’s ability to seek out information on the best way to help their child. When I was beginning this journey with my son, not one professional suggested specific services that I could access to receive assistance and guidance. A lot of praise for being pro-active and best wishes were sent my way as I faced the huge challenge of my son’s behaviour problems. I went about finding services and getting placed on waiting lists that often took many months (two years for Sensory Integration Therapy). If a child is “at risk,” waiting for many months is not the best scenario and falls short of the early intervention ideal to treat or decrease the negative effects of the symptoms of autism.

In the early 1990s, the Internet was not as prevalent as it is now. Today, you can find virtually anything on any topic related, however remotely, to autism. Back then, information about wonderful programs travelled more slowly, from family to family in support groups, sometimes from physicians or community agencies to families. The Autism Symposia were very helpful in providing some direction. However, they were a little overwhelming: you had to be able to take in all the information, assimilate it, and develop your own plan of action to help your child. The book displays at these events also provided information about treatment options.

Even if you can develop a plan or are lucky enough to engage professionals to assist in implementing early interventions, a new problem arises. Suppose a family were to go ahead with the Applied Behavioural Analysis strategy, they would (in the early 1990s) have had to fund it themselves to the best of their ability. Couple this with a nutritional approach, perhaps eliminating gluten or casein from the diet, providing recreational activities involving memberships, joining clubs or leagues, and so on. It is financially ruinous to provide all these services to one child in a family, while going through all the emotional turmoil, fear and exhaustion, as well as maintaining the household on a minimum budget.

So, yes, early intervention is wonderful – the earlier, the better. But as parents, our first step toward intervention must include answers to some questions: Who can provide information to families on how to find out if your child is at risk? Who can help fund the implementation of whatever program is deemed most effective for a child? Who helps the family decide which is the best plan or direction to take? And are there financial strategies in place to help the parents emotionally?

I feel thankful to have survived these last 11 years, doing my best to wade through available information and try to find the right programs to help my son. I also feel thankful that an alert family member recently recognized the signs of exhaustion and burn-out and took the initiative to seek out supports for me and respite opportunities for
my son. The waiting lists for these services are also very long, and some programs are not even taking names because their waiting list is endless. I eventually got my son signed up for bi-monthly weekends. This has been a positive experience, and I would hope all families dealing with such overwhelming issues, especially families with lower functioning autistic children, will have easier access to the same information.
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VOICES FROM THE FIELD -
Intervention in Children with Autism Spectrum Disorder

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Service perspective

Clinicians working with young children with autism rely on the outcomes of intervention research in order to develop best practices in their work. We should be encouraged by research efforts to identify treatments across professional fields that are effective for this population. However, clinicians from all professional disciplines continue to struggle with matching interventions to individual children and families. Making clinical recommendations as to the type, content and intensity of each intervention for each unique child is an ongoing problem. Papers appearing in the online encyclopedia of the Centre of Excellence for Early Childhood Development1-3 review the effects of varied interventions for young children with autism, including social/emotional development, which is of particular interest to front-line clinicians.

An examination of the research cited by Harris1 and by Bruinsma, Koegel and Kern Koegel2 reveals that the field of applied behaviour analysis has contributed the majority of the intervention research in autism. However, the field may be somewhat remiss in the apparent lesser focus on efforts to address improving social competence. More importantly, the method of discrete teaching of social skills, typically with extrinsic motivation, suggests a possible mismatch between method of instruction and desired outcome. A different type of motivation may be needed for some children to participate in social relationships; methods to induce this motivation are still elusive. The challenge of measuring social competence is certainly a contributing factor. Both researchers and clinicians need a structured assessment tool to evaluate social competence that is sensitive enough to capture qualitative changes in children’s social behaviour. Otherwise, we run the risk of being limited to teaching only elements that are easily measurable. The field of speech-language pathology will need to contribute to intervention research more vigorously, especially in the domain of social skills development. Often, the first clinicians to recognize the signs of autism spectrum disorders and begin intervention are speech-language pathologists, the logical agents for teaching social communication skills. Positive outcomes from studies enlisting peers as agents in intervention are promising, but these techniques have yet to materialize in most integrated settings. Harris1 also highlights research on intervention for social/emotional impairments in autism, undoubtedly one of the more complex symptoms of this disorder. Her review documents the challenges involved in measuring social functioning or social competence.
as a discrete outcome. The complexity of this behaviour has likely led to the need to break down skills that contribute to social competence and subsequently teach these skills individually. Operationalizing “social skills” may be a necessary exercise in order to develop goals and measure change. However, teaching social skills as one component of a program for a child with autism may be contributing to the limited generalization and disappointing long-term benefits of discrete social skills teaching. Instead, social competence may be the observable unification of competent communication, imitation and play skills in young children, and not a subset of skills to be addressed separately in an intervention program. Teaching fundamental skills such as communication, imitation and play within the context of social interaction may contribute more to improved social competence and decrease the amount of time required to “teach” generalization. For example, gross motor imitation, if taught in the social context of copying an action in a familiar song, may be more likely to reoccur naturally in the child’s settings (an integrated setting or with parents and other family members). Consequently, the skill is elicited naturally because the social contexts within which these skills are taught are likely to reoccur in the child’s daily settings. Certainly, clinicians agree that there is some need to teach skills in more contrived social contexts, particularly to allow for adequate exposure and practice. When social skills are targeted, then social skills can improve. When communication skills are targeted, these too improve. If, however, communication skills are targeted within the context of social relationships, then children may improve their social competence.

Another body of research reviewed by Harris focused on identifying factors that have a positive impact on the social behaviour of children with autism and strategies that facilitate social interaction and elicit appropriate behaviours in small group or integrated settings. Facilitative strategies such as time delay, environmental arrangement and teaching peers (and others) to persist in their efforts to initiate communication with a child with autism are common clinical strategies used by speech-language pathologists and early interventionists to elicit appropriate social behaviours. Unfortunately, it does not appear that such environmental supports and facilitative strategies are being implemented in the field in a systematic way. It may be necessary to provide more training for front-line workers so that they may use these techniques in their clinical and educational settings and measure their effectiveness.

Of particular note is a strategy described in several research studies suggesting the use of naturally occurring reinforcement to support the development of social competence. These studies reviewed by Hwang and Hughes begin to address the crucial element of intrinsic motivation to socialize. As autism was defined years ago, it may have been necessary to teach social skills using external reinforcers. However, in our current environment it may be beneficial, as the age at time of diagnosis continues to decrease, to strive to teach skills in a social context that is in and of itself reinforcing for the child or becomes so, as relevant associations are fostered. Clinicians may now have a unique opportunity to influence the early development of social communication in children with autism differently than they have in the past.

Parent characteristics that have been identified as enhancing the impact of early intervention primarily include education and optimism. Knowing this positive impact,
the resource network has a responsibility to promote parent competence in interacting with their child with autism and encourage hopefulness for their child’s future. Parents are compelled to gather information about autism very early following a diagnosis. Unfortunately, parents often need to wait for access to services and typically end up forging ahead with their own research, usually on the Internet, which often leads to discouragement, thereby undermining our professional efforts to encourage parents to feel optimistic.

There is a relative dearth of autism intervention research from the field of speech-language pathology. Given that many hallmark features of autism are chiefly within this profession’s scope of practice, the presence of speech-language pathologists in the field of autism intervention research needs to be amplified, taking the lead from respected contributors such as Prizant, Wetherby, Schuler and others.

Szatmari\(^3\) comments that it will only be possible to properly evaluate treatment effects with randomized controlled trials. There is a clear need to gather a large data pool that includes information on child and parent characteristics, effective and facilitative environmental supports, direct teaching methods and the most effective level of intensity of these interventions in order to begin to prescribe appropriate management. The outcomes from these studies will ultimately drive resource designation and impact clinical work. The value of systematic qualitative research, however, will need to be acknowledged as contributory in the area of early intervention in autism until our data pool is large enough to develop hypotheses to drive the trials. This will allow us to make more definitive statements about best practices in the field of autism intervention.
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La Leche League Canada (LLLC) (la lay-chay) and Ligue la Leche are the two Canadian affiliates of La Leche League International (LLLI), providing mother-to-mother services in English and French respectively to thousands of pregnant and breastfeeding women annually. It is from this perspective that we have reviewed the articles on breastfeeding and related topics in the Centre of Excellence for Early Childhood Development online encyclopedia.

Breastfeeding is important to the health of the population even in developed countries and particularly for disadvantaged women and children. Health Canada\(^1\) and the Canadian Paediatric Society\(^2\) recommend exclusive breastfeeding to six months, appropriate introduction of solids and then continued breastfeeding to two years and beyond.

LLLC provides practical help to meet these recommendations. There is much more work to be done to create an environment in which breastfeeding is seen not only as the normal way to feed babies, as stated by Greiner,\(^3\) but also the normal way to nurture babies and young children and to foster the development of the mother-baby relationship.

We were disappointed that breastfeeding was so rarely mentioned in the encyclopedia other than in articles specifically related to feeding. Articles on attachment, prematurity, sleep, crying and early intervention strategies did not seem to recognize that breastfeeding involves distinctly different circumstances for mothers, babies and families than does artificial feeding.

Some articles view breastfeeding as the exception rather than the norm. For example, Woodward and Liberty\(^4\) refer to research showing that breastfed babies have “improved alertness,” “significantly higher scores on the orientation and motor scales,” “better self-regulation,” “fewer abnormal reflexes,” and so on. In reality, these babies are normal, while babies who are not breastfed have decreased alertness, significantly lower scores on orientation and motor scales, more abnormal reflexes, and so on. As Weissinger\(^5\) has observed, language and perspective are important.

Canada has relatively high rates of breastfeeding initiation, but the duration rates are poor and have not changed in years. Disadvantaged women are the least likely to initiate breastfeeding.\(^6\) Therefore, all families will benefit from a more integrated and
interdisciplinary approach to breastfeeding promotion, protection and support, such as the approach called for by Caulfield and in the Breastfeeding Committee for Canada’s Baby-Friendly Initiative in Community Health Services. This approach would bring together a variety of disciplines, such as early child development, nutrition, psychology, health promotion, anthropology, etc., as well as lactation experts and community-based organizations that have learned first-hand how to help women to have successful breastfeeding experiences.

Greiner points out that the evidence for peer support in extending duration is strong. Women need the opportunity to find ways to integrate breastfeeding and parenting. Here are just a few examples of why lactation research and expertise need to be linked with early childhood development research, practice and policy:

- Sleep researchers and practitioners need to be aware of issues such as how brain patterns and behaviours during sleep in a breastfeeding dyad, particularly in a co-sleeping context, are different than for mothers and babies who are not breastfeeding, and that breastfeeding mothers have varying milk storage capacity (not production capacity) that determines how often an infant needs to feed. This should influence the design of research, interventions and policies so they support the breastfeeding relationship, rather than interfering with it.
- Similarly, researchers and practitioners working with crying issues need to understand that the assessment of parental concerns is different if the infant is breastfed. For example, problems in breastfeeding management (such as oversupply, over-active letdown, etc.) may cause or exacerbate crying, yet can usually be resolved with knowledgeable help. In other cases, parents need intervention or coping strategies that preserve breastfeeding.

Gaps described by women between evidence and their experiences:

- Artificial feeding is frequently viewed as equivalent to breastfeeding and although breastfeeding is promoted, women often get little practical help from professionals.
- Despite the value breastfeeding brings to the entire community, mothers feeding their babies in public places are frequently subjected to criticism and negative comments, discouraging not only the mother being criticized, but other women around her.
- Workers outside the health system who provide support to mothers (for example, social workers and child-care providers) may unintentionally give advice or recommendations that negatively affect breastfeeding because they are uninformed. All those who work with pregnant women and mothers of infants or young children should receive training about the value of breastfeeding and basic breastfeeding management.
- Disadvantaged mothers, in particular, often must return to work or school in the early weeks or months after birth; separation can make breastfeeding more difficult. Breastfeeding-supportive policies would provide adequate leave and income to all new mothers in the early months.
The breastfeeding papers in the CEECD encyclopedia review a portion of the extensive research on breastfeeding, and our paper has touched on a few additional points. Increased breastfeeding duration is an important health promotion goal that will result in a healthier child and adult population and significant savings for families and society. Breastfeeding is a complex activity involving two people in an intimate relationship and needs to be recognized as being distinctly different. On behalf of breastfeeding families, we call for a more integrated approach to research, practice and policy development that uses breastfeeding as a lens to guide questions, strategies and policies, and that involves the expertise and experience of community-based organizations and individuals.
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BREASTFEEDING

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VOICES FROM THE FIELD -
Policy Implications of Child Development Research
for Early Childhood Education and Care Policy

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Policy perspective

The CEECD summaries of child-care research are written from the perspective of child care’s impact on child development. Nine prominent researchers sum up research concerned with the use of child care by two age groups; Belsky,1 Howes2 and Owen3, with a commentary by Andersson,4 consider zero to two-year-olds and Ahnert and Lamb5 McCartney,6 Peisner-Feinberg,7 with a commentary by Barnett,8 write about the two-to-five age group. Overall, there are two main conclusions to be drawn from the diverse studies reviewed: one, as Kathleen McCartney concisely notes, “the main conclusion is that the effects of child care are complex” and two, as Barnett comments, “overall, the research reviewed provides support for our hopes while it puts to rest the most serious fears.”

From a policy perspective, it is useful to consider this body of research from several points of view: first, understanding the importance of particular policy contexts; second, within the frame of broader social and family policy; third, considering the care/early education ties; and finally, fully acknowledging social and economic changes in families and gender roles.

First, the context of almost all the papers is primarily the United States, which – while its child development research is much more extensive than other countries’ – is at the low end of the spectrum of social and family policy. The papers summarize contemporary, mostly American, child development research to respond to such key policy questions as: What are the short- and long-term effects of varying quality on child development? Does the age at which child care begins influence development? Are there differential effects of child care on children of different backgrounds?

There are several good examples that illustrate the importance of understanding the context in order to be able to interpret research. For example, most of the papers’ data about the labour force participation of mothers of young children (pertinent to the question about the age of entry to child care) are from the U.S., and Belsky comments that “a growing number of children seem to be spending more and more time at younger ages in child care arrangements.” While the National Institutes of Child Health and Child Development (NICHD) study found that 72.8% of children were in child care
before the age of six months, and 58.1% by the age of three months, the Canadian trend is quite different. In the past few years, fewer very young Canadian children have been in child care, as the extension of paid maternity/parental leave to one year in 2000 has encouraged longer leaves. The proportion of Canadian women returning to work after about a year has jumped from 8% to 47%, with more fathers likely to take leave as well.

In another context-specific point, Belsky comments that “placing children in an average nonmaternal care facility for long hours does seem to be associated with some (modest) developmental risk.” Here it is important to be specific about the term “average.” The quality of “average” child care in the U.S. appears to be quite different from average child care in Sweden and different even from Canada where, while research finds that centre-based child care is often less than exemplary, it is still less likely to be very poor quality (using the same measures) than American child-care centres.

The point here is not that the research findings are not valuable but that – as Andersson, a Swede, emphasizes in his paper - the social/economic/policy context needs to be taken into account when drawing conclusions.

Second, as Canadian social policy groups such as Campaign 2000 and Canadian Policy Research Networks (CPRN) have described, a social program like child care is best considered as part of a larger “mix” of social and family policy. This is alluded to several times in the papers, for example by Belsky, who proposes “that parental leave be extended (and preferably paid) to mark the duration provided in some Scandinavian countries.” But discussion of concern about very long hours of child care as a possible risk factor could well include consideration of why parents work such long hours in North America. Labour policies such as minimum wages, legislated hours of work and length of holidays; income-security programs such as child benefits; flexible and well-supported leave provisions for child illness or to permit part-time work (as in Sweden); and policy-driven efforts to address work/family balance issues are all part of broader social and family policy, of which child care is but one part (albeit an essential and central part).

A third policy-related perspective on child care is that the dual purpose of high quality child care – enabling parents to work and providing educational/social activities for children – is now well accepted; indeed, “child care” is often called “early childhood education and care” (ECEC). Barnett’s paper addresses this issue. He points out that “even children whose mothers are not in paid employment also commonly participate in similar arrangements” and that attendance for much of the day is nearly universal in some countries by age three. This point is very pertinent to any discussion of “quality” as it is hard to argue that poor or inadequate quality child care provides early childhood education. Generally, while all the papers consider the social and cognitive benefits of high quality child care, they tend to concentrate much more on the “care” part of the picture than on the “education.” Barnett links “an inadequate appreciation of the educative function of child care” to the reluctance of some governments to assume responsibility for it. In a country like Canada, which – like the United States – has two
separate policy and program streams for “care” and “education,” with the “care” stream garnering poor government support, this perspective is very pertinent.

Finally, one of the most salient points almost all the papers make from a policy perspective is that mothers of young children in all countries are in the paid labour force in large numbers – even higher proportions in Canada than in the United States. While at one time it was fairly well established that mothers were the primary caregivers and educators of young children, economic circumstances and social norms have changed, so that it is unlikely that large numbers of mothers will go back into the home to care for young children on a full-time basis. But some countries have not yet worked out new mechanisms, institutions or social arrangements to provide what mothers and families once provided on their own.

