BUILDING TOGETHER

A Model for the Community-Based System of Services for Early Childhood Development

Vancouver Island

January 2004

PART 1: Building the Model

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INTRODUCTION

In the spring of 2003, an initial meeting was held between the Ministry of Children and Family Development (MCFD), Vancouver Island Health Authority (VIHA) and School Districts within the Vancouver Island region in order to explore, propose and initiate a partnership to address issues pertaining to early childhood development

As a first step in the process, VIHA agreed to draft a discussion paper (attached as *Part 2 - Building Together: Founded on Research*) to use as a tool to share common understanding of current research and strategies that are showing positive outcomes for early child development (ECD). Following the presentation of that paper, further commitment and agreement to move towards a partnership was supported. Work began towards delineating the structure and functioning of the partnership as well as construing a model for a comprehensive ECD support system.

The purposes of this paper are:

1) To outline the mission, goals, outcomes, and guiding principles of the system for ECD, and the memorandum of understanding endorsed by the three sector partners

2) To construct a model for a system of services and supports for ECD that:

   - Describes a multi-level framework for the delivery of ECD services encompassing universal, targeted and clinical services within a seamless system

   - Provides a comprehensive overview of the essential component services and supports for early childhood development along a developmental continuum. These services and supports comprise the building blocks within the framework

Memorandum of Understanding

Between:
Ministry of Children and Family Development,
Vancouver Island Health Authority and School Districts

WHEREAS

A) The Parties agree the early years are critical in the development and future wellbeing of the child in establishing the foundation for competence and coping skills that will affect learning, behavior, health, and lifetime outcomes.

B) The Parties agree that children thrive within families and communities that can meet their physical and developmental needs and can provide security, nurturing, respect, and love.

C) The Parties agree to strive for the most effective and efficient approaches to child health and development.

D) The Parties agree that the most effective and efficient approaches require collaboration and partnership across the broad array of domains and sectors that influence the development and wellbeing of all children.

E) The Parties agree that a mix of universal, targeted and clinical services will contribute to the wellbeing of all children.

F) The Parties agree to build a relationship based on mutual trust and mutual respect.

G) The Parties agree that their relationship is a shared responsibility based on openness, mutual accountability, and transparency.

H) The Parties agree on the need for a respectful and ongoing dialogue regarding early childhood development issues.

Therefore the Parties agree as follows:

1.0 PURPOSES

1.1 The purpose of this Memorandum of Understanding is to establish a dialogue and decision making process for a collaborative and well co-ordinated community-based system of early childhood supports and services that promotes and protects the healthy development of children and families

1.2 The dialogue and decision-making process will focus on:
   a. Promoting family and community capacity to support child and family development;
   b. Enabling communities to develop and deliver services within a comprehensive, consolidated, community-based system of services;
   c. Reinvesting in promotion and prevention toward less reliance on intervention, remediation, and treatment;
   d. Promoting innovation and shared initiatives;
   e. Encouraging multisectoral and interdisciplinary approaches

1.3 Reviewing existing protocols and agreements to ensure consistency with this memorandum of understanding

1.4 The dialogue and decision making process will be carried out through the Committee which is established in section 2.0 and is comprised of representatives of the signatories

2.0 VANCOUVER ISLAND EARLY CHILDHOOD SERVICES COMMITTEE

2.1 A committee will be established, comprised of appointed representatives by each of the following signatories:
   a. The Ministry of Children and Family Development
   b. The Vancouver Island Health Authority
   c. The School Districts

   and representatives from:
   d. The Vancouver Island Regional Planning Committee
   e. The Vancouver Island Aboriginal Transition team

2.2 Each of the representatives referred to in section 2.1 will appoint one alternate who will attend meetings of the committee in the absence of the representative appointed in that section

2.3 The role of the Committee will be to:
   a. Establish a strategy to monitor progress on this model of community-based system of early childhood services;
   b. Establish a communication plan to introduce this model of community-based system of early childhood services;
   c. Evaluate progress on this model of community-based system of early childhood services; and
   d. Review the priorities within this model of community-based system of early childhood services

3.0 TERM AND REVIEW

3.1 This MOU shall come into effect as of the date of the signatures and will remain in effect for a (5) five-year period from that date (the "Term")

3.2 This MOU and activities associated with it will be reviewed annually by the Parties during the Term

VISION

It is the vision of the Ministry of Children and Family Development, Vancouver Island Health Authority, and Vancouver Island School Districts that all children and youth achieve optimal functioning and wellbeing. This vision serves the dual purpose of making early years as experientially positive as possible and in turn, provides a basis for optimal development into adult life. [a]

MISSION

The mission of our partnership is:

- To establish a model for a collaborative, co-ordinated, community-based system of early childhood supports and services that promotes and protects the healthy development of children and families
- To establish a single unified process that all signatories will agree to in regard to planning, allocation of resources, and evaluation of the early childhood system of supports and services in the Vancouver Island region

OUTCOMES

1) Healthy pregnancy and birth[1]
2) Healthy growth and development (physical, social, psychological, spiritual) of young children[2]
3) Capable and responsive parenting and caregiving
4) Protective and nurturing environments for children
5) An effective early childhood system of services, with joint initiatives, that meet the service system criteria outlined in our guiding principles

[a] *Celebrating Success: A Self-regulating Service Delivery System for Children and Youth*. Health Canada. 2000.P.7

GUIDING PRINCIPLES

Services and supports comprising the system for early childhood development will be:

- Child-centered and family-focused
- Community-based
- Strength-based
- Inclusive
- Evidence-based
- Outcome-based
- Collaborative, well coordinated
- Timely, responsive, flexible

These guiding principles are based on foundational values and beliefs regarding how human beings ought to be treated when engaged in seeking and using ECD services and how services can be most effective. They are firmly embedded in professional experiences and philosophies that guide ECD strategies. These principles are evolving in nature and imprecise measurement of such concepts as "coordinated", "community-based" and "family-focused" underscore the critical need for more descriptive, explanatory investigations in these areas, including qualitative and quantitative research.[b] Nevertheless, these principles require some basic level of definition to provide common understanding between sectors, disciplines, communities and families.

Child-centered and family-focused

In all planning and decisions the well-being and safety of the child is of primary importance. The essential features [c] of a family-focused approach to ECD services include: (1) treating families with dignity and respect, particularly with respect to their cultural and socioeconomic characteristics; (2) providing choices that address family priorities and concerns; (3) fully disclosing information so that families can make informed decisions; and (4) providing service that supports and upholds family self-regulation.[d]

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[b] Shonkoff, Jack P. and Deborah A. Phillips, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* National Academy Press. 2000p.367

[c] Shonkoff, Jack P et al. p.366.

[d] Sanders, Matthew R. *Triple P Positive Parenting Program: Toward an Empirically Validated Multilevel Parenting and Family Support Strategy for the Prevention of Behaviour and Emotional Problems in Children.* Clinical Child and Family Psychology Review. Vol. 2, No.2. 1999. p.75.

Community-based

The essential characteristics of a community-based model are reflected in the extent to which services are delivered in an non-stigmatizing, normative environment that has both physical and psychological proximity to where young children and their families live.

Strength-based

Strength-based refers to the commitment to recognize the positive potential of people – children, families and communities, with an emphasis on their strengths. A strength-based philosophy "allows us to recognize hurt while focusing on hope, and recognize pain while focusing on promise". [e]

Inclusive

Services should be provided in a manner that respects family, community, and cultural differences. Services should be available and accessible (addressing barriers and encouraging participation[3]) for all families with young children. An inclusive philosophy upholds "success for all".

Evidence-based

Outcomes for children will be best when ECD strategies are based on sound research and evidence.

Outcome-based

Services are supported by evaluation at all levels.

Collaborative, well-coordinated

Partnerships in all aspects of service design and delivery are supported. Interdisciplinary and intersectoral partnerships are encouraged and created at all levels and maintained to make services effective and efficient.

Timely, responsive, flexible

[e] *Home Visitor Training Manual*. Minnesota Department of Health, Maternal and Child Health Section. www.health.state.mn.us

A MULTI–LEVEL FRAMEWORK

A multi-level framework for the system of early childhood development (ECD) serves to recognize and facilitate several key objectives. Foremost is a need to shift the focus of services and resources towards promotion and prevention from traditional reactive interventions. With our growing knowledge of strategies that can positively affect the outcomes of all children and with the growing success of early interventions, we can lower the incidence of children needing intensive therapies and protections. [4]

Furthermore, if we are to sustain and improve the quality of the next generation of citizens, we need to set high priority on the optimal development of all young children. We know that approximately one-quarter of all children on Vancouver Island are vulnerable for poor developmental outcomes and that we cannot identify these children through traditional measures of socioeconomic status.[f] Vulnerable children are found across all socioeconomic boundaries. To reduce this figure requires effective ECD programs for all families with young children, not just targeted programs or programs for children with special needs.[g] [5] If we focus on successful outcomes for all, not just the avoidance of negative outcomes for those at risk, then we are more likely to move to a system of supports that all parents need.

Researchers have concluded that ensuring that all children will thrive can only be achieved with a rational mix of universal programs designed to build capacity and promote well-being for all children, targeted interventions to reduce risk for some populations, and clinical services for children showing abnormalities in development.[h] (see Diagram 1) Furthermore, targeted measures to support children and families who are at risk or having difficulties has proven to work best within a system available to everyone.[i]

The right mix and proportion of resources and efforts devoted to each level within the universal-targeted-clinical spectrum, and the components within each level, requires an understanding of which strategies are supported by the best currently available research evidence, and which are not. Fortunately, research and evaluation over the past several decades have determined which interventions are making a real difference in children's outcomes. These interventions originate from a wide variety of disciplines and domains, and work best when offered as a part of a continuum of services. They provide the building blocks for assembling proven services and supports within the framework.

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[f] Mustard, Fraser and Frances Picherack. *Early Child Development in British Columbia: Enabling Communities.* May 2002. p.iv. www.founders.net

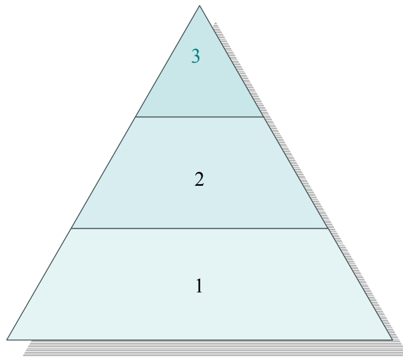
[g] Ibid. p.26

[h] Keating, Daniel P and Clyde Hertzman. *Developmental Health and Wealth of Nations.* The Guilford Press. New York. 1999.p.309.

[i] McCain, Margaret and J. Fraser Mustard. *Reversing the Real Brain-Drain: The Early Years Study*. April 1999. Publications Ontario.p.141.

Diagram 1

A Multi-Level Framework of ECD Services and Supports [j]



Level 1
Universal Strategies:

Possible examples: media promotion for awareness of early childhood developmental issues, normalizing parenting programs, and early literacy strategies; well-baby clinics, early growth and developmental screening; day care and preschool

Level 2
Targeted Strategies:

Possible Examples: brief counseling sessions in response to specific concerns, early intervention referrals (speech, physiotherapy, infant development), "targeted" day care, supported child care, etc.

Level 3
Intensive Strategies

Possible Examples: intensive medical services, child protection and intervention, therapies for families experiencing marital discord, mental illness, etc.

[j] Adapted from the Triple P multi-level system of parenting and family support.
(see www.triplep.net)

ESSENTIAL ECD SERVICES AND SUPPORTS WITHIN THE FRAMEWORK[k]

The purpose of this section is to delineate the essential services and supports to families that have shown evidence of making a positive difference to the outcomes of early childhood development. As the partners to this paper, communities, and funders share knowledge of the research and evidence-based strategies that have the greatest impact on children's lives, it is hoped that they will better be able to:

- Locate strengths, gaps, and insufficiencies in services within communities,
- Identify opportunities to collaborate, coordinate, and/or integrate services to address the gaps and improve services,
- Recognize where some services need to change to come into line with the evidence, and
- Set goals and priorities for funding and future planning for ECD Initiatives

Services and Supports along the Continuum of Child Development

All parents need some kind of support to ensure their children get the best start in life during the early years; the essential services and supports outlined here form the basic level of support for early child development that should be available to all families. The continuum of these services and supports corresponds to the development needs of the child from conception through to kindergarten age. (see Diagram 2)

From conception to about one and a half years, services and supports are primarily focused on the parents and primary caregivers, particularly the mother, as the crucial stimulation for the child's development comes from these persons. By the toddler years children have started to develop through social and play-based interactions with other children. This period of development is still driven by the quality of stimulation by parents (children spend most of their time with parents), but now the interactive stimulation provided by play with other children and early educators is an important driver in development and has a large influence on the development of core capability of the brain in literacy and language, numeracy, behaviour, emotional control and social skills.

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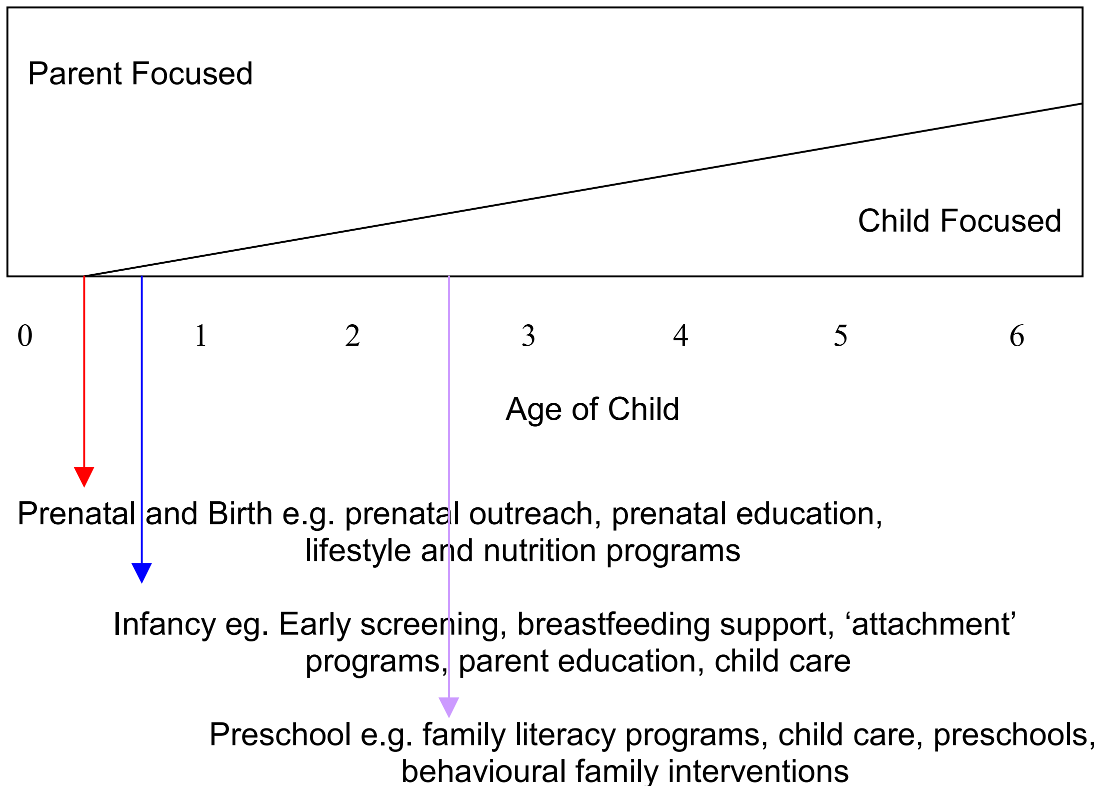
[k] This compilation relies heavily on the work of Paul D. Steinhauer and the Sparrow Lake Alliance (see www.growinghealthykids.com); the work of First Call: BC Child and Youth Advocacy Coalition, *Early Childhood Development in BC: First Call's Framework for Action*, March 2003 (www.firstcallbc.org); *Early Child Development in British Columbia: Enabling Communities*, May 2002, by Fraser Mustard and Frances Picherack (www.founders.net); and *A Policy Framework for ECD in BC,* prepared by the ECD Funder's Network, November 2002.

Diagram 2

Continuum of Supports and Services for ECD[1]



The examples above (e.g family literacy programs) are a sampling of evidence-based strategies that are proven to have positive influence on early childhood development.

[1] Adapted from McCain, Margaret and J. Fraser Mustard. *Reversing the Real Brain-Drain: The Early Years Study*. April 1999. Publications Ontario. P.107, 108.

1. Prenatal and Birth Services and Supports

"The primary goal of strategies during this stage would be to ensure the overall physical and psychological health of the mother-to-be and the optimal uterine development and normal delivery of a healthy infant….A secondary goal would be to ensure that the mother-to-be had freedom from intolerable levels of stress along with the psychological health and the sources of personal support that would favour the close involvement and sensitive attunement to the infant that is so important for the formation of secure attachment." [m]

Services and Supports [n]

- High quality prenatal primary health care
- Early identification, assessment, and treatment of medical and psychosocial risk
    - Including screening for attachment disorder and mental illness
- Supports for mother-to-be in achieving optimal lifestyle in pregnancy
    - Optimal diet
    - Engagement in active living
    - Elimination/decrease in alcohol, drug and tobacco use
    - Elimination/reduction of stressors including factors related to poverty, domestic violence, and social isolation
    - Opportunities for increased psychosocial support
- Prenatal education for pregnancy, birth, and new born care
- Outreach to socially isolated parents/caregivers

New Research and Evidence-Based Strategies to Note:

- Research supporting the effectiveness of nurse home visiting programs for early childhood development and maternal outcomes. [6]
- Controversy regarding the effectiveness of lay home visitors programs for early child development outcomes and maternal life course outcomes.[7] [8]
- Population approaches to the reduction of low birth weight (LBC), as well as targeted interventions.[9]
- Growing body of knowledge regarding the role of stress in LBW. [10]
- Canada Prenatal Nutrition Program (www.hc-sc.gc.ca)
- Growing Together (www.growinghealthykids.com)

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[m] Steinhauer, Paul D. *The Primary Needs of Children: A Blueprint for Effective Health Promotion at the Community Level.* Sparrow Lake Alliance. April 1996. p. 9

[n] See www.growinghealthykids.com especially – Transition to the First Year – Influences on Positive Outcomes

2. Services and Supports for Infancy

"The goals and strategies during the first year would be:

- *To ensure that the infant's basic physical needs are met (nutrition, housing, medical care, safety)*
- *To ensure that every child receives high-quality and consistent nurturing within a secure, physically and emotionally safe environment*
- *To promote and sustain a parent/child relationship that will support the healthy development and socialization of the child within the family*
- *To support and when necessary, to improve, parenting capability*
- *To ensure the early identification and referral for assessment/or intervention directed towards problems in the infant, or the relationship between the child and the primary caregiver should the need arise*
- *To ensure that the child receives the cognitive stimulation essential for cognitive and language development*
- *To ensure adequate support for caregivers and accessible linkages to community resources"* [0]

Services and Supports

- Public health visits to all newborns/families
- Accessible well-baby clinics/immunization clinics
- Breastfeeding support and services
- Early screening, identification, referral, assessment and intervention for problems related to the development and growth of the infant
- Early screening, identification, referral, assessment and intervention for problems related to the primary caregiver's ability to be sensitively attuned to the infant and be responsive to the infant's clues (e.g. adjustment difficulties, depression, attachment disorder)
- Parent/caregiver education, support, resources and referral ~ encompassing essential parenting knowledge, positive parenting skills, social supports, and community support (encouragement for the importance of parenting, normalizing parent education), etc.
- Parent/child play-based learning opportunities for the promotion of early literacy and language, etc.
- Available, accessible, affordable quality childcare that is "family-centered" for all families who require this service; childcare information and referral service (*Childcare is an essential service for early childhood development although the present signatories to the Memorandum of Understanding do not have funding responsibilities in this domain.)
- Outreach to socially isolated parents/caregivers
- Intensive, therapeutic, quality, "family-centered", child care as 'intervention' for vulnerable children and families
- Specific supports for infants with developmental delays, disabilities, and behavioural issues
- Services to address safety of parent/child from family and community violence

[0] Steinhauer, Paul D. p.10

- Intervention when infant is at risk for neglect and abuse

New Research and Evidence-Based Strategies to Note:

- The effectiveness of quality child care programs as intervention for vulnerable infants and families[11]
- Population health strategies raising awareness of the importance of parenting, normalizing parenting concerns and parent education.[12] (see also www.triplep.net)
- The effectiveness of offering targeted programs within or alongside universal programs[13]
- Accumulating knowledge regarding attachment disorder interventions[14]
- Role of home visiting programs; paraprofessional and nurse home visitor programs and implications (see Endnotes)
- Potential of Family Learning Programs (parenting and family literacy programs, toy lending libraries, clothing exchanges)[15]
- The Prevention of Preterm Delivery Through Improved Prenatal Care in France (see www.growinghealthykids.com)
- Stay on Track, Leeds Grenville Health Unit, Ontario (see www.growinghealthykids.com)

3. Services and Supports for the Preschool Years

" The primary goal of strategies at this stage is to ensure that all preschoolers receive continuous care in nurturing and stimulating environments" and are supported in mastery of the "universal developmental tasks" of this age" [p] [16] [17]

Services and Supports:

- Well-child and immunization clinics
- Early screening, identification, referral, assessment and intervention for problems related to the development and growth of the child
- Parenting services: community support, social support and outreach to socially isolated parents; parenting education(knowledge); positive parenting skill development; parenting referral services
- Parent/child learning programs emphasizing play-based, problem-solving opportunities including play groups, early literacy, early numeracy, music, dance, etc
- Opportunities for children to interact positively with other children and adults other than family members
- Links to other institutions such as schools, libraries recreation, and cultural activities in communities
- Available, accessible, affordable quality childcare that is "family-centered" for all families who require this service; childcare information and referral service (*See note under Infancy)

[p] Steinhauer, Paul D. p 10, 11.

- Intensive, therapeutic, quality, “family-centered” child care as an ‘intervention’ for vulnerable children and families
- Specific services and supports for children with developmental delays, disabilities and behavioural issues and for children who have experienced trauma
- Intervention when a child is at risk for neglect and abuse
- Services to address safety of parent/child from family and community violence
- Quality preschool experience. [q]

New Research and Evidence-Based Strategies to Note:

- Positive outcomes of Parenting and Family Literacy Centres in Toronto [11]
- Success of ‘Behavioural Family Interventions’ (BFI) with young children displaying social and behavioural problems[18 19]
  e.g. The Incredible Years (see www.incredibleyears.com), Triple P (see www.triplep.net), COPE (see www.hhsc.ca/ccfc/)
- Quality “family-centered” child care programs for vulnerable children and their families[20]
  E.g Perry Preschool Project (see www.highscope.org)
- French experience with publicly funded preschools[21]
- United Kingdom experience with preschool programs[22]
- There is mounting evidence that the public school system has a vested interest and a role to play in ECD[23]

[q] From the *Canadian National Child Care Strategy: Getting the Architecture Right Now,* John Godfrey MP, November 2002. It is the recommendation for the Liberal Caucus Social Policy Committee that 1 billion dollars be spent towards establishing a comprehensive program “so that by 2007, every 3-5 year-old child who needs it should have a preschool place.”

4. Support for Communities

"Communities make key contributions to the well-being of children through formal and informal networks. This priority includes supports to strengthen community capacity to meet the needs of children and families from an healthy community perspective." [r]

Services and Supports

- Supports for sustained community-based planning and service integration
- Supports for communities to engage in mapping child development, community assets, and socioeconomic characteristics, in order to assess how well communities are doing in supporting ECD

New Research and Evidence-Based Strategies to Note:

- Better Beginnings, Brighter Futures. Contact Ray DeV. Peters, Research Coordination Unit, Queen's University. www.bbbf.queensu.ca [24]
- Human Early Learning Partnership and community mapping. www.earlylearning.ubc.ca

[r] Mustard, J. Fraser and Frances Picherack. p. 7.

ENDNOTES

[1] "Health is seen as the extent to which an individual or group is able, on the one hand, to realize aspirations and to satisfy needs, and, on the other hand, to change, or cope with the environment. Health is therefore seen as a resource for everyday life, not as the objective of living; it is a positive concept emphasizing social and personal resources as well as physical capacity." – *World Health Organizations, 1984*
"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."
From the Constitution of the World Health Organization

[2] *The Well-being of Canada's Young Children: Government of Canada Report 20*02, delineates five domains of child-wellbeing:

1. Physical Health and Motor Development – the child's general state of health and gross and fine motor skills
2. Emotional Health – The child's self-esteem, coping skills and overall emotional well-being
3. Social Knowledge and Competence – The way a child behaves and is able to communicate feelings and wants
4. Cognitive Learning – The ways in which a child perceives, organizes and analyzes information provided by his or her social and physical environment
5. Language Communication – The ability of a child to communicate, including receptive and expressive language skills

See www.socialunion.gc.ca/ecd_e.html
We have added spiritual wellbeing in recognition of the understanding of the whole person as held by many diverse peoples in Canada including traditional aboriginal cultures. Spiritual well-being includes the ways in which the child is connecting to the beliefs and values of the culture and community he or she lives in; it is associated with the concept of self-actualization; and may be concerned with developing beliefs in a "unifying force".
See "*Many Voices, Common Causes: A Report of the Aboriginal Leadership Forum on Early Childhood Development:,* March 2003, p.5. www.acc-society.bc.ca

We have collapsed these 6 domains of well-being into four categories – physical, emotional, psychological and spiritual health and development

[3] *A Policy Framework for Early Childhood Development in British Columbia.* November 2002. Prepared by the ECD Funders' Network. p. 3.
"From prenatal classes to good quality day-care, hundreds of ECD services are available to families (in B.C.) However, families need resources to locate and pay for them. In many cases, parents may not know that they need a certain service or that a program even exists. Low-income families face additional barriers when it comes to connecting with appropriate services. While many programs are subsidized, cost can still be a factor. Other barriers include transportation, language, literacy levels and sense of legitimacy. For these reasons, outreach programs have proven to be the most effective method of bringing families together with the services they needs."

[4] Waddell, Charlotte et al. *Child and Youth Mental Health: Population Health and Clinical Services Considerations*. Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia. April 2002.
Researchers across sectors of early childhood development point out repeatedly that the number of children at risk for poor outcomes, or who have recognized delays or disorders – whether they be in physical, cognitive, social, emotional or behavioural development – preclude the ability of clinical services alone to reduce the burden of suffering. They are calling for greater attention (and investment) in population health strategies in order to better meet the needs of greater numbers of children. Furthermore, there is growing evidence that many early childhood disorders represent disorders that will continue into adolescence and adulthood – "a further impetus to shift resources to population approaches that encompass both prevention and early intervention in order to reduce the burden of suffering." p.8.

Brazelton, T, Berry and Stanley I. Greenspan. *The Irreducible Needs of Children*. Pereus Publishing. 2000. p.105
"The prevention model that you are talking about would reduce the number of children in special needs classes. By paying attention to the children with motor, attentional, language, social and emotional, and family challenges, we would reduce the numbers who go on to need very intensive classes."

[5] Willms, J. Douglas. *Vulnerable Children.* University of Alberta Press. 2002. p. 365.
"My view, therefore, is that we cannot ignore the weight of neuroscience that supports the need of early intervention, but there is also substantial evidence indicating that child development does not end at age three, or five, or even later. Much like the nature-nurture controversy, this debate is not productive. Nearly everyone would agree that ensuring all children get a good start in life is important, and most would agree that we need to provide the necessary support for those who do not get a good start. The important question is how we can achieve both aims, and the findings of this research bear on this issue. Our findings suggest that , during the early years, it is more difficult to discern which children are vulnerable and that vulnerability is not strongly associated with socioeconomic status. As children get older, it is easier to assess their cognitive and behavioural development, and the relationship with SES becomes stronger. Therefore, these findings suggest that universal and preventative interventions would likely be more effective during the early years, from zero to age five, but thereafter we need to support successful schooling – as a universal intervention – and complement the efforts of parents and teachers with successful, targeted interventions for those who require additional support. From social-policy perspective, this direction allows us to recast the early-versus-late start debate as a call for action: we need to ensure that all children have the best possible start, while ensuring that those who have chronic difficulties, or who encounter difficult experiences later in life, receive the support they need."

[6] Olds, David et al. *Prenatal and Early Childhood Nurse Home Visitation*. Juvenile Justice Bulletin. Office of Juvenile Justice and Delinquency Prevention. November 1998.

[7] Olds, et al. *Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial*. Pediatrics, vol 110, no.3. September 2002.

[8] Bryant, Donna. *Are We at Home Yet with Home Visiting?* Plenary presentation at the 35th Annual Banff Conference. March 2003. www.childhood-excellence.org Programs evaluated included: Hawaii Health Start, HIPPY, PAT, Olds Nurse Visitors, etc

[9] Da Salva, O. *Prevention of low birth weight/preterm birth*. The Canadian Guide to Preventative Health Care: The Canadian Task Force on the Periodic Health Examinations. Ottawa: Health Canada. 1995. p. 38-50.

[10] Kramer, Michael et al. *The Contribution of Mild and Moderate Preterm Birth to Infant Mortality.* JAMA. August 2000. Vol. 284. no.7.

[11] From Margaret McCain and J. Fraser Mustard. *Reversing the Real Brain-Drain: The Early Years Study.* April 1999. Publications Ontario. p. 45.
"The Carolina Abecedarian Project was designed to examine the effect of early childhood education and parent support on child development among families who were classified as disadvantaged on socioeconomic criteria. The program was begun just weeks after the child's birth. The children were randomly assigned either to the intervention group or the control group. At school entry all the children were assigned to either a school-aged intervention program that ran until age eight or to a control group. The preschool early child development program was a full-day, year-round, centered-based intervention with an infant/toddler (zero – three years)-to-teacher ratio of three to one and a child (three to six years) – to-teacher ratio of six to one. The parents were involved and engaged and asked to provide supplemental educational activities at home. Home visits were made about 15 times a year.
At the end of the preschool program, the intervention group significantly outperformed the non-intervention group, in terms of the IQ measurements. All Children who had the preschool program had betters cores on reading and mathematics at age 15. The support given to children from the non-intervention group (no preschool program) when they entered the school system had little or no effect. The mothers in the intervention program became better educated and were less likely to be unemployed. This study shows the value of quality early child development and parenting involvement for both mothers

and children…. In subsequent study, the effects of early child development programs and home visiting programs were examined. The group of children who received only home visiting was similar to the non-intervention group in terms of cognitive development."

[12] Taylor, Ted and Anthony Biglan. *Behavioural Family Interventions for Improving Childrearing: A Review of the Literature for Clinicians and Policy Makers*. Clinical Child and Family Psychology Review. Vol.1 no.1. 1998.
"…clinicians have created, evaluated and refined behavioural family interventions to the point that we can have some confidence that many families that receive such intentions will benefit. We will not reap the full benefit of the knowledge gained, however, unless we shift from a clinical perspective to a public health perspective on family functioning." p. 55.

[13] Cunningham, Charles. *Parenting Programs for Families of Preschool Children*. Also Niccols, Alison. *Right from the Start and other Attachment-Focused Parenting Programs*. Plenary presentations at the 35th Annual Banff Conference. March 2003. www.childhood-excellence.org
Drs. Cunningham and Niccols have researched parenting programs that have specific goals for targeted populations (these are COPE: for parents with children displaying emotional and behavioural problems, and RIGHT FROM THE START for mothers at risk for poor attachment with their infants) and are offered within community settings. The parent groups include a heterogeneous mix of high and low functioning parents. Outcomes have been very good and "catchment" has increased due to the non-stigmatizing community settings and the committed efforts to overcome other barriers to program utilization. Especially there was an increase in utilization of programs by various ethnic minority groups.

[14] Barnard, Kathryn E. *Influencing Parent-Child Interactions for Children at Risk*. In Guralnik, Michael J. *The Effectiveness of Early Intervention*. Paul H. Brookes Publishing. 1997 pp. 249-265
Benoit, D et al. *Atypical Maternal Behaviour Before and After Intervention*. Infant Mental Health Journal. 2001 Vol. 22. p. 611-626
Niccols, Alison. *Right from the Start and other Attachment-Focused Parenting Programs*. Plenary presentation at the 35th Annual Banff Conference. March 2003. www.childhood-excellence.org

[15] Mustard, Fraser and Frances Picherack. *Early Child Development in British Columbia: Enabling Communities.* May 2002. www.founders.net See Appendix 4, p. 60.
The Ontario "Parenting and Family Literacy Centres" were instituted in 1981 in five inner city schools. These Centres were designed to improve the school readiness of young children in those neighbourhoods through parent/child play-based learning opportunities, as well as toy lending libraries, child care, parent employment services, adult literacy, etc. By 1995 there were 34 school-based Centres. Children attending the Centres were significantly better prepared for schooling than were their peers. They fared better across all Early Development Index scores including physical well-being, social competence, emotional maturity, cognitive development, and general knowledge and communication skills

[16] Steinhauer, Paul D. *The Primary Needs of Children: A Blueprint for Effective Health Promotion at the Community Level.* Sparrow Lake Alliance. April 1996. p. 10,11.
"To achieve competency and mastery during the preschool years, all children will need to be accomplish successfully the following universal developmental tasks. The will need to: become secure and to develop adequate self-esteem; extend their sense of trust, which is derived from the availability, sensitive responsiveness and continuity of their caregivers; learn to relate to children and adults in addition to their caregivers and to extend the development of their social skills; learn to cope successfully with their anxiety and aggression; extend their physical and intellectual development and to develop their imagination and growing intellectual development and to develop their imagination and growing variety of skills and interests; play independently with others; learn to focus their attentions."

[17] Brendtro, Larry k., Martin Brokenleg, and Steve Van Bockern. *Reclaiming Youth at Risk: Our Hope for the Future.* National Education Service. Indiana Revised 2002. P. 46.
It is noteworthy that traditional Native child-rearing practices supported four components of self-worth that parallel the universal developmental task of building self-esteem that Steinhauer outlines above. These are: (1) significance was nurtured in a cultural milieu that celebrated the universal need for belonging; (2) competence was ensured by guaranteed opportunities for mastery; (3) power was fostered by encouraging the expression of independence; and (4) virtue was reflected in the preeminent value of generosity.

[18] Raver, C. Clybele and Jan Knitzer. *Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three-and-Four-Year-Old Children*. National Centre for Children in Poverty. 2002. p. 6.
"Emotional development and academic learning are far more closely intertwined in the early years than has been previously understood. What research tells us is that, for young children, emotional and behavioural difficulties may stabilize or escalate and negatively affect early school performance. In turn, early school performance is predictive of later school outcomes. Thus, paying attention to the emotional status of young children has important implications for policy and practice strategies designed to promote school readiness."

[19] Over the past 20 years, the field of child mental health has been steadily advancing its knowledge and skills for treating emotional problems of young children and their families. There is now considerable evidence that teaching parents positive parenting and consistent monitoring skills results in significant improvements in childhood social, emotional and behavioural problems and that the postivie effects generalize to school and community settings. These 'behavioural family interventions' (drawn from the fields of social learning, cognitive and behavioural and developmental theory) are also having positive outcomes for decreasing family and marital factors which mediate the risk of poor child development. Some outstanding examples of 'behavioural family intervention' programs include:
www.incredibleyears.com Primary Researcher Carolyn Webster-Stratton
www.triplep.net Primary Researcher Matthew R. Sanders
and COPE www.hhsc.ca/ccfc/ Primary Researcher Charles E. Cunningham.
See Cunningham, Charles. *Parenting Programs for Families of Preschool Children*. Plenary presentation at the 35th Annual Banff conference. March 2003. See www.childhood-excellence.org

[20] From Margaret McCain and J. Fraser Mustard. April 1999. p. 46.
"The Ypsilanti/High Scope Study has demonstrated that a very high quality intervention program, with parent participation, can drastically change outcomes even if the program starts at age three. The Ypsilanti/High Scope program for high risk Michigan children between the ages of three and six was a sophisticated program with quality curriculum, extensive staff training, and parental involvement. The-two-and-a-half hour, five days a week, centre-based program for 30 weeks each year, was supplemented by 90-minute teacher home visits. This programs had a series of long-term effects, including: reducing the risk of dropping out of high school, reducing the incidence of teenage pregnancy; and enhancing employment and reducing reliance on welfare…. The results… indicated that the enriched adult instruction and parental involvement between three and six years diminished the negative behaviour outcomes in later life." This program did not have the same long-term effects on IQ that the Carolina Abecedarian project produced, confirming what is now known about the great deal of brain development that takes place in the first three years. p.47.

[21] Margaret McCain and J. Fraser Mustard. April 1999. p. 49.
"Studies of the French Ecoles Maternelle have found that participation in early preschool program has an impact on later school achievement across all socioeconomic groups. The longer the children attend the preschool programs (which begin at two-and-a-half years), the better their school achievement in the first grade. The ecoles maternelle are public nursery school programs operated within the school system…. The teachers have the equivalent of a master degree in early education."

[22] Margaret McCain and J. Fraser Mustard. April 1999. p.47.
"In the United Kingdom, a large longitudinal study examined effects of half-day preschool, child care and play groups on children's academic achievement and cognitive development. They reported that children who attended any form of organized preschool program when they were three and four years old showed improved cognitive development and academic achievement compared to children who did not. Disadvantaged children gained slightly more than advantaged children. The study concludes that: "the overall differences in the children's means scores according to their preschool experience were large relative to the effects of other social and family factors." The U.K. study supports the practice of parent involvement in early child development settings. Children tended to do better when parents (usually mothers) participated in their own child's program, compared to children attending programs whose parents did not participate and to those children who did not attend any program."

[23] Fraser Mustard and Frances Picherack. *Early Child Development in British Columbia: Enabling Communities.* May 2002. See pp. 21,25,61, www.founders.net

The evidence includes:

1) Results of the Early Developmental Index (EDI) measurements in BC are showing that many children who are entering kindergarten are performing at significantly lower levels than their age mates. There is a gradient in performance of children in the EDI assessment at the time of school entry related to socioeconomic characteristics of the districts in which children live. Furthermore the percentage of children entering school with a low EDI measure affects future performance of all children in the classroom, not just the vulnerable children themselves.
2) We know from U.S. studies that school performance by state is related to the preparation of children in the preschool period. Although the schools can influence academic performance, the preschool ECD period has a significant effect on school performance.
3) Parenting and Family Literacy Programs located in schools has had positive effects for the school environment, academic performance of students, and improved parent/teacher relations.
4) "Mustard and Picherak make a point a number of times that early child development programs and services are best linked to schools, on the one hand to link them to learning, and on the other to provide integration with existing institutional arrangements for learning. The authors feel strongly enough about this last point to suggest that ECD programs and services should be made the responsibility of the Ministry of Education, as the goals of ECD programs are primarily to aid learning outcomes." (Quote from *A Literature Review of the Effectiveness of School-Based Services, Information Partnership*, September 2002. P. 8. www.InfoPartners.ca)

[24] Peters, Ray DeVrie. *Better Beginnings, Brighter Futures*. Research Coordination Unit Queen's University. http://bbbf.queensu.ca

This comprehensive, 25-year longitudinal, community-based demonstration project was initiated by the Province of Ontario in 1990 to discover effective ways of supporting the healthy development of young children and strengthening family and community life in disadvantaged neighbourhoods. It is one of the most ambitious research projects of its kind in disadvantaged communities in North America. Early findings indicate that communities who focussed their programming on child, or parent and child projects that were intensive and continuous had the strongest improvements in children's behavioural and emotional health.

Better Beginnings, Brighter Futures is a community development initiative in which communities are funded to enhance existing services or to provide a new services to promote ECD. The major partners were Child Welfare, Public Health, Housing Authority, local schools, and faith community services. The local steering committees included 50% residents from the neighbourhoods involved. The BBF organizations became successful catalysts for collaboration among agencies, improved efficiency in use of resources, and improved service availability and accessibility