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Barriers to Services Promoting Child Emotional, Behavioural, and Social Health

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Introduction

In this paper on barriers to service, we will begin by defining the parameters of our work. Barriers are defined as both real and perceived obstacles that prevent or interfere with access to services. Services are defined as specific intervention or prevention strategies to decrease child emotional, behavioural, and social problems. We define emotional, behavioural, and social problems broadly as within the area of children's mental health, views on the causes and definitions of problems vary widely.[1]

Our focus is children from 0 to 5 years of age who are living in low-income families. However, the paucity of literature on this kind of population has led us to look more broadly to services working to decrease child emotional, behavioural, and social problems. As a result, the conclusions reached and the implications discussed herein apply beyond this specific population.

Background

Over 1.2 million Canadian children are poor.[2] Repeated cross-sectional studies that provide a snapshot of how children are doing at a single point in time have demonstrated an association between low income and a variety of child morbidities,[3-6] including emotional, behavioural, and social difficulties. Longitudinal studies which allow for the investigation of the impact of low income on child development over time further demonstrate that the greater depth and duration of poverty in early life (preschool and early school years), the greater the impact on child outcomes will be.[6-7] This article focuses on poor, young children up to 5 years of age — a population at high risk for developing emotional, behavioural, and social difficulties.

Key Questions

The framework for identifying barriers to services to decrease child emotional, behavioural and social problems for low-income families with young children examines four specific questions:

1. Are services effective?
2. Are services available?
3. Are those in need seeking referral to services?
4. Are services accessible?

Research

Are Services Effective?

A number of services for low-income families with young children have been rigorously evaluated and appear to be effective. These specific individual services consist of certain day care and preschool programs,[8] parenting programs,[9] and nurse home visitation services.[10] A complete review of these services is beyond the scope of this article. Other services for low-income families with young children are currently being carefully evaluated (eg, support/education groups for single, low-income mothers of young children).[11] Preliminary results are positive, but the evaluation of these services remains incomplete.

It is alarming how few of the programs for low-income families with young children have been rigorously evaluated. The same is true, more broadly, for the gamut of services aimed at decreasing child emotional and behavioural problems.

In addition to the need to do more evaluation, it is also important to consider what method of evaluation has been adopted. Research strategies to evaluate services range from efficacy research (the study of how a service works under ideal conditions) to effectiveness research (the study of how a service works in the real world). Assessment of services in the real world is important, since on one hand participants in efficacy studies may not be representative of those who attend conventional clinical or community-based services, and on the other hand services provided in efficacy studies may be highly controlled and may not accurately represent services provided in the real world.[12,13,14] An effectiveness evaluation framework is therefore most relevant to services evaluation.

Are Services Available?

The availability of services aimed at decreasing child emotional and behavioural problems varies according to where a family lives. Therefore, services are neitherreadily available to all low-income families with young children, nor to other populations of families and children in Canada. In general, services are more readily available in urban (as opposed to rural) settings, and in southern (as opposed to northern) regions of Canada. Indeed, research suggests that only a relatively small proportion of children with emotional and behavioural problems actually receives professional help.[15,16] While every child with emotional and behavioural problems may not need professional resources, increasing service availability, through the creation of new services, along with hiring new service personnel, and redistributing resources[17] would be important steps towards breaking down barriers to services for many families, including low-income families with young children

Are Those in Needs Seeking Referral to Services?

Families may not seek services if the problem for which the service is sought is poorly understood (problem recognition) or if their understanding of the available service is unclear of unfavourable (service perception). Difficulties with problem recognition include parents', teachers', or health care providers' inabilities to identify the need for service,[1] denial of problem severity,[1] and the belief that the problem can be "handled" without intervention[1,18] or will get better on its own, with time.[18] In addition, the family must have reached some degree of readiness for change[19] before services are sought.[11] Difficulties with service perception include lack of trust in or negative experiences with the providers, lack of desire on the part of the child to receive help, and stigma related to mental health problems.[11] Education about the norms and deviations in the emotional,

behavioural, and social development of children 0 to 5 years old, and about helpful approaches to specific child and family problems may help families and others make better-informed decisions about whether a service is needed. Establishing community awareness regarding children's mental health problems, receiving supportive comments from others who have used the services or from community leaders, and making efforts to decrease stigma may also be helpful.[20]

Are Services Accessible?