The research presented in these papers makes it apparent that – while the details may be complex – much is known about the effects of child care and the factors associated with its effects. High quality child care, provided by well-educated, sensitive early childhood educators, well-supported and accompanied by a good mix of other family policies, is a benefit, not a danger, to the social and cognitive development of children across the economic spectrum. As McCartney points out, “child care is now an ordinary part of life for children in most western countries.” The key policy challenge is to take the knowledge from the research presented in these papers and put it into practices and public policies that ensure that the effects of child care on children and families are the best they can be.
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VOICES FROM THE FIELD -
Child Care and Young Children: A Practitioner’s View

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Service perspective

The research findings of the CEECD papers1-8 confirm that demand for child care continues to escalate for all age groups. More and more mothers participate in the workforce at increasingly earlier points in their child’s life. However, the availability of regulated child care continues to lag far behind the supply. The development of new spaces has been painfully slow, inconsistent and uneven in Canada. For example, the Quebec government has taken the lead by significantly expanding spaces with the goal of universal accessibility for all children regardless of reason for service. The province of Manitoba has developed a Five Year Plan for Child Care (2002), designed to enhance three major elements: quality, accessibility and affordability. Child care appears to be on the upswing again in Ontario. In early 2004, the Ontario government announced it will spend $9.6M in federal child-care money to help cash-starved daycare centres make health and safety improvements. But some provinces, such as British Columbia, have experienced serious reductions in government funding at a time when the need is greater than ever and early childhood development is a hot topic.

We are miles away from universal access, but the scope of the gap becomes more clear when we also consider the ever widening range of service needs: for children with disabilities, part-time care, evenings, weekends, seasonal needs of farm families, on reserve programs, military families deployed for months at a time, and those in isolated communities. Parents of children with disabilities continue to need child care long past the age of 12. There is much pressure on facilities to extend hours, expand spaces and be flexible. But this is not easily, cheaply or quickly accomplished when dollars are scarce, the workforce is depleted, and government funding policies may lead to a loss of revenue to the centre or family child-care provider that provides flexibility.

The importance of quality child care is a strong and consistent theme throughout all the CEECD papers.1-8 There is consensus that quality, positive child-care experiences can enhance child development. But research shows that high-quality child care is in short supply, accounting for only 10 to 15% of child care available in the United States.2 This is also the case in Canada. You Bet I Care, Caring and Learning Environments: Quality in Child Care Centres Across Canada states that “the majority of the centres in Canada are providing care that is of minimal to mediocre quality. Fewer than half of the preschool rooms (43%) and slightly more than a quarter of the infant/toddler rooms
(28.7%) are also providing activities and materials that support and encourage children’s development.” 9 Steven Barnett says that “quality of care is frequently low, and the primary reason is the relatively high cost of quality.” 8 This is absolutely true. Too many licensed programs struggle with inadequate and unstable funding that never stretches far enough to enable fair wages and benefits, well trained and resourced caregivers, a developmentally stimulating program and a physical space designed/adapted/suitable for early child-care education (ECCE). In my opinion, we are not going to improve quality until we resolve the underlying issues that make it difficult to attract and retain a skilled child-care workforce, including those who provide family child care.

There are several gaps in research, practice and policy that would foster better child-care service delivery. Several of the CEECD papers mention the lack of longitudinal data for child outcomes2,4,7 and the need to better define and disseminate information about quality.2 This is true, but we also lack current data about the existing system of child care as a service or a profession. We are trying to build a universal, accessible, quality system, identify priorities, make recommendations, yet all too often we are forced to guess because we don’t have the information we need when we need it. For example, we know we need “more” child care, but how much more? Which areas are most underserved? What is “affordable” child care? The Canadian National Child Care Study (CNCCS) included a parent component administered to a sample of Canadian economic families with children under the age of 13. 10 Approximately one in every 90 Canadian households was included in the CNCCS sample. But those data are well over a decade old and therefore useless in planning for the child-care system of a new millennium. The You Bet I Care project, a comprehensive study on quality and wages, working conditions and practices in centres and family child-care homes (1991 and 1998), is now also dated.9 Most of our Canadian research is short-term and project-funded; it does not re-occur often enough to paint a picture of the Canadian context or provide enough basic information for advocates and stakeholders to use in our day-to-day work.

Political will is often a huge factor in whether child-care programs blossom, float or sink. Child-care advocates, eyes focused primarily on the licensed sector, have been lobbying provincial and federal governments for decades to provide the kind of leadership and funding and infrastructure that will enable practice and policy to reflect current research. Even the smallest bit of positive change was likely preceded by hours of meetings, much lobbying, many rallies, mountains of letters, petitions, campaigning and leading of the charge. We lobby for regulation and ongoing improvements to regulation as better practices and methodologies are uncovered. We lobby on behalf of families for new spaces, for better benefits, wages, working conditions and accessible ECCE training for the workforce. Then we lobby for post-diploma programs and funding support for tuition.

Child-care organizations and associations, mostly small, membership- or project-funded with shoestring budgets, led primarily by volunteers, strive to get and keep child-care funding dollars flowing, raise awareness of quality indicators, keep members informed of new research and trends, do public education, produce resource materials and provide formal and informal training opportunities through workshops, conferences and institutes. It is increasingly difficult to find volunteers to participate in advocacy, and registered
charities now put their status at risk if heavily engaged in advocacy. In order to really get and keep child care on the policy agenda as the centrepiece of early childhood development initiatives, new and more powerful voices from academia, research and business must be recruited as active and ongoing partners.

It’s past time to embed the integrated principle of early childhood care and education for children aged 0 to 12 years into the infrastructure of our country. Let’s get on with the implementation of national guidelines for service delivery; develop a nation-wide accreditation program for training institutions and child-care facilities and certification of administrators and practitioners; and infuse real money into a universal system in which all children receive the very highest quality of early childhood care and education.
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VOICES FROM THE FIELD
Early Learning Care and Education:
Applying an Integrated Approach

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Service perspective

Why integrate child care and school? The evidence is clear. OECD’s report, *Starting Strong II: Early Childhood Education and Care* suggests governments should provide a more coherent system of early childhood services to working parents. This suggestion is based in research that indicates countries that integrate their care and education services for children under one ministry or agency generally achieve more coordinated and goal-oriented services of higher quality for young children aged birth to 6 years. The immediate and lasting positive effects of quality child care on language, cognitive development and school achievement are proven by numerous findings from longitudinal studies as well as smaller trials with long-term follow-ups.

Why then in Canada as well as many other liberal economic nations, is there a split management approach to early learning?

The split-management approach stems from a common history amongst Anglo-American countries which established two different kinds of “care” and “education” systems for young children. In the 18th century child care institutions were established for abandoned or neglected young children as a social protection measure. In the 19th century, “infant schools” were established which served more affluent families and their desire to provide early learning opportunities for their children outside the home environment.

After women joined the workforce in large numbers during and after World War II, there was an increased need for child care. These children were not abandoned or neglected but were in need of quality care due to mothers working outside the home. Parents are now interested in combining the two elements of “care” and “learning.” While governments in the Scandinavian countries adapted child care to the changing needs of parents to combine care and education, many other developed nations kept the differentiation between care and education. Instead of following the Scandinavian example and establishing a central governing body for care and education of young children, the care fell under the supervision of a Social Welfare or Health Departments while the education of older children (3-5 year olds) was the responsibility of Education Departments.
While a new integrated sector has emerged across Europe, Canada lags behind. A reason for this stems from the government’s view that early learning and child care is a private responsibility for parents. Is it the states’ responsibility to provide pre-school education or is it a private responsibility of parents? The government’s response to that question paved the way for how each country decides to deal with the care and education of its youngest citizens. While many countries are under the influence of an integrated system that better supports life-long learning, Canada has not made a significant national move on this issue. Lack of national leadership has a lot to do with the fact that education and child care are under the mandates of each provincial government. The result of the existing fragmentation of services and lack of coherence for children and families is evident in Canada’s patchwork approach to early learning.

There are a few examples of integrated systems which are starting up across the country. For example, in Ontario, a new program called “Full Day Learning” will be scaled up by 2015 for all 4- and 5-year-olds. This integrated model will have Early Childhood Educators working together with Kindergarten teachers to address the care and learning of a group of children.

While the English school boards in Ontario are getting ready to implement this model, it is important to note that all of Ontario’s French-language school boards already offer full-time early childhood education programs in French. This integrated approach of full day learning for 4- and 5-year olds was built upon the belief that the earlier children are exposed to French, the greater the likelihood that they will acquire and develop strong language skills. Integral to their approach is building and maintaining close links between existing French-language day cares and French-language schools, improving the quality of the delivery of full-time early childhood education programs, and meeting the need for high quality materials and resources to support learning are the key interventions in aménagement linguistique for young children.

There have been successful pilots of this approach in Ontario. One such pilot is the Toronto First Duty (TFD) project. The project began in 2001 with broad child development and parenting support goals and a vision of universally available, integrated early childhood services. In terms of achievements, comparisons across the implementation period showed that progress was made in each of the five sites on service integration as well as on program quality improvement. There was also evidence of positive effects on children’s socio-emotional development and on parents’ engagement with school and learning, using comparisons with matched communities without TFD programs.

In another province, Prince Edward Island, a full day of learning approach that integrates early learning and care with the education system is also underway. Prince Edward Island will offer a full-day, school-based kindergarten program in 2010. A Kindergarten Transition Team is now working to transfer the program from the community to the school system. The team includes representatives of the Department of Education, school boards, and early childhood sector and partner groups.
In Quebec, there has been a lot of government support for early learning. This is evident in the subsidizing of child care spaces across the province which brought down the fees to $7 per day for parents. At this point, this support for early learning has not transferred to a system of integration for the early learning sector and the education system. Children in Quebec are not required to attend school until the age of six. Prior to school age, the majority of them are in child care settings.

In order to see significant progress towards an integrated system, there must be leadership at the top, within all levels of government. Children’s rights advocates in Canada have called for a national commissioner for children. A National Children’s Commissioner as a focal point for children at the national level was also one of the recommendations in the Senate’s 2007 study of children’s rights in Canada, entitled Children: the Silenced Citizens. As well as taking on issues such as the rights of children, this office could assist with pulling together a national framework that could lead the way for nationwide integration of the early learning and care approach within the education system.

How long will it take nations like Canada to adopt a fully integrated system? That is a difficult question to answer. In the meantime, there are significant steps being made which will provide Canadian specific data and research on the reasons why supporting this approach should be undertaken.

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VOICE FROM THE FIELD -
Pediatric Feeding Disorders: The View from One Clinical Setting

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Service perspective

The CEECD reviews1-5 on eating behaviour in young children, taken collectively, do an excellent job of covering the breadth of issues in this field. They confirm the progress that has been made over the last two decades in raising general awareness of the importance of eating behaviour in young children as a health concern and the progress that has been made in the biopsychosocial6 framework that underpins current treatments when problems arise. They also highlight nicely the challenges that face the field. Benoit’s caution that the field of feeding problems in infants and young children is still plagued by “inconsistent definitions, differing and essentially non-validated diagnostic and conceptual frameworks and inconsistent methodologies”1 should be kept in mind by anyone reading the literature or working in this area.

This problem is particularly evident in discussions on the general incidence of feeding problems in which the data cited are typically 20 to 25 years old and the research was conducted with essentially non-validated and differing definitions. It is understandable that investigators do this because at the current time there is simply no better information. Canadian pediatric tertiary-care centres have responsibility for the health of the infants, children and adolescents living within their catchment area. Accepting that health-care dollars will continue to be scarce, if rational decisions are to be made in terms of the allocation of resources, then we need to have a better understanding of the numbers of children with specific types of feeding issues. For example, Black2 in her review focuses on the development of healthy eating styles for children in the general population in order to prevent the myriad of health issues that arise from obesity. The overall cost for society of the “obesity epidemic” is projected to be massive,7, 8 and thus an ounce of prevention may save considerable money in the long term for provincial health-care budgets. At the same time, Piazza4 presents data suggesting that successful intensive behavioural intervention for children to wean them from tube feeds results in a net cost savings. While in an ideal world both initiatives would be funded, the reality on the front lines is that choices on where to allocate scarce resources are having to be made. Having more accurate information on the incidence and natural course of feeding issues, both in the medically vulnerable and in the general, currently healthy populations, would be helpful in guiding the development of services.

In terms of promoting healthy eating behaviour in the general population, Black2 presents a constructive overview, calling for research into why children have selective food
preferences (the “picky” eaters). A recent longitudinal study found that children’s food preferences varied considerably across food groups, with children liking more than 75% of breads, pastas and desserts, but less than half of the vegetables or meat alternatives. Food preferences were formed early and remained surprisingly stable, with little change observed between the ages of two and eight. Importantly, children enjoyed a wider variety of vegetables as infants than during the toddler or pre-school years. This has focused attention on the toddler years and the transition to independent eating of regular table foods. We clearly need to know more about this specific transition period so that effective interventions can be designed for the general public. Burklow’s comments in this regard that “feeding programs need to collaborate with community programs” and “these primary intervention efforts need to be empirically tested” are quite convincing.

In terms of the severe end of the spectrum (children who are medically vulnerable and require prolonged tube feeding), Ramsay suggests that a key research question is “how effective are behavioural interventions for severe problematic feeding behaviours in medically ill infants?” I would refine that question, since numerous individual studies, as summarized in the CEECD review by Piazza and more systematically by Kerwin, have demonstrated that behavioural interventions are effective for severe feeding problems. Behavioural interventions, however, are not effective for all children. Research needs to look at the factors associated with unsuccessful treatment — is it because there are underlying physical issues involving the basic appetite mechanism of these children, as Ramsay’s paper suggests, or are there aspects of behavioural treatment that make transfer of behavioural strategies into the home setting difficult for some families? Burklow’s paper presents a series of questions in this regard, such as the impact of behavioural interventions on relationships within the family unit, that now need to be explored.

Establishing intensive behavioural interventions for severe feeding problems has been and will remain problematic for Canadian institutions for several reasons. First, there is the problem of “economy of scale.” Piazza does not provide the specific details behind her cost estimates for the intensive treatment of feeding problems; however, the figures would inevitably be dependent on questions of scale (i.e. how many children can the program treat during a year and are those children “available” for treatment). Intensive feeding programs based in the United States, like the one at the Kennedy Krieger Institute in Baltimore, literally draw pediatric patients from all over the U.S. and the world and thus have no problem maintaining a patient pool that makes intensive feeding programs economically viable. Given the population difference between the U.S. and Canada, it is unlikely that the incidence of severe feeding problems would be high enough for many parts of Canada to make the establishment of such intensive feeding programs feasible. Therefore, Burklow’s recommendation that “for children who require intensive feeding treatment, additional models of treatment need to be explored” is particularly important for Canadian service delivery.

Secondly, most Canadian university graduates of clinical training programs in psychology are well schooled in the cognitive-behavioural framework, but the emphasis is generally on the “cognitive” part, with graduates having relatively little experience applying the behavioural techniques of shaping and contingent consequences with the developmentally young. With the increasing recognition of applied behavioural analysis
as the treatment of choice in the early intervention for autistic spectrum disorders, this
may eventually expand the training models in some programs, but it will still be years
before this would have an impact on service delivery.

On a closing note, in their CEECD reviews Benoit and Ramsay both stress the need for
the continued development of interdisciplinary feeding teams and the training of experts
in the field of pediatric feeding disorders as important policy priorities. If we are ever to
overcome the problem of “inconsistent definitions, differing and essentially non-validated
diagnostic and conceptual frameworks and inconsistent methodologies,” however, then
policy must also include a mechanism to bring Canadian professionals together to discuss
and resolve these inconsistencies and differences; to facilitate multi-centre studies that
can answer key research questions; and to form advocacy strategies so that this important
area of child development can receive the necessary government and public support.
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VOICES FROM THE FIELD -
A Perspective from a Treatment Program for
Children with Eating Disorders

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Policy perspective

Eating behaviours and feeding disorders are important topics in child development. Policies relating to these issues have broad social implications. Of particular interest is Black’s paper on helping children develop healthy eating habits, which outlines factors that are important in the development of healthy eating. Most useful is how the environment and the eating relationship affect the acquisition of healthy eating habits. It is important that policies are developed to make this information available and easy to implement. This research not only has the potential to prevent feeding difficulties, but can also help us as a society to optimize the growth and development of our children.

Reading the expert reviews on feeding disorders, I am struck by a number of issues. Foremost is how little we understand about a human behaviour that is universal and which carries with it social and cultural significance. While empirically supported treatments exist, they all rely on a behavioural model. What about the children or families who cannot make use of this model? Why are there so few validated treatment options? It may be that, as Benoit states, despite how commonplace they are, the complexity of feeding and eating problems in childhood is partly responsible. Policy is required that supports the development of a wider range of treatment options and furthers our understanding of who will benefit from which treatment models.

Even in subject areas where a lot of information exists, we struggle to see that this information is disseminated in both professional and public arenas. For example, we know a great deal about normal growth and development and how to monitor these over time. We have standardized growth curves that are easily available and yet, in my experience, are rarely used. Very few community physicians keep growth curves on their patients. In our eating disorder treatment program, we ask for growth curves on every child referred and are not surprised to notice that less than a quarter of the patients we see have had their growth and development charted on a growth curve – the easiest and cheapest way to detect abnormalities in weight and height. This is of particular concern in light of the discussion in the expert articles, which argue for a simple screening tool for feeding difficulties. Clearly, we need to explore ways of motivating health-care providers to implement existing tools as well as working on developing new ones.
In the public arena, particularly among parents, disseminating information about healthy eating and the feeding relationship is paramount. While public-health agencies work hard to inform and educate families, our society is constantly battered by misinformation. We are surrounded by “experts” who write books about the “right” way to eat, and all of a sudden “right” means low-carbohydrate or low-fat. How does this misinformation affect parents’ choices when feeding their children? At our clinic, it is not uncommon to see this misinformation in action. Most parents initially believe that their child’s weight loss is healthy, that being thin is good; they have absorbed a message our society sends out clearly, “you can never be too thin.” This can delay detection of serious eating problems and as a result may affect a child’s long-term outcome.

As a society, we also need more than just information. We need to consider how we live our daily lives. In North America, in a time of dual-income families, where everyone is harried, fast food may be irresistible. Is there no way to make fast food a healthy option? Policy-makers should consider social structures that need to be influenced to allow parents the time and the options that allow for healthy eating.

We also need to consider whether the line between feeding disorders and eating disorders is blurring. Children as young as five and six years old – an age group that traditionally would only have seen feeding disorders – are being diagnosed with disordered eating (such as anorexia nervosa and bulimia). Can a child with a feeding disorder become a child with an eating disorder if they are rewarded with admiration for their slender physique? Disordered eating behaviours have over time become quite common in adolescents and older children. Is it only a matter of time before they become common in younger children as well? The research in the overlap of disorders in this age range is sparse. We need to support research in this area and allow it to inform policy development so that we can protect our children from the onslaught of eating disorders.

Finally, when developing policy, we will have to be careful as a society that our attempts to prevent or address one condition do not support the development of another. For example, when focusing on informing the public on the “dangers of obesity,” a state that comes with no scientifically proven solution and that for some is a healthy state, we risk creating a cultural obsession with thinness that confuses parents and children alike and influences our relationships with food in an unhelpful way. Will panic over the alleged obesity epidemic bring about a feeding disorder or an eating disorder epidemic? We require policy that explores these issues and helps us develop effective, sensitive policy that does not carry with it unwanted side effects.

In conclusion, the expert articles are helpful in summarizing what we know about how to develop healthy eating habits in children. However, they also highlight the large gaps that exist in research, treatment development and policy. Our initial steps should support research and then move to a coherent, validated prevention and treatment implementation model. I am optimistic that moving forward in a careful and gradual fashion will get us to the desired outcome.
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VOICES FROM THE FIELD -
Reflections on Practice in the Field of FASD

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Service perspective

The introduction to the CEECD synthesis on the topic of Fetal Alcohol Spectrum Disorders (FASD) describes it as an “avoidable” or “preventable” birth defect. These descriptors imply that if a woman does not drink alcohol during her pregnancy, she will not have a child with this disability. It does not necessarily follow that it is possible to prevent alcohol intake during pregnancy. If we acknowledge that 82% of women of childbearing years drink alcohol and most women generally do not plan their pregnancies, then it is unlikely that FASD can be totally prevented. Many women can stop drinking once their pregnancy is confirmed; however, some cannot. Given that women drink to cope with the experience of poverty, childhood abuse, violence, isolation and other painful life situations, and that messages about alcohol use during pregnancy are inconsistent, we need to understand that we are “swimming upstream” with our awareness and prevention campaigns.

It is certainly our experience that services for the birth-to-five population are limited. However, there are more services given to this younger age group than to children over the age of six or to adults. Services for individuals past the age of six are almost non-existent. It is my impression that in Canada, we put a great deal of emphasis on early intervention services that are delivered until age six and then terminated. It seems we believe that if intervention occurs early enough, potential deficits in functioning will be avoided and existing problems can be eliminated. Yet the research in this field indicates that FASD is a lifelong disability and therefore, support and intervention services need to be available over the lifespan.

Riley’s comments on community screening for FAS raise the issue of voluntary versus mandated involvement in screening programs and follow-up services. Women often voice their fears about having child welfare agencies remove their children if they are identified as using alcohol during pregnancy. For this reason, many parents may be reluctant to give permission for the screening of their children. Further to this, Riley indicates that screening that doesn’t lead to diagnosis is of limited usefulness. I would add to this that screening or diagnosis without intervention services to which families can be referred has ethical implications. Families believe that a diagnosis will open the door to services for their children. Without ongoing intervention services, families are left with limited education and little support for understanding the complex nature of the disability.
We have learned that intervention programs need to be structured to meet the needs identified by families. They require flexible, confidential, tangible support services with voluntary participation. Intervention extends beyond the family unit to reach the larger service system surrounding them. It really needs to be multi-systemic to prevent secondary disabilities. Most families, extended families, schools, daycares and other community agencies know very little about FASD and how to intervene. Yet the avoidance of secondary disabilities depends on the education of those who comprise the child’s world and the quality of their intervention. We have learned that education and advocacy work with all the systems surrounding the individual, such as school, daycare, income assistance and other organizations involved with the child and family, requires twice the amount of time spent in direct contact with the family. The level of involvement with all the various systems requires lower caseloads than most agencies are prepared to embrace.

I agree with Cole’s comments on the need to evaluate the effectiveness of existing programs and services. When developing our intervention program, we extrapolated from Sterling Clarren’s* concept of the “external brain.” Many of our intervention strategies recognize the organic brain differences associated with the disability and, in the words of Diane Malbin*, “try differently rather than harder.” We focus on changing the environment surrounding the individual to accommodate to them. Our intervention looks at adapting environments by building in memory, creating predictable routines, adjusting expectations and teaching about the strengths and challenges of each child. Simultaneously, we assess the sensory integration of the child and provide remedial intervention. (Remediation is usually focused on changing the environment surrounding the child.)

We have learned that the education and advocacy components of intervention services in the field of FASD are not usually identified, yet they are an absolutely essential component and of primary importance when trying to avoid secondary disabilities. We know that secondary disabilities occur because the central people in each child’s life lack an understanding of the neurobehavioural impact of prenatal exposure to alcohol. In our experience, people learn about the disability over time and need to be given bite-sized chunks of information as they can digest it. This has implications for the length of time an intervention program is available to a child, their family and the multiple systems surrounding them.

Parents need a partner to walk them through the process of educating the child’s world about the disability. Parents soon burn out when repeatedly faced with educating the same school system, the same daycare, facing intolerant systems that punitively address their child’s behaviour. Every time there is another transition in the family and child’s life, there is an enormous educational component attached to the transition.

There is general consensus that much research still remains to be done in the field of FASD. In my opinion, however, the research is substantial and years ahead of policy to address this issue at the local or regional level or the availability of service programs. In spite of the “lifelong” impact of FASD, many affected individuals cannot access existing disability services. They are ineligible for educational supports in the school unless their
behaviour is extreme. The family is not eligible for respite services unless their child’s Developmental Quotient is below a certain level. In addition, most service programs designed to address FASD specifically are still “experimental” in design and predominantly funded as pilot projects, without long-term funding commitments. There appears to be very little political will to fund programs to meet the needs of this population.

* Dr. Sterling K. Clarren, MD, Professor of Pediatrics and currently the medical doctor for the University of Washington FAS Diagnostic and Prevention Network Clinic and Director of Infant Inpatient Services for Children’s Hospital and Regional Medical Center.

* Diane Malbin, MSW, clinical social worker, program developer and consultant who provides information and services for individuals, families and agencies. She works for FASCETS (Fetal Alcohol Syndrome Consultation, Education and Training Services, Inc.), Portland, Oregon.
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VOICES FROM THE FIELD
Head Start Policy

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Service Perspective

In Saskatchewan, Head Start is currently available in 79 distinct First Nations communities. Each one serves only about 15 children and is run with the unique needs of the community it serves in mind. In this light, these Head Start programs differ significantly from the large, often multicultural Head Start programs typically seen in major U.S. cities. The CEECD Encyclopedia articles on Head Start policy focus on research done in the Head Start programs based in large, disadvantaged urban centres. Still, they do offer some insight that can be useful for programs based in small Saskatchewan First Nation communities.

The CEECD Encyclopedia articles are encouraging in that they provide empirical evidence for what many workers in the field know instinctively to be true – that the Head Start programs are cost effective and offer positive long-term results. Zigler also highlights the fact that it is difficult to produce meaningful, multifaceted, long-term change with only a few months of intervention, which is information field workers can bring to policy makers to support requests for funding for extended programs. Currently, Saskatchewan Head Start programs in small First Nations communities offer only a one-year program for children aged three, but a future goal is to expand it to a two-year program that would serve children starting at a younger age.

Importantly, in small Saskatchewan communities consisting primarily of First Nations people, the goals of the Head Start programs differ from those set up in large urban centres. Poverty is not necessarily the only or even primary concern. Rather, preserving culture and language are key mandates. Also, the programs focus not only on the direct needs of the children they serve but also the adults’ needs in the community who care for these children.

Gaps between research, policy and practice
The Head Start programs serving First Nations communities in Saskatchewan employ members of the community, often the parents or relatives of the children who participate in the programs. The programs, therefore, serve as an employer as well as a resource for teaching parents and other caregivers healthy and appropriate life and parenting skills. These programs also act as a hub for providing families with other services and a
screening tool for early identification of children with special needs. These key benefits are not discussed in any of the CEECD papers.

Still, many of the CEECD Encyclopedia papers do cover some of the challenges faced in small Saskatchewan Head Start programs. These include proper teacher training for small and often remote and isolated communities, and the need for funds to pay well-trained professionals.\textsuperscript{1,3} Currently, the staff at each Saskatchewan Head Start program require at least a one-year certificate or two-year diploma in early childhood development, but ideally the minimum requirement would be a bachelor’s degree.

The CEECD Encyclopedia papers provide a summary and critique of the various assessments of Head Start programs and policies conducted to date.\textsuperscript{1,2} While the studies themselves have been conducted on Head Start programs that differ dramatically from those serving First Nations Communities in Saskatchewan, the critique of the studies provides insight on how such assessments should be conducted in any community. In Saskatchewan, the tracking process for the benefits of Head Start programs consists primarily of parents filling out short questionnaires and has yielded positive feedback to date. Informal qualitative feedback from parents and teachers has also been positive. A more formal analysis of the benefits of these programs, however, would be beneficial for setting future goals and directing policy. The CEECD Encyclopedia papers suggest that such an analysis is complex and requires a certain level of expertise.\textsuperscript{1,2,3} The Canadian government could take the lead on implementing such research in partnership with First Nations (participatory action research), as they have access to the appropriate expertise and resources.

When tracking the benefits of Head Start programs serving First Nations communities in Saskatchewan, it is important for researchers to understand the communities’ focus on the whole child as part of a multigenerational community. Assessing benefits should include such factors as culture and language retention as well as the improved health status of children, their parents and their community. Documented evidence of benefits such as these is helpful for attaining community support and government funding. Narrow outcomes such as school readiness simply do not capture many of the important features of programs aimed at small First Nations communities.

Comments recorded by Alison Palkhivala
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Policy perspective

There are now home visiting programs in virtually every jurisdiction across Canada. As in the United States, many of these programs emerged out of pressing policy needs to prevent child maltreatment. Policy-makers are continually challenged to make decisions based on limited evidence, frequently in the absence of rigorous evidence. For example, results from an early evaluation of the Hawaii Healthy Start program were sufficient for the Hawaii state legislature to implement the program across the state, despite the lack of a comparison group in the evaluation. This pattern of policy-making, which has been common in the history of home visiting, reflects an ongoing tension between advocacy and science.

There is now considerable evidence on the effects of home visiting studied under optimal research conditions (i.e. efficacy), including the randomized trials and longitudinal follow-up studies of Olds, Kitzman and colleagues. More importantly for policy, there is also emerging evidence of the effects of home visiting studied under real-world conditions of service delivery (i.e. effectiveness), including the randomized trials of Early Head Start and Hawaii Healthy Start.

This Encyclopedia of Early Childhood Development contains research summaries by Kitzman, Olds, and Zercher and Spiker, as well as a commentary by Daro. These four papers by pioneers in the field provide a good overview of major recent research findings on home visiting and their implications for policy and practice. The present paper builds on the foregoing by focusing on (a) current gaps in home visiting research; (b) current challenges for home visiting across Canada; and (c) opportunities for home visiting across Canada, with recommendations for future research and evaluation to improve policy and practice, and ultimately the real-world effectiveness of home visiting across Canada.

What We Need to Know: Current Gaps in Home Visiting Research

Effectiveness of home visiting: Recent meta-analyses of efficacy studies provide important information to policy-makers in terms of what can be expected from home visiting programs and the magnitude and durability of effects. However, far less is
known about the effectiveness of home visiting in real-world service delivery settings across different jurisdictions, as discussed in the summaries by Kitzman, Olds, Zercher and Spiker, and Daro.\textsuperscript{17,18,19,20}

**Effective ingredients of home visiting:** In light of extensive efficacy evidence on home visiting, there is growing consensus that the field must now move from asking whether early childhood intervention works to asking how it works.\textsuperscript{21,22,23,24,25,26} As discussed by Kitzman\textsuperscript{17} and Zercher and Spiker,\textsuperscript{19} we must identify the effective or “active” ingredients of home visiting. One of the most promising lines of research focuses on the working relationship or alliance between parent and home visitor,\textsuperscript{21,23,24,27} as discussed by Kitzman.\textsuperscript{17}

**Cost-effectiveness of home visiting:** The relative costs and benefits of home visiting studied under optimal research conditions (i.e. cost-efficacy studies) suggest that, in general, the benefits of home visiting outweigh the costs.\textsuperscript{28} It is important to provide policy-makers with information on the relative costs and benefits of home visiting studied under real-world conditions of service delivery (i.e. cost-effectiveness studies), especially amid rising public concerns about government accountability and the public return on public investments. Basic questions of “how much” and “for how long” are foremost in the minds of decision-makers when allocating resources to accomplish policy goals, especially those as complex as facilitating healthy ECD. As Zercher and Spiker note,\textsuperscript{19} home visiting has not fulfilled earlier expectations of a low-cost solution to pressing societal problems. Nonetheless, current public investments in home visiting and other ECD programs are relatively minor compared to the costs of major societal problems such as child abuse, which costs Canada an estimated $15 billion per year.\textsuperscript{29}

**What We Face: Current Challenges for Home Visiting across Canada**

**The human resource challenge:** As the debate on the relative efficacy and effectiveness of paraprofessional vs. professional approaches to home visiting continues (briefly discussed in the summary by Olds\textsuperscript{18}), policy-makers face the perennial demand-supply challenge of human needs vs. human resources.\textsuperscript{30} Consider, for example, the policy goal of preventing child maltreatment. Researchers have been critical of Canada’s failure to implement evidence-based programs for children.\textsuperscript{31} What if policy-makers decided to implement a nurse home visiting program across Canada? In terms of need or demand, conservative estimates of various forms of child maltreatment (under age six) from recent prevalence studies range from 45 to 860 per 100,000.\textsuperscript{32,33,34} In contrast, in terms of the human resources supply, there are only 754 nurses per 100,000.\textsuperscript{35} Community health nurses – perhaps the most appropriate subgroup of nurses to provide home visiting – represent a mere 68 per 100,000.\textsuperscript{35} Given the magnitude of need, there simply will never be enough nurses to meet this demand, even if all existing nurses were redirected from clinical services (e.g. emergency care, long-term care) to this prevention effort.

This human resource challenge is not unique to home visiting. It applies more broadly to all human services, especially those where demand exceeds supply by several orders of magnitude (e.g. mental health). This demand-supply imbalance highlights the policy imperative to reduce the size of the population that requires clinical services through effective universal and targeted programs.\textsuperscript{36} While debates regarding universal vs.
targeted approaches continue, the reality is that most home visiting programs are targeted. Yet most programs cannot effectively target families at risk for childhood maltreatment. Investments in effective universal programs are therefore a top policy priority.

The challenge of negative effect: Infrequently discussed in the early childhood intervention literature is the issue of negative effects (for exceptions, see references 40 and 41). For example, the unintended, unfavourable effects of home visiting for the highest-risk participants in the randomized effectiveness trials of Early Head Start and Hawaii Healthy Start stand in sharp contrast to results from the randomized efficacy trials of Olds and colleagues, where the highest-risk participants appeared to benefit the most from home visiting. The Olds results are similar to the results of other well-known randomized efficacy trials, including the Carolina Abecedarian Program and High/Scope Perry Preschool Program, which both focused on very high-risk samples of children and families. Canada needs more evidence on whether ECD programs delivered in the real world do more good than harm.

What We Can Do: Opportunities for Home Visiting across Canada

Learning what works in the real world: As jurisdictions across Canada continue to implement and deliver home visiting programs, funded in part by the historic intergovernmental agreement on ECD, an unprecedented opportunity has emerged to learn what works in the real world on a nationwide scale. This opportunity can be realized if the ongoing challenge of allocating sufficient public resources for rigorous community-based evaluation can be surmounted.

Given that most home visiting programs across Canada are targeted, with many using quantitative measures of risk to assign families to intervention, there is an opportunity for rigorous evaluation using, for example, the regression-discontinuity design (RDD). In the RDD, participants are assigned to either the intervention group or control group solely on the basis of a cut-off score on a pre-test measure. The RDD is one of two “convincing quasi-experiments” that stand out because of their high quality of causal inference. The RDD provides an unbiased estimate of treatment effects, just like the randomized experiment. It can be used whenever policy dictates that special need or merit should be a prerequisite for access to the particular services whose effectiveness is to be evaluated. It is therefore an optimal evaluation design for programs that are targeted to the most needful families, including home visiting.

A broader question for policy and practice is the appropriate role of home visiting within the larger system of ECD programs and services, as briefly discussed in the papers by Kitzman and Daro. There is a growing consensus that Canada needs a comprehensive system of ECD, as discussed at a CEECD conference in May 2004. Jurisdictions across Canada urgently need policy evaluation at this system level, where the effectiveness of

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1 Building a Comprehensive Early Childhood Development System. The PowerPoint presentations of this conference are available at the following address: http://www.excellence-earlychildhood.ca/colloques.asp?lang=EN&docID=5
home visiting can be situated in the context of other ECD programs in their varying combinations and sequences over the first years of life. In order to address this fundamental question, as part of a comprehensive ECD system, jurisdictions across Canada need a nationwide resource network to support rigorous longitudinal evaluation of their ECD investments. ECD evaluation resources include knowledge, skills, expertise and technical assistance. Such resources are not evenly distributed across Canada. Some provinces, but not all, have local access to world-class ECD evaluation capacity. An important question for scientific centres of excellence with nationwide mandates, such as the CEECD and the Canadian Language and Literacy Research Network (CLLRNet), is their future role in such a national network of ECD evaluation resources. This is, of course, a question for the funders of these centres, which include government policy-makers.

