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A Review of Children's Mental Health Services for Children Aged 0 to 6 Years Old in Ontario

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Abstract

One in 5 children suffer from mental illness within Ontario, with little information known about the 0 to 6 year old population and service provision outcomes. This paper presents the definition and prevalence of mental illness among children aged 0 to 6 years old, identifies services provided for addressing children's mental health issues in Ontario for this population, and presents evidence related to the outcomes of such services. Discussion and recommendations for both practice and future research in the area of children's mental health are provided, with some final thoughts to conclude the paper.

Acknowledgments

My thanks go out to my supervisor, Dr. Lynn Martin, for all of her time and effort spent reviewing and discussing my work with me. Without her, this paper would not have happened. Also, thanks to my second reader, Dr. Fred Schmidt, who gave me valuable information that would have otherwise remained unknown due to accessibility issues in this area of health, and especially of his own agency that has been referenced within the section of childcare consultations, for which I have been informed of its unique status in programming nature and not necessarily representative of services offered across the province. Of note, and brought to my attention by Dr. Schmidt too, was the book entitled: "Age and Gender Considerations in Psychiatric Diagnosis- A Research Agenda for DSM-V" (Narrow, First, Sirovatka, & Regier, 2007), which describes mental disorders in relation to infancy and early childhood, but which was unable to be accessed due to time constraints at the time of submission of this paper.

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"*Are you and your family dealing with a child experiencing emotional, behavioural, psychological or social problems*?"

This opening, on the Parents for Children's Mental Health website (2007), is not only indicative of the multitude of mental health issues facing children today, but also the impact upon the entire family unit. In Canada, children's mental health problems pose a tremendous burden, of which, attention deficit/ hyperactive disorder, anxiety, and depression are some of the most common illnesses (Children's Mental Health Ontario (CMHO), 2007). Besides the 1 in 5 children that have a mental health problem; 1 in 10 children have aggressive behaviour problems, 1 in 3 children experience physical or sexual abuse; and 1 in 20 children start school without the skills needed (Offord Centre, 2004). Mental health problems among children and youth have increased in recent years and are estimated to increase by 50% by the year 2020 according to The European Commission (2004). Further, research indicates that the commencement of difficult behaviours in childhood (e.g. anxiety, antisocial behaviour, and conduct problems) may lead to a lifetime of serious psychosocial disturbances, with greater incidence of substance abuse and criminal behaviours in adolescence and adulthood (Keenan, 2002).

Good mental health in children depends on: secure relationships being formed with adults; the ability to express emotions and appropriately control behaviour and emotions in certain situations; a sense of uniqueness and confidence; independence in problem

solving and making choices; the ability to cope with change; and motivation to try new experiences and explore the environment (Canadian Mental Health Association (CMHA), 2004). The emotional health of young children is an important indicator of well-being that ties directly to many areas of their development, including their ability to build healthy self-esteem, bond with people around them, and learn tasks both within and outside of formal academic settings (Keenan, 2002).

Research evidence suggests that the most favorable time to influence determinants of social and emotional well-being is during childhood (Willms, 2002). Prevention programs (e.g., parenting classes that address the causal factors of mental health issues) have been demonstrated to significantly improve social and educational outcomes, while reducing the ensuing prevalence of behavioural problems (Waddell, Hua, Garland, Peters, & McEwan, 2007). In light of such evidence, and yet with such high rates of suffering still prevalent within Ontario (and Canada in general), a combined public health and children's mental health strategy is needed to promote social and emotional well-being, and to both prevent and treat children's mental health problems.

Mental illness during childhood not only negatively impacts the life of the child (e.g., self-esteem, social interactions, stigma), but also his/her family (e.g., parental discord, relationship with siblings) (Here To Help, 2006).The focus for this paper, therefore, is on early childhood mental illness and the mental health services available to children aged 0 to 6 years and their families in Ontario.

The first section of this paper presents the definition and prevalence of mental illness among children aged 0 to 6 years old. The second part of this paper identifies services provided for addressing children's mental health issues in Ontario, and evidence related to the outcomes of such services is presented in part four. The last section provides discussion and recommendations for both practice and future research in the area of children's mental health, with some final thoughts to conclude the paper. It should be noted that most information on mental illness during childhood (e.g. prevalence, outcomes) covers the period of 0 to 18 years of age. Where possible, specific information on children aged 0 to 6 years will be provided.

Part 1: Defining Children's Mental Health & Illness

This section addresses what children's mental health and illness is, along with six of the most common mental health disorders in preschool children.

The World Health Organization (WHO) acknowledged the multidimensional nature of health in 1948, defining it as "a complete state of physical, mental and social well-being and not merely the absence of illness" (Shah, 2003). It took another 26 years before Marc Lalonde, Minister of Health, released: "*A New Perspective on the Health of Canadians*" in 1974, expanding the concept of health to include environment, genetics, lifestyle, and the organization of health services (Centre for Addiction and Mental Health, 2006). This not only incorporates the fact that service organization is important in

relation to the public's health, but addresses the importance of the environment that a person lives within.

Health Canada (2002) reports that mental illness is characterized by changes in behaviour, thinking, or mood (or a combination there of), and is associated with a significant amount of impaired functioning or distress over an extended period of time. Mild to severe symptoms vary depending upon four variables: the type of illness; the individual; the family; and the socio-economic environment (Health Canada, 2002). Further, mental illness does not discriminate, affecting people from all educational backgrounds, income levels, and cultures (Health Canada, 2002). The Hincks-Dellcrest Centre (2001) expands upon Health Canada's notion of mental illness not being socially discriminatory, reporting that the growing isolation of children and families within communities is due in part to a wide range of social trends, which ultimately needs to be responded to with care and information if the problem is not to worsen as children age. The WHO (2005) expands upon these definitions when writing specifically about child and adolescent mental health, stating that not only is psychological functioning and well-being important, but that the capacity to achieve and maintain this, is just as crucial.

Since the Kirby and Keon report of 2006, whereby the committee felt that they were not well placed to make recommendations regarding autism due to being uncertain as to whether autism was a mental illness or not, as well as Autism Ontario (2006), the leading source of information and referral on autism in Ontario, stating that autism is not a mental illness, the disorder is not to be included within this paper. It appears that clarity in this

area is needed in order to serve both children with mental health issues, and children with autism, more effectively.

Common Mental Health Disorders in Children Aged 0 to 6 Years

It can often be difficult to decide if a child has a mental health problem (CMHO, 2007). One has to decide if a child is acting appropriately for their age, or whether the way that they are acting is a sign that the child is in need of mental health support (CMHO, 2007). Thus, defining a problem can be a problem.

The Diagnostic and Statistical Manual IV-TR, most commonly referred to as the DSM-IV-TR, is the definitive guide to mental health disorders in Canada (American Psychiatric Association, 2000). Some of the most commonly diagnosed mental health disorders in children 0 to 6 years are briefly described below with the specific 0 to 6 prevalence rates given where possible. Again, much of the available information focuses on children aged 0 to 18 years:

1) Attention deficit/ hyperactivity disorder (ADHD). This is the most common psychiatric disorder affecting children within Canada, which is observed in children with hyperactive and impulsive symptoms (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA), 2007). There are approximately 3-4% of females, and 8-10% of males under the age of 18, 5-12% of school-aged children have ADHD (CADDRA, 2007).

*2) **Anxiety disorders**.* These are a group of conditions, characterized by a sense of threatening or imminent disaster (Anxiety BC, 2007). Egger & Angold (2006) approximate that 9.4% of the preschool population (aged 2 to 5 years) have such disorders, but found that little epidemiologic or clinical research has focused on the classification, characteristics, or prevalence of preschool clinically significant anxiety disorders or symptoms.

*3) **Oppositional defiant disorder and conduct disorder**.* Within children these appear in the form of consistent displays of aggressive behaviours (Offord Centre for Child Studies, 2006). Keenan & Wakschlag (2004) believed that theirs was the only study reporting findings of referred and non-referred preschoolers (2.5 to 5.5 years) in relation to both oppositional defiant and conduct disorder, with symptoms being rare among non-referred preschool children (2%), and yet commonly endorsed (34.2%) in referred preschool children.

*4) **Depression.*** This, at any one time, is found in approximately 3.5% of children and adolescents aged 5 to 17, with the rate increasing with age (Waddell, McEwan, Sheperd, Offord & Hua, 2005). Egger & Angold (2006) found that 2.1% of 2 to 5 year old children experience depression, but also speak to the limited number of studies on preschool depression.

5) Eating disorders. They are classified as an encompassing nutritional intake problem, with approximately 25% of normally developing infants, and up to 80% of infants with developmental delays, experiencing feeding problems (Steinberg, 2007).

6) Attachment. Attachment focuses upon a child's need for protection and comfort, and a caregiver's provision of appropriate care in a timely nature in response to those needs (Goldberg, 2005). Although not seemingly a common disorder in children's mental health by itself, attachment theory has had a profound impact upon hospital policies, institutional care, child custody, promotion of parent-child relationships, and childcare, with a marked acknowledgement of the critical importance of attachment within children's mental health (Goldberg, 2005).

