

# BEYOND BUILDING BLOCKS: INVESTING IN THE LIFELONG MENTAL HEALTH OF ONTARIO'S THREE- TO SIX-YEAR-OLDS

Policy paper developed by the Ontario Centre  
of Excellence for Child and Youth Mental Health

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## Policy paper writing team

This paper was collaboratively developed by representatives from:

<b>The Ontario Centre of Excellence for Child and Youth Mental Health</b>	The Ontario Centre of Excellence for Child and Youth Mental Health drives high-quality child and youth mental health service delivery by mobilizing knowledge and setting the bar for excellence and collaborating with others to pursue continuous quality improvement. We promote evidence-informed service planning and delivery and support practical research to close knowledge gaps when they get in the way of effective and accessible services.
<b>Infant Mental Health Promotion</b>	Infant Mental Health Promotion is a national organization guided by professionals from agencies serving infants, young children and their families, who aim to improve outcomes across the lifespan through translating and promoting the science of early mental health into practice with families during pregnancy, infancy and early childhood.
<b>School Mental Health Ontario</b>	School Mental Health Ontario (SMH Ontario; formerly SMH ASSIST) is a provincial implementation support team, working alongside the Ministry of Education, to help Ontario’s 72 district school boards in their efforts to enhance student mental health and well-being. SMH Ontario is supported through Ontario’s investments in creating a comprehensive mental health and addictions system for the province and provides leadership, implementation coaching, resources, and a provincial learning network related to effective practices in school mental health. In addition to assisting with the selection and uptake of evidence-based, implementation-sensitive mental health promotion and prevention programming, SMH Ontario provides support with educator capacity-building, organizational conditions, student leadership and differentiation for specific populations (including early years mental health).



## Advisory committee

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# Executive summary

There is general agreement between researchers, experts and direct service providers that promoting mental health across the lifespan and acting early to prevent mental illness leads to a stronger society and economy (Conference Board of Canada, 2017; Heckman, 2011; Reynolds, Temple, White, Ou, & Robertson, 2011). As well, it has been shown that the inability to regulate emotions — which is part of healthy social-emotional development in early years — can be a predictor of poor educational attainment, reduced financial stability and compromised health in adulthood (Moffitt et al., 2011).

In this policy paper, we focus on the mental health and social-emotional development of children between three and six years old. With the introduction of structured early learning or care and kindergarten, many children expand their relational networks, experiences and environments. While most meet their social-emotional development milestones as expected, those who are challenged to do so do not always receive the type of support needed, when they need it. Recognizing the signs of delayed development in young children can be difficult for families and care providers, and without a sense of potential responses, these issues can remain unresolved and become more complex over time. Furthermore, recent Ontario data suggests that in recent years there has been an increase in children who experience social-emotional vulnerability upon entry into kindergarten (Early Development Instrument, 2016a). Since early life experiences influence later outcomes, we need to collectively work to ensure that all Ontario children have access to safe and supportive relationships, environments and experiences to optimize lifelong health and good outcomes for society.

To better understand the issue, we undertook targeted consultations with a wide range of key stakeholders (research representatives from several provincial ministries, parents/caregivers, professionals from education and early learning and care settings, and service providers from health and allied health settings). We also reviewed current evidence on this topic and scanned possible programs that can support healthy social-emotional development in three- to six-year-olds. We then used this information to develop eight specific policy recommendations to guide a cross-sectoral, collective response to meet the social-emotional needs of three- to six-year-olds. Once the policy paper and recommendations were drafted, we consulted with our advisory committee, diverse stakeholders and

community tables to refine further. In advancing these recommendations, it is essential that we understand and account for the diversity of Ontario's communities and ensure that our responses are contextually, culturally and linguistically appropriate. With this integrated approach, together we can promote lifelong mental health from very early on in the lives of Ontarians.

## **RECOMMENDATION 1: CREATE A COMMON POLICY AND PRACTICE FRAMEWORK FOR THE PROVINCE TO ALIGN EFFORTS AROUND INFANT AND EARLY MENTAL HEALTH.**

We need a common vision across ministries and different levels of government related to education, health, development and community and social services, since funding allocations are critical in shaping decisions about service delivery and ensuring resources for coordination. Participation from adult sectors (such as mental health and addictions, settlement services, etc.) is also needed to support parents/caregivers both individually and as part of the family ecosystem to facilitate effective, lifelong health and well-being. A whole government approach (which includes a focus on an Indigenous worldview) is essential for ensuring a common policy and practice framework that supports funding decisions and resources to be distributed in ways that are 1) aligned with the needs of young children and their families; and 2) represent the cultural and linguistic diversity of the province.

## **RECOMMENDATION 2: ENSURE THE AVAILABILITY OF HIGH-QUALITY PRESERVICE TRAINING AND ONGOING LEARNING AND TRAINING ON SUPPORTING SOCIAL-EMOTIONAL DEVELOPMENT IN THREE- TO SIX-YEAR-OLDS FOR EARLY LEARNING AND CARE PRACTITIONERS, TEACHERS, PRIMARY CARE, PUBLIC HEALTH NURSES, ETC. TRAINING CONTENT SHARED SHOULD BE BASED ON THE LATEST EVIDENCE ON SOCIAL-EMOTIONAL DEVELOPMENT AND MENTAL HEALTH IN THE EARLY YEARS, WITH A FOCUS ON RELATIONSHIP-BASED PRACTICE.**

While this paper is a starting point, there is currently no consistent and comprehensive understanding of early mental health and key social-emotional development milestones across the various disciplines that regularly

engage with or support young children and their parents/ caregivers. Without a shared understanding of the developmental continuum, providers struggle to know when to be concerned about a behaviour and how best to respond in culturally and linguistically appropriate ways. A common body of knowledge, therefore, needs to be developed by leaders with expertise in the area, to guide the supports we provide to our youngest Ontarians. This body of knowledge should be based on the latest evidence on social-emotional development and mental health in the early years and be promoted (at no cost) to service providers across all relevant sectors (including but not limited to early learning and care practitioners, teachers, public health nurses, mental health service providers and allied health professionals). This knowledge should be culturally and linguistically appropriate, should inform both preservice training and ongoing professional development opportunities, and should be tailored to the knowledge needs of those in particular professional roles, both in terms of content and depth.

**RECOMMENDATION 3: DEVELOP AND PROMOTE RESOURCES AND TRAINING MATERIALS TO SUPPORT PARENTS TO UNDERSTAND AND OPTIMIZE THE SOCIAL-EMOTIONAL DEVELOPMENT OF THREE- TO SIX- YEAR-OLDS.**

Parents and caregivers also need access to knowledge about social-emotional development and mental health in the early years. Customized resources (developed with parents' and caregivers' knowledge needs in mind and delivered according to their learning preferences) should be available to support them in identifying challenges and ensuring their child receives the right supports at the right time. These materials should be co-developed with family members, experts and support providers to ensure an evidence-informed learning product that integrates insights from each group. As well, these resources and training materials should integrate language and cultural identity considerations. Such resources should help parents to support children in acquiring core competencies in social-emotional development such as empathy, resilience, self-esteem and confidence, emotional regulation, emotional literacy, conflict resolution, problem-solving, stress management and social awareness within early learning and school settings, as they are essential for children to thrive and avoid future behavioural and emotional challenges (Evidence Exchange Network for Mental Health and Addictions, 2016). Across the literature, there is general agreement regarding the most effective components of social-emotional learning (SEL) programming, which includes: 1) embedding SEL programs into the whole school environment and the general classroom curriculum; 2) programs that incorporate sequenced, active and interactive, focused and explicit

learning; 3) a focus on skill building; 4) involvement of parents and caregivers; and 5) programs that are targeted for all ages and all education levels (Evidence Exchange Network for Mental Health Addictions, 2016).

**RECOMMENDATION 4: STRENGTHEN AND ENHANCE PARTNERSHIPS ACROSS SECTORS TO ENSURE EFFECTIVE COMMUNICATION, CLEAR AND EFFICIENT SERVICE PATHWAYS AND ACCOUNTABILITY FOR THE PROVISION OF EARLY MENTAL HEALTH SERVICES.**

A consistent theme that surfaced during our data collection was the need to better connect parts of the system of care to ensure consistency in the way that mental health services for young children are structured and delivered. For optimal care, strong communication between providers across education, early learning and care, primary care and community-based child and youth mental health services is essential. Coordination and collaboration across services, and an infrastructure to support this knowledge sharing to implement a comprehensive plan of care, is critical (e.g. creating an electronic file that allows practitioners to share the child's information, treatment plan, etc. or hosting case conferences and wraparound meetings where all providers and the family come together regularly to identify treatment goals, monitor progress, etc.). Pathways between health, education and community mental health need to be strengthened to ensure more consistent support for children and families. Considerations need to be made with respect to language needs and cultural identity.

**RECOMMENDATION 5: IDENTIFY AND IMPLEMENT STANDARDIZED TOOLS TO COLLECT DATA ON CHILDREN THREE- TO SIX-YEARS-OLD ACROSS SECTORS TO INFORM TREATMENT PLANNING, SHAPE SUPPORTS AND PROVIDE A PROVINCIAL SNAPSHOT OF HOW OUR YOUNGEST ONTARIANS ARE DOING.**

We currently lack an accurate and comprehensive understanding of the social-emotional status of our youngest children. To ensure that services and supports for Ontario's three- to six-year-olds are evidence-informed, we need accurate and timely data on the needs and strengths of this population (i.e. developmental outcomes, existing family and social support, social determinants of health and other known risk factors). To facilitate this, standardized tools and related guidelines should be developed and used both to inform early intervention and treatment at the family level, and to provide a broad picture of how children are doing at the provincial level.

Data collection across school boards is also essential. As mental health promotion and social-emotional learning programs are introduced and new early years mental health resources developed, it will be important to monitor uptake, use, fidelity and effectiveness. Educator, principal and parent/family voices can also be very instructive in ongoing quality improvement efforts. In addition, tracking of individual student interventions (which could be collected anonymously but which should include culture, race and language information) should incorporate numbers related to referrals to the school teams, board school mental health professionals or community mental health agencies; positive behaviour management data; progress monitoring with strategy implementation; suspensions and expulsions; as well as statistics on any modifications or accommodations to a child's school day or participation. Good platforms and tools currently exist and can be adapted or enhanced to include these elements to better understand the province's mental health needs, challenges, available resources and current practices. This knowledge can be used to guide our collective response and support for children and families in a way that is culturally and linguistically responsive.

**RECOMMENDATION 6: PROVIDE ADEQUATE FUNDING FOR RESEARCH, IMPLEMENTATION AND ONGOING EVALUATION OF EVIDENCE-INFORMED PROMOTION, PREVENTION AND INTERVENTION PROGRAMS FOR EARLY MENTAL HEALTH.**

Ensuring positive social-emotional development and early mental health for Ontario's three- to six-year-olds requires targeted investments to support the implementation and ongoing evaluation of evidence-informed promotion, prevention and intervention efforts. While many programs currently support mental health in the early years, few have been rigorously evaluated. Common approaches and components to these programs have been identified, such as increasing knowledge and skills and promoting quality relationships, but we need more information on what works, for whom and in what settings.

**RECOMMENDATION 7: ENSURE THAT CHILDREN EXPERIENCING POOR SOCIAL-EMOTIONAL DEVELOPMENT ARE IDENTIFIED EARLY AND RECEIVE REGULAR SCREENING AND TARGETED SUPPORT.**

Children exhibiting signs of mental health vulnerabilities should be identified early and once identified, have access to regular support or intervention. Collaborative efforts between primary care, community-based providers and those working in early learning and care settings are essential. Parents and caregivers should be provided

with some immediate support while waiting for further assessment and intervention.

For example, here in Ontario, Bruce County Children's Services partnered with local school boards beginning in 2000 to administer the Ages and Stages Questionnaire (ASQ) to families at each of the schools' kindergarten registration sessions (Let's Learn Grey Bruce). Parents were asked to bring their child's completed ASQ to the registration, which was then scored by a staff person from Children's Services. In cases where a child's score indicated a risk for developmental delay, the screener (with consent from the parent/caregiver), would make direct referrals for follow-up supports.

In 2018, the Let's Learn program was reviewed internally by Bruce County and there was a consensus that although the completion of the ASQ at kindergarten registration had value, there was not enough time to provide appropriate supports to children with needs prior to entering school. As a result, Bruce County Children's Services is launching Bruce County's Journey Through the Ages and Stages this year (2019). In its first phase, Bruce County will work in partnership with child care agencies to administer the questionnaire to all families in the child care system so that issues can be flagged and intervention can be swift. Moving forward, Bruce County's hope is that the completion of regular screenings, including the ASQ-SE:2, will be a service agreement requirement of all child care centres as part of their onboarding process with new families.

In the next phase, Bruce County will be reaching out to other child care and early years service providers (e.g. medical, child and family services, etc.) to coordinate efforts with partners that are screening and identifying at-risk children that are not involved in the licensed child care system. This proactive approach will allow for the community to be more responsive to children's learning, development and well-being.

**RECOMMENDATION 8: ENSURE THAT ALL CHILDREN AND FAMILIES HAVE ACCESS TO HIGH-QUALITY MENTAL HEALTH SERVICES THAT ARE TAILORED TO CHILDREN FROM THREE TO SIX YEARS OF AGE AND ROOTED IN STRONG FAMILY ENGAGEMENT. NEED FOR MORE RESEARCH AND ONGOING EVALUATION.**

There is no single approach that will meet the needs of every young child who may be vulnerable to poor social-emotional outcomes. With appropriate training and professional development, practitioners across sectors who work with children and their families will have a strong foundation in

early mental health and will be able to work with families to identify appropriate solutions for their child, particularly those between the ages of three and six. To do so effectively, practitioners must be able to understand a family's context and assess their strengths and needs.

Family engagement practices are consistent with a family-centred philosophy of care that recognizes families as the experts when it comes to supporting their children; promotes an equal partnership between families and care

providers; and values the role of the family in decision-making and implementing the plan of care for their child (Lieberman & Van Horn, 2005). Collaboration between parents/caregivers from across cultural and linguistic groups and service providers across sectors is critical for ensuring strong social-emotional development in our youngest children and sustained positive outcomes that will contribute to their success over time.

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## Why does infant and early mental health matter?

There is general agreement between researchers, experts and direct service providers that promoting mental health across the lifespan, and that acting early to prevent mental illness leads to a stronger society and economy (Conference Board of Canada, 2017; Heckman, 2011; Reynolds, Temple, White, Ou, & Robertson, 2011). Scientific advances in behavioural and social sciences, epigenetics and neuroscience have established clear links between early mental health and later developmental outcomes (Shonkoff et al., 2012). For example, empirical studies show that a child's first relationships, and the quality of their interactions with parents/caregivers, significantly contribute to their development and well-being (Crockerberg & Leerkes, 2000; Gilkerson et al., 2018; National Research Council and Institute of Medicine, 2000; Zeanah & Zeanah, 2009). We also know that exposure to early adversity, the presence or absence of risk and protective factors and the social determinants of health influence a child's trajectory (Zeanah & Zeanah, 2009). This is particularly true during the first six years of life, a critical period of physical and emotional development (Dube et al., 2001; Metzler, Merrick, Klevens, Ports, & Ford, 2017; Shonkoff et al., 2012).

Optimal mental health is a positive state of well-being through which individuals experience a sense of purpose, hope, belonging and meaning (First Nations Mental Wellness Continuum Framework, 2015). Early childhood mental health (also called healthy social-emotional development or infant mental health) refers to "the [young] child's developing capacity to: experience, manage and express the full range

of positive and negative emotions; develop close, satisfying relationships with other children and adults; and actively explore their environment and learn, all in the context of family, community and culture" (Cohen, Oser & Quigley, 2012, p. 1). The building blocks for good mental health across the lifespan are established early.

Unfortunately, some children experience challenges early in life and show signs of vulnerability through their emotions and behaviours. Up to 70 percent of young adults who live with a mental health problem state that their symptoms started in childhood (Government of Canada, 2006) and sadly, many children who experience mental health challenges do not outgrow these difficulties on their own (Breslau et al., 2014). When we fail to address early signs of challenges in a timely or appropriate way, children are at risk for developing mental health problems (Shonkoff et al., 2012). For example, early difficulties in managing aggression and following rules have been associated with later substance use, poor peer relations, antisocial behaviour, delinquency and violence in the later years (Havighurst et al., 2013; Ocasio et al., 2015). Social-emotional vulnerability is also connected to poor school readiness, which can have a significant negative impact on a child's performance and success in educational settings over time (Raver, 2005; Rimm-Kaufman, Curby, Grumm, Nathanson, & Brock, 2009). In fact, it has been shown that the inability to regulate emotions (as part of healthy social-emotional development) can be a predictor of poor education attainment, reduced financial stability and compromised health in adulthood

(Moffitt et al., 2011). Clearly, the impact of early experiences on later outcomes reinforces the need to ensure that all children have access to safe and supportive relationships, environments and experiences that optimize their social-emotional development.

Meeting this aspirational goal, however, can be a challenge. In keeping with prevalence rates for older children and youth, parent/caregiver-reported data from Canada's National Longitudinal Survey of Children and Youth has shown that 18 to 21 percent of our country's toddlers, preschoolers and elementary/intermediate school-aged children present with some type of social-emotional vulnerability (e.g. anxiety, aggressive behaviour, over-activity; Willms, 2002). Results

from the Early Development Instrument (EDI)\* have shown a 1.4 to 3.2 percent increase from 2004 to 2015 in levels of vulnerability regarding physical health and well-being, social competence and emotional maturity among Ontario's kindergarten students (Early Development Instrument, 2016a).

Understanding the scope of these issues as they emerge in Ontario schools and communities is an essential first step toward generating new ways for parents/caregivers, community and health service providers, and educators in learning settings to collaboratively support the mental health and well-being of Ontario's three- to six-year-old children.

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## Our purpose and scope

The current policy paper focuses on a special aspect of the "early years": the mental health and social-emotional development of children between three and six years old. With the introduction of structured early learning or care and kindergarten, many children expand their relational networks, experiences and environments. This is an optimal time to promote positive early social-emotional development and to identify and address social-emotional concerns when they do arise. To support social-emotional development fully, however, we need to start even earlier (between birth and three years of age), since the preceding years form the foundation of positive development later.

In this paper, we draw on empirical research, insights from parents and families and the views of practitioners from education, early learning and care, and health and allied health settings to provide concrete recommendations to guide collective action for supporting the early mental health of Ontario's three- to six-year-olds. Given the influence of experiences that take place from the time around birth to age three, we also consider the contribution of a child's earliest experiences to their social-emotional development between ages three and six.

### Audience

This paper and its recommendations are primarily aimed at policy advisors and decision-makers from various government ministries and local decision-making bodies. We also hope

a wide range of professionals and organizational leaders working within education, early learning, primary care, allied health, child welfare and other sectors find the information valuable to their work and respective roles.

### Guiding questions

The specific questions guiding this work are:

- Why is mental health in the early years so important?
- What does optimal mental health and development look like in the early years?
- What are the key factors that influence early mental health?
- What are the current concerns and opportunities regarding social-emotional development for three- to six-year-old children within early care and formal education settings?
- What are the current best practices in mental health promotion and early identification of social-emotional vulnerability?
- What are the current best practices for responding to social-emotional challenges exhibited by young children between ages three and six?

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\* The EDI is a 103-item questionnaire completed by kindergarten teachers during the second half of the school year which measures a child's ability to meet age-appropriate developmental expectations in five domains : physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge (Offord Centre for Child Studies, 2018).

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# Our approach and methods

## Team approach

This paper was collaboratively developed by the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre), Infant Mental Health Promotion (IMHP) and School Mental Health Ontario (SMH Ontario). Our three organizations represent the mental health, child development and education sectors and formed the core team that managed the project and led the research, data collection, analysis and writing. We recognize that the relationship between early development and mental health is complex. Together our organizations represent the perspective of each of our fields and have worked to identify ways we can collaborate across our stakeholder groups to support the mental health of our youngest Ontarians.

To guide this work, we convened an advisory committee of policy advisors and experts from child care, early learning, junior/senior kindergarten, recreation, public health, occupational therapy and children's mental health (please see page 2 for the full list of advisors). This group met at various points over the course of this project to provide guidance feedback and to contribute to generating concrete recommendations for action.

## Methods

### LITERATURE REVIEW

We conducted a comprehensive literature review to address the guiding questions listed above and accessed the following databases during our search: Education Resources Information Center (ERIC), Psych-Med, Medline, PubMed, Cochrane Library and ProQuest. Key words and search terms included: social-emotional development, mental health, parent/caregiver-child relationships, resilience, teacher training, attachment, interventions, treatment, regulation, delayed school start, suspension, expulsion, challenging/difficult/aggressive/non-compliant behaviour, anxiety/depression/withdrawal, children, preschool, kindergarten, childcare, early years, and early childhood. Most of the research found was from the United States. Studies with weak methods or design were excluded (for a full list of inclusion and exclusion criteria, see Appendix A).

### ONLINE SURVEY

To better understand the social-emotional development and mental health of young children in Ontario from the perspective of those who live, or work closely with, three- to six-year-olds, we gathered insights from professionals from early learning and care settings, health and allied health settings, parents/caregivers and policy advisors/ministry staff (to view survey tools, see Appendix B). Together, we heard from:

- 209 parents/caregivers of three- to six-year-old children
- 553 early learning and care practitioners, educators and support staff (e.g. principals, registered early childhood educators, resource consultants, junior/senior kindergarten teachers, education assistants, etc.)
- 422 health and allied health professionals (e.g. social workers, psychologists, public health nurses, mental health counselors, home visitors, occupational therapists, physiotherapists)
- seven policy advisors from provincial ministries (e.g. the Ministry of Education and the Ministry of Children, Community and Social Services) and federal agencies (e.g. Public Health Agency of Canada)

Surveys were distributed in both English and French through the professional networks of the advisory committee members, child and youth mental health agencies, school boards and other organizations who shared survey links with their staff and parents/caregivers. Recipients were encouraged to forward the surveys to relevant others. When necessary, agencies assisted parents/caregivers to complete surveys. No personal or identifying information was sought.

### KEY INFORMANT INTERVIEWS

Leaders from early learning and care, education and health and allied health sectors, along with parents/caregivers who had a unique perspective on this topic, were identified by the core team and advisory committee members to take part in semi-structured, key informant interviews with the project lead (for interview guides, see Appendix C). A total of 24 interviews were completed either by telephone or in person (in English only). Interviews were recorded and related notes were shared with each participant after the interview to ensure accuracy of the information collected.

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# Early mental health and optimal development

While this paper focuses on the mental health of children between three and six years of age, it is important to understand how the preceding years establish the foundation for a child's optimal development during this time (Zeanah & Zeanah, 2009). As such, we briefly discuss the impact of the preconception and prenatal environment on infant and early mental health and describe key social-emotional developmental milestones from birth to age six.

## Preconception

Even before pregnancy, life events and environmental, social, psychological and genetic factors in a mother's life can influence a baby's development (Centre for Disease Control and Prevention, 2018; Witt, Wisk, Cheng, Hampton, & Hagen, 2012). For example, preconception stressful life events (e.g. the death of a loved one, divorce, infertility problems, etc.) have been shown to increase the risk for very low birth weight and poor health at nine and 24 months of age (Cheng et al., 2016). Given the association between preconception health and later outcomes, a family's preconception history should be considered when working to understand and respond to a child who struggles with their emotions or behaviours.

## Prenatal development

A child's experiences in utero can have a profound impact on their neurobiology and physiology, which in turn can affect their social-emotional development (Sheridan & Nelson, 2009). For example, prenatal exposure to maternal stress and anxiety (Van den Bergh, Mulder, Mennes, & Glover, 2005), alcohol (Niccols, 2007), and drugs (Behnke, Smith, Committee on Substance Abuse, & Committee on Fetus and Newborn, 2013) are known to negatively influence the developing brain and have an enduring impact on a child. Studies from the growing field of epigenetics have also shown how the prenatal environment can influence how genes are expressed; which in turn can impact biological and physiological processes and social-emotional functioning (i.e. epigenetics; McCain, Mustard, & Shanker, 2007).

## Birth to one year: Attachment

Forming a secure attachment with a primary caregiver is the key social-emotional milestone during the first year of life. From the very beginning, a child will communicate their needs and feelings and will selectively seek support, nurturance and protection from a specific caregiver. The caregiver's consistent sensitivity and responsiveness to the child's distress cues will in turn help the child to feel secure and safe enough to confidently explore their immediate surroundings.

## One to three years: Autonomy and self-awareness

This developmental stage is marked by exploration, curiosity and goal-directed behaviours, which together support a child's autonomy and the evolution of their sense of self. A child's quest for autonomy is coupled with a continued need for security from the caregiver, and this tension can lead to frequent temper tantrums and non-compliant behaviours. While these "new" behaviours may be challenging to manage for caregivers, parents and those working with children, they are considered developmentally appropriate for this age range. However, there may be cases where the frequency, intensity and duration of the behaviours may not be within the "normal" range and may require a targeted response.

## Three to four years: Emotional competence

As a child's social network expands, there are increased opportunities for cooperative and joint play with peers. During this stage, we also see gains in a child's self-esteem, the development of their sense of identity and their understanding and expression of language and emotions. Together, these social opportunities allow a child to develop empathy and an understanding for others' feelings and points of view. This in turn leads to increased compliance and appreciation for discipline and rules. This stage is also

marked by a sharp increase in vocabulary, which better equips a child to express their needs, wants and worries through language instead of behaviour.

## Four to six years: Self-control and the emergence of a conscience

Older preschoolers have a developing imagination and experiment within the different events that take place around them. By age five, the child embraces life and learns to cope with frustration. With the emergence of a

conscience, children in this age range tend to adopt rules and accept them as their own. They make improvements in turn-taking, cooperative play and other prosocial behaviours and show enhanced motor control, refined language and advancing cognitive abilities. By age six, a child has a more sophisticated range of emotions that allows them to better control their anger and aggression, and they have the coping skills needed to manage complex emotions such as guilt, shame, worry and jealousy. During this stage, their increasing capacity for warmth and reciprocity also enables them to navigate relationships with more skill and ease.

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# Key influences on social-emotional development and early mental health

Social-emotional development is influenced by the complex interactions between risk and protective factors at the level of the child, parents/caregivers, their relationships and community (i.e. the social determinants of health).

## Risk and protective factors

For young children, risk and protective factors “increase or decrease the risks of developmental disruptions and psychopathology” (Zeanah & Zeanah, 2009, p. 10). When considering the impact of risk factors on development, it is important to note that “risk” refers to probability, not certainty, and that single factors typically do not lead to poor outcomes on their own. Instead, it is the accumulation of several risk factors, in the absence of protective factors, that can negatively influence a child’s developmental course. In fact, a landmark longitudinal investigation on the impact of adverse childhood experiences (ACEs<sup>†</sup>) on later development showed that as the number of ACEs increased, the risk for developing several chronic physical and mental illnesses also grew (Felitti et al., 1998). Another study examining the relationship between ACEs and academic risk among a sample of elementary school children found that the greater the number of adverse childhood events experienced by a child, the greater the risk of poor attendance, difficulties managing behaviour and failure to meet grade-level

standards in mathematics, reading or writing (Blodgett & Lanigan, 2018). With individual risk factors such as preterm birth (Nix & Ansermet, 2009) or having a teenage mother (Hans & Thullen, 2009), the same holds true: single factors are associated with only a small increased risk for later difficulties, but the risk grows with the number of factors present.

Fortunately, protective factors within a child’s life can mediate “the effects of risk, may enhance competence, or may protect the individual against adversity” (Zeanah & Zeanah, 2009, p. 10). Protective factors — particularly positive relationships — (Zeanah, Boris, & Larrieu, 1997), can have a profound buffering impact on adverse experiences in childhood (Ludy-Dobson & Perry, 2010; Sege et al., 2017). For example, having a supportive relationship with at least one trusting person (mentor, sibling, etc.) has been shown to buffer the negative impacts of a child’s witnessing high marital conflict between their parents/caregivers (Kelly, 2012). High levels of awareness and engagement on the part of educators and parents/caregivers can also help mediate the academic, social and self-regulatory challenges that can surface as a result of early adversity (Pears & Peterson, 2018). It is therefore important to assess both risk and protective factors in shaping a helping response when a child is struggling to manage their emotions or behaviour.

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<sup>†</sup> Adverse childhood experiences include the following: physical, sexual and emotional abuse, physical and emotional neglect, domestic violence, substance misuse within household, mental illness, parental separation or divorce and incarcerated household member.

## Child factors

Some children may be at greater risk than their peers for developing social, emotional and developmental difficulties because of individual biological influences (Walker et al., 2011) such as low birth weight and prematurity (Nix & Ansermet, 2009) or personality characteristics such as temperament (Lengua & Wachs, 2012). Again, the presence of these risk factors does not mean that later difficulties are inevitable; no two children will have the same response to the same experience (Cicchetti & Rogosch, 1996). Every child has different strengths that can help to protect them against the impact of risk on development (McDonald, Kehler, Bayrampour, Fraser-Lee, & Tough, 2016). For example, positive self-esteem and strong problem-solving and communication skills can foster resilience, which can buffer children from the effects of negative experiences (Rutter, 1987).

## Parent/caregiver factors

Risk and protective factors also exist at the parent/caregiver level and are important to consider when understanding a child's developmental trajectory (McDonald et al., 2016). A parent/caregiver's circumstances can significantly impact their ability to respond to a child, ultimately affecting the quality of the parent/caregiver-child relationship. For example, when parents and families are well-supported, live in positive and stable conditions and have access to information and resources, they can be a protective force that contributes to resilience in their children in the face of adversity. In contrast, a child's developmental outcomes may be compromised if their parent/caregiver has themselves experienced childhood trauma (Lieberman, Padron, Van Horn, & Harris, 2005), substance use (Boris, 2009), teenage pregnancy (Hans & Thullen, 2009) or poor mental health (Goodman & Brand, 2009). Yet even in these difficult circumstances, adaptive coping strategies, the ability to maintain a social support system and high self-efficacy have been shown to protect both parents/caregivers and their children against adverse experiences (McDonald et al., 2016).

## Relational factors

A child's ability to achieve key social-emotional milestones is influenced by the interaction of many factors, particularly the nature and quality of their primary relationships (Zeanah, Boris, & Larrieu, 1997). In the earliest years, the quality of the child's primary relationships are critical and a secure attachment is formed by engaging with and responding

to the child's cues (Leerkes, Blankson, & O'Brien, 2009). While the child's relationships begin at home and set the stage for future development, it is not surprising that as the child grows, interactions with other adults in their network (e.g. extended family, neighbours, primary care physicians, educators, etc.) play an increasingly important role in supporting them to achieve social-emotional milestones (Howes, Galinsky, & Kontos, 1998; Lisonbee, Mize, Payne, & Granger, 2008).

## Social determinants of health

Social determinants of health are social and economic factors that can profoundly influence individual health and mental health outcomes (Canadian Mental Health Association, 2018). These determinants include race, gender, disability, Indigenous status (i.e. the impact of colonization on families and caregiving practices, and the resulting intergenerational trauma), income and income distribution, education, employment and job security, housing, food security, social exclusion, health services, social safety net and early childhood development (Mikkonen & Raphael, 2010). Low socioeconomic status, for example, can create barriers to accessing safe affordable housing, health and social services, and quality child care — all of which can influence a child's early social-emotional development and mental health (Meins, Centifanti, Fernyhough, & Fishburn, 2013).



**Table 1: Comprehensive (but not exhaustive) list of possible risk and protective factors influencing the health and mental health of three- to six-year olds<sup>‡</sup>**

<b>LEVEL</b>	<b>RISK FACTORS</b>	<b>PROTECTIVE FACTORS</b>
<b>Child</b>	<ul style="list-style-type: none"> <li>• exposure to toxins in utero</li> <li>• preterm birth</li> <li>• low birth weight</li> <li>• physical challenges/congenital abnormalities</li> <li>• difficult, slow to warm up temperament</li> <li>• dysregulated feeding routines</li> <li>• dysregulated sleeping routines</li> <li>• disruptive or inhibited behaviour</li> <li>• low self-esteem</li> <li>• poor coping skills</li> <li>• disengagement with peers, school, athletics, religion, culture</li> </ul>	<ul style="list-style-type: none"> <li>• healthy in-utero environment</li> <li>• full-term birth</li> <li>• positive physical development</li> <li>• easy temperament</li> <li>• regulated feeding routines</li> <li>• regulated sleeping routines</li> <li>• positive behavioural and social-emotional development</li> <li>• high self-esteem</li> <li>• good coping skills</li> <li>• engagement with peers, school, athletics, religion, culture</li> </ul>
<b>Parent/caregiver</b>	<ul style="list-style-type: none"> <li>• experience of abuse, trauma or loss from childhood</li> <li>• low self-esteem</li> <li>• lack of feelings of competence</li> <li>• poor problem-solving, social and interpersonal skills</li> <li>• poor physical health</li> <li>• poor mental health</li> <li>• problematic substance use</li> <li>• maladaptive coping strategies</li> <li>• lack of access to a support network</li> <li>• poor supervision</li> <li>• marital conflict</li> <li>• criminality</li> <li>• young age, low education, single parent status, low income</li> <li>• unplanned pregnancy</li> <li>• lack of sound knowledge about child development</li> <li>• hostile attitudes about parenting/caregiving</li> </ul>	<ul style="list-style-type: none"> <li>• high self-esteem</li> <li>• feelings of competence</li> <li>• good problem-solving, social and interpersonal skills</li> <li>• good physical health</li> <li>• good mental health</li> <li>• adaptive coping strategies</li> <li>• resilience</li> <li>• access to support network</li> <li>• good supervision</li> <li>• marital cohesion</li> <li>• planned pregnancy</li> <li>• sound knowledge about child development</li> <li>• joyful attitudes about parenting/caregiving</li> </ul>
<b>Relationships</b>	<ul style="list-style-type: none"> <li>• attachment trauma</li> <li>• insensitive, unresponsive, misattuned to child's distress</li> <li>• family conflict</li> <li>• inconsistency/unpredictability with child</li> <li>• negative, hostile affect toward child</li> <li>• parent/caregiver-child conflict</li> </ul>	<ul style="list-style-type: none"> <li>• secure attachment</li> <li>• sensitive, responsive, attuned to child's distress</li> <li>• family cohesion</li> <li>• consistency, predictability with child</li> <li>• positive, loving affect toward child</li> <li>• parent/caregiver-child cohesion</li> </ul>

<sup>‡</sup> Content from this table has been drawn from: Belsky & Fearon (2002); Bhutta, Cleves, Casey, Cradock & Anand (2002); Felitti et al. (1998); Harland et al. (2002); Keenan (2000); Kohn, Lengua & McMahon (2000); Muris & Ollendick (2005); Rosenblum et al. (2004); and Werner (2000).

Table 1 (continued)

LEVEL	RISK FACTORS	PROTECTIVE FACTORS
Society	<ul style="list-style-type: none"> <li>• education</li> <li>• employment and working conditions</li> <li>• food insecurity</li> <li>• availability of health services and social resources</li> <li>• housing</li> <li>• income and income distribution</li> <li>• race/ethnicity</li> <li>• sexual orientation</li> <li>• social exclusion</li> <li>• social safety net</li> <li>• societal cohesion</li> </ul>	

Policy advisors and those working with children ages three to six need to understand and consider how factors at the child, caregiver, relationship and societal levels influence early social-emotional development to ultimately reduce risk factors (as much as possible) and capitalize on protective factors.

# Social-emotional development and behaviour

For many infants and young children, social and emotional development unfolds as expected (Cohen et al., 2005). When children are on track and reaching their social-emotional milestones, they learn to develop close, meaningful relationships with caregivers and other children; to regulate their emotions and tolerate stressful and frustrating situations; to actively explore and learn from their environment; and to engage in prosocial behaviours such as following rules, sharing and listening to instructions (Cohen et al., 2005, 2012).

The interplay of genetics and other contextual risk and protective factors may sometimes lead to a social-emotional vulnerability or early mental health problems in some children (Bohlin, Hagekull, & Rydell, 2000; Calkins & Fox, 2002; Cohen et al., 2005; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012). Such observable behaviours and emotions may include (but are not limited to) aggressive, inattentive, impulsive or overactive behaviours (i.e. externalizing behaviours). Some children may also exhibit internalizing behaviours such as anxiety, social withdrawal, low energy and irritability. (For a more complete list of internalizing and externalizing behaviours, see Table 2.) Among infants and young children, internalizing behaviours can be very subtle and may go unnoticed, especially by those without comprehensive knowledge of infant and early mental health (Cohen et al., 2005; Kokkinos,

Panayiotou, & Davazoglou, 2004; Zeanah, Stafford, Nagle, & Rice, 2005).

It is important to consider the intensity, frequency, duration and severity of either internalizing or externalizing behaviours and the child’s age and developmental stage before concluding that there is a cause for concern. For example, it is typical and healthy for toddlers to have temper tantrums as this is part of the development of their sense of independence (Landy, 2009). Yet such behaviour from an older child may warrant closer attention and monitoring, since temper tantrums would be considered atypical for their developmental stage. Similarly, while a child is developmentally expected to identify and engage with people outside their family between the four and six years of age (Landy, 2009), some children may take more time to warm up to new people. If a child in this developmental period shows withdrawn behaviour and a lack of interest in forming social relationships with other children over a prolonged stretch of time, however this may however be a cause for closer monitoring. In our survey with early learning and care providers, 29 percent of participants identified “difficulty standing in line” as a challenging behaviour. Several respondents, however, suggested that this expectation was developmentally inappropriate for a young child, highlighting the need for greater understanding of what should and should not be expected of children this age.

**Table 2: Internalizing and externalizing behaviours**

INTERNALIZING BEHAVIOURS <sup>§</sup>	EXTERNALIZING BEHAVIOURS <sup>**</sup>
<ul style="list-style-type: none"> <li>• anxiousness</li> <li>• perfectionism</li> <li>• sadness</li> <li>• fatigue or low energy</li> <li>• social withdrawal</li> <li>• irritability</li> </ul>	<ul style="list-style-type: none"> <li>• inattention</li> <li>• hyperactivity</li> <li>• impulsivity</li> <li>• aggression</li> <li>• emotional fluctuations</li> <li>• low frustration tolerance</li> <li>• oppositional behaviour</li> </ul>

# Social-emotional development of three- to six-year-olds in formal care and education settings

Many of Ontario’s three- to six-year-olds attend some type of structured early learning and care or education program (i.e. preschool or junior and senior kindergarten) and it is within these settings that children experience several “firsts”. These include being with a large group of children, receiving education and care from several different adults, and being in a more structured setting over the course of a relatively long day. These environments also bring about new expectations, structures and transitions, and a child’s level of social-emotional development is often reflected in their ability to manage these demands (Aviles, Anderson, & Davila, 2006; Gilliam et al., 2016). For example, a child with poor emotional regulation (an indicator of low social-emotional competence) may become easily agitated when learning a new concept and this agitation may manifest as verbal or physical aggression toward themselves or others (Aviles et al., 2006). Emotion regulation challenges can conversely present themselves in behaviours that are less disruptive and therefore less detectable until they become more obvious in adolescence (Kokkinos et al., 2004; Landy, 2009). These include, but are not limited to, anxiety, depression, a lack of energy, withdrawn behaviour and psychosomatic complaints (Eisenberg et al., 2001; Landy,

**In our survey** with early learning and care providers, 83 percent of respondents indicated that supporting social-emotional development was a key element of their role in working with young children in their respective programs or settings.

2009). In early care settings (where children are expected to socialize and engage with new children), behaviours such as anxiety, depression and withdrawal may interfere with a child’s capacity to develop relationships with their peers and other adults (Landy, 2009). Social-emotional competence is clearly key to the success of children in educational settings and contributes to several areas of growth and development (Landy, 2009).

§ Gilliam, Maupin, & Reyes, 2016

\*\* Dobbs & Arnold, 2009; Havighurst et al., 2013; Gilliam et al., 2016; Williford, Wolcott, Whittaker, & Locasale-Crouch, 2015

## Social-emotional development, school readiness and academic outcomes

School readiness refers to the extent to which children's skills and competencies will help them to be successful when they enter school. Five domains of development are reflected when considering school readiness: health and physical development, approaches to learning, language development and communication, cognition and general knowledge, and social and emotional development (National Education Goals Project, 1997). School readiness involves more than just the traditional academic indicators such as literacy and numeracy, since social-emotional wellness also significantly contributes to smooth transitions into kindergarten and early school success (Pears & Peterson, 2018; Peth-Pierce, 2000; Zero to Three, 2016). For example, to flourish in early learning care and education settings, children need to be able to concentrate, persist with difficult tasks, manage difficult emotions, communicate effectively, establish meaningful relationships, be curious about the world, be eager to try new experiences and respect adult authority (Raver, 2003; Zero to Three, 2016).

**Just under half of early learning and care respondents felt confident that children in their care were prepared to participate in their respective programs.**

Recent Ontario-based data show that most young children are doing well as they transition to school and formal care settings; however, childcare providers and educators do notice that some young children demonstrate social, emotional and behavioural problems in educational settings (Early Development Instrument, 2016b), which often become barriers to school and academic success (Whitted, 2011). In one U.S. study, preschool teachers reported that managing challenging student behaviour was the single greatest concern in the classroom (Carter, Van Norman, & Tredwell, 2011). While internalizing and externalizing behaviours in the classroom are equally concerning in terms of the social-emotional development of young children (Baker, Grant, & Morlock, 2008), research has shown that internalizing behaviours are more likely to be overlooked by less experienced educators since these are subtle indicators of what may be a problem (Baker et al., 2008; Henricsson &

**Our survey and interview data** show that early learning and care providers cite a child's difficulty controlling impulsive behaviours (82 percent), difficulty expressing feelings (80 percent) and aggressive behaviours as the most common challenges in their settings. Aggressive behaviours may include physical aggression, threats, emotional outburst, destruction of property, running away and attempts at self-harm. Noncompliance, manipulation, disrespect, swearing and sexualized behaviours were also noted. These findings were also consistent across parents/caregivers and health and allied health professionals.

Rydell, 2004) and because they do not call for urgent management (Kokkinos et al., 2004).

The early development interview (EDI; Offord Centre for Child Studies, 2018) is a multidimensional tool used to understand development and which may help educators to reflect on both externalizing and internalizing indicators of social-emotional health. The EDI is a high-quality measure of a child's ability to meet age-appropriate developmental expectations in domains related to school readiness at school entry (EDI, 2014–15). In Canada,

### Domains of social emotional health (EDI, 2016b)

1. Overall social competence
2. Responsibility and respect
3. Approaches to learning
4. Readiness to explore
5. Prosocial and helping behaviour
6. Anxious and fearful behaviour
7. Aggressive behavior
8. Hyperactive and inattentive behaviour

findings from EDI data have suggested that in most jurisdictions, approximately one-quarter of children have been entering kindergarten with vulnerabilities in at least one developmental domain (EDI, 2014–15). In terms of social competence and emotional maturity respectively, 10.7 percent and 12.3 percent of Ontario children were considered vulnerable, and approximately 14 percent of children were considered at risk for social-emotional vulnerabilities (EDI, 2014–15).

## Structural influences on social-emotional development

There are several structural factors that can interact with a child’s social-emotional vulnerabilities and together, they can influence their mental health and success in formal care and education settings. The ratio of adults to children within a given setting, for example, can affect a child’s experience in early education/daycare program or kindergarten class and can likely impact children’s social and behavioural outcomes (e.g. responsiveness to adults and peers, initiative, cooperative behaviour; Friendly, Ferns, & Prabhu, 2009).

For example, according to a early years coordinator who responded to our survey, smaller child-to-provider ratios have been associated, for the most part, with improved developmental outcomes for children, such as better school readiness, language comprehension and fewer behaviour problems (Friendly et al., 2009; NICHD Early Child Research Network, 1999; Vandell & Wolfe, 2000). Lower ratios likely allow for more quality one-on-one child-educator interactions and support a positive relationship between the two, which can contribute to positive developmental outcomes in young children (Shim, Hestenes, & Cassidy, 2009).

While child-to-adult ratios influence developmental outcomes such as academic achievement and cognitive/ social-emotional competence, other considerations such as staff training and experience, staff compensation and access to support staff have also been shown to affect children’s achievement in the classroom setting (Browne, Magnuson, Schindler, Duncan, & Yoshikawa, 2017; Eleni & Giosta, 2018; Friendly et al., 2009; O’Brennan, Bradshaw, & Furlong, 2014; Scheck, Kinicki, & Webster, 1994). On the positive side, greater structure and predictability, solid routines and consistency within the environment have all been found to help children regulate their emotions and behaviours (Breitenstein, Hill, & Gross, 2009). These structural elements should be collectively considered to ensure quality early learning, care and culturally responsive education in formalized settings (Schools, 2013).

**“Class size [can be a problem] for some of these little ones. There’s too much noise and too many children in the room... [There’s no more] than 30 [children] but [even] 29 is too many [for them]. The number of adults that have to interact with a child on a daily basis is also too high... so forming those relationships can be challenging for the child.”**

– Early years coordinator



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# Current responses to challenging behaviours in early learning and care and education settings

Early learning/care settings are wonderful places to inspire a sense of belonging, curiosity and wellness among young children. They are also natural settings through which children can build social-emotional skills like identifying and managing emotions, problem-solving and navigating peer relationships. However, when some students show a pattern of difficulty with their behaviour or emotions, staff members are challenged to find ways to address this proactively and consistently, in order to ensure ongoing high-quality learning for all students. This is a common problem in early learning/care settings across North America. In some jurisdictions, students who have consistent difficulty with managing their behaviour and emotions may be removed from the classroom environment for a period of time. For example, in a U.S. study, data from 3,898 preschools across 40 states showed that the expulsion rate for preschoolers was 3.2 times higher than the rate for students enrolled in kindergarten to grade 12 (Gilliam, 2005). In the same study, approximately 10 percent of prekindergarten teachers indicated that they expelled at least one preschool child in the past year and 20 percent expelled multiple children as a response to difficult behaviours (Gilliam, 2005).

In contrast, provincial data collected as part of the development of this paper (n=553) shows that educators in Ontario rarely resort to expulsions and suspensions to manage children's challenging behaviours in early learning and care/education settings. Instead, initiating a slower integration into a program (e.g. modified start date, modified times for attending), the use of specific classroom strategies (e.g. promoting self-regulation, having the child arrive to class at a quieter time, exercising flexibility around program expectations, promoting increased parental/caregiver involvement, having increased one-on-one support for the child or using child-specific plans) tend to be preferred ways of addressing issues as they arise. Respondents were clear that these modifications took place only in cases where the program or school setting was unable to meet the child's individual needs for some reason (in most cases, either due to structural or funding issues). Respondents also suggested that modifications were sometimes the

result of other issues such as significant mental health concerns that could only be supported within the context of a more formalized intervention. Most early learning and care providers (54 percent) had "never" or "infrequently" made accommodations to the participation of a child in their education program or setting as a way of managing difficult behaviours in the classroom. Of the remaining 46 percent of staff, 16 percent reported having responded to challenging behaviours with a modification "fairly frequently" and 30 percent shared that they "often" or "almost always" rely on this approach as a response.

Concerning behaviours that have most often prompted the use of modifications included aggressive behaviour (83 percent), challenges with emotion regulation (58 percent), difficulty expressing needs or feelings (39 percent), difficulty listening to and following instructions (38 percent) and difficulty paying attention (31 percent). Severe separation anxiety, running away, inability to stay awake, and in rare cases severe aggression causing significant safety risk to the child or their peers, were other reasons because of which early learning and care providers modified a child's school participation. Data from our parent/caregiver survey shows that of the families who experienced some form of a modification to their child's school day, more than half (56 percent) were provided with little to no support or advice to cope with the situation.

It is important to note that this information was collected for the purposes of this project alone, and therefore is not a full and accurate representation of what is happening province-wide to respond to this issue. Therefore, there is a clear need for a coordinated, comprehensive approach to data collection to better understand the prevalence of behavioural challenges and early mental health concerns in these young learners, and how these issues are managed in Ontario's early care and learning programs. There is an opportunity for educators, early learning specialists, school mental health professionals and clinicians in health/allied health settings to work together to collaboratively implement solutions to support children who are struggling.

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# Supporting positive social-emotional development from the beginning

Despite efforts to promote social well-being and to intervene early when a problem arises, it may be necessary in some cases to modify or adjust a child's school day to respond to social-emotional concerns. However, for many, mental health promotion, prevention and early identification and intervention may be the key to preventing social-emotional difficulties and behavioural challenges from persisting and worsening — or from impacting the individual, their family and the broader society (Shonkoff et al., 2012; Breitenstein, Hill, & Gross, 2009; Conners-Burrow et al., 2012; Reynolds et al., 2011; Government of Canada, 2006). There is great evidence suggesting that structures and supports that are grounded in developmentally appropriate social-emotional skill building, classroom management practices, culturally responsive and positive teacher-child interactions, and prosocial peer interactions are most likely to meet the needs of vulnerable children (Assembly of First Nations, 2012; Brown, 2015; Cohen et al., 2012; Durden, Escalante, & Blicht, 2015; Gilliam, 2005; Jennings & Greenberg, 2009; Lisonbee et al., 2008; Whitted, 2011; World Health Organization, 2003; Zeanah et al., 2005).

There are also significant economic benefits to optimizing mental health of children in their early years. In 2011, Nobel Prize winner James Heckman completed a cost-benefit analysis which demonstrated that investing in the early years pays for itself, with a return of seven percent or more. In fact, Heckman's more recent research found that high-

quality birth-to-five programs for disadvantaged children can deliver a 13 percent return on investment through increased school and career achievements and reduced remedial education, health and justice system costs (Heckman, 2017).

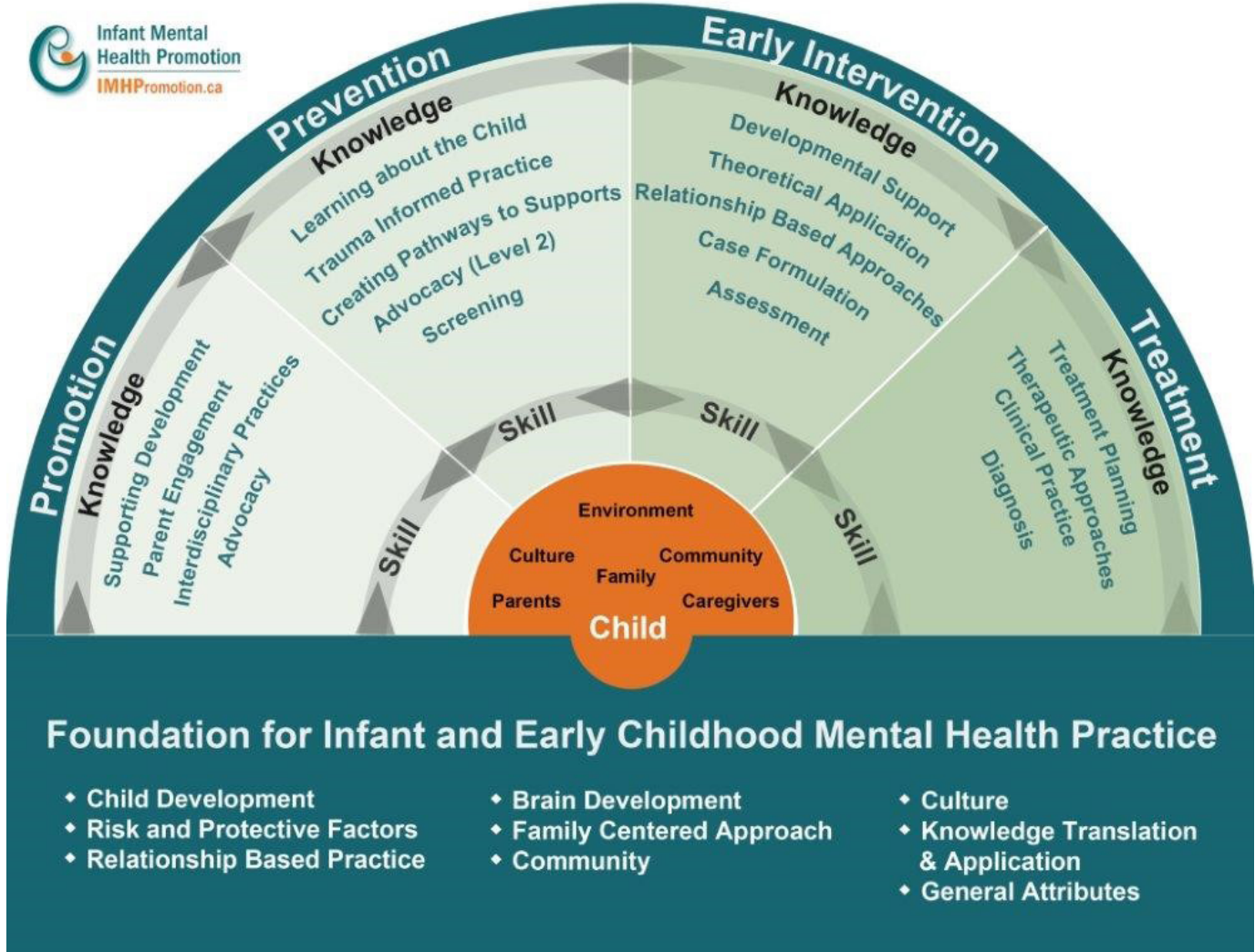
Longitudinal findings from another cost-benefit analysis indicated that when low-income children participated in Chicago's Child-Parent Centres' early childhood intervention starting at age three instead of receiving the standard educational interventions, the total return to society was \$10.83 per dollar invested (Reynolds et al., 2011). The source of benefits primarily included savings in special education, grade retention, averted criminal justice system and victim costs, and increased earnings and tax revenues (Reynolds et al., 2011). For children who started the intervention at school age instead of during the preschool years, there was still a return to society, but it dropped from \$10.83 to \$3.97 per dollar invested. This finding clearly highlights that the earlier the intervention, the better the social and economic benefits (Reynolds et al., 2011).

As illustrated in Figure 1, mental health promotion and prevention, assessment and early intervention are all important in terms of an integrated approach to supporting optimal social-emotional development for all children. Below, we discuss each of these in turn. Specific treatments for those who need a more targeted response are also essential but beyond the scope of the present paper<sup>††</sup>.

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<sup>††</sup> Please see this [environmental scan of evidence-informed programs for children from birth to age six](#). In this scan, we review evidence-informed programs for Tier 2 and Tier 3 level programs/services and provide contextual information on key factors and messages about the social and emotional development of children from birth to six years of age, including: current definitions of infant and early childhood mental health, the importance of this stage of development, the linkages between brain development and the environment (as well as the role of stress), executive function and self-regulation, temperament, resilience, positive caregiving relationships, attachment, play, and cultural considerations.

Figure 1: Competencies framework



The competencies framework illustrates the foundational knowledge and skills required to work with children under six years of age. Adapted from *Core Competencies for Practice in the Field of Infant Mental Health*, Infant Mental Health Promotion (2018). [An accessible breakdown of the graphic](#) is available on the Infant Mental Health Promotion web site.

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# Mental health promotion and prevention

Mental health promotion for young children involves strengthening the parent/caregiver-child relationship to support optimal development (Public Health Ontario, 2015). Mental health promotion efforts are made available and accessible to all parents/caregivers and focus on increasing awareness and understanding of the importance of early social-emotional development in young children. Such messages emphasize the vital role that parents/caregivers play in creating and maintaining healthy relationships, environments and experiences for all children, particularly from birth to age six. Other areas of focus include helping parents/caregivers to recognize resilience and vulnerability and to support their babies to express and regulate their emotions (Cohen, Onunaku, Clothier, & Poppe, 2005). Home visiting, parenting groups, play groups, parent education events and other population-level efforts that attend to culture and language are common mental health promotion activities that increase awareness and knowledge broadly. They can help address problems before they become more serious (Cohen et al., 2005).

In Ontario, parents/caregivers with children from birth to age six can access EarlyON Child and Family Centres across the province at no cost. These centres provide a safe, nurturing and stimulating environment for children to play, and parents/caregivers can take part in play-based programming to support children's social and cognitive development, health and well-being (Toronto District School Board, 2014). As well, parents have the opportunity to build positive relationships with parent workers, local schools and other caregivers prior to their child's entry into formalized education settings. EarlyON centres (operated by the Toronto District School Board, and formerly known as Parenting and Family Literacy Centres) have been shown to have a positive impact on children's early learning and development. Specifically, children and families who regularly attended EarlyON centres were rated as having significantly more successful transitions by kindergarten teachers at school entry when compared with those who had not attended the program (Yau & Ziegler, 2005). EDI data at school entry similarly showed that children who attended the centre with their parents/caregivers had significantly higher EDI scores across all domains than those who had no program exposure (Yau & Ziegler, 2005).

**To support the creation of mentally healthy classroom environments in Ontario,** School Mental Health Ontario (SMH Ontario) has created a [professional learning series and related resources for educators](#).

SMH Ontario also offers a suite of resources, designed for and with educators, to build their mental health literacy. The Ministry of Education's Supporting Minds document provides the foundation for much of the knowledge shared within this professional learning series, which includes facilitated learning sessions, online tutorials, web trainings and print materials. A range of materials has also been provided to help educators to embed social emotional learning within the fabric of the school day. For example, the online [Everyday Mental Health Classroom Resource](#), co-created with teacher federations and school mental health professionals, is available free of charge for all educators.

Creating a special focus on early years mental health knowledge and skill development would be an excellent addition to this suite of learning and training resources.

While creating a foundation for positive social-emotional health begins well before children enter school, it is important that there are ongoing efforts to provide meaningful opportunities for them to learn about and practice ways to identify and handle their emotions, to cooperate and resolve conflicts with classmates, and to manage and tolerate stressful and frustrating situations (Jennings & Greenberg, 2009). For example, social-emotional

learning (SEL) is one approach to mental health promotion that has been proven effective in significantly improving social-emotional skills, academic performance, resilience and coping skills and social-emotional development, as well as in reducing internalizing and externalizing behaviours (Evidence Exchange Network for Mental Health and Addictions, 2016). A recent review of evidence-based social-emotional learning programs highlighted six main elements that were common across effective protocols: identifying and managing emotions, developing and maintaining relationships,

cultivating a sense of identity and mattering, coping with stress, practicing good executive functioning skills, and maintaining an optimistic outlook (Evidence Exchange Network for Mental Health and Addictions, 2016). As well, educators can promote positive outcomes by supporting skill development, by regularly modeling healthy relationships and behaviours and by creating and facilitating mentally healthy classrooms that are language-rich, predictable, well-managed and engaging (Jennings & Greenberg, 2009; World Health Organization, 2003).

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## Early recognition and assessment

Adults who work with children across a range of settings (including early learning and care, education and health) are well positioned to observe whether a child is on track for meeting behavioural and developmental milestones. These observations, along with meaningful discussions with parents/caregivers, can help unpack the different factors that might be contributing to a child's concerning behaviours or development, and identify potential responses and supports. Collaborative, ongoing discussions between all service providers and parents/caregivers are essential for ensuring a holistic approach to care across supports and settings.

Even before entering early learning and care environments, there is great opportunity to support the social-emotional development of young children within primary care and pediatric health settings, since children regularly visit family physicians and pediatricians during their earliest years (Zeanah & Gleason, 2009; Cappelli & Leon, 2017). Parents/caregivers also tend to seek input from primary care providers when they have concerns about their child's sleeping, feeding, language or behaviours. Many primary care practitioners report feeling ill-equipped to discuss mental health issues because of lack of training or time needed to address mental health concerns (Horowitz et al., 2007, 2015). However, these providers can play an important role in identifying challenges early since they understand family background (i.e. risk and protective factors), can observe parent/caregiver-infant interactions, provide parents/caregivers with information and counselling about child development and conduct structured behavioural screenings when needed (Zeanah & Gleason, 2009).

Our survey data show that 47 percent of Ontario professionals from the early learning and care sector have referred children in their care to family physicians and pediatricians when there were concerns about social emotional development. Primary care practitioners can be supported to identify early social-emotional challenges

using routine, high-quality developmental screening tools, which can be particularly helpful in accurately detecting developmental risk in infants and young children where the behavioural signs may be quite subtle (Cohen et al., 2005). Results can be used to both identify issues and provide direction to help professionals appropriately respond to the indicated risk to optimize a child's developmental outcomes (Cohen et al., 2005).

Several tools are currently available to help primary care practitioners identify potential risks for poor social-emotional development. For example, the Nipissing District Developmental Screen (Nipissing District Developmental Screen Intellectual Property Association, 2000) can help providers broadly understand how a child is progressing. Another tool, the Ages and Stages Questionnaire (ASQ; Squires, Twombly, & Potter, 2009) is a first-level comprehensive screening and monitoring program that helps identify infants and young children who, based on their level of developmental risk, may require further assessment (Squires, Twombly, & Potter, 2009). For children in the early years, it is recommended that the ASQ be used in conjunction with the Ages and Stages Questionnaire Social-emotional (Squires, Bricker, Twombly, 2015) which specifically focuses on a child's social-emotional behaviour and is used broadly across child populations (including across a number of Indigenous communities in Western Canada).

Ultimately, multiple sources of information (e.g. observations, parent/caregiver reports) and sensitivity to children's and families' culture are required to gain a comprehensive understanding of a child's social-emotional developmental status, but the structured use of checklists, screening and assessment tools is an efficient and sensitive way to begin the conversation about infant and early mental health. Once a clear picture of the child's challenges starts to emerge, a collaborative approach to intervening and addressing challenges is needed.

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# Early intervention programs to promote optimal social-emotional development

There is no single program, approach or solution to resolving the challenges experienced by children with mental health difficulties. Each child has a unique etiology that underlies their issue and a specific context in which it is expressed. However, a scan of intervention programs and approaches specific to addressing social and emotional challenges for this age group<sup>‡‡</sup> has shown that regardless of the intervention, three key program elements are critical for producing positive outcomes for children and their families: 1) enhancing the knowledge and skills of service providers; and 2) building knowledge and skills related to social-emotional learning among parents/caregivers and children through mental health promotion programming, and promoting quality relationships.

## Enhancing knowledge and skills

Those who work with children between three and six years, including early learning and care providers and kindergarten educators, have diverse educational backgrounds and experiences, and different levels of training and cultural understanding. Within a child's circle of care, this has resulted in an uneven understanding of infant and early childhood mental health and varying level of skills for identifying and addressing challenges (Kulkarni, Persaud, & Hill, 2015). Some teachers, for example, receive minimal or no specific training on early mental health in their preservice education, which can then impact their ability to interpret and manage challenging behaviours in classroom settings—particularly when it comes to internalizing problems (Kokkinos et al., 2004). This is supported by our surveys and key informant interviews; Ministry and policy advisors highlighted the absence of mental health content in both preservice training and ongoing professional development for those working with young children as a critical barrier to healthy social-emotional development in Ontario's three- to six-year-olds.

Training strategies that teach educators how to support children who are struggling with their behaviour and emotions and promote a positive learning environment have been found to improve teacher self-efficacy (Steed & Duran, 2013) and children's social competence (e.g. their approach to learning and executive function; Morris et al., 2013). Equipping teachers with knowledge and skills related to early years mental health that is in keeping with their role in promoting social-emotional development is an important step forward. In addition, educators need easy access to action-oriented resources, tools and materials that they can draw on to promote positive mental health, maintain calm and welcoming classrooms and intervene early when students show that they are struggling to manage their behaviour and emotions (School Mental Health Ontario, 2019).

## Social-emotional Learning and mental health promotion

Parents/caregivers are critical for ensuring their children's success, and therefore building their knowledge and skills is essential for supporting positive social-emotional development in their children's early years (Fung & Fox, 2014; Furlong et al., 2012; Pears, Kim, Healey, Yoerger, & Fisher, 2015). There are several mental health promotion approaches parents/caregivers can draw upon (CMHA, 2019).

Parent education groups have shown to be effective in enhancing parents' social-emotional learning about their child's development. For example, a parenting program targeting parents'/caregivers' awareness about emotion regulation and emotion coaching skills was shown to reduce child behaviour problems, as reported by parents, caregivers and teachers (Havighurst et al., 2013). Similarly, a parenting training program designed to help parents/caregivers use child-centred skills (e.g. praise, describing appropriate

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<sup>‡‡</sup> Please see this [environmental scan of evidence-informed programs for children from birth to age six](#). The scan includes 37 studies looking at 35 unique programs or approaches across education settings (preschool, junior and senior kindergarten), home settings or combined education and home settings.

behaviour, appropriate play, etc.), similarly showed significant improvements in the children's conduct problems and adaptive functioning at follow-up, as well as decreased parenting and caregiving stress (Niec, Barnett, Prewett, & Shanley Chatham, 2016). Finally, an early pathways program involving parent/caregiver-directed training about the importance of the parent/caregiver-child relationship through psychoeducation and cognitive-behavioural strategies was found to reduce child behaviour problems, increase prosocial behaviours and ultimately decrease the number of clinical diagnoses following treatment (Fung & Fox, 2014).

Educating parents/caregivers about the importance of their own mental health and strategies to maintain well-being have also been proven effective in managing their child's problem behaviours. For example, parents/caregivers who participated in a mindfulness-based stress reduction program not only described feeling less stressed following the intervention but also reported fewer behavioural problems in their children (Neece, 2014). In addition to helping parents/caregivers learn and implement strategies to directly support their child, several learning and care respondents in our survey shared that their organizations support parents/caregivers to build their knowledge about developmental milestones, their own social emotional needs and the importance of attachment through workshops and psychoeducational programs.

While practitioner- and parent/caregiver-directed interventions are essential for managing challenging behaviours, there is also great value in enhancing children's own social-emotional literacy (Evidence Exchange Network for Mental Health and Addictions, 2016). For example, following the completion of a school readiness parenting program, children's behavioural functioning improved significantly — even more so for those children who completed an enhanced social-emotional and self-regulation training that was embedded within the broader curriculum (Grazino & Hart, 2016). A rigorous study involving over 200 children (from kindergarten to grade three) similarly showed that school-based lessons about monitoring emotions and self-control (i.e. reducing escalating behaviours) decreased teacher-reported problems and resulted in substantial reductions in disciplinary referrals and suspensions over a four-month period (Wyman et al., 2010). In other research, children who participated in a mindfulness-based program embedded within a preschool setting showed greater improvements in social competence and learning compared to peers in a control condition (Flook, Goldberg, Pinger, & Davidson, 2015). These examples demonstrate the importance and value of including children as active participants in their own development, particularly within the context of early learning and school settings.

Seeds/Roots of Empathy and MindUP™ are two examples of evidence-based social-emotional learning programs that have been designed for implementation with young children in early childhood settings and classrooms (i.e. prekindergarten to grade eight) to nurture and foster foundational social-emotional skills. Several studies have shown the positive impact of these programs on early mental health through improvements in young children's cognitive and emotional control/regulation and peer acceptance and a decrease in symptoms of depression and aggressive behaviour (Connolly et al., 2018; Schonert-Reichl et al., 2015). Both programs also include the active participation of parents/caregivers in their child's social-emotional development. MindUP™ in particular provides caregivers with a curriculum that can be implemented at home to promote healthy dialogue about social-emotional wellbeing and to improve relationships.

All parties involved in a child's circle of care (including the child themselves) can benefit from greater knowledge, skills and SEL. In fact, the value of involving all stakeholders in the process of continuous learning has been demonstrated in a randomized controlled longitudinal study of over 1,000 prekindergarten children and their parents/caregivers in a disadvantaged neighbourhood in New York City (Dawson-McClure et al., 2015). The 13-week family-centred, school-based behavioural intervention included a parenting intervention (i.e. promoting knowledge, positive behaviour support, behaviour management and involvement in early learning) with a concurrent group for children to promote social-emotional skills and self-regulation. Professional development for prekindergarten and kindergarten teachers was also included to help improve the classroom climate and equip educators with strategies to optimize students' social-emotional development and early learning. The intervention intentionally brought together the parent and child groups to provide families with the opportunity to build positive relationships and practice newly learned skills within a supportive environment. Findings from this study showed significant improvements in parenting knowledge, decreased negative and inconsistent parenting, and a lower rate of conduct problems when compared to families and children who received prekindergarten education as usual (Dawson-McClure et al., 2015). The success of the intervention seems to stem from involving the child's entire circle of care and removing potential barriers, like childcare for other children in the family, incentives for participation and program completion, and continued in-person and phone engagement from teachers. Ensuring culturally sensitive care and promoting quality relationships among caregivers, children and educators were also key success factors (Dawson-McClure et al., 2015).

## Promoting quality relationships

While knowledge and skills are essential, “relationships provide the foundation for social-emotional skill development” (Whitted, 2011, p. 10). To ensure positive developmental outcomes, children need responsive, sensitive and engaged adults to help them hone these important life skills. Even in cases where children are exposed to adverse experiences, those who have positive, supportive relationships with engaged caregivers and appropriate rules and boundaries are more likely to experience positive outcomes when they begin formalized education than those who do not (Duncan et al., 2007; Raver & Knitzer, 2002).

Parent-child interaction therapy (PCIT) is one intervention, for example, that focuses on supporting parents/caregivers to use child-centred and strength-based approaches when interacting with their children. PCIT has been shown to not only decrease externalizing behavioural challenges in children, but also to reduce parenting/caregiver stress (Niec et al., 2016). The Early Pathways Program (Fung & Fox, 2014), which increases prosocial behaviours and reduces disruptive ones through child-led play and psychoeducation, is another example of an intervention that builds a strong relationship foundation between children and adults.

Relationships *between* providers are also essential for producing positive outcomes for a child. The early childhood mental health consultation (ECMHC) model used in the U.S., for example, highlights the importance of fostering relationships between early care and education providers, children and their families (Conners-Burrow et al., 2013; Fischer, Anthony, Lalich, & Blue, 2014; Perry, 2011). Here in Ontario, our survey data shows that to address social-emotional development concerns in young children, early learning and care respondents often rely on outside specialists, resource consultants, special needs educators and members of their own leadership team to collaborate and problem-solve together. The alliance and trust built between a mental health consultant and education providers helps to build capacity, which in turn can improve the relationship between providers and children and enhance the overall classroom climate (Perry, Dunne, McFadden, & Campbell, 2008). This model has been shown to reduce problem behaviours and increase social skills through the

use of more positive classroom management strategies (Fischer et al., 2014; Gilliam et al., 2016; Ocasio et al., 2015; Perry et al., 2008; Raver et al., 2009), prevent suspensions and expulsions in preschool settings (Perry et al., 2008; Vinh, Strain, Davidon, & Smith, 2016) and decrease teacher burnout (Conners-Burrow et al., 2013). Developing ongoing and collaborative relationships between educators and a classroom-based or onsite mental health provider (e.g. psychologist, psychiatrist, social worker, etc.) who can provide consultation seems to be effective for positively managing and responding to challenging behaviours (Gilliam, 2005).

Less costly programs and strategies that directly focus on the child-teacher relationship to achieve positive outcomes are also useful in supporting a child’s social-emotional development. For example, interventions that aim to increase teachers’ sensitivity and responsiveness have been shown to improve relationship closeness and competence and decrease conduct problems in young children (Driscoll & Pianta, 2010; Williford et al., 2015).

Programs and interventions that support early years mental health are clearly most successful when 1) delivered by well-trained professionals working together with parents/caregivers and children themselves; and 2) characterized by positive relationships that promote social-emotional development and wellness. Here in Ontario, while a range of child and youth mental health services are offered across the continuum of care in each community, an environmental scan by Clinton et al. (2014) demonstrated that significant inconsistencies and gaps exist in the provincial infant and early childhood mental health system. As such, too many children and families who require social, emotional and behavioural support are not receiving the help they need (Cooper, Masi, & Vick, 2009). Data from our survey shows that even when services are available, several barriers (including distance, long waitlists, costly services, lack of access to services in one’s first language, low cultural awareness and competencies) interfere with families accessing these supports in a timely way. In the next section, we offer evidence-informed recommendations aimed at closing these gaps and ensuring positive social-emotional development for our youngest Ontarians.

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# Recommendations

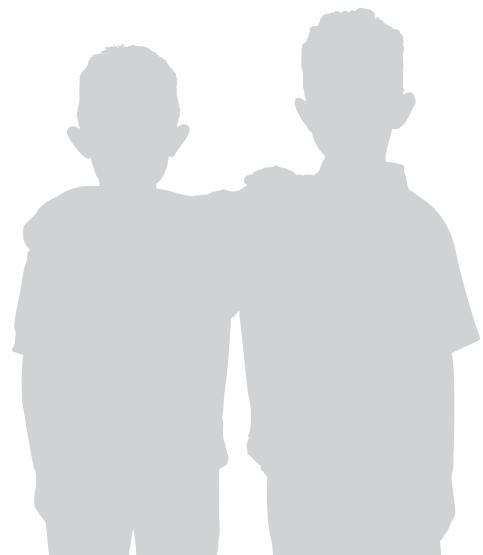
We propose eight recommendations intended to guide a cross-sectoral, collective response to meet the social-emotional development needs of Ontario's three- to six-year-olds. These recommendations were informed by the findings of our literature review, surveys and key informant interviews, and later refined through discussions with our advisory committee. Once drafted, we consulted with diverse stakeholders and community tables to refine further.

## 1 Create a common policy and practice framework for the province to align efforts around infant and early mental health.

We need a common vision across ministries and different levels of government related to education, health, development and community and social services, since funding allocations are critical in shaping decisions about service delivery and ensuring resources for coordination. Participation from adult sectors (such as mental health and addictions, settlement services, etc.) is also needed to support parents/caregivers both individually and as part of the family ecosystem to facilitate effective, lifelong change. A whole government approach (which includes a focus on an Indigenous worldview) is essential for ensuring a common policy and practice framework that supports funding decisions and resources to be distributed in ways that are 1) aligned with the needs of young children and their families; and 2) represent the cultural and linguistic diversity of the province.

## 2 Ensure the availability of high-quality preservice training and ongoing learning and training related to supporting social-emotional development in three- to six-year-olds for early learning and care practitioners, teachers, primary care, public health nurses, etc. Knowledge shared should be based on the latest evidence on social-emotional development and mental health in the early years, with a focus on relationship-based practice.

While this paper is a starting point, there is currently no consistent and comprehensive understanding of early mental health and key social-emotional development milestones across the various disciplines that regularly engage with or support young children and their parents/caregivers. Without a shared understanding of the developmental continuum, providers struggle to know when to be concerned about a behaviour and how best to respond in culturally and linguistically appropriate ways. A common



body of knowledge, therefore, needs to be developed by leaders with expertise in the area, to guide the supports we provide to our youngest Ontarians. This body of knowledge should be based on the latest evidence on social-emotional development and mental health in the early years and be promoted (at no cost) to service providers across all relevant sectors (including but not limited to early learning and care practitioners, teachers, public health nurses, mental health service providers and allied health professionals). This knowledge should be culturally and linguistically appropriate, should inform both preservice training and ongoing professional development opportunities, and should be tailored to the knowledge needs of those in particular professional roles, both in terms of content and depth.

### 3 Develop and promote resources and training materials to support parents' and children's social-emotional learning to optimize the social-emotional development of three- to six-year-olds.

Parents and caregivers also need access to knowledge about social-emotional development and mental health in the early years. Customized resources (developed with parents' and caregivers' knowledge needs in mind and delivered according to their learning preferences) should be available to support them in identifying challenges and ensuring their child receives the right supports at the right time. These materials should be co-developed with family members, experts and support providers to ensure an evidence-informed learning product that integrates insights from each group. As well, these resources and training materials should integrate language and cultural identity considerations. They should also support children in acquiring core competencies in social-emotional development such as empathy, resilience, self-esteem and confidence, emotional regulation, emotional literacy, conflict resolution, problem-solving, stress management and social awareness within early learning and school settings, as they are essential for children to thrive and avoid future behavioural and emotional challenges (Evidence Exchange Network for Mental Health and Addictions, 2016). Across the literature, there is general agreement regarding the most effective components of social-emotional learning (SEL) programming including the following: 1) embedding SEL programs into the whole school environment and the general classroom curriculum; 2) programs that incorporate sequenced, active and interactive, focused and explicit learning; 3) focus on skill building; 4) involvement of parents and caregivers; and 5) programs that are targeted for all ages and all education

levels (Evidence Exchange Network for Mental Health Addictions, 2016).

### 4 Strengthen and enhance partnerships across sectors to ensure effective communication, clear and efficient service pathways and accountability for the provision of early mental health services.

A consistent theme that surfaced during our data collection was the need to better connect parts of the system of care to ensure consistency in the way that mental health services for young children are structured and delivered. For optimal care, strong communication between providers across education, early learning and care, primary care and community-based child and youth mental health services is essential. Coordination and collaboration across services, and an infrastructure to support this knowledge sharing to implement a comprehensive plan of care, is critical (e.g. creating an electronic file that allows practitioners to share the child's information, treatment plan, etc. or consistently hosting case conferences and wraparound meetings where all providers and the family come together regularly to identify treatment goals, monitor progress, etc.). Pathways between health, education and community mental health need to be strengthened to ensure more consistent support for children and families. Considerations need to be made with respect to language needs and cultural identity.

### 5 Identify and implement standardized tools to collect data on children three- to six-years-old across sectors to inform treatment planning, shape supports and provide a provincial snapshot of how our youngest Ontarians are doing.

We currently lack an accurate and comprehensive understanding of the social-emotional status of our youngest children. To ensure that services and supports for Ontario's three- to six-year-olds are evidence-informed, we need accurate and timely data on the needs and strengths of this population (i.e. developmental outcomes, existing family and social support, social determinants of health and other known risk factors). To facilitate this, standardized tools and

related guidelines should be developed and used both to inform early intervention and treatment at the family level, and to provide a broad picture of how children are doing at the provincial level.

Data collection at the level of the school board is also essential. As mental health promotion and social-emotional learning programs are introduced and new early years mental health resources developed, it will be important to monitor uptake, use, fidelity and effectiveness. Educator, principal and parent/family voices can also be very instructive in ongoing quality improvement efforts. In addition, tracking of individual student interventions (which could be collected anonymously but which should include culture, race and language information) should incorporate numbers related to referrals to the school teams, board school mental health professionals or community mental health agencies; positive behaviour management data; progress monitoring with strategy implementation; suspensions and expulsions; as well as statistics on any modifications or accommodations to a child's school day or participation. Good platforms and tools currently exist and can be adapted or enhanced to include these elements in order to better understand the province's mental health needs, challenges, available resources and current practices. This knowledge can be used to guide our collective response and support for children and families in a way that is culturally and linguistically responsive.

## 6 Provide adequate funding for research, implementation and ongoing evaluation of evidence-informed promotion, prevention and intervention programs for early mental health.

Ensuring positive social-emotional development and early mental health for Ontario's three- to six-year-olds requires targeted investments to support the implementation and ongoing evaluation of evidence-informed promotion, prevention and intervention efforts. While many programs currently support mental health in the early years, few have been rigorously evaluated. Common approaches and components to these programs have been identified, such as increasing knowledge and skills and promoting quality relationships, but we need more information on what works, for whom and in what settings.

## 7 Ensure that children experiencing poor social-emotional development are identified early and receive regular screening and targeted support.

Children exhibiting signs of mental health vulnerabilities should be identified early and once identified, have access to regular support or intervention. Collaborative efforts between primary care, community-based providers and those working in early learning and care settings are essential. Equipping those working with these children with some knowledge can also help to ensure that parents and caregivers have some immediate support while waiting for further assessment and intervention.

For example, here in Ontario, Bruce County Children's Services partnered with local school boards beginning in 2000 to administer the Ages and Stages Questionnaire (ASQ) to families at each of the schools' kindergarten registration sessions (Let's Learn Grey Bruce). Parents were asked to bring their child's completed ASQ to the registration, which was then scored by a staff person from Children's Services. In cases where a child's score indicated a risk for developmental delay, the screener (with consent from the parent/caregiver), would make direct referrals for follow-up supports.

In 2018, the Let's Learn program was reviewed internally by Bruce County and there was a consensus that although the completion of the ASQ at kindergarten registration had value, there was not enough time to provide appropriate supports to children with needs prior to entering school. As a result, Bruce County Children's Services is launching Bruce County's Journey Through the Ages and Stages this year (2019). In its first phase, Bruce County will work in partnership with child care agencies to administer the questionnaire to all families in the child care system so that issues can be flagged, and intervention can be swift. Moving forward, Bruce County's hope is that the completion of regular screenings, including the ASQ:SE:2, will be a service agreement requirement of all child care centres as part of their onboarding process with new families.

In the next phase, Bruce County will be reaching out to other child care and early years service providers (e.g. medical, child and family services, etc.) to coordinate efforts with partners that are screening and identifying at-risk children that are not involved in the licensed child care system. This proactive approach will allow for the community to be more responsive to children's learning, development and well-being.

## 8 Ensure *all* children and families have access to high-quality mental health services that are tailored to children from three to six years of age and rooted in strong family engagement.

There is no single approach that will meet the needs of every young child who may be vulnerable to poor social-emotional outcomes. With appropriate training and professional development, practitioners across sectors who work with children and their families will have a strong foundation in early mental health and will be able to work with families to

identify an appropriate solution for their child, particularly those between the ages of three and six. To do so effectively, practitioners must be able to understand a family's context and assess their strengths and needs.

Family engagement practices are consistent with a family-centred philosophy of care that recognizes families as the experts when it comes to supporting their children; promotes an equal partnership between families and care providers; and values the role of the family in decision-making and implementing the plan of care for their child (Lieberman & Van Horn, 2005). The collaboration between parents/caregivers from across cultural and linguistic groups and service providers across sectors is critical for ensuring strong social-emotional development in our youngest children and sustained positive outcomes that will contribute to their success over time.

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## Limitations of this work

This paper is one of the first comprehensive reports that specifically focuses on the social-emotional development of three- to six-year-olds by bringing together academic literature and the input and experiences of diverse stakeholders including parents/caregivers across Ontario. As with any study, however, there are several limitations inherent in this work. First, this paper was developed in response to concerns from Ontario's community-based child and youth mental health service providers and educators about challenging behaviours in formal care and education programs; how children's participation in these programs was affected by these challenges; and parents'/caregivers' difficulties in managing them. To date, there has not been any systematic collection of data on this topic in Ontario, and it is therefore difficult to understand the scope and prevalence of social-emotional development challenges among three- to six-year-olds and to truly understand how these challenges impact participation and success in structured care and education settings. Much of the research that does exist comes from the United States; there is an opportunity then to draw on methods and tools that have been used by American researchers as a starting point to understand the issues locally.

Second, while great efforts were made to reach and engage diverse stakeholders, our recruitment strategies may have led to some sampling bias and non-response bias; this has likely affected who responded, who didn't and why. A related concern is our small sample sizes, particularly for families.

Therefore, while common themes emerged from our surveys and interviews, we recognize that this paper does not reflect the full range of perspectives of parents/caregivers across the province. Despite this, we have engaged with a broad range of stakeholders who, along with parents/caregivers, are essential supports for children in this age range. We are confident that the information gathered and our suggestions for moving forward will support a cross-sectoral, collaborative response to addressing this important issue in ways that will prevent challenges from persisting over time.

Finally, throughout this document, we have referenced the need to ensure that cultural and linguistic factors, strengths and gaps are considered both in understanding the child and family context and crafting potential responses and supports. In future work, attention should be paid specifically to how culture and language along with race and ethnicity are all at play in the lives of all of Ontario's children, youth and families. These dimensions should be addressed in possible responses and supports that are shaped in partnership with the range of educators, service providers and families.

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# Conclusion

The building blocks for strong mental health and well-being across the lifespan are established in the early years. While many children successfully meet their social-emotional development milestones as expected, those who are challenged to do so do not always receive the right support, at the right time. Recent Ontario data suggests that there are many children who experience social-emotional vulnerability upon entry into kindergarten (Early Development Instrument, 2016a). Positive social-emotional development in the early years can lead to good educational attainment, financial stability, and health and wellness (Moffitt et al., 2011). Given the impact of early life experiences on later outcomes is well-established, we must act to ensure that all our children have access to safe and supportive relationships, environments and experiences, as this will contribute to lifelong health in individuals and communities.

Therefore, it is essential that families and care providers are equipped with the knowledge required to recognize such challenges and work with professionals to respond with services that can address these concerns in a timely, appropriate way. In this policy paper, we have collaborated

across education, early learning and care and child and youth mental health sectors to 1) surface the unique needs of our province's three- to six-year-olds; and 2) to provide evidence-informed recommendations to guide a collective response to ensure healthy social-emotional development and positive lifelong mental health for all Ontarians. As we move forward, we need to take a close look at how we currently promote mental health across the lifespan and how we can act early to prevent mental illness as we age. We need to better equip children, families and professionals among all relevant sectors (including families/caregivers, educators and professionals in health and allied health settings) with the best information about early mental health and social-emotional development, as they all play a pivotal role in ensuring positive mental health for children — and therefore must all be part of our collective response. With discussions and reforms currently underway in Ontario, there is an opportunity to move forward with these recommendations to support greater integrated care and a strong, cross-sectoral response to improve the mental health outcomes of three- to six-year-olds across our communities.

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# Glossary of terms

The existing literature uses many terms interchangeably. The following lexicon reflects the most commonly used or accepted definitions that are used throughout this report.

**Adverse childhood experiences (ACEs):** negative early life experiences (e.g. abuse and neglect, parental mental illness, domestic violence) which have been associated with poorer lifelong health and behaviour outcomes, including, but not limited to, alcoholism, substance abuse, heart disease, missed work, suicide attempts and early death; Felitti et al., 1998). It has been demonstrated that as the number of ACEs increase, the higher the risk of poor outcomes later in life (Centers for Disease Control and Prevention, 2016; Luby et al., 2017).

**Attachment:** the earliest and most significant relationship between caregiver and child (Bowlby, 1982). The quality of the attachment relationship is determined through caregivers' responsiveness and sensitivity to a child's distress

cues (Sroufe, 2005). Attachment is known to be predictive of child developmental outcomes and is the template for a child's future relationships and core beliefs (Bretherton & Munholland, 2008).

**Atypical behaviours:** include behaviours that fall outside the expected or normal range of development in comparison to peers (National Center for Learning Disabilities, 2018). Behaviours may also vary in terms of frequency and severity as not one child exhibits the same pattern of behaviours the same way, over the same period of time.

**Challenging behaviours:** within the context of the current paper, challenging behaviours are those demonstrated by children with such intensity, frequency or duration that they are often difficult for early educators and teachers to manage within the care or classroom setting. Challenging behaviours can be of the externalizing (see definition below) or internalizing (see definition below) type.

**Developmental screening tools:** support the early identification of children who may be at risk for developmental delays. When used accurately, developmental screening tools can improve children’s developmental outcomes as they provide families with the opportunity to seek early intervention in the timeliest manner (Committee on Children with Disabilities, 2001).

**Early learning and care practitioners:** professionals such as registered and designated early childhood educators (RECEs/ DECEs), education assistants (EAs), resource consultants and special needs educators who work with 3- to six-year-olds within a childcare centre, early years program or any early learning and care setting. Within the context of this paper, managers, supervisors, directors and principals of early learning and care settings are also acknowledged by this term.

**Early development instrument (EDI):** a teacher-completed questionnaire that assess a child’s developmental profile across five domains: physical health and well-being, emotional maturity, social competence, communication skills and general knowledge and language and cognitive development (Early Development Instrument, 2016). The EDI is completed during the second half of the kindergarten school year.

**Effortful control:** an area of social-emotional development that allows a child to focus their attention and to inhibit an immediate response (Landy, 2009). Effortful control has been shown to be key to children’s academic achievement, positive teacher-child relationships and classroom participation (Valiente, Lemery-Chalfant, Swanson, & Reiser, 2008).

**Emotional regulation:** “sometimes called affect regulation, refers to the process by which people control or self-regulate internal reactions to emotions as well as their outward expressions” (Landy, 2009, p. 443). For infants and young children, caregivers play a key role in assisting and support the development of emotion regulation (Landy, 2009).

**Epigenetics:** the study of how environmental influences affect the expression of genes. Within the context of the current paper, understanding the process of epigenetics of young children is particularly important given the rapid rate of brain development that takes place during the earliest years. Early experiences cause epigenetic changes that influence whether, when and how genes give “instructions” for a child’s capacity to build health, skills and resilience (Center on the Developing Child, Harvard University, 2017).

**Executive function:** a higher level of cognitive functioning that allows a child to perform simple daily tasks such as concentrating, focusing on multiple tasks, controlling desires and setting a goal to achieve. It requires a set of skills that

depend on three types of brain function: working memory, mental flexibility and self-control (Center on the Developing Child, Harvard University, 2017).

**Expulsion:** a form of disciplinary action with no time limit, restricting a child from participating in school activities or visiting school grounds. Students may be expelled from their own school or all schools within the school board (Ontario Ministry of Education, 2018).

**Externalizing behaviours:** refers to outwardly exhibiting challenging behaviour(s) and may reflect negative responses to peers, educators or their environment (Liu, 2004). Behaviours include inattention, hyperactivity, impulsivity, aggression, emotional lability, low frustration tolerance, non-compliance and oppositional behaviour (Gilliam et al., 2016; Havighurst, Wilson, Harley, Kehoe, Efron, & Prior, 2013; Dobbs & Arnold, 2009; Williford, Wolcott, Whittaker, & Locasale-Crouch, 2015).

**Health and allied health professionals:** select professionals such as psychiatrists, psychologists/psychological associates, speech and language specialists, audiologists, physiotherapists, occupational therapists, social workers, child and youth workers, public health nurses, nutritionists, dieticians, child health consultants, home visitors and family support workers.

**Infant and early childhood mental health:** “the capacity of a child to form close/secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment — all in context of family, community, and culture” (Cohen, Oser, & Quigley, 2012, p.1). Throughout this paper, we will be using the terms early mental health and social-emotional development interchangeably.

**Internalizing behaviours:** internalized behaviours are difficult to observe as they vary from child to child and are not as overtly expressed. They include, but are not limited to, withdrawn behaviour, anxiousness, extreme shyness, perfectionism and sadness (Gilliam et al., 2016).

**Modified participation or delayed school start:** a strategy used within early learning, care settings, and formal education as a response to challenging behaviour(s). Families may be asked to transition their child slowly (half-days, few hours per day or part time during the week). Within the context of this paper, modifications also included the promoting self-regulation, having the child arrive to class at a quieter time, exercising flexibility around program expectations, promoting increased parental/caregiver involvement, having increased one-on-one support for the child or using child-specific plans.

**Policy-makers:** within the context of this paper, refers to lead members from provincial agencies such as the Ministry of Health and Long-Term Care and the Ministry of Education.

**Protective factors:** characteristics associated with reducing the impact of risk factors. Protective factors can increase resiliency to adverse situations (Beckwith, 2000).

**Preconception stressful life events (PSLEs):** maternal stressors (i.e. environmental, social, psychological, genetic) factors prior to conception which have an impact on a developing baby (Witt et al., 2014). Examples include, but are not limited to, neighbourhood disadvantage, domestic violence and prior or current maternal mental/physical health illnesses.

**Resilience:** the ability to recover from traumatic events/experiences and thrive in the face of adversity. Every child is born with resiliency, but it is built through positive relationships and a secure attachment. (National Scientific Council on the Developing Child, 2012).

**Risk factors:** biological, psychological, family, community or cultural factors that increase the probability of poor developmental outcomes (Beckwith, 2000).

**School mental health leaders/professionals:** registered social workers, psychologists or psychological associates, whose role is to assist with the development and implementation of the Board Mental Health and Addictions Strategy (School Mental Health Ontario, 2019).

**Self-regulation:** the ability to modulate emotions and behavioural responses to contextual demands. It develops over time with the presence of a supportive and buffering caregiver relationship (National Scientific Council on the Developing Child, 2012; Chang, Shaw, Dishion, Gardner, & Wilson, 2014). Self-regulation is an important skill that can mitigate problem behaviours and can be a protective factor against mental health disorders (Chang et al., 2014).

**Social-emotional development:** “the capacity of a child to form close/secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment — all in context of family, community, and culture” (Cohen, Oser, & Quigley, 2012, p.1). Also referred to as infant and early childhood development. Both terms used interchangeably within the paper.

**Social determinants of health:** the societal and economic factors that can profoundly influence individual health and mental health outcomes (Canadian Mental Health Association, 2018). These determinants include race, gender, disability, Indigenous status (i.e. the impact of colonialism on families and caregiving practices, and the related

intergenerational trauma prompted by this), income and income distribution, education, employment and job security, housing, food security, social exclusion, health services, social safety net and early childhood development (Mikkonen & Raphael, 2010).

**Social-emotional learning (SEL):** the process by which children and adults learn and effectively apply knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and engage in responsible decision making (Collaborative for Academic Social, and Emotional Learning, 2019). It is an effective and evidence-based approach to promoting positive mental health and improving developmental outcomes of young children.

**Stakeholders:** individuals that contribute valuable knowledge and expertise surrounding social-emotional development of Ontario’s three- to six-year-olds including parents/caregivers, early learning and care educators, health and allied health professionals and ministry personnel.

**Suspension:** a disciplinary action, in response to a child’s challenging behaviour(s). Refers to removal of a student from their school setting for a certain time frame (i.e. 1–20 school days) Student is asked to remain off school grounds and refrain from participation in school activities (Ontario Ministry of Education, 2018).



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# Appendix A: Methodology for literature review

## Inclusion and exclusion criteria:

INCLUSION CRITERIA	EXCLUSION CRITERIA
English	
Three to six years old	
Articles from 2007 to 2017	
Interventions (for best practice)	Prevention or universal studies
Types of intervention: Dyadic group Caregiver Classroom-based Home-based Community-based Randomized control trials	Rebirthing, holding, coerced eye contact
Improvement in: Development Parent child relationship Teacher’s perspective of behaviour Academic achievements	

## Databases:

- ERIC
- Psych-Med
- Medline
- PubMed
- Cochrane Library
- ProQuest

In addition, the team will explore social media platforms and news coverage.

## Key terms:

### Three- to six-year-old mental health

- promoting school readiness/resilience in early years/early childhood/preschool/kindergarten
- promoting social-emotional development in childcare/preschool/kindergarten/ early years/early childhood/
- promoting infant mental health in childcare/preschool/kindergarten/early years/early childhood
- parent-child relationships in the early years/early childhood
- teacher training on self-regulation/social-emotional development
- professional learning
- capacity building
- building attachment in childcare/preschool/kindergarten/early years/early childhood
- interventions in kindergarten/preschool/childcare for challenging behaviours

- interventions in kindergarten/preschool/childcare for difficult behaviours
- treatment in kindergarten/preschool/childcare for challenging behaviours
- treatment in kindergarten/preschool/childcare for difficult behaviours
- regulation difficulties in kindergarten/preschool/childcare
- dysregulation difficulties in kindergarten/preschool/childcare
- school suspension in kindergarten/preschool/childcare
- school expulsion in kindergarten/preschool/childcare
- modified school days in kindergarten/preschool/childcare
- delayed school start in kindergarten/preschool/childcare
- mental health three-/four-/five-/six-year-olds
- mental health three- to six-year-olds
- difficult behaviour in kindergarten/preschool/childcare
- challenging behaviour in kindergarten/preschool/childcare
- aggressive behaviour in kindergarten/preschool/childcare
- non-compliant behaviour in kindergarten/preschool/childcare

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## Appendix B: Survey tools

### EARLY LEARNING AND CARE SURVEY

1. What is your professional role?

- Registered early childhood educator
- Resource consultant (child care settings)
- Educational assistance
- Junior kindergarten teacher
- Senior kindergarten teacher
- Principal
- Special needs teacher
- Supervisor/Director of an early years program (child care, OEYC)
- Public health nurse
- Other \*(Please specify your response in the space below)

2. How many years have you worked in this profession?

- Under 6 months
- 6 months to 1 year
- 1–3 years
- 3–5 years
- More than 5 years

3. What city or town do you work in?

4. Among those working within your program/setting, the following definition was developed and is used when referring to infant and early mental health:

Infant and early childhood mental health, sometimes referred to as social and emotional development, is the developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community, and culture (Cohen, Oser & Quigley, 2012, pg. 1).

With this definition in mind, to what extent do you support children’s social-emotional development in your current program/setting? \*(Please check one item from the list below.)

- Almost always
- Often
- Sometimes
- Seldom
- Never

5. When working with children between three to six years of age in your program/setting, how well prepared do you feel they are to participate in your program/setting in terms of social-emotional development? \*(Please check one item from the list below.)

- Almost always
- Often
- Sometimes
- Seldom
- Never

6. What current practices, strategies or programs do you use to support social-emotional development in your program/setting? (Please select ALL that apply.)

- Reading books with children about managing emotions, building relationships and communication, etc.
- Role play with puppets or dolls to teach children about problem solving, sharing, relationship building, etc.
- Using developmentally appropriate language to guide children's interactions with peers and adults
- Including communication strategies in your program or setting \*(e.g. invite children to ask their peers how they are doing, use pictures of emotions to prompt conversation)
- Overall classroom management \*(change the environment and create spaces)
- Other (please specify):

7. In your experience, what are the most challenging behaviours you have observed with this age group in your program/setting? (Please select ALL that apply.)

- Difficulty standing still in a line
- Difficulty paying attention/focusing on one activity
- Aggressive behaviour(s)
- Difficulty listening to and following instructions
- Difficulty separating feelings from actions
- Difficulty controlling impulsive desires
- Difficulty expressing needs
- Difficulty expressing feelings using language
- Other (please specify):
- I have not observed or experienced any challenging behaviours with children

8. In your experience, what social and emotional challenges in young children do parents/caregivers attending your program/setting typically report as most concerning?\*( Please check ALL that apply.)

- Difficulty standing still in a line
- Difficulty paying attention/focusing on one activity
- Aggressive behaviour(s)
- Difficulty listening to and following instructions
- Difficulty separating feelings from actions
- Difficulty controlling impulsive desires
- Difficulty expressing needs
- Difficulty expressing feelings using language
- Other (please specify):
- I have not come across a parent or caregiver who has expressed concerns about their child's/ children's challenging behaviour

9. What types of supports and programs are currently available in your community to help parents and caregivers support early social-emotional development?\*( Please check ALL that apply).

- Workshops delivered by:
  - Schools
  - Child care
  - Hospitals
  - Public health
  - EarlyON programs (e.g. drop-in centres, hubs)
  - Other (please specify):
- Children's mental health or family services in your community
- Drop-in programs (e.g. at an Early Years Centre)
- Walk-in clinics
- Developmental screening
- Infant development programs
- Speech and language therapy
- Occupational therapy
- Hospitals
- Other\*(please specify):

10. When you make referrals which of the following do you make most often?

- Children's mental health or family services in your community
- Drop-in programs (e.g. at an Early Years Centre)
- Walk-in clinics
- Hospitals
- Family physician/clinic
- Childcare
- Other\* (please specify):

11. Based on your experience, to what degree is your confidence to support families of children between three to six years old and their child's early social-emotional development?\* (Please check ONE item from the list below.)

- High
- Moderate
- Low
- None
- I'm not sure

12. Within your community, how familiar are you with the supports and resources available to parents in their community that can help them support their child's social-emotional development?\* (Please check one item from the list below.)

- Extremely
- Very
- Moderately
- Slightly
- Not at all

13. When children experience difficulty in your program/setting, is it a common practice to modify their participation in some way? For example, deferring program start, attending partially each day, etc.

- Almost always
- Often
- Fairly frequently
- Infrequently
- Never

Please elaborate:

14. What type of concerns can lead to modification of a child's participation in your program/setting?

- Challenges with regulating emotions
- Difficulty standing still in a line
- Difficulty paying attention/focusing on one activity
- Aggressive behaviour(s)
- Difficulty listening to and following instructions
- Difficulty with expressing needs or feelings
- Inability to follow instructions
- Other (please specify in the space below):

15. What supports are available to you when a child demonstrates challenges with social and emotional development in your program or setting?

- Special needs teacher
- Resource consultant
- Supervisor, director or manager in charge
- Outside specialists (e.g. mental health specialist, psychologist, social worker, public health nurse)
- Additional staffing
- Other\* (please specify):

16. When concerned about a child's social-emotional development what steps do you take in response?

## HEALTH AND ALLIED HEALTH PROFESSIONAL SURVEY

### 1. What is your professional role?

- Psychiatrist
- Psychologist/psychological associate
- Child and youth worker
- Social worker
- Mental health counselor
- Public health nurse
- Nutritionist
- Dietitian
- Home visitor
- Physiotherapist
- Occupational therapist
- Family support worker
- Child health consultant
- Other \*(Please specify your response in the space below)

### 2. How many years have you worked in this profession?

- Under 1 year
- 1–5 years
- 5–10 years
- 10–15 years
- More than 15 years

### 3. What city or town do you work in?

### 4. Among those working within the infant and early mental health sector, the following definition was developed and is used when referring to infant and early mental health:

Infant and early childhood mental health, sometimes referred to as social and emotional development, is the developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community, and culture (Cohen, Oser & Quigley, 2012, pg. 1).

Keeping this definition in mind, what practices, strategies or programs do you currently use to support social-emotional development for three- to six-year-olds in your setting? (Please check ALL that apply and specify in the space provided.)

- Treatment programs \_\_\_\_\_
- Intervention strategies \_\_\_\_\_
- Referral to other specialist(s) \_\_\_\_\_
- Referral to child welfare agencies  
\_\_\_\_\_
- Family therapy \_\_\_\_\_
- Child centred play therapy \_\_\_\_\_
- Child-teacher relationship training  
\_\_\_\_\_
- Early childhood mental health services/consultation  
\_\_\_\_\_
- Mindfulness-based stress reduction  
\_\_\_\_\_
- School-readiness programs \_\_\_\_\_
- Other\* (please specify): \_\_\_\_\_

### 5. In your experience, what are the most challenging behaviours you have observed with this age group in your program? (Please select ALL that apply.)

- Difficulty standing still in a line
- Difficulty paying attention/focusing on one activity
- Aggressive behaviour(s)
- Difficulty listening to and following instructions
- Difficulty separating feelings from actions
- Difficulty controlling impulsive desires
- Difficulty expressing needs
- Difficulty expressing feelings using language
- Other (please specify):
- I have not observed or experienced any challenging behaviours with children

6. In your experience, what social and emotional challenges in young children do parents/caregivers attending your program typically report as most concerning? (Please select ALL that apply.)
- Difficulty standing still in a line
  - Difficulty paying attention/focusing on one activity
  - Aggressive behaviour(s)
  - Difficulty listening to and following instructions
  - Difficulty separating feelings from actions
  - Difficulty controlling impulsive desires
  - Difficulty expressing needs
  - Difficulty expressing feelings using language
  - Other (please specify):
  - I have not come across a parent or caregiver who has expressed concerns about their child's/ children's challenging behaviour(s)
7. In your setting, what are the most common concerns why three- to six-year-old children are referred to your services? (Please select ALL that apply.)
- Difficulty with regulating emotions
  - Difficulty standing still in a line
  - Difficulty paying attention/focusing on one activity
  - Aggressiveness
  - Difficulty listening to and following instructions
  - Difficulty expressing needs or feelings
  - Dysregulation of behavior
  - Other (please specify in the space below):
8. What types of supports and programs are currently available to help parents support early social-emotional development?
- Workshops
    - o Schools
    - o Child care
    - o Hospitals
    - o Public health
    - o EarlyON programs (e.g. drop-in centres, hubs)
    - o Other (please specify):
  - Drop-in programs (e.g. at an Early Years Centre)
  - Children's mental health centres
  - Developmental screening
  - Infant development programs
  - Speech and language
- Occupational therapy
  - Psychotherapy
  - Other\* (Please specify):
9. In addition to the supports and programs you offer, what other services might you recommend to help professionals support early social-emotional development?
- Workshops
    - o Schools
    - o Child care
    - o Hospitals
    - o Public health
    - o EarlyON programs(e.g. drop-in centres, hubs)
    - o Other (please specify):
  - Drop-in programs (e.g. at an Early Years Centre)
  - Children's mental health centres
  - Developmental screening
  - Infant development programs
  - Speech and language
  - Occupational therapy
  - Psychotherapy
  - Other\* (please specify):
10. When you make referrals which of the following do you make most often?
- Children's mental health or family services in your community
  - Drop-in programs (e.g. at an Early Years Centre)
  - Walk-in clinics
  - Hospitals
  - Family physician/clinic
  - Childcare
  - Other\* (please specify):
11. Aside from the treatment or intervention and services you provide, what additional supports might you recommend when concerned about social-emotional development in a child between three to six years old?\* (Please check ALL that apply.)
- Speech and language therapist
  - Occupational therapist
  - Hearing services

- Child Care
- Infant development
- Developmental screening
- Developmental pediatricians
- Other\* (please specify in the space below):

12. Have you ever completed a developmental screening questionnaire for a child between the ages of three to six? For example, the Ages and Stages Questionnaires (ASQ: 3R and ASQ-SE).

- No
- I am not sure
- Yes (please specify what type and where):

13. If you answered yes to the question above, how often are you using these tools to screen for challenges in early mental health?

- Never
- Seldom
- Sometimes
- Often
- Almost always

14. If a child participating in your program has experienced/is experiencing modified day or partial participation in a program/setting because of challenges with his/her behaviour, what did this process look like? (For example, were supports offered to child and family during the modified day, suspension or expulsion; as well, when the child returned to the program?) (Please use the space below to answer).

## PARENT/CAREGIVER SURVEY

1. Please indicate the age of your child, keeping in mind this child when completing the survey.

- 3 years old
- 4 years old
- 5 years old
- 6 years old

2. Please indicate your child's gender.

- Male
- Female
- Other

3. Has your child been referred to a service or received additional support for social-emotional development, behavioural challenges, language development, or mental health concerns?

- Yes
  - o Please tell us more: why your child was referred, to whom your child was referred to and what type of support(s) did your child receive?
- No
- I'm not sure

4. Are you or your child currently receiving any services or additional supports (i.e. children's mental health, family services, drop in programs, walk in clinics etc.)
- Yes; I am receiving services or additional supports
  - Yes; my child is receiving services or additional supports
  - Yes; both my child/children or myself are receiving services or additional supports
  - No; neither my child/children or myself are receiving services or additional supports
5. Is your family/child currently receiving any of the following services or additional supports? (Check ALL that apply.)
- Children's mental health or family services in your community
  - Drop-in programs (e.g. at an Early Years Centre)
  - Walk-in clinics
  - Developmental screening
  - Infant development programs
  - Speech and language
  - Occupational therapy
  - Hospitals
  - Other\* (please specify):
  - My child is currently on a wait list for additional support services
    - Please explain the type of service and how long the estimated wait period is:
6. In addition to activities within the home or with friends, do you access any of the following supports? (Please check ALL that apply.)
- Bring my child to programs like early learning centres and other age specific offerings
  - Attend parent/caregiver workshops geared to my child's developmental ages and stages
  - Attend specific programs for child social and emotional development
  - Bring my child to mindfulness programs or yoga
  - Other (please specify):
7. This age group of children can present some challenging behaviours. Please indicate what behaviours are difficult or raise concern with your three- to six-year-old? (Please select ALL that apply.)
- Difficulty standing still in a line
  - Difficulty paying attention/focusing on one activity
  - Aggressive behaviour(s)
  - Difficulty listening to and following instructions
  - Difficulty separating feelings from actions
  - Difficulty controlling impulsive desires
  - Difficulty expressing needs
  - Difficulty expressing feelings using language
  - Other (please specify):
  - I have not observed or experienced any challenging behaviours with my child
8. How often do you find it challenging to manage your child's behaviour?
- Almost always
  - Often
  - Sometimes
  - Seldom
  - Never
9. Where do you tend to observe the challenging behaviours that you identified in question no. 8? (Select ALL that apply.)
- At home (please specify):  
\_\_\_\_\_
  - In the community (i.e. playing at the park, while out shopping or running errands, attending social gatherings; please specify):  
\_\_\_\_\_
  - When attending programs (please specify):  
\_\_\_\_\_
  - When attending child care/school (please specify):  
\_\_\_\_\_
  - Other (please specify):  
\_\_\_\_\_
  - I have not observed challenging behaviours with my child

10. In your community, where can you go to get information about social-emotional development for your three- to six-year-old(s)? (Please select ALL that apply.)

- My local community centre
- Public libraries
- My family doctor or child's pediatrician
- The staff at my child's care setting
- My friends and family
- Workshops
- Early Years Centres
- Children's mental health centres
- Drop-in programs
- School readiness programs
- I'm not sure where to get this information
- Online, websites or social media (please specify):
- Other (please explain):

11. As a parent or caregiver, how useful are the services and additional supports that are available for your child for supporting their social-emotional development?

- Very useful
- Somewhat useful
- Not that useful
- Not useful at all

12. Has your child ever participated in a structured program with other children (e.g. childcare, school, or other group program)?

- Yes
  - Please specify what type of program and how often your child attends:
- No

13. If your child has participated in a structured program, have you ever been asked to withdraw or modify your child's participation in that program because of challenges with his/her behavior? (For example, wait to return to school, later/delayed start date, attend half days, temporally suspended, expelled, etc.)

- No
- Yes (please let us know what happened, why and how your child's participation was modified)

14. If you have been asked to withdraw or modify your child's participation in a structured program, were you provided advice or support? (Please check ALL that apply.)

- No, nothing was provided to me.
  - Please explain:
- Yes, I was given feedback and support to help my child
- Yes, I was provided with a list of resources to contact on my own
- Yes, I was provided with support and referrals for other services that I did not need to reach out to on my own
- Yes, I was provided additional advice or supports not listed.
  - Please tell about this:
- I feel that my child's program staff went above and beyond to try to support me and my child
  - Please tell us what happened:

If you have another child between the ages of three to six who you would like to keep in mind when completing this survey, please fill out another survey for that specific child.

## POLICY-MAKER AND MINISTRY STAFF SURVEY

1. Please tell us which Ministry and department you represent:

2. Social-emotional development is defined as:

Infant and early childhood mental health, sometimes referred to as social and emotional development, is the developing capacity of the child from birth to five years of age to form close secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community, and culture (Cohen, Oser & Quigley, 2012, pg. 1).

Keeping this definition in mind, and the work within your ministry, please tell us your opinion on the current challenges related to ensuring the healthy social-emotional development of Ontario's 3- to 6-year-olds. Please select all that apply and provide additional comments below

- Challenges related to recruiting trained staff with a solid foundation in early learning and care
- Ensuring appropriate education and professional development related to development in 3- to 6-year-olds.
- Ensuring appropriate education and professional development related to the unique mental health needs of 3- to 6-year-olds.
- Difficulty establishing clear knowledge and support needs for this group of children
- Difficulty translating policy into practice as it relates to this group of children
- Other:

Please provide additional comments as required:

3. Are there specific practices related to support needs you would like to explore?

- 1) \_\_\_\_\_  
2) \_\_\_\_\_

4. A review of literature will provide a synopsis of the following:

- What is known about the development of mental health in young children three to six years of age.
- How early mental health influences a child's mental and physical well-being in the short term and the long term.

- How vulnerability for poor mental health can be recognized in three to six-year olds.
- What strategies or interventions have proven to be successful when responding to young children who may be indicating a vulnerability for poor mental health.

What are we missing? What additional elements should we explore?

5. The following methods will be used to develop the policy paper:

- A review of literature
- Key informant interviews with stakeholders from the Ministry of Child and Youth services, Ministry of Education, parents, practitioners, educators, school and community mental health professionals, policy makers, organizational leaders
- Practitioner and parent online surveys

Are there any other groups that need to be engaged as part of this work?

6. From a policy perspective, are there any other policy related issues or initiatives we should look at further?

7. What are the policy challenges?

8. What kind of information would be helpful in their policy role specific to early mental health as a policy maker?

9. As you pick up this policy paper what are you hoping to get out of this — what are your needs and hopes for this paper?

10. What modality would be most useful and ensure the uptake of the information (i.e. in-person presentation, webinar, executive summary, think tank)?

11. Please provide any additional thoughts/ recommendations you have for us as we begin this important work.

# Appendix C: Interview guides

## EARLY LEARNING AND CARE LEADER QUESTIONS

Name:

Date:

Organization:

Position:

City/town in which you work:

Social-emotional development is defined as:

Infant and early childhood mental health, sometimes referred to as social and emotional development, is the developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community, and culture (Cohen, Oser & Quigley, 2012, pg. 1).

1. Keeping this definition in mind, what are the most frequently occurring mental health challenges you have observed within your organization for children three to six years old?
2. What are the behaviours that accompany those frequently occurring mental health challenges for this age group? (i.e. If aggression is frequently occurring, please describe the forms of aggression reported to you such as, biting, hitting with objects, pushing etc.)
3. In your organization do you have a specific strategy/focus/initiative to support early mental health in children between the ages of three to six years?
4. If yes, please describe the strategy/focus/initiative?
5. What qualifications do you expect staff to have specific to supporting early mental health within your organization?
6. What specific knowledge, skills and training do the professionals (ECEs, teachers, teaching assistants etc.) in your organization have to recognize mental health concerns in children three to six years old?
7. Does your agency provide ongoing training on early mental health?
8. If yes, what is provided and how often is it available?
9. How does your organization connect with other services/agencies that may continue to be involved with the mental health of a child three to six years of age?
10. What types of supports are available within/outside your organization for you when there is concern about a child's mental health between the ages of three to six?
11. What types of supports are available in your organization for families and caregivers when there is concern about a child's mental health between the ages of three to six?
12. What do you feel are the biggest barriers to providing optimal early mental health and support to children three to six years old?
13. For those who arrive at your organization with a diagnosis or a concern about the child's mental health, is there a process to connect with the agencies that may have provided care to that child prior to the organization they are currently attending (child care, OEYC, family literacy centres, child welfare etc.)? If so, what does this look like?
14. Is support in early mental health for children three to six years of age a primary focus of your role in your organization?
15. For those children three to six years of age with ongoing early mental health concerns (some of whom may or may not have a diagnosis), what approach is taken by your organization to provide treatment, intervention or connect the family or child with the appropriate services?
16. Do you include a developmental screen questionnaire for children three to six years old in your registration process? If yes, is it possible to get a copy?

## HEALTH AND ALLIED HEALTH PROFESSIONAL QUESTIONS

Name:

Date:

Organization:

Position:

City/town in which you work:

Social-emotional development is defined as:

Infant and early childhood mental health, sometimes referred to as social and emotional development, is the developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community, and culture (Cohen, Oser & Quigley, 2012, pg. 1).

1. Keeping this definition in mind, what are the most frequently occurring mental health challenges you have observed for children three to six years old?
2. Is support in early mental health for children three to six years of age a primary focus of your role in your organization?
3. In your agency/organization do you have a specific strategy/focus/initiative to support early mental health in children between the ages of three to six years?
4. If yes, what does that look like?
5. What qualifications do you expect staff to have specific to supporting early mental health within your organization?
6. Once within your organization, what specific knowledge, skills and training do you offer your staff to help them recognize and respond to early mental health for children three to six?
7. How does your organization respond to the concern raised about a child between the ages of three to six years within your organization?
8. How does your organization connect with other services/agencies that may continue to be involved with the mental health of a child three to six years of age?
9. At what point does a child leave service from your organization?
10. If you use a developmental screen questionnaire for young children, is it possible to get a copy?



## POLICY ADVISOR AND MINISTRY STAFF QUESTIONS

Name:

Date:

Organization:

Position:

City/town in which you work:

Social-emotional development is defined as:

Infant and early childhood mental health, sometimes referred to as social and emotional development, is the developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community, and culture (Cohen, Oser & Quigley, 2012, pg. 1).

1. Keeping this definition in mind, within your Ministry, please tell us what you have heard from colleagues or communities about current challenges related to ensuring the healthy social-emotional development of Ontario's three- to six-year-olds.
2. Is early mental health a priority within your Ministry? If yes, what initiatives are underway?
3. What is your understanding/knowledge about early mental health in children three to six years old?
  - Very good
  - Good
  - Fair
  - Poor
  - Very poor
4. What strengths and challenges are raised when supporting those in the community working with this age group?
5. Would you be interested to learn more about young children's mental health challenges and how to support healthy social-emotional development in children three to six years old? If yes, please explain what you would like to learn more about and how this will impact your future work.
6. Are there other colleagues/experts/parents/caregivers or professionals we should speak with?
7. In your opinion, what are some ways to improve or build capacity for children three to six across the province (compared to how things are now)?
8. What would be needed in order for this improvement to happen?
9. How can this policy paper support this?





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Mental Health