Governments need good information to make good decisions. Ultimately, governments will stand or fall on their ability to meet the needs of their constituents, so the question comes full circle to all of us as Canadians. To truly improve the well-being of our children and families, as citizens we must demand that our governments invest our public resources in an effective and comprehensive system of ECD for all Canadians.
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VOICES FROM THE FIELD -
Prenatal and Postnatal Home Visiting

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Service perspective

Historically, the provision of home visits to families with young children has been a hallmark of public-health nursing practice designed to improve maternal and child health. During the last 20 years, there has been a proliferation of research on the effectiveness of home visiting programs provided by a variety of professionals, paraprofessionals and lay health advisors on a range of maternal and child health outcomes. More recently, researchers have synthesized the findings of this research in an effort to guide policy, practice and future research.

As each of the Centre of Excellence for Early Childhood Development (CEECD) papers on this topic¹-⁴ has noted, home visiting programs vary in terms of their primary goals, theoretical underpinnings, populations served, background, training and supervision of service-providers, and duration and intensity of interventions. Most home visiting programs attempt to improve children’s health and developmental outcomes and/or reduce child abuse and neglect by altering maternal health-related behaviours and/or parent-child interaction. Some home visiting programs are universal; however, as noted by Kitzman,² most programs are directed towards families with children at risk for poor health and development outcomes.

The CEECD papers¹-⁴ state that the effects of home visiting programs on maternal and child-related outcomes have been mixed. However, there are a number of lessons to be learned from the extant research that can inform service-providers and policy-makers.

Home visiting programs that have the most benefits for children’s health and development share a number of features. They are directed towards families and children at risk (i.e. adolescents, socially disadvantaged mothers with their first child, medically or developmentally at-risk children, families with characteristics that place them at risk for abuse and neglect). They are based on theories of development and behaviour change and they utilize a curriculum. Home visiting programs using highly trained intervenors have a greater impact on outcomes and there is some evidence to suggest that nurses are particularly effective in having a positive impact on maternal and child health outcomes, such as children’s social and emotional development, maternal caregiving, child abuse and neglect, timing of subsequent pregnancies, as well as future employment and welfare dependence.
The research also suggests that home visiting programs should be only one component of a coordinated service system for families with young children. For example, Zercher and Spiker\(^3\) state that certain sub-populations of children, specifically those in the poorest families or those who are low birth weight premature infants, benefit from comprehensive early intervention programs that combine home visiting with centre-based or clinic-based interventions focused directly on the child. Such programs have produced short- and longer-term benefits such as improvements in parent-child interaction, cognitive and behavioural outcomes and high school completion, as well as reductions in juvenile arrests. Although not specifically identified in the CEECD papers,\(^1\)-\(^4\) home visiting services and comprehensive early intervention programs need to be embedded in healthy public policies that address the systemic causes of poverty and family disadvantage.

Children from birth to six years of age comprise 8.3% of Toronto’s population (205,200 children).\(^5\) One of the functions of the Planning and Policy section of Toronto Public Health is to contribute to evidence-based programming.

Public-health programming in Ontario is provincially mandated. Some public-health programs are 100% provincially funded, while others are cost-shared between the province and the municipality. The Healthy Babies, Healthy Children (HBHC) program is a 100% provincially mandated and funded prevention/early intervention initiative designed to help families promote healthy child development and help children achieve their full potential. The goal of the program is to promote optimal physical, cognitive, communicative and psychosocial development in children. Specific objectives focus on: enhancing parental support; promoting effective parent-child interactions; increasing parental confidence, knowledge and abilities; and improving child health and development.\(^6\) The program does not specifically address longer-term outcomes related to maternal life course and child development, such as timing of subsequent pregnancies, future maternal employment, maternal welfare dependence, and adolescent criminal and antisocial behaviour. The Nurse-Family Partnership Program\(^7\),\(^8\) has been shown to have a positive impact on these longer-term outcomes.

The HBHC program provides a blended model of home visiting services for high-risk families that includes visits from public-health nurses as well as supervised and trained peer or lay home visitors. The lay home visitor is the main contact with the family and the province has stipulated that the ratio of lay visits to professional visits should range between 3:1 to 6:1, with a minimum ratio of 3:1 lay visits to professional visits.\(^9\) The program does not employ a standardized curriculum or identify specific interventions. The frequency and duration of visits are based on the family’s needs. Funding constraints preclude the intensity and duration of intervention employed in some of the home visiting programs highlighted in the CEECD papers.\(^1\)-\(^4\)

A provincially-funded evaluation of the HBHC program during the first two years of implementation found that children in high-risk situations who received HBHC home visiting services scored higher on most infant development measures, such as self-help, gross-motor skills, fine-motor skills and language development, than children in “high-risk” situations who did not receive these services.\(^9\) However, the long-term impact and cost-effectiveness of the program is yet to be determined.
Implementation of the HBHC program has identified a number of issues that need to be addressed through primary research. These issues, many of which have also been identified in the literature, include:

- Which type of intervenor is most appropriate for different client situations/needs?
- What is the optimal duration and intensity of intervention required to achieve the intended program outcomes?
- Which families have the potential to benefit the most from the program?
- How can clients most at risk be effectively engaged and retained in the program?
- What is the impact of the quality of the relationship between the intervenor and the family on retention in the program and client outcomes?
- Do interventions need to be tailored when provided to culturally diverse populations?

As previously noted, the research also suggests that home visiting programs are only one component of a coordinated service system for families with young children. The HBHC program acts as a catalyst for a coordinated, effective, integrated system of services and supports for healthy child development and family well-being. The Mayor’s Roundtable on Children, Youth, and Education is currently developing a framework for integrated service planning and delivery in Toronto. Toronto Public Health continues to work with other stakeholders, through a number of community networks and coalitions, to enhance the service system as well as improve service coordination at the individual family level. One initiative involves a pilot project to coordinate services for vulnerable homeless or under-housed young pregnant women. Another initiative has been the development of a Service Coordination Model for Families and the provision of training regarding the model to public-health nurses and staff in community agencies.

Zercher and Spiker note that some children, specifically those in economically disadvantaged families or those who are low birth weight premature infants, benefit from comprehensive early intervention programs that combine home visiting with centre-based or clinic-based interventions focused directly on the child. The federal government’s commitment to investing $700 million in the coming fiscal year with a commitment of up to $5 billion over five years to universal early learning and child-care programs, distributed in Ontario as part of the province’s Best Start strategy, is encouraging. However, the research suggests that the envisioned programs may not be sufficient to promote the optimal development of children who are most at risk. Canadian research needs to be undertaken in large urban environments such as Toronto to evaluate the effectiveness of comprehensive early intervention programs such as those described by Zercher and Spiker. Such early intervention programs are multifaceted and often include parent training, home visiting, counselling, health and nutritional services and referral to community and social service agencies in addition to centre-based early learning and care. As well as directly focusing on the child, the programs focus on the child’s parents and/or primary caregivers and the family as a unit, promoting income adequacy, adult education, job training, safe housing, family management skills and healthy lifestyles.

There is evidence to suggest that Canadian children living in low-income families and/or those living in low-income neighbourhoods are more likely to: be born at low birth
weight, experience chronic illness, have difficulties with vision, hearing, speech, mobility, dexterity, cognition, emotion, pain and discomfort, experience higher rates of injury and/or have higher mortality rates. In the year 2000, nearly three in 10 (29%) of Toronto children from birth to age five (51,000 children) were living in low-income households (i.e. those whose annual household income fell below Statistics Canada’s pre-tax Low Income Cut Offs). The City of Toronto recognizes that poverty is a key determinant of children’s health; a cross-departmental committee, including representation from public health, has been established to improve the well-being of children living in poverty. Toronto Public Health is developing a position paper on child poverty that will document the impact of poverty and associated disadvantages on children’s health, as well as the impact on their future health as adults. This position paper will be used to inform an action plan related to child poverty.

Research has identified a number of characteristics of effective home visiting programs. However, current policy directions pose challenges to integrating these findings into service delivery. There needs to be continued dialogue among researchers, policy-makers and administrators in order to ensure that best practices are incorporated into home visiting and other early intervention programs. Funding is required so that exemplary programs, which have demonstrated their effectiveness in the United States, can be researched in the Canadian context. Finally, it is critical to continue to advocate for healthy public policies to support families with young children. Without such policies, not all Canadian children will have the opportunity to achieve optimal health and developmental outcomes.
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VOICES FROM THE FIELD -
A Prevention Project For Low-Income Families

Leslie McDiarmid, Project Coordinator
Better Beginnings, Better Futures

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Service perspective

“Frontline workers often use current empirical research as guidelines to make decisions when developing new programs or refining existing ones,” says Leslie McDiarmid, Project Coordinator of Better Beginnings, Better Futures in Ottawa, Ontario.

Better Beginnings, Better Futures is a community-based primary prevention research initiative for young children (from birth to age five) and their families living in disadvantaged communities in Ontario. McDiarmid works with young children and their parents in specific Ottawa neighbourhoods where children are at risk for developmental problems. The CEECD papers on low income relate to some situations that McDiarmid sees in her work.1-6

What are the implications of the research findings in the CEECD papers for your work?

Most research is done in a specific context. Better Beginnings, Better Futures uses research information and applies research findings that are relevant to their settings. For instance, about a year ago, Better Beginnings, Better Futures introduced Books for Babes, a new program for children in their community based on research indicating that young children living in low-income neighbourhoods demonstrate a serious lack of expressive language but do extremely well in receptive language. In comparison, research generally indicates that children who regularly attend daycare have more opportunities for language development. The goal of Books for Babes is to help improve children's expressive language and, to a lesser extent, their receptive language. In order to ensure that these young children have regular and consistent exposure to language skills (something that daycare settings provide), the staff works with the children's parents, using books as a tool for encouraging reading, telling or making up stories, playing games, etc. “It is vital to model engagement,” McDiarmid states. Parents need to interact more frequently with their children and give them the time and space to respond back and to develop and improve their language skills. In keeping with a community-based approach, the Books for Babes initiative is delivered in numerous settings, including homes and community indoor and outdoor settings.
The CEECD papers provide information that will assist Better Beginnings, Better Futures in evaluating what they already do and in planning, developing and implementing future programs to help disadvantaged families and their young children.1-6 The key elements that these papers address are access, exposure, specific program elements and the concepts of holistic models. McDiarmid believes that the CEECD papers will generally inform her and her colleagues in these areas, although they lack specific details on the concepts presented.1-6 McDiarmid feels that the CEECD information will encourage Better Beginnings, Better Futures staff to look at other related papers (e.g. home visiting, parental support) to get a more complete picture of programs and services that can be offered.1-6

In particular, the CEECD papers indicate that some home visits never happen.1-6 Better Beginnings, Better Futures has been able to provide about 80% of their scheduled visits. McDiarmid would like further information on the recommended frequency of visits to low-income families for maximum effect.

The CEECD papers also mention a number of studies indicating that home visiting by a nurse is more effective than lay home visits.1-6 Although they have a nurse on staff, Better Beginnings, Better Futures is a lay home visiting program. This made McDiarmid wonder what specific elements in nurse home visiting make a difference: Is it the credential of the home visitor or specific elements of the program?

After reading the CEECD papers, McDiarmid is reassured that the Better Beginnings, Better Futures prevention project is on the right track, having addressed the issues of access, quality, community involvement and a holistic, flexible approach to program development and implementation in low-income communities.1-6

Where are the main gaps between research, practice and policy and how might they be overcome?

Reading the CEECD papers reminds us how important it is to recognize that “there is strength within these families and within these children” and although research is generally deficit-based, it is very important to determine the strengths of these disadvantaged families – where they excel and why.1-6 Day-to-day programming is quite removed from longitudinal research. Some parents regularly wonder why the researchers never ask anything good about their children and why all the tools used only measure the negative. “How [much better] could we inform programs and policies if we understood the strengths as opposed to only the deficits?” McDiarmid thinks the strength-based/capacity approach would be helpful in the long run, but she has yet to see a shift there. In the meantime, Better Beginnings, Better Futures focuses on family strengths when they prepare their programs.

Another aspect that should be considered is the very culturally diverse community within high-risk neighbourhoods. There appears to be little research on programming in very diverse communities. Research should be focusing not only one culture but rather on diversity within a community, so that service-providers can better understand the impact
of diversity and the kind of programming that would better serve these diverse communities.

Most of the research mentioned in the CEECD papers seems to focus on specific programs and specific outcomes.1-6 McDiarmid would like to gain a fuller understanding of holistic programming with many different goals and a continuum of services.
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VOICES FROM THE FIELD -
Why Money Matters: Low Income and Child Development

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Policy perspective

Many Canadian children experience poverty at some point in their childhood. According to the National Longitudinal Survey of Children and Youth, close to one in three children was poor at least once in 1994, 1996 or 1998 and about one in 10 was consistently poor over these three years. Persistent high levels of child poverty pose a critical challenge to policy-makers and society in Canada. Clearly, much more can be done to enhance the economic security of low-income households and to address the deleterious consequences of economic inequality for children and society more broadly.

The question from a policy perspective is how best to invest time and resources to this end. Does money really matter? Or is it a marker for something else? Should governments focus on direct service and therapeutic interventions to promote children’s psychosocial development instead? Should they pursue a “targeted” approach to transfers and benefits, or attempt to build a more “universal” infrastructure to foster healthy child development and support families?

Bringing research evidence to bear on social policy, however, is not an easy task. “Research in the social sciences seldom produces unequivocal findings that can be used to make objective judgments to form public policy.” Data on the impact of low income on the psychosocial development of children are a case in point, as amply illustrated in the CEECD papers. There are no easy answers. In our haste to find “the” key intervention – the “magic bullet” – we run the risk of throwing the baby out with the bath water, literally.

Low family income has been linked to a variety of developmental outcomes; specifically, children from poorer families are more likely, for example, to experience behavioural problems and cognitive difficulties. Within this group, children living in persistent poverty or in severe poverty tend to be more vulnerable than those who experience low income for shorter periods of time or live in households with incomes close to the poverty line. Yet the pathways and mechanisms through which poverty produces negative effects among children are not clear. Other characteristics of low-income families and/or environmental conditions appear to be more important in predicting children’s psychosocial development, including parenting skills, the cohesiveness of the family unit,
the mental health of mothers, and the extent to which parents engage with their children.\textsuperscript{3,4}

On the face of it, this research would seem to suggest that money does not really matter, that service interventions to enhance parenting skills and the like are potentially more effective in ensuring that children get off to a good developmental start. Predictably, there has been a great deal of controversy about these findings within policy circles and among practitioners. The research calls into question the efficacy of income transfers – which in their current incarnation respect the autonomy of low-income families to make decisions in the best interests of their children – while bringing back memories of home visitors berating poor mothers at the turn of the last century.

In reality, as most will attest, a range of factors or determinants contribute to healthy child development, including household income and access to services and supports. It may well be that service interventions targeted to low-income children may produce better psychosocial outcomes than a transfer strategy would. (This begs the question as to which interventions are best in this regard, a subject about which we have surprisingly little evaluative information\textsuperscript{6,7}). At the same time, money must always be part of the mix, precisely because of the complex ways in which access to financial resources shapes the environments within which children grow and hopefully prosper. Differences between parents in social and emotional functioning are not immutable or pre-determined. The characteristics of any family and the context in which they live are interactive and dynamic. “It may be that cash benefits by themselves have small effects but if they are coupled with efforts to reduce social exclusion and provide social support, they could have dramatic and lasting effects.”\textsuperscript{2}

In this regard, the literature on income inequality should alert us to the powerful role that the social environment plays in health.\textsuperscript{9} We are still feeling our way towards an understanding of what this means. For those living at the bottom of the income ladder, the link with both material deprivation and restrictions on social participation and the opportunity to exercise control over one’s life is clear and damaging. Studies of adults – those looking at cardiovascular disease in particular – are persuasive on this point.\textsuperscript{10} Predictably, new longitudinal research is finding a similar gradient in health among children as well.\textsuperscript{11}

Money does matter; not having enough to meet basic needs matters; not being able to participate in the social and economic life of one’s community matters. While an income strategy alone may not be enough to tackle vulnerability among all children, it is a critical component of any strategy that is serious in its intent to enhance healthy child development, at the level of the individual child and family and at the level of the child population as a whole.
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Policy perspective

The importance of nutrition throughout the lifecycle is stressed in the three papers by Devaney,1 Black2 and Reifsnider.3 Devaney1 describes the American Supplemental Nutrition Program for Women, Infants and Children (WIC), which provides services to improve the nutritional status of pregnant women and children. Devaney1 concludes that research on the effectiveness of the WIC program suggests positive effects but also highlights the difficulty of measuring program impacts. Black2 provides information on eating problems in children and describes environmental influences on children’s eating habits. Reifsnider3 pinpoints the importance of improving nutrition among women of child-bearing age and their children rather than focusing solely on nutrition during pregnancy and the postpartum period. This commentary will focus on Canada’s efforts to address nutrition from a population health perspective, highlighting work underway to bridge gaps between policy and research.

In Canada, nutrition for healthy growth and development is addressed through the broad lens of a population health perspective. The document Nutrition for Health: An Agenda for Action4 builds on the Framework for Population Health by providing a model for addressing nutrition issues in communities across Canada. The population health perspective recognizes that health is determined not only by health care and personal health practices, but also by other social, economic and physical factors called determinants of health.

For example, in the document Nutrition for a Healthy Pregnancy: The National Guidelines for the Childbearing Years,5 women’s health and nutrition are addressed from a population health perspective. The guidelines not only focus on nutrition during pregnancy but also provide guidance on how to optimize health before, during and between pregnancies. The document recognizes that the availability of foods and an individual’s capacity to make food choices are greatly influenced by the determinants of health.

Food choices, which play a direct role in nutritional health, significantly influence health status. Taking personal responsibility for one's health is important; however, food choices are not simply a matter of personal choice. It is essential to remember when developing
policies and programs for Canadians of all ages that economic and social forces, together with factors related to the physical environment, influence what foods are available and a person's individual capacity to make choices.

Actions by policy-makers and community leaders must consider all determinants of health and must be based on a foundation that includes research, information and public policy. A collaborative approach to nutrition policy development is also favoured since decisions related to health, agriculture, education, social and economic policies affect nutritional health. Nutrition is an issue that forms part of the mandate of many organizations, both government and non-government, serving as a component of health programs that target settings, life stages, vulnerable populations, disease prevention and health promotion. Provinces and territories play a critical role in promoting nutritional health and well-being at the community level. While many programs vary from province to province and between communities, many build upon standards and guidelines developed collaboratively at the national level, such as Canada’s Food Guide to Healthy Eating.6

Policies and programs that support healthy eating and enhance population health require sound evidence as well as the capacity to measure progress and outcomes. Currently, the available evidence regarding what Canadians are eating, the determinants of eating behaviour and the effectiveness of current interventions to support healthy eating is weak, which concurs with some of the challenges mentioned by Devaney and Reifsnider.1,3 Monitoring the nutritional health of Canadians has been hampered by a lack of national and ongoing surveillance data to assess the impact of policy and regulatory decisions. Data from the Canadian Community Health Survey (Cycle 2.2 Nutrition Focus) will offer a rich dataset through which actual dietary intake by Canadians of all ages will be analyzed. This dataset will provide evidence on the dietary intakes and eating patterns of Canadians to better inform food and nutrition policies and programs.

Evolving nutrition research in Canada is critical not only for women of child-bearing age and their children but for both genders and all age groups. This can only be accomplished by enhancing the capacity to undertake such research. The importance of considering an appropriate paradigm of evidence pertinent to the constructs of an upstream population health approach (health promotion and disease prevention) rather than individual lifestyle approaches should be recognized. A series of synthesis papers on the determinants of healthy eating, including both individual and collective determinants and their interactions, was commissioned by Health Canada’s Office of Nutrition Policy and Promotion (ONPP) to inform policy-makers on key knowledge and research gaps. In order to facilitate the dissemination and knowledge transfer of key findings to a multi-disciplinary audience, ONPP, its provincial partners and Canadian Institutes of Health Research’s Institute of Nutrition, Metabolism and Diabetes are coordinating the publication of a special journal supplement on the determinants of healthy eating. The next step will be to bridge the gaps between research, practice and policy by engaging researchers, policy-makers and practitioners in a dialogue for action on moving forward a research agenda designed to promote and support healthy eating at all ages.
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VOICES FROM THE FIELD -
Improving the Nutritional Health and Well-Being
of Women and Young Children

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Service perspective

Although the reviewed CEECD papers are American in context,1,4-9 except for the two articles on preterm infants by Canadian researcher Sheila Innis2 and Stephanie Atkinson,3 the problems that are identified can be generalized to Canadian nutrition practitioners. The issue-specific and general comments are fully recognized in my current role as a researcher and consultant and in my past years of experience as a front-line pediatric dietitian in both clinical and public-health settings.

One of the greatest challenges in dietetic practice is the level of nutrition expertise in primary health-care services. Nutrition has been recognized as a key determinant of maternal and child health outcomes, but appropriate and sufficient allocation and prioritization of resources are lacking. Using a multidisciplinary life-cycle approach, the CEECD research findings support the need to review and consider the realignment of early intervention resources and strategies to address key nutrition issues.1-9 This requires the inclusion of and access to sufficient numbers of registered dietitians. This also includes an increased level of nutrition knowledge by other allied health and social-service professionals through additional and ongoing education and training.

The CEECD papers provide evidence that support the many Canadian maternal and pediatric nutrition initiatives, as well as the many proposed initiatives seeking funding support.1-9 This includes national work on dietary guidelines for the target populations, including revision work on “Nutrition for Healthy Term Infants,” a national collaborative growth statement, and the upcoming Canadian Community Health Survey 2004 Nutrition component. Other regional, provincial and program-specific initiatives (e.g. Canada Prenatal Nutrition Program, Better Beginnings Better Futures) provide pockets of nutrition information that may or may not be generalizable to our target populations in practice. But until Canadian population-level, cross-sectional and longitudinal nutrition monitoring and surveillance data are available, nutrition practitioners are limited in their work and the application of this much-needed knowledge. This lack of information influences dietary guidelines and revisions, dietary assessment and intervention practices and nutrition promotion and disease prevention strategies.
There are many research gaps that could inform practice:

- The lack of Canadian population-level nutrition data;
- The lack of monitoring and surveillance of nutrition data in Canada;
- The lack of reliable and content-valid nutrition questions for health surveys and nutritional risk screening tools;
- The lack of comprehensively formulated survey questions to investigate the complex issue of maternal and child nutritional health;
- The lack of research on factors influencing the nutritional health and well-being of women and children;
- The lack of resources (financial and human) to evaluate nutrition promotion interventions;
- Insufficient education and training of health and social-service professionals on key nutrition issues affecting the nutritional health of women and young children;
- Inadequate nutrition expertise to provide a multidisciplinary approach to continuity of care to women and children;
- Insufficient “voice” to inform and influence multiple levels of decision- and policy-makers.

At times, overcoming these obstacles appears overwhelming but nutrition practitioners are making advances at the local, regional, provincial and national levels, such as:

- Calgary Health Region has implemented standardized growth measurements in their universal four-year-old immunization clinics. These local growth data will provide baseline information on the growth status of young Calgary children and can be used in the evaluation of a number of health initiatives, including obesity prevention. This work can also contribute to the best practices in growth assessment methodology, and will be useful for comparisons with other populations or groups of young children.
- The Northern Ontario Perinatal and Child Health Survey (NOPCHS) Focused Report on Nutrition provides a glimpse of some nutrition issues for Northern Ontario children between the ages of two and six. This report includes data on parents’ self-reported weights and heights of their child; child meal and snack frequency; child enjoyment and variety of foods and household food security. This report was driven by the lack of data and investment in healthy eating research in Canada and specifically Northern Ontario, and the need for public-health program developers and policy-makers to learn more about healthy eating.
- NutriSTEP (Nutrition Screening Tool for Every Preschooler) is a multiphase nutrition screening tool development and validation project with an overall goal of improving the nutritional health of preschool children (three to five years of age) through the development of a valid and reliable screening tool for use by parents/caregivers and child-care providers, as well as nutrition and health professionals across Ontario and Canada. This tool will increase awareness and educate parents by enabling them to recognize nutritional risk factors and issues, and thus seek early intervention to promote their child’s health and help prevent chronic problems such as obesity.
These initiatives, along with many others, are communicated and positively encouraged through various nutrition networks and collaborations, such as Dietitians of Canada and its Pediatric Nutrition Network. Through these efforts and a strong professional voice, there will be more positive influences with policy-makers. The current political environment and public opinion on health-care priorities and the health status of Canadians (e.g. rising obesity rates) will help the nutrition profession play its advocacy roles, as well as helping to gain recognition of the importance of providing appropriate and sufficient professional nutrition services designed to improve the nutritional and overall health and well-being of Canadian women and children.
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VOICES FROM THE FIELD
Obesity: Challenges in Prevention

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Perspective Service

We have an obesity problem beyond comprehension in this country. According to Statistics Canada, in 2004, 26% of Canadian children and adolescents aged 2 to 17 were overweight or obese,\(^1\) while 8% were obese. Over the past 25 years, the obesity rate in this age group has tripled.\(^2\) The CEECD papers\(^3\)–\(^8\) present critical research in this area. Accessible, relevant, refereed, up-to-date and with Canadian content, they are a valuable tool when discussing this topic, and have significant implications.

Several points presented in these papers are of particular note. Chaput and Tremblay state, “Prevention of obesity in children should be the first line of treatment.”\(^4\) This is crucial, yet in practice, real prevention factors are often not considered. For example, many schools in Newfoundland and Labrador have a new policy prohibiting fried foods from the cafeteria menu. But the real dilemma is that, just 200 metres away, there’s a fast food restaurant. There has to be a philosophical change.

Chaput and Tremblay also point out that “obese children are exposed to weight stigma and may be vulnerable to psychological effects, such as depressions, and social effects, such as isolation. Consequences of bias like isolation or social withdrawal could contribute to the exacerbation of obesity through psychological vulnerabilities that increase the likelihood of over-eating and sedentary activity.”\(^4\) This stigma is visible in schools every day, and is important to take into account when designing and implementing prevention programs. Blaming children is not the way to resolve or deal with this situation.

In addition to the papers by U.S. and Canadian researchers, those by Wabitch (Germany)\(^7\) and Reilly (U.K.)\(^6\) reveal that the same problems and concerns are quite prevalent across western cultures. Obesity is even creeping into developing countries, as a result of current eating patterns. Chaput and Tremblay point this out in their introduction: “Obesity has replaced malnutrition as the major nutritional problem in some parts of Africa, with overweight/obesity being as much as four times more common than malnutrition.”\(^4\) Even in Canada, where segments of the population are undernourished, it does not mean these same communities don’t face problems of obesity, too. Some current nutrition programs aim to address both these issues.
Gaps between research, policy and practice
Unfortunately, even with all this research at our fingertips, Canada still has one of the highest rates of obesity in the world. This suggests that we need more applied research, that is, research to show us what prevention programs and measures work. We need more examples of prevention programs in early childhood centres that address the issue of obesity. What kinds of programs are effective for children ages 3 to 5? How can we gear programs to their level and cognitive ability? As these papers show, the first five years of life are critical in developing healthy eating and lifestyle habits.

We also need to pay more attention to cultural differences, taking into account different eating patterns. A fair amount of research has been done on First Nations and obesity, but this is only one of the many cultural groups living in Canada. In a country that prides itself on its multiculturalism, it is imperative that we have more culturally-relevant research. There are large pockets of eating patterns that should be studied. For example, the eating patterns of people in rural Newfoundland and Labrador may be substantially different from those of people living in Montreal or Toronto. Even within those major cities, there are hundreds of different ethnic and cultural groups—Toronto has been recognized as one of the most multicultural cities in the world. Fortunately, the new Canada Food Guide does take this diversity into account.

Paediatric exercise is another key component of obesity prevention. However, it is critical that we look at paediatric exercise from a child development perspective. For example, the heart rate of a 4-year-old is different than that of an adult. Often, in child care settings, activities are based on adult parameters. This dooms initiatives to failure from the start. It is important for both educators and researchers to be informed of child-specific parameters, so as to recognize what exercises and activities are appropriate for young children. In order to address the issue of obesity, we have to look at the population we are serving.

Some key research questions still need to be addressed in greater depth. What are the impact of infant-feeding practices on the development of overweight and obesity? While several of the CEECD papers touch on this question, it would merit a study of its own. What are the parental and environmental influences on obesity? Even though such influences vary according to location, some factors are relevant to the country as a whole.

The research shows that disposition for obesity starts in the early years and, in many cases, follows people throughout their lives. It is critical that we act early to promote good nutritional habits and an active lifestyle, so as to prevent the stresses obesity places not only on these individuals but on our health system and society as a whole.

Comments recorded by Eve Krakow
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VOICES FROM THE FIELD -
Parental Leave: An Important Social Policy

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Policy perspective

Parental leave – its duration, generosity of financial support – is indeed an important policy issue and the papers assembled by the CEECD provide a helpful entry. Of particular value is Lero’s careful assessment of the state of research in the field, which underlines the need to see parental leave as one factor among several determining maternal and child-health and child-development outcomes. The involvement of fathers, sources of parental stress and family support, workplace factors and the availability and affordability of quality early childhood care all enter into the equation. While to some extent these factors are idiosyncratic, all are influenced by public policy as well as prevailing national (and local) attitudes and norms. Policy-makers therefore need to think about parental leave not only in terms of how long and at what level of support, but also about how parental-leave policies fit within a broader pattern of social and labour market policies.

The research really brings out an important problem: the greater part of research on this issue, available in English, is conducted in the United States, yet increasingly, the United States is an anomaly. The U.S., along with Canada and several European countries, has a high female labour force participation rate, a large part of which is full-time. It is also among the top countries in terms of the share of lone parents (mainly mothers). Yet until recently, there was no legislated right to parental leave and the 1993 legislation offered only 12 unpaid weeks’ leave for those who met the conditions. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires a majority of lone parents and low-income parents to seek paid employment, while providing limited support for child care. This is in contrast to Europe and even Canada. While the European Union has embraced the goal of at least 60 percent female employment by the year 2010, it has also adopted norms of a 14-week paid maternity leave and three-month parental leave and is promoting the expansion of affordable, quality early childhood care. Canada has recently instituted a 50-week paid parental leave option and entered into a multilateral framework agreement with the provinces whereby the federal government agrees to spend $900 million over five years to promote early childhood education and care.

This suggests, as Lero and Field note, that extreme caution must be exercised in generalizing from the American studies. Conversely, more comparative research needs to be done, with a greater effort to break down linguistic and other barriers to the
communication of research results from Europe. While the OECD’s multi-country study, Starting Strong, focuses on early childhood education and care, it provides the kind of in-depth analysis of this important part of the broader context in which parents choose to work or to take leave at the birth of a child.

Europe, moreover, offers a variety of social and labour market policy combinations, with some countries favouring long leaves at low rates of remuneration while others favour shorter but better paid leaves. Some studies suggest that the former pattern produces a clear class-divided pattern, mothers with low education being the main users of long-term care. This raises the question of the extent to which class and race structure outcomes for children and their parents and how policy choices exacerbate or mitigate this.

Duxbury raises the important question of who takes the leave. She focuses on the fact that it is primarily women who take the leave, despite the use of the neutral term “parental.” The shift from exclusively maternal leave to parental leave options and terminology does reflect an attempt to move away from the assumption that it is mothers whose behaviour and mental health count most for the development of children. Yet the latter assumptions remain deeply embedded in the literature, especially the studies arguing that “parental” employment in the early years leads to negative child development and “social capital” outcomes. The use of such apparently neutral terminology can have the unfortunate effect that even those who do not share this bias ignore the gendered leave-taking patterns and thus the implications of longer leave packages for women’s equality with men. It is not, however, just a matter of women’s equality. Too little attention is paid to “fathering” and the factors that influence the extent and manner of fathers’ involvement. Some recent literature has begun to delve into experiences, but much more research – again, set within an explicitly comparative framework – needs to be done.
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VOICES FROM THE FIELD -
Parental Leave and the Well-Being of Parents and Young Children

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Service perspective

Although there is little literature supporting the hypothesis that a mother’s early return to work is detrimental to the health of her baby, it may be a contributing factor, which can cause increased stress and anxiety in some mothers who lack support.1

Women in two-parent homes with middle-class social economic status appear to be positively affected by returning to work. It provides them with role privileges and greater economic security, leading to enhanced mental status. Working mothers’ ability to deal with their early return to work also appears to be related to their job satisfaction. The more support women receive at home and work, the greater their psychological well-being and ultimately, the better the relationship that is created with their child.

Maternal mental-health status is a major determinant in fostering the healthy maternal-child relationship basic to early childhood development and to decreasing the mother’s risk of physical illness. Fatigue appears to be an inevitable outcome of parenthood, usually magnified in mothers who choose to breastfeed. If motherhood itself triggers a host of complex and often conflicting emotions, “working motherhood” will magnify these conflicts. For example, mothers who must return to work sooner may face a lack of resources, emotional distress at being absent from their children, self-doubt about their maternal ability, role overload and spousal conflicts.2

In our present multicultural context, if motherhood is central to the culture but the woman needs to work to support herself, she may find herself in psychological conflict that can lead to negative reports of health. New mothers may also be at risk for postpartum depression. This can only be exacerbated by the multiplicity of stressors facing the mother who returns to work soon after giving birth.

Single mothers, with little support and/or limited financial resources, appear to have the most physical illnesses and emotional distress. They may have to care for their children in small, unkempt and insecure conditions, have very little time for themselves and have few outlets for personal needs. Children of parents in high-stress situations with insufficient support networks are known to be at risk for Shaken Baby Syndrome.
Children of depressed parents engage in less stimulating play and develop negative mood and attachment difficulties. A mother with depression is unable to engage in positive interactions with her child, and parents are at risk of using inconsistent discipline, which often leads to adjustment problems. Because these children do not have parents who can help them learn how to manage negative feelings, they often deal negatively with new challenges. When combined with the stress of financial difficulties, these negative characteristics are magnified.

Although Canada has one of the most generous policies in parental leave in terms of duration, the plan’s financial benefits may not allow all families to maintain their lifestyle, which becomes an additional burden for the family. While some mothers receive up to 90% of their salary for 20 weeks due to their employer’s additional compensation, the majority receives significantly less. Self-employed mothers, for example, do not benefit from any parental leave and often return to work within their baby’s first month of life.

As a society, we are very aware of the benefits of breastfeeding. In fact, recent literature suggests that a child should be breastfed for at least six months and ideally, up to two years. This is particularly difficult for the working mother who faces a guilt-ridden choice between working or breastfeeding. Although benefits of breastfeeding have been well documented for both mother and child, a mother’s level of fatigue will ultimately affect the results of breastfeeding. Due to lack of support, mothers often give up breastfeeding much sooner than most health-care professionals would recommend.

In Quebec, quality daycare is not always available. With the present waiting time at approximately one to two years in our public daycare system, the family may need to turn to private care. When a mother must return to work, the issue of daycare becomes an additional burden, both financially and practically, in terms of choices.

Although Canada has a one-year parental leave in place, that policy alone is not enough to protect all mother-child developments. As more and more women find themselves engaging in multiple roles, they are assuming two major familial roles – wife and mother – and one major social role – worker in the labour force. Because of their expanded roles, changes in the domestic division of labour and childcare patterns must also occur.

As a society, we should insist that our government:

- consider how to protect new families by making the policy accessible to ALL mothers, including self-employed families;
- make the availability and accessibility of quality daycare for all a priority. Daycare should be made available before the mother returns to work so that both mother and child can adapt to the change;
- encourage all employers to have a daycare. If it is not possible to have an internal daycare, employers should be encouraged to link up with a community daycare so that there is available and accessible daycare for all their returning mothers;
• provide additional supplements to all mothers who decide to breastfeed, not only mothers who are on social welfare. This would increase the financial benefits of staying home longer, as well as promote breastfeeding and all its related benefits;
• increase the financial benefits provided during maternal leave to help the family to adapt to the arrival of the newborn and provide all factors necessary to foster the optimum growth and development of EVERY child.

As a society, we should request employers to:
• give all women access to job-sharing on their return from maternity leave. This would permit a gradual return to full-time work. Not only would this increase the mother’s work satisfaction and decrease maternal stress, it would ultimately boost productivity;
• be breastfeeding-friendly. This would not only boost the employer’s reputation with all working women; it would also increase their retention level and increase the mother’s job satisfaction. To allow mothers to breastfeed, the company could either increase flexible hours to allow a mother time to breastfeed her child or provide frequent breaks, a private room and appropriate storage area. This would ultimately prolong the benefits of breastfeeding.

As individuals within our society, we need to:
• acknowledge paternal parental leaves as a norm, rather than an exception. The attachment developed between father and child definitely promotes child development while decreasing the mother’s stress level. This would demonstrate that we, as a society, value our children and their development as a joint responsibility, not solely a maternal responsibility.
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VOICES FROM THE FIELD
Parenting Skills: Evaluating and Designing Effective Parent Education Programs

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Service Perspective

The CEECD papers on parenting skills\(^1\)\(^-\)\(^10\) provide a rich balance of different points of view from key people in the field, presenting the main issues and research findings clearly to a general audience. As a whole, the papers confirm that parenting is critically important to children’s development—a fact that is sometimes downplayed amid the myriad of messages about other factors that contribute to a child’s social and emotional development, such as their non-parental care environments. While there is no single answer as to how to maximize parenting, there is some consensus in the field that warmth combined with control is optimal. To this end, the summary offered by Bornstein and Bornstein\(^4\) of Baumrind’s typology of parenting styles—authoritarian, indulgent permissive, authoritative, neglectful—is helpful in establishing a framework for discussion.

The CEECD papers also show that in general, the research says that parenting education can make a difference. This is important for community practitioners, and a key concern of the Canadian Association of Family Resource Programs (FRP Canada), a national, non-profit organization that promotes the well-being of families by providing national leadership, consultation and resources to those who care for children and support families. We have noted a real desire among people working with parents to find out what seems to work well, so that they can offer the best programs possible.

It is refreshing to see included in this collection the Trivette and Dunst\(^2\) paper, which is more focussed on the process of offering parenting support programs than on the content. Typically, research on the impact of parenting education studies specific programs or curricula, when in fact, how we do things may be just as important as what we do, perhaps even more so. In particular, Trivette and Dunst examine the effects of family-centred help-giving that involves two important dimensions: relational practices (compassion, active listening, mutual trust, etc.) and participatory practices (i.e. to what extent parents are involved in deciding what knowledge they need and how they want to acquire it). Trivette and Dunst conclude that participatory help-giving practices lead to the strongest outcomes. This research suggests that program developers and facilitators
PARENTING SKILLS

should provide many opportunities for participant choice and decision-making when designing and offering parenting programs.

Gaps between research, policy and practice
The flexibility required in order for a parenting program to be truly participatory creates certain challenges for researchers, however. To gather evidence using the scientific method, parameters must be strictly controlled, ensuring the same “dose” every time. Only then can the evidence about impact be directly tied to the specific program. The prevailing view of program developers and policy makers, therefore, is that the curriculum should not be modified in any way, because that would throw the validity of the research into question. As a result, some parenting programs currently being offered in Canada do not encourage or even permit adaptations in response to participants’ particular interests or needs. This pressure to strictly “teach” the curriculum rather than to facilitate shared learning is a natural (and unfortunate) development, flowing from the current practice of rewarding programs that can produce evidence of effectiveness from multiple research studies and penalizing those that can’t.

When thinking about future directions in this area of research, I would hope that more attention could be paid to identifying the elements or components of parenting programs that appear to be effective—both content and process. Some of these elements are identified throughout the CEECD papers, which is very helpful. Community practitioners often prefer to build their own programs in response to the parents they serve, and may feel restricted by the constraints or limitations of programs developed for other populations or based on theories such as behaviour management that originated in clinical settings. They might find it more helpful to know what combination of elements (information and process) would make up a good parenting program. That way, they could apply this knowledge by trying to ensure that these elements are included in their own program designs.

As well, the development and dissemination of simple, economical and non-intrusive instruments that are designed to measure program quality and effectiveness would be extremely helpful because they could be applied to many different programs and settings. Some facilitators are uncomfortable using research instruments that have high literacy levels or are deficit- rather than strength-based. We need to find ways of conducting research that are consistent in every way with the goal of building parental competence and confidence.

The CEECD papers provide a good overview of this topic, demonstrating that it is a complicated issue. As Belsky6 noted, “there should be no single way to promote growth-fostering parenting.” When making decisions about choosing parenting programs, this is a statement well worth remembering.

Comments recorded by Eve Krakow
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VOICES FROM THE FIELD
Learning Through Play: A View from the Field

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Service perspective

The summary of research on learning through play provided in the CEECD articles\textsuperscript{1-3} and accompanying commentary by Howe\textsuperscript{4} comes at a time when many play advocates believe that play is “under siege.”\textsuperscript{5} It also comes at a time when many Canadian early childhood educators are striving to secure a pedagogical focus on play in the development and implementation of early learning curricula. These reviews provide a valuable foundation for interpreting the available evidence on learning through play, as well as raising more fundamental questions about the significance of play in early childhood.

For the past decade public attention in Canada has been focussed on the critical importance of early experience and ensuring that children, particularly disadvantaged children, are ready for school. The expansion in the provision of public early learning programs in Canada is one of a series of significant changes in both the social and physical environments in which early childhood unfolds in this country that is affecting young children’s opportunities for play. There is concern that the decline of opportunities for unstructured free play in the early years may be a contributing factor in rising childhood obesity levels, as well as increased levels of anxiety and stress in young children.\textsuperscript{6-8}

Play is becoming institutionalized in early childhood

Young children are spending more time in early learning and child care environments at an earlier age, with the result that play is becoming “institutionalized.” As early childhood professionals experience increasing pressure to be accountable for learning as well as developmental outcomes, the long blocks of time devoted to free play in many early childhood programs are disappearing, crowded out by a focus on pre-academics as the foundation of school readiness. “Free play”—the kind of play that children control and direct themselves—happens in the leftover time, when there is nothing “more important” to do.

Reassuringly, “learning through play” is resurfacing in the lexicon of recent provincial early learning policy and curriculum documents.\textsuperscript{9-15} These approaches however, tend to focus on play as a means to an end, rather than an end in itself. Howe reminds us that “we must not lose sight of the meaning and importance of free play for children.” What is
needed now is a renewed focus and accountability for ensuring that young children have adequate opportunities to play for the sake of play.

**Gaps in the research**
The CEECD reviews\(^1\text{-}^3\) highlight the heterogeneity of the play phenomenon – with its multifaceted, paradoxical and ubiquitous qualities and multiple, overlapping classification schemes. Play describes such a wide range of behaviours that the question of a definition precise enough to support a research agenda continues to be problematic. The precise nature of the relationship between play and learning remains elusive. We are reminded that the existing evidence does not establish a clear cause and effect relationship between play and learning; it is suggestive rather than definitive. The state of evidence is fragmented and in some senses contradictory. Pellegrini and Smith\(^5\) suggest that the significance of play in learning may be overstated; arguing that some of the key benefits derived from play may also be achievable in other ways. In contrast, Hirsh-Pasek and Golinkoff\(^2\) claim that “play is a critical ingredient in learning,” even, as the title suggests, that play = learning. From a different conceptual starting point Christie and Roskos\(^1\) argue that play is “a highly engaging and meaningful context for learning,” a position that sounds more like the metaphor used by Hirsh-Pasek and Golinkoff in a previous work, that play is the “crucible” of learning.\(^16\)

If one considers the child’s perspective, it’s easy to conclude that play and learning are not the same at all. Learning is generally speaking the by-product of children’s play, something that adults observe, but that is more or less unintentional, and often unimportant to the child. And although it is abundantly clear to adults that learning is embedded in play, the learning we observe is often not linear, nor is it efficient. In the words of noted play historian and philosopher Johan Huizinga, “play is a thing by itself.”\(^17\)

**Promising evidence**
Each of these authors agrees that the clearest evidence that children can learn while playing lies in the relationship between play – specifically sociodramatic play - and literacy. The most effective means of translating this finding into practice is not so clear. Christie and Roskos\(^1\) report that creating literacy rich environments has been shown to be an effective strategy in achieving short term gains. The addition of environmental print as well as other innovative literacy props to children’s play environments has been a part of pre-service education of early childhood professionals for many years. The adult role as scaffolder in young children’s play is also familiar in professional practice; however there continue to be barriers to the widespread use of such strategies in the field. Early learning and child care programs in Canada do not have enough resources to support regular program planning and the kind of ongoing professional development needed to sustain best practice. Nonetheless, a clearer focus on the early literacy connections – and their relationship to language development and use – is both warranted and achievable in professional education and practice.

Neuroscientific research is beginning to reveal dimensions of play that might be more salient than originally thought. A recent multidisciplinary review of play research claims
that “playing is a way of building and shaping the emotion, motivation and reward regions of the brain.”¹⁸ These findings suggest something beyond a functional, linear relationship between play and learning. Play may have a fundamental influence on children’s disposition towards learning – on the development of self regulation, executive function, flexibility, adaptability and resilience. These are exciting findings with significant implications for practice and for the education of early childhood professionals. A pedagogy of play might well have a broader focus than academic, cognitive learning.

Hirsh-Pasek and Golinkoff² reference the development of a new approach to curriculum called Tools of the Mind, based on the correlation between sociodramatic play and executive function. This work, while promising in some regards, is troubling in others. Its creators, Elena Bodrova and Deborah Leong observe, quite accurately, that many early childhood environments are chaotic – children don’t appear to be engaged in any sustained or meaningful kind of activity. Tools of the Mind is based on the assumption that children no longer know how to play, and it is systematically designed to teach them to engage in “mature, intentional” sociodramatic play. Yet we know that play is what children do spontaneously, typically much more skilfully than any adult, and even in situations of war and natural disaster. When adults step in to guide children’s play, the play is usually lost. Play is child directed – children learn to play from one another. Play is a resilient phenomenon. We must create the conditions that allow it to flourish.

A research agenda that informs policy and practice
There is a clear commitment to play in policy and in practice, but the research agenda is unclear and unfocussed. What is most urgently needed is research that supports the translation of policy into practice, guided by research questions that inform practice. Before we can turn suggestive evidence into definitive evidence, there must be enough rich play happening to study its benefits to early learning.

Emerging questions include:

- What are the conditions that support sustained episodes of child directed free play in institutional settings such as child care and preschool programs? In particular, what are the conditions that allow sociodramatic play to flourish and develop in complexity, given its demonstrated impact on literacy, language and executive function?
- What is the impact of the institutional context on opportunities for different forms of play, e.g., outdoor play, rough and tumble play, solitary pretend play? How can the context be adapted to support the full range of play experiences?
- What is the impact of same age peer play-groups on the traditional child-child transmission of play culture?
- What are effective adult strategies to deepen and enrich children’s play, in particular the progressive development of sociodramatic play?

The nature of play demands longitudinal, interdisciplinary research. We need new theoretical frameworks for understanding the meaning of evidence gathered from
multiple perspectives of anthropology, sociology, developmental psychology, biology and neuroscience.

**Implications for the education of early childhood professionals**
Sustained child directed play still occurs sporadically in some programs, but often seems to be the result of benign neglect rather than intentionality. Practice and pedagogy must be confident, consistent and intentional. If the clearest research evidence that children can learn through play is in the relationship between sociodramatic play and learning in several domains, it follows that early childhood educators need to know how to provide opportunities for progressive development of sustained episodes of rich sociodramatic play. Early childhood professionals must support play because they know it works. Adults need to know how to enter as well as exit the play context – to guide, facilitate and support – and then get out of the way.

Play is what children do. “There is indeed an argument that the right to play is the one that is most distinctly children’s; that it defines almost the right to be a child.”18 Play must not be hijacked by an early learning agenda.

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VOICES FROM THE FIELD
Preschool Programs: Early Learning and Child Care

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Policy Perspective

Child care is known by a number of terms, including Early Childhood Education and Care; Early Learning and Care, and Early Childhood Development. The Child Care Advocacy Association of Canada (CCAAC) defines child care as a non-compulsory program that supports the optimal development and learning of children aged 0-12 years. At the same time, it enables parents to work, study and care for other family members and participate in their community; it provides supports and resources to help parents become active participants in their children’s early learning, and promotes women’s equality.

Because we are very concerned about the impact of policy development, research papers like those produced and circulated by the CEECD\(^1\)\(^-\)\(^3\) are very important to our work. For example, the CCAAC recently completed a two-year project, funded by the Government of Canada, called “Pedagogy, Policy and Quality.” The purpose of this project was to facilitate a national dialogue on curriculum issues in national policymaking, in order to establish a national pedagogical framework that will enhance children’s early learning and development. This project came about following the release of Starting Strong II, a comparative report by the Organization of Economic Cooperation and Development (OECD) examining early childhood education and care programs and policies in 20 countries. Of all the countries studied, Canada was the only one that had not articulated a vision for early learning and child care.

Papers such as Kagan and Kauerz’s “Preschool Programs: Effective Curricula”\(^2\) were particularly helpful in setting the stage for this discussion. Often, people associate the word “curriculum” with formal education, thinking immediately of tests and lesson plans. Both the Kagan and Kauerz paper and the commentary by Jane Bertrand\(^3\) open up a dialogue about what curriculum means in terms of young children. What are our goals for Canadian children during the preschool years? How concerned should we be about measuring children’s development before they go to school—and why? What do we know about the impact of the quality of the environments and interactions in the early years? These are just some of the key questions.

Organizations like the CEECD also play an important role in synthesizing some of the international literature and drawing attention to research that truly reflects the Canadian
context. Too often, we are influenced by U.S. research that may not reflect the situation in Canada. For example, a number of U.S. studies have raised questions about child care having a negative impact on children’s development. However, when interpreting these results, differences between the two countries must be taken into account. For example, whereas Canada has a relatively comprehensive parental leave program, enabling many families to stay home and care for their infant in that very critical first year, the U.S. does not have such supports in place. Therefore, when talking about the impact of centres or programs on children’s development, we need to use caution to ensure we are looking at all of the Canadian factors.

Gaps between research, policy and practice
In general, the literature shows that quality in early education and child care leads to good child development outcomes. For many of us advocating high-quality early learning and child care, there is growing discontent with governments’ lack of attention to these evidences. There is a belief by some that the care of children is a private matter and is the responsibility of families; however, children’s well-being is a matter of public concern. Failure to make children’s early years a priority results in much higher societal costs later on.

While the quality and quantity of early learning and child care programs varies from province to province, there is no jurisdiction in Canada outside of Quebec that has moved beyond the patchwork of services towards a system of quality affordable child care. The province of Quebec, has made the implementation of a universal child care system a high priority. When setting up its program, the Quebec government worked hard to develop standards and a curriculum, drawing on research and what we know from the experience of other countries. While it is not without its flaws, Quebec’s system is the closest that Canada has to a universal child care program, similar to those in other countries.

Evidence also debunks the myth that publicly-funded programs of early learning and child care are too costly. When Quebec implemented its child care program, in the first year alone, the province had a 40% return on every dollar.4 Canadian economists Cleveland and Krashinsky predict a return of $2 to the economy for every $1 invested in child care.5 Moreover, Schweinhart1 highlights the importance of teacher qualifications, stating: “Effective preschool programs need qualified preschool teachers who know how to contribute to children’s cognitive and social development and do so.” At the moment, much of Canada’s early learning and care arrangements are underground. By formalizing the system and professionalizing the workers, not only does the quality of care improve, but ripple effects can be seen across the economy.

There is growing awareness among parents and the general public that Canada needs to catch up to the rest of the world and do better to assist families and to provide support for early learning and child care programs. Finding a space in an early learning and child care program with qualified educators and quality programming should not be a matter of luck. We need to move away from ideological-driven decision-making and pay attention to the strong body of Canadian and international research and evidence.

Comments recorded by Eve Krakow
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Service perspective

The World Health Organization’s World Report on Violence and Health (WRVH), released in 2002, underscores the importance of the health sector’s role in violence prevention. Among its recommendations are two that pertain particularly to those of us working on the frontlines of child maltreatment prevention: to promote primary prevention responses; and to strengthen responses for victims of violence.

The CEECD papers on prevention discuss the role of health professionals in universal or primary prevention of child maltreatment, i.e. strategies aimed at all children and families to promote healthy and safe child development. The medical assessment for child maltreatment should be part of regular well-child care, in which the physician aims not only to prevent infectious diseases and accidental injury, but also to identify factors that might predispose the child and family to maltreatment. When health-care providers identify children and families at risk for maltreatment, they can make referrals for supportive interventions aimed at mitigating the vulnerability factors.

Children who have been maltreated may present for health care as part of regular well-child care, or specifically as a result of their maltreatment. This gives health practitioners a vantage position from which to identify these children and, in so doing, take the first step to ending their ill treatment. The health-care provider can initiate these interventions by assessing the child; reporting the suspected maltreatment (as required by law in many jurisdictions); providing treatment, counselling and rehabilitation for the child and family or making the appropriate referrals; and monitoring the ongoing health of the child and the response to the interventions used.

One of the disappointments of working in this field has been the realization that front-line health practitioners are often reluctant to inquire about risk factors and to identify child maltreatment when it presents itself. Studies have shown a variety of causes for this reluctance. In a recent article, Levi and Loeben review the literature on the subject of professionals’ failure to report suspicions of abuse and their underlying reservations. These include fear of the legal, financial and emotional hardships that follow a report, and the potential of doing more harm than good to the child and family, and fear of losing the relationship they have established with a family. The authors argue that significant problems arise from a lack of clarity regarding the threshold that has been set for
reporting, i.e. that the term “reasonable suspicion,” included in some form in most reporting legislation, is not well enough defined. Professionals interpret what constitutes abuse based on their own experience and on cultural factors, though knowledge has been demonstrated to improve discernment of what constitutes abuse.

There is no question that much knowledge has been amassed regarding the medical assessment of suspected child maltreatment since 1962, when Kempe wrote his first article on the Battered Child Syndrome. Application of this knowledge in the field allows evidence-based decisions on the likely mechanism or force that harmed a child. Findings found to be specific for non-accidental injury indicate that maltreatment has taken place even in the absence of any available history. Examples include skin bruises in the shape of a loop or other object pattern, and seminal fluid or sperm on a prepubertal child. Conversely, consideration must be given to conditions, either congenital or acquired (condition developed later in life), whose manifestations may be confused for abuse. Among these are infections such as impetigo (bacterial skin infection); skeletal dysplasias (diseases of bone formation); bleeding disorders and certain cultural practices, (e.g. coining: a procedure that involves rubbing warm oils or gels on a person's skin with a coin or other flat metal object to release the bad blood); lichen sclerosus (chronic inflammatory skin disorder affecting the genitals); and failure of midline fusion (a congenital malformation that appears as a groove in the genital area). Other findings, such as an enlarged hymenal opening and spiral fractures, once thought to be indicative of abuse, have been shown to be non-specific as to cause.

Certain findings are evidence of child maltreatment if they are not accompanied by a plausible accidental history, preferably witnessed by an objective party, or evidence of organic (natural) disease. Examples of these are any bruising or fracture in an infant who is not yet mobile; bruises, especially if they are multiple, over soft parts of the body rather than bony prominences; rib fractures in infants; bilateral burns in stocking or glove distribution with clear lines of demarcation between scalded and normal skin; and penetrating genital injuries. The combination of subdural hemorrhages, especially if these are found between the two hemispheres of the brain, together with diffuse, multilayer retinal hemorrhages, rib and metaphyseal (growing part of the bone) fractures, with or without evidence of impact trauma, places abusive head injury high on the differential diagnosis.

In most cases, the main factor that allows clinicians to distinguish accidental from non-accidental injury is the lack of correlation between the explanation provided and the child’s condition, given the child’s developmental age. This requires a careful and detailed history and a meticulous physical examination, together with the appropriate investigations to identify hidden signs of trauma and detect or rule out organic or accidental causes. The conclusions from this medical assessment must take into account the psychosocial and forensic information gathered by child protection and law enforcement professionals, which means communication among these three sectors must be timely and clear.
In spite of all the available knowledge and skills required, a recent Canadian study has shown that pediatric trainees, who will become the health practitioners best able to safeguard the well-being of children, are only receiving limited training and are exposed to few cases dealing with child maltreatment. There are many competing specialties and pathologies to be mastered during pediatric training and limited time. Child abuse, however, is not an inconsequential problem. The annual incidence rate in 1998 was between 5.1 and 12.9 victims per 1000 children in developed countries, while a 1990 Canadian survey showed about a quarter of the people had been physically abused during their childhood, and about 13% of females and 4% of males were sexually abused.

The WRVH is a clear call to the health sector to take the lead in violence prevention. The knowledge, skill and influence needed to do this effectively are within the grasp of health-care professionals. What we need is more widespread and more effective education efforts and a remuneration system for health-care providers that recognizes that child maltreatment cases require much more time than the billable encounter with the patient and family. We also need further advances in our knowledge of injury mechanisms and factors that differentiate non-accidental injury from other causes, so that children can be protected more effectively without causing unnecessary distress to families who are not placing their children’s well-being at risk. This should also increase professionals’ level of comfort in working with this difficult problem.
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VOICES FROM THE FIELD -
Fertility Clinic Counselling Perspective

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Service perspective

The CEECD reviews by Golombok, Sutcliffe, and McMahon are welcomed by those of us who counsel infertile individuals. In large measure, this is due to the reassurance that preliminary controlled studies and particularly the longitudinal work that is emerging on psychosocial adjustment of singleton and twin children born from these technologies are not demonstrating significant differences between them and children conceived by more conventional means. Each author red-flags the issue of higher-order multiple births as a central worry, but this concern is likewise reflected in the science and practice of infertility, where much energy is now invested in attempting to limit the occurrence of triplets and more. Those of us who counsel the infertile can relax – sort of.

What is also evident from these reviews is that key questions regarding some of the most basic aspects of the technologies have yet to be answered. Chief among these is the result of gamete donation (egg and sperm) and embryo donation on the psychosocial well-being of children who will eventually become adults with families of their own. We do not know in an empirical sense whether it is best to disclose and how much to disclose to children born from donor gametes and embryos. We do not know how children born from donor embryos will view the likelihood they were frozen as embryos, stored and donated to other infertile people by genetic parents who could neither destroy nor rear them. We do not know how releasing parents from biological limitations such as menopause will affect children born from donated gametes or donated embryos to women of advanced maternal age and their equally aged partners. We do not know how children will view what McMahon describes as the “designer baby” possibility of the technologies until they reach adulthood and tell us whether their selection as a “good quality embryo” through pre-implantation genetic diagnosis or choice of donor made a difference to them in terms of parental expectation and performance.

Canada recently passed legislation governing reproductive technologies that addresses the delicate balance of the needs of the infertile, the well-being of children and Canadian sensibility regarding what is and is not acceptable in the science and practice of reproductive technology. It is hoped that this legislation will provide a climate for increased interaction between fertility clinics and child development specialists, lend support for longitudinal study of children born from reproductive technologies and evolve as our knowledge of consequences for children increases. As McMahon so aptly puts it,
“Practitioners, policy makers, and researchers need to remain mindful that the birth of a child through reproductive technology may only be the beginning of a complex and evolving story as the implications of the in-vitro fertilization process…unfold over time.”

Those of us in the front line are balancing the needs of our infertile patients, the potential consequences to children and the possibilities of science. The reviews of Golombok, Sutcliffe, and McMahon are reassuring in that it appears parenting styles and child development are similar irrespective of mode of conception, at least in the early years. We can tell prospective parents that the building blocks of putting sperm and egg together for people who cannot conceive without such intervention do not alter normal family development. The literature gives no indication that the experience of parental infertility or the technology itself makes children conceived in this way somehow different from others.

What we have no way of knowing is how the large cohort of children conceived through the use of the technologies will view our efforts 30 years from now. It is evident that we must continue to pay attention and proceed with caution with careful study of the long-term impact of the various permutations of a technology that carries with it the possibility that children will be integrating a whole new story of their origins. It has been possible for some time for a child to be born to parents with whom he or she has no genetic relationship, to be born to a woman whose sole purpose was to gestate a pregnancy she had no genetic relationship to, or to have a genetic “parent” who is a sibling or close friend of the birth parent and maintains a relationship to the child from that perspective. We have no choice but to wait for these children to tell us whether researchers, policy-makers, practitioners and ethicists have asked the right questions, funded the right research and formulated the right policies in anticipation of what we think their experiences might be.
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VOICES FROM THE FIELD
Resilience: Promoting the health, safety, and well being of the population, particularly children and youth

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(Published online March 17 2008)

Service Perspective

As the articles in the CEECD Encyclopedia point out, the development of resilience in children is multifactoral, relating to both internal traits and the external environment. The entire community must be involved in making the changes that support resilience in children. Each Encyclopedia article emphasizes different factors that affect resilience, such as poverty, community violence, and parental stability.

As Luthar points out, problems arising in school-aged children are much easier to prevent early on than manage once they “crystallize” later in life. In this sense, it is necessary to nurture resilience in children starting very early in life and continuing throughout childhood. We need to ask key questions such as, what compromises child development? How and why do problems arise? How do we make a change in individuals or groups of children?

Sameroff notes that, in order to improve children’s resilience, it is necessary to make improvements in multiple areas of their lives, such as in their families, peer groups, schools, and neighbourhoods. Meaningful changes can only be made by impacting all levels of aggregation: the individual, the family, the neighbourhood, and the community as a whole. Every level of government should be involved in ensuring that the societal infrastructure is there to support positive human development. While many interventions focus on ‘fixing’ individuals and relationships, there should be more focus on building a strong and healthy community and society that can support positive human development. A strong sense of belonging to a family and a community makes children less likely to resort to gangs and other negative influences for a sense of belonging. The articles on resilience from the CEECD Encyclopaedia provide some of the tools needed for making meaningful changes at all levels of society. These include ensuring young children have good nutrition as well as opportunities for learning and strengthening community networks and parental support.

In building resilience in children, we cannot forget the adults who care for them. Parents and caregivers need to know how to foster ongoing, enduring, and reciprocal positive attachments with children, and they need the resources to provide a secure home. The city of Prince Albert is in the process of developing early childhood development and parenting centers that focus on supporting the family from day one. We are also stepping
RESILIENCE

up efforts to address addiction and substance abuse, targeting not only the problem itself but also its early roots.

_Gaps between research, policy and practice_
One of the biggest hurdles to developing programs that nurture resilience is the lack of communication among professionals in the field, researchers, and policy makers. To help overcome this hurdle, we need professionals who have the skills, knowledge, and mandate to facilitate knowledge exchange among these three domains.

To optimize information exchange, professionals in each domain and across different areas of research must use the same language and become familiar with each others’ technical jargon and buzzwords.

Professionals working in the field require scientific evidence that can be presented to policy makers in order to align policy with current needs. Researchers, therefore, must focus on the needs of field workers in their research and make their directives clear. It is also important to provide data demonstrating cost effectiveness of proposed interventions. Policy makers should be presented with research data in informal settings where they feel comfortable asking questions, pointing out constraints that they face, and engaging in meaningful dialogue.

The CEECD Encyclopedia articles are useful for facilitating knowledge exchange and dialogue because they summarize thousands of pages of research from different but related areas into a few salient, data-rich pages. They use language that anyone involved in the field can understand, and they help professionals working in the field to better understand the developmental roots of the problems they face every day. Similarly, CEECD workshops in which leading policy makers meet with researchers and field workers have been very powerful forums for knowledge exchange and dialogue.

It would be helpful if the CEECD Encyclopedia could include more information about the social determinants of health, well-being, and competence. Additional information on epigenetics or how our environment affects genetic expression, as well as recent developments in neuroscience with respect to resilience would also be most welcome.

Comments recorded by Alison Palkhivala
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VOICES FROM THE FIELD -
School Readiness, Academic Success and School Completion from an Early Childhood Perspective: A Practitioner’s View

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Service perspective

The findings of the CEECD papers\textsuperscript{1-10} underline the multiplicity of factors that are associated with school readiness, academic achievement and school completion. While all of the authors\textsuperscript{1-10} agree that early childhood experiences prior to school entry can play a major contributing role to children’s school success, the reader is also struck by the numerous gaps in our research and knowledge about the interplay of variables during the early years.

Five key themes emerge as important to school success:

- The early development of child-specific skills such as language, emergent literacy, self-regulatory behaviour, positive interpersonal relationships and intrinsic motivation to learn;
- The impact of parenting style and parental interest/involvement in the educational process;
- The quality, intensity, duration and accessibility of formal early childhood programs;
- Broad socio-cultural and economic factors such as income, parental formal education levels, ethnicity, home language, family mobility and neighbourhood cohesion;
- The degree to which schools have developed pro-active, positive relationships with families and early childhood service-providers to create a community climate conducive to early learning and to facilitate the successful transition of young children into school.

To date, much of the school success research related to the early years has focused on the effectiveness of formal early childhood programs – specifically demonstration preschool and \textit{Head Start} initiatives working with disadvantaged children in high-need neighbourhoods in the United States. \textit{The Perry Preschool High Scope Program} and the\textit{ Carolina Abecedarian Preschool Program}, both child-focused, centre-based part-time programs, are frequently identified as having the best short- and long-term results.\textsuperscript{2,6} The newer Chicago Child-Parent Centre approach, which combines a school-based preschool
program beginning at age three with family support programs that encourage parent involvement in the educational process, is also emerging as a positive model.2,6

Yet the lack of comparable, longitudinal research for other types of child-care settings leaves many questions unanswered. This is troubling, given that the majority of young children in Canada are now spending significant amounts of time in informal and formal full and part-time care settings while their parents are working or studying.

Smith2 points to the importance of examining two broad aspects of early childhood program quality to support positive child outcomes:

1. Structural issues such as small group size, favourable child-staff ratios, well-trained staff and low staff turnover;

and

2. Process issues such as positive interactions among children and staff, language-enriched, developmentally appropriate programming, a climate of caring and respect, and attention to individual needs and learning styles within the group setting.

The research also suggests that the most effective early childhood programs usually have a parent involvement component that promotes parent engagement in the child’s learning and encourages an interactive positive parenting style through role modelling, informal peer support and specific parent education activities.

Despite the acknowledged importance of parenting style to school success, there has been remarkably little research in this area. For example, we have no studies that help us to understand the links between healthy parent-child attachment and bonding during infancy and the implications for school success. Further exploration is also required regarding the importance of parental planning, support and advocacy during key early childhood transitions. Lastly, we need to have more information about the relative merits of home visiting/outreach family support models versus community-based group-oriented parent education approaches that include a formal child-minding component.

Another area of school success research that is sadly lacking is assessing the importance and benefits of early screening and timely early intervention services for children with developmental delays, mental health concerns or family risk factors. Too often, preventable conditions are not detected until time of school entry; at which point the interventions usually become more intensive, invasive, long-term and costly from both a human and financial perspective.

Finally, as noted by Rumberger,5 parents and early childhood service-providers cannot be expected to take full responsibility for ensuring school success. Even after accounting for socio-cultural and economic differences between communities, it is important to recognize that schools, through their structure, student composition, teaching resources, instructional approach, interpersonal climate and attention to home/school relationships must intentionally plan for school success. This school responsibility also includes becoming a focal point in the local community, so that even prior to school entry,
families with young children already feel attached to and comfortable with their
neighbourhood school and some of the school staff. In addition, schools must develop
collaborative relationships with early childhood service-providers, encouraging the use of
school facilities and engaging in broader public efforts to meet the needs of younger
children and their families. New research from British Columbia on school readiness
using the *Early Development Instrument* is beginning to suggest that it may be this
“community partnership/community capacity-building” approach to early childhood,
which could help to explain some of the community differences in children’s school
readiness levels.

In conclusion, school success research is still very rudimentary and in the past has tended
to focus narrowly on demonstration preschool approaches. As academics and
practitioners, we now know from recent brain development research that the experiences
of the first six years of life are extremely important and have lifelong implications for
health, well-being and school achievement. These experiences are within the complex
context of family and community. It is my hope that the dialogue begun under the
auspices of the CEECD will help to spotlight areas for further research that can
encourage informed planning and best practice among parents, service-providers,
community partners, policy-makers and funders alike.
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VOICES FROM THE FIELD -
The Transition into Kindergarten:
Building on the Foundation of Prior Experience

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Service perspective

Introduction
The empirical findings from the Pathways Project reported by Gary Ladd\(^1\) demonstrate unequivocally that the attributes children bring to kindergarten, especially their behavioural dispositions, social and relationship-building skills, self-regulatory skills and ability to communicate, are important determinants of how well they adjust to school. The nature of the relationships children form with their kindergarten classmates and teachers, the attitude they develop towards school during this grade, and the extent of their willingness to engage in classroom activities strongly influence their later psychological and social development and the level of their scholastic achievement.

Relevant questions about the transition into kindergarten concern the antecedents and determinants of the knowledge and abilities that foster children’s positive adjustment to school.\(^2\) Children’s early development is strongly influenced by: the extent to which their parents are nurturing and responsive to their needs and wishes; the availability of language and other developmentally appropriate stimulation in the child’s home; the degree to which the child’s community is physically and emotionally safe; and, for many children, the extent to which their child-care experiences support and encourage their well-being and development.

Children thrive in child-care settings, whether centres or family child-care homes, where the adult interacts with children in a warm, sensitive, responsive manner, the environment is safe and language-rich, and there are activities that promote pro-social interaction, creativity, exploration and problem-solving. Children participating in this type of high-quality child care are more socially competent with their peers and with adults, have higher levels of language skills and obtain higher scores on tests of cognitive abilities.\(^3,4,5,6\) These findings hold true even after adjusting for factors known to influence child development, such as maternal education level, parental child-rearing practices, family socio-economic status and the level of linguistic and cognitive stimulation in the home. The positive impact of high-quality child care on children’s social, linguistic and cognitive development persists well into elementary school, thereby establishing a trajectory associated with scholastic success.\(^7,8,9\)
A recent paper from the NICHD Study of Early Child Care,\textsuperscript{10} cited by Rimm-Kaufman,\textsuperscript{11} raised concerns by reporting that the more time children spent in non-maternal care across the first 4.5 years of life, the more externalizing problems and conflicts with adults they exhibited in kindergarten. The researchers qualified this finding by noting that the effects of length of time in child care were modest and smaller than those of maternal sensitivity and indicators of family socio-economic status. In addition, they pointed out that the direction of the effects is not clear. It is possible that children who are more aggressive and difficult are placed in child care at younger ages and for longer periods of time.

**Implications: What Does the Child-care/Early Childhood Research Tell Us?**

Five conclusions emerge from the research:

- The effects of child care on children’s well-being and development and their transition into school vary primarily as a function of the quality of the child care the children experience.\textsuperscript{5,6,12}
- All children benefit from high-quality child care and the optimal development of all children is compromised by poor quality child care. Coming from an advantaged home is not sufficient to protect children from the negative effects of poor-quality child care.\textsuperscript{13,4}
- There is a solid base of knowledge about the structural variables, such as adult-child ratio and adult training, required for high quality child care, whether centre- or home-based,\textsuperscript{14,15,16} and a growing understanding of the role of non-structural variables such as remuneration levels, a positive organizational climate in the child-care centre or family child-care agency and the extent of government funding.\textsuperscript{17,18}
- The most relevant child attributes for success in kindergarten are social awareness and social skills such as friendship-making, self-regulation, knowing how to resolve conflicts with other children constructively, the ability to communicate needs, wants and thoughts verbally, and an enthusiastic approach to new activities.\textsuperscript{1,11}
- Coordination between child care and kindergarten reduces the discontinuity between the two settings and assists children to make the transition into school.\textsuperscript{19}

**Implications for Governments**

We know that all children, whether from advantaged or disadvantaged homes, benefit from high-quality child care and we know what contributes to the development and maintenance of quality child-care programs. The challenge for governments is to take the information provided by research and implement government practices and public policies that are consistent with what we know. Good quality child care requires: (1) stable, predictable and sufficient funding to enable programs to maintain a physical environment conducive to quality programming and to attract and retain child-care providers who are able to implement activities that support children’s emotional and physical safety and their development; (2) regulations, such as training requirements and adult-child ratio standards, based on the most current research regarding what is required for high quality child care and enforcement of regulations; and (3) an infrastructure that
includes accessible training and professional development opportunities in all parts of the country, other supports associated with high quality such as family child-care resource programs, mechanisms for the collection of comparable, reliable data to assist in evaluating and planning child-care services, and funds for research to answer specific program delivery questions.

Since all children benefit from good quality child care, regardless of their family background, universal access is more appropriate than targeting at-risk children. Universal access requires a sufficient supply of affordable, high quality child-care spaces in all communities for all the parents who wish to use them. Affordability requires acknowledgement of the reality that providing a quality program is expensive and most parents cannot afford the fees that programs have to charge in order to provide high quality child care.

Research on school transition has identified the most relevant aspects for success: good social skills, linguistic competence and a mindset that enthusiastically embraces new experiences and learning opportunities. Government policies and practices should be directed to enhancing child-care experiences that build on these empirically validated aspects of what is required for school readiness and successful transition into kindergarten. Child care presents a wonderful opportunity for children to interact under the guidance of knowledgeable adults who are able to assist them to learn the rules of social interaction and who provide play-based activities that support child-directed exploration and learning by hands-on experience. Pressures to push the kindergarten curriculum down to child care and have children engage in “academic” activities must be resisted.

Children’s transition into kindergarten is smoother when there is communication and coordination between the current child-care setting and the receiving kindergarten. In all but one Canadian jurisdiction and many American states, responsibility for child care for children under age six does not rest with the same government department that is responsible for elementary schools. This fact may partly explain the tendency, in both countries, for child-care and kindergarten programs to act as if they were in two different silos with no means of communication. There is a pressing need to enable and encourage collaboration between child care and kindergarten during transition planning for children and during their initial period in kindergarten, a time when many children also continue to participate in child care. Governments stand to gain a great deal of information about what works and does not work through the Toronto First Duty project. This is a three-year pilot study (2002-2005) on five sites in different parts of the city where child-care, kindergarten and parent-support programs have been brought together to form a single seamless program. This pilot project is being evaluated by faculty of the Department of Human Development and Applied Psychology at the Ontario Institute for Studies in Education, University of Toronto.

**Implications for Child-Care Programs**

A positive organizational climate and a director who fosters collegiality among her staff and gives them a sense of being valued are key non-structural components of quality.
This important fact needs to be kept in mind by owners or boards of directors when hiring directors for a centre or family child-care agency.

Many child-care programs face parental and/or government pressure to ensure that children have “pre-academic” skills before they enter kindergarten, for example, the ability to recite the alphabet, count at least up to 10 and write their name. However, the current conceptualization of emerging literacy and numeracy emphasizes the value of children being exposed to language and stories and having opportunities for hands-on exploration and participation in activities that promote an understanding of number and symbol. When required, child-care programs need to educate parents about the importance for kindergarten of social knowledge and abilities, communication skills and a willingness to take risks and explore, and assure parents that children really are learning when engaged in activities that promote these child attributes.
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SCHOOL TRANSITION

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VOICES FROM THE FIELD -
Transition to School Practices: the Need for Evidence

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Policy perspective

What we do not know about transition to school could fill volumes. What we do know is very ably summarized by Early\(^1\) and comes largely from a series of articles written by her, Pianta and colleagues, based on a large survey of U.S. kindergarten teachers carried out in the mid-1990s.\(^2,3,4\) Love and Raikes\(^5\) emphasize that the transitions start early, reminding us about the longitudinal studies showing lasting results of prior-to-school interventions (e.g. Carolina Abecedarian or Infant Health and Development Program), focused on cognitive skills and parenting skills among families of children who were economically or developmentally disadvantaged.

The conclusions of both reviews are straightforward and intuitive: improvement in facilitating transition for children and families prior to the beginning of a school year, individualizing the practices when needed, and high-quality preschool programs improve children’s developmental outcomes when they start school. These recommendations are based on teachers’ perspective and on well-documented links between children’s experience in high-quality preschool and better academic outcomes.

Notwithstanding the above, the current research base on transition to school has major gaps in knowledge, which make it difficult to ensure that policy recommendations are accurate. I will address three of them below.

The first and most obvious one in the Canadian policy context is that all the research comes from the U.S. While many of the universalia are directly applicable to the Canadian context, when it comes to specific practices, policy planning – which involves taking stock of funding levels, teacher training, community options and population structure, to name just a few factors – needs to be directly relevant. The standard transition activities in Canada, which vary not only from province to province but even from school board to school board, most often involve a half-day session in June prior to kindergarten entry that gives a small group of children with parents the opportunity to visit the school and meet the principal and the teacher. In many schools, groups are small enough to allow for some individual conversation. This is often followed by another opportunity for an informal school visit in late August (frequently called “a lemonade party”). Finally, many school boards practice the so-called “staggered” entry to the first level of kindergarten. This means that before starting with the whole class, each child
experiences his or her kindergarten classroom once with only four or five other children, and once with half of the class. Such small-group beginnings also give the teacher an opportunity to recognize those who might be facing more transition adjustment problems. Nevertheless, it is currently not known whether these practices, fairly standard in Canadian schools, actually work in improving transition outcomes.

Secondly, only a systematic monitoring of how children’s preschool history combined with school’s transition procedures and individual transition experience results in adjustment outcome in the first year of school can provide a sound basis for practice. While it is obvious from the survey carried out by Pianta, Early and colleagues in the U.S. that optimal practices are those that consider individual needs of students, the optimal balance between a group and individual approach is difficult to establish without more detailed research. Moreover, only systematic and standardized information about children’s preschool experience, collected several months prior to school entry, can facilitate tailoring transition practices to individual needs.

Third, the process of transition is stressful/challenging to every child to a certain degree. Therefore, transition practices could be conceptualized as a type of preventive process, ameliorating the outcomes. With these two tenets, policy thinking could follow the model proposed by Offord and colleagues in advocating a balance among universal, targeted and clinical approaches to intervention in children’s mental-health issues, depending on the needs of children, their families and communities. Anecdotal evidence suggests that no matter what a child’s (and family’s) preschool experience was, the transition to school is a stressful process. In most cases, the environment is new; often children have to ride a bus for the first time in their life, they have a new teacher, and they have to make new friends, follow new routines and play on a new playground full of older children. Canadian children entering language-immersion programs also have to start learning a new language. All children require preparation for this transition and need to participate in basic transition procedures. Creating an opportunity to observe children and/or talk to parents several months prior to school entry will identify a proportion of children who require a more intensive approach, an increased “dose” of preparation. Very few of those will probably need even more help, including close involvement of the family. Such a model, followed with a systematic monitoring of children’s adjustment in kindergarten, coupled with teacher reports on their teaching experience would provide the most reliable knowledge for evidence-based recommendations so far.

We already know that there is a group of children – and families – who need intensified assistance with transition: the families of children with identified special needs. There is scant literature on the transition experience of these children, all of which comes from the U.S. While the issues are fairly obvious, and most if not all school boards in Canada have policies in place to ensure these children have their educational needs assessed; the process of transition and adjustment is often neglected. In view of the fact that most primary-grade children with special needs actually attend mainstream classrooms, inadequate consideration of their adjustment to such a setting prior to school entry is regrettable.
The final challenge in implementing the best transition practices goes beyond the lack of knowledge base. Like many “in-between” issues, transition is not a process naturally owned by anybody. It is not the preschool’s responsibility any more and not yet really the schools’ responsibility either. Nevertheless, it appears that schools have the most to gain, since their functioning can be greatly improved by faster and more positive outcomes of the process. Adjusted children learn better and faster and hopefully are less disruptive, thus making the teacher’s work easier. However, schools are systems that are already stretched very thinly, and additional resources are difficult to come by without appropriate justification.

Without the ability to make a connection between specific transition practices and the adjustment of the whole family to the school environment, we will only be able to make educated guesses in terms of policy recommendations. Ultimately, until research can demonstrate clearly that a planned and early preparation for transition leads to better educational outcomes, it is probably unlikely that money will be poured into funding transition practices.
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VOICES FROM THE FIELD -
Infants’ and Children’s Behavioural Sleep Problems
A Practice Perspective

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Service perspective

Papers summarizing the research in the Centre of Excellence for Early Childhood Development (CEECD) online encyclopedia emphasize the importance of organized sleep patterns and consolidated nocturnal sleep for optimal child development.\(^1\) For example, Thoman\(^3\) indicates that disorganization in sleep can place children at risk for serious emotional, social and cognitive developmental consequences, and Sadeh\(^1\) suggests poor sleep may lead to chronic adverse effects on psychosocial development. The authors’ comments support the importance of practice to assist parents with infants and young children to resolve behavioural sleep problems. However, there are gaps in the research literature about such sleep problems.

Several papers question the consistency of definitions of sleep problems in infancy and childhood, the relationship between night-time sleep and daytime behaviour in infants and children, the long-term implications of sleep patterns on development and the kinds of treatment that should be employed in a variety of family contexts. Thus, evidence about the long-term implications of sleep patterns on development, the incidence of behavioural sleep problems and the kinds of treatment that should be employed is either lacking or contested.

The nature of the evidence has implications for clinical practice. Wiggs has argued that parents will be better disposed to interventions that improve a child’s social or emotional development.\(^7\) However, it is difficult for practitioners to find strong evidence to support such claims. Parents have justification for being sceptical about the utility of interventions in the absence of such evidence, particularly when the lay literature provides conflicting views about behavioural sleep problems and optimal solutions. More longitudinal research is necessary to support causal relationships between early sleep problems and longer-term social and behavioural difficulties.

Clinical practitioners often work with parents who describe long-term sleep deprivation (lasting from months to years), difficulty thinking, discordant relationships with partners and children, and depressed moods. I am heartened by the CEECD papers’ emphasis on the negative effects of infants’ and children’s behavioural sleep problems on families, specifically parental functioning at work, parent-child interactions, family and marital harmony, parent mood and parenting.\(^1\) Those authors’ claims fit with many of my
experiences in working with families with sleep problems. It is, however, disheartening to find the question that is consistently raised in the literature: Are sleep problems infant problems or parent problems? Although parents often need help with realistic expectations, in my opinion, a behavioural sleep problem is a family problem that should not be assigned to one family member in isolation from the others. Children develop in families; each family member is affected by other members. It is difficult to imagine a child whose optimal development would be unaffected by distressed and tired parents, even if that child could compensate for night-time sleep deficits in the daytime. In my experience, many parents report that young children who have difficulty sleeping at night also have difficulty with naps and are often “catnapping” or sleeping for only 20- or 30-minute periods.

The literature is inconsistent about the persistence of sleep problems. While some authors argue that sleep problems from early infancy are persistent if not treated, others argue that they are transient and self-limited in nature. Given the conflicting literature, practitioners have difficulty honestly answering parents’ questions about whether their children will grow out of the problem if no intervention is undertaken and must indicate there are no definitive answers.

Questions raised by researchers about which kinds of treatment should be employed and when are important. In my opinion, recent work that categorizes particular approaches as well established, probably efficacious or promising is not helpful in practice. In one paper, unmodified standard extinction and parent education have been categorized as well established, graduated extinction has been categorized as probably efficacious, and bedtime routines have been categorized as promising. The research agenda emphasizes evaluating a specific approach and presents “mixed” approaches as problematic. In practice, a total picture, which includes naps, feeding, playing and sleeping patterns, bedtime routines and approaches to night waking, indicates that a mix of interventions is helpful for parents’ efforts to resolve behavioural sleep problems.

While there is no doubt that for research purposes objective measures and a lack of reliance on maternal report are important, in practice parental reports form the primary feedback about whether strategies were effective. Given that a number of the CEECD authors argue that there is compelling evidence to support the efficacy of specific non-pharmacological treatments for bedtime and night waking problems and that those treatments are generally acceptable to parents who are defining the behavioural sleep problems, practitioners should raise the questions: When are researchers going to refrain from calling for more empirical testing and accept some interventions as empirically valid; and When will the policy agenda move forward to implement empirically sound interventions in a variety of practice environments?

In other western countries (e.g. Australia and England), sleep clinics have been established, often by child health nurses, and infants and young children are being exposed to systematic community-wide interventions to resolve behavioural sleep problems. In Canada, despite claims by several CEECD authors that behavioural sleep problems are a major public-health issue and early sleep hygiene is imperative, there is
little evidence that healthy infant and child sleep has been incorporated in the policy
agenda and no evidence of systematic interventions to assist parents with children’s
behavioural sleep problems. In my opinion, widespread screening and implementation of
effective interventions should be undertaken, with empirically-based evaluative
components. I agree with several authors who argue that health-care professionals require
more sleep training; however, community health nurses, who are often consulted by
parents, are overlooked in the CEECD authors’ discussions of health-care professionals
who could benefit from further sleep training.\textsuperscript{1-9} France and Blampied also emphasize the
lack of research into quality treatment services for children who have special needs or
who are disabled.\textsuperscript{9} The research agenda must capture effects of behavioural sleep
problems on children’s long-term social, cognitive and emotional development, including
those who are disabled.
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VOICES FROM THE FIELD -
Tobacco Cessation for Pregnant Women

Colleen Kearns, Public Health Nurse
Smoking cessation program for pregnant women

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Service perspective

The greatest challenge to working with pregnant women is recruitment. I agree with Melvin that the rate of deception is very high with regard to self-reported smoking status during pregnancy.5 How can we help pregnant women feel comfortable talking about their smoking?

The decision was made to recruit women into our program by working with our Public Health Information Line. When a pregnant woman calls the line to sign up for prenatal classes (before her twentieth week of pregnancy), she is asked whether she smokes or not. If she does, she is asked whether she would be willing to talk with a public health nurse about her smoking. It is made very clear that no pressure will be put on the woman during this phone conversation. In my experience, women who use tobacco in pregnancy often feel very guilty. Every effort must be made to make the woman feel comfortable while engaging in practical counselling on the phone. All women are offered practical problem-solving/skills training (see Melvin5), such as how to anticipate smoking triggers and how to deal with other smokers in the household. All clients in counselling are also offered a package of self-help pregnancy-specific quitting materials mailed to them upon request.5

Many women feel they require a home visit for a one-on-one counselling session to quit smoking. During these home visits, which usually last for one hour, I use incentives such as sugarless gum, water bottles, toothbrushes and toothpaste to help the woman quit smoking.8 All clients receive follow-up one month after their initial phone call or home visit.

I counsel women on the phone or at home and also offer smoking cessation groups. All clients who wish to attend a group are offered free bus tickets to get to and from the group. They are also offered subsidized nicotine-replacement therapy nicotine gum or the patch (with a doctor's certificate) if they are unable to quit smoking on their own (Ontario Medical Association 1998).

Experience has shown me that a woman who shows no signs of wanting to quit smoking is often at least willing to reduce her cigarette consumption.8 She may also be willing to make her home and car smoke-free. This is a very important step in harm reduction and
we always encourage the women, saying that their efforts are very important and that one day they may have success with cessation as well.8

I agree with Hennrikus and Lando that pregnancy provides an opportunity for a mother to extend stopping smoking for the baby into quitting for life.8 I disagree with the authors, however, about the lack of materials on relapse prevention. All of our clients who quit smoking are given a copy of Start Quit, Stay Quit, a relapse prevention guide for women who have quit smoking in pregnancy. Their partners receive a separate resource on how to support their partner’s cessation efforts. All clients are also encouraged to breastfeed for as long as possible, since cessation of breastfeeding has been linked with relapse of cigarette smoking.

In my opinion, the main gap between research and practice is the area of tobacco consumption in pregnancy and its impact on child development. The area of study that I do not incorporate in my work is the link between women who smoke in pregnancy and potential problems with psychosocial development in their children. Fried states that it is important for service providers to be aware of the long-term problems associated with smoking in pregnancy.3 It would be interesting to learn how we can give pregnant women effective counselling on smoking cessation and discuss potential behaviour problems in their future children, such as aggression, conduct disorders, hyperactivity and crime.3 In terms of planning future programs, I feel this information would be ideal to share with women of reproductive age before they ever become pregnant, rather than during pregnancy. With that in mind, I plan to use this information in the future when planning presentations to high schools on preconception health.
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