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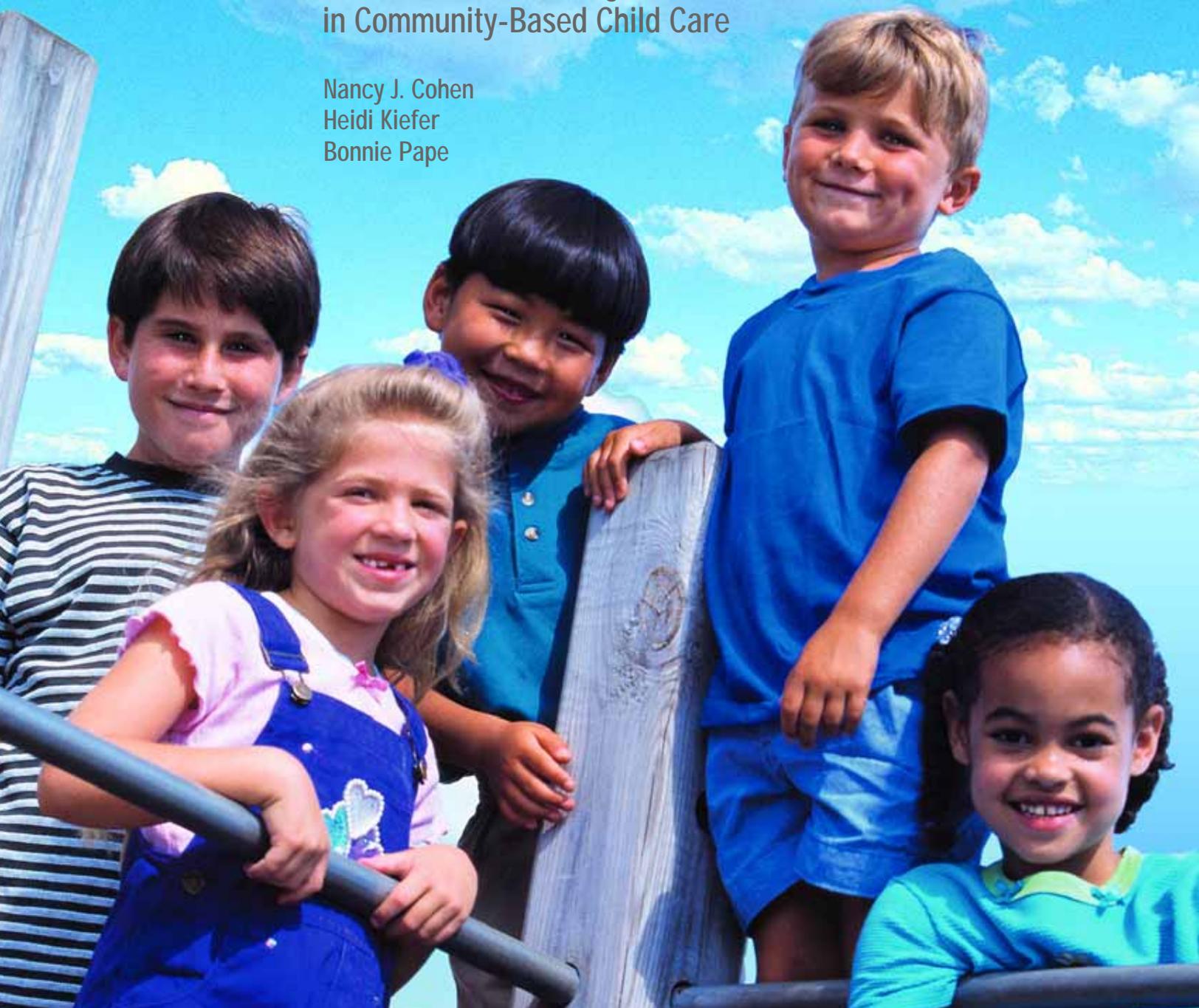## with Care

Strategies for Promoting the Mental Health of Young Children in Community-Based Child Care

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PARTICIPATING CHILD CARE CENTRES

British Columbia
Cariboo Child Care Centre, Kamloops
College of New Caledonia Demonstration
Day Care Centre, Prince George
Grandview Terrace Child Care Centre, Vancouver
Langara Child Development Centre, Vancouver
Plum Blossom, Vancouver
Simon Fraser University Child Care Society, Burnaby
University of British Columbia Child Care Services, Vancouver
West Wood Players Ltd., Port Coquitlam

Alberta
Churchill Park Child Development Centre, Calgary
City West Day Care, Edmonton
Edmonton Northwest Child Care Centre, Edmonton
Fulton Child Care Association, Edmonton
Jasper Place Child and Family Resource Society, Edmonton
Louise Dean Child Care Centre, Northwest Calgary
Marlborough Day Nursery, Calgary
Primrose Place Family Centre, Edmonton
Red Deer Day Care, Red Deer
Southview Child Care, Edmonton

Saskatchewan
Children's Choice Child Development Centre, Prince Albert
Families First Child Care Centre, Saskatoon
Kidzone Child Care, Regina
MacKenzie Infant Centre, Regina
Meadow Lake and Area Play Corner Centre, Meadow Lake
SIAST Children's Day Care Centre, Regina
Southwest Day Care Centre, Southwest Moosejaw
Wascana Day Care, Regina
YWCA Child Development Centre, Saskatoon

Manitoba
Care-A-Lot Nursery Inc., Winnipeg
Discovery Children's Centre Inc., Winnipeg
Knox Day Nursery, Winnipeg
Morrow Avenue Child Care Program for Families, Vital
Sunnyside Child Care, Winnipeg
Univillage Student Day Care, Winnipeg

Yukon
Ashea Day Care, Whitehorse
Child Development Centre, Whitehorse
Creative Play Day Care, Whitehorse
Dluwkat Hit Day Care, Teslin
Nakwaye Ku Child Care Society, Whitehorse
Tri'inke Zho Day Care, Dawson City

Northwest Territories
Northern Tikes Association, Yellowknife
Women's and Children's Healing and Recovery Program/Child Care Centre, Yellowknife

Ontario
Cardinal Leger Child Care Centre, Scarborough
Guildwood Child Care Centre, Scarborough
N'Sheemaehn Child Care, Scarborough
Owen Community Child Care Centre, North York
St. Bede Child Care Centre, Scarborough
Sunnybrook Creche, Toronto

Quebec
Centre de la Petites Enfants Les Bois Verts, Montreal
CPE Dorval, Dorval
CPE St. Mary's, Montreal
McGill Community Child Care Centre, Montreal
Royal Victoria Hospital Child Care Centre, Montreal
Saint Andrews Early Childhood Centre, Westmount
West End Day Care, Montreal

New Brunswick
Chatham Day Care, Miramichi
Energi Centre, Val D'amour
Garderie ABC Day Care, Moncton
Kindertots Children's Centre, Miramichi
Saint John YMCA Child Care Centre, Saint John

Nova Scotia
Apple Tree Landing Children's Centre, Canning
Bell Road Child Care Centre, Halifax
Boys and Girls Club Child Care Centre, Yarmouth
Children's Place Day Care, Antigonish
Cobequid Children's Centre, Lower Sackville
Creative Approach Preschool, Halifax
East Preston Day Care Centre, East Preston
Playschool Day Care, New Waterford
Point Pleasant Child Care Centre, Halifax
Sydney Day Care Centre, Sydney Cape Breton
Town Day Care, Glace Bay
Wee Care Developmental Centre, Halifax

Newfoundland
College of the North Atlantic Children's Centre, St. John's
Creative Beginnings Child Care Centre, St. John's
Daybreak Parent Child Centre, St. John's
Fisher's Children's Centre, Cornerbrook
The Children's Centre, St. John's

Prince Edward Island
Campus Kids Child Care Centre, Charlottetown
Child Development Centre, Charlottetown
Magic Moments Child Care Centre, Tignish
Montessori Kindergarten and Nursery School, Pool's Corner
The Kid's Place, Summerside

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EXECUTIVE SUMMARY

> *...child care is a labor problem, a social problem, a regulatory problem, an intergovernmental problem, an administrative problem, a community and of course a familial problem* – (Gormley, 1995)

Over the last decade, mounting evidence has made it clear that the foundations of mental health are shaped from the earliest days of life. Research has provided a deeper understanding about environmental influence on psychosocial development and how neural connections related to this critical area of development are formed. Widespread awareness of the importance of the first six years of life has led the Government of Canada to establish programs, research, and policies that meet the needs of young children and their families. A call for projects on early childhood care and development by Human Resources Development Canada (now Social Development Canada) stimulated us to undertake the *Handle With Care* project. The broad goal of this project is to raise the awareness of child care professionals, government, and parents about opportunities for centre-based community child care settings to promote the mental health of young children.

The need for out-of-home child care as a vital support for working parents is no longer questioned. Centre-based child care has been suggested as a particularly good site for mental health promotion given the large number of children enrolled and research delineating child care's potential impact on children's early development and family functioning. Using this setting for mental health promotion becomes an increasingly important topic given the growing number of children spending time in child care and especially the increasingly young age of these children. The project focuses on children in centre-based child care because it is the most common form of regulated non-parental child care.

There are at least three key reasons for paying greater attention to promotion of mental health in child care. First, Early Child Care and Education (ECCE) practitioners are increasingly concerned about children's mental health. Not only are more children entering the child care system at younger ages but many are also experiencing the effects of family instability, divorce, economic strain, child abuse and neglect, and exposure to negative community events. Second, an extensive body of research indicates that early disruptions in emotional development can have long-term negative consequences in terms of psychosocial functioning and learning. Third, social and emotional development are important to ensure that when children enter school, they are ready to learn. Child care has the potential of becoming one of the universal carrier systems, along with medicine,

public health, social services, and education that have regular and frequent contact with a large number of children.

Mental health promotion activities seek to enhance mental health and take into account the broad psychosocial factors that affect health. In particular, the goal of mental health promotion is to develop age-appropriate and culturally relevant life skills that have the potential to contribute to mental health. Specific to the present report, the case is made that mental health promotion for children in centre-based care is associated with good practices that foster children's social and emotional development, build family and community connections, and create a positive working climate for those in the child care field.

For the *Handle With Care* project, we undertook a review of the literature and carried out an environmental scan for which we interviewed both ECCE practitioners working directly with children and ECCE centre directors in 81 centres across Canada. Participating centres were recommended because of their reputation for integration of positive and useful practices related to mental health. The questions for the environmental scan interviews were drawn from information in the literature related to social and emotional development as well as advice from advisors. The following areas were explored in these interviews: **1)** building trusting relationships between practitioners and children; **2)** supporting individual characteristics and self-esteem; **3)** fostering independence and problem solving skills; **4)** encouraging understanding of and expression of emotions; **5)** respecting diversity and the rights of others; **6)** helping children build positive peer relationships; and **7)** helping children deal with changes and transitions. Due to the changing developmental needs of children, responses to the interview questions for infants, toddlers, and preschoolers were considered separately. Our interviews with ECCE practitioners across Canada indicated that mental health promotion tactics are frequently employed in child care settings although they are not typically labelled as such.

Descriptions about centres' policies and arrangements of the physical setting considered to underpin mental health promotion for young children were also solicited. Further, we asked about the ways that practitioners: **1)** interact with parents, **2)** support and respect a child's home language and culture, and **3)** receive support themselves in the work environment. The review shows how transactions between the children, parents, ECCE practitioners,

community, and society as a whole, are responsible for children's development.

The *Handle With Care* project has two products. One is this summary of recent literature relevant to the issue of mental health promotion in child care and consequent implications for policy. It encompasses knowledge about child development and characteristics of high quality child care. To highlight how theories can translate into practice, examples provided by practitioners who participated in the scan have been included. The second product of this project is a booklet intended for practitioners in the field. It summarizes practical techniques described in the scan interviews that we hope will be useful in all centres. Including two components (review and booklet) in this project creates a strong link between the theoretical and practical aspects of mental health promotion in child care.

In completing the scan interviews and compiling responses to prepare the booklet and this report, a number of important issues became clear. First, recognition of the diversity of culture, family backgrounds and life experiences of Canadian children makes the consideration of mental health promotion complex. While we consistenly encourage practitioners to acknowledge and respect different family characteristics and choices, we must concede that many examples of suggestions presented here and in the booklet may not be consistent with all family and cultural expectations and practices. Practitioners are advised to be responsive to individual children and their circumstances. In fact, a flexible approach that accomodates the particular needs of children's is just as important as the actual strategies practitioners use. Connected to this, use of the term "parents" is meant to include parents and/or other adults in children's home lives that influence their development and may have interactions with child care centres. Ongoing transactions between the child, parent, ECCE practitioners, community and society as a whole, are responsible for children's social and emotional development.

The review begins with an overview of the project and introduction of terminology and issues in Chapter 1. Then, the child care research literature informing us about factors that influence outcomes for children in centre-based child care is reviewed with a focus on areas of development most pertinent to mental health (Chapter 2). In this context, factors that enhance mental health as well as those factors that undermine mental health are examined. The review then turns to a description of the current child care scene in Canada including the statistics and standards of child care settings and practitioners (Chapter 3). In Chapters 4 to 6, what we consider as the cornerstones of efforts to promote mental health among children in centre-based care will be examined more fully. In Chapter 4, we

describe the developmental characteristics and developmental needs of young children in three age periods from infancy to age 5 (infant, toddler, and preschool periods). We then go on to consider indirect effects on promoting children's mental health through child care centres practitioners' relationships with parents and centres' collaboration with community resources (Chapter 5). Then, in Chapter 6 we examine how the quality of the work environment for practitioners working directly with children and directors contribute to children's mental health. The final chapter of the report (Chapter 7) pulls together themes in the report to draw implications for policies and practices concerning mental health promotion in centre-based child care. Paramount to this is the recognition that no coherent policy has been established that encompasses the myriad of interrelated factors linked to supporting children's mental health in child care. This chapter concludes with a list of recommendations arising from the review.

Recommendation 1: Given both labour market forces and individual choices of working women, child care spaces for children from infancy onward should be increased and representatively distributed in all regions throughout Canada.

Recommendation 2: High quality centre-based care is essential for promoting children's mental health. There is now ample evidence of the characteristics necessary for setting standards and regulations that ensure high quality centre-based care for children from infancy onward. All provinces and territories need to take leadership in contributing to a coherent and coordinated national policy supporting mental health promotion in early childhood education and care. This must be done with guidance from and collaboration with the federal government.

Recommendation 3: Within child care centres a special emphasis must be placed on setting guidelines for optimizing practitioner: child ratios. This is essential to mental health promotion as it emphasizes the needs of children for both warm supportive relationships and for relationships with specific practitioners who are sensitive to children's individual characteristics and needs.

Recommendation 4: Information on opportunities for mental health promotion in daily activities in child care should be widely circulated.

Recommendation 5: Policies that recognize adults' needs in child care must be established nationwide. This is as important as recognizing children's needs.

Recommendation 6: There is tremendous variation across provinces in the educational requirements for ECCE practitioners. ECCE education, specifically, has consistently been associated with

child care quality. Therefore, ensuring that staff meet high educational requirements is essential. Improving the educational status of ECCE practitioners goes hand in hand with improving their status, working conditions, and access to ongoing professional development in promoting children's mental health.

Recommendation 7: Families are inevitably affected by their children's child care arrangements that, in turn, can influence children's mental health. Guidelines need to be set for collaboration between practitioners, parents, community resources, and multicultural communities as an essential component of promoting the mental health of young children.

Recommendation 8: Federal and provincial funding is needed to increase the availability of child care, to ensure universally high quality child care through a comprehensive certification process, and to improve practitioners' education, salaries, and working conditions.

Recommendation 9: The federal government, through Social Development Canada, has made a commitment to funding research on child care. This ongoing commitment is applauded and further research on topics related to mental health promotion in child care is strongly encouraged.

These specific recommendations should be considered in light of an announcement in the recent 2004 federal budget of a commitment of $5 billion for child care over the next 5 years. This increased funding is intended to allow for expansion of the availability, accessibility, affordability, and quality child care services. How this commitment plays out in the provinces and territories will be important to watch.

CHAPTER 1:
Introduction

Purpose of this Project

The *Handle With Care* project was undertaken to consider how policies and activities relating to centre-based child care have the potential to promote the mental health of young children. The growing knowledge base about the developmental needs of young children in child care, and the growing trend toward child care for infants and toddlers, combine to make this a critical issue at the present time. The project focused on children in centre-based child care as it is the most common form of regulated non-parental child care. Research has identified characteristics of quality and experience that distinguish centrebased care from other forms of non-parental out-of-home care, such as family child care. Additionally, Canadian provinces and territories consistently separate regulations concerning these types of care.

Products of this Project

The products of this project were informed by both a review of the literature and an environmental scan for which we interviewed both Early Child Care and Education (ECCE) practitioners working directly with children and ECCE centre directors across Canada. One product is a summary of recent research literature relevant to the issue of mental health promotion in child care and implications for policy presented in this report. It encompasses knowledge about child development and about characteristics of high quality child care. Information from the literature, as well as advice from project advisors, helped us to formulate the list of questions for the environmental scan interviews with ECCE practitioners. In these interviews we asked about the policies and the specific practices and techniques used in the centres to promote mental health. Some examples from the interviews are included in the review to link theory and research with the existing practices. We also asked about perceived barriers to applying these practices. Together, the review of the literature and the responses from the environmental scan were used to create the second resource document of this project, a booklet intended for practitioners in the field. It summarizes the scientific bases for promoting mental health and practical techniques described in the scan interviews that we hope will be useful in other centres.

For the scan, ECCE practitioners from 81 centres across Canada were interviewed (see Table 1 for distribution of centres). Of the participating centres, 83% were non-profit. On average, 62 children were enrolled in each centre. In terms of the ages of children, 41% of the centres enrolled infants, 79% enrolled toddlers, and 94% enrolled preschoolers. The participating centres were recommended because of their reputation for integrating positive and useful practices related to mental health.

In the interviews with ECCE practitioners and directors we used a standard set of questions to inquire about the specific techniques relating to areas of social and emotional competence commonly linked to mental health. Because of the changing developmental needs of children, responses to the interview questions for infants, toddlers, and preschoolers were considered separately. The following areas were touched upon in these interviews: **1)** building trusting relationships between practitioners and children; **2)** supporting individual characteristics and self esteem; **3)** fostering independence and problem solving skills; **4)** encouraging understanding of and expression of emotions; **5)** respecting diversity and the rights of others; **6)** helping children to build positive peer relationships; and **7)** helping children deal with change and transitions. Descriptions of characteristics of the centres' physical environments and policies that underpin mental health promotion for young children were also solicited. As part of this, we asked about the ways that practitioners: **a)** interact with parents, **b)** support and respect a child's home language and culture, and **c)** receive support themselves in the work environment (*see Appendix I for the scan interviews*).

Knowledge Base

There is now widespread awareness that experiences in the early years set the stage for development and lifelong mental health. Research findings show that most of the brain's neural pathways supporting communication, cognition, social development, and emotional well-being grow rapidly in the first three years of life (Nelson, 1999). This brain development is influenced by multiple determinants including positive stimulation, nutrition, and nurturing. Using this knowledge, the period from infancy to early childhood can be considered a window of opportunity for enriching environmental input. Conversely, it can be considered a window of susceptibility to stressors such as family dysfunction, inadequate stimulation or care, and limited resources resulting from poverty (Cicchetti & Rogosch, 1996; Zeanah, Boris, & Larrrieu, 1997). For instance, the Canadian Institute of Child Health, in its recent report (*The Health of Canada's Children, Third Edition of the CICH Profile*, 2000), showcases mental health as an area of particular concern. Response to these concerns has been to promote optimal physical health, learning, and social and emotional adjustment as early as possible.

There is recognition that children are confronted earlier than ever before with issues and challenges that involve regulating their emotions, making friends, and dealing with conflict. The goal of mental health promotion is to develop age-appropriate and culturally relevant life skills that have the potential to

contribute to mental health. These include enhancing a range of individual characteristics, such as the capacity to: **1)** form secure attachment relationships; **2)** easily express emotions directly; **3)** acquire and use the social skills necessary for friendships and participation in group activities; and **4)** have a positive sense of self-esteem and self-efficacy. All of these factors will be included under the umbrellas of mental health and mental health promotion in this review. It is also important to acknowledge that age appropriate cognitive and language abilities are interrelated with children's mental health (Cohen, 2001; Breton, 1999).

Reasons for Mental Health Promotion in Centre-Based Child Care

There are at least three key reasons for paying greater attention to promoting mental health in child care. First, ECCE practitioners are increasingly concerned about children's mental health. Not only are more children entering the child care system at younger ages but many are experiencing the effects of family instability, divorce, economic strain, child abuse and neglect, and exposure to negative community events. Second, an extensive body of research indicates that early disruptions in emotional development can have long-term negative consequences in terms of social and emotional functioning and learning. Third, social and emotional development are important to ensure that when children enter school they are ready to learn (Knitzer, 2000). Thus, it is clear that fostering positive social and emotional development is essential for promoting mental health. Additionally, child care has the potential of becoming one of the universal carrier systems, along with medicine, public health, social services, and education that have regular and frequent contact with a large number of children.

Current Issues in Child Care

The need for out-of-home child care as a vital support for working families is no longer questioned. Due to an increase in the number of women in the work force from both dual earner and single parent families, a growing number of children are attending community child care centres (Lero, Pence, Goelman, & Brockman, l991; Doherty, Lero, Goelman, LaGrange, & Tougas, 2000). Currently there is also greater reliance on out-of-home child care not only for preschoolers but for infants and toddlers. In Canada, the labour force participation rate of women is 73% and, for mothers of children under the age of 3 years, 65.8% (Friendly, Cleveland, Colley, & Lero, 2003). Many of these women rely on the services of child care centres. Despite this, it is estimated that only 20% of children who require such care can be accommodated (Seifert, Canning, & Lindemann 2001). Accompanying this, there have been concerns about the impact that early and/or extended enrolment in child care might have on children's development, and particularly on their social and emotional development.

Concerns are heightened by the fact that families are faced with increasing stresses, such as divorce and the working status of single parents, that contribute to parents' decisions about whether to rely on child care. Matching family needs with child care services is now considered to be a factor contributing to overall family functioning. Families are inevitably affected by their children's child care arrangements which, in turn, can influence their children's development and mental health (Vandell, Dadisman, & Gallagher, 2000). As Gormley (1995) points out:

> *child care is a labor problem, a social problem, a regulatory problem, an intergovernmental problem, and administrative problem, a community and of course a familial problem."*

Conceptual Issues and Terminology Concerning Mental Health Promotion, Prevention, and Early Intervention

It is important to define terms central to the report and to place our work into the context of the broader field of children's mental health. *Mental health promotion* is often confused with other activities such as *prevention* and *early intervention*. The definition of mental health promotion adopted by the Canadian Mental Health Association encompasses activities delivered to the population as a whole as well as specific populations and settings. Mental health promotion activities seek to enhance mental health and take into account the broad psychosocial factors that affect health (Willinsky & Pape, 2002). Generally, mental health promotion activities: **1)** focus on enhancement of well-being as well as self-control and self-efficacy; **2)** are oriented towards taking action on the determinants of mental health; **3)** include a wide range of strategies such as communication, education, organizational change, community development, and local activities; and **4)** acknowledge and reinforce the competencies of the population or a population group.

Mental health promotion activities are distinguished from prevention activities which are focussed solely on children and families considered to be "at risk" and from early intervention activities that are directed at children and families with identified problems. It is important to acknowledge, however, that while the goals of mental health promotion, prevention, and early intervention are different, they are not mutually exclusive; even when a child is at risk or is already displaying some social and emotional problems, it is important, nevertheless, to promote mental health to prevent problems from becoming more severe or extensive (Magyary, 2002).

More specific to the present report, the case will be made that mental health promotion for children in centre-based care is

associated with good practices that foster children's social and emotional development, build family and community connections, and create a positive working climate for those in the child care field. Some indicators of positive mental health include a child's secure relationships with adults, ability to express emotions and to control emotions and behaviour to meet particular situations, confidence and sense of being unique, autonomy in making choices and problem solving, self motivation to explore and try new experiences, capacity for having fun, and ability to cope with change. Our interviews with ECCE practitioners indicated that mental health promotion tactics are frequently employed in child care settings although they are not typically labelled as such.

By including both a review of the literature and interviews with individuals working in the field, we hope to create a strong link between the theoretical and practical aspects of mental health promotion in child care. As will be shown throughout the report, the literature identifies early childhood as a critical time which influences children's overall development and has long-term consequences, including later mental health. Since centre-based child care presents a context with particular conditions that influence this stage of children's lives, mental health promotion should be an essential element in the provision of child care services, and policies and practices must be exercised accordingly. For example, as we will see in the review, the literature emphasizes the importance of ensuring early secure attachment relationships with primary caregivers, including ECCE practitioners. When we talked to practitioners they provided many examples of how they see operationalizing children's need for attachment security in the child care setting, even though they do not explicitly identify these practices as mental health promotion. The quotes from the environmental scan, inserted in this review, provide concrete examples of how the theories advanced in the literature are actually being implemented in childcare centres across Canada. This booklet, that is the second product of this project, builds on these examples and offers tips and ideas for how mental health promotion plays out on a daily basis. It highlights how broad areas of development can be considered and enhanced in everyday interactions with all children. Thus, it underlines the potential of child care centres to be places where a substantial number of children may be affected by promotion efforts. It also acts as a resource for practitioners to actively and consciously implement useful mental health promotion practices.

Prevalence and Persistence of Mental Health Problems

Epidemiological studies have shown that the prevalence rates for behavioural and emotional problems among preschoolers is similar to that found among older children, around 15-20% (Campbell, 2002; Richman, Stevenson, & Graham, l982; Silva, McGee, & Williams, l983). There are no data concerning the prevalence of mental health problems in infancy. This absence of information is striking because infants increasingly are being referred for mental health services because of abuse and neglect, and vulnerability to physical, emotional, and developmental disorders associated with medical conditions and biological factors (e.g., difficult temperament), socioeconomically disadvantaged environments, parent adjustment, and psychological problems that impede parenting such as maternal depression. Referrals for infant adaptive difficulties involving feeding, sleeping, and behavioural regulation also are common and it is now understood that these seemingly physical symptoms often have psychological underpinnings and reflect problems of infants in their relationships with important caregivers (Cohen, Muir et al., 2000). However, persistence of problems from infancy onwards appears to be related to having a history of adjustment problems and specific temperament factors relating to self regulation (Prior, Smart, Sanson, & Oberklaid, 2001).

The case for making efforts to promote mental health is strengthened by evidence that although some children's behaviour problems observed in early childhood lessen with age, a significant number of such problems persist into later childhood with oppositional behaviour and attentional problems being most persistent (Campbell, 2002; Lavigne, Arend, Rosenbaum, Christoffel, & Gibbons, 1998a,b 1998b; Prior et al., 2001). Data from longitudinal studies have demonstrated that children who show aggressive behaviour in the preschool years are at high risk for a range of antisocial behaviours later in childhood (Broidy et al., 2003). Moreover, there is evidence that even children who do not meet formal criteria for a social or emotional disorder, nevertheless, may be functionally impaired (Angold, Costello, Farmer, Burns, & Erkanli, 1999).

Understanding the Complexity of Children's Development

The mental health of children has been conceptualized as the outcome of a dynamic interplay between risk and protective factors (Prilleltensky, 1994). The work of developmentalists, such as Bowlby, Gesell, and Piaget has guided our understanding of critical events that take place during infancy and early childhood, a few of which include mother-infant attachment, emotion expression and regulation, social competence, and language development (see Bowlby, 1969; Gesell, 1928; Piaget and Inhelder, 1947; Watson, 1924). Research and clinical work have shown that experiences of the infant and young child provide the foundation for long-term physical and mental health. Children's educational needs and later life successes cannot be divorced from critical features of their early development

(Hernandez, 1997) which now typically includes out-of-home child care. We will be discussing the enhancement of areas of children's social and emotional development related to mental health promotion in Chapter 4.

Most researchers now share the perspective that developmental outcomes are the result of interactions between individual and environmental factors at a number of levels, as part of a larger ecosystem. In short, transactions between the child, parent/family, community, and institutions which influence children, and society as a whole, are responsible for children's developmental outcomes (Rae-Grant, 1994). While diverse variables have been identified as being associated with outcomes for children, there are multiple pathways and processes that determine patterns of adaptation and maladaptation (Cicchetti & Rogosch, 1996; Zeanah, et al., 1997). This variability in outcome is, in effect, a result of the combination of risk and protective factors at play in each particular child's life (Rae-Grant, 1994).

Risk Factors

Risk factors are variables found to increase the likelihood of intellectual delay, social and emotional disorders, or physical health problems in children and can be organized according to four headings: **1)** child characteristics, such as low birthweight, developmental delay, and difficult temperament; **2)** parenting practices and problems in the parent-child relationship, especially insensitive interactions with children; **3)** parental history and functioning such as family adversity and stress; and, **4)** socio-demographic and societal factors such as poverty and characteristics of the community in which children are living (Landy & Tam, 1998). A consistent finding has been that as the number of risk factors in a child's life increases, the negative effect is enlarged disproportionately (Sanson, Oberklaid, Pedlow & Prior, 1991).

Patterns of multiple risks are frequently identified as being endemic amongst families living under conditions of economic disadvantage. Economic disadvantage per se is not to blame but factors associated with disadvantage. These include unemployment or risk of unemployment, isolation, and a range of family stresses, health problems, and lack of resources, including limited quality child care, all of which increase the risk for mental health problems in both families and children. While the proportion of children living in poverty had decreased over the 1990s to 18.5% according to 1999 figures (Progress in Canada's Children: 2002 Highlights from the Canadaian Council on Social Development), it was still higher than the 15.2% reported in 1989 when the House of Commons unanimously committed itself to eliminate child poverty by the year 2000. In provinces with strong economic growth in the 1990s (i.e., Alberta and Ontario) the child poverty rate has fallen to the lowest levels in Canada, but the depth of poverty is greater than in most other provinces, which likely reflects deep cuts in social assistance rates in these provinces.

Protective Factors

Counterbalancing risk factors are protective factors, those conditions that contribute to successful adaptation and child resiliency when confronted with stresses or exposure to risk factors (Masten & Coatsworth, 1998). Protective factors fall into similar categories as risk factors: **1)** personal characteristics within the child such as high intelligence that helps a child not only to achieve academically but to have good problem solving skills, good social skills, and an easy going temperamental style; **2)** relationship and parenting factors that provide children with a secure relationship with a warm, caring, and empathetic adult; **3)** a favourable family environment including supportive parents, family closeness, and adequate rule setting; and **4)** a social environment, such as the child care setting, or community that reinforces and supports positive efforts made by a child (Landy & Tam, 1998; Werner & Smith, 1982). Salient in the conceptualization of protective factors is that, because they modify risk factors, they can function even in the presence of risk (Rae-Grant, 1994). It is these protective factors that are typically kept in mind when designing mental health promotion activities.

Reinforcing this is the fact that resilience is a dynamic rather than a fixed attribute and depends on opportunities as well as personal characteristics. Thus, for instance, exposing children to positive role models provides experiences that help children to develop personal characteristics necessary for learning, and positive interactions with peers and adults. As well, providing parents with opportunities to reduce stress in their lives by supporting their need for employment, disseminating information on parenting, and facilitating parents' sensitive interactions with their children enhances parents' skills and, thus, children's development. High quality child care also can be protective, helping children to maintain a steady developmental course.

Types of Risk and Protective Factors

Beyond considering the number of risk and protective factors, the types of factors at play are important (Sanson et al., 1991; Zeanah et al., 1997). Parenting variables are often identified as key factors in the development of children's emotional and behavioural difficulties. A lack of parental sensitivity, responsiveness and attunement to young children's cues and negative affect towards the child can lead to the development of an insecure attachment, which is a known risk factor for the development of later emotional and social difficulties (Ainsworth, Blehar, Waters, & Wall, 1978; Clarke-Stewart, 1988; Goldberg, 2000). Chronic family adversity and stresses have been found to correlate with attachment security, although researchers found variables related to parental personality problems to be the most powerful predictors of insecure attachments in children (Shaw & Vondra, 1993). Factors that interfere with the development of a positive parent-child relationship thus

also constitute developmental risks. Reasons for problematic parent-child interactions may include a lack of parenting information, maternal depression, mental illness, distorted parental attributions and a parent's unresolved loss or trauma (Landy & Tam, 1998). Children with a reduced level of parental stimulation or emotional support may exhibit social and emotional problems in childhood that are associated with behaviour problems later in life (Cohen & Beckwith, 1979; Lyons-Ruth, Alpern, & Repacholi, 1993). This is important in the context of this review because such family factors override many characteristics of child care experience in determining outcomes. At the same time, many of the essential characteristics of families are represented in adult-child relationships in the child care centres and these are important for children's mental health as well. Children can both benefit from good quality care and be negatively affected by poor quality care (Hungerford, Campbell, & Brownell, 2002), something that will be discussed more fully in Chapter 2.

Summary

There has been growing consensus amongst developmentalists and child educators that the early years offer a unique opportunity for influencing children's development and later lives. Numerous critical events take place during infancy and early childhood, such as parent-infant attachment, the beginning of the ability to self regulate emotions and behaviour and the emergence of language. Life experiences of the infant and young child form

the foundation for their later educational needs and overall well-being. Transactions between the child, parent(s), community, and society as a whole, are responsible for children's development. Consideration of factors that contribute to mental health of young children in centre-based child care, and discussion of techniques that can foster positive mental health, are therefore timely. Centre-based child care has been suggested as a particularly good site for mental health promotion given the large number of children enrolled and research delineating child care's potential impact on children's early development and family functioning.

Structure of the Review

To set the stage, we will begin the review with what the child care research literature tells us about factors influencing outcomes for children in centre-based child care with a focus on areas of development related to mental health (Chapter 2). In this context, factors that enhance mental health as well as those factors that undermine mental health are examined. The review will then turn to a description of the current child care "scene" in Canada including the statistics and standards of child care settings and practitioners (Chapter 3). In Chapters 4 to 6 we will examine what we consider the cornerstones of efforts to promote mental health among children in centre-based care. In Chapter 4, we describe the developmental characteristics and developmental needs of young children in three age periods from infancy to age 5 (infant, toddler, and preschool periods).

Completed Scan Centres – Distribution

	Infants	Toddlers	Infants & Toddlers	Pre-Schoolers	Totals
British Columbia	3	1	0	4	8
Alberta	2	4	2	2	10
Saskatchewan	1	2	0	6	9
Manitoba	1	0	1	4	6
Yukon Territories	0	3	0	3	6
Northwest Territories	0	0	0	2	2
Ontario	2	1	0	3	6
Quebec	1	2	0	4	7
New Brunswick	0	0	0	5	5
Nova Scotia	1	3	0	8	12
Newfoundland	1	2	0	2	5
Prince Edward Island	0	1	0	4	5
Totals	12	19	3	47	81

Centres are listed according to the age group with which interviewed ECCE practitioners most regularly work.
Information gathered from the interviews with practitioners and directors reflect their experience with these children.

Examples from our scan of practices that promote mental health in each of these age groups will be used by way of illustration. We will go on to consider indirect effects on promoting children's mental health through child care centres practitioners' relationships with parents and collaboration with community resources (Chapter 5). Then, in Chapter 6, we will look at the contribution of the quality of the work environment for ECCE practitioners and directors to children's mental health. The final chapter of the report (Chapter 7) will pull together themes in the report to draw implications for policies and practices around mental health promotion in centre-based child care.

CHAPTER 2:
What Research Tells Us About The Effects Of Out-Of-Home Care For Young Children

The need for centre-based child care is widely acknowledged. At the same time, the impact of such care on young children, and especially the extensive care of infants, has been controversial. Research done over the last decade has permitted examination of the multiple interrelated factors in the child, the family, and the child care setting that contribute to outcomes of young children enrolled in centre-based child care. In this chapter we will review this research with a particular focus on outcomes relevant to mental health. Detailed consideration of these multiple interrelated factors provides some of the information needed to think about opportunities that can be provided in centre-based care to promote the mental health of young children.

Historical Shifts in Child Care Research

To put the current research into perspective requires looking back to how questions surrounding the outcomes of children's experiencing out-of-home care have changed over the past 40 years.

Research in the 1960s and 1970s

Systematic evaluation of the outcomes of child care began in the 1960s and 1970s. During this period, research focussed on high quality university based child care centres or children who participated in child care programs intended as early interventions for children living in high risk conditions. The questions that were asked were limited to whether out-of-home child care was either beneficial or harmful for children and did not address the conditions that could affect these outcomes (Hungerford, Brownell, & Campbell, 2002).

Research in the 1980s

In the 1980s, researchers expanded the focus to distinguish characteristics of child care settings of varying degrees of quality. It was recognized that numerous aspects of the centre experience had the potential to influence children's development. Systematic measurement of child care quality became a priority leading to the development of the Early Childhood Environment Rating Scale (ECERS; Harms & Clifford, 1980). More recently, a comparable scale for infants and toddlers has been devised (Infant and Toddler Environmental Rating Scale; ITERS) (Harms, Clifford, & Cryer, 1998). The ECERS became the standard rating scale both for evaluating the environment of child care and for practitioners' self assessment.

The ECERS (and now the ECERS-Revised) measures and describes what high quality programs should look like in seven key areas: Space and Furnishings, Personal Care Routines, Language and Reasoning, Activities, Interaction, Program Structure, Parents and Staff. Research has shown that child care programs that achieve high ratings in each of these areas produce the best long-term outcomes for children. Some of the structural dimensions assessed with these scales are relatively straightforward to quantify (e.g., group size, adult-child ratio). However, the more complex process variables that denote the actual care received by children, and are most closely related to mental health (e.g., quality of practitioners' interactions with children), are less so. It is more difficult to achieve reliable and valid ratings on these relational indices.

Although the ECERS and ITERS scales continued to be refined and revised, they still only measured isolated factors. Conclusions tended to be based on correlations between certain factors and child outcome measures, with no study geared towards the various interactions of factors. Research during this period also did not take either contextual variables or characteristics of children into account. Additionally, the majority of studies looked at cross-sectional comparisons, thereby providing only a snapshot of child outcomes rather than tracking development over time.