While each of these conditions is known to affect children aged 0 to18 years, less is known about the prevalence and impact of these conditions among young children (i.e., 0 to 6 years). Future work should address this gap in the literature and evidence base.

Part 2: Children's Mental Health Services in Ontario

This section addresses the decision to seek mental health services for children aged 0 to 6 years, as well as the types of services offered to children and their families in Ontario.

Getting Help

Because of their dependence on others, especially in the preschool years, children are among the least able to advocate for themselves (WHO, 2005). Therefore, the decision to seek treatment for children's mental health issues is primarily out of a child's hands (WHO, 2005). While parents most often make the decision to seek help for their child, a number of barriers make it difficult for them to do so. For example, parental concerns regarding the social stigma that surrounds mental health problems (Starr, Campbell, & Herrick, 2002) or the belief concerning the lack of available and effective treatments (Starr, Campbell, & Herrick, 2002), the child's age (Wolpert & Fredman, 1996), parental socioeconomic status (Gold, 2007), and geographic location (Boydell, Pong, Volpe, Tilleczek, Wilson & Lemieux, 2006) may affect their decision or ability to get help for their child.

The decision to seek help is also influenced by the child's school teachers and counsellors, though their perceptions regarding the need for treatment may not always align with those of the parents (Farmer, Burns, Phillips, Angold, & Costello, 2003). Increasingly, school mental health programs are becoming more common, and are potentially very important mechanisms in the early identification and referral of needful students (Rones & Hoagwood, 2000. Haynes, 2002).

Gathering information and consulting with multiple sources (including parents, teachers, peers, and the child him/herself) is not only essential in the decision to seek mental health

services, but also to obtain a more complete and comprehensive picture of the child's needs, as well as his/her strengths and weaknesses (Haynes, 2002).

Children's Mental Health Services in Ontario

Over 100,000 children (0 to 18 years) within Ontario in any given year receive children's mental health treatment (Barwick, Boydell & Omrin, 2002). This number is apparently representative of about 20% of the population who likely requires such service (Barwick, et al, 2002).

Ontario's children's mental health system includes approximately 250 community-based agencies (Ontario Public Service Employees Union, 2005). However, CAFAS in Ontario (2005) report that their Ontario government mandated screening tool is used in 107 children's mental health organizations, which includes 84 community-based and 23 hospital-based centres. Children's Mental Health Ontario (CMHO) (2007), an association that aids children's mental health centres share information and advocate for policies, programs and funds to improve the state of children's mental health throughout the province, includes 87 (included within the 250) community-based children's mental health centres. This disparity in numbers appears to set the scene for the need for clarity within children's mental health, which, in this case, includes definitions.

The services are usually provided to children on an out-patient basis (i.e., while they continue to live within the home) (CMHO, 2007). Parents may directly contact the agency themselves, or be referred by a professional (e.g., teacher, family physician, social

worker, or community healthcare worker) (CMHO, 2007). Most often, the child and family are placed on a waiting list prior to receiving treatment (CMHO, 2007).

The types of services provide by such organizations include, but are not limited to: crisis intervention; group and individual therapy; family counselling; behaviour management; psychiatric treatment (including pharmacological treatment), parent support and training, residential care, school programs, and day treatment (CMHO, 2007). These organizations are funded by payment transfers under the Child and Family Services Act (CFSA), by the government of Ontario (Ontario Public Service Employees Union, 2005), and are provided free of charge to families (CMHO, 2007).

In addition to such services, parents may also access mental health clinicians (e.g. psychologist) in private practice at a fee, where payment for service becomes the responsibility of the family (CMHO, 2007).

The Provincial Centre of Excellence for Child and Youth Mental Health (2008) has created a self-opted directory of children's mental health services, which, although not fully comprehensive, covers services offered across the province. Table 1 shows the distribution of 164 organizations offering support to children 0 to 6 years old in nine geographical regions of the province, including: Northern, North-East, Eastern, South-West, Central-West, Hamilton-Niagara, Toronto, Central-East, and South-East .

Region	Areas encompassed	Number of Service Agencies
Toronto	Toronto	30
South-West	Bruce, Grey, Huron, Stratford Lambton, London, Oxford, Windsor, Chatham-Kent, St-Thomas	27
Central-West	Dufferin, Wellington, Peel, Waterloo, Halton	22
Central-East	Haliburton, Simcoe, Victoria, Peterborough, York, Durham, Northumberland	21
Hamilton-Niagara	Brantford, Hamilton-Wentworth, Haldimand-Norfolk, Niagara	18
Eastern	Renfrew, Ottawa-Carleton, Presscott & Russell, Cornwall	16
Northern	Kenora, Rainy River, Sudbury, Maritoulin, Algoma, Sault Ste. Marie	15
North-East	Temiskaming, Parry Sound, Nippissing, Muskoka	8
South-East	Lanark, Hastings, Lennox & Addington, Kingston, Leeds & Grenville	7

Table 1. Number of Mental Health Service Agencies in Ontario for Children Aged 0 to 6 years (The Provincial Centre of Excellence for Child and Youth Mental Health, 2008).

The type of services offered varies quite extensively from one organization to another and from one region to another. However, according to the Provincial Centre for Excellence for Child and Youth Mental Health (2008), some common types of services provided in all regions included:

- assessment, case management, and counseling/therapy;
- mental health promotion; and
- public awareness and education.

However, the availability of services in the person's native language and cost of services varies greatly across the province (The Provincial Centre of Excellence for Child and Youth Mental Health, 2008). For example, only two of the nine regions (22%) offer native language services at all, and seven of the nine (78%) regions offer services in French in less than a third of their organizations. The proportion of organizations that offer services free of charge is greatest in Toronto (75%); while this is true for only about one third of organizations in the other regions. In fact, in Central-East region, thirteen of the twenty-one organizations (62%) charge partial or full fees for services.

Types of Services Provided to Children and Families

Upon contact with a children's mental health agency in Ontario, most will begin with a phone interview between the parent/caregiver and trained mental health professional using the Brief Child and Family Phone Interview for children 4 years old and up (Cunningham, Pettingill, & Boyle, 2000). Zero to 3 year old scales are pending according to BCFPI (2007). During this 20-40 minute standardized interview, the professional aims to identify what mental health problems are causing concern, and how serious they may be (CMHO, 2007). This is not only intended to understand why service is being sought, but also to learn more about the child and his/her family (CMHO, 2007). In addition, the information gathered from this interview generates a wealth of data that describes the scope and severity of the challenges that face all clients (EMYS, 2006). With the information gathered during this interview, the child/family is then referred to appropriate services, which can involve one or many of the following components: intensive services, preschool consultation, parent education, day treatment, school

programs, hospitalization, telepsychiatry, and pharmacotherapy. A brief description of each type of service, the types of issues addressed, the goals of service, treatment/ intervention methods used, and writer critique follows:

a) Intensive child and family service. These services are reserved for children with serious behavioural or emotional problems; for example, risk of harm to self or others, risk of losing their home, school or daycare placement, has witnessed violence, has been physically abused, or has problems relating to others (Peel Children's Centre, 2008). Services can include office-based counselling and/ or home-based intensive programs for children and families with complex needs (Woodview Children's Mental Health and Autism Services, 2008)

The main principles for these types of services include: that the child is central in the process, and screening, assessment, and intervention are carried out in a way that is natural, familiar, and non-threatening to the child; the child and family context is to taken into account; family involvement and engagement is integral; thoughtful strategies are to be matched to all issues related to the child and family characteristics pertaining to the issues; and documenting, monitoring and evaluating the quality of intervention, implementation, and outcomes is needed (CMHO, 2002).

Screening and assessment measures that are frequently used with families and children 0 to 6 years include, but are not limited to: the Preschool and Early Childhood Functional Assessment Scale (PECFAS), which is a mental health worker assessed questionnaire

that measures functioning in eight areas and utilized on children 3 to 7-years-old; the Eyberg Child Behaviour Inventory, whereby a caregiver or teacher rates the child's behaviours using a questionnaire in order to distinguish typical behaviours from those indicating significant behavioural disturbances; the Conners Rating Scales Multi Health Systems Inc. (CPTRS), which assesses psychopathology and problem behaviour including hyperactivity and conduct disorder in children 3 to 17 years of age; and the Peabody Picture Vocabulary Test (PPVT III), that is used on children aged 2.5 years to adult and measures the child's receptive vocabulary as well as estimates their verbal ability (CMHO, 2002).

Research upon these assessments and screenings appears to span a spectrum (CMHO, 2002). The PECFAS researchers provided concurrent validity and reliability assessed on a single sample size of 30 children, with inter-rater reliability being rated as high as was internal consistency of 5 subscales, with more research was underway in 2002, but which cannot be retrieved in January 2008 (CMHO, 2002). The Ontario CAFAS & BCFPI Advisory Committee (2007) meeting minutes from September 20, 2007 note that the measures use: "was discussed a few years ago as a pilot but the ministry has not mentioned it again. Algoma, CDI, CFC of Sudbury and Algonquin are all interested in the use of the PECFAS" (n.p.). The Eyberg studies found a reliability rating of test-retest .86-.88 when testing and retesting the questionnaire (CMHO, 2002). Research found that good validity was established with conduct disorders. Sensitivity was .80 and specificity .86 (CMHO, 2002). The CPTRS researchers showed test and retest reliability of .72-.91, with discriminatory validity with construct and concurrent validity were well

established, but predictive validity was weak (CMHO, 2002). The PPVT III studies were rated with consistent internal reliability consistency of .92-.98, and test-retest of .91-.94 (CMHO, 2002). The Nipissing District Developmental Screening (NDDS) questionnaire, as promoted by Health Canada since 1996(NDDS, 2007), has faced validity claims with no reliability and no research conducted (CMHO, 2002).

Assessment is said to guide the treatment within children's mental health centres, and is specific to the child's presenting problems and needs (Peel Children's Centre, 2008). Mental health workers collaborate with families to create a plan, counsel the family, give advice about parenting, and possibly arranging for a consultation with a psychologist or psychiatrist (Peel Children's Centre, 2008). With flexibility, the worker will treat the child in the home, daycare centre and/or school (Peel Children's Centre, 2008).

CMHO (2002), published an "Early Childhood Training Guide" in 2002, which includes screening and assessment, and planning intervention strategies. Within the guide, "Promising practices in early childhood mental health treatment and intervention for specific disorder" (p.1), speaks to various interventions for disorders such as; ADHD, depression and anxiety. Such interventions include: cognitive-behavioural therapy and psychotherapy, but as viewed within the literature, "promising practices" do not appear to hold solid ground or specific direction for practice. CMHO (2002) acknowledge knowing that common treatments are more beneficial when aimed towards specific developmental issues and different populations. However, this reflects the state of the field, whereby few effectiveness studies have been done. They further believe that:

"Promising practices indicate that an integrative knowledge-based approach may be more effective in making a better fit between who needs what" (CMHO, 2002, p.11). The words "may be" do not provide conclusive evidence to these practices, and in effect leave them open for interpretation.

There appear to be three main approaches towards intervention with children 0 to 6-years-old: play therapy; group therapy; and family therapy (CMHO, 2002). Play therapy can include the child, sibling, group, and/or family, and is usually delivered as Non-directive therapy, Theraplay, Cognitive Behavioural Therapy, Structured therapy, Behavioural therapy, Psychoanalytic therapy, or Brief Solution-Focused therapy (CMHO, 2002). Group therapy can include the child, parent, or child and parent, and service is therapeutically provided through; Behavioural, Cognitive Behavioural Therapy, Non-directive, Psychoanalytic, and Solution-Focused theories (CMHO, 2002). Family therapy includes; Structural therapy, Narrative therapy, the McMaster Model, Psychoanalytic therapy, Brief Solution-Focused therapy, Wrap Around, or Multisystemic Therapy as laid out by the "Children's mental health services for children zero to six: Review of the literature and practice guide (CMHO, 2002).

Most agencies appear to provide generalist information regarding their specific approach to intervention with children and their families aged 0-6 years, as viewed via The Provincial Centre of Excellence for Child and Youth Mental Health's (2008) self-opted directory of children's mental health services. Many parent education services are explicitly described, and will be addressed later within this paper. However, Kinark Child and Family Services (2008) is one agency that provides clear information regarding

their use of Multisystemic Therapy (MST), stating that the work is evidence-based, and encompasses all aspects of children's lives by addressing their specific needs and involving everyone involved within the child's/ youth's life (families, peers, school personnel, community members) within the therapy. However, MST Services (2007), a private but university-affiliated and licensed organization that aids in the dissemination and implementation of MST, proclaims that: "*MST is a research-proven and cost-effective treatment for youth with serious behavioral problems*" (n.p.), along with showing research evidence for the adolescent population only. Kinark (2008), does not specifically state if these services are used with the 0 to 6 population serviced by them, but does write of the therapy being used to help "children and youth". Further within their website, Kinark Child and Family Services (2008) speaks to the 0 to 6 programs, which include the evidence-based services of 'Incredible Years' and 'Right from the Start'. There appear to be conflicting messages to mental health agencies by CMHO (2002) advocating MST use within it's 0 to 6 practice guide, along with possible conflicting practices by some mental health agencies, such as Kinark Child and Family Services (2007), who could be utilizing MST practice with the 0 to 6 age group, when it is evident from the MST Services (2007) research and website that the services are appropriate for the adolescent population.

However, these intensive services most often work within a strength-based, culturally sensitive model, whereby the approach to service is centered on the client and their family, and considers him or her within their whole context, respecting their needs and preferences (CMHO, 2006).

b) Preschool consultation program. Childcare programs having little success using traditional resources to support children with difficult behaviour such as; anger and aggression, lack of impulse control, extreme anxiety, and difficulty with social skills, may seek a preschool consultation from a children's mental health centre (Children's Centre Thunder Bay, 2008).

The goal of consultation within childcare settings is to enhance the skills of childcare workers and families in support of healthy development of children within child-care settings (George Hull Centre, 2008). With parental consent, childcare staff is provided with resource materials and strategies on how to adapt the environment to better meet the needs of the child, as well as the provision of information and education (Children's Centre Thunder Bay, 2008). Referral to the mental health centre for more intensive support or further clinical assessment, or to other appropriate community resources, may also be offered (Children's Centre Thunder Bay, 2008).

Upon an internet search of "preschool consultation Ontario", and associated words there of, in the first three months of 2008, minimal information with regards to the actual operations of preschool consultants was retrieved. The agencies referenced above were exhausted of their content. Thus, if it is difficult to obtain basic information at the professional mental health level, one must ask what occurs at the professional childcare level. However, upon one last search before this paper was submitted, the Aisling Discoveries Child and Family Centre (2007) website, located in Toronto, was sourced and revealed detailed information regarding its services to community childcare providers

as well as program goals and responsibilities. It is information such as this that provides clarity and ease of access to services.

c) Parent education groups. There appear to be three main parenting programs delivered in Ontario: Nobody's Perfect; The Incredible Years; and Triple P, which can be found either by doing a general internet search or specific children's mental health agency search (Haliburton Victoria Brock Ontario Early Years Centre, 2008; Public Health Agency of Canada, 2003; Children First, 2008). Other programs, such as Right From the Start aimed at parents pf children up to 2 years of age (Eastern Ontario Health Unit, 2005) and Caring Dads (Scott & Crooks, 2007) do exist but do not appear as widespread.

All three main programs appear to hold similar goals of: strengthening parenting skills by improving communication, setting limits, discipline and problem solving, self-sufficiency and resourcefulness of parents; promoting children's development through positive parenting practices; promoting safe, engaging, low-conflict and non-violent environments for children (Haliburton Victoria Brock Ontario Early Years Centre, 2008; Public Health Agency of Canada, 2003; Children First, 2008).

In the early 1980's Health and Welfare Canada in part developed Nobody's Perfect, whilst although not developed from a particular theoretical framework, Strypneck (2002) reports that the principles are consistent with a human ecological framework. The program is aimed at families of children 0 to 5 years, is either 6 or 8 weeks in length, and

is the only early years parenting program promoted on the Public Health Agency of Canada's website (2008).

Meanwhile, Webster-Stratton carried out much research during the 1980's. Programs were developed for families with children ages 3 to 8 with conduct problems; namely The Incredible Years, with the major theory being that of the social learning model (The Incredible Years, 2008). The 12 week curriculum has been adopted by many children's mental health centres, early childhood centres, child protective agencies and schools throughout Canada and other countries (The Incredible Years, 2008).

Most recently, Triple P (Positive Parenting Program) has been slowly implemented within parts of Ontario as a multi-level, preventatively-orientated parenting program, derived from Australia (Sanders, Markie-Dadds & Turner, 2008). The theoretical framework stems from social learning models, models of child and family behaviour therapy, developmental research, developmental psychopathology, and social information processing (Sanders, Markie-Dadds & Turner, 2008). It is evidenced based, and Triple P has the strongest empirical support of any intervention with children, particularly those with conduct problems (Children First, 2008).

In general it appears that parent education classes have evolved over the years, through coalitions and research in the professional stratosphere, being disseminated widely throughout Ontario.

d) Day treatment. Day treatment provides children's mental health services for students who have difficulty functioning in a regular school setting because of social,

emotional and/or behavioural concerns and operates under the Child & Family Services Act - Child & Family Intervention, Mental Health Act, Youth Criminal Justice Act and Section # 20 of the Education Act Regulations (Thunder Bay Catholic District School Board, 2008). The entry level for these programs, with regards to age limits, appears to vary from 3.8 years, (Learning Disabilities Resources Community, 2002) 4 years (Aisling Discoveries Child & Family Centre, 2006), to a more generalized "elementary school aged" (Thunder Bay Catholic District School Board, 2008) criteria.

A generalist goal of all age range day treatment is to re-integrate children back into a regular classroom by assisting them to develop their academic, behavioural, and social skills (Niagara Child and Youth Services, 2008).

Classrooms are generally located within community schools, and work in partnership with local school boards (Aisling Discoveries Child & Family Centre, 2006). These programs can deliver individual play therapy, family therapy, marital therapy, parent group, occupational and/or speech therapy, and behavioural management in connection with the national curriculum (Learning Disabilities Resources Community, 2002). The day treatment schedule is influenced by the school year, and can include service through the summer months. Integration back into the school system is accomplished in a planned and transitional way (The York Centre for Children, Youth & Families, 2008). Again, limited explicit information is available upon a children's mental health agency internet search.

e) School-based programs. The Ontario Public School Boards' Association (2008) has lobbied for collaborative funding in order to enable all school boards to have on-site mental health workers at school. The goal of school-based mental health programming is to have quick, less formal access, and immediate availability of counselling services (The Ontario Public School Boards' Association, 2008).

Assistance to students, by on-site mental health workers, helps them explore alternative solutions to problematic behaviours, and actively work upon these choices (The Ontario Public School Boards' Association, 2008). Other programs help students learn the skills of conflict resolution, anger management and peer mediation (The Ontario Public School Boards' Association, 2008). These programs have a direct impact in reducing aggressive behaviour and potentially violent incidents (The Ontario Public School Boards' Association, 2008).

Currently, there is no comprehensive report available on the level of children's mental health services available within Ontario according to the Committee on School Health (2004). The Committee on School Health (2004) discuss some schools offering specific mental health services on campus through local mental health agencies, and feel that "*although some schools may not offer any clearly defined mental health programs, most of them offer at least a school guidance counselor*" (n.p.). One has to question whether "at least" is good enough for today's children, along with the aloofness of the definition of mental health services within schools.

f) Hospitalization. There are 37 hospital-based programs, and 21 public hospitals are specifically designated for children's mental-health outpatient services

within Ontario (Stevenson, 2003). In-patient services within hospitals provide treatment for children whose mental health needs cannot be met on an outpatient basis (Mental Health Service Information Ontario, 2005). Humber River Regional Hospital in Toronto has six inpatient beds that are used for acutely ill children and adolescents needing 24-hour protective, therapeutic environment and close professional assessment and stabilization (Mental Health Service Information Ontario, 2005). Along with psychiatrists, child and youth care workers, nurses, social workers and teachers work collaboratively with families within a medical/ psychoeducational model of service (Mental Health Service Information Ontario, 2005).

Upon a physician's referral of children aged birth to 5-years-old, the Infant Psychiatry Programme at Sick Children's Hospital, Toronto provides consultations, assessments and short-term treatments (The Sick Children's Hospital, 2005). Reasons for referral include concern regarding the child's physical health, such as; infants and young children with feeding difficulties, issues with the parent-child relationship, attachment problems, behavioural problems and difficult temperament (The Sick Children's Hospital, 2005). Mental health issues as a result of serious infant and child illnesses, developmental delays, and traumatic experiences may also warrant referral to these services (The Sick Children's Hospital, 2005).

Hospitals, such as Markham-Stouffville Hospital in York Region can provide assessment, short-term therapy, family intervention, group therapy, parental groups, linkages with and education to schools and community programs (Mental Health Service Information

Ontario, 2005). Once again, explicit information regarding services provided is weak upon an internet search.

g) Telepsychiatry. Ontario's telepsychiatry program, operated out of Sick Children's Hospital (Central), Children's Hospital of Eastern Ontario (Eastern), and Child and Parent Resource Institute in partnership with London Health Sciences Centre, St. Joseph's Regional Mental Health Care London, Windsor Regional Hospital and the University of Windsor (Western), is described as "*a creative solution for increasing access and reducing wait times for children and youth in rural, remote and underserved communities*" (Ministry of Child and Youth Services, 2007, n.p.).

Videoconferencing is used to provide access to clinical consultations with a child psychiatrist without children and their families having to leave their local communities. The program provides services to areas such as; Kenora, Thunder Bay, Cornwall, Owen Sound and North Bay, to name a few. Another benefit of the programme is the provision of education and training to increase professional expertise and capacity within remote communities (Ministry of Child and Youth Services, 2007).

h) Pharmacotherapy. Psychotropic medication of preschool children with a mental health disorder is not generally the first option provided (Mental Health Canada, 2004). After first understanding the factors that may be contributing to the condition, psychosocial treatments may be given, with some being as effective as medication (Mental Health Canada (2004). If medication is prescribed, monitoring and evaluation

should occur regularly, along with up-take of other strategies, such as; family support services, educational classes, behavior management techniques, as well as family therapy (Mental Health Canada (2004).

Parents are encouraged by Mental Health Canada (2004) to learn everything they can about medications prescribed for their child, including potential side effects. Further, education and mindfulness regarding the goals of a particular treatment, such as change in specific behaviors is recommended (Mental Health Canada, 2004).

Overall, the types of treatments described here may or may not be similar to those for older children suffering mental health disorders and issues. What is important to remember, as mentioned within the text, is the rapid development during the first six years of life, both in terms of normality of emotions and behaviours exhibited, as well as the effects of treatments, both in the short- and long-term.

Part 3: Challenges to mental health service delivery

A number of challenges exist in the delivery of children's mental health services in Ontario, including continued emphasis on the biomedical model of care, access to services, lack of an evidence base, and system fragmentation. A description of each problem, why it makes service delivery challenging, and suggestions for change follows:

Philosophy or Model of Care

Healthcare within Canada has traditionally been underpinned in its organization and delivery by a biomedical model of care (Taylor & Field, 2003). This model focuses on the physical processes, such as the pathology, the biochemistry and the physiology of a disease (Taylor & Field, 2003). It does not take into account the role of social factors or individual subjectivity (Taylor & Field, 2003). Children's mental health is no different being understood from a framework of dysfunction and pathology (biomedical model) rather than from a framework of strength and resiliency (Taylor & Field, 2003).

Ideological and theoretical differences contribute to inter-professional tensions with those involved in psychotherapy and pharmacotherapy in rivalry positions in the marketplace for patients or clients as well as in the scientific and intellectual marketplace (Taylor & Field, 2003). The Canadian Paediatric Society (2006) writes of the difficulty for parents and health professionals alike, in navigating the provincial mental health system due to the system not being integrated, with service and information being fragmented. They speak of the need to establish a program to promote inter-disciplinary best practices in prevention, treatment, community interventions and social supports (Canadian Paediatric Society, 2006).

Access to Services

There are a number of barriers to children's mental health services related to access, including availability, timeliness, and eligibility.

a) Availability. In April 2007, the Ontario government emphasized their belief that supports and services be provided to children and their family as close to home as possible (Ministry of Child and Youth Services, 2007b). However, this is often not the case. For example, persons in rural, remote, and northern regions often do not have access to services within their community, have a lack of anonymity, and have to drive great distances to get to communities that do (Boydell, Pong, Volpe, Tilleczek, Wilson, & Lemieux, 2006). After an Ontarian study that looked at families' experience in seeking treatment for their 4-18 year old with psychosocial problems, Reid, Evans, Belle Brown, Cunningham, Lent, Neufeld, Vingilis, Zaric & Shanley (2006) suggested that a single point of co-ordinated intake for child and youth mental health services would possibly work best in larger communities, and yet smaller communities could better benefit from children's mental health centres.

Methods of decreasing barriers to accessing service need to continue according to Ried, et al (2006), with novel self-help interventions needing to be tested. Here, initiatives such as the Building Connections Project (2008), where internet seminars of Triple P parenting information are available for download, versus having families travel long distances to gain the same information. This is also cost effective, although follow-up and effectiveness cannot be achieved.

b) Timeliness. In 2004, the Ontario Association of Children's Aid Societies (OACAS, 2004) announced that the province's children's mental health system has the capacity to serve approximately 140,000 children/families per year, and that on average,

there is a 5 month wait for service. Families appear to be involved with multiple agencies in some cases, in multiple states, i.e. waiting for assessment with one agency whilst waiting for treatment with another (Ried, et al, 2006). Providing co-ordinated care would both help families manage the complexities of the system, and yet curtail duplication of service delivery, which in turn would reduce the burden upon the system (Reid, et al, 2006).

Inter-disciplinary collaboration and development of wait time benchmarks is recommended by the Canadian Paediatric Society (2006), but should this be carried out at the local, municipal, or provincial level, as mentioned above?

*c) **Eligibility.*** Though appropriate services may be available to children and their families in a particular region, the child in need may not always meet the eligibility requirements for service. For example, there remains controversy as to whether autism is a mental illness (Kirby & Keon, 2006; Autism Ontario, 2006), and so the appropriateness (and funding) of some mental health services for children with autism is still being debated, and again the issue of navigating the system is illuminated. In the mean time, children and families often go without needed services.

In order to deal with the issue of access to needed services, the Ministry of Children and Youth Services has allocated approximately $24.5 million in new monies to address gaps in local service needs and reduce wait times in the hope of improving the system's ability to respond sooner to families' and communities' needs (Ministry of Child and Youth Services, 2007b). While this funding is definitely welcome, it will not solve all issues, in particular, eligibility for some mental health services.

Fragmented System

The last two sections covered many of the points of fragmentation, but the issue itself deserves and requires attention. The Child Welfare League of Canada (CWLC) (2007) provided the following statement upon the event of Canada's First National Child and Youth Mental Health Day and Ontario Children's Mental Health Week in May 2007: "*Those issues encircling mental health in Canada are numerous: fragmented and under-funded services or lack of available services, lack of national mental health strategy and the stigma of being afflicted with mental health illnesses are just a few*" (n.p.).

Waddell, et al (2005) reiterate this belief, but add that: "fragmentation among jurisdictions, sectors, and disciplines is a long-standing problem in children's mental health" (p.230). The CWLC (Child Welfare League of Canada, 2007) also believed that the first step in developing a national mental health strategy was to encourage collaboration by organizations providing family and children's services. This all came after the Ontario Ministry of Children and Youth Services delivered the Ontario's Policy Framework for Child and Youth Mental Health in November of 2006, which aims to foster collaboration amongst all involved in the responsibility for the healthy development of Ontario's children and youth (Ontario Ministry of Children and Youth Services, 2006). Communities, including the families, caregivers and all providers of services to child and youth, including: health, education, child protection, social services, recreation, heritage and culture, the adult mental health sector and all levels of government, were all named as responsible persons within the framework (Ontario

Ministry of Children and Youth Services, 2006). This highlights the need to work collaboratively without placing blame, for it is everyone's responsibility to work at achieving this measure in order for it to become a reality. Dollars alone will not solve the issue, but neither will man-power alone.

Lack of an Evidence Base

Barwick, , Boydell, Basnett, O'Hara, Ferguson & Haines (2006) write that: "all too frequently, children receive mental health care that is based on practices that have little supporting evidence or, at worst, poor outcomes" (n.p.), and yet empirically supported treatment that is given to children, holds significant evidence that it holds better outcomes than other forms of treatment, or no treatment at all. What does appear important within children's mental health is the need for increased evidence-based practices. Needs would be more adequately met and the impact of services and programs would be greater according to Children's Mental Health Ontario (CMHO, 2005).

Programs appear to have been long-standing without evaluation, thus with Canada's ever-changing demographics, one must wonder about perceived notions with regards to the content of delivered service and material. The CMHO (2005) further report the need for standardized outcome measurement tools for practice, but with the flexibility to accommodate variation within communities. Here the important issues appear to be acknowledged, with professionals discussing the components required for Ontario's Policy Framework for Child and Youth Mental Health, but the question about fulfillment, once the framework is finalized, remains. Overall, evidence-based practice appears best

practiced when research methods, theories, and findings are well researched by the practitioner as well as the researcher, taking into account the existing values, beliefs and practices of the origin and nature of what constitutes legitimate evidence (Dopson, Locock, Gabbay, Ferlie & Fitzgerald 2003).

The new CMHO (2008) "*Evidenced-based Practice Consultation Paper*" appears to have taken what it self-labels as "a proactive approach" (p.4) to the emerging benchmark, which is the delivery of evidence-based, practice. The organization aims to implement the new standards to all agencies seeking accreditation from CMHO (CMHO, 2008). Of course this does not guarantee compliance of other agencies, practitioners and sectors, but it is clearly a start to a unified service.

Part 4: Literature Review of Service Outcomes

This section intends to focus and include information on research outcomes of the specific 0 to 6 years old children mental health services within Ontario as described within this paper, i.e. intensive child and family services, preschool consultation program etc. Statistics Canada (2008) reports upon the pending 2006 to 2007 (Cycle 7) report of The National Longitudinal Survey of Children and Youth (NLSCY), which is a long-term study of Canadian children, following their development and well-being from birth to early adulthood. Information about factors influencing a child's social, emotional and behavioural development was collected from the Labour Force Survey's (LFS) sample of respondent households, along with monitoring of the impact of these factors on children's development over time (Statistics Canada, 2008). The release of the data is scheduled for

November 2008 (Statistics Canada, 2008). This inevitably brings about information regarding service needs, but knowledge regarding service outcomes is also imperative.

a) Intensive Child and Family Services. *Access:* Two studies within Ontario appear to have been carried out with regards to seeking out mental health services. One study by Shanley, Reid & Evans (2008), carried out in London, Ontario sought to examine how parents (n=60) navigate the various children's mental health services available. The researchers found that parents of children 4 to 17 years old, had generally sought help for two different child problems, contacted 5 different agencies within a year, with 20% of parents accepting treatments that they did not want (Shanley, et al, 2008). Some of the same researchers had carried out an earlier, similar study within 16 children's mental health agencies in Ontario (n=300) (Reid, Evans, Cunningham, Lent, Neufield, Vingilis, Zaric,& Shanley, 2006). However, they also wanted to seek the impact of poor continuity of care, but felt afterwards that they had been unable to achieve this due to children being on waitlists, along with the complexities of the care continuum (Reid, et al, 2006). These researchers concluded that families require assistance to navigate the system, more cross-section collaboration is needed, and that a definition of what constitutes waiting in mental health is needed (Reid, et al, 2006).

The researchers of both studies gained much demographic information at the same time as realizing the limitations of their studies (Shanley, et al, 2008; Reid, et al, 2006). Thus, three matters of need have been accomplished; data collection, service evaluation, and evidence-based practice. However, the 0 to 3 year old population is not represented here.

Intake: Barwick, et al (2006) found that after 6 years of implementing the BCFPI and CAFAS tools, 100 service provider organizations within Ontario have adopted the tools; over 4,100 child and youth workers, social workers, psychologists, and psychiatrists have been reliably trained to use the CAFAS tool; and 600 specialists have been trained to use the BCFPI tool. However, the data generated from this material has only produced information for children 6 years and older. This is disappointing considering that the BCFPI (2007) can be used on children 3 years and older, the availability of the preschool CAFAS form (CMHO, 2002), and the fact that so much training has been carried out with these tools. Of other concern that the researchers comment upon is: "*Both a "carrot" and a "stick" have a role in the uptake of evidence-based practices. Use of the tools was not included in service provider contracts until 2004 and, when they were, uptake increased*" (Barwick, et al, 2006, n.p.). Workers and agencies cannot ask for more if they are not willing to carry out the work in order to achieve what they are asking for. This does not mean that workers and agencies should be required to do more work with less time and money, but rather change the way they operate.

Treatment: Three treatment studies from within Ontario were found: a six-month follow-up study of therapeutic outcomes of two mother-infant psychotherapies (Cohen, Lojkasek, Muir & Parker, 2002); A study using Modified Interaction Guidance to reduce disruptive caregiver behaviour (Madigan, Hawkins, Goldberg & Benoit, 2006); and a pilot study looking at child trauma treatment (Copping, Warling, Benner & Woodside, 2002).

The first study by Cohen, et al (2002), carried out two different psychotherapies upon parents (n=58) of infants 10 to 30 months of age. Positive outcomes six-months later were established for both forms of therapy, for which one was shorter in length than the other (Cohen, et al, 2002). Very similar effects in treatment outcome indicated that client choice and their therapist's choice in one form of treatment over the other is not compromised (Cohen, et al, 2002). However, the researcher's believe that in the current climate of managed care, they would not want the therapy yielding quicker results to be preferred by agencies (Cohen, et al, 2002). This appears to speak to individualized care, and one may seek to clarify, through further research, what factors determine a therapist's choice in approach, and yet also why quicker results are not encouraged, if not only for the client's sake with development occurring so rapidly during the early years, but also for other clients upon a waiting list, and the tax-paying public.

The second treatment study, again found positive results within a reanalysis of a preexisting study that examined the usefulness of a measuring tool (Atypical Maternal Behaviour Instrument for Assessment and Classification) as an indicator of the reduction of disrupted caregiver behaviours while in attachment-based intervention (Madigan, et al, 2006). However, the study only held 11 parents with infants 7 to 32 months of age (Madigan, et al, 2006). This self-acknowledged limitation, along with no long-term outcomes, make it difficult to use this study alone, but as Madigan, et al (2006) write that the *"findings suggest several important clinical implications for the use of effective attachment-based interventions in the promotion of caregiver responsiveness"* (p.523).

The final treatment study observed from within Ontario is that of child trauma, whereby researchers reported on families (n=27) that completed a "promising" 21 session trauma treatment model (Copping, et al, 2002). The results from this pilot study, that being a decrease in conduct and social problems in the children and caregiver depression, gave support for further evaluation of the researcher's model, but a control group had not been present during this initial study, along with greater numbers of participants (Copping, et al, 2002). The results were displayed as a whole group, making it difficult to ascertain the implications for the 4 to 6 year olds.

Thus, through these three research studies, evidence of the need for health promotion, community awareness, data collection, program evaluation and knowledge of prevalence is given.

b) Preschool consultation programs. There appears to no retrievable preschool program consultation research within Ontario, possibly due to the limited number of agencies offering such a service. However, the Canadian Mental Health Association (CMHA) (2004) report the outcome of the Early Childhood Care Project, which investigated how child care centres can promote young children's mental health (0 to 6 years), to be a booklet: "Handle With Care". The publication sought the promotion of children's mental health in the context of development of age-appropriate and culturally relevant life skills benefiting all children's emotional and social development (CMHA, 2004). No follow-up and post-evaluation is evident.

The lack of material appears to speak for itself in this case, with the need for on-going government commitment to ensure that children are well cared for during the time away from their parents, as well as mental health promotion needing to span sectors of care.

c) Parent education groups. The Public Health Agency of Canada (2003) report that several evaluation and impact studies have been carried out, showing that the *Nobody's Perfect* program is successful at reducing isolation and increasing confidence and parenting skills. However, no links are provided in order to retrieve the studies, as well as no research was available upon an internet and university library search, and so no critique can be made regarding this claim.

Little outcome evidence to parent education programs within Ontario appears to exist. A one 1-year follow-up study carried out by Bradley, Jadaa, Brody, Landy, Tallett, Watson, Shea & Stephens (2003), was sourced, with the researchers reporting that few community programs have been evaluated despite recognition of the need for parenting interventions to prevent childhood behavioural problems. The researchers used a brief psychoeducational group-based parenting video: 1-2-3 Magic, which incidentally had not been formally evaluated, upon an experimental (n=89) and control (n=109) group of parents of children aged 3 and 4 years (Bradley, Jadaa, Brody, Landy, Tallett, Watson, Shea & Stephens, 2003). The acknowledged weakness of results based solely on parent report did not discourage the researchers from believing that the study "demonstrated a reasonable level of efficacy" (p.1177), "and (did) appear to offer promise as a preventive intervention" (p.1177). It is questioned as to whether "reasonable" and "offer promise" are words that hold solid ground?

A preliminary evaluation of an intervention program for maltreating fathers: "Caring Dads", was studied in the London-Middlesex area of Ontario by Scott & Crooks (2007) The outcomes for the program were acquired by pre-and post self-reported assessments of clients (n=23), showing positive results (Scott & Crooks, 2007). However, the researchers themselves found fathers "faking good" at a level of 55.2% on one assessment form, and although the men's levels of stress reduced in all domains tested, none were able to reach levels of significance (Scott & Crooks, 2007). This sheds light onto the need to be cautious when viewing research findings, but also on lessons to be learned from research.

Again, the lack of research for a potentially widespread public coverage of service is evident within Ontario. Once again, evidence of the need for health promotion, community awareness, data collection, program evaluation and knowledge of prevalence is given.

d) Day treatment. No day treatment studies for Ontario's preschoolers have been accessible during a comprehensive internet and university library search. Further highlighting the evidence of the need for evidence.

e) School-based programs. Outcome studies on school-based mental health models are limited (Committee on School Health, 2004). The Ontario Public School Boards' Association (2008) reports the demonstrated enormous benefits for children of school-based mental health programs through pilot studies. However, with no on-going

funding to support them The Ontario Public School Boards' Association and Children's Mental Health Ontario have collaboratively urged the government to expand the number of partnerships between children's mental health centres and schools in order to reach more children earlier and more effectively (The Ontario Public School Boards' Association, 2008).

One such school and children's mental health agency partnership is that of The George Hull-Highfield Community Enrichment Project created by the Ontario government in response to the 1983 Ontario Child Health Study on children's mental health needs (George Hull Centre, 2008).

The preliminary and mid-term results of a 25-year longitudinal study led by Queens University, show the results for the George Hull-Highfield Community Enrichment Project were the strongest in the province (George Hull Centre, 2008). With 90% of the children speaking English as a second language, up to 100% population turnover each year, and three main components of the project: In-School Support (Junior and Senior Kindergarten based); Family Support (0 to four years); and Community Development (all ages), one may feel that such claims as being the best in the province were difficult to achieve (George Hull Centre, 2008). Although no further links to research information are given, the George Hull Centre (2008) reports that after 5 years the children showed a decrease in problem behaviours, and an increase in positive behaviours (self-control and cooperativeness); families showed improved health and well-being; parents held better home-school relations; and the area became a safer neighbourhood.

One main concern is the validity of this study (without official research results) with a population turnover rate of up to 100%, as well 90% of children speaking English as a second. Is either the population or information gathering able to be accurate? As well, one has to wonder if the agency itself carried out any research of it's own looking at prevalence and program evaluation for example in order to gain vital information in a neighbourhood that appears to be responsive to community efforts. Without explicitly referencing the research information, it cannot be effectively utilized by the general community and other researchers. However, these results are optimistic and projects such as this should be observed and replicated if evidently effective.

f) Hospitalization. One hospital-based research study was found regarding children aged 3 to 12 years with gender identity disorder (Cohen-Kettenis, Owen, Kijser, Bradley & Zucker (2003). Here, the researchers were seeking demographic information, social competence information, and knowledge of behaviour problems in children (n=358 in Toronto, n=130 in the Netherlands) with gender identity disorder as part of a cross-national and cross-clinic comparative analysis (Cohen-Kettenis, Owen, Kijser, Bradley & Zucker, 2003). Of significant difference between the countries was the age of the child at referral, with 40.5% of children under 6 years old in Toronto, versus 13.1% in the same age group in the Netherlands. Of further significance was the percentage of 3 and 4 year olds referred (22.6% Toronto vs 2.3% Netherlands) (Cohen-Kettenis, Owen, Kijser, Bradley & Zucker, 2003). Other findings viewed more similarities than differences amongst the populations (Cohen-Kettenis, Owen, Kijser, Bradley & Zucker, 2003). The researchers appear to lay caution to generalizing their findings due to their use of only two countries within the cross-national study, suggesting further study to

ascertain the ability to generalize the findings (Cohen-Kettenis, Owen, Kijser, Bradley & Zucker, 2003). This is not amongst the common disorders in 0 to 6 children's mental health, but obviously significant when observing the study. Research studies such as this one can therefore fulfill the need for community awareness regarding issues such as gender identity.

Grand River Hospital in Kitchener, Ontario gave basic data collection information within the Mental Health Service Information Ontario (2004) website. Here, the figures of 139 children (2 ½ to 5 years of age) attending their Preschool Diagnostic and Treatment Service, with an average length of stay being seven to eight months, is given (Mental Health Service Information Ontario (2004). However, it is not known what year this information pertains to: 2007, 2004 or the previous fiscal year from the date of the website: 2003. Validity: yet another issue brought to light, in the need for evidenced-based research.

g) Telepsychiatry. Analytic research into the impact and effectiveness of telepsychiatry has not kept pace with the proliferation of the service, thus Greenberg, Boydell & Volpe (2006). The one qualitative study that was retrieved looked at caregiver and service provider's perspectives regarding the use of telepsychiatry in rural northern areas of Ontario (Greenberg, Boydell & Volpe, 2006). Though frontline worker's and local agencies feel enhanced capacity in remote and rural areas, the research findings highlight the importance of additional mental health training for rural service providers in order to successfully support clients with mental health needs and their families (Greenberg, Boydell & Volpe, 2006). Families interviewed commented upon the

reduction of travel expenses and lost wages from missed work days due to travel in the past (Greenberg, Boydell & Volpe, 2006).

This study was not specific to 0 to 6 year old children with mental health problems. Of interest would be the study of prevalence of rural and urban 0 to 6 children's mental health cases, both now in light of the relative novelty of telepsychiatry, versus years from now, and the impact of the service. The basic need for current prevalence is posed here, along with data collection, community awareness (of most importance here is professional awareness), evidenced-based practice, government commitment, and service evaluation.

h) Pharmacotherapy. There appears to be much caution surrounding pharmacotherapy in children 0 to 6 years. As of 2002, there were no medical interventions used as a treatment of choice for anxiety disorders due to there being no definitive evidence of effectiveness, with some medications putting children at risk for serious side effects (CMHO, 2002). In 2002, stimulant medication was the medical treatment of choice, but caution was encouraged in medicating young children, with side-effects monitored regularly (CMHO, 2002). Today, stimulant medication is still used, but research has found that while medication is effective in reducing the behavioural symptoms of many children with ADHD, academic knowledge and social skills are not improved by medication (Teachadhd, 2008). Within the scope of childhood depression, treatment in the form of medication alone is not enough due to the strong developmental (e.g. attachment and neglect) and environment factors (CMHO,

2002). Much research appears to be needed in this field, and especially in light of a child's development and environment as suggested by CMHO (2002).

In carrying out a comprehensive general internet search as well as a university library search, the issue of the lack of retrievable research and information regarding preschool children's mental health services within Ontario was substantially lacking. This is not to say that articles do not exist, but if all one has to reply upon are facts and figures of prevalence, along with "what is not working", one has to wonder how lessons from the past can be either built upon or understood comprehensively from the ground up, if information is not accessible.

Overall, as Mental Health Canada (2004) reflects: "In the field of mental health, new studies are needed to tell us what the best treatments are for children with emotional and behavioural disturbances" (n.p.).

Part 5: Recommendations for research, practice, and policy

This section offers recommendations related to research, practice, and policy, in the area of children's mental health in the province of Ontario.

Recommendations for Research

1) Knowledge of prevalence. The Ontario Government admits that: "*research on the prevalence of mental health disorders in Canadian children and youth is limited*" (Ontario Ministry of Children and Youth Services, 2006, p.2). This has been shown to

be an issue throughout this paper, with "approximate" prevalence in mental health disorders, along with service outcomes showing low participant numbers, and no prevalence for service outcomes for the most part. The accuracy of the incidence and prevalence of children's mental health conditions is the first step in assessing burden, which, along with the projected impact, is the fundament of appointing public health policy in order to appoint services and resources (The Provincial Centre of Excellence for Child and Youth Mental Health, 2006b).

The numbers alone are not enough to establish issues within any health matter, but they appear to be a starting point, and a point at which people begin to understand the importance of an issue. Children's mental health appears to need more numbers in order to gain more awareness and funding, thus utilizing what is mandated, i.e. the BCFPI, but also implementing the PECFAS, and using other creative forms of evaluation, such as; assessment forms that programs already utilize, which are then correlated. Agencies cannot sit upon old, although possibly effective, methods if they cannot prove validity. Why should the government give the tax-payer's dollars to public sector efforts that cannot demonstrate effectiveness? However, people are not pieces of machinery that can be fixed in a certain timeframe and manner. The government also needs to be made aware of this, as does the public.

2) Service evaluation. Dr. John D. Griffin (2007), General Director of Canadian Mental Health Association from 1951 to 1971, wrote:

"Mental Health transcends medical concern with sickness and health. It relates to the whole spectrum of organized social living. It has to do not only with spotting and treating children with mental health problems in the school, but with the whole fabric of the school itself. Thus the mental health problem of the community, while having an important psychiatric aspect, will not be resolved successfully by psychiatric planning alone. It will involve careful joint study and planning with many professional disciplines, including among others, psychology, education, social work, theology and the law" (n.p.).

This, when compared to the "Children's Mental Health Services for Children Zero to Six: Review of the Literature and Practice Guide" (CMHO, 2002b), appears in line with reports of advances in biological and neuropsychological research, which show that all organisms acclimatize to their surroundings, and neither developmental potential or behaviour are genetically fixed or limited by strict critical periods. Advancement in the understanding of early child development has also shown the importance of the ecological context, beginning with the child, extending to the family, and widening to include the community (CMHO, 2002b).

However, problems arise when one is given the knowledge that Dr. Griffin wrote his words in 1964 (Griffin, 2007). Much has been stated over the years, and yet little change appears to have occurred. This is where the need for further research of service practice and treatments is needed. The world of technology appears to have moved rapidly from records, black and white televisions, and dial telephones to mini CD's, HD television,

and cellular phones since the time of Dr. Griffin's words. It is time to move children's mental health forward through research that is evidence-based. The new CMHO (2008) "*Evidenced-Based Practice Consultation Paper*" appears to be a positive step in the right direction.

Recommendations for practice

1) Community awareness. The Standing Senate Committee (Kirby and Keon, 2006) found that society's response towards mental health is lacking, with the need to enhance funding significantly, as well as integrate the mental health sector in order to create a seamless service. Thus, the service is fragmented and under funded. The Committee (Kirby and Keon, 2006) further identified the diversity amongst consumers, but the way that services are accessed by individuals is not based on needs. The relative importance that was placed upon bringing all related sectors, such as; education, youth justice, child and youth welfare, and health, into the solution (Kirby and Keon, 2006), creates the notion that the fragmentation is cross-sectional, and lacks collaboration.

The Ministry of Child and Youth Services (2007b) reiterated much of the Senate Standing Committee Report (Kirby & Keon, 2006), reporting that the child and youth mental health sector has evolved to meet local needs over time, thus service delivery can appear fragmented and inconsistent. As well, there are known gaps between what has been recognized to improve mental health, and actual service delivery practices (The Ministry of Child and Youth Services, 2007b). Accountability within the sector's infrastructure (community and government levels) is compromised by gaps which

obstruct the performance and capacity to improve (The Ministry of Child and Youth Services, 2007b).

It does appear that collaboration and integration have overcome the formidable forces of degree, although significant problems remain within the system as a whole (The Provincial Centre of Excellence for Child and Youth Mental Heath, 2007). Child and youth mental health services are delivered through regional multi-service agencies, with representatives from children's mental health, youth justice, prevention, early intervention and child welfare regularly working together to streamline the service continuum and work out budget arrangements (The Provincial Centre of Excellence for Child and Youth Mental Heath, 2007). To ensure that children have access to services across the vast region, through the Integrated Services for Northern Children (ISNC) program, the ministries of Children and Youth Services, Health and Long-Term Care, Education and Northern Development and Mines came together and created service hubs that are located in major cities across Northern Ontario (The Provincial Centre of Excellence for Child and Youth Mental Heath, 2007). One study of the program reviewed a random sample of 327 client charts, held a series of semi-structured in-person interviews with 100 clients and providers involved with the program (Minore, Boone, Arthur, & O'Sullivan, 2005). Of the intervention cases, 35.6%, and 51.2% involving mediators demonstrated the unavailability of services in client charts, along with 45.6% of client charts recording a substantial time gap in services (Minore, et al, 2005).

Community collaboration (meaning the public and private sectors and the general public) needs to occur in a sustained effort to both advocate and practice for positive mental health in children, for this population cannot do either alone. This also requires the accessibility of information both at the community and professional level.

2) Data collection. According to the Senate Standing Committee report (Kirby & Keon, 2006), the preschool years hold two challenges: the first being the identification and provision of services to children who are at risk of developing, or living with, mental illness; and the second being to effectively manage the transition into school from early childhood (0 to 5 years).

Dick, Kavanagh, Spalding, & McKeever (2005) carried out comprehensive research on Ontario's children's treatment services, and within the area of children's mental health, they found that no comprehensive administration with individual level records was compiled, along with the inability to study utilization of these services at the population level. Province-wide utilization analysis is impaired. It is not possible to study joint utilization of mental health and rehabilitation services across sectors (e.g. access and quality evaluations in treatment services would require access to mental health services data, which is not currently available, and physician service data, which is available that are linked at an individual level (Dick, et al, 2005). With these study findings of a significant awareness of catchment areas and service delivery being overlapped, duplication of services seems all too probable, along with duplication of spending of tax-payers dollars.

During District Health Council interviews, Dick, et al (2005) found three consistent problematic areas: insufficient capacity in the system for mental health services; rural access problems; and fragmentation of services, which were perceived to be related to a shortage in healthcare professionals. Of the 16 District Health Councils in Ontario, 15 identified lack of service capacity to meet the regional need for children's mental health service. Twenty-nine percent, almost one third of respondents, identified knowledge of other agencies offering the same spectrum of services along with overlapping catchment areas. Overall, system fragmentation was observed, with multiple organizational sectors, and more than one ministry involved in delivery of some services, which led researchers to illuminate the need for a blueprint for a cohesive delivery strategy for children's services.

Bickman (2004) believed that Ontario is heading in the right direction in reform by using the Brief Child and Family Phone Interview (BCFPI), as described within this paper, as well as the "*Evidence Based Practices Project*". However, not all the elements necessary for improvement are present (Bickman, 2004). Bickman (2004) felt that three approaches were necessary for the reform of clinical outcomes: system level (increased access, organizing and systemizing through cross-collaboration, and tailoring services); treatment (evidence-based practice); and professionalism (instruction, experience, and selection both of facilities and clinicians).

Barwick, Boydell, & Omrin, (2002) developed a knowledge transfer infrastructure as a means to disseminate the knowledge regarding measurement tools within children's mental health. The researchers believed that:

"The field of children's mental health needs to build a culture of research utilization. Unless leaders come to appreciate how use of the BCFPI and CAFAS (The Child and Adolescent Functional Assessment Scale) *measurement tools can improve service delivery, the measurement initiative will never be more than a bureaucratic requirement that is adhered to at it's most minimal level. And, they will never fully realize that it can be so very much more" (p.43).*

The difficulty with this is that the CAFAS should be rated on all children ages 6 years of age and upwards who receive mental health services (CAFAS in Ontario, 2002), and the BCFPI on children 3 years of age and upwards (BCFPI, 2007). Thus, all children receiving mental health services under the age of three years are being missed, and those under 6 years of age are only being measured using the BCFPI. CAFAS (2002) does publish a downward version of the mandated CAFAS called the Preschool and Early Childhood Functional Assessment Scale (PECFAS), for children ages 4 to 7 years old. However, this still compromises measurement of children's mental health services for children under 4 years of age, and the material supporting the information does not include whether the scale is mandated as is the CAFAS.

No references can be accessed for the "*Evidence Based Practices Project*" that Bickman (2004) spoke of. However, CMHO (2008) believe that they have taken a proactive role in the field of children's mental health in the implementation of evidence-based, empirically supported service delivery models. Their paper, entitled: *"Evidence-Based Practice Consultation Paper"*, intends to engage stakeholders in the process of moving forward with the ultimate goal that all services delivered by children's mental health providers become evidence-based, empirically supported, and result in clinical outcomes that are positive for participants (CMHO, 2008).

Data collection is obviously in need of reform, and especially at the preschool level, where standardized and mandated data collection is all but non-existent. Being able to retrieve data, once it is delivered, at a central point would allow for further work and research to be more easily achieved, and thus less time consuming in a world that strives for efficiency.

3) Health promotion. The Standing Senate Committee Report stresses the importance of reaching children early through the school system (Kirby and Keon, 2006). The committee felt that by promoting dialogue about both mental health and illness at an early age, a generation where stigma no longer poses a risk to the lives and well-being of those in need of support and/or treatment (Kirby and Keon, 2006). Following the Senate Standing Committee report of 2006, The Provincial Centre of Excellence for Child and Youth Mental Heath (2006) felt that children's mental health and needs should be kept at the forefront of the process, with early intervention not being

forgotten due to running the risk of perpetuating a system that aimlessly tries to catch up to the needs of children who suffer unnecessarily and who invariably grow up to access the adult system.

This speaks to the need to continue and further enhance the focus of well-being in young children, such as the Landy, Peters, Arnold, Allen, Brookes, & Jewell (1998) evaluation of an early intervention, tracking and referral system: "Staying on Track", whereby infants, preschoolers and their families (n=201 comparison group to cohort 3 in1991, n= 181, 160, 145 cohort 3 1990-92 respectively, n= 97, 85, 84 cohort 2 1990-92 respectively, and n= 218, 210, 198 cohort 1 1990-92 respectively) were followed for 3 years by public health nurses who worked to improve child development through the program. Positive effects were seen within the treatment group, as well as one third of the children being tracked being identified as requiring referral due to difficulties or risk factors (Landy, Peters, Arnold, Allen, Brookes, & Jewell, 1998).

Stevenson (2003) places the average cost to treat one child for a year at a children's mental-health centre at $2,500, compared to over $120,000 to keep a young person in custody for a year. Moreover, the cost to the federal and Ontario governments of school-drop out due to a lack of appropriate treatment of Ontario youth with mental illness is approximately $1.9 billion annually (Stevenson, 2003). The list continues, thus the importance of illness prevention and not cure, but strength-based (CMHO, 2002), turning it into health promotion is shown. The cost may be enhanced in the short-term as programs are increased in one area and then a slowly decreased in other areas that

become less utilized over time, but the long-term cost at the individual level, through to the societal level can only be positive.

Thus, further mental health promotion work, better awareness of service availability within communities, and increased tracking of individuals and outcomes to inform best practices is needed.

Recommendations for policy

1) Continued commitment. Specialized treatment services for individual children and families in a range of community and hospital settings have typically addressed children's mental health problems within Canada (Waddell, et al, 2005). Surveys from Canada, the US, and the UK have indicated that less than 25% of children with mental disorders receive specialized treatment services, although it is known that some receive school-based or primary care services for their mental health problems (Waddell, et al, 2005). In essence, treatment needs are not being met.

Conversely to Waddell, et al (2005), *"The Ontario Child Health Study"* (Ontario Ministry of Children and Youth Services, 2006) determined that only one in six children and youth with a mental illness received some form of specialty mental health service. This discrepancy, of less than 1:4 and 1:6, highlights the apparent inconsistency in data collection. Apparently: "These rates may be even lower for Aboriginal children, (and) it is clear that the need for child and youth mental health services and supports outpaces the sector's capacity to respond" (Ontario Ministry of Children and Youth Services, 2006,

p.2). However, with the words "may be", one has to wonder if there is clarity in suggesting service needs within a framework that is supposed to guide changes within children's mental health services.

The Senate Standing Committee (Kirby and Keon , 2006), submitted its report *"Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada"* on May 9, 2006. The report was an extensive culmination of consultations across the nation regarding mental health and illness in Canada, with a full chapter dedicated to children's mental health (Kirby and Keon, 2006). As a result of the report, The Mental Health Commission of Canada was created with goals of promoting the development of a national strategy, launching an anti-stigma campaign, and creating a knowledge exchange centre, along with a children and youth advisory committee being included within the initiative (The Provincial Centre of Excellence for Child and Youth Mental Heath, 2006).

With such extensive investigation, one wonders how the words "may be" were able to be published, and moreover, how $4.5 million in regional annual allocations in order to address community priorities that are based on the Ministry of Child and Youth Service's Policy Framework (Ministry of Child and Youth Services, 2007b) was able to be provided.

With respect to specific prevention and promotion outcomes within Ontario, Waddell, McEwan, Garland, Peters & Hua (2007) were unable to identify any programs at the

national or provincial/territorial level in Canada in 2003 that were specific to children's mental health. The group was also told by policymakers that little national coordinating activity had taken place within recent years with regards children's mental health. Waddell, et al (2007) go on to remark that of the 40 programs that they initially identified as having potential relevance to children's mental health, 15 provincial/territorial and 2 national early childhood development programs met criteria for relevance to children's mental health. This was explained to the researchers, by policy-makers, as primarily due to the early childhood development emphasis on child-health, which stemmed from the federal government transferring $2.2 billion to territories and provinces, over five years in an effort to improve early childhood development programs (Waddell, et al, 2007).

Ontario held the only program; "*Better Beginnings, Better Futures*" that explicitly included mental health within its major goals, demonstrated positive mental health outcomes in children, and included many features seen in effective prevention programs (Waddell, et al, 2007).

The government has obviously begun to show it's commitment in recent years. The challenge now is the on-going commitment that is required by the government in order to sustain effective practices, but also review other practice methods that have been shown to be ineffective or inadequate. This is both cost effective for the tax-payer, but also for programs that are effective and yet struggling due to limited funds that have been allocated elsewhere.

Final Thoughts

The WHO (2005) suggests that the only way to reduce the burden of illness associated with mental illness, in a sustainable manner, is through prevention. As Waddell, et al (2007) describe, the impact upon health, happiness, and productivity is both immense and long-term in relation to mental illness, and necessitates a boarder public health approach. Both risk and protective factors, and the interaction of these factors from which mental disorders develop (i.e. causal processes) needs to be further investigated in order to suggest effective prevention approaches (Waddell, et al, 2005). This recommendation can only be reiterated by this writer as an important, and yet easily lost suggestion in light of the density of interventions and treatments within children's mental health.

Overall, there are a variety of interventions, from a variety of community and national stakeholders, which have been described within this paper for the 0-6 year-old population. From promotion, prevention, and treatment perspectives, observing the social context in which the child lives, from both strength-based and evidenced-based approaches has been shown to be the way to understand and support them effectively (Griffin, 2007, CMHO, 2002b). It now appears that this same understanding has been placed in motion with regards "mental health" and the implementation of "Ontario's Policy Framework for Child and Youth Mental Health" (The Ministry of Child and Youth Services, 2007b).

The goals of the Policy Framework (The Ministry of Child and Youth Services, 2007b) cannot be faulted, except for the inevitable complex and long-term task to fulfill them.

However, with such vigorous investigations to achieve such a framework that includes "possible" statistics, along with goals that may be interpreted as the children's mental health sector framing itself within a weakness-based model, one has to wonder about the "shared responsibility" that is envisioned within the framework aims (The Ministry of Child and Youth Services, 2007b). The tax-paying public must make itself as responsible for the implementation of the framework as much as the top levels of government, for only then can it be truly stated that it is a "shared responsibility".

And finally, further measurement of service usage by the 0 to 6 year old population is needed. This will support and cement a firm foundation, showing the importance and commitment of children's mental health services in the infant, toddler and preschool years.

The wheel seems to have been reinvented many times over within the scope of children's mental health services, and now seems to have been set in motion with the framework policy (The Ministry of Child and Youth Services, 2007b). What all stakeholders need to assert themselves to is the generation of speed, whether not enough, or too much, for each child is relying on these stakeholders to apply the accelerator or the brakes and help them.

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