An effective, available service that is recognized as necessary to families and young children is still of little use if families cannot access the service. Accessibility barriers include waiting lists, service costs, transportation, inconvenient times or locations, child care, parental mood, language and cultural issues, and literacy.[1,11,21] Low-income families may favour non-clinic based interventions[21,22] although not all studies consistently support this view.[23] Studies on intervention attrition have shown that socio-economically disadvantaged families in which parents have little education, present with psychopathologies and experience high levels of stress are most likely to drop out of services and programs.[24,25] These features are shared by many low-income families.

The barriers identified have provided logical parameters for the methods used to increase service accessibility. These include provision of childcare, assistance with transportation costs, varied program times and locations, low-cost or free programs, and efforts to accommodate literacy, language, and cultural differences. Another approach to increasing service accessibility is to ask families about their preferences. Consumer research marketing techniques have been applied to a variety of families, including low-income families, to identify program preferences.[26,27,28] Issues such as timing, instructor qualifications, and program research base were identified as important features.

Conclusions

Our framework for understanding barriers to services for helping children with emotional and behavioural difficulties is based on four specific questions: (1) Are services effective? (2) Are services available? (3) Are those in need seeking referral to services? (4) Are services accessible? Barriers to treatment were identified in all of these areas. First, in terms of service effectiveness, some services for this population of families have been evaluated and found to be helpful. However, many services have not been adequately evaluated. Second, service availability varies according to whether recipients are in urban vs. rural or southern vs. northern locations. Third,

difficulties with both problem recognition and service perception may exist, creating barriers to service use by low-income families with young children. Finally, numerous barriers to service accessibility have been identified.

Implications

Removing barriers to services for low-income families with young children (and for many other Canadian families) is a task that varies according to the barrier to be surmounted. Recommendations must therefore reflect this specificity. Interventions that have proven effective should be widely available, whereas those that have not should be subject to evaluation. Careful attention should be paid to issues of respondent burden when asking families to answer evaluations.[15] Moreover, it should be noted that barriers to service accessibility relate to broad issues such as national and provincial health care planning, specifically in terms of recruitment and funding for health care professionals who work with young children and families. Planning is needed to ensure that adequate resources are available to serve at-risk populations of children and families. Difficulties related to problem recognition and service perception may be overcome through appropriate education about normal and deviant child behaviour, and community acceptance of services. Barriers to service accessibility have been well documented, and careful planning around service timing and location, childcare, and transportation assistance can also be very helpful in reducing these barriers. Consideration of all these issues should therefore be a routine part of both service planning and service budgets.

References

1. Owens PL, Hoagwood K, Horwitz SM, Leaf PJ, Poduska JM, Kellam SG, Ialongo NS. Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry* 2002;41(6):731-738.
2. Statistics Canada. Persons in low-income before tax: 1996-2000. Available at: http://www.statcan.ca/english/Pgdb/famil41a.htm. Accessed August 06, 2003.
3. Lipman EL, Offord DR, Boyle MH. Relation between economic disadvantage and psychosocial morbidity in children. *Canadian Medical Association Journal* 1994;151(4):431-437.
4. Lipman EL, Offord DR. Psychosocial morbidity among poor children in Ontario. In: Duncan GJ, Brooks-Gunn J, eds. *Consequences of growing up poor*. New York, NY: Russell Sage Foundation; 1997:239-287.
5. Lipman EL, Offord DR, Dooley MD. What do we know about children from single-mother families? Questions and answers from the National Longitudinal Survey of Children and Youth. In: Human Resources Development Canada, Statistics Canada, eds. *Growing Up in Canada: National Longitudinal Survey of Children and Youth*. Ottawa, Canada: Human Resources Development Canada, Statistics Canada; 1996:119-126. Catalogue No. 89-550-MPE, no. 1.
6. Brooks-Gunn J, Duncan GJ. The effects of poverty on children. *Future of Children* 1997;7(2):55-71.
7. Duncan GJ, Brooks-Gunn J. Income effects across the life span: integration and interpretation. In: Duncan GJ, Brooks-Gunn J, eds. *Consequences of growing up poor*. New York, NY: Russell Sage Foundation; 1997:596-610.

8. Zoritch B, Roberts I, Oakley A. Day care for pre-school children. *Cochrane Database of Systematic Reviews* 2002;4.
9. Barlow J, Parsons J. Group-based parent-training programmes for improving emotional an behavioural adjustment in 0-3 year old children. *Cochrane Database of Systematic Reviews* 2002;4.
10. Olds DL, Henderson CR Jr., Chamberlain R, Tatelbaum R. Preventing child abuse and neglect: a randomized trial of nurse home visitation. *Pediatrics* 1986;78(1):65-78.
11. Lipman EL, Secord M, Boyle MH. Moving from the clinic to the community: The Alone Mothers Together Program. Canadian Journal of Psychiatry-Revue *canadienne de psychiatrie* 2001;46(7):657.
12. Streiner DL. The 2 "Es" of research: efficacy and effectiveness trials. *Canadian Journal of Psychiatry-Revue canadienne de psychiatrie* 2002;47(6):552-556.
13. Weisz JR, Donenberg GR, Han SS, Kauneckis D. Child and adolescent psychotherapy outcomes in experiments versus clinics: why the disparity? *Journal of Abnormal Child Psychology* 1995;23(1):83-106.
14. Jensen PS, Hoagwood K, Petti T. Outcomes of mental health care for children and adolescents: II: Literature review and application of a comprehensive model. *Journal of the American Academy of Child and Adolescent Psychiatry* 1996;35(8):1064-1077.
15. Boyle MH, Offord DR. Prevalence of childhood disorder, perceived need for help, family dysfunction and resource allocation for child welfare and children's mental health services in Ontario. *Canadian Journal of Behavioural Science* 1988;20(4):374-388.
16. Boyle MH. Children's mental health issues: prevention and treatment. In: Johnson LC, Barnhorst D, eds. *Children, families and public policy in the 90s*. Toronto, Ontario: Thompson Educational Publishing; 1991:73-104.
17. Canadian Academy of Child Psychiatry. Physician Resource Committee. Child Psychiatry in Canada. Position Statement; January 2002.
18. Pavuluri MN, Luk SL, McGee R. Help-seeking for behavior problems by parents of preschool children: A community study. *Journal of the American Academy of Child and Adolescent Psychiatry* 1996;35(2):215-222.
19. Prochaska JO, Velicer WF, Rossi JS, Goldstein MG, Marcus BH, Rakowski W, Fiore C, Harlow LL, Redding CA, Rosenbloom D, Rossi SR. Stages of change and decisional balance for 12 problem behaviors. *Health Psychology* 1994;13(1):39-46.
20. Lovato LC, Hill K, Hertert S, Hunninghake DB, Probstfield JL. Recruitment for controlled clinical trials: Literature summary and annotated bibliography. *Controlled Clinical Trials* 1997;18(4):328-352.
21. Cunningham CE, Bremner R, Boyle M. Large group community-based parenting programmes for families of preschoolers at risk for disruptive behavior disorders: utilization, cost effectiveness and outcome. *Journal of Child Psychology and Psychiatry and Allied Disciplines* 1995;36(7):1141-1159.
22. Hazell PL, Tarren-Sweeny M, Vimpani GV, Keatinge D, Callan K. Children with disruptive behaviours II: Clinical and community service needs. *Journal of Paediatrics and Child Health* 2002;38(1):32-40.
23. Harrington R, Peters S, Green J, Byford S, Woods J, McGowan R. Randomised comparison of the effectiveness and costs of community and hospital based mental health services for children with behavioural disorders. *British Medical Journal* 2000;321(7268):1047-1050A.
24. Spoth R, Goldberg C, Redmond C. Engaging families in longitudinal preventive intervention research: Discrete-time survival analysis of socioeconomic and social-emotional risk factors. *Journal of Consulting and Clinical Psychology* 1999;67(1):157-163.
25. Kazdin AE, Mazurick JL. Dropping out of child psychotherapy: Distinguishing early and late dropouts over the course of treatment. *Journal of Consulting and Clinical Psychology* 1994;62(5):1069-1074.
26. Spoth R, Redmond C. Identifying program preferences through conjoint analysis: Illustrative results from a parent sample. *American Journal of Health Promotion* 1993;8(2):124-133.

27. Buchanan D, Cunningham C, Miller H. Factors affecting parent participation in courses and groups. Poster session presented at: Children's Mental Health Ontario Annual Meeting; May, 2002; Ottawa, Ontario.

28. Rohrer JE, Vaughn T, Westermann J. Mission-driven marketing: a rural example. *Journal of Healthcare Management* 1999;44(2):103-116.