Research from the 1990s

The complexity of factors influencing outcomes for children attending child care has only begun to be addressed since the early 1990s. Taking a broad perspective, this research assumes that the effects of child care experience on the child at any age are not simply related to single factors, but to the ongoing transactions between characteristics of the child, the family, the child care centre, and the larger social and cultural context (Burchinal, Ramey, Reid, & Jaccard, 1995; Deater-Deckard, Pinkerton, & Scarr, 1996). The largest study of this kind is a national longitudinal study undertaken in the U.S., the Early Child Care Research Network study that is funded by the National Institutes for Child Health and Development (NICHD ECCRN, 1994). For this study, parents at 10 sites across the U.S. were solicited just after their child's birth and prior to making child care arrangements. Children from this study have been followed into middle childhood, and plans are afoot for continuing into adolescence. Questions addressed with data collected for the NICHD ECCRN study go beyond whether child care is good or bad for children to identify the circumstances in which various outcomes prevail. Moreover, because it is a longitudinal study, it captures many common life scenarios, such as changes in child care arrangements, and addresses the fact that child care effects may be different at different points in time.

A multitude of child and family characteristics have been examined in the NICHD ECCRN, as well as characterstics of the child care centres themselves. Child characteristics studied include:

gender, temperament, intelligence, cognitive and language development, and indices of emotion and behaviour regulation. Family demographic factors cover educational and occupational levels of parents, maternal age, family income and composition, and place of residence, all of which may influence parents' choice of child care arrangements. Also, the characteristics of the family being examined include attachment security, parental warmth and sensitivity, cognitive stimulation, behavioural guidance strategies, quality of the marital relationship, spousal support, and the emotional adjustment of parents (NICHD ECCRN, 1994). Finally, aspects of the child care setting itself are considered, such as type, stability, amount and quality of care. These include child care features measured with the ECERS, ECERS-R and ITERS scales as well as more extensive study of factors such as the quality of the practitioner-infant/child relationship. Although the study does have limitations (i.e., children were not randomly assigned to different child care settings), significant insights have been gained into the impact of multiple interrelated factors influencing a range of outcomes for children who experience out-of-home care for varying periods of time.

Interrelatedness of Areas of Development and Mental Health Promotion

It is important to acknowledge that the research on the outcomes of child care has consistently shown that children's language and cognitive development are related to the quality of child care (NICHD ECCRN, 2000c, 2003c). Therefore, it is essential to highlight the interrelatedness of social and emotional development with cognitive and language development in respect to mental health promotion. Language and thought are both the tools and products of growing competence in self regulation, emotional development, and peer relationships. For instance, 3 year old children with more advanced language and cognitive development were rated by both mothers and practitioners as more positive with peers and by mothers as less negative and aggressive (NICHD ECCRN, 2001a). In contrast, some children described as inhibited, shy, or withdrawn as preschoolers have been shown to have language problems that persist into the school years, affecting both achievement and social relationships (Evans, 1996). Unlike the controversies that have characterized the literature on the effects of child care on attachment and emotion regulation, the consensus of research is that it is quality of care that is related to cognitive and language development during the first 3 years of life (Lamb, 1998) and prior to entry into school (age 4.5 years) (NICHD ECCRN, 2000a, 2003a; Shonkoff & Meisels, 2000).

The impact on language and cognitive development is often most striking in high quality child care settings serving socioeconomically disadvantaged children or those at risk for

developmental problems, although this is not always the case (Shonkoff & Phillips, 2000). Of critical importance to outcomes in cognition and language is the verbal environment of the child care setting (NICHD ECCRN, 2000b). Children in centres where practitioners have had specialized training in early development and have more education generally fare better (NICHD ECCRN, 2003a). These practitioners not only talk more with children in their care but also respond sensitively to the children's efforts to communicate.

Given the important role of stimulating early language and cognitive development as a component of mental health promotion, it is also the case that many children have language impairments that are unsuspected unless a routine assessment is done (Cohen, 2001). Children with problems in understanding language are at the highest risk. Since problems with receptive language competence are also related to emotion and self-regulation, regular screening for language competence should become part of a plan for mental health promotion in centre-based care (Cohen, 2001).

The focus in this report, however, is on social and emotional development. Important issues and ideas for promoting language and cognitive development can be found in other publications (e.g., Girolametto & Weitzman, 2002). In the next sections, we will turn to considering what research on child care tells us about the relationship between attending centre-based child care and important elements of social and emotional development that are related to mental health: attachment security, children's self regulation of their emotions and behaviour, and social relationships with peers.

Child Care and Attachment Security

It is generally agreed that children's mental health is closely related to having secure attachment relationships with primary caregivers, typically parents (Goldberg, 2000). The term attachment refers to a biologically primed behavioural system which operates under threatening conditions and enables children to seek safety and comfort from distress through proximity to a preferred caregiver.

Attachment security has become associated with mental health promotion because it is related to so many other aspects of development. Secure attachment provides a foundation for infants to: **1)** regulate their emotions and behaviour; **2)** have a sense of inner confidence and efficacy; **3)** express their curiosity and eagerness to explore their environment; **4)** enjoy more relational pleasure and harmony with their caregivers which fosters their openness to other relational experiences, such as with peers; and **5)** have the capacity to have secure and enduring relationships which ultimately provide the foundation for their own children's secure attachment. In contrast, infants who are not securely attached have caregivers who are unpredictable

and either provide minimal or inconsistent care and may even be frightening to the children. In these cases, infants may: **a)** appear to be withdrawn, easily distressed, or disorganized, **b)** be preoccupied with getting their attachment needs met (safety and comfort), **c)** be less likely to exhibit the sociability, curiosity, and exploration of securely attached infants, and **d)** have less satisfying social relationships.

In the past, there was concern that attending out-of-home child care might be equated with insecure attachment to parents and its negative sequelae. Maternal care was seen as unique in quality, especially for infants. For instance, almost 20 years ago Belsky (1986) warned that:

...entry into routine child care in the first year of life is a risk factor for development of insecure attachment, aggressiveness, noncompliance, and withdrawal in preschool and early years.

Contrary to this dire warning, the results of the NICHD ECCRN, and other studies, have shown that, in general, child care alone does not have a negative impact on attachment security with mothers in either infants or children. The current research findings show that there is not a simple or direct relationship between child care attendance and children's attachment security. Rather, when children's relationships with their mothers are not secure, coupled with enrollment in low quality care for extensive periods (i.e., more than 10 hours per week), or in unstable child care arrangements, children's mental health suffers (NICHD ECCRN, 2001b).

Additionally, research has now shown that characteristics of ECCE practitioners that promote mental health are similar to those of parents in a secure attachment relationship. They are attentive, warm, sensitive, and responsive to children both when they are and are not distressed. This conclusion applies to infants, toddlers, and preschoolers (NICHD ECCRN 1998a, 1998b, 2001b).

The structural features of child care, and the education and training of ECCE practitioners contribute to attachment relationships. Lower child:staff ratios and smaller group sizes are related to process measures, including the practitioners' relationships with the children and the tenor of the classroom setting (e.g., positive vs. negative emotional climate), and predict both cognitive and social competence in children (Howes, 1997; NICHD ECCRN, 2000b; Phillips, Mekos, Scarr, McCartney, & Abbott-Shim, 2001). Moreover, Howes (2000) found that only a small proportion of child-practitioner relationship quality was explained statistically by problem behaviours (9%), indicating that practitioners can even form positive relationships with troubled children. This is important to mental health promotion in that it suggests that a downward spiral of behaviour problems could be halted early on.

Compensatory effects of child care also are apparent. In particular, it has been shown that when maternal sensitive responsiveness and affection are low but quality of child care is high, children are more likely to be securely attached than when quality of care is low both at home and in child care (NICHD ECCRN, 2001b). Furthermore, it has been shown that depressed mothers who rely on child care have more positive interactions with their infants than do depressed mothers who do not (Cohn, Campbell & Ross, 1991; NICHD ECCRN, 1999a, 1999b). This latter finding is important because many early intervention policies and programs are driven by the assumption that good out-of-home child care can compensate for high risk home environments (see Cohen & Radford, 1999). It also lends support to the potential for child care as a site for mental health promotion.

Although findings consistently indicate that a good relationship with an ECCE practitioner has a beneficial effect on children, there is a caveat. The rate of child care practitioner turnover is very high. In the U.S. it is around 30% per year. It is somewhat lower in Canada (22%) a figure far above that of teachers in public schools. There is considerable variation across provinces in both staff turnover and staff vacancy rates. The *You Bet I Care!* study found that turnover rates were highest in Alberta (44.8%) and Saskatchewan (32.2%) (Doherty et al., 2000; Goelman, Doherty, Lero, LaGrange, & Tougas, 2000). The high rate of turnover among ECCE care practitioners is primarily due to low pay and poor working conditions. Although there are now excellent programs for training child care practitioners, many individuals working in child care settings are not highly trained and do not have an adequate theoretical and practical background in early child education and child care. Moreover, child care practitioners are often young themselves; they may be in the process of leaving home and have issues of attachment and separation of their own. Where turnover is high and practitioners are stressed, children's security suffers (Doherty et al., 2000).

How improvements to practitioner training and compensation can lower staff turnover and strengthen services is illustrated by the American military model of child care. In 1989, the Military Child Care Act was passed to address the weak standards of the system's child care quality. Recognizing that labour-intensive child care meant staff salaries accounted for the greatest expense in program budgets, efforts were focused on raising compensation without increasing parent fees. Subsidies and funds from the military services budget were provided to offset lost revenue and resulted in military parents paying less for child care services then non-military families. Child care staff's pay became standardized and more in line with other military base positions requiring similar levels of training, education, and responsibility. Additionally, salary increases and career advancement became dependent on specific training levels and training and curriculum specialists were

added to the core centre staff to focus on child development issues (Shonkoff & Phillips, 2000).

These changes reduced staff turnover to less than 24% in 1993 from 48% in 1989 (Zellman & Johansen, 1998). Children and their families benefit from the programs having extended operating hours to support military staff's irregular working hours. Parents are also offered daily information about their child's experience in care and parents are included on inspection teams and advisory councils. With half of enrolled children under the age of three, primary practitioners are assigned to all children and these young children were allowed to follow their own sleep and feeding schedules. Moreover, the system in place for military children is comprehensive, consisting of a seamless network of child care, outreach programs and child development centres with a single point of entry to access care and other services (Lucas, 2001). Quality is ensured through four annual unannounced inspections by a certification team that considers a wide range of factors such as developmental programming, staff training, and building standards. While only 10% of American child care centres were accredited in 2001 by the National Association for the Education of Young Children, more than 98% of military child development centres had attained this level of recognized quality (Lucas, 2001).

It can be reasonably concluded that children's mental health is promoted by secure relationships with parents and ECCE practitioners who are sensitive and responsive to the children's and families' needs. Child care practitioners will benefit not only from awareness of the importance of ensuring a positive social and emotional climate of the classroom but by feeling that they themselves are supported, nurtured, and well compensated. As well, regular ongoing discussions and supervision around attachment related issues are critical for effectively dealing with the emotional lives of children. In order for ECCE practitioners to provide this environment, they need working conditions and training that facilitate their being a stable part of children's lives.

Child Care and Emotion and Behaviour Regulation

Young children gradually learn to regulate and control their own emotions and behaviour. The capacity to regulate emotions and behaviour is one of the outcomes of a secure attachment relationship. Conversely, a certain proportion of children have clinically significant problems controlling their emotions and behaviour that will become chronic. For instance, children who are aggressive and disruptive are rejected by their peers and show lower academic achievement throughout childhood (Jimerson, Egeland, Sroufe, & Carlson, 2000).

A recent report from the NICHD ECCRN study presents

findings regarding the impact of extensive child care on emotion and behaviour regulation over the first 4 years of life. Results indicated that parents and practitioners of children who had extensive early child care experience rated these children as having more externalizing behaviour problems and more adult-child conflict at 4.5 to 5 years (NICHD ECCRN, 2003b). It appears to be the cumulative quantity of nonmaternal care, initiated in infancy and experienced across the infancy, toddler, and preschool years, that is most predictive of social and emotional adjustment rather than the amount of time spent in nonmaternal care during any single period. In an earlier report, however, it was shown that greater experience in groups with other children predicted more cooperation and fewer problems (NICHD ECCRN, 1998a, 1998b).

The ECCRN results were confirmed by another set of investigators who monitored children's cortisol levels, an indicator of stress at different points during the day (Watamura, Donzella, Alwin, & Gunnar, 2003). They showed that many children in child care have higher levels of cortisol in the afternoon than children being cared for at home at the same time of day. Furthermore, the differences between cortisol levels taken at home and at child care were greater for toddlers than for infants. At the same time, they observed that cortisol was lower for those children who played often and more complexly with peers and that boys were more likely to show the rise in cortisol level than girls. The authors concluded that although the child care environment has challenges, those toddlers who have the skills to play in a complex manner with peers have lower concentrations of cortisol.

Not surprisingly, the findings of these studies captured the attention of the media as well as parents, child practitioners, and researchers, and raised alarm. Because of the potential impact of such findings on decisions around out of home care, the authors looked at the results more closely. They found, first, that although behaviours were rated as problematic by parents and ECCE practitioners, the behaviour of children with varying amounts of time spent in child care did not differ when they were observed directly and rated by trained independent raters. Second, from a statistical perspective, the effects of extended exposure to child care were low to moderate. Third, and perhaps more important, a number of non-child-care-related variables, such as maternal sensitivity and family income, were stronger predictors of problem behaviours than was quantity of child care. This finding is not limited to the NICHD ECCRN study and other studies have shown that factors including family characteristics, along with child care quality, are contributors to child outcomes (Deater-Deckard et al., 1996; Egeland & Hiester, 1995; Howes, 1990). A recent study of a large Canadian sample of mothers of over 3000 children aged 2- to 3-years showed that aggression was actually more common

in children looked after by their own mothers than in those attending group child care, particularly in high risk families (Borges, Rutter, Côté, & Tremblay, 2004). Fourth, the level of behaviour problems in the NICHD ECCRN study was not sufficient for clinical concern. In fact, there may be benefits to being more outspoken and independent (although not more aggressive) as children move toward school entry. Greater experience in groups with other children has been shown to predict more cooperation and fewer problems (NICHD ECCRN, 1998a), a finding consistent with some of those reported by Watamura et al. (2003) cited above.

Although findings from the NICHD ECCRN study raise concerns, one has to be careful about making assumptions about what is the cause and what is the effect. The design of these studies did not allow for systematically controlling factors by random assignment of children to differing amounts of time spent in child care.

Additionally, it is important to remember that inborn characteristics of the child are important determinants of the capacity for emotion and behaviour regulation. For example, a "difficult" temperament (i.e., negative emotionality) is a general risk factor, relating to regulation of emotions and behaviour and to both internalizing and externalizing behaviour problems (Campbell, 2002). Another inborn characteristic, gender, is also important. Boys are more vulnerable to the effects of maternal employment than girls, as reflected in a greater incidence of defiant behaviour, and may have a less positive experience than girls because they have more disciplinary interactions with practitioners. It is interesting to note that this research has paid less attention to children whose temperamental style leads them to be shy and withdrawn.

Looked at from another perspective, child care experience can have compensatory effects on emotion and behaviour regulation for children at risk. For instance, Hagekull and Bohlin (1995) observed that children who had an insecure relationship with their mother, and who attended child care early, were less withdrawn than were insecure children who remained at home. As well, child care quality had a positive effect on externalizing behaviours for children from less advantaged homes as well as positive effects on boys' internalizing problems and sense of effectiveness. There is also some evidence from Early Head Start programs that children in an enriched program have fewer behaviour problems than comparison groups who do not have an enriched experience (Brotman, Klein, Kamboukos, Brown, Coard, & Soskinsky, 2003). Unlike the NICHD ECCRN and other studies of mainstream child care, in Head Start research projects, children are randomly assigned to the enriched programs so that the evidence is clearer that the positive effects on behaviour result from program participation. Furthermore, it has been suggested that high

quality child care can serve a compensatory function for children who are temperamentally difficult in infancy (Volling & Feagans, 1995).

In summary, there are numerous factors both outside of and within child care that influence self-regulation. The capacity to regulate emotions flexibly facilitates exploration, learning, and behaviours required for participation in social relationships. The same broad question asked regarding attachment security applies to emotion and behaviour regulation, that is, whether and under what conditions does early child care promote or interfere with development of self regulatory capacity. As was the case for attachment, the answer is that the quality of the child care setting and family factors together are important. At the same time, there appears to be a risk for some elevation of behaviour problems and conflict with adults among children who begin child care early, continue for a long period of time, and have multiple changes in child care arrangements.

Although certainly provocative, the results must be taken as suggestive rather than definitive. Because the need for centre-based care is not likely to decrease in the years to come, it is important to use these results to think about implications for mental health promotion.

Child Care and Peer Relationships

Until relatively recently it was assumed that children under 5 or 6 years of age were not capable of friendship in the sense of stable intimate relations. In fact, children's peer relationships, even in the earliest years are now recognized as an important context for socialization, including support, cooperation, conflict management, moral reasoning, and sex-typed behaviour (Hartup, 1996). Toddlers begin to learn about social roles and tasks and social expectations relevant to social interactions. For instance, when toddlers were followed longitudinally for two to three years, Howes (1987) found that many children did form close and stable relationships and that the friendships lasted for the length of the study. As well, these friendships were associated with the development of social competence in interactions with other children. Mutual friends lessened peer rejection, especially when children were attempting to enter play groups. Further, children who lost their friends because they moved away, showed a decline in the frequency of competent social play with peers over the subsequent year. It also has been found that, by the age of 3 years, children were competent in dyadic play with a familiar peer (O'Brien, Roy, Jacobs, Macaluso, & Peyton, 1999). There was relatively little conflict observed and, when it occurred, it did not disrupt ongoing play for more than a few seconds. In general, children seemed to prefer giving in to their friend and returning quickly to play rather than engaging in extended negative interactions. Friends also have been reported to help each other through transition experiences or at the start of child care.

What influences peer relationships among children in centre-based child care? When peer competence was assessed by mother and practitioner report, and by observations of children in the child care settings, both practitioner sensitivity and responsiveness were the most consistent aspects of child care experience associated with positive, skilled peer interactions, regardless of the amount of time children spent in child care or how much experience they had with other children in child care (NICHD ECCRN, 2001a). Furthermore, when practitioners were more involved and invested in the children under their care, the children engaged in more advanced social play with peers, exhibited more positive affect with peers and were less hesitant or withdrawn. Moreover, when child care quality was high, earlier enrollment and longer participation was associated with greater peer social competence (Andersson, 1992). Additionally, in high quality child care settings, temperamentally inhibited children seem to overcome some of their fearfulness with peers. In contrast, in low quality settings, social inhibition was exacerbated (Volling & Feagans, 1995). The quality of child-practitioner attachment relationships has been explored and it has been shown to be related to three aspects of children's social competence: prosocial behaviour (care or concern on the part of one child toward another such as helping and comforting), practitioner-rated social competence, and, children's expression of positive emotions (NICHD ECCRN, 1996). The more secure the child-practitioner attachment relationship is, the less likely children were to be irritable and isolated, and the better able children were to negotiate solutions to conflicts with peers.

On the negative side, when practitioners change, young children are less sociable with peers and more aggressive (Howes & Hamilton, 1993). Normative developmental shifts in characteristics of peer relationships also must be factored into the equation. In the NICHD ECCRN study (2001a, b), the social play of children in child care was observed to become more positive and less negative between 24 and 36 months. While the younger 2-year old children were able to form and gain support from friendships, they were less skilled in resolving conflicts by negotiating or establishing verbal rules for sharing available toys. When these children reacted to conflict with strong negative affect, their conflicts lasted longer and were more likely to be carried over into new conflicts over different toys. Thus, spending more time with other children did not have a positive impact on children at the age of 2 years; under these circumstances children were more negative and aggressive

with peers. By the age of 3 years, however, children who had more experience with other children were more positive and skilled with peers. From these results, Hungerford et al. (2000) concluded that experience with both adults and peers plays an important role in moulding the growth of peer relationship skills in the first years of life. Moreover, the association betweenvariables changes; at age 2, positive experiences with adult practitioners were important for positive interactions with peers. At the age of 3, greater experience with other children predicted more positive skilled peer interactions. This developmental shift may shed light on the recent findings of the NICHD ECCRN (2003b) described earlier. The age period of 4.5 to 5 years may mark another developmental period where aggression and noncompliance re-emerge, perhaps as a component of the independence and assertiveness that children need to cope with the increased demands of school entry.

It will be recalled that although the recent NICHD ECCRN report (2003b) indicated that children who had spent extensive time in child care were rated as more aggressive and less socially competent by parents and practitioners, direct observation of children with peers by trained raters did not confirm this. Moreover, Watamura et al. (2003) found that children who were socially competent showed a lower degree of increase in cortisol level.

There remains considerable controversy about what factors influence children's peer relationships. Children themselves, through their temperamental style, cognitive ability, verbal facility, gender, and sociability elicit different kinds of care from practitioners and from peers. The relative role of these individual characteristics and the roles of experience with practitioners remains untested as does the influence of experience with same-age compared to mixed age peer groups, or with larger or smaller peer groups (Hungerford et al., 2000).

Taken together, research has shown that children form close friendships at an earlier age than once believed. Characteristics of the child (e.g., temperament), family relationships, and relationships with the ECCE practitioners are all associated with social competence with peers. Furthermore, aspects of the ECCE practitioner-child relationship are differentially associated with development of social competence with peers during different developmental periods. Practitioners can play a major role in building and supporting children's friendships not only through their relationships with children but through their practices in the child care setting, such as recognizing the importance of close friendships in young children and the value of this for mutual support.

Summary: Optimal Conditions for Nonparental Child Care

Research indicates that the quality of out-of-home care and of the ECCE practitioner-child relationship matter in promoting children's mental health. In particular, when practitioners are warm and responsive to children's interests, questions, and requests, children are more independent, cooperative, sociable, and happy (Clarke-Stewart, 1991; Lamb, 1998). In contrast, in classrooms where practitioners create a negative climate and are not familiar with the developmental needs of children, children are more fearful, stressed, and less motivated to learn (Howes & Hamilton, 1992). Benefits also accrue to children when child care practitioners have more education and training, when there is a small adult to child ratio, and where care is stable.

The increased emphasis on studying multiple factors in relation to child care outcomes makes it clear that promoting the mental health of young children must simultaneously address characteristics and interrelationships of the child, the centre, and the ECCE practitioners. In promoting mental health in child care, how to involve and integrate multiple areas of development must be carefully considered. Because it is recognized that factors outside these settings, such as family relationships, powerfully influence child outcomes, mental health promotion strategies must also consider children's lives beyond the centre environment. Generally, this suggests that mental health promotion be individualized, taking into account the multiple factors affecting children's experience of child care.

CHAPTER 3:
The Child Care Scene in Canada

Before discussing specific activities and strategies for promoting mental health in community-based child care, it is important to get some sense of broader issues around centre-based child care in Canada that potentially influence children's mental health. As noted in Chapters 1 and 2, mental health promotion for children in centre-based settings is associated with good practices that foster children's social and emotional development, build family and community connections, and create a positive working climate for those in the child care field.

The most striking thing that comes across when attempting to describe the child care "scene" in Canada is that there is not a unified or uniform approach to systems of out-of-home non-parental care. Each province and territory exerts control over how child care services are initiated, the standards and maintenance of quality, the type of funding that assists programs and how centres will be regulated. Moreover, whether and how these issues are targeted financially and through policy varies across regions. Thus, mental health promotion for children in child care centres is directly impacted by provincial and territorial attention to the quality of centre services.

In the remainder of this chapter, we will further examine the elements that combine to create the child care scene in Canada that have an impact on children's mental health. These elements may at first seem piecemeal, but taken together, they help to form an understanding of what needs to happen in order for mental health promotion for children to be supported in community-based child care settings. First, we look at the need for more child care spaces in Canada. Second, we look at the changing structure of Canadian families and variables that show evidence of influencing the child care selection process. Characteristics of families using centre care is related to issues that centres encounter with children and with involving parents in the centre. Third, we describe challenges that child care practitioners currently face working in the child care field. Fourth, we explore how regulations across Canada prescribe standards aimed at supporting children's social and emotional development. Although comparisons regarding structural variables (e.g., staff:child ratios) have been researched in-depth, the variables we focus on are related more to processes represented by children's experiences.

The Growing Need for Centre-Based Care in Canada

There is a pressing need for more regulated child care spaces across Canada. This increased demand for child care outside the home has been dictated by the growing workforce participation of women. In 2001, 73% of women with their youngest child between the ages of 3 and 5 years were in the paid labour force, up from 37% in 1976. For mothers with a child younger than 3 years, 66% worked for pay (Childcare Resource and Research Unit, 2001). Women who are employed during pregnancy also tend to return to work soon after giving birth; between the years 1996 and 1999, 90% of women returned to work within one year according to the 1999 Survey of Labour and Income Dynamics (Statistics Canada, *The Daily*, 2002). This means that many children require nonparental care at younger ages. Despite this, over the last 10 years spending on regulated child care has actually decreased by roughly $70 million throughout the country (Bailey, 2003).

As of 2001, there were approximately 593,430 regulated child care spaces in Canada for infants, toddlers, preschoolers and school age children. These included both home- and centre-based care. Within this total, an estimated 317,841 were regulated centre-based spaces (Friendly, Beach, & Turiano, 2001). With close to 1.4 million children affected by the child care industry (Stafford, 2002), it is clear that many Canadian children are receiving unregulated nonparental care. In fact, the most prevalent form of child care arrangement is unregulated care outside the home (Kohen, Hertzmann, & Willms 1998). Although such arrangements may provide adequate or even quality care, they cannot be assumed to be developmental programs that actively promote learning or social and emotional development (Friendly, 1997).

In 1993, the federal government established a promise for national child care that would allow working parents, wherever they lived, access to affordable, high quality child care. Throughout the 1990s, federal and provincial governments tried but failed to agree on how to assign federal money to child care within provincial jurisdictions. In 2000, the $2.2 billion *Early Childhood Development Initiative* was introduced by the federal government. This five year program provided for provinces and territories to invest into four broad areas of early childhood education (Government of Canada Report, 2002). But the initiative was problematic in that none of the federal money distributed among regions was specifically earmarked for child care, which was viewed as only one component in an overall attempt to address young children's well-being. Jurisdictions had flexibility in how to spend their funds, resulting in an uneven injection of money into quality, licensed, regulated child care. As a result, no national approach emerged to ensure quality practices geared towards supporting children's development in child care settings, of which mental health promotion is a component. The 2003 federal budget included a financial agenda to fulfil the original promise of a decade ago, committing $935 million over five years with the requirement that if provinces and territories are to receive

money, spending must be devoted to creation of affordable regulated child care (*Government of Canada website, 2003*). Very recently, the March 2004 federal budget comitted $5 billion over five years to increase the availability and quality of child care spaces. Although it is too soon to know, hopefully this injection of funds will go some way in alleviating the pressure for high quality child care spaces (Clark & Fagan, *Globe & Mail*, 2004).

The information presented above indicates that there is a need for a cohesive policy for child care in Canada and suggests that funding must adequately address issues of both quantity and quality. The reality is that funding to meet the demand for more child care spaces is likely to be prioritized over assistance to centres to raise standards for the centre environment and education of staff. Increasing levels of quality in child care centres, however, are needed to support practices necessary for the mental health promotion of children in these settings.

The Changing Structure and Background of Canadian Families

Today, fewer children are being reared in what would be considered "traditional" families. While the majority (86%) of young children continue to be raised within two parent families, the composition of these families may consist of both biological parents or be blended in terms of one biological parent and one step-parent (Human Resources Development Canada & Health Canada, 2002). Common-law partnerships (including same-sex couples) also have increased by 8% from 1981 to 2001, with 13% of children living with common-law parents, more than four times the percentage of twenty years before. The dissimilarity of two parent families may mean that children have assorted family values and expectations imparted to them.

Shifting family arrangements constitute major life changes for the children involved. They may have to adapt to relocation, spend less time with one or both parents and adjust to the introduction of new partners in a blended family and possibly step-siblings. Especially significant is the trend that children are experiencing these events at young ages. Marcil-Gratton (1998) described how 25% of children born in the late 1980s would experience parental separation before reaching six years of age as compared to 5% of those born in the early 1960s. In 1998, the proportion of children living in lone-parent families was 16% (Canadian Council on Social Development, 2002), accounting for a relatively large share of families in all provinces and territories and with the majority of these families headed by women (Statistics Canada, *Women in Canada*, 2001). Often children being brought up by single parents face challenges, such as inadequate economic resources. In 1998, 53% of all

single mother families had incomes that fell below the low income cut-off. Additionally, single parents in Toronto experienced an 18% decline in income between 1990 and 1999 (Canadian Council on Social Development, 2002). Living in poverty has a proven detrimental effect on children's mental health (e.g., Landy & Tam, 1998).

Not only is there a heterogeneous mixture of structures in Canadian families, but there is also a diverse array of cultures represented. It is estimated that by the year 2016 visible minorities will account for 20% of the total adult Canadian population and 25% of the child population (Esses & Gardner, 1996). Currently, more than half of recent immigrant children belong to visible minority groups (Canadian Council on Social Development, 2002). While European ethnic groups still comprise the largest proportion of Canadian citizens, Asian and Middle Eastern immigrants contribute significantly to the population, with Chinese, South Asian, Eastern Asia and Black minorities accounting for the largest percentages (Canadian Census, 2001). Kelly (1995) predicted that West Asian and Arab communities in Canada will show the fastest growth.

Immigrant children are more likely than non-immigrant children to live below the low income cut-off and have parents who work more than 50 hours per week. Additionally, approximately two out of every three children who came to Canada between 1997 and 1999 could not speak either of the two official languages when they arrived to the country (Canadian Council on Social Development, 2002). Canada's approach to multiculturalism encourages people of various cultural backgrounds to maintain their customs while, at the same time, share in the Canadian experience (Esses & Gardner, 1996). This means that immigrant children are also typically faced with learning and integrating new social conventions into their own cultural approaches. Younger children may have the difficult task of learning about two cultures at the same time.

Aboriginal children also have different experiences from the majority of the population. Roughly 28% of Aboriginal children from birth to age five lived in single parent families in 1996 (Human Resources Development Canada & Health Canada, 2002). Approximately 12% of these children in the same age group were not even living with their parents, but with other relatives (*Statistics Canada Nation Series*, 1996). Over half of the latter children were living in low income families, which is especially disconcerting when children and youth comprise more than half of the Aboriginal population as compared to 33% of the general population (Canadian Council on Social Development, 2002). Aboriginal children also experience dramatically higher rates of death from injury and severe disabilities than other children in Canada (*The Health of Canada's Children*, 2000). In terms of child

care, a recent initiative by Human Resources Development Canada has committed funding to increase access to affordable and quality regulated child care for Aboriginal parents (Human Resources Development Canada, 2001).

Summary and Implications of Changes in Canadian Family Structures and Background for Mental Health Promotion in Centre-Based Care

Family structure and background impact children's experiences, creating various forms of upbringing and challenges for Canadian children. While many of these children may be in centre-based child care, the diverse backgrounds and household situations of these children means that a universal approach to child care practice is not appropriate. Appreciation of children's larger life contexts can help practitioners deal with their individual stresses and the expectations placed on them. This highlights the need for communication between centre and home to ensure child care practitioners have knowledge about important aspects of children's lives outside of the centre. As we will see in Chapter 6, current ECCE practitioner education often is not adequate in this respect.

Factors Influencing Child Care Selection

Family Factors

There is growing recognition that family and child characteristics are highly related to child care choices (Seifert et al., 2001). Consequently, understanding the child care selection process is an important topic in thinking about centre-based child care as a site for mental health promotion. Research emphasizes not only the direct effects of the home on children but also the indirect effects of parents' management of their child's time outside the home (Singer, Keiley, Fuller, & Wolf, 1998).

Parents have the primary responsibility for deciding what forms of care their children will receive. If parents decide on nonparental care, they must decide on what type of care they prefer and secure it by themselves. Families differ in their propensity to select centre-based child care over other forms of care. Consequently, when considering mental health promotion in child care centres, it is vital to have an understanding of the reasons families choose a particular type of care. On a larger scale, finding common ground between family beliefs and professional perspectives concerning the early care and education of young children is imperative to guaranteeing quality services for all families (Holloway & Fuller, 1999). In considering the factors that influence parents' child care choices, it is apparent

that matters of availability, family characteristics, and child care structure interact when parents decide their children will be cared for in centre settings.

Geographic Location and Availability

The type of community in which a child is raised contributes to the accessibility and affordability of different child care arrangements. The supply of centre-based care varies from region to region (Connor & Brink, 1999). Using data from the National Longitudinal Study of Children and Youth (NLSCY), Norris, Brink, and Mosher (1999) found that families living in rural areas use nonparental care only slightly less (35%) than families that live in the city (40-42%). While there are more child care centres situated in urban as compared to rural areas, this does not necessarily mean the number of spaces in regulated child care centres reflects the demand that exists. Moreover, most children in regulated child care centres are toddlers and preschoolers and there are significantly fewer regulated spaces for infants (Friendly, 2001). Parents wishing to place their infants in centre-based child care may be faced with waiting lists for spaces. Additionally, fees for infant spaces tend to be higher than those for older children, in part, due to the need for lower staff:child ratios. In general, even though parents may desire high quality care for their children, lack of available spaces may ultimately alter their primary concern to just finding day care, period (Bradbard, Brown, Endsley, & Readdick, 1994).

American studies have started to identify differing child care placement patterns across large regions of their country (Singer et al., 1998; Kisker, Hofferth, Phillips & Farquhar, 1991), but there are only limited data for Canada. Norris et al. (1999) reported that different types of care used does vary across regions with child care centres and family child care used the most in Quebec and least in the Atlantic provinces. Care by relatives is most common in the Atlantic provinces and in British Columbia. The issue concerning why discrepancies are found between regions (which may involve matters of provincial policies and funding, population demographics, and family preferences) remains to be fully examined.

Practical considerations regarding centre location and hours of operation may further govern parents' child care options. Parents strive for the ideal of care close to home and work environments. Those with limited access to transportation may have fewer child care choices available to them. Although many studies have shown that parents place greater importance on quality characteristics of care than practical ones (e.g. location, hours of operation, cost) (Peyton, Jacobs, O'Brien, & Roy, 2001), this is not always the case. Johansen, Leibowitz, and Waite (1996) found mothers most often cited location and hours as important factors in choosing care. Although parents may feel strongly about quality issues, the need

for an arrangement with flexible hours can overshadow this (Atkinson, 1987; Rodd & Milikan, 1994). The prioritizing of practical considerations of care arrangements has been linked to family characteristics such as working longer hours and stress experienced by mothers because of working more hours and/or having larger families (Johansen et al.,1996).

Family Characteristics

Family Income

In most studies, family income level is the most important factor determining which child care services parents choose, with higher income families more likely than lower income families to decide on centre-based care or in-home care by a non-relative (Peyton et al., 2001). Every element of an infant's child care experience, including age of entry and amount of care, has also been associated with household income (NICHD ECCRN, 1997a, 1997b). Cost of care and family income limit child care options (Pungello & Kurtz Costes, 1999). Income significantly discriminated between mothers who based their child care decisions on quality vs. practicality. Mothers with higher incomes tended to choose care based on quality, used centre-based or home- based care more often than relative care, and were more satisfied with their care arrangements (Peyton et al., 2001). For low and middle income single mothers, cost was the most important factor in deciding on which child care centre to use (Leslie, Ettenson, & Cumsille, 2000). In this latter study, higher income single mothers in this study considered both quality and practical issues, focussing on hours of operation and staff training

Family income is especially relevant when considering that fees for full time centre-based child care in Canada increased throughout the 1990s, rising 12.5% for infant care, 20.3% for toddler care and 18.9% for preschool care (Doherty et al., 2000). Often it is the middle income families who are most hard pressed to meet child care expenditures. Families with higher earnings can more easily meet these costs, and subsidies are available to those with lower economic resources to obtain regulated child care services; 36% of children in low income families in 2001 received a fee subsidy (Friendly et al., 2001). To put this into context, the average net income of the middle 20% of couples grew by only 3% between 1984 and 1999, in contrast to 43% for the top 20% of couples.

Parent Education

Closely linked to income level is parental education. Children of better educated parents are more likely to receive nonparental care (Singer et al., 1998). Selecting age-appropriate care, placing a greater value on the educational elements of programs and seeking programs that promote children's self-esteem is associated with mothers with higher education. Less educated mothers tend

to place more emphasis on didactic methods of teaching and academic skill acquisition for preschoolers. Prioritizing centre care characteristics, mothers with higher levels of education have been found to emphasize staff:child ratio and curriculum type as compared to less educated mothers who focused on cost (Leslie et al., 2000).

Extent of Parent Work Hours

The extent to which mothers work has also been shown to impact child care arrangements. In the NICHD ECCRN study (1997b), mothers who worked daytime hours placed their infants into child care centres and homes more than mothers with varying hours and non-daytime hours. As well, by 12 months of age, infants of mothers with daytime schedules received more centre-based care and a decreased amount of parental care. Mothers who work more hours have also been found to place their children in centre or family child care more than mothers who work relatively few hours (Caruso, 1992). Generally, children whose mothers work part time are more likely to be cared for by relatives or in informal child care arrangements (Gable & Cole, 2000).

Family Ethnicity

Ethnicity of families is another characteristic that may contribute to whether centre-based care is selected for children. American studies have found disparities in the types of care used among Caucasian, African-American and Latino families and suggest that while European-American mothers may be more likely to choose regulated care, mothers in minority ethnic groups are more likely to select non-regulated arrangements (Kontos, Howes, Shinn, & Galinsky, 1995; Hofferth & Wissoker, 1992). It appears that different ethnic groups possess diverging child rearing beliefs and practices that could influence child care selection. Singer et al. (1998) argue that variability in centre availability may also exist across ethnic communities and contribute to differences in enrolment rates. Canadian research into the possible impact of ethnicity on child care selection is virtually nonexistent. This gap is startling when so many cultures are represented in this country. The drastically different ethnic composition of Canada from the United States means that exploring how and why different minority groups in Canada select centre-based and other forms of nonparental care would be a worthwhile endeavour. Understanding various perceptions and expectations concerning centre care would be beneficial when determining useful strategies for working with these children and families and, in this way, would contribute to promoting children's mental health. It would also inform our knowledge about the availability of centres among various ethnic communities.

Child Characteristics

Research has shown that parents consider their child's age a principal concern when choosing child care. Using the NLSCY data base, Seifert et al. (2001) showed that most children entered nonparental care around two years of age and tended to remain in care. The majority of studies have found that the type of care children are placed in differs depending on age. Mothers with younger children typically use family child care and mothers of older children are more likely to use centre care (Casper, 1996; Galinsky,1992). While this trend may be related to several factors such as the lesser availability of infant care within centres and its cost, alternatively, it also may be associated with maternal beliefs about the characteristics of centre care. Pungello and Kurtz-Costes (1999) suggest an ideology of "home as a haven" is at play whereby, for infants, mothers value a home-like atmosphere and individual adult-child interactions that are assumed to be provided in family day care or more informal arrangements. As their children grow older, mothers may prefer centre-based environments because they believe that it is more developmentally appropriate for preschoolers to learn to concentrate and to develop school readiness and social skills.

Summary and Implications of Canadian Family Characteristics for Mental Health Promotion in Centre-Based Child Care

Parents differ in what they require and expect of centre-based programs. As a variety of factors limit child care options for families, the choices they make may ultimately affect how parents relate to child care practitioners and, in turn, affect how children experience their child care setting. Families also are more stressed if they are not satisfied with their child care choices, which impacts on their children's mental health. By recognizing the needs and preferences of families, centres can better ensure connection and consistency between home and centre environments and, in this way, contribute to children's mental health.

Challenges of ECCE Practitioners
The Work of ECCE Practitioners

In the past, child care staff's primary role was to care for the children enrolled in their centre. This "care" seemed to be synonymous with babysitting. The recognition that the early years are critical for children's development, and the reality of a large proportion of children spending significant amounts of time in child care, has broadened the public's perception of practitioners' responsibilities to embrace both nurturing and providing an environment for learning. Quality centre experiences for children of all ages are now defined,

in substantial part, by their practitioners (Howes, Phillips & Whitebook, 1992; NICHD ECCRN, 1996: Peisner-Feinberg & Burchinal, 1997). There is greater acknowledgement that practitioners must actively work towards good outcomes for children. Thus, practitioners "care" encompasses several tasks, including promoting child development, ensuring children's safety and well-being and maintaining responsive relationships with individual children (Stafford, 2002). Although not explicit in these activities, promoting mental health is a component that threads through all of them. The complexity of work and level of skill required of those in child care vocations has led to Early Childhood Care and Education (ECCE) practitioner becoming the most accepted term for individuals in the field.

Although job titles in child care centres differ among jurisdictions, generally there are three main position types: **1)** a director or supervisor who typically manages all aspects of the centre including systems, policy, services/programs/practices and financial issues in the delivery of child care services (Teidka, 1999). Directors may also focus entirely on administrative tasks or be responsible for such tasks in combination with duties involving direct work with children, **2)** an ECCE practitioner who has primary responsibility for a group of children and may additionally act in a supervisory role to other practitioners (Human Resources Development Canada, 2003). The practitioners provides child care services that promote the cognitive, intellectual, emotional development and physical safety of children. A practitioner works under the guidance of the director and in cooperation with other centre staff (Teidka,1999); **3)** an ECCE practitioner assistant who works with children in a similar manner to an ECCE practitioner but functions under her/his supervision and usually also maintains equipment and assists in housekeeping duties (Human Resources Development Canada, 2003). Responsibilities in each of these roles may additionally include such tasks as communicating and providing information to parents, attending staff, committee and/or board meetings and collaborating with community resources. Currently, in Canada, child care is a female dominated workforce (97%) with a relatively high percentage of young workers (Human Resources Development Canada, 2003). The *You Bet I Care!* study (Doherty et al., 2000) indicated that a substantial proportion of ECCE practitioners are between the ages of 25 and 34, while directors and supervisors are primarily over the age of 40 and have been in the field for more than 10 years.

Increasing awareness about the quality of care on child outcomes has led to efforts to understand how practitioners behave and how they should be trained to provide growth-promoting care (Bredekamp, 1987a, 1987b) (see *Table 2* at the end of this chapter for an overview of practitioner characteristics in child care and social and emotional development in Canadian

provinces and territories). In turn, greater emphasis has been placed on exploring how the characteristics of child care, as a field, and, more specifically, aspects of the centres in which practitioners work, impact the child care workforce. While there are rising expectations regarding education and professionalism for ECCE practitioners, Canada has yet to develop consistent training and compensation standards to support this. Later, in Chapter 6, we will discuss how these factors and more centre-specific factors are significant in creating a positive work environment for practitioners and can aid in the mental health promotion of children in centre-based care.

Wages of ECCE Practitioners

Wages and benefits to employees accounted for approximately 69% of all expenses incurred by the Canadian child care industry in 1999 (Stafford, 2002). However, in 2000, the average ECCE practitioners earned only $20,600, which is more than $13,000 below the average wage for the rest of the economy (Stafford, 2002). While the majority of full-time ECCE practitioners receive paid sick days, only about half receive extended health care and only about one-quarter of full-time educators work in centres that make contributions to a retirement fund or pension plan (Doherty et al., 2000). The low compensation and poor benefits that characterize the field are often cited as contributing to the problem of centres attracting and retaining qualified staff (National Association for the Education of Young Children, 1999).

Doherty, Friendly, and Forer (2002) argue that the fee level that the average parent can afford is inadequate to provide centres with the amount of revenue required to deliver high quality programs supportive of children's development. Government funding, they argue, is essential for provision of quality services, citing the *You Bet I Care!* study report of a positive correlation between receipt of a government wage enhancement grant and ITERS and ECERS-R scores. There are government grants that exist to supplement centre wage and salary enhancements as well as professional development and training. Other subsidies marked for expenses, such as rent for centre facilities, may enable centres to reallocate more money to staff wages. But government financial assistance for centres varies across provinces and territories, meaning that areas that receive less funding rely heavily on parent fees, such as Newfoundland (82%), Nova Scotia (73%), New Brunswick (69%) and Prince Edward Island (67%). In contrast, provinces with more generous subsidy and grant programs have centres that depend less on parent fees, such as Manitoba (34%) and Saskatchewan (38%) (Beach & Bertrand, 2000).

Commercial *vs.* Non-Profit Child Care Centres

Centre auspice may also affect the amount of money allocated to staff remuneration. Most child care centres in Canada are non-profit, as opposed to commercial, though the distribution ranges from a large proportion of non-profit centres in Saskatchewan (98%) and Manitoba (92%) to a high percentage of commercial centres in Newfoundland (80%), and Prince Edward Island (76%) (Stafford, 2002). In non-profit centres, which are not permitted to make profits, services are incorporated under provincial legislation that requires operation to be handled by either a board of directors consisting of volunteers, a parent co-operative, or an organization with charitable or non-profit status. In contrast, commercial centres are private businesses incorporated under provincial legislations that are permitted to return profits to operators who may be an individual, a partnership, or a corporation (Doherty et al., 2002).

Sector differences affect how much control directors and supervisors have over centre funds. Non-profit centres must reinvest surplus revenue back into the organization whereas commercial centres have full discretion regarding whether profits are directed back into the centre or distributed to owners or shareholders. Additionally, non-profit centres usually have greater access to resources such as government assistance in the form of free or subsidized space (Harms, Cryer, & Clifford, 1990). This, in turn, is likely to enable directors in non-profit centres to use more resources for employee remuneration and expenditures related to the provision of quality care (Doherty et al., 2002).

ECCE Practitioner Education

The Canadian Child Care Federation's National Statement on Quality Child Care (Canadian Child Care Federation, 1994) offers the following as some of the standards regarding the suitability and training of ECCE practitioners: **1)** experience and formal post-secondary accredited early childhood education and care training, minimally including study of child development and developmentally appropriate practices for the early years; **2)** specialized training at the post-diploma or degree level (where available) when working with infants, school-age or special needs children, or as centre administrators; and **3)** continued opportunities available for professional growth through ongoing in-service training.

While the research literature consistently underscores the link between the preparation and education of practitioners and their consequent skill and knowledge (Gable & Cole, 2000), this is not reflected in the regulatory requirements regarding practitioner education across Canada. As can be seen in *Table 2*, provinces and territories vary greatly in the qualification systems for classifying child care practitioners. Each province and territory mandates for different proportions of teaching staff with various levels of education, with no jurisdiction minimally requiring that all staff have ECCE training. There is also no consistency between provinces and territories in requiring that practitioners dealing with infants, toddlers or special needs

children have specialized education pertaining to these areas. As well, training for administration for directors is not an educational requirement in any region in Canada. Interestingly, only 28% of directors in the *You Bet I Care!* study (Doherty et al., 2000) reported having training or education in business administration or centre management despite 68% of directors indicating that a prerequisite for the position should include specific course work in administration.

Early childhood care and education training programs are also operated under the discretion of each province and territory. This means that among the 120 institutions across Canada that deliver this type of post-secondary education, program definitions, requirements and content vary by jurisdiction (Beach & Bertrand, 1998). Typically, the core content of programs consist of courses in child development, ECCE methodology and behaviour guidance and includes a supervised field placement component (Beach & Bertrand, 1998). However, in terms of certificate and diploma programs and field placement duration and the organization of courses, considerable variation exists (Beach & Bertrand, 1998). Overall, the differences in regulatory educational requirements and training standards among jurisdictions highlight the lack of national agreement concerning the definition of a trained or qualified staff member or supervisor in regulated ECCE settings. This may reflect differences in the degree to which jurisdictions value or consider the importance of child care work. Even on a national front, Human Resources Development Canada lists the following as useful experience and skills for the field: babysitting, meal planning and arts and crafts (Human Resources Development Canada website, 2003). Ultimately, this suggests that the value associated with early childhood experiences is not matched with investment in the individuals and the work that contributes to them.

In light of these differences, experts and researchers have called for higher minimal standards that are consistent across Canada for the education of ECCE practitioners. After investigating the issues facing the child care sector, *Our Child Care Workforce Study* (Beach & Bertrand, 1998) recommended that there be increased training requirements for many practitioners. This was based on the recognition that many practitioners in Canada do not have training related to child development and early childhood education. Meanwhile, a survey of key informants in the *Partners in Quality Project* (Kaiser & Rasminsky, 1999a) indicated that a two year program was a minimum academic standard for practitioners. Moreover, most informants viewed community college curricula as inadequate. They perceived a need for more complete articulation of theoretical foundations that address the "why" and "what" of practices, a better blend of theoretical and practice based knowledge and better mechanisms to incorporate

new research and emerging issues into the knowledge base (Kuhn, 1999). Key reasons for a more completely defined knowledge base included: **1)** developing a consistent and coherent public image for the field; **2)** establishing a base from which practitioners can speak confidently; **3)** interacting more effectively with other professionals; and **4)** providing an identifiable base upon which to continue building knowledge (Kuhn, 1999).

It has been recognized that access to training is a barrier to the human resource development of the child care workforce (Beach & Bertrand, 1998). Though regulations regarding staff's minimal educational requirements differ across provinces and territories, there is evidence showing that education levels of front-line staff across Canada is rising dramatically. The *You Bet I Care!* study (Doherty et al., 2000) reported that 70.8% of all teaching staff in 1998 had obtained either one, two or three year ECCE diplomas or post-diploma credentials as compared to the 58.0% indicated by the *Caring for a Living* survey (1991; cited by Doherty et al., 2000). Additionally, 10.9% of teaching staff in 1998 held an ECCE-related B.A. or higher degree as compared to 7.0% in 1991 (Doherty et al., 2000). While specialized knowledge and skills of staff working directly with children during critical periods of their development is undoubtedly beneficial, the earning potential of child care teaching positions fails to reflect this when the average income is comparable to parking lot attendants in Canada (Doherty et al., 2000). Simply put, there may be little incentive to attain higher levels of education if the ceiling for subsequent income is so low.

The recent funds budgeted by the federal government for child care is intended to enhance the complement of trained practitioners across Canada. Given the unevenness in minimal training required in various provinces, it will be important to see how this commitment unfolds.

Professionalism

There is a growing movement towards professionalism within the child care field. Conceived as a means by which quality assurance can be established and maintained, Caulfield (1997) describes professionalism as involving a shared set of skills that are used to improve the quality of caregiving practices and interactions between professional practitioners and the children and families with whom they work. This reflects an obvious benefit to those receiving child care services but, at the same time, implies an incentive for practitioners to strengthen their identity across settings (i.e., centres and home care) as a knowledgeable and skilled workforce, and, as a result, increase the level of status attached to work involved in child care. Child care's lack of respect from other professionals and the public at large is often cited as a negative aspect of the career (Doherty et al., 2000).

"Setting standards to distinguish professional practice and establishing mechanisms to maintain and monitor these standards is central to the process of professionalization" (Kuhn, 1999). Critical to the development of these standards is the recognition of what knowledge and skills are needed (input standards), how tasks are carried out (process standards) and what the evaluation and results of such standards are (performance standards) (Employment & Immigration Canada, 1993). In terms of child care, identified reasons for supporting professional standards include greater visibility for the work of caring for and educating young children, increased recognition and respect for practitioners as caring, knowledgeable and skilled, shared meaning and knowledge, greater coherence in practice across settings, improved working conditions and financial compensation and mechanisms to establish and monitor standards for increased public accountability (Ferguson, Flanagan-Rochon, Hautmann, Lutes, Masson, & Mauch, 2000; Kuhn, 1999).

However, the nature of child care work is, in some respects, at odds with the components of professionalism. For instance, the level of expertise inherent in professional standards is associated with expert-client relationships that are impersonal. But this is incompatible with the recommended caring relationship practitioners have with children and the supportive relationships they have with parents. Additionally, collaborative approaches that practitioners undertake with other staff and parents is inconsistent with professionalism's element of autonomy in practice. Another challenge to professionalization in the child care field is that practitioners themselves have not reached a consensus concerning the issue and evidence points to the ambivalence of many practitioners about being referred to as professionals.

A number of institutions now exist in Canada to support professionalism in child care. Professional child care associations are present in most provinces and territories; most largely focus on centre-based care. Such associations, representing large proportions of practitioners and thereby having strength in numbers, have been able to take an advocacy role in working towards legislative recognition of ECCE as a profession. Additionally, they serve as a mechanism for defining occupational standards and codes of ethics, which may clarify expectations for and about professional practitioners. The Canadian Child Care Federation has very recently developed and approved a set of occupational standards for child care practitioners (Personal communication, Nov. 2003). Child care centres and practitioners may also go through formal accreditation and credentialling processes, furthering professional standards by complying with high quality standards of practice.

The National Academy of Early Childhood Programs, based in the United States, sponsors the best known accreditation system for child care centres. Through a process intended to establish standards for services that are above the mandatory government requirements (Doherty, 1999), centres must successfully complete self-study and validation phases and then be judged in compliance with criteria in order to receive accreditation status for a period of three years. The self-study component, in particular, has been associated with improving program quality, promoting awareness in practitioners of what high quality care is, providing a useful form of professional development, assisting programs to define their goals, and aiding in reflective practices by practitioners (Bredekamp. 1990; Zellman & Johansen, 1995). Accreditation also serves as a tool for the marketing of child care programs by offering an assurance of quality to potential clients. However, some research suggests that accreditation is often sought out by centres of relatively higher quality (Whitebrook, Sakai, & Howes, 1997) and that, in and of itself, accreditation is not effective in dealing with poor quality (Doherty, 1999).

Individual child care practitioners may also engage in the process of "credentialing" as a means of certifying that they have acquired specific qualifications and/or competencies. Credentialing is seen as providing assurance that a person is able to translate theory into good practice (Doherty, 1999), even though research is lacking on whether credentialing is correlated with higher quality care. Depending on their level of experience and education, practitioners may be credentialed as ECCE graduates, or go through equivalency validation or competency-based assessment processes. Jurisdictions differ in terms of organizations that are responsible for credentialing, with some offering such services through government agencies and others through provincial child care associations. Additionally, in British Columbia, Alberta, Manitoba, Prince Edward Island, Newfoundland, and Labrador, ECCE graduates are required to be credentialed in order to be employed in certain positions (Doherty, 1999).

Summary and Implications of Practitioners' Education and Professionalism for Mental Health Promotion in Community-Based Child Care

Despite increasing acknowledgement that characteristics and training of ECCE practitioners significantly contribute to quality care, and therefore to promotion of children's healthy social and emotional development, many aspects of the child care field fail to highlight and reward this. Directors and ECCE practitioners working directly with children are constantly engaging in important interactions with children, parents and community resources, yet the level of compensation afforded to them is equivalent to occupations involving far less skill. This has a powerful impact on those who choose to enter the field, those who remain in it, and the public's perception of child

care work. Additionally, Canada has yet to develop a national perspective on what constitutes appropriate training to be considered qualified for different positions and, consequently, lacks a clear conception of what a qualified practitioner or director is. As a result, minimal requirements for practitioners vary across jurisdictions, and no consistent standards exist to define the knowledge and skills needed to provide quality care for children. Among practitioners themselves, who represent a montage of different educational backgrounds, consensus has yet to be reached regarding professionalism in the field. Access to resources, and other forms of support that allow centres and practitioners to aspire to higher professional standards, are also inconsistent across the country. In total, these factors amount to a contradiction in terms. While public attention and funding have emphasized the importance of the early years and the impact of quality child care, at the same time, there has been widespread neglect of what to do to ensure that ECCE practitioners are encouraged and supported in their contributions to quality care. To include mental health promotion as an important component of child care services requires a significant amount of specialized knowledge. Improved compensation, status, and working conditions can act as incentives and reward for practitioners' increased level of training and professionalism in this area.

Regulations Supporting Social and Emotional Development in Child Care Centres

Regulations that outline minimal standards and practices for supporting children's social and emotional development vary across the regions of Canada. Consequently, there may be jurisdictional differences in public understanding that child care has a developmental purpose over and above ensuring children's safety (Doherty et al., 2002). Unlike other countries that have established policy systems to form a unified vision for their child care, Canada has a fragmented system with no clear scope concerning child care centres' goals for children. Yet, what is perceived as desirable child outcomes and evidence of high quality in child care is determined by the country's goal for that care (Doherty, 1997). France, for instance, employs a dual child care system, providing publicly funded care for younger children under the auspice of the social welfare system, while children over the age of two may attend free universal preschools operated by the education system (Kamerman, 2000). School readiness in terms of cognitive development is the focus of these services (Kaiser & Rasminsky,1999a). Most Scandinavian countries employ a similar approach to services as France but, instead, emphasize social and emotional development. Without a clear national conceptualization of what child care centres should be advancing in children's development, there is little direction in Canada for regulations as to how centres should do it.

Minimal Standards of Care

While regulations do not ensure high levels of quality care, they provide the basic infrastructure regarding what is considered an acceptable child care program. Koch (1998) describes regulations standards as "consensus on those acceptable minimum standards of care critical to the protection of children. Rules are clear and easily understood, supported by research findings as reducing the risk of harm and economically feasible". Regulations can be considered preventative mechanisms that reduce hazards in three broad risk areas: safety hazards, health hazards, and developmental impairment (Stevens, 1996). This latter area is more difficult to assess than the others and is most dependent on current research about developmental issues and good practices.

Typically, studies about the impact of licensing regulations on child care quality have concentrated on structural factors (such as staff: child ratios) that are predictive of process quality, which is equated with children's experiences in child care. Process quality includes interactions with practitioners and activities and materials. In the United States, the *Cost, Quality and Child Outcome Study* (1995) found that states with more demanding licensing standards had fewer poor quality child care programs as compared to states with fewer standards. Higher quality care in the centres under stricter regulations was associated with better staff:child ratios, staff with more specific education related to early childhood, and more experienced directors. Research has also identified that the prediction of process quality from structural factors varies somewhat across age groups. Higher process quality has been found in infant-toddler classrooms with moderately experienced and better paid teachers and more experienced directors. In preschool classrooms, process quality was higher with teachers with more education, a moderate amount of experience and better pay. Additionally, better adult:child, lower centre enrolment and a lower proportion of infants, toddlers and subsidized children in the centre further predicted process quality for preschoolers (Phillipsen, Burchinal, Howes, & Cryer, 1997).

While structural variables can be viewed as elements of a framework that may enhance children's development and thus prevent harm in any domain, there is growing recognition that regulations should actually proactively address how to enhance performance in all developmental domains, including social and emotional development. Gallagher, Rooney, and Campbell (1999) recommend that greater explicit emphasis be placed on developmental enhancement through specific detailed regulations that describe the practices they are meant to promote and match current thinking in the child development field.

Standards for Developmental Enhancement

Regulations in provinces and territories across Canada still concentrate on standards concerning child protection rather that child development. However, some regions have more

thorough standards about developmental enhancement than others. For instance, British Columbia, in describing the program requirements expected of child care centres, specifically outlines how centres are to attend to different developmental domains of the children enrolled. With regard to emotional development, the regulations state that centres must have program standards that help children develop a positive self-concept, develop an accurate perception of self, express positive and negative feelings in appropriate ways, and provide a comfortable atmosphere in which children feel proud of their cultural heritage and cultural sharing is encouraged. Regulations relating to social development include the promotion of sharing, working cooperatively, respecting the personal feelings and property of others, and facilitating a child's feeling of belonging to family, community and the world at large (British Columbia Community Care Facility Act Regulations, 2002). Few provinces and territories specifically highlight what to foster in these areas of development. Another exception is the Yukon, where centre-based child care programs must include activities that promote independence, self-esteem, cultural awareness, social responsibilities and community involvement, as well as individual interaction between children and adults.

Another way in which some jurisdictions have emphasized developmental considerations is through regulations dealing with behaviour guidance or discipline strategies. While all jurisdictions prohibit physical forms of punishment, many also prohibit treatments that directly impact children's social and emotional development. British Columbia, again, stands out, stipulating that no child be subjected to belittling or degrading treatment that humiliates the child or undermines the child's self-respect.

Summary and Implications of Setting Regulations for Quality Care for Promoting Mental Health in Community-Based Child Care

Before the specific elements of quality care necessary to support children' s mental health can be specified, it is first important to acknowledge that mental health promotion is a key goal of child care. In turn, good practices must be spelled out in regulations in order to raise the level of quality in centres, a matter above and beyond ensuring child protection. By implementing regulatory standards conveying practices that foster social and emotional development, child care centres would have clearer guidelines about how to accomplish this type of work and jurisdictions would have a stronger basis from which to monitor and assist centres in meeting these standards.

Table 2: Qualifications for Child Care Staff

Provinces	Staff Educational Classification	ECCE Practitioner Requirements	Supervisor Requirements
British Columbia	**Early childhood educator** Basic ECCE training program from recognized institution; and 500 hours of work in Canada. **Infant toddler educator** Same as ECCE; and post basic ECCE infant and toddler training program from recognized institution. **Special needs educator** Same as ECCE Post basic ECCE special needs training program from recognized institution. **Assistant** In process of qualifying for ECCE certificate, or **Responsible Adult** 19 years of age Completed a course on care of young children or relevant work experience.	**0-3 Years** 4 or fewer children: 1 infant & toddler educator 5-8 children: 1 infant & toddler educator 1 early childhood educator 9-12 children: 1 infant & toddler educator 1 early childhood educator 1 assistant. **30 months-School Age** 8 or fewer children: 1 early childhood educator. 9-16 children: 1 early childhood educator 1 assistant 17-25 children: 1 early childhood educator 2 assistants	No additional qualifications are required.

Table 2: Qualifications for Child Care Staff

Provinces	Staff Educational Classification	ECCE Practitioner Requirements	Supervisor Requirements
Alberta	**Level 1 qualification certificate** Completed child care orientation course approved by Minister. **Level 2 qualification certificate** One-year certificate in early childhood development or education from a college. **Level 3 qualification certificate** Two-year diploma in early childhood development or education from a college.	**8 a.m.-4:30 p.m.:** 1 in 4 staff have Level 2 or 3 qualification certificate. **All other times:** All staff have at least a Level 1 qualification certificate.	Full-time program director must hold Level 3 qualification certificate. One such director must be on the staff of the child care centre at all times.
Saskatchewan	At least 16 years of age. **Early Childhood Educator I** 120 hour intro ECCE course from recognized institution. **Early Childhood Educator II** One-year ECCE certificate from recognized institution. **Early Childhood Educator III** Two-year ECCE certificate from recognized institution.	All staff (working 65+ hours per month) meet Qualifications of Early Childhood Educator I.	At least 18 years of age **Director** Meets or exceeds the qualifications for an Early Childhood Educator II. **Supervisor** Meets or exceeds the qualifications for an Early Childhood Educator I.
Manitoba	**Early Childhood Educator II** Child care program diploma from recognized institution or competency assessment program. **Early Childhood Educator III** Child care program degree from recognized institution or child care program diploma and child care specialization certificate from recognized institutions, or competency assessment program & child care specialization certificate from recognized institution. **Child Care Assistant** Not eligible on basis of educational requirements for classification in ECCE II or III level.	Two-thirds of staff in a full time day care meet the requirements of a Early Childhood Educator II or III. At least one staff person per group of children in a full time day care centre meet the requirements of a Early Childhood Educator II or III.	Centre director meets requirements of Early Childhood Educator III and has one year experience with children in day care or a related setting or of a Early Childhood Educator III.
Ontario	No regulatory classification and education breakdown for different positions.	At least one staff person for each group of children must hold an ECCE diploma from a recognized institution.	Supervisor must hold an ECCE diploma and at least two years experience working in a day nursery with children at the same age and developmental levels as the children in the day nursery where the supervisor is to be employed.

Table 2: Qualifications for Day Care Staff - continued

Provinces	Staff Educational Classification	ECCE Practitioner Requirements	Supervisor Requirements
Quebec	The following are considered acceptable qualifications for working in a child care centre: • An ECCE. certificate or diploma or successful completion of all the specialization courses for an ECCE. Diploma. • A bachelor's degree in preschool education, in preschool and elementary school education, in psychology with a specialization in child development or in child study. • A diploma in special education techniques supplemented by an attestation of college studies in ECCE or a university certificate in early childhood or day care education . • A bachelor's degree in psychology, psychoeducation, remedial teaching, special education or elementary school education and 2 college or university level courses one in hygiene and health of young children and the other in child day care services in Quebec. • A college studies attestation in ECE, teaching diploma with specialization in kindergarten or preschool education, or university certificate in early childhood or day care education, supplemented by 3 years experience with preschool children in a day care service or health, social services or educational establishment. • A college studies attestation degree in Native children education.		
New Brunswick	16 years of age No regulatory education requirements for staff working with children.		No regulatory education requirements.
Nova Scotia	No regulatory classification and education breakdown for different positions. The equivalent of early childhood education includes: completion of Grade XII. Minimum two years experience in a licensed child care facility. Completion of full credit course in post-secondary program covering one of the following: human growth and development with emphasis on the child or curriculum development and implementation of programs for young children; and completion of 25 hours in training programs, seminars or workshops addressing the topic not completed by way of post-secondary education.	At least two-thirds of staff must have completed an ECCE training program through a recognized institution or it's equivalent.	Chief administrative officer must have completed an ECCE training program or its equivalent.

Table 2: Qualifications for Day Care Staff - continued

Provinces	Staff Educational Classification	ECCE Practitioner Requirements	Supervisor Requirements
Newfoundland	**Lead staff person** Level 1 certification in: Preschool B ECCE infant toddler or specific Certificate. Preschool Level I certification and an infant-toddler orientation course (depending on the classification for the group of children to which that person is assigned). One year experience in that classification. **Other staff** Entry level certification in the preschool (orientation course) or infant-toddler (not available, must be Level I classification for the group of children to which that person is assigned.	At least one lead staff person per home room.	Operator (managing daily operations) must have Level 2 certification and two or more years of work experience in the classification of certification. Preschool Level 2 certification: ECCE specific diploma. Infant-Toddler Level 2 certification: Preschool Level 2 and an infant-toddler orientation course.
Prince Edward Island	One full-time staff member in each program must have a one year early childhood development diploma or university child study degree. All staff are required to have 30 hours of in-service training every 3 years.	0-2 years 1:3/maximum group size of 6 children. 2-3 years 1:5/maximum group size not specified. 3:5 years 1:10/maximum group size not specified. 5-6 years 1:12/maximum group size not specified.	Minimum one year early child development diploma or university child study degree.
Northwest Territories	All primary staff must be 19 years of age Support staff under the supervision of a primary staff person may be under 19 years. No regulatory education requirements for staff working with children. It is noted that every primary staff person should have an awareness of early childhood development theory and the ability to apply that theory to the operator's program.		No regulatory education requirements.
Yukon Territory	**Child Care Worker I** Completed a 60 hour introduction course on early childhood development or the equivalent. **Child Care Worker II** Completed one year of training in early childhood development. **Child Care Worker III** Completed two or more years of training in early childhood development.	50% of staff must meet or exceed Child Care Worker I qualifications. 30% of staff must meet or exceed Child Care Worker II qualifications. 20% of staff must meet or exceed Child Care Worker III qualifications.	No additional qualifications are required.

CHAPTER 4:
Promoting Mental Health in Child Care: Developmental Considerations and Applications

Activities that can promote mental health depend on understanding the developmental capacities and needs of young children at different ages. We will briefly look at the major developmental tasks related to mental health promotion during each of the three age periods delineated for our scan of child care centres: **1)** infants (birth to 18 months), **2)** toddlers (18 months to 3 years); and **3)** preschoolers (3 to 5 years). It is also important to emphasize that these components are interrelated. However, for the purpose of our discussion we will treat the various components of social and emotional development separately. The components of social and emotional competence to be discussed below include: **1)** attachment formation, **2)** emotion and behaviour regulation, **3)** emotion understanding and expression, **4)** development of a sense of self including self esteem and self-efficacy; and **5)** peer relationships. Some specific activities or tactics that ECCE practitioners we interviewed found to be effective are included as examples in the following sections.

Attachment Security: Building Trusting Relationships Between ECCE Practitioners and Children

Forming a secure attachment to parents and other caregivers is important for social and emotional development across the life span (Bowlby, 1969). Essential to attachment is the development of an emotional tie between children and primary caregivers during the first year of life that is dependent on the way that caregivers respond to the child, especially when distressed. Parents and other family members are the first and foremost trusting relationships and attachment figures for children, but children also form attachments with their primary ECCE practitioners. Although the specific nature of ECCE practitioner-child interactions changes over the period from infancy through the preschool years, attachment relationships at all ages are characterized by the ECCE practitioner (and other caregivers) acting in particular ways:

• rapidly responding to a child who is frightened, ill, or otherwise distressed by comforting and soothing them; as children gain language skills they are able to talk about distress as well as receive physical comfort;

• building trust in their availability and consistency;

• providing predictable routines, responses, and traditions so that the children know they can count on the practitioners for support;

• creating a safe environment for children to explore, and gradually separate and become more autonomous;

• taking an active interest in the children and offering encouragement;

• encouraging verbal exchange that is reciprocal rather than directive;

Development proceeds more optimally for children who are securely attached (Goldberg, 2000). As mentioned in Chapter 2, secure attachment is associated with children's capacity to regulate emotions and behaviour, feel confident and effective, and have more harmonious social relationships with adults and peers.

Infants

The roots of attachment formation with preferred attachment figures emerges around the middle of the first year. Although parents are infants' first and foremost attachment figures, research reviewed in Chapter 2 makes it clear that infants also form attachment relationships with their ECCE practitioners.

Due to their limited mobility and need for external care and regulation, infants who attend centre-based child care need the frequent attention and ministrations of selected ECCE practitioners. This explains the necessity for a lower practitioner: child ratio for infants than for older children. Children gradually come to prefer certain practitioners and, by 6 or 7 months, show fear and avoidance of practitioners with whom they are not familiar. This parallels the attachment process with parents. Early relationships with young infants revolve primarily around sleeping, feeding, and soothing. Within the attachment relationship both interactive reciprocal and exploratory play will develop, beginning by 4 to 8 months (Bornstein & Tamis-LeMonda, 1990; Cohn & Tronick, 1987). Fear and avoidance of strangers means that infants have come to expect care and protection from certain specific individuals. It is presumed that infants form a kind of mental representation of parents and practitioners that includes their expectations about these relationships. Moreover, feeling secure in their primary attachment relationships, infants increasingly exercise an innate curiosity to explore their environment, using attachment figures as a base. The selective attachment relationship persists but infants gradually use the positive experiences with attachment figures as a template for relationships with a broader range of individuals, both adults and children. Practitioners' participating in the scan described many ways they make a connection with infants:

> I give the children time to become comfortable with me. I won't push myself on them; I wait until they come to me. I don't invade the child's space. The first time at the centre I don't hug and snuggle children right away. It's not appropriate because I am a stranger to them. The second time I put a toy in between myself and the child as a way of getting closer but not too close. Maybe the third time I will share some physical affection with the child.

> We have a primary caregiving system and this allows staff to build bonds with both parents and infants. I get to know the family's values and the infant's cues. One individual is consistently responsible for an individual child's toileting and feeding and that really helps in making a connection.

> I don't just act on the children. I try to make them active participants in what's happening as well. I talk the children through routines like diapering and establish eye contact. I tell them what's coming and what will happen; that makes things predictable for babies and will help them understand what's going on and what they need to do. I also do what I tell them I'm going to do. For instance, if I say "I'll be right back", I make sure that I do come back. It's always about following through and being consistent.

> I work hard on forming an attachment with the child at the beginning of care. It takes time and patience to build trust but eventually the child feels "I matter to somebody". I encourage parents to come for visits before the start of care to build relationships between staff and parents. This helps mommy to feel comfortable and gets the baby used to staff voices. It doesn't take the baby a long time to adjust.

> With research indicating that children form attachment relationships with ECCE practitioners, in addition to their primary attachment to their parent, it is clear that practitioners need to work closely with parents around attachment related issues. Starting care in an unfamiliar environment with new adults, children will look to parents to gauge the safety of the setting and practitioners. They may base their reactions to such situations on parents' responses.

> I don't let a parent sneak out. For instance, a mom has a baby in her arms and turns the baby over to staff and says "I have to go but I'm going to leave you with Bertie". Eventually the baby reaches out for the staff. This is important to build trust.

Toddlers

During the toddler period, a major task for children is balancing attachment and exploration needs with increasing movement toward autonomy and individuation. Although toddlers continue to want to interact with parents and practitioners, they also have ideas of their own and want to reach their own goals ("Me do it."). The attachment relationship forms the context for this kind of autonomous exploratory behaviour. There is now also a keen awareness that sensitive responsive caregiving stimulates and supports children's early learning so that toddlers feel appropriately challenged and not frustrated in their learning experiences. Thus, toddlers learn through their early relationships

and with the support of attachment figures. There is currently tremendous interest in an approach valuing an "emergent curriculum" which relies on attentive responsiveness to children's individual interests as a means of building new knowledge.

Moreover, rapid growth in cognition and language link with other areas of development so that, for instance, children's capacity to observe regularities in their lives leads them to develop conscious expectations and to predict and anticipate what is to happen. For this, establishing schedules and routines is an important part of child care. In the toddler years, children gain the cognitive awareness of routines and are able to use this to feel secure. Words begin to supplement physical actions and toddlers show growth in their ability both to express feelings and to be comforted by words. Furthermore, separations are less difficult for toddlers because they can be reassured that their parents or practitioners will return for them. These are some examples of what the ECCE practitioners said about forming and maintaining attachment relationships with toddlers:

> I bond with them on their level. I become involved in what they are doing or respond when the child becomes involved in what I am doing. Through these opportunities I can give words to the things that I am doing and what children are doing. It helps children identify what they are feeling in terms of their emotions, body, etc.

> I keep the children informed of the day's activities and let them know what their choices are, make sure their physical needs are met, and respond with approval in words, touch, smiles, and proximity. I maintain a calm tone of voice and speak to the child at eye level to create and build an atmosphere of trust.

> Staff set examples by listening, letting children choose activities, and being flexible to change activities that the children are not interested in.

> When a child starts care and first comes to the centre, one teacher is available just for that child. Another teacher comes in for the other children. The new child gets the teacher's undivided individual attention. They take things slowly and there's no pressure on the child. The teacher is always conscious of the child's feelings. Previous to that, the teacher makes a home visit and gets a sense of the child's likes and interests. Then she can incorporate these into the room and the child sees something they like immediately.

Preschoolers

While preschoolers still need physical comfort and a sense of safety and support, they are more independent than infants and toddlers. Moreover, during this period both adults and children increasingly take into account others' attitudes, wishes, and needs in negotiating outcomes. Children must have adequate language skills for versatility in negotiating

relationships and establishing a sense of self as independent of others. At the same time, this growing capacity increases the potential for conflict with others when they have opposing goals and plans. Helping children to manage negative affect is an important role played by both parents and ECCE practitioners. A preschooler who is able to say "I am mad" or "I am sad" is more likely to gain the support and understanding from adults than one who throws tantrums or breaks toys. Negotiation around goals is what Bowlby (1969) called the "goal corrected partnership", and successful negotiation is important for maintaining important attachment relationships. Practitioners reported ways in which they make accommodations that suit preschoolers' growing maturity:

> Every child is unique and I need to know their individual characteristics and how they will respond. I take cues from children so that they will feel respected and that I am there for them. I also let them know that the rules and routines are for everyone. We do a lot of explaining of reasons for different rules at the centre. This helps the children to know the practitioner's role and understand why she's there.

> It's important for me to be the same person for the children, in terms of disposition and mood, every day, regardless of what happens at home and in my personal life. But if there are negative things going on, children may notice small changes in me. When that happens, I share my feelings in a simple way that lets them know I am not acting differently because of them.

> Listening and responding to both their words and actions. Being respectful and treating the children as individuals. I adapt according to the child, different personalities, and likes and dislikes.

> Allowing the children to express themselves. Listening, echoing what they're saying and adding on both in order to make sure I understand their feelings and to confirm their feelings. The rules are reasonable and consistent but children can experiment and express themselves within those.

Emotion and Behaviour Regulation

In its broadest sense, the terms emotion and behaviour regulation, or self regulation, have been used to refer to the capacity to regulate emotions and behaviour flexibly to meet the demands of a particular situation (Kopp, 2002).

With maturity, children gradually learn strategies for managing their own emotions and social interactions. Well-regulated children are good problem solvers, develop peer interaction skills in play, are more able to compromise and meet mutual needs when playing with peers, and make new friends. This contributes to social competence, self-efficacy, self confidence, and overall feelings of well being (Denham, 1993; Fox, 1994), all characteristics of good mental health. Children who begin school and who are not able to control their emotions and behaviour are at a distinct disadvantage.

More specifically, children must learn to comply with daily family and child care routines, something that typically begins in the second year of life. During the second and third years, children gain better understanding of their own and others' emotion states, can talk about emotions, and are better able to balance self defined needs and social-cultural values and norms. In the group setting, in particular, children must be attentive to practitioners' messages and signals and also have a secure attachment to the ECCE practitioner for this process to be successful. Even children as young as 10 months of age begin to monitor the facial expression and vocal tone of a familiar adult in unfamiliar situations (*social referencing*) and approach or retreat based on the adult's facial expressions and emotional response (Klinnert, Campos, Sorce, Emde, & Svejka, 1983). While children become increasingly compliant during the preschool years, they also have goals of their own. Thus, the capacity to assert preferences, to negotiate, and to compromise while regulating emotions and behaviour becomes increasingly more important.

Turning to caregiver behaviour, we can think of both proactive and reactive components of regulation. The child sees little of the proactive elements of caregiving which involve ensuring that the child's environment is as safe as possible (e.g., child proofing cupboards containing hazardous substances). The reactive component of caregiving involves sensitive and accurate responding to the child's perceptions of danger and resulting emotions. Because children may perceive danger in conditions that adults consider to be objectively safe (e.g., a new practitioner), the success of the practitioner in this domain is related to their ability to see things from the child's perspective and to read affective cues accurately.

Parents and ECCE practitioners also guide, coach, and support children to use strategies to manage emotions and behaviour appropriate to the situation at hand. This could involve redirecting a child, invoking rules about expected behaviours such as sharing, providing reassurance, and encouraging empathy for other children.

Infants

From the first months of life, children differ in temperament. Some infants are irritable, more difficult to soothe, and have difficulties with new situations and making transitions ("difficult" temperament). At the other end of the spectrum are infants who are slower to engage and shy ("slow to warm up" temperament). Parents and practitioners need to find ways to deal with different temperamental styles. For instance, infants who have a more "difficult" temperament may need to have the number and intensity of new stimuli kept to a minimum. As older children, they may need to be given more notice that a transition is about to take place. For infants who are slow to

warm up, practitioners may need to permit time for an infant to survey a new playroom or activity before stepping in to play. Thus, practitioners adapt situations to take into account individual differences in infants' temperamental style.

From 9 to 12 months, infants become better able to regulate their own physiological, emotional, and behavioural states and can move about their environment as they progress from crawling to walking, expanding their ability to regulate generally, explore, and show increasing autonomy. Infants scan their environment to look at and reach for interesting objects and join into interactions and exchanges with practitioners which become longer and more complex.

Practitioners who were interviewed in our scan reported the following:

> I constantly observe individual children and how they deal with situations. I immediately comfort and support them depending on individual needs and wants. For example, I have to respect the fact that some children want to be by themselves.

> I don't try to fix the problem. Instead I encourage the freedom of expression of emotion and create a safe space to release those emotions. If a child is banging their head on the floor, I put a pillow underneath.

> With physical challenges, such as the child getting stuck somewhere and trying to get out, I give the child a chance to try it for themselves. I encourage them and maybe help them a bit. If the child becomes upset and starts to cry, I guide and assist.

> I monitor the environment to anticipate problematic areas. I make changes as needed, adding or reducing stimulation. There are lots of choices in activities and I keep age appropriate expectations of children's behaviour. As well, I don't just use words, I also use actions which speak louder for this age group.

> I keep the tone of the room quiet with soft voices and not too much yelling. It makes it less overwhelming.

> I go with the child to activities and hold her hand. This lets her know that I'm there for her when she needs assistance. Gradually the child needs less assistance over time and becomes more comfortable.

Toddlers

The onset and rapid growth of language in the 12 to 36 month period is a major milestone in toddlers' developing capacity for emotion and behaviour regulation. When toddlers are good communicators they are more competent in regulating their own emotions and behaviour. However, strong emotions can disrupt their capacity to communicate needs. Therefore, although toddlers have begun to use language for self regulation, they still need continued adult support and responsiveness when the child is distressed or frustrated (Sroufe & Waters, 1977).

During this period not only do toddlers acquire a vocabulary for individuals, events, and objects in their environment but they can also label their own feelings, and their feelings for others, understand verbal feedback about the appropriateness of their emotions and behaviour, and think about ways to regulate them (Kopp, 1989). Because toddlers explore more and come into contact with new situations, objects, and people, ECCE practitioners play an important role in supporting these experiences. They do this not only by their proximity with toddlers but, increasingly, with talking and explaining things to them. Further, toddlers' capacity to put things into their own words helps them to gain control and prepares them for unfamiliar or potentially stressful situations. Toddlers learn much through imitation and attachment figures serve as models in these situations. Some strategies described by ECCE practitioners for helping toddlers regulate their emotions and behaviour are as follow:

> I give them words to confirm their emotions without judgment, "You're stomping your feet. Are you angry?" or "I think you're angry." Also, I provide them with words like "stop" and "I don't like that".

> Sometimes I sit with the child and have them breathe deeply along with me to calm down. I relate it to an imaginary balloon children have in their pocket that they blow up and then slowly let the air out and calm down.

> Some children need a quiet retreat to soothe themselves and then return to the group. We have a special cave they can go to that has soft blankets and pillows in it. We also offer appropriate ways to release frustration such as "squeezy balls" that compact to children's hands.

> If the group starts to run around too much, I call for a group discussion. "Can you tell Bev why we're all sitting here?". Children often respond with "Cause we're running". "Why is it not safe to run?" The children problem-solve, coming up with ideas like going outside. It's an opportunity to get children's feedback and it's a little learning session about why running isn't safe.

Practitioners also help children who are shy or slow to warm up to gradually enter groups so that they can participate socially.

> I introduce a shy child to other children individually, not as a group because it can be overwhelming.

> I find out the child's interests and then use them (e.g., playdough) to help stimulate the interest of other children who eventually may join the activity. I guide the child through the invitation to other children.

> I involve a shy child actively in important duties and tasks, focussing on and commenting on their strengths. I provide opportunities for their success and display their work.

Preschoolers

Preschoolers make tremendous strides toward emotion and behaviour regulation and episodes of negative emotion expression, such as tantrums, diminish (Kopp,1989). The cognitive ability to anticipate the consequences of behaviour contributes to improving affect and self regulation which is increasingly supported by children's internalization of social expectations. During this period, preschoolers are more competent in using language for self control as well as for learning and social and emotional communication. Growth in memory skills means that children are increasingly aware of connections between the past and present, and are able to predict future events based on past experiences (Kagan, 1984; Rovee-Collier, 1990). Examples of how practitioners work with these older children, especially to use language to control emotions and behaviour are as follows:

I try to get children to transfer high energy behaviour that may be unsafe into a slower pace. If I start using sign language with a child, there are no words and the child has to calm and quiet down in order to focus on what I'm saying and to respond.

We teach children calming techniques such as breathing in through their nose and out of their mouth, putting their hand on their chest to feel their breathing. Having the children look at a mirror at themselves and guiding them with "Take a look at your face. What does it look like? How do you feel when you see this face on others?" It helps them to understand what they're experiencing.

We have a "Behaviour Chart" at the centre which includes anger, sadness, etc. It shows "Do's and Don'ts" for expression of different feelings, with pictures and descriptions for each thing. Children can refer to it by themselves or with a practitioner. It encourages independence and self-control. It also takes the focus off the child and puts it on the paper.

I promote thinking first before acting. I talk to the children about their options before problematic situations happen, letting them know they can talk to the other child if they're in a conflict or they can go to a practitioner if they are angry or need time alone.

We make a point at the beginning of the year of talking with the children about what rules should be in place. I ask things like "Should we hit each other" and the children's response is "Well, we shouldn't hit". It puts the onus on the children to explain reasons why they should treat each other kindly and express themselves. Then, we can refer to it later on in actual situations.

"Rory the Lion" (has sound effects and actually roars) is under a paper bag during a shy child's first day of care. We say "He's feeling shy now and new to the group". Then Rory comes out and greets each child while singing songs using children's names. The shy child can use Rory during group games if they're not participating.

I partner the shy child with an outgoing one with excellent social skills. I explain to the outgoing child that "So and so finds it hard to ask you to play. Could you help her? The outgoing child is usually eager to try it. The children are at the same eye level and more one-on-one than what's available with staff. It's the same scenario as a new staff person clicking with one person that goes out of her way to make her feel comfortable.

Understanding and Expressing Emotions

Putting feelings into words and encouraging children to do so are important contributors to attachment security, to emotion and behaviour regulation, and to relationships with peers. By 2 years of age, children can identify and label basic emotions in themselves and others (Dale, 1996; Dunn & Munn, 1987). By 2 years, words about sensory perception, physiological states, and volition are common, followed next by words for the basic emotions of joy, anger, sadness, fear, and disgust, and words referring to moral approval (e.g., "good boy"). The capacity to identify more subtle emotions and conflicting feelings grows throughout the school years (Dunn, Bretherton, & Munn, 1987).

Infants

One fundamentally important example of emotion understanding and expression in early development is the infants' growing capacity to share pleasurable experiences with caregivers and to learn to use words to share interests and express feelings (Mundy & Willoughby, 1998; Wetherby & Prizant, 1993). It is not only a way of sharing emotion and interest but is another way that infants are able to experience themselves as having an impact on the world.

I give them words and simple language for their feelings and how to get their needs met. It's important to verbalize and validate their feelings with phrases like "You're sad because Mommy left."

I'm careful not to hinder self-esteem when they are just learning about their own "temperature". It's OK to feel angry and I provide an appropriate outlet. It's about labelling the emotions and not the child. They need to experience both positive and negative feelings.

Some stress helps children develop strengths. Staff meet their needs, but are not overindulgent in always doing things for them. Stress gives them the opportunity to understand what their bodies are feeling and what emotions feel like.

One little boy was not allowed to cry at home or play with dolls because his parents didn't believe boys should do that. As a result, he wasn't able to express emotions in different ways. I talked to the father about his son playing with dolls, explaining it was good practice because one day he'll be a father and will have to take care of babies.

Toddlers

In the toddler period, the process of understanding and expressing emotions is facilitated by increased language skills. While older infants are able to label some simple feeling states, toddlers have a wider emotional vocabulary. As well, between 2 and 3 years of age reference to causes of emotional states increases (Brown & Dunn, 1992). Toddlers also develop some autonomous self-soothing behaviours and use transitional objects for self-soothing and to cope with separation. Words concerning moral obligation, such as "have to," and words concerning cognitive processes, such as knowledge and memory ("I know"), do not appear until around 3 years (Shatz, Wellman, & Silber, 1983) when the child is capable of experiencing emotions such as shame and embarrassment.

How parents and other caregivers respond to toddlers' emotional displays contributes to how they cope with emotions and regulate emotions in particular contexts (Eisenberg, Fabes, Schaller, Carlo, & Miller, 1991). Within families, references to feeling states made by mothers and older siblings are related to 2 year olds' language around feeling states (Dunn et al., 1987). These kinds of conversations with adults and other children are just as important in the child care setting. When practitioners or other caregivers avoid discussion of feelings or mislabel or distort them, then children suffer in their own capacity to do so (Crittenden, 1996). Practitioners must also deal with behaviours that pose challenges. For instance, toddlers need to assert themselves and adults must control their own strong feelings in order to help toddlers cope with and regulate their behaviour. The process of understanding and expressing emotions is facilitated in child-focussed discussions about emotions and negotiations around conflicting goals (Dunn & Brown, 1991). Moreover, research has shown that children who express both positive and negative emotions appropriately are better liked by peers (Sroufe, Schork, Motti, Lawroski, & LaFreniere, 1984).

It is not simply conversation about emotions that is important but having extended conversations (Dunn, Brown, & Beardsall, 1991), something that may be more difficult in the child care environment. Significantly, this was an area in our scan with few extensive examples. Acknowledging and labelling feelings was a common response, suggesting perhaps that extended conversations are not frequent practice. Interestingly, the specific actions of ECCE practitioners that facilitate emotional expression have not been extensively studied in child care settings.

Practitioners and parents can also promote mental health by exhibiting and modelling for children their skills in coping with emotions. When parents or ECCE practitioners accurately label and are empathic with children's feelings, children are also likely to be empathic (Eisenberg et al., 1991). Although toddlers generally do not respond when another toddler is in distress, there is a higher rate of toddler attention to another toddler in distress when a practitioner responds sensitively to children who are distressed. Children are also more likely to show a prosocial response when they share an affective relationship with another child (Farver & Branstetter, 1994). This supports findings that, within families, siblings provide an important opportunity for a younger child to observe and learn from the distress and caregiving of others (Dunn, Brown, & Beardsall, 1991; Lamb & Zakhireh, 1997). This underlines the importance of practitioners promoting positive caring interactions between peers in their child care setting.

Toward the end of the toddler period, children begin to be able to organize narratives to talk about their experiences and inner life and share them with others, both verbally and through play. These narratives represent a convergence of skills that include using language to retell memories, anticipate experiences, process emotional events, problem solve, practice questions, and reflect on relationships with others (Dunn & Brown, 1991; Nelson, 1993). Narrative skills can also be used to talk through things that are puzzling or troubling (Nelson, 1993).

While labelling, describing, and talking about one's feelings helps toddlers to understand those feelings, it is also important for them to gain experience in regulating the behaviour of others (Vygotsky 1962). For instance, the interaction pattern encompassed in interchanges where the child gains not only attention but also the interest and affect of the partner is important for development of self regulatory capacity as well as for language and social cognitive development (Greenberg, Kusche, & Speltz, 1990).

> Toddlers have a sense of others' feelings but are still very egocentric at this age. I point out physical cues of other children, especially facial expressions, and label them. I put pictures on the wall of real people expressing different feelings."

> We talk about feelings during circle time. Children create expressions on the face of a circle head glued to a Popsicle. We also sing while looking into the mirror, picking one child and singing about their facial expression."

> Potty training is an overlooked milestone because it's seen as expected. Each child is very different because they have a different awareness of their bodies and it can be a vulnerable time. A variety of emotions may be expressed such as excitement, fear, stress, frustration, etc."

During the toddler period, play becomes another medium through which children can communicate about their feelings. Specifically, from 12 to 36 months of age play becomes more complex in that sequences of events come to be represented mentally; toddlers can use actions and words to stand for people and objects. This enriches the ease with which parents and practitioners can interpret and accurately respond to the toddler's inner world. In the process of symbolic pretend play alone and

with the practitioner, the toddler also has the opportunity to share feelings and to hone understanding of them as is shown in the next example:

> Shania's family was continually moving. While in the dramatic playhouse one day, Shania emptied all of the shelves in the kitchen. When asked what she was doing, Shania said "I'm moving again!" When the parents were told about this, they were reassured that this is a normal activity that gave Shania an opportunity to express her feelings.

Preschoolers

Between 3 and 4 years of age, children begin to understand that others' mental states (i.e., thoughts, ideas, and beliefs) are not necessarily accurate representations of reality. Preschoolers are able to see the views of themselves and of others so that they can both share understanding and also disagree. Preschoolers' growing capacity to express their thoughts and feelings verbally also means that they will use language more frequently to participate in interactions with adults and other children. They rely less on emotional or physical action to indicate attachment needs. They can ask for help or succour and express feelings in words in a way that others will understand. Preschoolers who are securely attached and have good verbal skills are confident that they will be understood by parents and other caregivers. For their part, parents and ECCE practitioners must allow appropriate autonomy and encourage and respect verbal expressions of feelings.

Preschoolers need practice in negotiating conflicts and disagreements. Opportunities for practice will make it more likely that a child can take into account others' attitudes, wishes, and needs. These early means of arriving at mutually satisfying decisions, at least some of the time, set the stage for later childhood. Associations have been found between the quality of mother-child conversations about emotions and later differences in social cognitive skills, including the ability to discuss emotions (Dunn et al., 1987), take another person's perspective (Dunn et al., 1991), and understand the beliefs and feelings of others (Dunn, Brown, Slomkowski, Tesla, & Youngblade, 1991). When conflicts arise, children without good language skills will have difficulty in these conversations and negotiations and may resort to immature means of negotiating, such as tantrums or aggression (Bloomquist, August, Cohen, Doyle, & Everhart, 1997). Therefore, practitioners need to be able to evaluate preschoolers' language competence. If they want children to use words to express feelings and to resolve conflicts it is necessary to know whether the children have the verbal capacity to do so (Girolametto & Weitzman, 2002). The critical importance of good language skills is illustrated by the following examples provided by practitioners who participated in the scan:

> I try to make children aware of the effect their actions have on others. With anything from daily toy taking to bullying, I comfort the child who is upset or hurt and then talk with them about their feelings, asking leading questions such as "Has this ever happened to you? How did you feel? How would you feel if this happened?" Sometimes I use an example about something I might feel, e.g., "I would be very upset if my mom left".

> There's a "Happy Box" at the centre. Children put things in it every day that make them feel happy. Periodically, we all go over, open it and share the items (i.e., dolls, stories) with the whole group. The children have the chance to tell everyone why the items made them feel good.

> We talk about problems; if a child is upset and wants to be alone I ask "why, do they want to be alone, not in the group", and give them some space and a choice of whether they want to talk or not. It's done in front of the other children. It helps the children learn that not everyone feels the same way as others all the time.

> We talk about children's feelings during major times. One child was going to the hospital for tonsil removal. I brought in relevant resources and books and talked about the positive aspects of a trip to the hospital. We had the child share her experience afterwards with the children.

Supporting Development of a Sense of Self, Self-Esteem, and Self-Efficacy

Throughout development children must gain a sense of themselves as individuals who are valued and who can have an impact on their environment. This is closely related to positive mental health.

Infants

Beginning in the latter half of the first year, increasingly infants become aware of their needs and how to express them. That they can make things happen in their environment is considered to be a sign of an emerging sense of self (Stern, 1985). However, initially, the caregiver structures infants' environment in a way that helps the infants to organize expectations and thus have some sense of control. Eventually, they can take on a greater capacity for control and participation in social interchanges on their own.

Infants who have sensitive and responsive practitioners feel that they are valued. Infants' sense of competence and efficacy is also influenced by the practitioner's ability to scaffold experiences so that infants are challenged within reasonable limits that allow for success with guidance and support.

> I show them how to feel proud of themselves. If a child makes a tall building of blocks, I encourage her to clap her hands and dance around. Meanwhile, I verbalize her accomplishment and use happy facial expressions (e.g.,bright eyes). It's about getting the children to look into themselves and feel proud rather than looking to me to feel proud of them.

> I give lots of praise and encouragement, smiles, hugs, and cheers when they accomplish something. I make sure to provide age appropriate materials to increase opportunities for success. It's important to allow children to do things at their own pace too.

> I provide them with self-help skills. I encourage them to feed themselves with a spoon, using hand-over-hand feeding practices. They get to wipe their own noses, wash their own faces, and they have the choice of when to have their bottles.

Toddlers

Self-understanding grows markedly in the second and third years. Toddlers are beginning to recognize themselves as unique individuals and, for instance, can identify themselves in a picture or in a mirror. Self-assertion is another sign of a developing sense of self and between 14 and 20 months, toddlers' behaviour is increasingly directed toward fulfilling their own wishes and goals. Older toddlers are also increasingly aware of the subjective states of others and are beginning to empathize with other children. However, because awareness of self and of others develop at the same time, and in conjunction with desires for having their own way, there is frequent conflict between children.

Language also becomes a tool for toddlers' continuing awareness of themselves and differentiation of self from others when they begin to use the words "I", "me", "mine" at 2 to 3 years to refer to themselves. As early as 12 months of age, children recognize that others have a point of view and intentions that differ from their own. As children move toward their third year, they start to use language to refuse assistance and insist on doing things themselves to assert their competence and autonomy. The frequent use of the word "no" by toddlers is one way of creating choice for, and thus defining, themselves. Self awareness and self understanding are dependent on the evaluation of others. A view of oneself as competent and lovable facilitates a positive sense of self while a view of oneself as incompetent and not valued can interfere with sense of self, reducing willingness to take risks to explore the environment and learn. Moreover, two- to three-year olds' mental health can be impacted by the fact that their emotional repertoire broadens to include emotions like pride, shame, guilt, and embarrassment that are evoked in social situations in response to others' evaluations. While more autonomous, at the same time, toddlers are anxious about losing the love of attachment figures and these fears are heightened when an attachment figure is rejecting or angry.

> I always give children choices to make them feel in control when solving problems. At this age, giving them two options is ideal and the number of choices doesn't overwhelm them. Also, I provide opportunities where they can succeed. "Find your shoe" for example, instead of "Put your shoe on", which isn't developmentally appropriate.

> All children have picture symbols to represent their names. They suit the personality of the child or their interests (e.g., fish, boat, dinosaurs). The symbol moves on with the child into the preschool room. We also have a chart display listing each child's likes, dislikes, and characteristics.

> I include children in the scheduling of our activities. It helps them feel a part of the whole experience and independent. We also have democratic votes about things like where we have circle time.

> When children spill something they often look to me for a negative reaction. I deal with it calmly and don't overreact.

Preschoolers

Just as in earlier years, preschoolers' sense of self develops through the way in which they receive social feedback with attachment figures, other adults, and peers. When the feedback is inaccurate, critical, and/or questioning, it elicits feelings of anxiety and low self-esteem. From the toddler years onward, there is evidence that adults overestimate what children understand. For instance, Kaler and Kopp (1990) found that toddlers' receptive language competence was directly related to their compliance to adult commands. Moreover, preschoolers referred for mental health services often have receptive language impairments (Cohen, Barwick, Horodezky, Vallance, & Im, 1998; Cohen, Davine, Horodezky, Lipsett, & Isaacson, 1993). Thus, inaccurate feedback may arise from misattributions for children's behaviour. This can happen, for instance, when children are accused of willful disobedience when, in fact, they do not understand or remember what was said.

Emergence of a "theory of mind" during this period means that children recognize that others can have different interpretations of the same situation (Astington, Harris, & Olson, 1988). One outcome of the development of theory of mind is that preschoolers begin to be capable of masking their true feelings. To avoid the discomfort of anxiety that interferes with positive self regard, some children may give the impression of not caring. This may be expressed through depression and withdrawal or by angry aggressive acting out which further impedes development of a sense of self.

> I keep a daily journal for each child and write down things done from the point of view of the child (e.g., "I worked with beads" and then paste some beads in the book). Parents write in what children do outside of the centre (e.g., "I went to the park."). Then they might paste some leaves in the book. During circle time we all share journal contents with other children.

> When a child has done something inappropriate and asks if I'm angry with him, I say "no" and reinforce that I'm upset about the behaviour but not at him. I explain that feelings are normal, everyone has a bad day, but I reiterate how to handle it in the future. I stress that tomorrow's a new day. I try to help a child understand that he can respond in a better way the next time.

> No nicknames. I give children the dignity of their names. Instead, I use their real names a lot, so they know that I know who they are and that I'm paying attention to them.

> I talk about a child's actions rather than be evaluative. "You're doing…" as opposed to "That's pretty." I ask them about what she's doing using open-ended questions and really listen. I try to find out about how the child feels and values the activity she's doing.

> When a child is expressing his opinions and preference I truly listen. He has my full attention, I'm down at his level, making eye contact and not allowing other children to interrupt. I don't respond for a few seconds after he's done in case he has more to say, then I repeat or rephrase what he's saying and extend his language without coercion. If the child agrees with what I've said, he lets me know. It makes him feel important because he has adult acceptance and I'm responding to what he's expressed in a respectful manner.

Children also now begin to remember events because of their personal significance and the emergence of "autobiographical memory" is one reflection of this (Nelson, 1993). Specifically, sharing memories with parents and practitioners allows the memories to be further enriched and personalized thus adding to self understanding (Nelson, 1993). By the time that children enter school they can describe their personalities (Eder, 1990) and can evaluate their own capacity to succeed or fail at tasks (Stipek, 1992).

Helping Children Build Positive Peer Relationships

From the toddler years onward, children's relationships expand to focus increasingly on peers. Children become less egocentric because they are both more cognitively able and have had more experience interacting and taking others' perspectives. They also value peers' perspectives more and more. This means that children must take peers' wishes and interests into account in play and, because of this, are more likely to negotiate, share, and cooperate with them. Establishing peer relationships is jointly influenced by the quality of relationships with attachment figures and by acquiring specific social cognitive skills. As noted earlier, there is ample evidence that warm, sensitive, and supportive relationships are linked to positive relationships with both adults and peers (Goldberg, 2000).

Toddlers

Although peer relationships do not come into full bloom until the preschool years, at home and in child care toddlers begin to learn about social roles and tasks and expectations relevant to social interactions in their culture and to the child care environment. These include: sharing and reciprocity, controlling emotions and behaviour in order to engage in social interactions, and establishing gender roles and social rituals. Toddlers also begin to internalize parents' and others' social values and

standards. Therefore, sometimes there can be a difference in what is expected of children at home and in child care. It is important for practitioners to be aware of these differences and make clear the differing expectations so that children are not upset or confused.

Toddlers' egocentric view of the world, combined with their need to feel autonomous and in control, sets limits on their ability to share or to acknowledge that others have different intentions than their own. In child care, toddlers tend to shift between solitary play, parallel play, and social interactive play with peers. Imitation of one another, shared interest in toys, and simple games are the norm (Brownell & Brown, 1992). Toward the end of the toddler period, children begin to show signs of cooperative play by taking on different roles and, in so doing, are learning the social skills necessary to engage with peers. Because toddlers cannot yet subordinate their own wishes in the service of sustaining reciprocal and harmonious play, joint play is often brief and conflicts frequently arise, particularly over the possession of toys. Practitioners participating in the scan offered the following suggestions:

> I create games about taking turns. When having two toddlers build a block tower, I guide each child to add a block. I give them time and praise them when each adds a block. This also helps them to gain an appreciation for each other's accomplishments.

> I use props to help children understand different perspectives. If a child pushes someone, I use dolls to show a similar scenario, identifying which doll is which child. It helps the children process it in a different manner outside the situation.

> They're so egocentric at this age. To promote empathy, I point out the physical cues of the other child, especially facial expressions. I also guide physical actions, such as rubbing the other child's head. Toddlers have a sense of others' feelings. I try to guide them through helping someone feel better.

> For children in conflict, I approach them calmly, stopping any hurtful language or action. I acknowledge both children's feelings and encourage both of them to express themselves. Gathering information about the situation, I use open-ended questions to get both kids talking about what the problem is. I ask them for ideas and solutions and then they have to choose a solution together. Then, I give them support in implementing the solution.

Preschoolers

The majority of young children in centre-based care are preschoolers. Beginning at 4 to 5 years, children form a broader range of social relationships. There is an impetus to maintain individual friendships over time, although friendship is still defined by who is or is not a playmate and by physical attributes (Selman & Schultz, 1990). Preschoolers are still egocentric in their thinking, which causes limitations in accurate understanding of another's perspective. Although preschool children develop positive, pleasurable interaction

skills, they also come into conflict, get into arguments, and are sometimes physically or verbally aggressive. Because preschoolers want to be accepted and valued by peers, these events can become an opportunity to learn about resolving conflicts. A considerable amount of research has tracked children's capacity to solve social problems with peers, a complex process which involves being able to define the problem, understand that the perceptions, beliefs, and feelings of the partner in conflict are different from one's own, generate and try out solutions, and come to an agreement that the problem is solved (Crick & Dodge, 1994; Yeates, Schultz, & Selman, 1991). Both increased social cognitive maturity and language skills are reflected in a growing ability to see and report circumstances from another's perspective, recognize and label emotions, reflect upon and talk about feelings, express empathy, talk about the consequences of one's actions on others, and discriminate between imaginary and real. Some ways in which practitioners used these emerging social cognitive skills are as follows:

> I help children think of things to make sad or hurt children feel better rather than saying sorry, which is often not meaningful because children are put on the spot. I involve both children and ask the hurt child what would make them feel better (i.e., a handshake or a hug).

> Sometimes, one friend finds new friends and the old friend feels left out. The old friend feels stressed, devastated and just wilts. It can be especially hard if their parents are friends as well. I talk to the friend who left the other one and encourage her to include the old friend. Also, I create activities based on common interests that the old friend can do with new children and change the group arrangement at times.

> I encourage children to walk in others' shoes, sometimes literally. One girl in our room has special shoes and her friends tried them on to understand how she walks and how it feels.

> When children are frustrated with each other, I help them verbalize everyone's perspective. I encourage working things out together by either sharing ideas or working alone on ideas and then sharing them. I try to make it a positive thing that they have different ideas.

> I try to empower the child who has had something taken away. I encourage their communication of how they feel and how to stand up for themselves by saying things like "What did you say? What could you say?." I let the children come up with their own ideas.

Summary

The developments in social and emotional competence described in this chapter are important components in preparing children for adjustment in child care and ultimately for entering school. In fact, over the last decade the definition of readiness for school has expanded beyond the cognitive and language domains to include social and emotional functioning (e.g., Raver & Knitzer, 2002). Examination of children's developmental needs and the research reviewed both in this chapter and in Chapter 2 relate practitioner and child characteristics to positive outcomes. It appears that from infancy onward, essential ECCE practitioner responsibilities include: **1)** providing a secure, safe, and supportive emotional environment for the child; **2)** understanding individual differences in children's temperament and cognitive-language development and tailoring interactions to be sensitive to these differences; **3)** promoting the capacity to share emotions directly with others; **4)** ensuring a child develops a sense of self and that they feel good about themselves and have a sense of their own effectiveness; and **5)** supporting children in negotiating their social interactions with peers and with adults. Important parts of ECCE practitioners' education include both learning the importance of these aspects of development and developing means of having an impact on them. Paralleling the distinction made in Chapter 1 between mental health promotion and mental health intervention, practitioners need to be equipped with proactive strategies. This increases children's capabilities to deal with difficulties in a resilient manner and thus promotes their mental health.

CHAPTER 5:
Promoting Mental Health Through Collaborations with Families, and Community Resources in a Multicultural Context

The focus in the preceding chapters was on general principles guiding children's development within the context of important relationships with ECCE practitioners and with family members. In this chapter, a broader range of factors related to mental health promotion in centre-based child care will be discussed. These factors include: **1)** the relationship that parents have with their children's ECCE practitioners; **2)** considerations for children in centre-based care growing up in a multicultural society; and **3)** collaboration of child care centres with community resources.

Promoting Children's Mental Health Through Parent-Practitioner Collaboration

Literature reviewed in Chapter 2 highlighted the quality of parents' relationship with their children as the primary influence on children's healthy development. Therefore, good communication between parents and ECCE practitioners would seem to be essential. Within the child care environment, the parent-practitioner relationship is intended to be a way that each learns more about the children by discussing home-child care similarities and differences, sharing concerns, working out strategies jointly for managing behaviours and circumstances, and understanding the family's cultural practices and beliefs. Child care organizations have strongly emphasized the importance of these aspects of the relationship between ECCE practitioners and families.

Parents and families should be actively involved in the learning and development of their children. Teachers should actively seek parental involvement and pursue establishing a partnership with children's families... Parents and families should be invited to share, participate, and engage in activities with their children... Families and parents should be invited to share activities that are developmentally appropriate and meaningful within their culture... The early childhood educator should ensure that parents are informed and engaged with their child in meaningful activities that promote linkages between the home and the early care setting – (National Association for the Education of Young Children, 1995, pp. 8-9).

There is empirical evidence to suggest that children enter the practitioner-child relationship with expectations and orientations derived from their family attachment relationships (Sroufe & Fleeson, 1988). While children's relationships with ECCE practitioners are independent of their maternal attachment relationships (Goossens & van IJzendoorn, 1990), children seeing their ECCE practitioner interacting in a positive way with parents likely contributes to building trust within the child care setting and has a salutary effect.

Parents optimally choose child care centre arrangements that provide the circumstances that they believe will meet their children's needs. Typically, these include: **1)** practitioners who are warm, sensitive and responsive; **2)** a safe, healthy environment and with activities that stimulate children's development; **3)** good communication between the parents and practitioners; and **4)** a child-rearing philosophy that matches that of the parents', especially where discipline is concerned. Additionally, parents sometimes have very specific preferences (e.g., how they want their child held or soothed). Furthermore, child rearing is related to cultural beliefs and expectations of children and these beliefs vary from culture to culture. This is an issue that is especially important with immigrant and Aboriginal groups, because there is often no one on staff with the same cultural background. As pointed out in Chapter 3, parents' financial resources and specific caregiving needs may limit their options. Thus, child care choice may be more the ideal than the norm.

While the importance of the parent-practitioner relationship has been emphasized in theory, it has been difficult to demonstrate empirically the actual outcomes of harmonious parent-practitioner interactions. Part of the reason is that child care choices are not random; families try to choose child care environments that are consistent with their own values and child rearing style (Goelman & Pence, 1987; Shpancer, 1998, 2002). Household economics tend to determine these choices. Thus, as discussed in Chapter 3, children enrolled in high quality child care centres tend to have parents with higher education and occupational status (Burchinal et al., 1995), whereas parents who live in more stressed and low socioeconomic environments are more likely to place their children into poorer quality care (Howes & Olenick, 1986). Authoritarian parents who use more punitive forms of discipline also tend to place their children in lower quality care (Scarr & Eisenberg, 1993). Further, whereas North American born parents tend to focus on their child having a warm relationship with their practitioner, new immigrants often look for a child care setting where their children will receive didactic instruction.

Research on the Parent-Practitioner Relationship

Child care itself has come about from a shift away from the exclusivity of family responsibility to a shared responsibility

for children. While the importance of practitioner-parent relationships in the ecology of child care has been widely supported, in fact, most of the research literature deals with this relationship indirectly and revolves around two issues: **1)** ECCE practitioners' and **2)** parents' perceptions of one another gleaned through self report questionnaires. Examination of the actual interactions between practitioners and parents is limited. Moreover, studies have typically employed small samples and captured a cross-sectional snapshot rather than tracking the relationship over time.

Research has shown that interactions between practitioners and parents are typically friendly and brief and that both parties tend to avoid controversial issues such as child rearing practices (Shpancer, 2002). Parents and practitioners do share child and family information and discuss children's experiences and behaviour, but this has been found to be the exception rather than the rule (Gazvini & Readdick, 1994). Parents often regard child care as a service for which they are paying and, consequently, choose to maintain a safe social distance from ECCE practitioners. Practitioners, in turn, consistently report that they know more about children and child development than do parents (Shpancer, 1998). At a practical level, communication is often difficult in busy classrooms and at drop-off and pick-up times when there are many parents to talk to at one time.

As noted above, research has documented that, generally, practitioners tend to rate parents' child rearing competence negatively (Shpancer, 1998). This is not reflected in their actual interactions with parents which typically are friendly and uncritical (e.g., Howes, 1991; Powell, 1989). In the few studies where parent-practitioner interactions have been observed directly, there is evidence of a positive association between parent-practitioner relationships and child outcome (Endsley, Minish, & Zhou, 1993; Smith & Hubbard, 1988). Smith and Hubbard (1988) reported a significant correlation between warm and reciprocal communication with practitioners and children's adjustment to child care. It also has been shown that mothers who engaged in more conversation about their children with the ECCE practitioner were more supportive and sensitive with their children (Owen, Ware, & Barfoot, 2000). Because children's experiences at home and in the child care setting are likely to be confounded, it is difficult to draw a link between children's experiences and practitioner-parent relationships per se. In particular, it is difficult to determine whether the findings of these studies represent a characteristic of certain parents (i.e., sensitivity) that generalize to the practitioner.

Moreover, it has been suggested that children themselves are agents of change both in the child care setting and at home (Scarr, 1992). For instance, children may transfer patterns of interaction that characterize their home life to the child care setting (Sroufe & Fleeson, 1986). As well, as noted above, children may draw

comfort from seeing positive interactions between ECCE practitioners and parents. While it has been tentatively suggested that parent involvement is important to quality care, clearly, this is an area deserving of more in depth research.

Ways that Parents and Practitioners Can Work Together

Working under the assumption that the parent-practitioner relationship is important in promoting children's mental health, some practical suggestions have been made for how to improve the quality of parent-practitioner communication. These include offering opportunities for small parent group discussions, consistently soliciting specific input from parents, and following up on parents' questions and suggestions. Other activities such as parent involvement in planning classroom activities and in assessments of their children, relating classroom activities to varying cultures, needs, and interests of children and families, sharing information through suggestion boxes, bulletin boards, and e-mail or automated phone systems, and allocating time for phone interactions also have been suggested (Rusher & Ware,1998). Following are some suggestions made by practitioners:

We do home visits, ideally before the start of care. Two teachers visit in the evening or on the weekend and stay for an hour. They leave the child with a book/CD from the centre. It creates a different relationship with the child and parents because they are more at ease. We also give parents a questionnaire to fill out about the home visits to get feedback.

We have pamphlets available for parents to know what kinds of things they might expect to see in their child when starting at the centre. I always acknowledge parents' feeling about separation from their child and provide materials and support for the child to show feelings through play. I keep a record of the child's behaviours so I can talk about them with my supervisor and the parents.

When parents use harsh discipline methods such as yelling at home, it makes children more stressed when they know they've done something wrong at the centre. For example, one child dropped some paint and started crying immediately, expecting to be yelled at. I'm meeting with the parents over time and handling it carefully.

I work with parents and deal with their anxieties and concerns about what goes on in the classroom. It has an effect on the children and reflects in their behaviour (e.g., more assertive, better able to express their needs).

Looking at parent-practitioner interactions from another perspective, Shpancer (1997) points out that focussing on the amount of parent involvement per se may lead to overlooking an important function of the practitioner-parent relationship which is to provide a kind of "buffer" for the child, activated at times when children are coping with stress. This could

pertain to stresses within the child care setting itself such as transitions and behavioural difficulties, or to stresses within the family that affect the child such as parent divorce or job loss. Practitioners need to be aware of the stresses in the home to make sense of the child's behaviour. Research suggests that with respect to divorce, for instance, short-term effects vary with children's personalities and family environment. Preschoolers show some consistent effects in their tendency to regress and exhibit behaviours such as thumb sucking, fear of abandonment and wetting to keep their mother from leaving, or self blame. It also has been observed that boys often express anger whereas girls tend to try to be perfect. Practitioners interviewed in our national scan found the following to be effective:

> When children show a reaction to losing a parent, or when parents separate and divorce we don't just dismiss a child's behaviour but look at the big picture and try to understand the reasons why a child is behaving in a certain way on a particular day. We take into account family differences.

> I try to find a book about the situation that the child is going through and read it with the child and try to discuss it with him/her. I ask whether the child minds if we talk about it in group so that other children can understand why a particular child is behaving in an unusual way. That gives the children a chance to share their own experiences and to show empathy.

> There are lots of student-parents at our centre who have a great deal of stress during exam times. Centre staff see the behaviour changes in children because of this. We try to anticipate these times with consistent routines and staffing. They keep continuity for children experiencing shifts at home.

> I create a visit calendar with children whose custody is between parents. It makes time more real and manageable. I also have children make cards for parents and mail it to them when they're not staying with them.

In the national scan, there was considerable variation in whether parents were systematically involved or invited to become involved in child care centres. ECCE practitioners listed a number of ways in which they try to include parents in activities or to share information such as:

• weekly or monthly newsletters

• bulletin boards

• phone calls

• conversation at drop-off and pick-up times

• written feedback about the child's activities

• open door policy for parents

• parent volunteer opportunities

• parent-board and committee participation in activities such as fund raising, hiring personnel, establishing programs, acquisition and use of materials, and setting policy

• individual parent meetings as necessary

• gradual entry process in order to understand child and parent needs

• involvement of parents in monthly planning meetings

• parent suggestion boxes

• observation booths

• daily communication books

• parent/family events

It is important to note that much of the research in this area implies a one-type-fits-all form of parent-practitioner collaboration. In reality, there are likely to be different types and modes of communication depending on a variety of child care and environmental factors. Child care centres need to be flexible and creative in ways of communicating with parents as well as involving them directly in children's programs. Additionally, centres can promote a centre community, enabling parents to be involved with other parents. Some ways to establish these kinds of conditions were described in our scan (see below). These are primarily ways of sharing information, providing child updates, and involving parents in programs. They do not address the more sensitive or conflictual issues that can arise in individual parent-practitioner interchanges.

• "Get-to-Know-You" social night at the beginning of the year

• child profiles filled out by parents at the start of care, covering their child's mental and physical development, how they deal with certain situations, the child's interests, likes and fears, sleeping patterns, discipline techniques, as well as asking parents how they'd like to be involved in the centre

• "Wish List" board for volunteer time, needed materials, etc.

• providing free child care during parent nights to "take away that roadblock for parents"

• parent focus groups several times a year to look at how the centre is running

• "Talk About Cards" where staff and children sit down and write "Today at day care I did…", listing activities and routines and then giving the cards to parents.

• daily journal for each child in which staff write down things done from the point of view of the child during the day ("I worked with beads"/paste some beads in); parents write in what children do outside of the centre ("I went to the park"/paste a leaf in) and children share their journal contents during circle time

• clothing swaps every month

• parent information centre which includes the biographies of staff and their certification

• "Wall of Fame" where parents leave notes and things to highlight special activities in the centre

• videotaping children a few times during the year and making tapes available for purchase by parents

- running a parent bulletin board through the centre's website for parents to exchange information and tips

- participation in fundraisers such as each parent contributing a recipe to a centre cookbook sale to raise funds

- a space in the centre for parents to have breakfast

- Family Game Nights several times throughout the year, providing a social opportunity for parents to communicate with others

- "Happy Grams" which are notes to parents from staff about specific positive events for the child during the week

- Monthly family functions such as "Imagination Market" where craft supplies are put out for parents and children to make things together

- "Questions of the Day" which is a magazine picture paired with questions and posted with all the children's responses; parents can see their child's answer and this promotes further discussion

- centre evaluations done by parents when they leave the centre

The issue of family involvement in child care may be more challenging in places like Canada where the dominance of values focuses on self reliance, individualism, and family privacy (O'Hara cited by Kyle, 2000b). Moreover, genuine parent involvement challenges early childhood programs to respond to concerns about childrearing values and practices, perception of the child's role, and cultural diversity, issues that are difficult and complex. Ironically, the more distant relationship between parents and ECCE practitioners also could promote the positive function of keeping ECCE practitioners moving toward professionalism within the early childhood field which would inadvertently reduce the influence and role of parents (Larner, 1995).

It also must be acknowledged that education and training of ECCE practitioners focuses on how to work with children. There is a need for expanding training so that practitioners will gain skills for working with parents and other family members who may be responsible for children. It is important to acknowledge that special training alone is not enough. Practitioners also need the maturity and confidence to think flexibly and to deal with potentially loaded topics that may arise when adopting a more active role with parents. Partnership with parents is an important undertaking but there is not one formula for establishing and maintaining this partnership.

Interestingly, ECCE practitioners participating in the scan felt that parents' lack of time interfered with the centre's relationships with parents dramatically more than a range of other factors. This factor was seen as more important than practitioners' lack of time, cultural/language and value differences, staff's reluctance to engage parents, practitioners feeling parents don't value their opinion, practitioners feeling

their role is to work only with children, lack of policies for parental involvement and lack of funding to implement new activities. While this may reflect bias in terms of self-reporting, it definitely does stress the importance of centres being flexible and creative in order to involve parents within centre activities in an effective manner. This is another area for curriculum development as well. ECCE practitioner education requires a stronger foundation in teaching about factors affecting parent-practitioner interactions and the impact of this particular relationship on children's mental health.

> One child didn't come to the centre every day and was always very upset. Her mother was going to take her out of the centre because she was always crying when she came in. I suggested to mom instead that the child come in every day for a week. It established a routine and the child became less distressed.

> One practitioner in our scan talked about her 2 year old daughter starting at a centre: "She was very upset when starting care. She was bored because there were lots of younger 2 year olds without language so she couldn't communicate with the others and spent the day alone." She had to approach staff about why her child was upset. The staff suggested they move the child into the 3 year old room and this resolved the problem. But she had to approach the staff, they didn't approach her.

> One parent was concerned about doing everything right for her little boy. She was concerned that at 14-15 months, the boy was too aggressive (e.g., hitting others). The staff invited mom into the observation booth and found out he hit because younger children would snatch things away from him. This helped the mom and teacher understand his behaviour. "Sometimes we tend to be more reactive; we need to try to be proactive to find triggers and alter the environment to prevent challenges"

Child Care in a Multicultural Society

There has been a shift in the demographics of Canadian society due to a high rate of immigration and an increasing awareness of the overlooked needs of Canadian Aboriginal peoples. Both immigrant and Aboriginal groups, themselves, must make choices about assimilation vs. maintenance of cultural uniqueness. Children grow up within a cultural context that sets values on certain kinds of experiences and ways of interacting. Parents rear children to behave in what they regard to be an appropriate way but this may not be appropriate in another culture. Many parents try to find a middle ground where cultural identity can be protected while, at the same time, children have the opportunity to participate in mainstream society. At the same time, the concern is that what ECCE practitioners regard as appropriate or inappropriate behaviour in children can lead them to evaluate children in terms of their own cultural norms. Moreover, what are actually cultural differences may be seen as differences in temperament. For instance, a child may be quiet and shy with teachers because they have learned to keep a respectful and non-assertive stance with adults.

Contrasts in values are most common along the following dimensions (Bromer, 1999):

• independence vs. interdependence as the primary goal

• activities for children that are object oriented vs. people oriented

• idea that children have their special places (e.g., children are encouraged to make choices about what activities they want to do) vs. inclusion of children in the adult world (if a child cannot go to an event, no one goes)

• child centred learning is valued vs. academic preparedness is valued

• teacher-child relationships are informal vs. teacher-child relationships are formal

• verbal communication is emphasized vs. multiple modes of communication are emphasized

• open expression of emotions is encouraged vs. regulation and control of emotions and their expression is encouraged

• the goal of discipline is to help children gain self control vs. the goal of discipline is to teach children to respect authority

• future-oriented time concepts influence planning vs. present-oriented time concepts influence planning

• scheduled planning vs. flexible planning

What are the developmental implications of the experience of growing up in the microculture of a family belonging to a minority group and then becoming a member of a different and dominant culture through child care? As early as the second and third year of life, children are interested in what is approved or disapproved behaviour. Notions of harm, responsibility, culpability, and positive justice vary across cultures and are in place by the third year of life. Some of the differences can be observed in children's pretend play in which 2 and 3 year olds begin to explore the social rules and roles of their world. For instance, Dunn (1996) cited a study in which American children engaged in more play about monsters, action figures, and cowboys whereas British children engaged in more play about farms, shopping, and domestic life. The question arises of how the experience of being in a child care setting, with a set of cultural practices and expectations that may differ from those a child experiences at home, affect development of a cultural self. As well, it is possible that ECCE practitioners will sometimes identify cultural differences as social and emotional adjustment problems, especially if awareness about how their own personal background impacts on their practices is lacking. Reflecting on this, one of the ECCE practitioners participating in the national scan said:

> Considering a child's "family culture" is important as well. For example, for one family certain types of food are very important; for another family rocking their baby to sleep is essential.

Promoting the Mental Health of Children in a Multicultural Society

Responsiveness to community values and cultural diversity has become an important guiding principle in child care. It has been recommended, for instance, that while ECCE practitioners are friendly, initially they should be more formal rather than presuming intimacy which may be resented or perceived as disrespect. Getting to know the norms of social interaction and appropriate behaviour toward both the child and parent for that culture is essential. Within the child care setting itself, children should be given opportunities to learn that children from different cultures may look or dress differently from them. Generally, young children do not understand prejudice and can mix happily together even though they might ask questions. Activities within the classroom and with parents that promote sharing cultural knowledge are often recommended (Keats, 1997). As children's feelings about their cultural identity affect their self esteem, it is essential to be supportive of cultural differences. It is important to recognize that the most significant outcomes are likely to result when integration of anti-bias messages and education about diversity are integrated into the day-to-day activities in child care settings rather than highlighted periodically (e.g., during a multicultural theme week or solely on holidays). However, this may be much easier to establish in centres where diversity dominates among children enrolled. There are probably more opportunities to informally acknowledge and support differences in heterogeneous groups of children than in centres where children share more similar cultural, religious, and socio-economic backgrounds. These latter circumstances likely require centres to more actively seek assistance from outside resources when implementing anti-bias education. Recommendations from the literature, as well as responses to our scan, indicated a number of practices to facilitate multicultural familiarity and understanding, including:

• ongoing discussion of cultural perspectives incorporated into programming

• centre policies highlighting proscriptions against children name calling or staff using racially loaded language

• developing awareness of similarities and differences between different cultural perspectives and practices through group time and books

• talking respectfully about other cultures and validating differences in a matter of fact way

Tremendous strides have been made in Aboriginal communities with federal funding to support child care. Within the last decade increased funding permitted opening more spaces so that parents could pursue job and educational opportunities. An important feature is that Aboriginal people themselves participate in the process guiding development of child care settings and curriculum to be consistent with their cultural

beliefs, particularly a holistic view of health and education. However, for Aboriginal children enrolled in child care centres located outside of First Nations communities, the means of taking cultural differences into consideration in the day to day routine in child care are less thoroughly discussed (Ball, 2002).

Factors That Interfere with Parent-Practitioner Relationships in a Multicultural Context

Systematic study of how to build parent-practitioner relationships in a multicultural context is relatively new. Results from a Canadian study in three cities indicated that although both ethnic minority parents and ECCE practitioners agree that minorities were not involved enough in child care settings, they disagreed about the reasons for the lack of involvement (Bernhard, Lefebvre, Kilbride, Chud, & Lange, 1998). Teachers perceived families as lacking interest in interacting with child care staff. Some of the comments made by practitioners were that parents were not interested in hearing about their child and saw child care as a babysitting service. The views of parents were different. Many parents said they wanted to know more about what was happening at the centre on a day-to-day basis. Moreover, parents thought that ECCE practitioners seemed to be busy and, although they would answer questions, rarely volunteered information. On the positive side, when practitioners did take time to talk with parents and ask questions, this was seen as a sign of interest and respect.

The above study also found that practitioners tended to be unaware of their basic differences from minority parents in what they perceived to be the goals of early childhood education with respect to cognitive and social skill development and respect for authority. Many parents felt their children were given too much freedom and had too many choices at the centre and wanted practitioners to be stricter. At the same time, practitioners felt that discipline was lax at home and that children were babied or spoiled by parents. It was concluded that although parents did not feel listened to by practitioners, this did not reflect ill intention on the part of the practitioners. It was suggested that institutional factors, such as practitioners being in an expert position so that they don't feel that they need to continuously consult with parents, were more prominent. Moreover, most practitioners worked in accordance with assumed universal patterns of child development and, for instance, often had different views from parents of what children can do at different ages.

Bernhard (1996) observed that preservice education continues to be based on a model of professional practice that does not incorporate cultural diversity. Families from different cultures vary in their world view, their social organization, language patterns, learning styles, and ideas about acceptable behaviour. Prominent in the findings were dramatic differences in parents' and practitioners' perceptions of even minor events. Understanding and respecting differences, and deciding whether and how child care practices should be adapted to support cultural diversity is a difficult issue. There were few or inadequate mechanisms in the education of ECCE practitioners for working within a multicultural centre or for involving parents and eliciting their input.

In another study, Bernhard, Lefebvre, Chud, and Lange (1997) interviewed university and college faculty in ECCE programs in 78 different institutions in the three provinces with the largest influx of immigrants (British Columbia, Ontario, and Quebec) as well as 199 graduates working in the centres to inquire about responsiveness of teacher education to diversity. Responses generally indicated that faculty members believed that the majority of their students were not well prepared to work with culturally, linguistically, and racially diverse populations. In line with this, graduates did not feel well prepared to work with diverse populations at the time of graduation. This means that faculty in training institutions must take responsibility for providing ECCE students with inclusionary approaches at both the theoretical and practical levels. One of the surprising findings from this study was that few respondents mentioned child development courses as an area affected by cultural diversity, although cultural beliefs do influence expectations around norms and milestones.

A number of recommendations followed from the survey done by Bernhard et al. (1997) including: **1)** development of a collaborative approach to working with families in core courses in the curriculum; **2)** providing students with extended, documented experience with diverse groups and assisting them to reflect on this; and **3)** avoiding reinforcing stereotypes and prejudices by devoting significant resources to preparing, supervising, and debriefing students who work in the field. A key component of training is teaching ECCE practitioners to be aware of and understand both their own cultural biases and those of the families they work with.

Directions for Child Care in a Multicultural Context

Obtaining education and practical experience working with parents from different cultures is essential given that approximately 20,000 immigrants arrive in Canada each year. To this end, Barrera (2003) has written about what she has called the "3rd Space" which encompasses both a skill and a mindset that supports respectfully holding divergent and sometimes contradictory views in one's mind at the same time while not forcing a choice between them.

> *...the skill of 3rd Space invites practitioners to shift from a dualistic and exclusive perception of reality to an integrative, inclusive perspective that focuses on the complementary aspects of diverse values, behaviours, and beliefs. This shift breaks the apparent deadlock between either-or choices by opening the possibility of a 3rd (or 4th, or 5th) choice. For example, how can a parent's apparently passive (or resistant) behaviour (i.e., not "cooperating" with caregivers) complement the caregiver goal of increasing desired cooperation? ...One answer might involve modeling cooperation with the mom rather than trying to change her behaviour. Another might involve reframing her behaviour as complementing, rather than contradicting the caregiver's.*
>
> – (Barrera, 2003, p. 10).

Using knowledge of cultural differences emerged in the scan as an important undertaking, and some staff showed sensitivity to and recognition of the importance of such issues.

> Staff seek information and insight from parents to work with children. In our centre the majority of families are Inuit. One Inuit infant had difficulty sleeping at the centre, so we talked to the mom and found out about their practice of "packing" children. The mother wears a parka with a deep sack that is meant to hold the child. It's important for these parents to keep the child close to them for the first two years. So the child was used to sleeping in this way and we actually incorporated "packing" into her sleeping routine and she is carried by one staff member.

Efforts to put working constructively with diversity into practice is further illustrated with a workshop toolkit, developed by the Calgary Regional Association for Quality Child Care and Diversity Learning Institute (2001), for creating more inclusive child care. Called *Clue into Inclusion*, the training modules are intended for professional development focussing on increasing awareness and developing skills that can be used on the job. Flexibility, understanding and accepting differences, recognizing and acknowledging one's own stereotypical assumptions, and providing services and supports that are sensitive to diversity are part of the training.

Promoting Mental Health Through Child Care Collaborations with Community Resources

The idea that "*it takes a village to raise a child*" has had an impact on how people think about promoting the well being of children in society. Mental health is promoted not only through interactions with family and with ECCE practitioners but, potentially, through participation in any number of groups, agencies, or organizations within the community. Further, in 1999, *The Early Years Study* report emphasised that *all* families and children can benefit from early childhood development and parenting programs and bemoaned the fact that many services are problem focussed and targeted at particular populations (McCain & Mustard, 1999). A major recommendation of the report was that there should be an active effort made to integrate family, educational, child care, and health care systems and services. The assumption of integrative programs is that both the learning and the social and emotional needs of children are addressed together.

Responses to the national scan indicated that, across Canada, child care centres do collaborate with or use a wide variety of community resources. The majority of centres reported working with developmental specialists (94%), public health (88%) and early childhood development and education associations (85%) on issues concerning children's social and emotional development. A substantial number also collaborated with medical professionals (76%), community colleges (70%), mental health agencies (68%), child welfare organizations (68%), schools (61%), and consultation organizations (61%). However, practitioners participating in the scan were not further questioned about the extent or intensity of these collaborations. Centre directors reported lack of time and lack of funding as significant barriers to collaborations with resources and individuals in the community.

According to scan responses, many child care centres themselves serve as a resource and take a role in providing information about the social and emotional needs of young children to the local community through presentations and workshops, brochures and posters, bulletin boards, newsletters and calendars, and newspapers.

Systematic Collaboration Between Child Care Centres and Community Resources

There has been much discussion regarding integrating centre-based child care with schools and other services for children and families. Integration of services has moved farther ahead in the U.S. than it has in Canada. For instance, initiatives such as the Schools of the 21st Century have begun to take root in the U.S. (Zigler, Finn-Stevenson, & Marsland, 1995; Zigler, Finn-Stevenson, & Stern, 1997). The framework for the Schools of the 21st Century is a tie between child care provision and family support services to a recognized institution, the public

schools. High quality child care and family support services are offered under the same roof for children from birth to 12 years. The Schools of the 21ˢᵗ Century, also have outreach components such as home visiting and health and nutrition services. There is no set format for the Schools but a constellation of services is delivered and coordinated that serve the needs of the families and children with the goal or providing a "seamless day". Flexibility and responsiveness are central to these programs.

Although each of the Schools of the 21ˢᵗ century is different, they all have the following guiding principles: **1)** access to high quality child care provided at hours suitable for parents' work schedules; **2)** a focus on development with particular attention to social and emotional development; **3)** provision of professional development for child care practitioners; **4)** promotion and encouragement of parent participation; **5)** provision of programs and services on a voluntary basis; and **6)** integration of child care and family support with the political and economic structure of society. A preliminary evaluation showed that parents who used The Schools' child care centres missed significantly less work because of failure of child care arrangements and showed a significant decrease in parental stress. Since parental stress is one major contributor to poor parenting skills, this latter finding is especially important (Finn-Stevenson, Desimone, & Chung, 1998).

In Canada, family resource programs have been suggested as a potential site for integration of services for young children (Kyle, 2000b). Family resource centres are not a set mix of services but consider their focus to be working with families generally. Nevertheless, in any family resource centre issues of child care are likely to be of considerable importance. The challenge remains of how to create true integration. Kyle (2000a, 2000b) recommended moving beyond initiatives and demonstration models to making fundamental systems reform in developing policy and funding frameworks. Summarizing current thinking on the delivery of high quality child care and family resource programs, Kyle lists the following attributes as necessary:

1) a holistic framework in which children's needs are understood in the context of their families and of their community life;

2) a framework that focuses on wellness and prevention rather than problems and deficits;

3) the interconnectedness of children's and families' needs for care, education, health, socialization, support, and recreation;

4) a combination of child and family services with family benefits such as parental leave;

5) recognition that child care has multiple functions that serve not only families but businesses and communities;

6) integration of child care and other child and family support services in ways that are flexible, responsive, and accessible,

acknowledging that funding criteria and program guidelines may need to be modified to enable integration and coherence at a higher systems level;

7) integration of services at various levels;

8) acknowledgement that integration and coordination require time, planning, adequate resources (e.g., staff training), and trust building;

9) provision of genuine opportunities for stakeholders to participate;

10) an understanding that quality is a relative concept and thus that ongoing reflection and discussion is required;

11) recognition that no single model will fit all contexts.

Kyle described some examples of integrative models development in Canada that highlight the range of options for integration, namely, the Calgary Rockyview Child and Family Services and the Hub models in Vancouver and Markdale, Ontario (South East Grey Community Outreach). In each of these, child care has been integrated with multiple services and supports for families to create a network that can be tailored to needs of individuals and the community.

For instance, the Calgary Rockyview Service model revolves around child welfare services but works to facilitate building capacity in families with support services. As part of this model, families are helped to choose the best child care arrangement for children and to determine the options available to families. Parents are provided with a range of regulated child care options including integrated programs for children with special needs.

In the South East Grey Community Outreach, over 20 different programs and services for children, youth, and families are offered throughout the south east area of Ontario. Programs are provided through hub sites in seven communities. Each site delivers a range of integrated programs including parent and practitioner support, a range of flexible licensed child care services, and recreation programs for children.

In British Columbia, Kiwassa Neighbourhood House coordinates a network of child care centres and assists parents in accessing information about child care subsidies and services. In addition, a wide range of family support programs are available such as a drop-in centre, parent education courses, and parent support groups for immigrant and Aboriginal families. The proximity of child care to a secondary school provides the support that teen mothers need to continue their education while contributing to the well-being of their children. All of these programs have a coordinator or manager on staff who can facilitate connections between individuals and local agencies and services.

A number of new integrative programs are also under way. In Toronto, First Duty, a collaborative initiative, is intended to bring together the three streams of kindergarten, child care,

and parenting supports into a single program. This program (started in 2002) was designed to meet the learning needs of children while, at the same time, meeting the needs of parents. First Duty includes the full spectrum of families in terms of socioeconomic status and cultural background. Through the Toronto First Duty sites, parents are able to access a range of child and family supports available in their community. Provision of seamless services for children and bringing together service practitioners and families are among the priorities. The intent of Toronto First Duty is to demonstrate to policy makers how existing early childhood and family programs can be transformed into a system for children 0-6 years of age. At the end of the three year project, each site will provide a working model.

Planning integrative services depends on geography, child and family needs, and sociocultural and political contexts along with organization of government services. For instance, internationally, there are differences in terms of which departments operate as an umbrella to child care. In Canada, this is mostly a ministry of community and social services. However, in European countries, child care for children 3 years of age and older often comes under the auspices of a department of education. Depending on these structures, there may be both limits and opportunities for collaboration.

Promoting Mental Health Through Mental Health Consultation to Child Care

Mental Health Consultation to Serve the Needs of all Children in Centre-Based Care

Even the most skilled ECCE practitioners run into stumbling blocks in designing strategies for dealing with challenges in the child care setting. The role of mental health consultants to child care has grown considerably across the last decade and can be seen as a companion piece to integrated services. Mental health consultation to child care is usually available to assist practitioners in addressing concerns and resolving problems around specific children and families, or certain program components. ECCE practitioners have typically sought services of a mental health consultant to help with solving problems with children who have been identified as having physical or social and emotional special needs (Kaiser & Rasminsky, 1999b).

Consultants also can play an important role in mental health promotion through helping practitioners put developmental knowledge into practice. Knitzer, Cohen, and Kaufman (2000) have listed tasks that consultants can carry out with child care staff that could enhance the mental health of children, staff, and families. These include: **1)** helping ECCE practitioners to carefully observe and understand behaviour; **2)** assisting practitioners to design classroom interventions to promote

emotional strengths and strong relationships, including social skill building; **3)** providing normative developmental information regarding what to expect in children at different stages and the importance of early relationships for them; **4)** helping practitioners to work effectively with families; **5)** helping practitioners to identify children or families that need specialized help and assist staff in making recommendations for seeking this; **6)** assisting ECCE practitioners, children, and families to deal with crises; **7)** helping design specific strategies for working with cultural differences; and **8)** integrating community beliefs and strengths and being knowledgeable about external community systems that serve children and families. The assumption is that consultation works best when it is collaborative, issue specific, and time limited, and when the consultant has a well defined set of skills.

Although many of the respondents to our scan expressed interest in having this kind of input, they felt that the availability of mental health consultants was limited. Without regular mechanisms for engaging the services of a consultant, some respondents felt that potential consultants could not be easily approached and engaged. Optimally, an ongoing relationship with a consultant would help both staff and families gain comfort with a familiar individual. More specifically, several scan respondents expressed the desire to seek information and insight from individuals such as medical professionals but felt in a lesser position to do so. Thus, the status of the child care field may hinder practitioners' confidence in initiating linkages to consultants and community resources.

Mental Health Consultation to Serve the Needs of Children with Special Needs in Centre-Based Care

Another kind of integration is related to inclusion of children with special needs in child care settings. Over the past three decades, children with a range of special needs have increasingly been included in community-based child care settings. The effects of inclusion of children with special needs into community child care have been positive, particularly for developmentally and physically handicapped children. More recently, preschool children with mental health problems are being placed into mainstream day care. There is a prevailing philosophy that children with special needs should receive services in normative settings where they will have the opportunity to participate in activities and to interact with their peers. Inclusive child care settings for children with special needs can afford opportunities for building cognitive and social capacities that exceed those in segregated care (Guralnick, 1990; Guralnick & Neville, l997) and thus can serve as an important component of mental health promotion. Research has shown that children with special needs (both physical and social-emotional) can become successfully included socially, especially if active intervention occurs to facilitate this process (Lero, Irwin, & Brophy 2000). In fact,

in inclusive settings, these children make better developmental progress than in segregated settings. Moreover, the presence of children with special needs does not compromise the development of peers who do not have such needs.

In addition, it has been shown that parents' concerns and fears about the delivery of specialized services, and the potential for social rejection of their children, are unwarranted. Rather, research has shown that practitioners' attitudes, competence, preparation, and ongoing specialized support are factors that contribute to the success of inclusion. The essential features of high quality inclusive programmes include practitioners specially trained for working with children with special needs, parent involvement, a family focus, and access to appropriate resources. It is important to acknowledge that the focus of both programs and research has been on children with developmental and physical challenges. The outcome for children with social and emotional problems has been less clear. Some evidence suggests that inclusion of these children puts a strain on staff that is less often encountered when working with children with more visible developmental and physical challenges (Irwin, Lero, & Brophy., 2000). In addition, working with parents in this group is more complex and difficult. They also may be less likely to be advocates for their children. As a result, more support both from and for ECCE practitioners to work with both children and parents may be necessary. Inclusive settings for children with mental health special needs also would benefit from ongoing input from mental health consultants.

Mental health promotion applies to children with special needs as it is assumed that they will benefit from the kinds of practices that were discussed in Chapter 4. In Nova Scotia, SpeciaLink, The Day Care Mainstream Information Network was launched in 1990 (see Irwin et al., 2000). The aim of this network is to promote awareness of child care inclusiveness and to encourage increases in the quality and quantity of day care inclusion. The kinds of activities that are recommended to support inclusion focus on: **1)** ensuring that staff receive some training in inclusionary principles; **2)** general information sessions about the benefits of inclusion for everybody be promoted and circulated regularly; **3)** ensuring that informational materials always state that all children are welcome; **4)** placing photographs and drawings on the walls that include children with visible disabilities; **5)** that some adaptive or modified
toys and equipment be present and visible (Irwin, 1997) and; **6)** that there be a range of options (e.g., short child care days).

According to Irwin (1997), most Canadian child care centres included some children with special needs at least some of the time. Relatively fewer of these settings are available to infants than to preschoolers and the full extent of the need for spaces is not known. Moreover, inclusion tends to be on an *ad hoc*

basis, depending on the centre. Unlike the United States where federal policy has made free and appropriate education for children with disabilities an entitlement, inclusion in Canadian child care remains voluntary on the part of the centres.

Summary

While Chapter 4 examined practitioners' direct influence on promoting children's mental health, this chapter indicates that ECCE practitioners must also establish connections beyond the centre setting. ECCE practitioners' collaborations with families and community resources are a potentially influential, although indirect, part of efforts to promote children's mental health. It is generally agreed that practitioners' relationships with parents are important contributors to children's mental health. While the importance of the parent-practitioner relationship has been emphasized in theory, it has been difficult to demonstrate empirically the actual outcomes of harmonious parent-practitioner interactions. Generally, research has shown that practitioners and parents hold differing views of the exact nature and importance of their relationships with one another. It also must be acknowledged that education and training provide more preparation of ECCE practitioners to work with children than with adults. Special training, maturity, and confidence to think flexibly and to deal with potentially loaded topics that may arise when adopting a more active role with parents are needed. Partnership with parents is an important undertaking but there is not one formula as to how to establish and maintain this partnership.

Collaboration with parents is complicated by differences in child and family background that create additional challenges. Understanding and respecting differences and deciding whether and how child care practices should be adapted to support cultural diversity is a difficult issue. A more concerted effort needs to be undertaken in education of ECCE practitioners, as both experienced practitioners and new graduates do not feel well prepared to work with diverse populations. This means that faculty in training institutions must take responsibility for providing ECCE students with multicultural approaches at both the theoretical and practical levels.

Furthermore, children and families stand to benefit by integration with other child and family services and resources, such as family resource centres, schools, mental health services and social services.

Finally, ECCE practicners have expressed a need for consultation from mental health professionals in their work with all children. The availability of consultants to work with centres that have integrated children with special needs is especially important. There is no standard model for how this integration should occur but some initiatives are pointing out potential ways that such collaborations might unfold.

CHAPTER 6:
Promoting Children's Mental Health Through Providing a Positive Work Environment for ECCE Practitioners

Mental Health of ECCE Practitioners

It has become clear in earlier chapters of this report, that mental health promotion for children is linked to children's relationships with ECCE practitioners. Therefore, the psychological well-being of ECCE practitioners is an essential contributor to promoting mental health in children in child care centres. A sense of personal accomplishment and the nature of the work itself contribute to practitioner commitment (Pope & Stremmel, 1992; Stremmel & Powell, 1990). However, working with young children on a daily basis is a physically and emotionally demanding task. Practitioners' well-being is impacted by the work atmosphere and whether it provides supports that appreciate and augment staff practices. In turn, this can influence staff's attitudes and approaches to children as well as the child care field. Clearly, a multifaceted approach must be taken in any attempt to develop initiatives for optimal working conditions for the child care workforce (Gable & Hunting, 2001).

High Turnover Rate Among Practitioners

It is estimated that one-third of ECCE practitioners leave their positions or the child care field annually, leading to concern about the instability of the child care workforce. Young children need to receive consistent care and education from ECCE practitioners who know and understand them. The fallout from instability of the child care workforce is illustrated by findings that toddlers who experienced more practitioner changes over a three year period were more aggressive as 4 year olds (Howes & Hamilton, 1993). The toddler period is particularly important because it is during this time that help in management of negative affect and aggressive impulses becomes a central role for practitioners. A change in children's primary practitioner has been associated with children becoming more withdrawn and aggressive even after they re-established a secure primary relationship with the new practitioner in the classroom.

Turnover also affects the practitioners who remain at the centre. When a practitioner leaves, co-workers remaining at the centre may invest less of themselves in the children and the centre and question their career path. As well, staff loss can result in extra responsibilities that take away from time to focus on children. Consequently, morale is lowered and further turnover may ensue (Whitebook & Bellm, 1999). Therefore, ensuring that good ECCE practitioners are retained is an essential component of mental health promotion for children.

Considerable evidence shows that many ECCE practitioners leave their positions because of low wages and job-related

stresses or burnout (Gable & Hunting, 2001). In a review of the literature, Goelman and Guo (1998) identified three personality factors that contribute to prevention of practitioner burnout, including stress management skills, a feeling of control over one's life, and degree of commitment to the child care profession, including the enjoyment of working with children. Gable and Hunting (2001) found that ECCE practitioners' commitment to child care was predicted not only by their annual income and benefits, but also their level of relevant education, satisfaction with a variety of workplace characteristics, and the "organizational climate". Broader issues relating to structure and whether the centre is profit or not-for-profit have also been shown to contribute to job stress (Goelman & Guo, 1998; Pope & Stremmel, 1992). Although we will consider some of these factors separately, practitioners' commitment to early child care and education and their own emotional well being are multidetermined.

Practitioners' Wages and Benefits

ECCE practitioners are among the lowest paid workers in the workforce. Centres that offer higher pay attract better quality teaching staff (Roditti, 2000). Several studies have shown that higher wage levels for staff are the best predictor of program quality in child care centres (Doherty, 1999). For instance, the *You Bet I Care!* study (2000) found staff member's wages to be a direct predictor of the levels of sensitivity, harshness, and detachment in interactions with children on the ITERS and ECERS-R measures. Lower quality may be predicted by low wage levels, in part, due to the correlation between low wage level and job dissatisfaction (Stremmel, 1991; Whitebook, Howes & Phillips, 1990). In turn, low job dissatisfaction has been linked to detrimental staff behaviours such as harshness with children (Phillips, Howes & Whitebook, 1991; Kontos & Fiene, 1987) as well as higher levels of staff turnover (Stremmel, 1991; Whitebook, Howes & Phillips, 1990).

Certainly, wages influence practitioner's feelings about child care as a career. Over a fifth of ECCE practitioners surveyed in the *You Bet I Care!* study (Doherty et al., 2000) did not expect to be in the field in three years' time, with low wages the most frequently cited reason. Providing a better salary was identified by over 85% of ECCE practitioners working directly with children and by directors as a way to make the child care field a more attractive working environment. Almost one-fifth of full-time ECCE practitioners in the *You Bet I Care!* (2000) sample reported engaging in additional paid work, with the majority claiming they did so to supplement their income (Doherty et al.,

2000). Wages also influence how practitioners feel about their work environment. Low pay contributes to the stress of a demanding position that typically requires meeting children's needs through activities and interactions, dealing with parents and possibly community agencies and contributing to the team of centre staff. In a field where a significant proportion of practitioners are under the age of 35, it is disconcerting that 35% of practitioners and 26% of directors expressed that they would not choose child care as a career again (Doherty et al., 2000). Overall, this highlights the fact that lack of adequate income in the field has the potential to diminish the number of experienced, committed, and satisfied ECCE practitioners there will be in the future.

In our scan, ECCE practitioners indicated several types of major and minor monetary considerations as means by which their centres considered their adult needs and showed they valued their teaching, including:

• Annual raises when centres have surplus revenue

• Paid breaks with relief staff so regular staff can be off the floor

• Health plans and benefits

• Vacation time

• Specified number of paid sick and mental health days

• RRSP contributions for staff at Christmas

• "Boosters": gift certificates from local businesses given to staff with their pay cheque every 2 weeks

• Baskets full of treats (worth around $35) given away in staff draws at every staff meeting

• 50/50 draws for staff every week for a pot of money

Working Conditions and Job Satisfaction
In addition to wages, job satisfaction is linked to the working conditions of child care centres. Ideally, working conditions meet staff's personal and professional needs, thereby increasing contentment in the work environment and enhancing staff performance. Consideration of staff needs regarding such things as appropriate numbers of children to care for, paid preparation time, and opportunities for professional development have been shown to be correlated with job satisfaction (Doherty, 1999). While environmental standards relating to the centre's environment for the growth, care, and development of children are considered, less attention is typically given to the environmental or organizational climate for the adults in child care and its relationship with the quality of care that the children receive (Doherty, 1997; Pope & Stremmel, 1992). Nevertheless, by actively attending to the adult needs of staff, centres convey respect and appreciation for the type of work staff do.

Organizational Climate
The term "organizational climate" generally refers to employee perceptions of the conditions in their workplace, a kind of workplace personality (Jorde-Bloom, 1995). Factors associated with a good organizational climate include characteristics of the physical setting, staff relations, participation in group decision making in centre-wide decisions, giving ECCE practitioners autonomy with regard to their own classrooms, consensus over goals, clarity around roles and expectations, opportunities for professional growth and supervisory support (Jorde-Bloom, 1995).

There have been few empirical investigations in child care settings that have systematically examined organizational climate. Pope and Stremmel (1992) studied organizational climate in child care centres using a number of criteria based on Jorde-Bloom's Early Childhood Work Environments Survey (Jorde-Bloom, 1996) that assesses climate along 10 dimensions: collegiality, professional growth, supervisor support, clarity, reward system, decision making, goal consensus, task orientation, physical setting, and innovativeness. They found that organizational climate and job satisfaction were distinct constructs; climate provides information about centre attributes while job satisfaction provides information about individuals. Job satisfaction was related to staff burnout and turnover. Although organizational climate was related to job satisfaction, it was not related to staff turnover.

Physical Setting
A great deal of importance is placed on the basic physical condition of child care centres with regards to providing safe and appropriate spaces for children (Peth-Pierce, 1997). It is also critical to consider the arrangement of adult spaces in centres. The necessity for practitioners to have a place to store personal belongings, a separate staff washroom and a lounge of their own is supported in the literature (Doherty, 1999). Child care staff's responsibilities often include tasks that are outside the direct supervision and care of children, such as preparation of program activities and materials, recording and evaluating individual children's progress, and holding meetings with parents and other staff. Yet, only 60% of practitioners in 1998 had access to a separate room set aside solely for staff use, a decrease from 1991 when 67% of practitioners reported having such a room available to them (Doherty et al., 2000). Thus, many ECCE practitioners are required to complete all their work-related tasks in the presence of the children. This also suggests that a substantial number of practitioners do not have areas they may go to for moments of privacy and relaxation. For practitioners without such areas, their positions involve constant multitasking.

ECCE practitioners who participated in our scan mentioned several accommodations to enhance staff comfort and convenience, such as a comfortable staff room with adult furniture and various amenities (e.g., microwave, fridge), a separate staff bathroom, individual mailboxes for parents and co-workers to leave notes, personal cupboards, cubbies for personal resources, and lockers for their own belongings. They also mentioned other ways in which attention to physical needs were addressed in their respective centres.

> The centre cares about staff's physical and mental health. For instance, an occupational therapist was brought in to give advice about preventing injuries by doing things like instructing practitioners about how to lift, special chairs, moving the right way, and using back supports on little chairs.

> The centre has an occupational health and safety committee.

> There's a computer in every classroom that makes it easy to put together notes about problems, conversations with parents, documents, self-reflection and evaluation.

> There are divider doors between rooms that are half-size. Children can't see over but adults can for interactions with each other.

> An ergonomic work station review was done and it affected staff's choice of footwear. The centre bought sneakers and necessary supplies and replaced small benches and chairs with exercise balls for staff to sit on (children could also play with the balls afterwards when not in use by staff).

> There is a resource library in the centre with journals and magazines that include suggestions for practitioner comfort and safety.

Staff Relations, Participation in Group Decision Making, and Role Clarity

Some studies have linked communication among ECCE practitioners, especially around the needs and behaviours of children and professional development, with job satisfaction (Stremmel, Benson, & Powell, 1993). In the *You Bet I Care!* study (Doherty et al., 2000), satisfaction with relationships among colleagues, as well as with the centre as a work environment, predicted quality in the preschool rooms. Collaborations between centre staff through frequent communication and regular meetings are beneficial. Practitioners working together as a team facilitates the implementation and maintenance of consistent practices with children and allows practitioners to receive support and guidance when dealing with challenging situations, ultimately improving their skills.

It is important to acknowledge that building relationships between staff can be a lengthy and difficult process to undertake given the work schedules of centre staff. Good working relationships are more likely when staff become aware of one another's beliefs and values. Moreover, practitioners are more satisfied with their jobs when

the people around them are friendly, respectful, and supportive (Kaiser & Rasminsky, 1999c). While the majority of centres in the scan reported regular staff and/or age group meetings, many had additional methods in place to foster staff relationships:

> A "Walking Club" has been started with staff who have breaks together. Staff spend 15 minutes of their lunch break walking around the campus where the centre is located. Not only is it good exercise, it's a good opportunity to have time away from the kids and talk informally to each other about the centre.

> Team meetings include room staff, assistants, supervisors, the behaviour consultant, speech and language pathologist, developmental therapist, occupational therapist, and physiotherapist. Everyone works together.

> There are professional development activities in staff meetings that are related to the team building of staff.

> When there is a problematic situation (e.g., biting), this usually results in a new policy. Staff really work well together and all review implementing new programs as related to individual children. Practitioner ideas get passed on to the Supervisor who passes them on to the Board every 2 months.

> The staff communication book is read by staff at the start of every day before going on the floor. They can vent and communicate thoughts through the book. It also helps ensure consistency among staff and supports substitutes when regular staff are away.

> Each staff is recognized as bringing a unique set of skills and we are given freedom to express those skills.

> There's a gym session once a week for the children with an instructor from outside the centre. This gives practitioners free time to discuss things together.

Practitioners have greater commitment to an organization where supervisors lead informative staff meetings, allow teacher autonomy regarding their own classrooms, foster group decision making in centre-wide decisions, and provide constructive feedback. Involving staff in the development of the centre's vision and goals creates unity and commitment (Jorde-Bloom, 1997). This provides opportunities for staff input into centre decisions, results in staff being part of how their work environment is shaped, and allows them to feel more trusted, resourceful and capable (Whitebook & Bellm, 1999).

> In September there is a strategic planning session involving discussion about centre strengths, weaknesses, opportunities and threats. Staff are involved in questioning and group discussion.

> Each staff comes to staff meetings with two questions: 1) What can I do to make my day run smoother? and 2) What can the centre do to make my day run smoother?

> Staff annually evaluate the centre's Board representatives.

> Staff can add to the agenda of upcoming staff meetings and each staff member gets five stickers to mark and prioritize agenda items.

> A box of staff comments is brought to the staff meetings. Comments from the box are read anonymously and we work as a team to deal with them.

> There are staff feedback questionnaires concerning policies, programs and ways to improve the centre.

Since the majority of ECCE practitioners' time is spent on the floor with children, opportunities to connect with parents and other staff as well as attend board meetings (in the case of non-profit centres) often take place beyond staff's typical working hours. Such meetings can contribute to positive relationships with children's parents and effective staff teamwork. This, in turn, can affect the quality of care received by centre children. However, time spent in such activities by staff is often not recognized in terms of compensation. The *You Bet I Care!* study (Doherty et al., 2000) found that 56% of teachers received pay for staff meetings held after hours, 45% for parent meetings held after hours and only 17% received pay for after hours board meetings. Additionally, 54% of teachers reported receiving paid preparation time. Arguably, the lack of compensation for such tasks devalues their importance to centre functioning as well as to child outcomes. It also shows disregard for staff's own personal time. In several Canadian jurisdictions, many teachers and directors basically donate a day of job-related unpaid work per week (Doherty et al., 2000).

Working relationships and staff satisfaction are also influenced by well defined responsibilities and clear policies and procedures which reduce conflicts, confusion, and stress (Jorde-Bloom, 1997). Ambiguity and conflict concerning roles in the child care setting is a frequent reason for burnout. Practitioners typically choose child care as a career because they want to work with children. However, frequently, they must either take on roles they did not anticipate or they are faced with multiple demands with insufficient support. Moreover, factors such as whether time is allotted for planning and preparation of materials vary across settings.

Some centres participating in our scan compensated staff for meetings held after hours. Others attempted to reduce imposing on staff's personal time by organizing staff meetings during the regular work day or providing meals to offset attendance to unpaid meetings. Paid preparation and programming time was less frequently reported. However, respondents did mention additional ways their centres demonstrated consideration for their time and energy.

> If a staff meeting occurs during a break, staff can use time later without using vacation time.

> If staff stay late they receive thank you notes the following day and sometimes treats.

> My centre's policy is that practitioners are on the floor for a maximum of 6 hours with children.

> We have flexible scheduling. Staff are able to switch shifts or take time off for personal appointments.

> Staff are encouraged to take longer breaks if the supervisor feels they need extra time.

> The supervisor posts schedules for maintenance and rotates staff duties.

Supervisors'/Directors' Relationships and Support

While licensing regulations offer the basic foundation for the procedures and practices involved in centre functioning, directors and supervisors manage aspects of the quality of life in the centre as experienced by children, parents and staff. The type of relationship that practitioners have with their centre's director is related to job satisfaction as well. Working conditions of staff are directly influenced by the administrative approach of directors and the type of organizational climate they foster. Job satisfaction of child care staff has been linked to directors' implementation of a well organized, flexible working environment, one that encourages and supports staff input into policies and programs, professional development and regular opportunities to discuss centre children (Doherty, 1999). Recognition of staff achievement, letting staff know their work is valued, and constructively assisting staff to improve their practices are all important elements of appropriate supervision (Kaiser & Rasminsky, 1999c). Directors who consider their staff's individual situations, interests and talents and accommodate them in terms of schedules and workload enable their staff to function at their best without being overwhelmed (Bloom, 1996; Jorde-Bloom, 1995). They may also play a critical role in encouraging and supporting staff's professional development.

> Applause Awards involve staff filling out sheets to recognize the good work done by others. They are asked to be specific about what was observed and the outcome. The sheets go into a draw at staff meetings for a prize.

> The Supervisor adds a personal note to each week's pay stub detailing positive effort, strengths and appreciation.

> Acknowledgements of practitioners' contributions are in the newsletter.

> We have a Fall Breakfast with the theme "Our teachers are stars because…" Secret letters are distributed to parents requesting donations for staff gifts. Centre children fill out stars with reasons their teachers are stars and we display them in the centre.

> The director tries to match staff interests with professional development activities.

> There is an annual in-house conference where half the day is focussed on personal and professional vision and development of the staff and the other half day is focussed on something that is fun like yoga. It alternates between more child focussed and more staff/personal focussed.

> Children at the centre make banners when a practitioner has finished an exam for school.

> Directors speak of staff with parents and the Board, talking about staff's strong points.

> Material and information from workshops the director has attended are brought into the centre.

> There are individual meetings between practitioners and the director once a month to touch base and discuss personal goals.

> Certificates are given to practitioners for things like good communication skills, attendance and professional development activities.

Directors tend to be primarily responsible for creating a safe environment in which practitioners feel that they can make and take new suggestions. Although collaborations cannot be forced, the director can model a demeanour that invites open communication.

> Directors and supervisors really listen to staff. It makes it more pleasant.

> The supervisor sets amazing positive examples (e.g., not talking badly about others). She is always positive with constructive verbal praise and is non-judgmental.

> The director is always accessible and keeps staff informed of what she is doing.

> The director uses the problem solving approach with staff; "I heard what you said. Is there another way you could have said that?"

> The director tours the centre often, offering feedback and helping out when needed.

The director's decision making power is also influenced by whether the centre is operated under a for profit (commercial) or a non-profit auspice. In a non-profit centre, a director is an employee of the board of directors that exists as a formal mechanism considerate of the needs and preferences of parents and the community. Directors in commercial centres may be either employees or owner-operators and decisions are based on the sole discretion of centre owners or shareholders. This can result in between-sector differences in the level of freedom directors have in policy and program decisions. Studies have reported that non-profit centres are significantly more formalized in organizational structure, with clear roles and responsibilities for staff and more opportunities for parental

and staff involvement in decision-making (Friesen, 1995; Lyon & Canning, 1999). Meanwhile, commercial centres have been associated with higher degrees of centralization or decision-making that is concentrated at a single point (i.e., the owner) with little input from others. Doherty et al. (2002) found that directors of commercial centres who are not owners, as compared to directors of non-profit centres, indicated greater restriction on their abilities to make daily administrative decisions, try out new ideas or to influence policy development, and felt the person they reported to was unresponsive to requests for direction. Greater leeway in the responsibilities of directors in non-commercial centres may allow them to establish clearer organizational practices that benefit from staff input which, in turn, can contribute to job satisfaction and staff performance.

Professional Education

Director Education and Training

Research has shown that one of the most important predictors of child care program quality is the background, experience, and training of the program director (Bloom, 1992). Evidence suggests that effective directors have knowledge and skills related to both child development and to management administration. For instance, research has demonstrated that training in administration for directors results in improved practitioner-child interactions (Doherty,1999), staff with more positive workplace attitudes, staff who are more supportive of children and provide more developmentally appropriate programming (Doherty et al., 2000), improved wages and working conditions for practitioners, and better practitioner:child ratios (Bellm, Burton, Shukla, & Whitebook, 1997). A wide range of skills related to both centre directors' management and leadership roles have been suggested as central to professional development. In the latter role, meeting the needs of working professionals, promoting professional advancement, and encouraging practices that reflect the ethnic and cultural diversity of the community should be priorities (Bloom & Rafanello, 1994).

> *Stresses of movement into a director's position must be acknowledged. Often these include issues of isolation without a peer group and a perceived tension of being an authority figure while simultaneously needing to provide responsive support to other adults in a nurturing environment (both practitioners and parents).*

Larkin (1999) recommended that successful strategies for addressing these issues include having an assistant director or mentor inside the organization who can act as a sounding board and maintaining external relationships with peers in other settings who can offer alternative perspectives on shared problems. In this survey, directors were not advocates of formal programs in educational administration, in spite of the difficulties

of learning by experience. They felt that the best preparation for early childhood administrators would encompass both practical and theoretical knowledge and include some form of internship.

ECCE Practitioner Training and Opportunities for Professional Development

Having adequate educational background and work experience is important for the self-esteem and self-efficacy of ECCE practitioners working directly with children (Howes, 1990). Additionally, children benefit in terms of both cognitive and social development when practitioners have higher education and levels of training in child development and early childhood education (Clarke-Stewart, Gruber, & Fitzgerald, 1994). Such children score higher on measures of school readiness, express more positive affect (Honig & Hirallal, 1998), and engage in more complex social and cognitive play (Kontos, Hsu, & Dunn, 1994; Rhodes & Hennessy, 2000).

Education *vs.* Experience

It has been suggested that there is a gap between ECCE practitioner education and training relating to the content of current research on child development and what is actually done in many child care programs. This is important in light of Honig and Hirallal's (1998) finding that education or training specific to child development and early childhood education was more important to child outcomes than educational level or years of service. Similarly, comparing practitioners who completed a 120-hour training program to those who did not, Rhodes and Hennessy (2000) found that practitioners who received training had higher levels of sensitivity and that children under their care showed higher levels of play than in classes where practitioners did not receive training. The effects of training were significant even though practitioners, in general, had an average of more than 6 years of experience working with children. As well, there is some evidence that practitioners with more training related to child development have fewer symptoms of depression (Casey & Fish, 2003).

Appropriate knowledge and skills pertaining to child care are essential. For instance, in one study, individuals with higher education, but less training specific to child care and less experience working in child care settings, were more likely to burn out. One unfortunate finding of this study is that educational attainment actually led to less organizational commitment and more staff instability (Stremmel et al., 1993). Burnout was especially high for individuals who had worked for more than a few years and less than 8 years. This suggests that pursuing further education in this field does not lead to a higher income but does open doors to other job options. These findings are disheartening given that practitioner education is one of the best predictors of quality caregiving and child outcomes (Cost, Quality & Child Outcomes Study Team, 1995).

The most common form of advanced training for ECCE practitioners involves obtaining in-class theoretical knowledge of child development coupled with supervised field placements in a child care setting. The latter is an integral part of preparation for ECCE practitioners, an opportunity to put theory into practice and to learn by working side by side with experienced practitioners. Individual supervision of students is essential to promote their capacity to translate theory into practice (Taylor, Dunster, & Pollard, 1999). In the optimal supervisory situation, learning occurs when meetings are frequent, when there is open, clear, purposeful communication, where the learner has a sense of autonomy that is supported by the supervisor, where criticism is constructive, and where the supervisor shows respect and provides a non-threatening atmosphere (Taylor et al., 1999). These qualities of child care supervision are similar to those designed to promote mental health of children and to promote mental health in the workplace generally.

Optimally, training fits the practitioners' individual needs as well as preparing them to meet licensing requirements. Currently, emphasis is being placed on going beyond content in order to help practitioners develop methods for observing and thinking about what they observe and feel, and how to respond to individual children's needs (Beach, Bertrand, & Cleveland, 1999). Although there is not a body of research relating specifically to child care, adult models of education suggest that experiential and relational training are more effective than didactic training (Zeece, 1999). A variety of means of providing such hands-on training have been offered including mentoring (Fiene, 2002) and reflective supervision (Bertacchi & Norman-Murch, 1999).

Mentoring

Mentoring is a process whereby an experienced person serves as a role model and guide to promote the professional development of less experienced persons. Optimally, the mentor is a professional (ECCE or otherwise) who is not directly affiliated with the centre. Mentors can provide individualized attention to trainees or staff with accompanying opportunities for self reflection (Singleton, 1999). There are various components to the mentoring process including: **1)** modelling new and appropriate teaching practices for students to observe before they try to use them; **2)** coaching as trainees implement curriculum activities and guide children's behaviours; and **3)** encouraging reflective practices or critical analysis of practices alone or with other practitioners. Using a randomized control design, Fiene (2002) compared an approach for infant practitioners who received intensive mentoring from an experienced early childhood professional with a minimum of 5 to 7 years of experience. In this process, the mentor first spent time observing the staff. Once the practitioner felt comfortable, the mentor made suggestions. The comparison group did not receive the mentoring intervention and only

had took part in the more typical workshop type training on infant caregiving available to them. Results indicated that sites that used the mentoring approach improved on the ITERS. The mentoring program lasted only 4 months, suggesting it was a very efficient means of training.

Optimally, it is best for a mentor to come from outside a centre because this facilitates staff to talk freely about their observations and uncertainties in practice, and to try new things. However, this is not always possible as both time and financial restrictions can interfere. One centre participating in the scan had begun the mentoring process by using in-house resources.

> A mentoring culture is being developed among staff over the next few months. The Director will come on the floor more and be more accessible to staff, more of a resource circulating around the whole centre rather than just in one room. It will enable the Director to support practitioners more, offer feedback, and promote more idea sharing.

Another centre had implemented the process for practitioners in training:

> The centre has a mentoring program for students from the college doing their practicum in the centre. It's especially important for infant teachers because the age group can be intimidating.

Reflective Supervision

Reflective supervision is the practice of a supervisor meeting regularly with staff members to discuss their experiences, thoughts, and feelings related to work with children and families. Again, optimally, this should not be done by the centre director or others staff member but rather by someone from outside of the centre so that staff can reflect freely on their practices and feelings. Key components of reflective supervision are reflection or "thinking out loud", collaboration, and regular meetings. Reflective supervision builds on evidence that learning takes place within the context of trusting relationships. It also builds on evidence that individuals bring to any relationship their experiences from their own past relationships which inevitably have an impact on how the practitioners deal with social and emotional issues among the children in their care. In the process, supervisors encourage staff to freely share their perspectives on challenges and possible solutions and to recognize the role of their own feelings in how they deal with these challenges. The reflective supervisor's role is to engage the staff member in a two-way conversation about the challenges, concerns, and ambiguities they encounter in their job as a crucial step in preventing frustration and burn-out. The reflective supervisor genuinely listens to the practitioners' perspectives and ideas. In the process, the supervisor models effective techniques for solving dilemmas while at the same time builds on the practitioners' strengths. Reflective supervision can also

take place in a group setting, again, with the understanding that there is trust and freedom to speak among the group members. It is presumed that the relationship modelled in the workplace carries over into the practitioner's interactions with children and families.

Implementing reflective supervision can be a lengthy process, as it is sometimes difficult for practitioners to get past traditional views of supervisors as authoritarian figures who judge the practitioners' competence. Practitioners may also feel that a supervisor is not aware of all of the issues in their classrooms. It has been suggested that an important first step in reflective supervision is articulating common beliefs and goals that are being worked toward despite the different roles played by each partner (Bertacchi & Norman-Murch, 1999).

Although reflective supervision is appealing and has been shown to have positive results, it is time consuming and potentially costly as specialized training or consultation is required. This may be one reason why reflective supervision practices *per se* were not evident in centres participating in the scan; instead, practitioners reported ways that they reflect alone or together with other staff on events in the centre:

> Cameras and microphones are placed throughout the centre. Staff are able to view tapes in order to reflect and modify their practices in self-evaluation.

> During prep time in the morning when staff meet for an hour, they reflect on what happened the previous day.

> I have a professional portfolio for writing down reflections, opinions, feelings, workshops attended, resource materials, special events and memories and letters from parents.

> I have my own individual journal in a little blue box on the teacher's shelf. It's for ideas, feelings, a stress reliever. I take it with me for planning.

> I teach orientation to new staff which causes me to reflect on my own practices.

> When I do an annual self-evaluation. I write down 5 goals for myself in the coming year and then talk them over with my director.

> I write things down about children during the program, recording their moods and responses. Then later I can reflect on their interactions.

Professional Development

Working in a field that requires keeping abreast of current knowledge concerning child development issues would seem to stress the importance of professional development activities in maintaining good practices. It is very likely that ECCE practitioners are now more than ever faced with challenges related to the heterogeneity of the families they serve. Nearly three quarters of centres participating in the *You Bet I Care!*

study (Doherty et al., 2000) reported including at least one child with special needs and almost 1 in 8 centres had five or more children with a disability, health problem and/or severe emotional or behavioural problem. It was also estimated that approximately 20,000 children between the ages of 0 to 6 years enrolled in child care centres had neither English nor French as their home language.

Achieving higher levels of education, knowledge and understanding is crucial to raising the educational standards and status of ECCE practitioners and bolstering the concept of the field as a profession. As well, professional development activities that go beyond providing basic skills to extending skills in specific areas and keeping abreast of changes in the field are crucial. In relation to this review, linking both developmental knowledge and mental health promotion in ways of managing the above challenges would be among these. Moreover, the opportunity to meet with peers potentially promotes the mental health of practitioners and reduces professional isolation. Opportunities for professional development empower individuals to take a more active role in their own professional lives, increase enjoyment of work, and boosts morale (Chandler, 1999).

Directors may be in a position to convey information about upcoming professional development activities outside the centre and allocate resources towards staff participation in such activities. In the *You Bet I Care!* study, Doherty et al. (2000) reported an increase in the percentage of front-line practitioners who had not engaged in any sort of professional development during the previous twelve months, from 13% in 1991 to 24% in 1998. Cost of participation, lack of information about professional development opportunities, and inability to obtain release time were the most frequently cited barriers. One-time professional development activities such as conferences and workshops were dramatically more common than credit courses leading to a higher credential (Doherty et al., 2000).

Many respondents in our scan indicated that their centres supported their ongoing professional development through encouragement to participate in professional development, setting individual practitioner goals for professional development, posting information about upcoming professional development activities, allowing practitioners to visit other centre settings to view practices, specifically budgeting for the fees and expenses associated with professional development activities and holding in-service training regarding issues or interests relevant to staff. Our scan showed that the majority of respondents engaged in one-time professional development activities within the previous year, with workshops and conferences reported most by directors (94% and 81%) and ECCE practitioners working directly with children (77% and 70%). This was similar to the *You Bet I Care!* study findings. In contrast, longer professional development activities pursuant to higher education credentials, such as

credit courses, were reported dramatically less often by directors (21%) and other practitioners (20%). Important to the idea of using centre-based child care as a site for mental health promotion, 67% of practitioners who attended workshops and 65% of those who attended conferences indicated that these activities involved social and emotional developmental issues in early childhood or child care. For directors, this was the case for 75% of those who attended workshops and 69% who attended conferences. This implies that early childhood care and education practitioners are recognizing that social and emotional development issues are significant to consider in relation to their practices and are actively furthering their knowledge and skills in this area.

Summary

Despite increased recognition of the various skills that practitioners in child care centres require, less attention has been paid to how the conditions of their specific work environment and, more broadly, child care as a career, shape their capacity to be effective in their work. Job satisfaction contributes to the reward and meaning ECCE practitioners derive from their work, and this will likely spill over to positive outcomes for the children in their care. In a field that demands that staff promote children's development and build productive relationships with parents and community resources, there is far too little compensation to acknowledge and reward the importance of this work. There is also a general lack of accommodation and appreciation for practitioners in terms of centre facilities and organizational structures that respond to their adult needs. Ultimately, oversights regarding the well-being of child care practitioners will lead to fewer individuals who are educated, experienced and committed to the field and will dissuade educated and committed individuals from entering into it. This can only have negative consequences for the mental health of children in child care centres. Undoubtedly, children suffer when high turnover rates impede the formation of enduring trusting relationships with practitioners and when practitioners have poor preparation for how to promote positive social skills and expression of emotions. Inevitably, as we appreciate the sensitive and critical nature of early childhood, we must also acknowledge how the well-being of the centre practitioners, who help shape this period of development for many children, is a key component of positive outcomes.

CHAPTER 7:
Implications for Policy and Practice

A convergence of circumstances bodes well for a major social policy initiative to launch an early childhood development system in Canada... there is a growing consensus about two things: first, the importance of the early period of human development, and, second, the need to realign and expand early childhood development programs to support young children and their families.
— (Beach & Bertrand, 2000, p. 47)

Throughout this review, activities essential to mental health promotion in child care have been described and opportunities for mental health promotion in this setting emphasized. That such efforts will have the greatest impact at the beginning of life, and that all children, and not just those considered to be "at risk", will benefit from early childhood programs, is being discussed with increasing frequency (McCain & Mustard, 1999). This is also the basic premise of the National Children's Agenda which is focused on children's issues from preconception to the age of 18. Within this broad agenda, the 1999 Speech from the Throne called for a federal-provincial-territorial "plan... [that] will set out common principles, objectives and fiscal parameters for all governments to increase resources and further strengthen supports for the Early Childhood Development Initiative by December 2000." Although transfer payments were made to the provinces and territories under this latter rubric, none of the funds were specifically earmarked for support of universal quality child care. Although there is general agreement about the importance of the early years, as well as the weaknesses in the child care system in Canada, there has not been a coherent policy regarding implementation of universal accesibility to and availability of child care.

Just recently, in the federal budget announced in March 2004, the government of Canada has promised $5 billion over the next five years to build a national system of child care. These funds, which are earmarked for licensed child care centres, are intended to expand the number of child care spaces and to ensure quality, universality, and accessibility as well as to ensure developmental programming.

In this chapter we will pull together the common threads that have run through this review in order to make recommendations for policies around what still needs to be done to ensure the promotion of mental health in young children. Through these recommendations, it will become clear that the onus for executing an effective Canadian child care system lies with all levels of government and the business community, as well as child care centres themselves.

In response to the recent promise of an injection of funds into child care, Sandra Griffin, Executive Director of the Canadian Child Care Federation recommended creation of a formal body, such a secreteriat of ministers of early learning and care. This would ensure that key issues shared in all regions of Canada could be addressed (Griffin, March 23, 2004).

Although there is general agreement about the importance of the early years, as well as the weaknesses in the child care system in Canada, there is as yet no coherent policy regarding implementation of universal accessibility to and availability of child care.

Recommendation 1: Given both labour market forces and individual choices of working women, child care spaces for children from infancy onward should be increased and representatively distributed in all regions throughout Canada.
There has been a rapid rise in dual-earner and single parent households over the last decade. For the most part, the rise has been spearheaded by an increase in the number of women in the workforce. This has meant that child care has moved from being a sole responsibility of the family to a shared responsibility of family and public institutions, centre-based care being one of these. Because many mothers return to the work force within 3 to 6 months following the birth of a child, there has been heightened demand for infant spaces which are in relatively short supply and typically have higher enrollment fees than those for other age groups. Accommodations to this demographic shift have been incorporated into some policy decisions resulting in such gains for parents as extension of parental leave, the Child Care Expense Deduction, and the National Child Benefit. The needs of First Nations/Inuit children also have been more soundly addressed through the development of the First Nations/Inuit Child Care Program.

Canada still needs to invest into child care policy, planning, and funding. While so much attention has been placed on the initial step of this process, simply increasing the number of centre spaces and families' access to them, it is essential to prioritize the quality component of spaces as they are implemented.

Accessibility of affordable, high quality and geographically convenient child care is an important social and economic necessity. Moreover, having the choice of a child care centre where practitioners' beliefs and values around childrearing are in line with those of the parent(s) also has become more important. When these requirements cannot be met, then non-preferred means of child care must be accepted. Not being able to find suitable child care contributes to parents experiencing stress which cannot help but be passed on both to their child and to the parents' performance in the workplace. Although it would be inaccurate to say that poor quality child

care is the only factor contributing to parent stress, it is one of them. Here, then, there is the potential for dual risk of the effects of parent stress on the child coupled with nonoptimal out-of-home care. Given considerable research indicating that parenting and family characteristics are the most powerful predictors of children's social and emotional outcomes, attention to ways that family stress can be reduced is imperative.

Recommendation 2: There is now ample evidence of the characteristics necessary for setting standards and regulations that ensure high quality centre-based care for children from infancy onward. All provinces and territories need to take leadership in contributing to a coherent and coordinated national policy supporting mental health promotion in early childhood education and care. This must be done with guidance from and collaboration with the federal government.

We cannot talk about mental health promotion in child care without simultaneously talking about ensuring that child care is of the highest quality. The research reviewed earlier in this report indicates that although children's relationships with their parents are most influential in explaining children's early social and emotional development, quality of out-of-home child care also is important. Specifically, regardless of maternal education, family income, child gender, and ethnicity, children's social and emotional development as reflected in more competent peer relationships, emotion expression, empathy building, and self confidence, as well as their cognitive and language competence, is linked with the quality of the child-care experience.

Quality is not a single dimension but comprised of various elements and their dynamic interaction including practitioner:child ratio, group size, ECCE practitioner (both practitioners working directly with children and directors) education and experience, staff wages, level of licensing regulations, and staff turnover. Together, these factors have been shown to predict 50% of the variation in the total score on the ITERS or ECERS (*Cost, Quality and Child Outcome Study*, 1995). Further, when we focus on what is most important for mental health promotion, it has been shown that providing a secure, safe, and supportive emotional environment, understanding individual differences in children's temperament and skills, facilitating the capacity to share emotions accurately and directly with others, and supporting children in negotiation of social relationships with peers and adults are key factors.

If child care quality is such a powerful predictor of children's mental health outcomes then an issue of concern for policy makers is that, in Canada, many child care centres do not meet standards associated with high quality (Friendly et al., 2001). A national survey of child care quality (Doherty et al., 2000) found that only 28.7% of all infant/toddler rooms and 44.3% of all preschool rooms were judged to be of "good"

quality. With establishment and monitoring of standards left in the hands of individual provinces the stated intentions of the National Children's Agenda are not realized.

As well, with a strong emphasis on meeting set criteria for licensing there is a risk of a disconnection between structural characteristics of child care settings and the processes essential to mental health promotion that the structures are intended to support. In particular, structural characteristics of child care include factors such as group size, adult:child ratio, and classroom organization, hygiene, and safety. It must be kept in mind, however, that beyond safety and hygiene issues, it is how structures provide support for the process of sensitive and responsive caregiving and facilitation of social relationships, as well as provide opportunities for building a sense of self and accompanying self-esteem and self-efficacy in children that are critical to mental health promotion (NICHD ECCRN, 2002a, 2002b; Doherty et al., 2000). In other words, in setting policy, explicit regulations dealing with developmental enhancement rather than child protection must be set.

Moreover, different levels of government (federal, provincial, and municipal) have differing responsibility for child care services. For instance, in Ontario, the federal government provides a block grant from which funds for child care are drawn, the province sets the policy and regulations, and the municipal government delivers child care services. In other provinces the provincial government plays the major role. There has been a longstanding discussion about the role of the federal government in relation to the provinces in setting policies for monitoring and funding child care (Friendly et al., 2001). An unfortunate dichotomy between a top-down and bottom-up approach has emerged (Beach & Bertrand, 2000) when, in fact, collaboration between government, provinces/territories, and practitioners is needed. It has been two decades since Canadian child care advocates highlighted the need for a national child care agenda that simultaneously puts forward a national program for child care with objectives, conditions, and funding. In light of the recent funding commitment of the federal government to child care, it is recommended that the federal government work to strengthen and make consistent regulations for high quality care for all children. The licensing guidelines should explicitly reflect appropriate early childhood principles and relevant research related to promoting children's mental health. Within the universal standards, attention to cultural needs and provincial and regional demographics is also required. In this process, licensing agents can play a more active role in promoting as well as judging quality of care. This would make both the licensing agent and child care centre dually accountable, relieving the current "buyer beware" attitude among many

parents seeking care for their children. Simultaneously, there needs to be public education for parents about quality care so that they can be active collaborators in the process.

Recommendation 3: Within child care centres a special emphasis must be placed on setting guidelines for optimizing practitioner:child ratios. This is essential to mental health promotion as it emphasizes the needs of children for both warm supportive relationships and for relationships with specific practitioners who are sensitive to children's individual characteristics and needs.

There is consistent agreement that children need to be in responsive nurturing environments. The literature on basic attributes of close relationships, including attachment relationships, has consistently set these down as prerequisites for promoting healthy relationships. Although this is widely acknowledged there is variation across provinces in acceptable practitioner to child ratios. Optimally, this ratio should be 1:3 for infants but in some provinces it is higher. Child care centres themselves need to play a role in augmenting practitioner-child relationships by striving beyond the minimal standards outlined in regulations. This should involve centres keeping abreast of quality issues and making use of quality measures such as the ECERS and ITERS. The key is for centres to implement, as well as maintain, quality practices. With this in mind, centres must try to establish structures and processes that steer them towards ongoing quality. Accreditation is one method centres can employ to actively evaluate and improve upon their practices. There is also need to attend not only to what practitioners are actually doing with children, which was emphasized in Chapter 4, but also to the behaviours that staff model in relation both to children and one another.

Recommendation 4: Information on opportunities for mental health promotion in daily activities in child care should be widely circulated.

There is currently an awareness that learning to control emotions and behaviour, manage conflict, and get along with peers and adults is as critical as cognitive, motor, and language development in preparing children for school and for life in general. Knowledge about the developmental needs of children drives efforts to promote mental health in child care. Many of these developmental considerations were outlined in Chapter 4 of this report and form the basis for the accompanying resource booklet. Key to mental health promotion is ensuring that children feel valued and that they have some degree of control and faith in their capacity to solve some problems on their own. Thus, sensitivity and adaptation to children's individual needs, facilitating extended conversations about one's own and others' emotions, promoting and supporting close friendships among children of all ages, and helping children to resolve conflicts rather than solve conflicts for them are all elements of mental health promotion.

It is critical that practitioners recognize that these areas can be focused on through structured activities, but it is probably more spontaneous, regular day-to-day interactions that create a larger and more meaningful imprint on children. Ultimately, this stresses that practitioners must constantly be flexible and accommodating in their ability to foster social and emotional development and acknowledge the impact they have on children. Finding opportunities for mental health promotion is just as important as forming them. In our national scan we were encouraged by the numerous examples of creative ways that ECCE practitioners have woven principles of mental health promotion into their day to day work with children of all ages. Nevertheless, we are still cautious in assuming that this approach applies to all centres. We do not know how widespread these practices are and whether a conscious link to mental health promotion has been made in the field at large.

Recommendation 5: Policies that recognize adults' needs in child care must be established nationwide. This is as important as recognizing children's needs.

There is a contradiction between the value that we now place on the early years and the investment made in the adults who care for children. Children need care from consistent and reliable adults and therefore low levels of practitioner education coupled with all too frequent staff turnover have a significant negative impact on children's mental health. Practitioners will benefit if they feel supported, nurtured, and well compensated themselves and, in turn, so will the children in their classrooms. Higher education, low staff turnover and higher staff salaries go hand in hand with practitioner warmth, responsiveness, and attentiveness to children's well being. Structural factors, such as low staff-to-child ratio and small group sizes, contribute to children in care being socially competent and having higher scores on a range of social and emotional behaviours (Phillips, 1987). Therefore, improving the well-being of practitioners through provision of higher salaries and benefits and more congenial working conditions is an important component of promotion of mental health in children. In a sense, undervaluing the work of ECCE practitioners also means undervaluing the importance of the early years for shaping the adult that the child will become.

Increasing the esteem of practitioners and the child care field also has the power to enable centre administrators to be more selective in the hiring process. If the status and benefits of child care positions improve, administrators will have added control in filling positions with practitioners who have the necessary knowledge and skills to further mental health promotion. This can replace the necessity of hiring individuals

to simply fill the gaps created by high turnover. Hiring practitioners that suit centre philosophies and goals can also further positive working conditions and relationships that may bolster practitioners' investment and commitment to particular centres and the children enrolled.

Recommendation 6: There is tremendous variation across provinces in the educational requirements for ECCE practitioner. ECCE practitioner education, specifically, has consistently been associated with child care quality. Therefore, both child care organizations and provinces must ensure that staff meet educational requirements. Improving the educational status of ECCE practitioners goes hand in hand with improving their status, working conditions, and access to ongoing professional development in promoting children's mental health.

Individual knowledge about child development makes it more likely that practitioners will provide an environment that promotes children's mental health. Child care is a field where ongoing professional development is necessary. To ensure child care quality through providing developmental appropriate practices, adequate education and practicum training of practitioners are essential. Moreover, to ensure consistent child care practice, practitioners within a centre need to have the same knowledge base. Just as there is variation in the quality of child care settings, similarly, there is variation in the preparation of practitioners in whose hands the children are placed for care and education. Although there are now some excellent early childhood education programs, in many jurisdictions there are minimal standards for basic education and some practitioners enter the child care field without any kind of training. Moreover, for those who receive minimal education a focus on the basic safety and structural standards for child care are likely to be the priority in the curriculum, leaving untouched the process issues essential to promoting children's mental health that we have discussed. In some provinces, in fact, there are no educational requirements for either ECCE practitioners working directly with children or directors (see Chapter 3, Table 2).

In contrast, countries such as New Zealand, Denmark, Sweden, and Spain have moved towards longer and higher level basic training for early childhood work. In those countries, three years is used as the main or "benchmark" period of training for practitioners working with children in the age range from 0 to 5 or 6 years. In most cases, the training is equivalent to the training for teachers in primary schools (Moss, 2000). These countries have reached a higher point of development in relation to training for early childhood education and care. Some reasons offered for this is that they have a history of comprehensive and readily available social welfare services and are smaller and more homogeneous countries than is Canada. Concerted effort must be undertaken to ensure this kind of quality education and higher basic education levels across Canada.

Careful thought needs to be given to continuing to modify the curriculum around social and emotional development and mental health of children. This is especially important with respect to infants and toddlers, as most of even advanced training is focussed on working with preschoolers. Education needs to incorporate new research and how this translates to practice. It is encouraging that the systematic study of quality of ECCE practitioners' behaviour in the *You Bet I Care!* study (Goelman et al., 2000) indicated that in most cases practitioners were warm attentive, and engaged, and were not harsh or detached. However, more specific skills around fostering social and emotional well-being may be needed. Adoption of reflective supervision practices is a valuable component of education and practicum training to increase awareness of what practitioners' own beliefs and relational history bring to the child care experience. Moreover, the curriculum for ECCE practitioners needs to be unified across Canada. Modifications in curriculum also need to take into consideration findings that identify common practitioner training gaps: collaboration with parents, work with infants and toddlers, bilingualism/multiculturalism, and special education. It is important to acknowledge that the need for specialized advanced training applies equally to teachers and directors. Moreover, training for directors needs to go beyond management skills to promote leadership skills that will help them to support the adult needs of teachers in the workplace. In the current climate, the downside of improving practitioner education is that it is often accompanied with lower job satisfaction and higher staff turnover. As was discussed in Chapter 3, social and emotional problems can arise when there are child care staffing changes, poor preparation of child care staff in how to promote social and personal skills, and high staff turnover.

Recommendation 7: Guidelines need to be set for collaboration between practitioners, parents, community resources, and multicultural communities as an essential component of promoting the mental health of young children.
In Chapter 5, we discussed the various collaborations that need to be forged in promoting children's mental health. Because family influences are paramount in children's lives, it is essential for practitioners and parents to develop positive mutually respectful working relationships.

Families inevitably go through periods of varying levels of stress. ECCE practitioners cannot be expected to handle all such challenges that come their way, such as parental depression, divorce, domestic violence, poverty, and family illness or death. Practitioners will need support themselves. Improving the skills of ECCE practitioners to communicate with families in distress, to offer appropriate support to the children who inevitably will show symptoms associated with these stressful life events should become essential components

of ECCE practitioner education and professional development. It is just as important to know when either mental health consultation in the child care centre or an external referral is required. Many of the child care centres in the scan utilized a range of community resources and services but this is not the case in all communities. There is also increasing discussion of formalizing coordinated systems of care and education. Beach and Bertrand (2000) noted that while several provinces have given a higher cabinet profile to child and family issues and have brought together prevention and early intervention programs, at the service delivery level little has changed. Budget allocation and service delivery of early child care and education programs remains separate from other programs for children and families. The exceptions are special initiatives, such as First Duty in Toronto, that may serve as models for service delivery in the future.

A thread running through practitioner-parent relationships in addition to coordination of services, is multiculturalism. Canada has been proud of its encouragement of maintaining cultural heritage. However, relatively little attention has been paid to finding ways to respond to the cultural diversity in Canada in child care. Although most centres show interest and respect for the practices and celebrations of different cultures, the deeper meaning of holding different assumptions, beliefs, and practices around mental health issues in children has barely been touched. The difficult job lies ahead in not only acknowledging differences but in finding ways to incorporate these differences into working with children and families so that no single viewpoint prevails over another but rather where what Barrera (2003) has called a "3rd Space" can be achieved. In terms of practitioner education, the generative curriculum, developed by Alan Pence and colleagues for use with Aboriginal communities (Pence, ND) is a good example of starting with the community's input while sharing a knowledge base on child development. Although there are such activities, there needs to be a national task force that brings together individuals with experience in working in a multicultural context to establish models of practice. In turn, as Howe and Jacobs (1995) have suggested, model centres might be established across the country which reflect a multicultural approach.

Finally, an even broader issue is whether child care should be an independent system or whether it should be integrated with other structures that could facilitate mental health promotion such as children's services, family resource programs, and education (e.g., Beach & Bertrand, 2000). Such integration seems eminently sensible as a way of ensuring the timely support of children and families and the results of ongoing pilot projects that have adopted this model (e.g., Toronto's First Duty) will be important to watch.

Recommendation 8: Federal and provincial funding as well as funding from the business community are needed to increase the availability of child care, to ensure universally high quality child care, and to improve practitioners' education, salaries, and working conditions.

Making necessary changes in child care policy and practice is expensive. Although Canadians, citizens and government alike, would agree that young children deserve to spend their days with well educated practitioners in richly resourced high quality child care centres, there is a perennial problem of funding to ensure high quality and adequate training and remuneration. Child care is currently funded by a combination of sources including government support and subsidies and parent fees. Yet more funding is needed to increase the availability of child care, to ensure universally high quality child care, and to improve practitioners' education, salaries and working conditions.

Although improved financial support for child care has been on the federal agenda for some time, there is evidence that the Canadian child care system has deteriorated rather than gained ground (Friendly et al., 2001). Hopefully, the new funding for child care announced in March of 2004 will assist in moving ahead.

In the wake of increased awareness about the importance of early childhood for all aspects of development, the Early Child Development Initiative was introduced in Canada. Although some funds have been spent on child care related services, funds have also gone into programs for targeted populations. Despite being of considerable importance, such efforts detract from the message that all children benefit from efforts at promotion of mental health and learning opportunities. Moreover, some special initiatives undertaken in Canada are likely to fade over time when funding runs out. Child care centres that are recipients of such funds need to be encouraged from the outset to think about how activities leading to a positive outcome can be continued when the special funding ends.

It is tempting to privatize child care and take a costly burden at least partially outside of the public funding arena. This would be a mistake as the research findings consistently show that quality of child care is higher in the non-profit than in the for-profit centres. Like other endeavours starting in children's earliest years, the full results of this investment are not immediately realized. However, the long term savings in relation to both mental health and school success could be tremendous. Sandra Griffin, Executive Director of the Child Care Federation of Canada (2003) called quality of care costs "an investment in the future".

In recent years the business community has been urged to engage more fully in this process by members from its own ranks. In a 2003 article, Charlie Coffey, Executive Vice President, Government and Community Affairs of the RBC Financial Group in Toronto said:

There's also no doubt that the time is now to convince corporate Canada to take a more active interest and leadership role in supporting childhood education and care. The key to convincing business revolves around building and selling a compelling business case-demonstrating that early childhood education and care matters to business.

In the U.S., a similar case has been made. Art Rolnick, Senior Vice President and Director of Research for the Federal Reserve Bank of Minneapolis and Rob Grunewald, Regional Economic Analyst (Minneapolis) argue that early childhood care and education programs could be portrayed as economic development initiatives and, in fact, should be placed at the top of the list for such initiatives, an investment in "human capital" as it were (Rolnick & Grunewald, 2003). This is especially important in the coming years given that the growth rate of the population will be declining and there are concerns that an adequate cohort of young adults be available to replace those retiring over the next two decades.

Employers are aware that good early childhood programs are critical to the recruitment and retention of parent employees. Thus, rather than see increased costs for producing high quality child care for all children as detracting from the economy, in the long run it will actually enhance it. The business sector can support government by both placing pressure on government to take action and by taking direct action itself through providing workplace child care, child care subsidies, after-school programs, parent networks for information and referral, sponsorship or investment in target children's initiatives, and representation on children's advocacy committees.

Recommendation 9: The federal government, through Social Development Canada, has made a commitment to funding research on child care. This ongoing commitment is applauded and further research related to mental health promotion in child care is strongly encouraged.

Research summarized in this report indicates that characteristics of families, children, and child care centres combine to influence children's social-emotional development and, thereby, their mental health. Consequently, it is important to continue to study factors that promote mental health in young children. It is also essential to evaluate ways in which ECCE practitioners, families, and community resources can work together to promote children's mental health. This is an important challenge in light of the multiplicity of family forms and the cultural diversity in Canada today.

Conclusions

Over the last decade there has been an explosion of knowledge that has made it clear that the foundations of mental health are laid down within the nervous system from the earliest days of children's lives. Of special relevance here is that, in parallel, there has been a tremendous growth in the need and demand for quality child care spaces for infants, toddlers, and preschoolers, and a deeper understanding of the essential characteristics of this environment for children's social and emotional growth. Having said this, there is still much lacking in the current child care "scene". Although important political processes have been set into motion with recent injection of funds into increasing child care spaces as well as improving the accessibility and quality of child care and enhancing developmental programming, to date, the promises of these efforts have yet to make a significant impact on child care. On one hand, there is general agreement about the importance of the early years, as well as the weaknesses in the child care in Canada. On the other hand, there is as yet no coherent policy that encompasses the myriad of interrelated factors that will support children's mental health. In particular, policies must address: universal provision of service inclusive of all children, strategies to improve quality that make a clear link between structure and process, adequate training and remuneration of practitioners, integrated service provision to meet the needs of children and parents with different work requirements, responsiveness to community values and diversity, and encouragement of community and parental input.

It is often difficult to gain a full grasp on mental health promotion for young children. One reason for this is that the perspectives of different interest groups prevail, particularly those that embody prevention and treatment. Although these initiatives are important we must also attend to the mental health needs of all children. The agenda for Canada is to develop a model where the various components essential to mental health promotion in child care are articulated and where the different interest groups work together in a complementary fashion. A collaborative working group, initiated at the federal level and including all provinces and territories at the table is needed.

REFERENCES

Andersson, B.-E. (1992). Effects of day care on cognitive and socioemotional competence of thirteen-year old Swedish school children. *Child Development, 63*, 20-36.

Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.

Angold, A., Costello, E.J., Farmer, E.M.Z., Burns, B., & Erkanli, A. (1999). Impaired but undiagnosed. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 129-137.

Astington, J.W., Harris, P.L., & Olson, D.R. (Eds.), *Developing theories of mind* (pp. 44-426). New York: Cambridge.

Atkinson, A.M. (1987). A comparison of mothers' and providers' preferences and evaluations of day care services. *Child and Youth Care Quarterly, 16*, 35-47.

Bailey, S. (2003). *Child care funding falls short of hopes but could relieve frazzled parents*, Child Care in the News. Retrieved September 9, 2003 from http://www.childcarecanada.org.

Ball, J. (2002). The challenge of creating an optimal learning environment in child care: Cross-cultural perspectives. In L. Girolametto & E. Weitzman (Eds.), Enhancing caregivers facilitation in childcare staff. Proceedings from symposium, Toronto, ON, October.

Barrera, I. (2003). From rocks to diamonds: Mining the riches of diversity for our children. *Zero to Three, 23*, 8-15.

Beach, J., & Bertrand, J. (1998). *Innovative training: Programs in early childhood care and education: Selected case studies*. Ottawa, ON: Child Care and Human Resources Steering Committee. Retrieved February 10, 2003, from www.cfc-fc.ca/docs/cccf/00001255.htm.

Beach, J., & Bertrand, J. (2000). *More than the sum of the parts: An early childhood development system for Canada*. Toronto, ON: Childcare Resource and Research Unit. (Occasional paper). Retrieved October 2, 2003 from: www.childcarecanada.org.

Beach, J., Bertrand, J., Cleveland, G. (1998). *Our child care workforce: from recognition to remuneration. A Human Resource Study of Child Care in Canada*. The Child Care Sector Study Steering Committee, Human Resource Development Canada. Main Report. Also in French. ISBN 0-9683704-3.

Bellm, D., Burton, A., Shukla, R., & Whitebook, M. (1997). *Making work pay in the child care industry: Promising practices for improving compensation*. Washington, D.C.: Center for the Child Care Workforce.

Belsky, J. (1986) Infant day care: A cause for concern? *Zero to Three, 6*, 1-6.

Bernhard, J.K. (1996). Child development, cultural diversity: The professional training of early child educators. *Canadian Journal of Education, 20*, 415-437.

Bernhard, J.K., Lefebvre, M.L., Chud, G., & Lange, R. (1997). The preparation of early childhood educators in three Canadian areas of immigrant influx: Diversity issues. *Canadian Children, 22*, 26-34.

Bernhard, J.K., Lefebvre, M.L., Kilbride, K.M., Chud, G., & Lange, R. (1998). Troubled relationships in early childhood education: Parent-teacher interactions in ethnoculturally diverse child care settings. *Early Education and Development, 9*, 5-28.

Bertacchi, J., & Norman-Murch, T. (1999). Implementing reflective supervision in non-clinical settings: Challenges to practice. *Zero to Three, 20*, 18-23.

Bloom, P.J. (1992). The child care center director: A critical component of program quality. *Educational Horizons*, Spring, 138-145.

Bloom, P.J. (1996). The quality of work life in NAEYC accredited and nonaccredited early childhood programs. *Early Education and Development,* Spring, 301-317.

Bloom, P.J., & Rafanello, D. (1994). *The professional development of early childhood center directors: Key elements of effective training models*. Paper presented at the National Association of Early Childhood Teacher Educators Preconference Session a the Annual Meeting of the NAEYC National Institute for Early Childhood Professional Development, Chicago, IL., June.

Bloomquist, M., August, G., Cohen, C., Doyle, A., & Everhart, K. (1997). Social problem solving in hyperactive-aggressive children: How and what they think in conditions of automatic and controlled processing. *Journal of Clinical Child Psychology, 26,* 172-180.

Borges A.I.H., Rutter, M., Côté, S., & Tremblay, R.E. (2004). Early childcare and physical aggression: Differentiating social selection and social causation. *Journal of Child Psychology and Psychiatry, 45,* 367-376.

Bornstein, M.H., & Tamis-LeMonda, C.S. (1990). Activities and interactions of mothers and their first born infants in the first six months of life: Covariation, stability, continuity, correspondence, and prediction. *Child Development, 61,* 1206-1217.

Bowlby, J. (l969). *Attachment and loss. Vol. 1: Separation*. New York: Basic Books.

Bradbard, M.R., Brown, E.G., Endsley, R.C., & Readdick, C. A., (1994). Parents' selections of proprietary day care centers for their school-age children: A study of three southeastern university communities. *Child and Youth Care Forum, 23,* 55-72.

Bredekamp, S. (Ed.) (1987a). *Accreditation criteria and procedures of the National Academy of Early Childhood Program*. Washington, DC: National Association for the Education of Young Children.

Bredekamp, S. (1987b). *Developmentally appropriate practice in early childhood programs serving children from birth through age 8*. Washington, DC: National Association for the Education of Young Children.

Bredekamp, S. (1990). *Regulating child care quality: Evidence for NAEYC's accreditation system*. Washington, DC: National Association for the Education of Young Children.

Breton, J.-J. (1999). Complementary development of prevention and mental health promotion programs for Canadian children on contemporary scientific paradigms. A Review. *Canadian Journal of Psychiatry, 44,* 227-234.

British Columbia Community Care Facility Act Regulations (2002). Available from: www.bcgeu.bc.ca.

Broidy, L.M., Nagin, D.S., Tremblay, R.E., Bates, J.F., Brame, B., Dodge, K.A., Fergusson, D., Horwood, J.L., Loeber, R., Laird, R., Lynam, D.R., Moffitt, T.E., Pettit, G.S., & Vitaro, F. (2003). Developmental trajectories of childhood disruptive behaviours and adolescent delinquency: A six-site, cross-national study. *Developmental Psychology, 39,* 222-245.

Brotman, L., Gouley, K.K., Klein, R.G., Castellanos, X.F., & Pine, D.S. (2003). Children, stress, and context: Integrating basic, clinical, and experimental prevention research, *Child Development, 74,* 1053-1057.

Brotman, L.M., Klein, R.G., Kamboukos, D., Brown, E.J., Coard, S.I., Soskinsky, L.S. (2003). Preventive intervention for urban low-income preschoolers at familial risk for conduct problems: A randomized pilot study. *Journal of Clinical Child and Adolescent Psychology, 32,* 246-257.

Brown, J.R., & Dunn, J. (1992). Talk with your mother or your sibling? Developmental changes in early family conversations about feelings. *Child Development, 63,* 336-349.

Brownell, C.A., & Brown, E. (1992). Peers and play in infants and toddlers. In V.B. Van Hasselt & M. Hersen (Eds.), *Handbook of social development: A life-span perspective* (pp. 183-200). New York: Plenum.

Burchinal, M.R., Ramey, S.L., Reid, M.K., & Jaccard, J. (1995). Early child care experiences and their association with family and child characteristics during middle childhood. *Early Childhood Research Quarterly, 10,* 33-61.

Calgary Regional Association for Quality Child Care and Diversity Learning Institute (2001). *Clue into inclusion: A workshop toolkit for creating more inclusive childcare centres*. Calgary, AB.

Campbell, S.B. (2002). *Behavior problems in preschool children*. New York: Guilford.

Canadian Child Care Federation. (1994). *National Statement of Quality Child Care*. Ottawa: Canadian Child Care Federation.

Canadian Council on Social Development. (2002). *The Progress of Canada's Children: 2002 Highlights*. 1-6. Available from www.ccsd.ca/pubs/2002/pcc02/hl.pdf.

Canadian Census (2001). Toronto Star, Tue Jan 7, 2003. Retrieved July 1, 2003, from www.thestar.com.

Caruso, D. (1996). Maternal employment status, mother-infant interaction, and infant development in day care and non-day care groups. *Child and Youth Care Forum, 25,* 125-134.

Casey, R.J., & Fish, A.M. (April, 2003). *Depression among children's caregivers*. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Tampa, Florida.

Casper, L.M. (1996). *Who's minding our preschoolers?* Current Population Reports (Series 70, No. 53). Washington, DC: U.S. Bureau of the Census.

Caulfield, R. (1997). Professionalism in early care and education. *Early Childhood Education Journal, 24,* 261-263.

Chandler, K. (1999). Professional development. In J. Morris (Ed.) *Innovative models for early childhood care and education training in Canada*. Research Connections Canada: In support of children and families, *3,* 103-126. Ottawa: Canadian Child Care Federation.

Childcare Research & Resource Unit (2000). *Early childhood care and education in Canada: Provinces and territories 1998*. Toronto: University of Toronto, Centre for Urban and Community Studies, Childcare Resource and Research Unit.

Childcare Resource and Research Unit. (2001). In BRIEFingNOTES. Early childhood education and care in Canada 2001: Summary. Toronto: University of Toronto, Centre for Urban and Community Studies. Available from www.childcarecanada.org.

Childcare Resource and Research Unit. (N.D.) In BRIEFingNOTES. Summary. More than the sum of the parts: An early childhood development system for Canada. Toronto: University of Toronto, Centre for Urban and Community Studies. Available from www.childcarecanada.org.

Cicchetti, D. & Rogosch, F.A. (1996). Equifinality and multifinality in developmental psychopathology. *Development and Psychopathology, 8,* 597-600.

Clarke, C., & Fagan, D. (2004, June 3). PM plans $5-billion in daycare [CA]. *Globe and Mail*. Retrievd July 28, 2004, from http://action.web.ca/home/crru.shtml?x=59349.

Clarke-Stewart, A. (1988). The effects of infant day care reconsidered: Risk for parents, children, and researchers. *Early Childhood Research Quarterly, 3,* 293-318.

Clarke-Stewart, A. (1991). Does day care affect development? In E.C. Melhuish & D. Wolke (Eds.), International perspectives on day care for young children (Special Issue). *Journal of Reproductive and Infant Psychology, 9,* 67-78.

Clarke-Stewart, A., Gruber, C.P., & Fitzgerald, L.M. (1994). *Children at home and in day care*. Hillsdale, NJ: Lawrence Erlbaum.

Cohen, N.J. (2001). TLC[3]: A national initiative to enhance the language and cognitive development of children 0-5 years. *Journal of Speech and Language Pathology and Audiology, 25,* 103-113.

Cohen, N.J, Barwick, M., A., Horodezky, N.B., Vallance, D.D., & Im, N. (1998). Language, achievement, and cognitive processing in psychiatrically disturbed children with previously identified and unsuspected language impairments. *Journal of Child Psychology and Psychiatry, 39,* 865-877.

Cohen, N.J., Davine, M., Horodezky, N., Lipsett, L., & Isaacson, L. (1993). Unsuspected language impairment in psychiatrically disturbed children: Prevalence and language and behavioral characteristics. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 595-603.

Cohen, N.J., Muir, E., Lojkasek, M., Muir, R., Parker, C.J., Barwick, M., & Brown, M. (1999). Watch, Wait, and Wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. *Infant Mental Health Journal, 20,* 429-451.

Cohen, N.J. & Radford, J. (1999). *Impact of early intervention on adult outcome.* Ottawa, ON: Health Canada NHRDP, Information and Dissemination Branch.

Cohen, S.E., & Beckwith, L. (1979). Preterm infant interaction with the caregiver in the first year of life and competence at age two. *Child Development, 50,* 767-776.

Cohn, J.F., Campbell, S.B., & Ross, S. (1991). Infant response in the still-face paradigm at 6 months predicts avoidant and secure attachment at 12 months. *Development and Psychopathology, 3,* 367-376.

Cohn, J.F., & Tronick, E.Z. (1987). Mother-infant face-to-face interaction: The sequence of dyadic states at 3, 6, and 9 months. *Developmental Psychology, 23,* 68-77.

Coffey, C., & Hargrove, B. (2003). Our future rides on this budget. Child care in the news. OPED, the Globe and Mail. Available from www.childcarecanada.org/ccin/2003/ccin2_17_03.html.

Connor, S., & Brink, S. (1999). *The impacts of non-parental care on child development.* Hull, QC. Applied Research Branch Strategic Policy, Human Resources Development Canada. Catalogue No: MP 32-30/00-1E. Available from www.hrdc-drhc.gc.ca/arb.

Cost, Quality, and Child Outcomes Study Team (1995). Cost, quality and child outcomes in child care centers: Key findings and recommendations. *Young Children, 50,* 40-44.

Crick, N.R., & Dodge, K.A., (1994). A review and reformations of social information-processing mechanisms in children's social adjustment. *Psychological Bulletin, 115,* 74-101.

Crittenden, P. (1996). Language and psychopathology: An attachment perspective. In J. Beitchman, N.J. Cohen, M.M. Konstantareas, & R. Tannock, (Eds.) *Language, learning and behavior disorders: Developmental biological, and clinical perspectives,* (pp. 59-77). New York: Cambridge University Press.

Dale, P.S. (1996). Parent report assessment of language and communication. In K.N. Cole, P.S. Dale and D.J. Thal (Eds.), *Assessment of communication and language, Vol. 6,* (pp. 161-182). Baltimore, MD: Paul H. Brookes.

Deater-Deckard, K., Pinkerton, R., & Scarr, S. (1996). Child-care quality and children's behavioral adjustment: A four-year longitudinal study. *Journal of Child Psychology and Psychiatry, 37,* 937-948.

Denham, S.A. (1993). Maternal emotional responsiveness and toddlers' social-emotional competence. *Journal of Child Psychology and Psychiatry, 34,* 715-728.

Department of Finance Canada. (2003). The budget in brief, 2003. Building the Canada we want. Available from www.fin.gc.ca.

Doherty, G. (1997). *Zero to six: The basis for school readiness.* Ottawa: Applied Research Branch, Human Resources Development Canada.

Doherty, G. (1999). Elements of quality. In S. Sullivan, K. Bose, & L. Levesque (Eds.), *Research Connections Canada: Supporting Children and Families, 1,* 5-56. Ottawa, ON: Canadian Child Care Federation.

Doherty, G. (1999). Multiple stakeholders: Multiple perspectives. *Research Connections Canada, 1,* 57-81. Ottawa: Canadian Child Care Federation.

Doherty, G., Friendly, M., & Forer, B. (2002). *Child care by default or design? An exploration of differences between non-profit and for-profit Canadian child care centres using the "You bet I care!" data set.* Toronto, ON: University of Toronto, Child Care Research Unit, Centre for Urban and Community Studies.

Doherty, G., Lero, D.S., Goelman, H., LaGrange, A., & Tougas, J. (2000). *You bet I care! Caring and learning environments: Quality in regulated family child care across Canada.* Guelph, ON: Centre for Families, Work and Well-Being, University of Guelph.

Dunn, J. (1996). Children's relationships: Bridging the divide between cognitive and social development. *Journal of Child Psychology and Psychiatry, 37,* 507-518.

Dunn, J., Bretherton, I., & Munn, P. (1987). Conversations about feeling states between mothers and their young children. *Development Psychology, 23,* 132-139.

Dunn, J., & Brown, J. (1991). Relationships, talk about feelings, and the development of affect regulation in early childhood. In J. Garber & K.A. Dodge (Eds.), *The development of emotion regulation and dysregulation* (pp. 89-108). New York: Cambridge University Press.

Dunn, J., Brown, J., & Beardsall, L. (1991). Family talk about feeling states and children's later understanding of others' emotions. *Developmental Psychology, 27,* 448-455.

Dunn, J., & Munn, P. (1987). The development of justification in disputes. *Developmental Psychology, 23,* 791-798.

Dunn, J., Brown, J., Slomkowski, C., Tesla, C., & Youngblade, L. (1991). Young children's understanding of other people's feelings and beliefs: Individual differences and their antecedents. *Child Development, 62,* 1352-1366.

Employment and Immigration Canada (1993). *Occupational Standards and Certification Overview: Issues and Trends.* Ottawa: Minister of Supply and Services.

Eder, R.A. (1990). Uncovering children's psychological selves: Individual and developmental differences. *Child Development, 60,* 1218-1228.

Egeland, B., & Hiester, M. (1995). The long-term consequences of infant daycare and mother-infant attachment. *Child Development, 88,* 474-485.

Eisenberg, N., Fabes, R.A., Schaller, M., Carlo, G., & Miller, P.A. (1991). The relations of parental characteristics and practices to children's vicarious emotional responding. *Child Development, 61,* 622-637.

Endsley, R.C., Minish, P.A., & Zhou, Q. (1993). Parent involvement and quality day care in proprietary centers *Journal of Research and Childhood Education, 7,* 53-61.

Esses, V.M., & Gardner, R.C. (1996). Multiculturalism in Canada: Context and current status. London, ON: University of Western Ontario. Available online: Retrieved September 16, 2003, from www.cpa.ca/cbsnew/ 1996/ful_edito.html.

Evans, M.A., & Bienert, H. (1992). Control and paradox in teacher conversations with shy children. Canadian Journal of Behavioural Science, *24,* 502-516.

Farver, J.A.M., & Branstetter, W.H. (1994). Preschoolers' prosocial responses to their peers' distress. *Developmental Psychology, 30,* 334-341.

Ferguson, E.E., Flanagan-Rochon, K., Hautmann, L.G., Lutes, D., Masson, A., & Mauch, D. (2000). Toward a best practices framework for licensing child care facilities in Canada: Executive Summary. Halifax, NS: Child Care Connection.

Fiene, R. (2002). Improving child care quality through an infant caregiver mentoring project. *Child and Youth Care Forum, 31,* 79-87.

Finn-Stevenson, M., Desimone, L., & Chung, A.-M. (1998). Linking child care and support services with the school: Pilot evaluation of the school of the 21st century. *Children and Youth Services Review, 20,* 177-205.

Fox, N. (Ed.) (1994). The development of emotion regulation: Biological and behavioral considerations. *Monographs of the Society for Research in Child Development, 59* (2-3), Serial No. 240.

Friendly, M. (1997). *What is the public interest in child care? Policy Options, 18,* 3-6.

Friendly, M. (2000). *Child care and Canadian federation in the 1990's: Canary in a coal mine.* Occasional paper (No. 11), Toronto: University of Toronto, Centre for Urban and Community Studies.

Friendly, M. (2001). Is this as good as it gets? Child care as a test case for assessing the Social Union Framework Agreement. *Canadian Review of Social Policy, 47,* 77-82.

Friendly, M., Beach, J., & Turiano, M. (2001). *Early childhood education and care in Canada 2001.* Toronto: University of Toronto, Childcare Resource and Research Unit, Centre for Urban and Community Studies.

Friendly, M., Cleveland, G., Colley, S., & Lero, D. (2003). *The state of data on early childhood education and care in Canada.* Toronto: University of Toronto. Childcare Resource and Research Unit.

Friendly, M. & Lero, D. (2002). *Social inclusion through early childhood education at care.* Toronto: Laidlaw Foundation.

Friesen, B.K. (1995). *A sociological examination of the effects of auspice on day care quality.* Calgary, AB: Department of Sociology, University of Calgary.

Fuller, B. Eggers-Pierola, C., S.D. Liang, X., & Rambaud, M.F. (1996). Rich culture, poor marks: Why do Latino parents forgo preschooling? *Teachers College Record, 97,* 400-418.

Gable, S., & Cole, K. (2000). Parents' child care arrangements and their ecological correlates. *Early Education & Development, 11,* 549-572.

Gable, S., & Hunting, M. (2001). Child care providers' organizational commitment: A test of the investment model. *Child and Youth Care Forum*, *30,* 265-281.

Galinsky, E. (1992). The impact of child care on parents. In A. Bloom (Ed.), *Child care in the 1990s* (pp. 159-171). Hillsdale NJ: Erlbaum.

Gallagher, J.J., Rooney, R., & Campbell, S. (1999). Child care licensing regulations and child care quality in four states. *Early Childhood Research Quarterly, 14,* 313-333.

Gazvini, A.S., & Readdick, C.A. (1994). Parent-caregiver communication and quality of care in diverse child care settings. *Early Childhood Research Quarterly, 9,* 207-222.

Gesell, A. (1928). *Infancy and human growth.* New York: MacMillan.

Girolametto, L., & Weitzman, (2002). Responsiveness of child care providers in interactions with toddlers and preschoolers. *Language, Speech, and Hearing Services in Schools, 33,* 268-281.

Goelman, H., Doherty, G., Lero, D.S., LaGrange, A., & Tougas, J. (2000). *You bet I care! Caring and learning environments: Quality in child care centres across Canada.* Guelph, ON: Centre for Families, Work and Well-Being, Guelph, ON: University of Guelph. Available from http://uoguelph.ca/cfww.

Goelman, H., & Guo, H. (1998). What we know and what we don't know about burnout among early childhood care providers. Child and Youth Care Forum, *27,* 175-199.

Goelman, H., & Pence, A. (1987). Effects of child care, family, and individual characteristics on children's language development: The Victoria Day Care Research Project. In D.A. Phillips (Ed.), *Quality in child care: What does research tell us?* (pp. 105-120). Washington, DC: National Association for the Education of Young Children.

Goldberg, S. (2000). *Attachment and development.* London, EN: Arnold.

Goossens, F.A., & van IJzendoom, M. (1990). Quality of infants' attachments to professional caregivers: Relation to infant-parent attachment and day-care characteristics. *Child Development, 61,* 832-837.

Gormley, W.T. (1995). *Everybody's children: Child care as a public problem.* Washington, DC: The Brookings Institution.

Government of Canada Report. (2002). *The well-being of Canada's young children: Government of Canada Report.* Ottawa, ON: Human Resources Development Canada & Health Canada. Catalogue No: RH64-20/2002, ISBN: 0-662-69912-6. Available from www.Canada.gc.ca.

Government of Canada (March 13, 2003). News Release. Supporting Canada's children and families. Available from www.socialunion.gc.ca \nws\130303_e.htm.

Greenberg, M.T., Kusche, C.A., & Speltz, M. (1990). Emotional regulation, self control and psychopathology: The role of relationships in early childhood. In D. Cicchetti & S. Toth (Eds.), *Rochester symposium on developmental psychopathology, Vol. 2* (pp. 21-55). New York: Cambridge Press.

Griffin, S. (2003). An ounce of prevention. *Interaction, 17*, Ottawa: Canadian Child Care Federation.

Griffin, S. (2004). Speech from the Throne – Speedier plan for child care is encouraging. Media release Child Care Federation of Canada. Retrieved February 6, 2004, from www.cccf-fcsge.ca/pressroom/Feb2_2004_thronespech.htm.

Grunewald, R., & Rolnick, A.R. (2003, March.). *Early childhood development Economic development.* Fedgazette, Federal Reserve Bank of Minneapolis. Available from http://minneapolisfed.org/pubs/fedgaz/03-03/opinion.cfm.

Guralnick, M.J. (1990). Social competence and early intervention. *Journal of Early Intervention, 14,* 3-14.

Gurlanick, M.J., & Neville, B. (1997). Designing early intervention programs to promote children's social competence. In M.J. Guralnick (Ed.), *The effectiveness of early intervention,* (pp. 579-610). Baltimore, MD: Paul H. Brookes.

Hagekull, B., & Bohlin, G. (1995). Day care quality, family and child characteristics and socioemotional development. *Early Childhood Research Quarterly, 10,* 505-526.

Harms, T., & Clifford, R. (1980). *The Early Childhood Environment Rating Scale.* New York: Teachers' College Press.

Harms, T., Clifford, R., & Cryer, D. (1998). *Early Childhood Environment Rating Scale-Revised.* New York: Teachers College Press.

Harms, T., Cryer, D., & Clifford, R. (1990). *Infant/Toddler Environment Rating Scale.* New York: Teachers College Press.

Hartup, W. (1996). The company they keep: Friendships and their developmental significance. *Child Development, 67,* 1-13.

Hernandez, D.J. (1997). Child development and the social demography of childhood. *Child Development, 68,* 149-169.

Hofferth S., & Wissoker, D.A. (1992). Price quality, and income in child care choice. *Journal of Human Resources, 27,* 70-11.

Holloway, S., & Fuller, B. (1999). Families and child care: Divergent viewpoints. In S. Helburn (Ed.), *The child care crisis, Annals of the American Political Science Association, 56,* 98-115.

Honig, A.S., & Hirallal, A. (1998). Which counts more for excellence in childcare staff – Years in service, education level or ECE coursework? *Early Child Development and Care, 145,* 31-46.

Howe, J., & Jacobs, E. (1995). Child care research: A case for Canadian national standards. *Canadian Psychology, 36,* 131-148.

Howes, C. (1987). Quality indicators in infant and toddler child care: The Los Angeles Study. In D.A. Philllips (Ed.), *Quality in child care: What does research tell us?* (pp. 81-89). Washington, DC: NAEYC.

Howes. C. (1990). Can change of entry into child care and the quality of child care predict adjustment in kindergarten? *Developmental Psychology, 26,* 292-303.

Howes, C. (1991). Caregiving environments and their consequences for children: The experience in the United States. In E.C. Melhuish & P. Moss, (Eds.), *Day care for young children* (pp. 185-198). New York: Tavistock/Routledge.

Howes, C. (1997). Children's experiences in center-based child care as a function of teacher background and adult: child ratio. *Merril-Palmer Quarterly, 43,* 404-425.

Howes, C. (1997). Teacher sensitivity, children's attachment and play with peers. *Early Education and Development, 8,* 41-49.

Howes, C. (2000). Social-emotional classroom climate in child care, child-teacher relationships and children's second grade peer relations. *Social Development, 9,* 191-193.

Howes, C., & Hamilton, C.E. (1992). Children's relationships with child care teachers: Stability and concordance with parental attachments. *Child Development, 63,* 867-878.

Howes, C., & Hamilton, C.E. (1993). The changing experience of child care: Changes in teachers and in teacher-child relationships and children's social competence with peers. *Early Childhood Research Quarterly, 8,* 15-32.

Howes, C., & Olenick, M. (1986). Family and child care influences on toddlers' compliance. *Child Development, 77,* 202-216.

Howes, C., Phillips, D.A., & Whitebook, M. (1992). Thresholds of quality: Implications for the social development of children in center-based care. *Child Development, 63,* 449-460.

Human Resources Development Canada and Health Canada. (2002). *The well-being of Canada's young children: Government of Canada Report.* Ottawa.

Human Resources Development Canada (2003). Job Futures: Early childhood educational assistants (NOC-6470). Available from http://jobfutures/ca.noc/6470p2.shtm.

Hungerford, A., Brownell, C.A., & Campbell, S.B.(2000). Child care in infancy: A transactional perspective. In C. Zeanah (Ed.), *Handbook of Infant Mental Health* (pp. 519-532). New York: Guilford.

Irwin, S.H. (1997). Including all children. Child and Family, Canada. Retrieved November 11, 2002, from http://collections.ic.gc.ca/child/docs/00000879.htm.

Irwin, S.H., Lero, D.S., & Brophy, K. (2000). *A matter of urgency: Including children with special needs in child care in Canada*. Child Care Visions Program of the Employability and Social Partnerships, Division of Human Resources Development Canada, SpeciaLink, NS: Breton Books.

Jimerson, S.R., Egeland, B., Sroufe, L.A., & Carlson, B. (2000). A prospective longitudinal study of high school dropouts: Examining multiple predictors across development. *Journal of School Psychology, 38,* 525-549.

Johansen, A.S., Leibowitz, A., & Waite, L.J. (1996). The importance of child-care characteristics to choice of care. *Journal of Marriage and the Family, 58,* 759-772.

Jorde-Bloom, P. (1995). The quality of work life in NAEYC accredited and nonaccredited early childhood programs. *Early Education and Development, 7,* 301-327.

Jorde-Bloom, P. (1996). Improving the quality of life in the early childhood setting, Resource guide and technical manual for the *Early Childhood Work Environment Survey*, Revised edition. Wheeling, IL: Early Childhood Professional Development Project, National-Louis University.

Jorde-Bloom, P. (1997). A *great place to work: Improving conditions for staff in young children's programs*. Washington, DC: National Association for the Education of Young Children.

Kagan, J. (1984). *The nature of the child*. New York: Basic Books.

Kaiser, B., & Rasminsky J. S. (1999a). Issues. Partners in Quality (1). *Research Connections Canada: Supporting children and families*. Ottawa, ON: Canadian Child Care Federation.

Kaiser, B., & Rasminsky J. S. (1999b). Relationships. Partners in Quality (2). *Research Connections Canada: Supporting children and families*. Ottawa, ON: Canadian Child Care Federation.

Kaiser, B., & Rasminsky J. S. (1999c). Infrastructure. Partners in Quality (3). *Research Connections Canada: Supporting children and families*. Ottawa, ON: Canadian Child Care Federation.

Kaler, S.R., & Kopp, C. (1990). Compliance and comprehension in very young toddlers. *Child Development, 61,* 1997-2003.

Kamerman, S.B. (2000). Early childhood education and care: an overview of developments in the OECD countries. *International Journal of Educational Research, 33,* 7-29.

Kaufman Early Education Exchange. (Summer, 2002). Set for success: Building a strong readiness based on the social-emotional development of young children. Kansas City: MO, The Ewing Marion Kaufman Foundation.

Keats, D.M. (1997). *Culture and the child: A guide for professionals in child care and development*. Chichester, EN: Wiley.

Kelly, K. (1995). Visible minorities: A diverse group. *Canadian Social Trends, 37,* 2-8.

Kisker, E., Hofferth, S., Phillips, D., & Farquhar, E. (1991). *A profile of child care settings: Early education and care in 1990*. Princeton, NJ. Mathematica.

Klinnert, M.D., Campos, J.J., Sorce, J.F., Emde, R.N., & Svejka, M. (1983). Emotions as behavior regulators: Social referencing in infancy. In R. Plutchik & H. Kellerman (Eds.). *The emotions: Vol. 2. Emotions in early development* (pp. 57-86). New York: Academic Press

Knitzer, J. (2000). Early childhood mental health services: A policy systems development perspective. In J.P. Shonkoff & S.J. Meisels (Eds.). *Handbook of early childhood intervention*, 2nd Edition (pp. 416-438). New York: Cambridge University Press.

Knitzer J., Cohen, E., & Kaufman (2000). *Using mental health strategies to move the early childhood agenda and promote school readiness. Starting Points: meeting the needs of our youngest children*. New York: Carnagie Corporation and National Center for Children in Poverty. Available from http://columbia.edu/dept\nccp\SpMenHlth.pdf.

Koch, P. (1998). *The role of licensing in child care: Licensing as an element of quality*. Unpublished manuscript. St Paul: NARA.

Kohen, D., Hertzmann, C., & Willms, J.D. (1998). The importance of quality child care. In J. D. Willms (Ed.), *Vulnerable children* (pp. 261-276). Edmonton, AB: University of Alberta Press.

Kontos, S., & Fiene, R. (1987). Quality, compliance with regulations and children's development: The Pennsylvania Study. In D. Phillips (Ed.), *Quality in child care: What does the research tell us?* (pp. 57-79). Washington, DC: National Association for the Education of Young Children.

Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1995). *Quality in family child care and relative care*. New York: Teachers College Press.

Kontos, S., Hsu, H.-C., & Dunn, L. (1994). Children's cognitive and social competence in child-care centers and family day care homes. *Journal of Applied Developmental Psychology, 15,* 387-411.

Kopp, C. (1989). Regulation of distress and negative emotion: A developmental view. *Developmental Psychology, 25,* 343-354.

Kopp, C. (2002). School readiness and regulatory processes. Society for Research in Child Development. *Social Policy Report, XVI,* 11.

Kuhn, M. (1999). Professionalism and quality. *Research Connections Canada, 2,* 65-90. Ottawa, ON: Canadian Child Care Federation.

Kyle, I.J. (2000a). Toward a framework for integrating early childhood development and family support programs – Part 1. *Canadian Journal of Research in Education, 8,* 21-36.

Kyle, I.J. (2000b). Exemplary models of child care and family support in other jurisdictions. Toward a framework for integrating early childhood development and family support programs – Part 1I. *Canadian Journal of Research in Education, 8,* 37-65.

Lamb, M.E. (1998). Nonparental child care: Context, quality, correlates, and consequences. In W. Damon (Series Ed.) I.E. Sigel & K.A. Renninger (Eds.), Handbook of child psychology: Vol 4. *Child psychology in practice*, (5th ed.) (pp. 73-133). New York: Wiley.

Lamb, S., & Zakhireh, B. (1997). Toddlers' attention to the distress of peers in a day care setting. *Early Education and Development, 8,* 105-118.

Landy, S., & Tam, K.K. (1998). Understanding the contribution of multiple risk factors on child development at various ages. *Findings of the NLSCY.* Ottawa: Statistics Canada.

Larkin, E. (1999). The transition from direct caregiver to administrator in early childhood education. *Child and Youth Care Forum, 28,* 21-32.

Larner, M. (1995). *Linking family support and early childhood programs: Issues, experiences, opportunities.* Paper (1), commissioned for Best Practices Project, Family Resource Coalition, Chicago, IL.

Lavigne, J.V., Arend, R., Rosenbaum, H., Christoffel, K.K., & Gibbons, R.D. (1998a). Psychiatric disorders with onset in the preschool years: I. Stability of diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 1246-1254.

Lavigne, J.V. Arend, R., Rosenbaum, D., Binns, H., Christoffel, K.K., & Gibbons, R.D. (1998b). Psychiatric disorders with onset in the preschool years: II. Correlates and predictors of stable case status. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 1255-1261.

Lero, D.S., Irwin, S.H., & Brophy, K. (2000). The nature and extent of inclusion. In S.H.Irwin, D.S.Lero, & Brophy (Eds.). *A matter of urgency: Including children with special needs in child care in Canada.* Child Care Visions Program of the Employability and Social Partnerships, Division of Human Resources Development Canada, SpeciaLink, NS: Breton Books.

Lero, D.S., Pence, A., Goelman, H., & Brockman, L.M. (1991). *Child care in Canada.* Paper presented at the Biennial Meeting of the Society for Research in Child Development, Seattle.

Leslie L.A., Ettenson, R., & Cumsille, P. (2000). Selecting a child care center: What really matters to parents? *Child and Youth Care Forum, 29,* 299-322.

Liang, X., Fuller, B., & Singer, J.D. (2000). Ethnic differences in child care selection: The influence of family structure, parental practices, and home language. *Early Childhood Research Quarterly, 15,* 357-384.

Lyon, M.E., & Canning, P. (1999). *The child care management study: A study of organizational behaviour in Canadian day care centres.* Halifax, NS & St. John's, NF: Mount St. Vincent University & Memorial University of Newfoundland.

Lyons-Ruth, K., Alpern, L., & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behaviour in the preschool classroom. *Child Development, 64,* 572-585.

Lucas, M.-A. (2001). The military child care connection. *The Future of Children, 1,* 129-133. Available from www.futureofchildren.org.

Magyary, D. (2002). Positive mental health: A turn of the century perspective. *Issues in Mental Health Nursing, 23,* 331-349.

Marcil-Gratton, N. (1998). *Growing up with mom and dad? Children and family instability.* Ottawa: Human Resources Development Canada, Human Resources Branch.

Masten, A. & Coatsworth, J.D. (1998). The development of competence in favourable and unfavourable environments: Lessons from research on successful children. *American Psychologist, 53,* 205-220.

McCain, M., & Mustard, J.F. (1999). *Reversing the real brain drain: The early years study.* Toronto: Canadian Institute for Advanced Research.

McKim, M.K., Cramer, K.M., Stuart, B., & O'Connor, D.L. (1999). Infant care decisions and attachment security: The Canadian transition to child care study. Canadian *Journal of Behavioral Science, 31,* 92-106.

Moss, P. (2000). Training of early childhood education and care staff. Chapter 2. *International Journal of Educational Research, 33,* 31-53.

Mundy, P., & Willoughby, J. (1998). Nonverbal communication, affect, and social-emotional development. In A.M. Wetherby, S.F. Warren, & J. Reichle (Eds.), *Transitions in prelinguistic communication* (pp. 111-133). Baltimore, MD: Paul H. Brookes.

National Association for the Education of Young Children. (1995). NAEYC position statement. Responding to linguistic and cultural diversity: Recommendations for effective early childhood education. *Young Children, 51,* 4-12.

National Institute for Child and Human Development Early Child Care Research Network. (1994). Child care and child development. The NICHD study of early child care. In S. Friedman and H.C. Haywood (Eds.), *Development follow-up: Concepts, domains and methods* (pp 377-395). New York: Academic Press.

National Institute for Child and Human Development Early Child Care Research Network. (1997). Child care experiences during the first year of life. *Merrill-Palmer Quarterly, 43,* 340-360.

National Institute of Child and Human Development Early Child Care Research Network (1994). Child care and child development: The NICHD study of early child care. In S.L. Friedman & H.C. Haywood (Eds.), *Developmental follow-up: Concepts, domains and methods* (pp. 377-396). New York: Academic Press.

National Institute of Child and Human Development Early Child Care Research Network (1996). Characteristics of infant child care: Factors contributing to positive caregiving. *Early child care Research Quarterly, 11,* 269-306.

National Institute or Child and Human Development Early Child Care Research Network (1997a). The effects of infant child care on infant-mother attachment security: Results of the NICHD Study of Early Child Care. *Child Development, 68,* 860-879.

National Institute of Child and Human Development Early Child Care Research Network (1997b). Child care in the first year of life. *Merrill-Palmer Quarterly, 43,* 340-360.

National Institute of Child and Human Development Early Child Care Research Network (1998a). Early child care and self-control, compliance, and problem behavior at twenty-four and thirty-six months, *Child Development, 69,* 1145-1170.

National Institute of Child and Human Development Early Child Care Research Network (1998b). Relations between family predictors and child outcomes: Are they weaker for children in child care? *Developmental Psychology, 34,* 1119-112.

National Institute of Child and Human Development Early Child Care Research Network (1999a). Chronicity of maternal depressive symptoms, maternal sensitivity, and child functioning at 36 months, *Developmental Psychology, 35,* 1297-1310.

National Institute of Child and Human Development Early Child Care Research Network (1999b). Child care and mother-child interaction in the first 3 years of life. *Developmental Psychology, 35,* 1399-1413.

National Institute of Child and Human Development Early Child Care Research Network (2000a). Characteristics and quality of child care for toddlers and preschoolers. *Applied Developmental Science, 4,* 116-135.

National Institute of Child and Human Development Early Child Care Research Network (April, 2000b). Early child care and children's development prior to school entry. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Minneapolis, MN.

National Institute of Child and Human Development Early Child Care Research Network (2000c). The relation of child care to cognitive and language development. *Child Development, 71,* 960-980.

National Institute of Child and Human Development Early Child Care Research Network (2001a). Child care and children's peer interaction at 24 and 36 months: The NICHD study of early child care. *Child Development, 72,* 1478-1500.

National Institute of Child and Human Development Early Child Care Research Network (2001b). Child care and family predictors of preschool attachment and stability from infancy. *Developmental Psychology, 37,* 847-862.

National Institute of Child and Human Development Early Child Care Research Network (2002a). Child-care structure➜process➜outcome: Direct and indirect effects of child-care quality on young children's development. *Psychological Science, 13,* 199-206.

National Institute of Child and Human Development Early Child Care Research Network (2002b). Shedding further light on the effects of various types and quality of early child care on infant-mother attachment relationship: the Haifa study of early child care, *Child Development, 73,* 1166-1186.

National Institute of Child and Human Development Early Child Care Research Network (2003a). Does quality of child care affect child outcomes at age 4? *Developmental Psychology, 39,* 451-469.

National Institute of Child and Human Development Early Child Care Research Network (2003b). Does amount of time spent in child care predict socioemotional adjustment during the transition to kindergarten? *Child Development, 74,* 976-1005.

National Institute of Child and Human Development Early Child Care Research Network (2003c). Modeling the impacts of child care quality on children's preschool cognitive development. *Child Development, 74,* 1454-1475.

Nelson, C.A. (1999). Neural plasticity and human development. *Current Directions in Psychological Science, 8,* 42-45.

Nelson, K. (1993). The psychological and social origins of autobiographical memory. *Psychological Science, 4,* 1-8.

Norris, C., Brink, S., & Mosher, P. (1999). *Measuring non-parental care in the NLSCY: content and process issues.* Applied Research Branch, Strategic Policy, Human Resources Development Canada. Technical Paper T-00-1E.

O'Brien, M., Roy, C., Jacobs, A., Macaluso, M., & Peyton, V. (1999). Conflict in the dyadic play of 3-year-old children. *Early Education and Development, 9,* 289-313.

Owen, M.T. , M. Ware, A.M., & Barfoot, B. (2000). Caregiver-mother partnership behavior and the quality of caregiver-child and mother-child interactions. *Early Childhood Research Quarterly, 15,* 413-428.

Peisner-Feinberg, E.S., & Burchinal, M.R. (1997). Relations between child-care experiences and children's concurrent development: The cost, quality, and outcomes study. *Merrill-Palmer Quarterly, 43,* 451-477.

Peth-Pierce, R. (1997). The NICHD study of early child care. Washington, DC: Child Health and Human Development. Available from www.nih.gov/nichd/html/new/early-child/Early_Child_Care.htr.

Pence, A. (N.D.) Canada First Nations collaborative research and development. Human Early Learning Partnership: University of British Columbia. Available from www.earlylearning.ubc.ca.

Peyton, V., Jacobs, A., O'Brien, M., & Roy, C. (2001). Reasons for choosing child care: associations with family factors, quality, and satisfaction. *Early Childhood Research Quarterly, 16,* 191-208.

Phillips, D. (Ed.) (1987). *Quality in child care: What does research tell us? Research monographs of the National Association for the Education of Young Children.* Washington, DC: National Association for the Education of Young Children.

Phillips, D.A., Howes, C., & Whitebook, M. (1991). Child care as an adult work environment. *Journal of Social Issues, 47,* 49-70.

Phillips, D., Mekos, D., Scarr, S., McCartney, K., & Abbott-Shim, M. (2001). Within and beyond the classroom door: Assessing quality in child care centers. *Early Childhood Research Quarterly, 15,* 475-496.

Phillipsen, L.C., Burchinal, M.R., Howes, C., & Cryer, D. (1997). The prediction of process quality from structural features of child care. *Early Child Research Quarterly, 12,* 281-303.

Phipps, S. (1999). *Does policy affect outcomes for young children? An analysis with international microdata.* Working paper series. Hull, QC: Applied Research Branch Strategic Policy, Human Resources Development Canada. ISBN: 0-662-28791-6. Available from www.hrdc-drhc.gc.ca/arb.

Piaget J., & Inhelder, B. (1947). *The psychology of the child.* New York: Basic Books.

Pope, S., & Stremmel, A.J. (1992). Organizational climate and job satisfaction among child care teachers. *Child Youth and Care Forum, 21,* 39-52.

Powell, D.R. (1989). Families and early childhood programs. Washington, DC: National Association for the Education of Young Children.

Prilleltensky, I. (1994). The United Nations Convention on the Rights of the Child: Implications for children's mental health. *Canadian Journal of Community Mental Health, 13,* 77-93.

Prior, M., Smart, D., Sanson, A., & Oberklaid, F. (2001). Longitudinal predictors of behavioural adjustment in pre-adolescent children. *Australia and New Zealand Journal of Psychiatry, 35,* 297-307.

Pungello, E.P., & Kurtz-Costes, B. (1999). Why and how working women choose child care: A review with a focus on infancy. *Developmental Review, 19,* 31-96.

Rae-Grant, N.I. (1994). Preventive interventions for children and adolescents: Where are we now and how far have we come? *Canadian Journal of Community Mental Health, 13,* 17-36.

Raver, C., & Knitzer, J. (2002). P*romoting the emotional well-being of children and families policy paper No. 3: Ready to enter: What research tells policy makers about strategies to promote social and emotional school readiness among three- and four-year old children.* New York: National Center for Children in Poverty.

Richman, N., Stevenson J., & Graham, P.J. (1982). *Preschool to preschool: A behavioural study.* London: Academic Press.

Rhodes, S., & Hennessy, E. (2000). The effects of specialized training on caregivers and children in early years settings: An evaluation of the foundation course in playgroup practice. *Early Childhood Research Quarterly, 15,* 559-576.

Rodd, J., & Milikan, J. (1994). Parental perceptions of early childhood services for pre-primary children in Australia. *Early Child Development and Care, 101,* 89-100.

Roditti, M.G. (2000). What works in child care. In M.P. Klueer & G. Alexander (Eds.), *What works in child welfare* (pp. 285-298). Washington, DC: Child Welfare League of America, CWLA Press.

Rolnick, A.R., & Grunewald, R. (January 24, 2003). Early childhood development: Economic development with a high public return. *Toronto Star, Business Section.*

Rovee-Collier, C.K. (1990). The "memory system" of prelinguistic infants. In A. Diamond (Ed.), The development and neural bases of hIgher cognitive functions. *Annals of the New York Academy of Sciences, 608,* 517-542.

Rusher, A.S, & Ware, A.M. (1998). Family centered child care: Where have we been and where are we going? *Early Child Development and Care, 145,* 67-79

Sanson, A., Oberklaid, F., Pedlow, R., & Prior M. (1991). Risk indicators: Assessment of infancy predictors of pre-school behavioural maladjustment. *Journal of Child Psychology & Psychiatry, 32,* 609-626.

Scarr, S. (1992). Developmental theories for the 1990s: Development and individual differences. *Child Development, 63,* 1-19.

Scarr, S., & Eisenberg, M. (1993). Child care research: Issues, perspectives and results. *American Review of Psychology, 44,* 613-644.

Seifert, T., Canning, P., & Lindemann, B. (2001). *A study of family, child care and well-being in young Canadian families.* Catalogue No: MP32-28/02-3-1E. Hull: QC. Human Resources Development Canada Publications Centre.

Selman, R. L., & Schultz, L.H. (1990). *Making a friend in youth: Developmental theory and pair theory.* Chicago: University of Chicago Press.

Shatz, M., Wellman, H.M., & Silber., S. (1983). The acquisition of mental verbs: A systematic investigation of the first reference to mental state. *Cognition, 14,* 301-321.

Shonkoff, J.P., & Meisels, S.J. (Eds.) (2000). *Handbook of early childhood intervention, second edition.* New York: Cambridge University Press.

Shonkoff J. & Phillips, D.A. (Eds.) (2000). *From neurons to neighborhoods.* Washington DC: National Academy Press.

Shpancer, N. (1997). The link between caregiver-parent relations and children's experiences in daycare and at home: What does the research tell us? *Early Child Development and Care, 135,* 7-20.

Shpancer, N. (1998). Caregiver-parent relationships in daycare: A review and re-examination of the data and their implications. *Early Education and Development, 9,* 239-259.

Shpancer, N. (2002). The home-daycare link: mapping children's new world order. *Early Childhood Research Quarterly, 17,* 374-392.

Shaw, D.S., & Vondra, J.J. (1993). Chronic family adversity and infant attachment security. *Journal of Child Psychology and Psychiatry, 34,* 1205-1215.

Silva, P.A., McGee, R.O., & Williams, S.M. (1983). Developmental language delay from three to seven years and its significance for low intelligence and reading difficulties at age seven. *Developmental Medicine and Child Neurology, 25,* 783-793.

Singelton, C. (1999). Mentoring: Sharing the authority for education with child care practice. In *Research Connections, Canada, Supporting Children and Families, 3,* 10-30. Ottawa: Canadian Child Care Federation.

Singer, J.D., & Keiley, M.K., Fuller, B., & Wolf, A. (1998). Early child-care selection: Variation by geographic location, maternal characteristics, and family structure. *Development Psychology, 34,* 1129-1144.

Smith, A.B., & Hubbard, P.M. (1988). The relationship between parent/staff communication and children's behavior in early childhood settings. *Early Childhood Developmental Psychology, 35,* 13-28.

Sroufe, L.A., & Fleeson, J. (1986). Attachment and the construction of relationships. In W.W. Hartup and Z. Rubin, (Eds.), Relationships and development (pp. 51-72). Hillsdale, NJ: Erlbaum.

Sroufe, L.A., & Fleeson, J. (1988). The coherence of family relationships. In R.A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships within families: Mutual influences.* Oxford: Clarendon.

Sroufe, L.A., Schork, E., Motti, F., Lawroski, N., & LaFreniere, P. (1984). The role of affect in social competence. In C.E. Izard, J. Kagan, & R.B. Zajonc (Eds.), *Emotion, cognition, and behavior* (pp. 289-319). Cambridge: Cambridge University Press.

Sroufe, L.A., & Waters, (1977). Attachment as an organizational construct. *Child Development, 48,* 1184-1199.

Stafford, J. (2002). *A profile of the childcare services industry.* Analytic Paper Series. Ottawa, ON: Statistics Canada, Service Industry Division, Catalogue No. 63-016-XPB, 4th quarter 2001.

Statistics Canada, Nation Series. (1996). *Aboriginal population in private households by age and sex, showing census family status for Canada, the provinces, territories and census metropolitan areas, 1996 census.* (Table 25-003). Ottawa, ON: Statistics Canada. Available from www.statcan.ca/english/cnsus96/ nation.htm (products and services).

Statistics Canada (1999). *Various issues of spending patterns in Canada.* Ottawa: ON. Statistics Canada. Catalogue No: 62-202-XPB.

Statistics Canada (2001a). *Immigrant population by place of birth and period of immigration.* Retrieved September, 2003 from www.statcan.ca/english/ Pgdb/demo25.htm.

Statistics Canada (2001b). Visible minority population by age. Retrieved Sept. 9, 2004, from: www.statcan.ca/ english/Pgdb/demo41.htm.

Statistics Canada, The Daily, April, 2002, Cat. No. 11-001E (Francais 11-001F).

Stern, D.N. (1985). *The interpersonal world of the infant.* New York: Basic Books.

Stevens, C. (1996). *Regulating human care and service programs: Study guides for citizens and advocates Part 1: Identifying agendas.* St Paul: NARA.

Stipek, D. (1992). The child at school. In M.H. Bornstein, & M.E. Lamb (Eds.), *Developmental psychology: An advanced textbook* (pp. 579-625). Hillsdale, NJ: Erlbaum.

Stremmel, A, (1991). Predictors of intention to leave child care work. *Early Childhood Research Quarterly, 6,* 285-298.

Stremmel, A.J., Benson, M.J., & Powell, D.R. (1993). Communication satisfaction, and emotional exhaustion among child care center staff: Directors, teachers, and assistant teachers. *Early Childhood Research Quarterly, 8,* 221-233.

Stremmel, A.J., & Powell, D.R. (1990). The relationship of classroom-focused information and self-perceived effectiveness to job satisfaction among child care workers. *Child and Youth Care Quarterly, 19,* 239-250.

Taylor, A.R., Dunster, L., & Pollard, J. (1999). …and this helps me how? Family child care providers discuss training. *Early Childhood Research Quarterly. Special Issue: Pathways to Child Care Quality, 14,* 285-312.

Teidka, H. (1999). *The value of early childhood care work: A preliminary study.* Report of results for Child Care Connection, Nova Scotia. Retrieved November 4, 2003, from www.cfc-efc.ca/docs/ccns/00000319.htm.

The Health of Canada's Children, third edition of the CICH profile (2000). Ottawa, ON: Health Canada.

Toronto First Duty (2002). *Starting Gate Report. Implementing integrated foundations for early childhood.* Available from www.city.Toronto.on.ca/ firstduty/sites.htm.

United Nations Convention on the Rights of the Child. Meeting our obligations under the United Nations. Convention on the Rights of the Child. (September 17, 2003.) Available from http://canadianheritage.gc.ca/ progs/pdp-hrp/.

Vandell, D.L., Dadisman, K., & Gallagher, K. (2000). Another look at the elephant: Child care in the nineties. In R.D. Taylor & M.C. Wang (Eds.), *Resilience across contexts: Family, work, culture and community* (pp. 91-120). Mahwah: NJ: Erlbaum.

Volling, B.L., & Feagans, L.V. (1995). Infant day care and children's social competence. *Infant Behavior and Development, 18,* 177-188.

Vygotsky, L.S. (1962). *Thought and language.* New York: Wiley.

Watamura, S.E., Donzella, B., Alwin, J., & Gunnar, M.R. (2003). Morning-to-afternoon increases in cortisol concentrations for infants and toddlers at child care: Age differences and behavioural correlates. *Child Development, 74,* 1006-1020.

Watson, J.B. (1924). *Behaviorism.* New York: Norton.

Watson, J., & Kowalski, H. (1999). Toddler-caregiver interaction: The effect of temperament. *Early Child Development and Care, 159,* 53-73.

Werner, E.E., & Smith, R.S. (1982). *Vulnerable but invincible: A study of resilient children*. New York: McGraw-Hill.

Wetherby, A.M., & Prizant, B.M. (1993). *Communication and Symbolic Behavior Scales*. Chicago, IL: Riverside Publishing Company.

Whitebook, M. & Bellm, D. (1999). *Taking on turnover: An action guide for child care center teachers and directors*. Washington, D.C.: Center for the Child Care Workforce.

Whitebook, M., Howes, C., & Phillips, D. (1990). *Who cares? Child care teachers and the quality of care in America. Final report of the National Child Care Staffing Study*. Oakland, CA: Child Care Employee Project.

Whitebrook, M.C., Sakai, L., & Howes, C. (1997). *NAEYC accreditation as a strategy for improving child care quality*. Washington, DC: National Center for the Early Childhood Work Force.

Willinsky, C., & Pape, B. (2002). Mental health promotion. In L. Young, & V. Hayes (Eds.), *Transforming health promotion practice* (pp. 162-173). Philadelphia: S.A. Davis.

Yeates, K.O., Schultz, L.H., & Selman, R.L. (1991). The development of interpersonal negotiation strategies in thought and action: A social cognitive link to behavioural adjustment and social status. *Merrill-Palmer Quarterly, 37,* 369-406.

Zeece, P.D. (1999). All dressed and no place to grow! *Child Care Information Exchange, 128,* 40-44.

Zellman, G.L., & Johansen, A.S. (1995). The effects of accreditation on care in military child development centres. In S. Bredekamp & B.A. Willer (Eds.), *NAEYC Accreditation: Decade of learning and the years ahead*. Washington, DC: National Association for the Education of Young Children.

Zellman, G.L., & Johansen, A.S. (1998). Examining the implementation outcomes of the Military Child Care Act of 1989. Santa Monica, CA: Rand National Defense Research Institute.

Zeanah, C. Boris, N.W., & Larrieu, L.A. (1997). Infant development and developmental risk: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 56,* 165-178.

Zero to Three: Centre for Programs of Excellence. Tips for Practitioners. Available from www.zerotothree.org/cpe/tip_2002_04.html.

Zigler, E.F., Finn-Stevenson, M., & Marsland, K.W. (1995). Child day care in the schools: The school of the 21st century. *Child Welfare, 74,* 1301-1315.

Zigler, E.F., Finn-Stevenson, M., & Stern, B.M. (1997). Supporting children and families in the schools: The school of the 21st century. *American Journal of Orthopsychiatry, 67,* 396-407.

APPENDIX I

Director Questionnaire

In the first part of our interview, we are asking you for examples of how the child care centre promotes the social-emotional development of enrolled infants, toddlers and/or preschoolers. These may be centre policies or guidelines concerning either individual children or groups, or specific physical features of the centre setting (for example, wall decorations, arrangement of furnishings) that support such policies or guidelines. We realize that these topics might overlap at times in the examples you provide us.

You may not have examples for all of the following areas of development. As well, some questions will apply to one age group more than others. Therefore don't feel that you need to comment on all of the items below. Please feel free to use this outline to prepare for the interview.

Information you share with us will not be discussed with others from your centre and, when reported, will be compiled with other respondents so that you will not be identified.

What is the maximum number of enrolled children the centre cares for? _____

What age group(s) of children does the centre care for?

❏ Infants   ❏ Toddlers   ❏ Preschoolers   ❏ School-age children

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A1-a   Helping Children To Build Relationships And Get Along With Others
For example: Encouraging children

- to develop trusting and secure relationships with staff
- to show empathy for others, that is, to share another child's (or adult's) feelings
- to share with and help one another
- to express positive emotions (i.e., excitement, pride, etc.) in an acceptable/appropriate way
- to respect beliefs, values and practices of people from diverse cultures or of people who seem different from them
- to express negative emotions (i.e., anger, sadness, etc.) in an acceptable/appropriate way

a. Please describe any centre policies or guidelines that are intended to help children build relationships and get along with others.

b. Are there ways in which the physical features of the centre setting have been arranged to promote this kind of social-emotional development?

A1-b   Helping Children To Feel Good About Themselves
For example: Encouraging children

- to feel competent and effective in the things they do
- to tolerate or deal with frustrations
- to recognize that they are unique individuals and to feel comfortable being themselves
- to self-regulate, that is, control their behaviour and emotions to fit the situation
- to work with their temperament style or personality
- to express their opinions and preferences and do things by themselves

a. Please describe any centre policies or guidelines that are intended to help children to feel good about themselves.

b. Are there ways in which the physical features of the centre setting have been arranged to promote this kind of social-emotional development?

A2-a   Helping Children To Deal With Stressful Situations
For example: Encouraging children

- to problem-solve in challenging situations
- to recover from upsets or stress and still feel good about themselves
- encouraging shy children to participate in activities and interactions with others

a. Please describe any centre policies or guidelines that are intended to help children deal with stressful situations.

b. Are there ways in which the physical features of the centre setting have been arranged to promote this kind of social-emotional development?

A2-b   Helping Children Deal With Change And Transitions
For example: Supporting children who:

• show distress when their parents drop them off at the child care centre

• become upset when they are beginning child care, leaving child care to go to school or changing child care arrangements

• experience major changes in their lives due to parent separation and divorce, parent illness or death, immigration, or loss of a special child care staff

a. Please describe any centre policies or guidelines that are intended to help children deal with change and transitions.

b. Are there ways in which the physical features of the centre setting have been arranged to promote this kind of social-emotional development?

A3   Other

a. Thinking about the previous questions (A1-A2), do you feel there are barriers that interfere with the centre's ability to support young children's development in these ways? If yes, have you been able to address these barriers?

b. Has the centre ever incorporated any packaged program curricula (i.e., "Making Friends" manual and video) to promote the areas of social-emotional development we've talked about? If yes, which ones has the centre used?

c. Are there currently any issues concerning social-emotional development that centre staff are being challenged by?

d. Please describe any policies the centre has concerning behaviour management, that is, actions that are permitted and prohibited for use by centre staff when dealing with challenging behaviour.

e. There may be some important parts of social-emotional development or some important events in children's lives that we have not asked about. Please describe any such situations that come to mind and what centre policies, guidelines or physical features address these situations.

f. Are there any policies and/or activities that you think would help the centre to promote the social-emotional development of children even more?

In the second part of our interview, we are asking you about the centre's relationships with parents of children enrolled and its relationships with resources and individuals in the community. As well, we want to know about ways in which the centre supports the emotional well-being of staff and how much the centre staff help guide the direction of centre activities.

B1   Relationships With Parents

a. Please describe any policies the centre has concerning staff communicating and/or meeting with parents of enrolled children (i.e., who, when, where and how staff communicate with parents).

b. Does the centre distribute parenting and/or developmental information directly to parents through the following ways or places?

❏ Centre does not provide parental/developmental information to parents

❏ Family resource centre

❏ Parent/family events

❏ Individual parent/staff meetings

❏ Daily communication book (log)

❏ Drop-off, pick-up times

❏ Newsletters

❏ Other (please specify) _____

c. Do parent committees or groups for the centre participate in advising on or decision-making for the following types of centre activities?

❏ No parent committees or groups

❏ Fundraising

❏ Policy/program recommendations/approval

❏ Hiring of personnel

❏ Establishing programs

❏ Acquisition and use of equipment and materials

❏ Overall supervision and administration

❏ Liaisons with other community services

❏ Other (please specify) _____

d. Do you feel that any of the following interfere with the centre's relationships with parents of enrolled children?

- ❏ Parents' lack of time
- ❏ Centre staff's lack of time
- ❏ Cultural/language/value differences
- ❏ Centre staff's reluctance to engage parents
- ❏ Lack of funding to implement new activities/events
- ❏ Lack of centre policies for parental involvement
- ❏ Other (please specify) _____

B2   Community Relationships

a. Does your centre distribute information to the local community on the social-emotional needs of young children through the following venues?

- ❏ Bulletin boards
- ❏ Newspapers
- ❏ Internet
- ❏ Radio/television
- ❏ Brochures/posters
- ❏ Presentations/workshops
- ❏ Newsletters/calendars
- ❏ Other (please specify) _____

b. Does your centre collaborate with any of the following resources and individuals concerning children's social-emotional development?

- ❏ Mental health agencies
- ❏ Public health
- ❏ Early childhood development/education associations
- ❏ Child welfare organizations
- ❏ Medical professionals
- ❏ Developmental specialists (i.e., psychologists, speech and language pathologists)
- ❏ Community centres
- ❏ Hearing and dental screening
- ❏ Family resource centres
- ❏ Community colleges
- ❏ Libraries
- ❏ Schools
- ❏ Churches
- ❏ Organizations providing consultation to day care
- ❏ Other (please specify) _____

c. Do you feel that any of the following interfere with the centre's collaboration with resources and individuals in the community?

- ❏ Don't consider it a relevant/important issue
- ❏ Lack of time
- ❏ Lack of funding
- ❏ Lack of experience in community involvement/collaboration
- ❏ Few opportunities in the community for partnerships
- ❏ Other (please specify) _____

B3   Staff Support And Roles In Decision Making

a. Are there ways in which you promote staff working together in a positive and respectful manner (i.e., in program delivery, handling conflicts, being supportive)? (please explain)

b. Are there ways in which you consider the adult needs of staff (i.e., staff meetings, mental health days) and make staff aware that their efforts at the centre are appreciated? (please explain)

c. Are there ways in which you involve centre staff in policy and program decision making? (please explain)

d. Are there ways in which you involve centre staff in discussions and decisions about centre children who pose particular challenges? (please explain)

In the last part of our interview, we are asking you about your education and experience with children.

C1   Experience

a. Which age groups of children have you worked with in your experience as an early childhood professional?

❏ Infants   ❏ Toddlers   ❏ Preschoolers   ❏ School-age children

b. How many years of employed child care experience do you have?

In your current position at this centre	_____ years
In other positions at this centre (total)	_____ years
At other child care centres	_____ years
In child care homes	_____ years
In other fields related to child care	_____ years

C2   Education

a. What is the highest level of education that you have completed specifically related to early childhood education, child development and/or child care provision?

❏ None

❏ Introductory/orientation course (less than 1 year)

❏ One-year college certificate/diploma

❏ Two-year college certificate/diploma

❏ Bachelor's degree

❏ Post-graduate degree

❏ Other (please specify) _____

In what year did you complete this last level of education?

_____

b. During the past 12 months, have you participated in any of the following types of professional development activities? Please indicate yes or no if these activities involved social-emotional development issues in early childhood or child care.

No professional development activities in the past 12 months	❏ yes	❏ no
Conference	❏ yes	❏ no
Workshop	❏ yes	❏ no
Non-credit course at a post-secondary institution	❏ yes	❏ no
Credit course at a post-secondary institution	❏ yes	❏ no
In-service training/consultation	❏ yes	❏ no
Visiting other education and care settings for ideas on improvement	❏ yes	❏ no

Other (please specify) _____

C3   Other

a. Please rate how much the following sources informed your awareness and understanding of social-emotional development?

	Not at all	Somewhat	Very
Completed education	❏	❏	❏
Continuing education (professional development)	❏	❏	❏
Parental experience	❏	❏	❏
Work experience (within child care settings)	❏	❏	❏
Work experience (in other areas of child care)	❏	❏	❏
Centre policies/initiatives	❏	❏	❏
Colleague consultation	❏	❏	❏
Consultation with community/social service agencies	❏	❏	❏

Other (please specify) _____

b. Where do you look for information about social-emotional development?

❏ I haven't looked for information on social emotional development

❏ Books, journals and magazines

❏ Internet

❏ Workshops and conferences

❏ School or community courses

❏ Colleagues/supervisors

❏ Early childhood and education associations

❏ Consultation with community/social service agencies

❏ Consultation with medical/developmental specialists

❏ Networking with other child care professionals

❏ Other (please specify) _____

c. Do you or the centre currently belong to any early childhood educator or child care associations? If yes, which ones?

Is there anything else about promoting social-emotional development in young children that you think is important but that was not addressed in the interview?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Teacher Questionnaire

In the first part of our interview, we are asking you for examples of what you do that you find helps to promote the social-emotional development of infants, toddlers and/or preschoolers in your child care centre. These may be techniques, strategies or activities (not necessarily programs) that you have used with either individual children or with groups.

You may not have examples for all of the following areas of development. As well, some questions will apply to one age group more than others. Therefore don't feel that you need to comment on all of the items below. Please feel free to use this outline to prepare for the interview.

Information you share with us will not be discussed with others from your centre and, when reported, will be compiled with other respondents so that you will not be identified.

Which age group of children do you primarily care for at your centre?

❏ Infants   ❏ Toddlers   ❏ Preschoolers   ❏ Both infants/toddlers and preschoolers

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A1-a   Helping Children To Build Relationships And Get Along With Others

a. In what ways do you help children develop a trusting and secure relationship with you?

b. In what ways do you help children show empathy for others, that is, share another child's (or adult's) feelings?

c. In what ways do you help children share with and help one another?

d. In what ways do you help children express positive emotions (i.e., excitement, pride, etc.) in an acceptable/appropriate way?

e. In what ways do you help children express negative emotions (i.e., anger, sadness, aggression, etc.) in an acceptable/appropriate way?

f. In what ways do you help children respect beliefs, values and practices of people from diverse cultures or of people who seem different from them?

A1-b   Helping Children To Feel Good About Themselves

a. In what ways do you help children feel competent and effective in the things they do?

b. In what ways do you help children to self-regulate, that is, control their behaviour and emotions to fit the situation?

c. In what ways do you help children tolerate or deal with frustrations?

d. In what ways do you help children to recognize that they are unique individuals and to feel comfortable being themselves?

e. In what ways do you help children work with their temperament style or personality?

f. In what ways do you help children express their opinions and preferences and do things by themselves?

A2-a   Helping Children To Deal With Stressful Situations

a. In what ways do you help children problem-solve in challenging situations?

b. In what ways do you help children recover from upsets or stress and still feel good about themselves?

c. In what ways do you help shy children participate in activities and interactions with others?

A2-b   Helping Children Deal With Change And Transitions

a. Children often show distress when their parents drop them off at the child care centre. In what ways do you help children deal with their distress at these times?

b. Children may become upset when they begin child care, leave child care to go to school or change child care arrangements. In what ways do you help children deal with the stress of making these kinds of transitions?

c. Children may experience major changes in their lives due to parent separation and divorce, parent illness or death, immigration, or loss of a special child care staff. In what ways do you support children through these events of loss and sadness?

A3   Other

a. Thinking about the previous questions (A1-A2), what have you observed that tells you these strategies have been successful?

b. Are there things that interfere with using these strategies? Have you been able to find ways to get around these?

c. There may be some important parts of social-emotional development or some important events in children's lives that we have not asked about. Please describe any such situations that come to mind and what you do in those situations.

d. Are there any policies and/or activities that you think would help the centre to promote the social-emotional development of children even more?

In the second part of our interview, we are asking you about relationships you have with the parents of children enrolled at the centre. As well, we want to know about what kind of supports your centre uses to maintain its staff's emotional well-being.

B1   Relationships With Parents

a. Are there ways in which you involve parents individually in their children's daily programs, routines and activities? (please explain)

b. Are there ways in which you involve parents in centre committees and parent events? (please explain)

c. Are there ways in which you involve parents in exchanging information about their children? (please explain)

d. Do you feel any of the following interfere with your relationships with parents of children enrolled at the centre? (please check all that apply)

❏ No centre policies for parental involvement   ❏ You feel parents don't value your opinion

❏ Parent's lack of time   ❏ You don't feel comfortable talking to parents

❏ Your own lack of time   ❏ You feel your role is to only work with the children

❏ Cultural/language/value differences   ❏ Other (please specify) _____

B2   Staff Support

a. Please describe any ways in which your centre provides opportunities for you to talk with other staff about concerns and receive feedback and suggestions.

b. Please describe any ways in which your centre considers your adult needs in the work setting (i.e., staffroom, scheduling, etc.)

c. Please describe any ways in which the management of the centre (Director, Board, Operator) show they value your teaching.

d. Please describe any ways in which your centre provides or supports opportunities for professional development.

e. Please describe any ways in which you individually reflect on and think about your daily experiences in the centre.

In the last part of our interview, we are asking you about your education and experience with children.

C1   Experience

a. Which age groups of children have you worked with in your experience as an early childhood professional?

❏ Infants   ❏ Toddlers   ❏ Preschoolers   ❏ School-age children

b. How many years of employed child care experience do you have?

In your current position at this centre	_____ years
In other positions at this centre (total)	_____ years
At other child care centres	_____ years
In child care homes	_____ years
In other fields related to child care	_____ years

C2   Education

a. What is the highest level of education that you have completed specifically related to early childhood education, child development and/or child care provision?

❏ None   ❏ Post-graduate degree

❏ Introductory/orientation course (less than 1 year)   ❏ Other (please specify) _____

❏ One-year college certificate/diploma   In what year did you complete this last level of education?

❏ Two-year college certificate/diploma   _____

❏ Bachelor's degree

b. In the past 12 months, have you participated in any of the following types of professional development activities?
Please indicate yes or no if these activities involved social-emotional development issues in early childhood or child care.

No professional development activities in the past 12 months	❏ yes	❏ no
Conference	❏ yes	❏ no
Workshop	❏ yes	❏ no
Non-credit course at a post-secondary institution	❏ yes	❏ no
Credit course at a post-secondary institution	❏ yes	❏ no
In-service training/consultation	❏ yes	❏ no
Visiting other education and care settings for ideas on improvement	❏ yes	❏ no

Other (please specify) _____

C3   Other

a. Please rate how much the following sources informed your awareness and understanding of social-emotional development?

	Not at all	Somewhat	Very
Completed education	❏	❏	❏
Continuing education (professional development)	❏	❏	❏
Parental experience	❏	❏	❏
Work experience (within child care settings)	❏	❏	❏
Work experience (in other areas of child care)	❏	❏	❏
Centre policies/initiatives	❏	❏	❏
Colleague consultation	❏	❏	❏
Consultation with community/social service agencies	❏	❏	❏

Other (please specify) _____

b. Where do you look for information about social-emotional development?

❏ I haven't looked for information on social-emotional development
❏ Books, journals and magazines
❏ Internet
❏ Workshops and conferences
❏ School or community courses

❏ Colleagues/supervisors
❏ Early childhood and education associations
❏ Consultation with community/social service agencies
❏ Consultation with medical/developmental specialists
❏ Networking with other child care professionals
❏ Other (please specify) _____

c. Do you currently belong to any early childhood educator or child care associations? If yes, which ones?

Is there anything else about promoting social-emotional development in young children that you think is important but was not addressed in the interview?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE