CHILDREN'S MENTAL HEALTH AND THE TRANSITION TO SCHOOL: SYSTEMIC ISSUES IN ONTARIO

by

Ingrid McKhool

Bachelor of Arts (Hon.), University of Toronto, 1992

A major research paper
presented to
Ryerson University

in partial fulfillment of the requirements for the degree of
Master of Arts
in the Program of
Early Childhood Studies

Toronto, Ontario, Canada 2011

Author's Declaration

I hereby declare that I am the sole author of this major research paper.

I authorize Ryerson University to lend this major research paper to other institutions or individuals for the purpose of scholarly research.

I further authorize Ryerson University to reproduce this major research paper by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

CHILDREN'S MENTAL HEALTH AND THE TRANSITION TO SCHOOL:

SYSTEMIC ISSUES IN ONTARIO

Master of Arts
Early Childhood Studies
Ryerson University

Abstract

Early intervention in mental health is critical to school readiness and social functioning, and mental wellness is linked to student achievement and success through the life span. Children aged four to six entering school with unaddressed mental health issues may struggle academically and socially, charting a course for low academic achievement that compromises their life chances. Many children are not captured through the Ministry of Education's labeling of exceptionalities or approach to inclusion. In addition, the current model lacks a systematic approach to monitoring the effectiveness of services. This study compiled descriptive statistics through a secondary analysis of previously collected community-based mental health services data in Ontario to better understand the needs of children four to six and the services provided to them before they enter school. Results were discussed in the context of a critical review of the literature related to mental health, early years and inclusion in school and community contexts. Recommendations include improved system measurement, development of a more age-focused community-based early intervention system and a reconceptualized practice of social inclusion to support children's transition to school.

Key words: children's mental health, inclusion, early intervention, school-based mental health, critical disability studies, school readiness

Acknowledgements

I would like to thank Carol Stuart, my supervisor, and Kathryn Underwood, my second reader, for their support and guidance during the writing process. Thanks also to Elaine Frankel, Aurelia Di Santo, David Lewis, Dragan Kljujic, Bruce Ferguson, Mehrunnisa Ali, Kerri Graham and Shani Halfon. Thanks to Ashmeet Lazaro for all her encouragement and kindness. And a special thank you to my dear friend and "on leave" partner, Aviva Rubin. Thanks Mom and Dad. Thank you Jeremy for all your support. Sophie and Elias, I hope I've made you proud.

Table of Contents

Author's Declaration ii

Abstract iii

Acknowledgements iv

LIST OF TABLES ..... *vii*

LIST OF FIGURES ..... *viii*

CHAPTER ONE *1*

Introduction 1

Purpose 3

Key Terms 4

Special Needs and Inclusive Education: Regulatory Context in Ontario 6

Conceptual Framework 8

CHAPTER TWO *10*

Literature Review 10

Prevalence of Mental Health Problems 10

Transitions and School Readiness 13

Service Delivery for Children's Mental Health in Communities and Schools 15

Bridging the Systems: Integrated Service Delivery and System Change 20

Special Education: Issues for Children's Mental Health Service Provision 23

Inclusive Education in Practice: Children's Rights and the Problem with "Inclusion" 28

Summary and Research Questions 30

CHAPTER THREE *31*

Methodology **31**

Overview 31

Research Design 32

The Original Survey 32

Target Group: Children Four to Six 35

Definitions of Variables 37

Secondary Data Analysis 40

Limitations and Generalizability 41

CHAPTER FOUR *44*

Results **44**

Profile of Children Served 44

Question One: What are the mental health needs of children aged four to six? 47

Question Two: What mental health services are currently provided for children aged four to six? 50

Summary of Findings 53

CHAPTER FIVE *55*

Discussion **55**

Key Themes 55

More Questions Than Answers 67

Suggestions for Further Research 67

Key Recommendations **68**

Conclusion **83**

APPENDIX 1: MCYS Mapping Tool [excerpts] **85**

References **89**

LIST OF TABLES

Table 1: MCYS Regions 37

Table 2: Definitions of MCYS Mental Health Functions 38

Table 3: Levels of Need 39

Table 4: Percent of Children in Programs Targeted to their Age Group 46

Table 5: Gender Distribution, Ontario 46

Table 6: Gender Distribution, Children 4-6 Subset, Ontario and Regions 47

Table 7: Level of Need, Ontario 47

Table 8: Level of Additional Need (selected), Ontario 49

Table 9: Percent of Referrals by Source, Children Four to Six Subset, by Region 51

Table 10: Mean Wait Time (Days), Selected Primary Functions, Children 4-6 Subset, by Region 52

Table 11: Cost per Child – Mean and Median, Ontario 52

LIST OF FIGURES

Figure 1: Percent of Children in Total Dataset Age 0-6 and 4-6 45

Figure 2: Percent of Children at Each Level of Need, Children 4-6 Subset, by Region 48

Figure 3: Children with Additional Needs in Children 4-6 Subset 49

Figure 4: Programs with Primary Functions, Children 4-6 Subset, Ontario 51

Figure 5: Mean Cost per Child, Children 4-6 Subset, by Region 53

CHAPTER ONE

The pre-school years present two challenges. The first is to identify and provide services to those children who are living with, or who are at risk of developing, mental illness. The second is to manage effectively the transition from early childhood...into the school system.

(*Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada, Sen. M. Kirby and W. J. Keon, 2006, art. 6.2.1)*

Introduction

Mental health is an essential determinant of overall health (WHO, 2008). A significant number of children begin school with mental health problems (Egger & Angold, 2006; Waddell, McEwan, Peters, Hua & Garland, 2007). While some have received specialized services in the community, most children with mental health problems do not, and their needs remain unaddressed (Waddell, et al., 2007). As a result, these children enter grade one exhibiting behaviours that can disrupt their learning and development, as well as the school environment (Hertzman & Bertrand, 2007). Many teachers have indicated they are unable to recognize potential issues or respond appropriately (Connor & Ferri, 2007; Kelly, Jorn & Wright, 2007; Loades & Mastroyannopoulou, 2009). As a result, children's needs may be ignored or problematized in the classroom. Additionally, children with a range of mental health issues are often excluded from special education service delivery, which sets them up for future disadvantage and failure (Loades & Mastroyannopoulou, 2009; Slee, 2006). Children

transitioning to school with unaddressed mental health issues begin to fall behind academically and struggle socially, charting a course for low academic achievement that compromises their life chances. The onset of behavioural and anxiety problems in the early years may lead to serious psychosocial disorders, criminality and substance abuse in later years (Offord & Lipman, 1996). It is now widely known that early intervention in mental health is critical to school readiness and social functioning, and that mental wellness is linked to student achievement and success through the life span (Ferguson, Tilleczek, Boydell, & Rummens, 2005). Learning environments that are adapted to meet the unique needs of all children are more socially equitable (Hehir, 2002). An inclusive approach embraces student differences and orients teachers and the broader society towards transformative social change that goes beyond the classroom (Slee, 2006).

More than a decade after Roy Romanow named mental health the "orphan child" of Canada's health care system (Romanow, 1992, p. xxxi), Senator Michael Kirby called children's mental health the "orphan's orphan" (Senate, 2006). Given the strong relationship between mental health and children's environments (Sandler, 1985), a knowledge-based and systematic approach that involves families, schools and communities would lead to an improved system that supports optimal mental health as children transition to school, setting them up for success through the lifespan.

Purpose

The purpose of this study is to explore systemic issues related to children aged four to six with mental health needs transitioning to school in Ontario. Given that unaddressed needs have serious implications for children's developmental, social, educational, and future vocational opportunities, a holistic, inclusive and systematic approach is needed to address mental health as early as possible. The goal of this study is to provide insights for knowledge-based systemic reform in Ontario's approach to delivering school- and community-based services to ensure a smooth transition for young children with mental health issues as they enter school.

This study seeks answers to the following questions in the Ontario context:

1. What are the mental health needs of children aged four to six?
2. What mental health services are currently provided for children aged four to six?

I have examined these questions through a secondary analysis of quantitative and qualitative data collected by the Ontario Ministry of Children and Youth Services (MCYS) in a "mapping exercise" it conducted in 2008 to gain a better understanding of the state of the province's children's mental health system. MCYS mapping involved the collection of information through surveys completed by MCYS-funded service providers regarding the programs they delivered in fiscal 2007/08. This original exercise was designed to take a point-in-time snapshot of the system, including: what types of mental health programs and services were available, where they were provided in the province, their wait times, and what types of regional variations existed; and which children received these service, including their age, gender, level of need, and concurrent disorders. The collected information was displayed in maps to demonstrate potential gaps, overlaps and opportunities for improvement in service provision across the

province. Additional information about the original mapping exercise is included in the methodology chapter.

In attempting to address the two research questions above through an analysis of MCYS data, further questions arise, related to understanding the unmet needs of young children, as identified by community service providers and the educational system. Therefore, I have attempted to bridge the two systems – community and school - through a secondary analysis of MCYS Mapping in the context of selected grey literature, policy and system models related to inclusion and mental health in school and community contexts, and in light of the potential for reconceptualizing inclusion practice in Ontario.

Key Terms

In this paper, "system" is defined as relating to the provincially-funded programs, services and approach taken across child-serving ministries including the Ontario Ministry of Children and Youth Services (MCYS) and the Ontario Ministry of Education (EDU).

"Community-based (mental health) services" are MCYS-funded services that provide a range of universal and targeted mental health functions, such as assessment, early identification, early intervention, emergency response, family/caregiver education and support, intervention, mental health promotion/illness prevention, navigation/service coordination, professional training, public education, referral and social/community supports (MCYS, 2006). These functions, which may vary in terms of frequency of delivery or intensity, constitute a comprehensive system of services to support children's mental health needs.

"Preschool children" and "children transitioning to school" denote children aged four to six who may be at home or in childcare, preschool or kindergarten, who are entering into formal education provided by the Ministry of Education at kindergarten and grade one levels.

MCYS's definition of "mental health" is aligned with the mental well-being component of the World Health Organization's (WHO) (1946) definition of health that includes mental health and development: "A state of complete physical, mental and social well-being, and not merely the absence of disease". Mental health is understood to include "all aspects of human development and well-being that affect an individual's emotions, learning and behaviour...not merely the absence of mental illness" (WHO, 2004). This definition underscores the importance of a continuum of service delivery that spans from illness prevention and mental health promotion to highly specialized services. Accordingly, the definition of "mental health needs" as defined by MCYS refers to a continuum that ranges from children who are not currently identified as being at risk of, or experiencing, mental health issues or problems (Level 1) through to children experiencing the most severe, complex, diagnosable mental illness that significantly impairs their functioning in most areas, such as home, school or in the community (Level 4) (MCYS, 2006). In this paper, "children with mental health needs" does not include children diagnosed with autism, learning disabilities, and other developmental delays who are eligible for other MCYS services in those domains based on their diagnosis, unless these children also have a concurrent mental health need.

Children with mental health needs may have a wide range of challenges that cause impairment in the school setting, and that are frequently referred to in the literature as emotional, social or behavioural difficulties. However, as Thomas and Loxley (2001) note, despite the fact that this label has come to be understood as a particular category of children, there is no standardized definition for "emotional and behavioural difficulties". Further, many children with mental health needs may not be formally diagnosed, and/or may not be designated under the Ministry of Education's labeling system for children with "exceptionalities", as described in the

following section.

Special Needs and Inclusive Education: Regulatory Context in Ontario

Because children aged four to six are entering into the school system, it is important to outline the province's regulatory framework for "special education", designation of "exceptionalities", and approach to "inclusion".

Ontario's 1980 enactment of Bill 82, which became known as the *Education Amendment Act* and is now part of the *Education Act*, marked a significant milestone in the province's obligation to ensure equitable education opportunities for all children. This legislation requires that all public school boards provide special education programs and services to students identified with exceptionalities (SEAC, n.d.).

"Special education" is governed through the *Education Act* (Ministry of Education, n.d.b) as follows:

> Some students have special needs that require supports beyond those ordinarily received in the school setting. In Ontario, students who have behavioural, communicational, intellectual, physical or multiple exceptionalities, may have educational needs that cannot be met through regular instructional and assessment practices. These needs may be met through accommodations, and/or an educational program that is modified above or below the age-appropriate grade level expectations for a particular subject or course. Such students may be formally identified as exceptional pupils. (Ministry of Education, n.d.b.)

All school boards are required through Regulation 181/98 to have an Identification, Placement, and Review Committee (IPRC) in place to identify students with "exceptionalities". These students are classified according to 12 labels within five broad categories: behaviour; communication (includes autism, hearing, language or speech impairment, learning disability); intellectual (includes giftedness, mild intellectual disability, developmental disability); physical disability; and multiple (combination of exceptionalities) (Ministry of Education, 2009).

The Ministry of Education does not provide a specific definition for mental health,

however children with certain expressions of mental health problems may interact with the ministry's system of labeling children with exceptionalities if they are identified under the "behaviour" category, defined as follows:

> A learning disorder characterized by specific behaviour problems over such a period of time, and to such a marked degree, and of such a nature, as to adversely affect educational performance, and that may be accompanied by one or more of the following:
> a) an inability to build or to maintain interpersonal relationships;
> b) excessive fears or anxieties;
> c) a tendency to compulsive reaction;
> d) an inability to learn that cannot be traced to intellectual, sensory, or other health factors, or any combination thereof. (Ministry of Education, 2000, p. 32).

All identified students must have an Individual Education Plan (IEP) outlining their special education services; some children who have not been formally identified with exceptionalities may also receive these services (Ministry of Education, n.d.b).

There is considerable debate in the literature about definitions for, approaches to and the intent of "inclusion" and "inclusive education" for children identified with special needs. According to the United Nations Educational, Scientific, and Cultural Organization (UNESCO):

> Inclusive education is central to the achievement of high-quality education for all learners and the development of more inclusive societies. Inclusion is still thought of in some countries as an approach to serving children with disabilities within general educational settings. Internationally, however, it is increasingly seen more broadly as a reform that supports and welcomes diversity amongst all learners (UNESCO, 2008, p.5).

Accordingly, in Ontario, inclusive education is defined as:

> Education that is based on the principles of acceptance and inclusion of all students. Students see themselves reflected in their curriculum, their physical surroundings, and the broader environment, in which diversity is honoured and all individuals are respected (Ministry of Education, 2009, p. 4).

The Ministry of Education's position is that inclusion in the regular classroom is the optimal placement for students with exceptionalities, while at the same time acknowledging that

segregated settings may be necessary at times to provide specific interventions (Ministry of Education, 2009). In general, inclusive education relates not just to access to regular classrooms, but also to socially just settings that promote children's active engagement. Regardless of definitions, teachers' knowledge and beliefs, administrative barriers and resource limitations result in provincial variations in inclusion practices for children with exceptionalities (Ministry of Education, 2009).

Ontario's *Human Rights Code* enshrines the right for all children to have equal access to educational opportunities and the duty for schools to accommodate the needs of students with disabilities (OHRC, 1990). The Human Rights Commission has articulated its position related to inclusion and access to education in its *Guidelines on Accessible Education* (OHRC, 2004). Mental health issues are included under this umbrella, despite the inconsistent policy and practice environment in Ontario's schools and boards.

Conceptual Framework

The key theoretical framework informing this paper is Bronfenbrenner's ecological perspective, which proposes that creating the conditions in the ecological environment - families, schools and communities - brings out the best child outcomes (Bronfenbrenner, 1994). Accumulating evidence now underlines the importance of supporting children and families within multiple interrelated and integrated contexts – early years programming, parenting supports, social and housing services, schools, vocational and health – to promote the best outcomes (Hertzman & Bertrand, 2007; Mustard & Young, 2007; Pascal, 2009). Additionally, such an ecological model is founded on collaborative, integrated planning and delivery of services within communities based on evidence and best practice.

My views are also informed by my policy development role in the provincial government. Government leadership is fundamental to creating the conditions for equitable social policy for a democratic and just society. However, system reform is complex and takes time; government may struggle to justify continuous focus and investment on long-term initiatives that are difficult to measure and designed to sustain social change. On the one hand, government seeks the transparent demonstration of positive outcomes through funding envelopes for specific programs; on the other hand, these types of programs may not be aligned with the critical discourse that can lead to inclusion practices that are valued and measured not just by how much they cost, but also by how well they create the conditions for true social justice.

In light of these perspectives, through this study I have considered how a province-wide, integrated and knowledge-based approach to system planning and service delivery can result in more inclusive environments and better outcomes for children aged four to six with mental health needs and their families, as well as society as a whole.

CHAPTER TWO

Literature Review

This chapter outlines the relevant foundational context, history and concerns related to the profile of children aged four to six with mental health issues and what the literature says about approaches, environments and models of service delivery that are most appropriate to best address their needs.

Prevalence of Mental Health Problems

According to the 2006 Census, there are 535,215 children aged zero to three and 415,360 children aged four to six, for a total of 950,575 children aged zero to six in Ontario, constituting almost 8% of the total population in Ontario, and 28% of the total population of children (aged zero to twenty one) in the province (Statistics Canada, 2006). The number of children aged four to six represents more than 3% of the total population in Ontario and 12% of the total population of children (Statistics Canada, 2006). In 2007, there were 116,165 children enrolled in junior kindergarten and 122,738 enrolled in senior kindergarten, for a total of 238,903 children (Ministry of Education, 2010).

It is estimated that 15 to 21 percent of children and youth have a mental health issue (Waddell, McEwan, Peters, Hua & Garland, 2007). Fourteen percent have a diagnosable disorder (Boyle & Lipman, 2002). Further, Carter et al. (2010) have indicated that approximately 22% of preschool children transitioning to school will have a psychiatric disorder that affects their functioning and would benefit from intervention services. One third of these have concurrent disorders. Seventy five percent of children with mental health disorders do not receive

specialized treatment (Waddell et al., 2007). Egger and Angold (2006) acknowledge the difficulties in assessing young children with disorders and illness, particularly given children's rapid and variable rates of development, the transient presentations of certain behavioural and emotional conditions, and the risk of inappropriately pathologizing or labeling normative individual or temperamental differences.

Mental health problems in children are commonly divided into internalizing and externalizing problems (Carter et al., 2010; CMHO, 2008). Internalizing problems include anxiety, mood disorders or depression; externalizing problems are acting out or behaviour problems that are challenging or disruptive (e.g., attention deficit hyperactivity disorder [ADHD], oppositional defiance or conduct disorder) (Carter et al., 2010; CMHO, 2008). Among children with problems, the most prevalent disorders are anxiety (6.4%), ADHD (4.8%), conduct disorder (4.2%), and depression (3.5%) (Waddell et al., 2007). While internalizing disorders (anxiety, depression) are the most prevalent, the results of the Brief Child and Family Phone Interview (BCFPI), a provincially-licensed intake tool used by approximately one third of community-based service providers in Ontario demonstrate differences in prevalence rates and gender variations in Ontario: boys are referred more frequently, earlier and usually for externalizing behaviours such as ADHD, conduct disorder and oppositional defiance disorder (CMHO, 2008), which suggests that girls with internalizing disorders are not being referred for services. Gender differences in the prevalence of certain types of disorders have been reported in the literature. Preschool-aged boys are more likely to be diagnosed with many specific externalizing disorders, such as oppositional defiance disorder, conduct disorder and ADHD (Carter et al., 2010; Egger & Angold, 2006).

In 2007/08, school boards reported that almost 14% of the total student population, or

288,526 students, received special education services (Ministry of Education, 2008). This included approximately 96,600 children not formally identified who received special educational programs and services. The Ministry of Education has not collected or published statistics on the number of kindergarten children identified with mental health needs, however, a calculation of 15 to 21 percent of the 2007-08 enrolment in junior and senior kindergarten (n=238,903) (Ministry of Education, 2010) suggests 35,835 to 50,169 children may have mental health needs.

Significant preventable developmental differences are seen in children entering grade one (Hertzman & Bertrand, 2007). It is widely understood that children's early development is influenced by a combination of factors, including the extent of family support, neighbourhood safety and resources, and community early intervention (Hertzman & Bertrand, 2007). Environmental factors such as poverty, family stress, underemployment and housing are associated with increased mental health problems (Carter et al., 2010). Expressions of problematic or challenging behaviour in young children may be attributed to or affected by their relationships with primary caregivers at home or in early learning environments (Egger & Angold, 2006). Unidentified and untreated problems can become disorders that span into adulthood (Feeney-Kettler, Kratochwill, Kaiser, Hemmeter & Kettler, 2010). Most adult psychiatric problems can be traced back to childhood and adolescence; the onset of antisocial behaviour, anxiety and conduct problems in younger years may lead to serious psychosocial disorders and, eventually, criminality and substance abuse in adolescence and adulthood (Offord & Lipman, 1996). Developmental assessments and mental health screens applied at a preschool and kindergarten population level help to identify potential problems early and support appropriate decision-making that involves families, teachers and other early learning and child care professionals (Feeney-Kettler, Kratochwill, Kaiser, Hemmeter & Kettler, 2010). Given the

importance of positive mental health and the range and severity of presenting mental health needs, the transition to school is a key opportunity for early identification and prevention, as well as coordination across child serving sectors.

Transitions and School Readiness

Starting school is a significant shift for all children, and those with additional needs experience unique challenges at this transition stage.

School readiness and transitions to school are conceptualized in many ways that reflect differing priorities on social, behavioural and academic preparedness (Carter, Wagmiller, Gray, McCarthy, Horwitz & Briggs-Gowan, 2010; Dockett & Perry, 2007; