

BUILDING TOGETHER: FOUNDED ON RESEARCH

A Discussion of Research Relating to the
Creation of a Community-Based System of
Services for Early Childhood Development
on Vancouver Island

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PART 2: Founded on Research

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BUILDING TOGETHER: FOUNDED ON RESEARCH

A Discussion of Research Relating to the Creation of a Community-Based System of Services for Early Childhood Development

PURPOSE

The purpose of this paper is to provide a common understanding of current research relating to early childhood education in order to facilitate discussion with key partners towards the building of a collaborative, cooperative, community-based system of early childhood supports and services.

SECTION 1 – Research and Evidence that is Influencing Our Thinking

A) Current research from the fields of neuroscience and child development has profound implications for a system of support and services for children and families.

Research in the fields of neuroscience and child development over the past two decades has revolutionized our understanding of how important brain development in the early years is to every aspect of a person's life course.¹ It is impossible to capture all this new knowledge in this discussion paper in any way that could do the research justice, but there are some key findings and implications of this research that must be noted when planning supports and services for young children and their families.

Prior to the availability of amazing technologies enabling us to 'see' the brain develop and function both *in utero* and after birth, we did not know that the great preponderance of brain development takes place after birth, especially in the first three years of life.² And we did not know the extent to which brain development is directly influenced by the environment. Not only do adequate pre- and post-natal nutrition and physical care influence development, but the ways in which parents (primary care givers) nurture and respond to infants and young children directly affects the "wiring" of the pathways of the brain. This in turn has a decisive and long-lasting impact on how people develop, their ability to make attachments, their capacity to learn, their behaviour and ability to regulate emotions, and their risks for disease in later life.³⁴ (See Appendix A)

"The kinds of attachments children have formed with their primary care givers at one year of age predict teacher ratings, behaviour problems, and quality of relationships with peers in preschool.... and can predict children's later school achievement... at age 16." Shore, p.31

Because brain development is so receptive to environmental influences, and because the brain has a remarkable capacity to change in response to experience, there are ample opportunities to promote and support children’s healthy growth and development.⁵ There is good evidence that a continuum of supports and services to families throughout pregnancy and the early years of life can make a significant difference to children’s outcomes.¹ These services include (but are not limited to) prenatal care and adequate nutrition, competent, responsive care during and following childbirth, immunizations, early screening, and high quality, affordable child care.^{6 7} Parenting is a key factors and supportive initiatives should begin as early as possible – from the time of conception – with programs of parent support, education and skills enhancement. Child development programs that involve parents can influence how the parents relate to and care for children in the home, and can greatly improve outcomes for behaviour, learning and health in later life.⁸

Although the brain does have remarkable capacity to change, there are sensitive times during which the brain is particularly responsive to learning; these ‘critical periods’ extend to such functions as vision, language, and cognitive skills as well as emotional control and peer social skills. If early opportunities to promote healthy development and learning are missed, later remediation will be more difficult and expensive, and may not have desired results.^{9 10} Prevention is best, but if it becomes evident that conditions are not optimal or that a child’s development is not progressing within acceptable norms, intervention must happen quickly and intensively. Children given timely, intensive and sustained help can overcome a wide range of developmental, learning, and health problems, in later life.¹¹

The knowledge is in. We know what is needed for optimal brain development of all children and the strategies and interventions to meet those needs. Given its importance for a healthy, educated, competent, and well functioning population, we must put that knowledge forefront in a system of supports and services for early childhood.

B) Research and evidence suggest that an effective system for children and families will blend universal, targeted, and clinical approaches^{12 13}

With the establishment of national data-base¹⁴ on the developmental and social well-being of children and youth, and with emergent information on “school readiness”¹⁵ and other significant indicators of early childhood well-being, we know very clearly that child development is not optimal in Canada.¹⁶ The evidence shows that there are significant numbers of vulnerable children across the socioeconomic spectrum.^{17 18 19} Chart 1 below shows that approximately 30% of children living in families who fall within the bottom quartile of household income experience significant “vulnerabilities” for poor development. However, each of the successive quartiles shows significant numbers so that over 20% of children from the highest income homes also display vulnerabilities.

ⁱ ‘Outcomes’ for children are the benefits they receive during or after their involvement in a program or as a result of an intervention. Outcomes may relate to developmental gains, knowledge, skills, behaviour, condition or status, etc.

Indeed, due to the sheer numbers of children in the “middle classes”, if we focus our system of services for children and families solely on socioeconomic indicators, we will ignore the greatest number of vulnerable children.^{20 21}

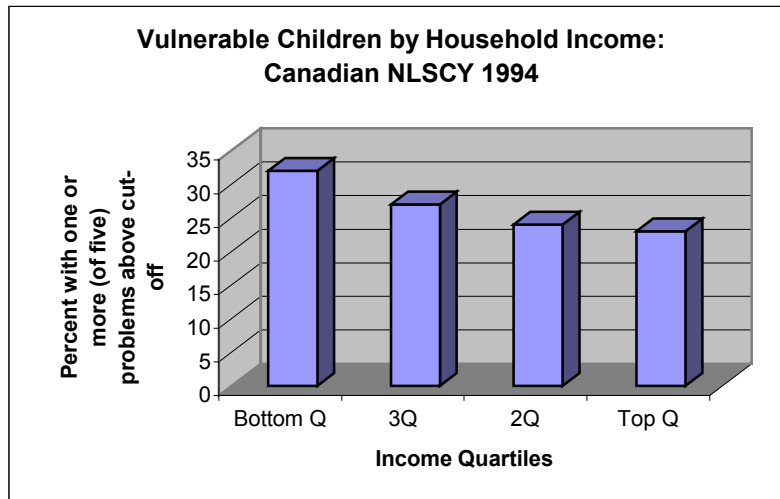


Chart 1: Canadian National Longitudinal Study of Children and Youth: Vulnerable Children by Household Income

Furthermore, targeting services for populations selected on traditional indicators such as socioeconomic status, as we have done in the past, is unlikely to have desired outcomes. Current research suggest that the biggest family effect on early childhood outcomes is not related to income and other socioeconomic factors, but rather to parenting practices.^{22 23} Findings of the Canadian National Longitudinal Study of Children and Youth show that positive and negative practices are found in both rich and poor families alike. Because positive practices are only weakly associated with socioeconomic status (SES), it is not feasible to identify parents with relatively poor skills on the basis of SES factors.^{24 25} It seems that most parents could benefit from supportive programs that improve their skills and in turn result in better child outcomes.^{26 27} If we focus on successful outcomes for all, not just avoidance of negative outcomes for those at risk, then we are more likely to move to a system of supports that all parents need.²⁸

Importantly, while there is much need to provide and improve services and supports for everyone, children “at risk” (or those not yet identified as “at risk”), and children with special needs, are best served when the conditions are in place for *all* children to thrive.²⁹ ³⁰ If primary needs of children are not met the likelihood of special services sand supports being able to make up for their absence is extremely limited.³¹

“To the extent that a child’s primary needs are met, that child is likely to develop into a healthy, confident, competent, responsible, productive, independent, content and self-controlled adult capable of sustaining warm successful relationships with others.”
 Paul Steinhauer, *The Primary needs of Children*, p.2

The response to the reality of children's circumstances is not to choose one approach over the others, but a recognition that the most effective strategy is to combine universal³² with targeted and clinical interventions, strengthening community parenting capacity and resiliency as a whole.^{33 34} Researchers David Offord et al propose that a multi-level approach, starting with universal programs and adding targeted and clinical programs as needed, has advantages.³⁵ First, it addresses the need to reduce the size of the population seeking clinical services. The enormous number of children and families experiencing difficulties precludes the possibility of offering sufficient intensive services.^{36 37} Addressing this problem, the Ontario COPE program is finding good success offering large group (25 participant) parenting classes through community facilities such as schools and child care settings that both attract families with greatest need and result in excellent outcomes.^{38 39} Second, there may be multiplier effects. For instance, a targeted approach might work better for high-risk children if the environment is facilitating due to a universal program.⁴⁰ Once again, this was found to be the case in Ontario where parenting programs designed to assist parents with children who are experiencing severe behavioural problems are offered within universal community setting and are part of menu of parenting classes. Parents are not "singled out" or stigmatized for seeking parenting help. This approach results in a much high rate of program attendance than experienced at standard clinics, including a higher attendance by ethnic minorities.⁴¹

"The so-called "collaboration imperative" has recognized the complementary nature of population health and clinical approaches, and the necessity of combining both approaches in order to improve outcomes for children..." Waddell, April 2002. p.8.

C) Research and evaluation have led to significant achievements in the design, implementation, and positive outcomes of interventions for children and families

Intervention and programs designed to improve outcomes for children and families have been undergoing rigorous research and evaluation over the last couple of decades. There is a far greater knowledge of what activities really do make a difference in the lives of children. The major approaches that have been well researched include:

i) Home Visiting Programs

Although there has been high expectation and hope for lay home visitor programs, research and evaluation have shown modest and mixed outcomes.⁴² There are some positive outcomes for families, for example, there is some evidence of enhanced maternal life course, but outcomes for children in terms of increasing language competency, reduction in behavioural and social problems, kindergarten readiness, etc. were very weak, if any at all. Lay home visitors do build relationships and trust with parents and respond to crisis, but they have not demonstrated success in assisting parents to change behaviours in a specific ways that results in improved child development outcomes.^{43 44}

Researchers are recommending that lay home visiting programs concentrate on improving their effectiveness, (particularly, moving towards incorporating a specific theory and practice of adult behaviour change) before expansion. Child outcomes may be influenced by home-based programs if the program enables or motivates a parent to spend more time with the child, engaging in nurturing and language-rich interactions.⁴⁵ Lay home visiting as an approach to delivering services is best used as part of a comprehensive family service program, coupled with other early child development in order to engage a family in services, to come to understand the family's needs and individual circumstances, and to encourage positive parent-child relationships.⁴⁶

In contrast to lay home visiting, nurse home visiting programs⁴⁷ have produced significant important effects on maternal variables that effect child development⁴⁸ and direct improved outcomes for young children. These outcomes include increases in mother-child responsive interaction, increased child emotional, language and cognitive development, and decreases in abuse and neglect.^{49 50} The nurse home visitation program was targeted for more vulnerable families, and the program has had the greatest results with the families who were at greatest risk, especially for mothers who were unmarried and low-income.⁵¹

ii) Enhanced Childcare Programs for Infants and Toddlers^{52 53}

There have been several well-researched enhanced childcare interventions with long-term follow-up. These programs have been targeted to children and families at highest risk for developmental delays including inner city children living in poverty, children of mothers with intellectual challenges, and one project was aimed at low birth weight infants at risk for developmental delays. These programs were often combined with parental support such as home visiting, job training for parents, etc. The childcare was of the highest quality with extraordinarily well educated staff, low staff turnover, and high teacher-child ratios. The earlier the children received the intensive care and education and the lower the mother's formal schooling, the greater and the more enduring the gains. Outcomes included higher academic achievement, lower rates of being held back in a grade, lower school drop out rates, lower delinquency, and higher employment rates as adults.

These studies strongly support the inclusion of a centre-based educational component in strategies targeted for the most vulnerable of children in order to improve cognitive, language and behavioural outcomes. The most striking outcomes have been achieved when childcare is combined with parent involvement components.⁵⁴

“Early care giving that is sensitive and emotionally responsive can buffer the effects of high-risk environments... It can promote positive change for children who have experienced poverty and abuse, and can interrupt the abusive patterns from one generation to the next.” Shore, p.31

iii) Behavioural Family Interventions

Over the past 20 years, the field of child mental health has been steadily advancing its knowledge and skills for treating emotional and behavioral problems of young children and their families.

There is now considerable evidence that teaching parents positive parenting and consistent disciplinary and monitoring skills results in significant improvements in childhood social, emotional and behavioural problems and that the positive effects generalized to school and community settings.⁵⁵ The ‘behavioural family interventions’ (drawn from the fields of social learning, cognitive behavioural and developmental theory) are also having positive outcomes for decreasing family and marital conflict, decreasing parental depression, and increasing parental satisfaction and efficacy, all factors which mediate the risk of poor child development. A few of these interventions are adding programming for children alongside those for the parents, and others are providing training for preschool teachers, with resulting enhancement of outcomes.⁵⁶

“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 problems serve as a kind of red flag. Without help, evidence suggests that these 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.” Cybele C. Raver, p.6⁵⁷

Some outstanding examples of ‘behavioral family intervention’ programs include: ‘The Incredible Years’, originating in Seattle Washington; ‘COPE’ based in Hamilton, Ontario, and ‘Triple P’ from Australia. All have had success in engaging “high risk” families in some way, for example, ‘The Incredible Years’ has been offered as a prevention program through Head Start and has had considerable success in lowering the incidence of child mistreatment among families served, and has enhanced school readiness.⁵⁸ ‘COPE’ has been successful in offering their program through community centres and attracting “high risk” families who would not come to clinical setting such as mental health centres.⁵⁹ And ‘Triple P’ is having success as a prevention strategy in high socioeconomically disadvantaged areas⁶⁰, as well as providing outreach to isolated families. ‘Triple P’ will be discussed in depth later in this paper as it not only offers parenting programs, but has also evolved to become a universal, multilevel prevention strategy.

“Behavioural family interventions have also been identified as one of the best strategies for the treatment and prevention of child abuse.”

A. Buchanan (ed.), *Parenting, Schooling and Children’s Behaviour*,
Chapter 8, 1998.

Another ‘family behavioural intervention’ of note is “Right from the Start”, a group program addressing disorders of attachment for parents with children under two years of age. Both high and low functioning parents attend this community-based program, making it prevention and targeted at the same time. The program is showing large positive effects on infant attachment.⁶¹ Because one in five children is at risk for developing an attachment disorder, and because of the severity of poor outcomes for children who are not securely attached, it is important to closely follow the evolution of interventions addressing attachment.

“... clinicians have created, evaluated and refined behavioural family interventions to the point that we can have some confidence that many families that receive such an intervention 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.”
Taylor and Biglan, 1998 p.55

iv) Family Learning Programs

‘Family learning programs’ cover a variety of initiatives whose purpose is to enhance the quality of parent/child interactions thereby optimizing the potential for brain stimulation and childhood development and increasing school readiness. These programs aim to inform parents about the importance of play-based problem-solving interaction with their children, as well as support this process through modeling by staff and the provisions of age appropriate activities, toys and experiences. These programs also provide opportunities for a child to interact with other children and adults, starting the process of social interaction and play with others that will increasingly have influence on his/her development.

The province of Ontario instituted “Parenting and Family Literacy Centres” in 1981 in five inner city schools. These Centres were designed to improve the school readiness of the young children in those neighbourhoods with an emphasis on parent/child play-based opportunities, as well as toy and book lending libraries, child care, parent employment services, adult literacy, etc. By 1995 there were 34 school-based Centres. Outcomes for these Centres show there is significant difference between children who attend the Centres and those who do not. (see Appendix B) Children attending the Centres were much more prepared for schooling than 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 communications skills.⁶² Parents also benefited in terms of acquiring parenting skills, establishing supportive social networks, and building rapport and links with the public schools. Kindergarten teachers reported that they understood the needs of their students better and felt they were more connected to the parents. The results are very encouraging, especially for inner city children, and the Ontario provincial government is expanding the Centres acting on the conclusions for the Ontario Early Years Study⁶³ that they will be universally beneficial

to all children and families. The optimum mix of programs offered at these Centres has not been evaluated.

Other programs that may be described as a “family learning program” include Mother Goose rhyme and song groups, Hanen Centre’s “You Make the Difference” program, library programs, and recreation arts and crafts programs. To some degree, these programs also provide structured parent/child interactive opportunities, although many of these have not yet been evaluated on their impact on child outcomes.

v) Preschools⁶⁴

There is broad evidence from many studies that children from low-income families benefit from high quality preschool programs. The children participating in these preschools had higher scores on achievement tests, lower rates of being held back in a grade, and a decrease in use of special education services as compared to the control groups who did not attend preschool. In the very long term they had increased graduation rates and decreases in crime and delinquency. Half as many of the children who had taken part the preschools received welfare as adults and twice as many owned their own homes, as did the control children. These preschool programs were intensive and very high quality in terms of teacher education, payment of teachers, class size, teacher supervision, and standard of learning. All were highly rigorously researched. All were also evaluated for their economic costs and benefits and the general findings were that every dollar spent on the preschool programs resulted in a seven dollar cost saving to tax payers (lower crime, higher employment, etc.).

In France, where preschools are part of the public school system, teachers have the equivalent of a master’s degree, and the programs are of the highest quality, results indicate that participation in preschool has a positive impact on later school achievement across all socioeconomic groups.⁶⁵ Studies in the U.K. and U.S. have also found that children in all socioeconomic groups benefited from preschool participation.^{66 67} Many researchers, practitioners and policy makers, while recognizing that current preschool quality standards are uneven and need improvement across Canada, are now urging that Canada move towards a universal public preschool system in order to offer all children this level of developmental opportunities.⁶⁸

At present, approximately 10% of Vancouver Island children are attending licensed preschool programs for children 2.5 to 5 years of age, while a further 12% are attending licensed group childcare for children 3 – 5 years old (which offer programming similar to preschools).⁶⁹ Although some families receive subsidies for preschool and childcare fees, costs remain a barrier for many families.

Conclusion:

Home visiting, family behavioural interventions, centre-based childcare, family learning programs and preschool interventions, have all been well researched and now comprise an array of effective supports and services to young children and their families. They all have their place along a continuum of services. (see Appendix C) It appears that most

families can benefit from family learning programs, family behavioural interventions, and quality preschools at some level of intensity. More burdened families and more vulnerable children are best served by a combination of these approaches, adding home supports and especially enhanced childcare programs, to give the greatest returns.

D) An effective system of services will reduce barriers and increase access to services for all families.

There are many barriers that must to be addressed to assure that all families can access the support and services they need for optimal functioning. These barriers include program costs, language, feelings of cultural or social distance, fear of being judged or stigmatized, and lack of awareness about programs or their value. For some communities, the major barrier is, of course, that the necessary programs simply don't exist.

“Since all families and children, in all socioeconomic circumstances, can benefit from early child development and parenting programs, it is important that programs evolve to be available to all families in all SES groups.”
Ontario Early Years Study p. 15.

The Ontario COPE project set out to assess ways in which to increase program utilization through decreasing barriers and increasing desirability of its programs. Surveying parents, COPE found the following factors influences the utilization of its parent programs: location of programs, duration, goals of the program, learning processes used (discussion, demonstrations, videos, etc) distance to travel to program (no more that 20 minutes commute, preferably under 20 minutes), program based on sound evidence (as opposed to those advertised as “new and innovative”), child care provisions, qualified staff, and time of day that programs are offered.⁷⁰ COPE found that families need different options – working parents preferred programs offered during evenings and Saturday mornings, while at-home parents and unemployed parents preferred week day programs. All families preferred that programs be offered in community settings such as schools or recreation centres.⁷¹

COPE responded to these finding and consequently has raised program utilization. They have moved programs into neighbourhood settings including schools in order to raise awareness of such opportunities for families and to decrease stigmatization. There are no fees, and they offer child minding and transportation vouchers. The programs are offered during weekdays, evening, and Saturday mornings. The have offered programs often and continuously to take into account that adults often need to see a program advertised several times before they are ready to consider acting.

“All universal support systems and specialized services should be made available in ways that avoid stigmatizing those who use them.” Steinhauer p. 7

The Triple P program in Australia approached the problem of program accessibility in a broader way. Over the past twenty years the program has evolved from a clinical research program which could only serve a limited population, to a multi-level family intervention strategy for the prevention and treatment of a wide variety of behavioural and emotional problems in children. They initiated a successful population strategy using television, print and other media to increase community awareness and support for the importance of parenting. The media supports other levels of intervention to send an optimistic yet realistic message to the community about practical solutions to commonly encountered problems, to normalize and de-stigmatize parenting difficulties, and to prompt parents to seek information or advice on children's behaviour if they need it. The strategy also includes providers in the primary care services (e.g. general practitioners, public health nurses, teachers, childcare workers, and allied health providers) as a part of a comprehensive parenting and family support system to improve the health status and well being of children and parents.⁷²

E) Researchers, practitioners, and policy-makers across all sectors and disciplines are urging collaboration to build a system of supports and services to ensure that all children thrive.

“...the problems of children do not come as neatly divided as government services do; put another way, children's needs often cut across service departments. Second, the actual numbers of children at risk far exceed the capacity of consumer-centered service delivery. The service delivery system needs to extend beyond any single branch and to extend its reach through prevention and population health approaches...”⁷³

“To provide the most effective and efficient risk reduction approaches, a coordinated and comprehensive approach is necessary. The concept of partnership implies that no one group, individual or agency need assume this role in isolation. Rather, the collaboration of multiple and diverse stakeholders including families, expands the arenas in which risk reduction can occur...”⁷⁴

“Any systemic approach to improving health and developmental outcomes must include a broad array of domains and sectors that influence the development and wellbeing of all children...”⁷⁵

“Communities are the functional unit within which children are raised. It is at the community level that most school policies are set. Social services, mental health, health care, and child protection services are all offered in the community. Media, religious organizations, and other volunteer groups are generally community-based. Changing [the outcomes for children] requires consistency and coordination among each of these groups to ensure that efforts are consistent with and build upon each other, and to ensure that all families who need and desire assistance can obtain it.”⁷⁶

SECTION 2 – Triple P – A Model of Service Delivery

A model for service delivery that we believe is exemplary in utilizing current research and evidence-based practice is the Australian Triple P (Positive Parenting Programs) model.⁷⁷ We also believe this model meets the standards outlined in *Core Service Requirements for Children and Family Authorities*, January 2003, set by the Ministry for Children and Family Development. It also fulfills a great many of the goals and specific recommendations of the *Child and Youth Mental Health Plan for British Columbia*, February 2003. We trust that it is a model that can be adapted by key partners in supporting all children to achieve optimal functioning, and that as a framework it provides great opportunity for collaboration and integration of sectors and services.

The Triple P model is a multi-level, parenting and family support strategy whose mission is to prevent developmental, behavioural, and emotional problems in children by enhancing the knowledge, skills and confidence of parents. It utilizes effective health promotion strategies, prevention interventions, and therapeutic treatments. Triple P is having tremendous success in changing parents' competencies and skills at the population level, which in turn is producing positive outcomes for children.⁷⁹

“As dysfunctional parenting is related to a wide range of health, social and educational problems in children and young people, we believed a population approach that sought to improve parental competencies was needed.”⁷⁸

The aims of Triple P are:

- To promote the development, growth, health and social competencies of young children
- To promote the independence and health of families by enhancing parents' knowledge, skills, and confidence
- To promote the development of non-violent, protective and nurturing environments for children
- To reduce the incidence of child abuse, mental illness, behavioural problems, delinquency and homelessness
- To enhance the competence, resourcefulness and self-sufficiency of parents in raising their children

The model's multi level framework aims to tailor information, advice and professional support to the needs of individual families. It recognizes that parents and children have different needs and desires regarding the type, intensity and mode (for example, groups or self-directed study materials) of assistance they require. Interventions range from broad media approaches at the Level 1, through to brief counseling offered by primary care practitioners at Levels 2 and 3, to more intensive programs at Level 4 and 5 that target broader family disturbances such as relationship conflict, parental depression and

stress. In short, it is a model that encompasses universal, targeted and clinical services for children and families within a seamless system.

Families can enter the system of intervention at any level. The multi-level model does not require a sequential progression from the least to the most intensive intervention, although this may be a common path. Some families may be referred immediately to Level 4 or 5 and may then receive support to maintain gains within the Level 2 or 3 format, and so on. Completion of one level does not preclude access to other services. At all points of contact, families are encouraged to reconnect if they are experiencing further difficulties.

The Triple P model is designed to cross sectors and disciplines. It is utilized by primary care professionals (doctors and public health nurses), mental health providers (psychologists, psychiatrists), social service staff (social workers), school personnel (teachers and counselors) and professionals from other disciplines (for example, child care providers) that serve families or interface with parents.⁸⁰ Triple P services are offered through a variety of settings including primary health care agencies, schools, community parent education programs, and mental health clinics.

The Triple P Model has the flexibility to allow for diverse programming within its system of services. Examples include: an early intervention program aimed at increasing the competence and decreasing the stress of parents of children who have disabilities; prevention and treatment for childhood obesity; development of self-directed programs for families living in remote and isolated regions; and expansion of programming beyond early childhood to elementary school years and adolescence.

Triple P has developed practice principles believed to be essential to the success of the model:⁸¹

- 1) Triple P draws on social learning, cognitive-behavioural and developmental theory as well as research into risk and protective factors associated with the development of social and behavioural problems in children. All levels of intervention are built upon research-based strategies designed to maximize parental self-regulation (which encompasses self-management, self-sufficiency, personal agency, and problem solving). These are foundational psychological constructs that uphold the principle of “first do no harm” while affecting adult ability to change behaviour.
- 2) At the population level, “minimally sufficient” interventions strategies are used that will lead to normal child development. That is, Triple P uses the least intervention needed to be effective and leave the family believing and feeling they are capable and competent.
- 3) Triple P uses media to strengthen family esteem. The goals of this strategy are to normalize and value the experience of parenting, to de-stigmatize the need for parental support, and to share positive strategies for parenting and family life. The messages of the media must be respectful of parents’ self-regulation.

Illustrative Outcome: The “Families” TV program resulting in significant reduced parental perceptions of children’s disruptive behaviour and significant increases in self-reported competence of mothers who viewed the TV program.⁸²

“Parents are more likely to adopt positive parenting methods when the importance of parenting skills is publicly supported by the broader community within which a parent lives.” Sanders, 2002, p.176

- 4) At the population level Triple P uses “first port of entry” access to families. This includes public health, family physicians, and daycare staff. These access points will enhance early detection of problems.
Illustrative Outcomes: parental self-efficacy and sense of competence was raised; parental initiated requests for assistance were increased.
- 5) Triple P provides universal parenting support at developmentally sensitive transitional points. Public health nurses have been trained for Level 2 and 3 interventions, that is, parenting help for specific problems (a low-dose intervention, provided through regular services that has led to “good enough”, meaningful change.) Family physicians are now being trained in these intervention strategies.
Illustrative Outcomes: Decreased conflict between spouses over parenting issues; decreased marital problems; decrease in maternal depression; and decrease in stress.
- 6) Services are expanded through an ecological model, for example, training and strengthening the knowledge and skills of day care workers, offering parenting interventions through the workplace, tailoring programs to go where parents are. Triple P has developed effective self-help manuals and videos for isolated parents, with telephone support.
Illustrative Outcomes: When parenting programs were offered through work sites, parental self-efficacy and competency was increased; absenteeism and work stress was decreased.⁸³ (Consequently Australian businesses are funding work place parenting programs.)
- 7) Services are to be sensitive to cultural and linguistic diversity, and address barriers that diverse cultures face. Practitioners must be mindful that within any one culture, there may not be homogeneity of values and practices. All parents from all cultures are operating from a set of beliefs and values, so all practice must be informed in this regard.
- 8) Support and services to families must be part of core services, not an add-on. Staff need quality training to assure that self-efficacy is high.

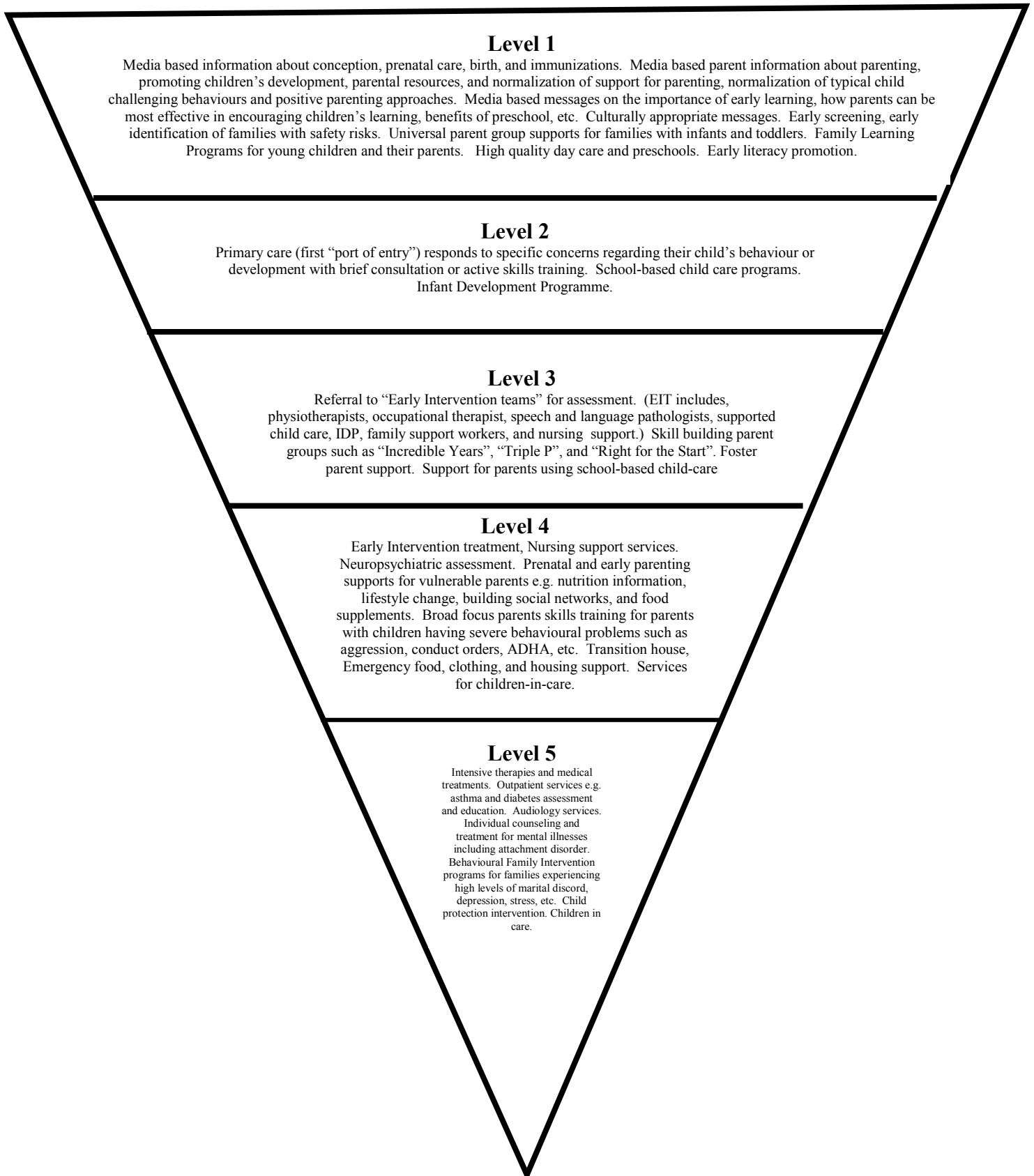
Towards Developing a Framework Adapting the Triple P Model

Please refer to the “Diagram 1: A Multi-Level System of Supports and Services”, on the next page. While the Triple P Model specifically addresses parenting services, we have attempted to broaden the model to include a whole spectrum of services and supports for young children and their families. We have located a sampling of services and supports provided for families and young children prenatally, during infancy, and in the early years, from across sectors and agencies within the “Levels” of service described by the Triple P model.

We have not prescribed which sector should do each specific activity, as there are many opportunities within this model to enhance collaboration and integration of services. For example, at the ‘universal’ level (Level 1), media programs and information can be a collaboration among health, mental health, social services and education to provide sound information, de-stigmatize the need for support, normalize the concerns of families, and make families aware of how and where to access services. There are opportunities for individual sectors, for example, mental health, to provide consultation and training to services providers from other sectors for broader screening and referral. Using “port of entry” services now offered through public health, primary care physicians, child care centres, social services, etc., brief interventions can be offered and referrals made to further services, as needed – both within and across sectors.

Using this multi-level framework to envision opportunities for collaboration and integration may facilitate thinking beyond “co-locations” of services to how best to share service delivery and limited resources

Diagram 1: A Multi-Level System of Supports and Services for Children and Families



SECTION 3 – Conclusion and Next Steps

A) Conclusions

- It is clear that the early years from conception to age six have the most important influence on a child's development – influencing learning, behaviour, physical and emotional health throughout the lifespan. It is a critical time when the primary needs of children must be met so they can achieve their optimal potential as adults. This stage of life deserves at least equal attention and resources that we give to the school age, high school and post-secondary years.⁸⁴
- All families and children from all sectors of society need the support of their communities to enhance or supplement their own resources. Some families will need more quantity and intensity of supports than others. When early child development is not optimal, due to social circumstances or special needs, intervention must be early, intensive and continuous.
- 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 risks for some populations, and clinical services for children showing abnormalities in development. Moreover, targeted and clinical strategies work best when aligned with or integral to population approaches.⁸⁵ Fundamental policy choices are required to determine what proportion of resources and efforts should be devoted to each component of this mix of interventions. Determining the right mix requires understanding of which interventions are supported by the best currently available research evidence, and which are not.⁸⁶
- Fortunately high quality, evidence-based interventions are available. 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 part of a continuum of services. They provide the building blocks for assembling proven services and supports within a system
- Barriers must be removed and the desirability of utilizing programs increased, so that all families can access the supports and services they need.
- Collaboration among all sectors, domains and agencies that have influence in the lives of young children and their families is essential to achieve optimal development for all children.

- The Australian Triple P model of parenting supports and services is as an example of a comprehensive system of services which has combined the best knowledge from the fields of research, practice and policy as described above. It is a model that can assist our discussion and deliberation in moving towards a comprehensive, collaborative system of service delivery.

B) Next Steps

Design a System of Services and Supports

What is needed to go forward, to move away from the “collection of services” that now exists, is to collaboratively build a system that works for the common good of young children and their families.⁸⁷

A true “system” requires:⁸⁸

- A mission statement or understanding of relevant purpose and goals
- A method of feedback, that is, a way to measure that outcomes are meeting the desired purposes and goals. Acting on a mission produces outcomes in two domains – a *consumer benefits* domain notes changes in the active registered consumers of service delivery organizations, while a *population benefits* domain notes any reduction in deficits and any building of assets and capacity in the general population of children and families.
- An executive capacity, to establish purposes and goals, to analyze and evaluate feedback, and to implement actions. The executive will note that some goals cannot be achieved without cooperative action between all partners in the system of care
- A self-regulating process, whereby ongoing and continuous improvements can be made within the system.

A true system of supports and services for young children and their families will lead to better quality, improved accountability, inter-organizational cooperation, less duplication, stronger community support, high staff morale, efficiency, and better use of resources.

The most important potential benefit to such a system of services and supports will be improved development and well being for children and families.

APPENDIX A

Rethinking the Brain

Old Thinking...	New Thinking...
How a brain develops depends on the genes you were born with.	How a brain develops hinges on a complex interplay between the genes you are born with and the experiences you have.
The experiences you have before age three have limited impact on later development.	Early experiences have a decisive impact on the architecture of the brain, and on the nature and extent of adult capacities.
A secure relationship with a primary caregiver creates a favourable context for early development and learning.	Early interactions don't just create a context; they directly affect the way the brain is "wired".
Brain development is linear: the brain's capacity to learn grows steadily as an infant progresses towards adulthood.	Brain development is non-linear; there are prime times for acquiring different kinds of knowledge and skills.
A toddler's brain is much less active than the brain of a college student.	By the time children reach age three, their brains are twice as active as those of adults. Activity levels drop during adolescence.

From Shore, Rima. *Rethinking the Brain: New Insights into Early Development*. Families and Work Institute. 1997. P.18.
ISBN 1-888324-04-x

APPENDIX B

Do Parenting and Family Literacy Centres Make A Difference?

This article is an abstract of the first-year evaluation report (1999 – 2000) on Parenting and Family Literacy Centres, prepared by Marie Yau and Susanne Zielger. The evaluation project was funded by the Atkinson Foundation.

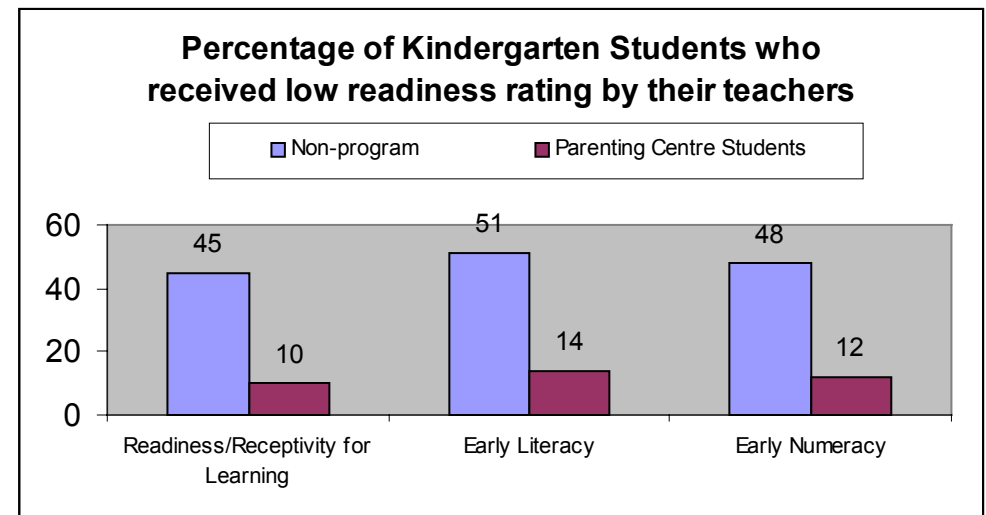
(August 2001)

Parenting and Family Literacy Centres were first set up in 1982 in five inner city schools in Toronto. By 1995 the number of in-school Parenting Centres grew to 34 spreading throughout the inner city downtown schools with a high proportion of the students coming from different language and cultural backgrounds within economically disadvantaged neighbourhoods.

One of the key mandates of these Centres is to increase the school readiness level of young children in these inner city neighbourhoods, where there has been a continuous concern with high rates of academic failure and school dropout. Recent data has shown that the majority of these children entering kindergarten were rated by their teachers to be not well prepared for formal schooling, or as not having developed the expected level of early literacy and numeracy skills for their kindergarten programs. To raise these children's school readiness level, Parenting and Family Literacy Centres were set up within these schools to provide for both the preschoolers and their parents or caregivers a "Readiness to Learn" program which would foster positive parent/child interactions and optimal development of the child.

In 1999-2000, with funding support of the Atkinson Foundation, both quantitative and qualitative data have been collected to ascertain the effectiveness of these in-school Parenting Centres. The first-year (1999 – 2000) data was gathered for four different sources – teacher assessment, Early Development Instrument, parent surveys, and teacher interviews. While further research is being conducted, this

preliminary research is extremely promising and shows that in-school Parenting Centres do make a difference for young students in inner city schools, especially those with high proportion of ESL populations. Hard data gathered from over 200 Kindergarten students indicate that young children who had attended the Parenting Centres with their parents or caregivers in these schools were much more prepared for schooling than their peers in same neighbourhood who had not attended the program. As illustrated in the chart below, about half of the Kindergarten children from the latter group had been rated by their teachers to have low readiness or receptivity level for learning, and a low level of early literacy and numeracy skills; on the other hand, for those who had attended the program, their chances of being rated as having low readiness levels were significantly smaller – around 10%.



To confirm the above findings, the Early Development Instrument (EDI)[1] assessment (administered in the North and South Areas of the Toronto public schools in Year 2000) was used as an independent source of data. Similar to the teachers' assessment mentioned above,

the EDI measure also show that 4-year-old children from the inner city schools sampled in this study had a much greater chance than the overall population to have low school readiness levels – especially in the areas of social competence, language development, and communication skills and general knowledge (see chart below). However, for children in those schools who had attended Parenting Centres with their parents or caregivers (yellow Bars), their chances of receiving low EDI readiness scores were significantly smaller than their peers who had no exposure to the program, and were comparable to the general population. In other words, the school readiness level of Parenting Centres children in these inner city schools was much higher than their peers in the neighbourhood, and was similar to that of the children across the city.

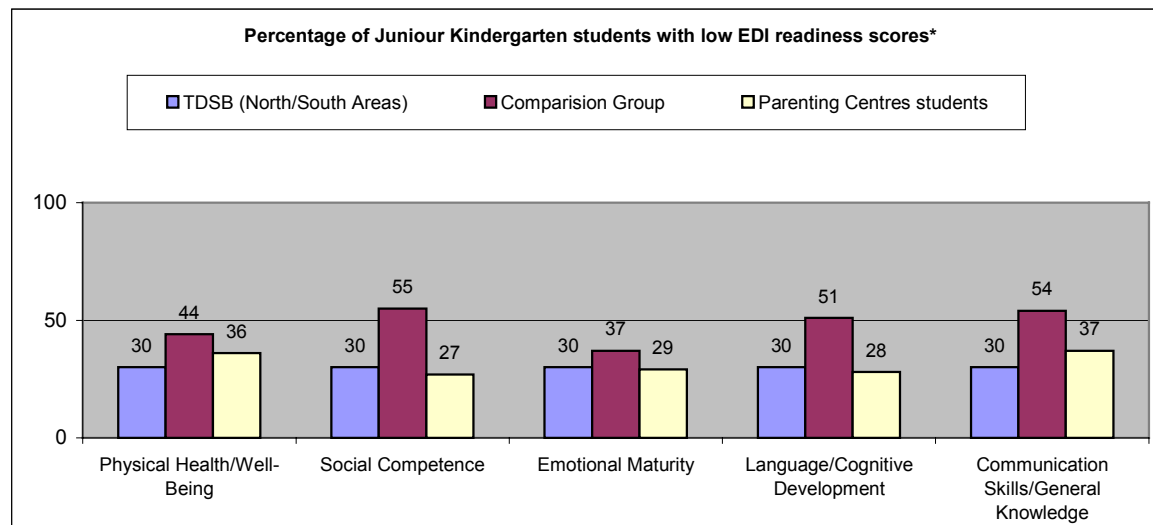
*The low EDI readiness scores in here were based on the lowest 30th percentile scores derived from the results of all JK students in the North and South Areas of Toronto public schools.

Teachers’ comments and observations were also consistent with the hard evidence described above. For instance, according to teachers’

interviews, some of the most obvious differences demonstrated by these young children were in the areas of language development, socialization, school adjustment, listening skills, as well as their ability to adjust to routines, follow instructions, play purposefully, and learn from and interact with adults.

Aside from the children themselves, parents also benefited in terms of acquiring valuable parenting skills, establishing a supportive social network, and building rapport and links with their child’s school. Finally, Kindergarten teachers also find their in-school Parenting Centres workers a great support to their work, particularly in helping them detect and understand with the parents of their students.

[1] This instrument, which was developed by the Canadian Centre for studies for Children at Risk (McMaster University) as part of the Readiness to Learn Projects funded by the federal HRDC, has been used as a community measure to gage Kindergarten students’ school readiness level at the group level. The instrument had been implemented in several school boards across Canada



References and Endnotes

- ¹ Shore, Rima. *Rethinking the Brain: New Insights into Early Development*. Families at Work Institute. 1997.
- ² Shore, Rima. p. 25.
- ³ McCain, Margaret Norrie and J. Fraser Mustard. *Reversing the Real Brain Drain: The Early Years Study*. Publications Ontario. April 1999. p. 5.
- ⁴ Hertzman, Clyde. *Human Early Learning Partnership Brochure*. 2003. “By the time children enter kindergarten, it is possible to identify the children who have not had secure, nurturing and stimulating early childhood experiences. They are less ready for school than other children – intellectually, socially, emotionally, and physically. Approximately 25 percent of Canadian children are developmentally vulnerable when they enter school.” p. 3.
- ⁵ Shore, Rima. 1997. p. x.
- ⁶ Shore, Rima. 1997. p. 57.
- ⁷ Mustard, Fraser and Frances Picharack. *Early Childhood Development in British Columbia: Enabling Communities*. May 2002. p.6. wwwFOUNDERS.net “Prenatal, birth and infancy experiences have a profound effect on the health and well-being of infants and young children, and contribute to continuing good health. This priority addresses needs related to prenatal, birth and infancy periods and includes supports for pregnant women, new parents, infants and care providers.”
- ⁸ McCain, Margaret Norrie. 1999. p. 7.
- ⁹ Brazelton, T. Berry and Stanley I. Greenspan. *The Irreducible Needs of Children*. Perseus Publishing. 2000. p. xd. “Our research, and that of others, demonstrates that in the first few years, the ingredients for intellectual, emotional, and moral growth are laid down. If they are not, it is true that a developing child can still acquire them, but the price rises and the chances of success decrease with each subsequent year. We cannot fail children in these early years.”
- ¹⁰ Mustard, Fraser and Frances Picherack. *Early Childhood Development in British Columbia; Enabling Communities*. May 2002. wwwFOUNDERS.net p. 5. “Although there is some evidence the special programs in education for children who have had a poor start can help overcome the odds, the gains are never what could be achieved if the children had a high quality early period of development.”
- ¹¹ Shore, Rima. 1997. p. xii.
- ¹² Keating, Daniel P. and Clyde Hertzman. *Developmental Health and Wealth of Nations*. The Guilford Press. New York. 1999
“An optimal mix of universal, targeting and clinical programs is needed to address these problems.” (p. 309)
- ¹³ Waddell, Charlotte, et al. *Child and Youth Mental Health; Draft Practice Parameters*. Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia. April 2002. “Universal programs are needed to build capacity of communities to promote optimal health and development for all children and youth. Targeted programs are needed to reduce risk for specific populations. Finally, specialized clinical services are needed for children most seriously affected.” p. 4.
- ¹⁴ The National Longitudinal Survey of Children and Youth (NLSCY) is a long term study of Canadian children that follows their development and well being from birth to early adulthood. The NLSCY began in 1994 and is jointly conducted by Statistics Canada and Human Resources Development Canada. The study is designed to collect information about factors influencing a child’s social, emotional and behavioral development and to monitor the impact of these facts on the child’s development over time. The survey covers a comprehensive range of topics including the health of children, information on their physical development, learning and behaviour as well as data on their social environment (family, friends, schools and communities). Findings of the NLSCY are presented in *Vulnerable Children*, Douglas J. Willms, ed., The University of Alberta Press, 2002.
- ¹⁵ Hertzman, Clyde. www.earlylearning.ubc.ca

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- ¹⁶ Steinhauer, Paul. *The Primary Needs of Children: A Blueprint for Effective Health Promotion at the Community Level*. Working Paper for the Promotion/Prevention Task Force. Sparrow Lake Alliance. April 1996. p. 2. "Although roughly two out of three of Canada's children are doing well, everywhere we look, we find children failing to flourish, and therefore unable to achieve their developmental potential. Rich children, middle-class children and poor children alike are all dealing with risk and neglect unimagined and unimaginable in previous generations...many children are at risk for not having their primary needs met."
- ¹⁷ McCain, 1999. p. 93.
- ¹⁸ Keating, Daniel, 1999. "Strategic problems arise for systems of care because high "relative" risks exist among relatively small segments of the population, compared with lower relative risks among broader segments of the population (which lead to higher "attributable" risks and thus greater public health impact overall)". p. 291.
- ¹⁹ Patterson, J et al. *Need and Demand for Parenting Programs in General Practice*. Archives of Disease in Childhood. May 2002. p. 471.
- ²⁰ McCain, Margaret Norrie. 1999. p. 92. Based on a "vulnerability index" developed in conjunction with the NLSCY. The index includes measures of learning and behaviour at different ages including vocabulary and math skills, emotional problems, aggression, anxiety, etc
- ²¹ Mustard, Fraser and Frances Picherack. May 2002. p. iv. "...23% of children in the 4 to 11 age group in British Columbia are vulnerable for poor human development in the future... To reduce this figure will require effective ECD and parenting programs for all families with young children, not just targeting programs or programs for children with special needs. Can a wealthy developed society justify having nearly one quarter of its young children vulnerable?"
- ²² McCain, 1999. p. 95.
- ²³ Mustard and Picherack, May 2002. p.18. "This is an important point since it emphasizes the need for public policy to stop focussing only on poverty and other so-called risk factors and to focus on the support quality and availability of caregivers (families and other caregivers, such as that provided in daycare) in the early years that can improve the outcomes for all children in all social classes...parenting and the quality of non parental care have a large effect in reducing vulnerability."
- ²⁴ McCain, 1999. p. 97.
- ²⁵ Willms, J. Douglas. *Vulnerable Children*. The University of Alberni Press. 2002. p. 365. "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."
- ²⁶ Patterson, J et al. 2002 "...research suggests that the existing provision of "indicated" interventions may be inadequate. The normal distribution of the Eyberg Intensity score [a well accepted measure of children's emotional and behavioural well being] suggests that childhood problems are a public health problem that would benefit from a population approach. These findings provide theoretical support for the universal provision of parenting programmes..."p. 471
- ²⁷ McCain, 1999. p. 51. "A key conclusion of the Early Years Study is that families – children and parents – from all socioeconomic groups in our society need support...to improve children's outcomes in learning, behaviour and health over the life cycle."
- ²⁸ Mustard and Picherack. May 2002. p. 26. "While children with special problems such as autism, mental health problems and fetal alcohol syndrome attract attention and resources, they are a minority of the 98,000 vulnerable children in the 4 to 11 category [in B.C.]. It is important to give programs for all families with young children equal priority for ECD investment as services for the very special needs groups."
- ²⁹ Steinhauer, Paul. 1996. p. 8. "...society can best achieve its goal of getting all children off to a successful start by focussing on meeting their primary needs (at four stages) in their development."
- ³⁰ Brazelton, T. Berry and Stanley I. Greenspan. *The Irreducible Needs of Children*. Perseus 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 early to the children with motor, attentional,

language, social and emotional, and family challenges, we would reduce the numbers who go on to need very extensive special classes.”

- ³¹ Brazelton, T. Berry and Stanley I. Greenspan. p. x.
- ³² “Universal” services are those that all children and families have the opportunity to access if they so choose. These services are aimed at building capacity and promoting well-being for all. “Targeted” services are designed for children and families “at risk” of developing vulnerabilities, while “clinical” services are provided for children and families displaying some kind of “disorder”.
- ³³ Willms, Douglas J. ed. *Vulnerable Children*. The University of Alberta Press. 2002. p. 365. “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 preventive 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 teacher with successful, targeted interventions for those who require additional support. From a social-policy perspective, this direction allows us to recast the early-versus-late 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.”
- ³⁴ Keating, Daniel. 1999. Chapter 15.
- ³⁵ Keating, Daniel. 1999. p. 309.
- ³⁶ Waddell, Charlotte, et al. *Child and Youth Mental Health; Population Health and Clinical Service Considerations*. Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia. April 2002. “Clearly, clinical services alone cannot achieve a marked reduction in the burden of suffering associated with mental disorders in children and youth. In recognition of this, many researchers and advocates have called for greater attention to (and investment in) population health strategies in order to better meet the needs of greater numbers of children and youth...shift resources to population health approaches that encompass both prevention and early intervention in order to reduce the burden of suffering.” p. 8.
- ³⁷ Steinhauer, Paul. 1996. p. 8. “...if the general strategies for meeting children’s primary needs...were in place, there would be fewer families dependent on specialized services, at least on a continuing basis.”
- ³⁸ Cunningham, Charles. *Parenting Programs for Families of Preschool Children*. Plenary presentation at the 35th Annual Banff Conference. March 2003. See website www.excellence-earlychildhood.ca (Slides 53 & 62).
- ³⁹ Alaggia, Ramona. *Making the Difference: Parenting in the Early Years*. IMPrint. Vol.31, Fall 2001. p. 3. “Community-based groups have shown higher retention rates, especially for families dealing with severe environmental stressors such as poverty.”
- ⁴⁰ Keating, Daniel. 1999. p. 309.
- ⁴¹ Cunningham, Charles. 2003. Slides 53 & 54. This has certainly been the experience of the Australian Triple P model of family services that is described further in this paper. Also recent experience in public health services within VIHA has found that a multi-level “menu” of services offered through a universal system has positive results.
- ⁴² Bryant, Donna. *Are We at Home Yet with Home Visiting?* Plenary presentation at the 35th Annual Banff Conference. March 2003. www.excellence-earlychildhood.ca Programs evaluated included: Hawaii Healthy Start, HIPPY, PAT, Olds, etc.
- ⁴³ Olds, David et al. *Home Visiting by Paraprofessionals and by Nurses: A Randomized Controlled Trial*. Pediatrics, vol. 100, no.3. September 2002. p. 493. There were effects shown by paraprofessionals on increasing responsive mother-child interaction in infancy that could indicate more secure

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- attachment and healthy emotional behavioral development, but these effects were significantly lower than those achieved by the nurses.
- ⁴⁴ Olds, David et al. *Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial*. September 2002. p. 495. "It is likely that professionals other than nurses can serve as effective home visitors for low-income parents of infants if they are given the right program resources, and effective paraprofessional models eventually may be developed. But until there is consistent evidence from well-conducted and randomized trials to support paraprofessional home visiting with any program model, the small effects observed here are elsewhere sound a cautionary note for the many maternal and child health and early intervention programs that purport to promote the health and development of pregnant women and infants with visitors who have limited professional training."
- ⁴⁵ Bryant, Donna and Kelly Maxwell. *The Effectiveness of Early Intervention for Disadvantaged Children*. In Michael J. Guralnick, (ed.), *The Effectiveness of Early Intervention*. Paul H. Brookes Publishing. 1997. p. 35. "Child outcomes may be influenced by home-based programs, if the program, by providing support, information, or toys, enables or motivates a parent to spend more time with the child, engaging in nurturing and language-rich interactions. Many home-only programs have failed to accomplish this. A combination approach (*in tandem with centre-based child development programs*) would clearly be most likely to effect child and parent change."
- ⁴⁶ Peters, Ray deV. *Comprehensive Community Based Projects*. p. 15. Plenary presentation at the 35th Annual Banff International Conference on Behavioural Science. March 2003. www.excellence-earlychoold.ca "Research shows that the combination of home visiting and parent education plus centre services for children produce the best results, as long as all the services are of high quality."
- ⁴⁷ Olds, David et al. *Home Visiting by Paraprofessional and by Nurses: A Randomized, Controlled Trial*. September 2002. p. 494. David Olds discusses possible explanation for the differences in results between paraprofessionals and nurses. One explanation that he supports is that nurses have a natural legitimacy and are viewed as authorities for concerns related to pregnancy, birth and infancy. Furthermore nurses are rated highest by the public of all professionals for their ethical standards and honesty, which gives them significant power to engage parents and influence adaptive change behaviour.
- ⁴⁸ Olds, David, Peggy Hill, and Elissa Rumsey. *Prenatal and Early Childhood Nurse Home Visitation*. Office of Juvenile Justice and Delinquency Prevention Bulletin. November 1998. p. 3. These maternal effects included reduction in use of tobacco prenatally, timing and likelihood of subsequent pregnancies, participation in the workforce, fewer months on welfare, fewer arrests and convictions, fewer problems related to drug and alcohol use.
- ⁴⁹ Olds, David et al. September 2002. p. 494.
- ⁵⁰ Olds, David. *Prenatal and Infancy Home Visiting by Nurses: From Randomized Trials to Community Replication*. Prevention Science, vol.3, no.3. September 2002. p. 153. The follow-up study when the children were 15 years of age showed fewer incidents of running away, fewer arrests and convictions, decreased cigarette use, and fewer behavioural problems related to drug and alcohol use.
- ⁵¹ Olds, David. *Prenatal and Infancy Home Visiting by Nurses: From Randomized Trials to Community Replication*. Prevention Science, vol.3, no.3 September 2002. p. 153.
- ⁵² Spiker, Donna. *Centre-based Programs for Infants and Toddlers*. Plenary presentation at the 35th Annual Banff International Conference on Behavioural Science. March 2003. www.excellence-earlychildhood.ca
- ⁵³ Bryant, Donna and Kelly Maxwell. 1997. p. 27.
- ⁵⁴ Bryant, Donna and Kelly Maxwell. 1997. p. 34.
- ⁵⁵ Triple P Canada Training Proposal. 2003. p. 24-25.
- ⁵⁶ Webster-Stratton, Carolyn. *The Incredible Years Training Series*. Office of Juvenile Justice and Delinquency Prevention Bulletin, U.S. Department of Justice. June 2002.

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- ⁵⁷ Raver, C. Clybele and Jane 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.
- ⁵⁸ Webster-Stratton, Carolyn. *The Incredible Years Training Series*. Office of Juvenile Justice and Delinquency Prevention Bulletin, U.S. Department of Justice. June 2002.
- ⁵⁹ Cunningham, Charles. *COPE: A Large Group, Community-Based Program for Parents of 3 to 12 Year Olds with Disruptive Behaviour Disorders*. Paper presented at the 35th Annual Banff International Conference on Behavioural Science. March 2003. www.excellence-earlychildhood.ca See also www.hhsc.ca/ccfc/ (click on universal, then groups)
- ⁶⁰ Triple P Newsletter. Autumn 1998. Available at www.triplep.net
“The program has been effective in reducing the incidence of seriously dysfunctional parenting, from twice the population average prior to the program down to the population level post-intervention. It also significantly reduced disruptive behaviour among the children of the participating families. Preliminary results show that these effects are maintained at 12-month follow up.... Results from the control group showed no change [over the same period].” p. 6.
- ⁶¹ Niccols, Alison. *Attachment-focused Parenting Programs*. Paper presented at the 35th Annual Banff International Conference on Behavioural Science. March 2003. www.excellence-earlychildhood.ca
- ⁶³ McCain, 1999, p. 156.
- ⁶⁴ Barnette, Steven. *Preschool Programs*. Paper presented at the 35th Annual Banff International Conference on Behavioural Science. March 2003. www.excellence-earlychildhood.ca
- ⁶⁵ McCain, Margaret Norrie. 1999. p. 49.
- ⁶⁶ McCain, Margaret Norrie. 1999. p. 47.
- ⁶⁷ Mustard and Picharack. May 2002. p. 25.
- ⁶⁸ Keating, Daniel. Closing Address of the 35th Annual Banff Conference on Behavioural Science. March 2003. Also see Donna Spiker’s workshop, *Child Care Quality Improvement*, and Steven Barnett’s plenary presentation, *Preschool Programs*. www.excellence-earlychildhood.ca
- ⁶⁹ Final Report of the 2001 Provincial Child Care Survey. Part III Results of Licensed Centre-Based Survey, pp 20-94. B.C. Ministry of Community, Aboriginal and Women’s Services. www.mcaws.gov.bc.ca/childcare/Childcar/research.htm The figures for preschools include children 2.3 to 5 years, while the group child care programs included children 3 to 5 years, so there is a percentage of children 30 months to 3 years attending licensed group care who are not included in these figures. The Report relates number of spaces available to children per 1000 which has been converted to percentages for this paper. It is not known what percentage of children attend both preschool and group child care. Note that these figures do not include Licensed Family Child Care.
- ⁷⁰ Cunningham, Charles. 2003. Slide 39
- ⁷¹ Cunningham, Charles. 2003. Slide 49
- ⁷² Triple P International. Canada Training Proposal 2003. p. 22.
- ⁷³ *Celebrating Success: A Self-regulating Service Delivery System for Children and Youth*. Health Canada. 2000. <http://www.hc-sc.gc.ca> p. 8.
- ⁷⁴ *Child and Youth Mental Health Plan for British Columbia*. February, 2003. p. 22.
- ⁷⁵ Waddell, Charlotte et al. April 2002. p.13.
- ⁷⁶ Taylor, Ted and Anthony Biglan. *Behavioural Family Interventions for Improving Child-rearing: A Review of the Literature for Clinicians and Policy Makers*. Clinical Child and Family Psychology Review. Vol.1 no.1. 1998. p. 13.
- ⁷⁷ Sanders, Matthew R. *Triple P: A Multi-Level System of Parenting Intervention*. Workshop given at the 35th Annual International Conference on Behavioural Science. March 2003
See website www.triplep.net

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- ⁷⁸ Sanders, Matthews R., et al. *The development and Dissemination for the Triple P Program: A Multilevel Evidence-based System of Parenting and Family Support*. Prevention Science, vol.3, no.3, September 2002. p. 173.
- ⁷⁹ Zubick, S.R. et al. *Prevention of Child Behaviour Problems via Universal Implementation of a Group Behavioural Family Interventions*. 2002. In the Evidence Base for the Triple P – Positive Parenting Program vol. 1. University of Queensland, 2003. Article 2.2 “The data suggest that if Group Triple P were to be implemented at the population level and achieved a comparable population reach, at two years post-intervention it would reduce children’s behaviour problems by 36.5%.”
- ⁸² Sanders, M.R. et al. *The Mass Media and the Prevention of Child Behaviour Problems: The Evaluation of a Television Series to Promote Positive Outcomes for Parents and Their Children*. J. of Child Psychology and Psychiatry. Vol. 41, no.7, pp. 939-948. 2000. Cambridge University Press.
- ⁸³ Martin, Alicia and M. R. Sanders. *Balancing Work and Family: A Controlled Evaluation of the Triple Positive Parenting Program as A Work-Site Intervention*. Manuscript submitted for publication 2002. The University of Queensland.
- ⁸⁴ McCain, Margaret Norrie. 1999. p. 52. “This period of life is as important for an educated, competent populations as any other period. Given its importance, society must give at least the same amount of attention to this period of development as it does to the school and post-secondary education periods of human development.”
- ⁸⁵ McCain, Margaret Norrie. 1999. p. 141. “Targeting measures to support families who are at risk or having difficulties is necessary, but works best within a system available to everyone.”
- ⁸⁶ Waddell, Charlotte, K. McEwan, J. Hua, C. Shepherd. *Child and Youth Mental Health: Population Health and Clinical Service Considerations*. Mental Health Evaluation and Community Consultation Unit. University of British Columbia. April 2002. p. 8.
- ⁸⁷ Celebrating Success. 2000. p. 10.
- ⁸⁸ Celebrating Success. 2000 p. 11.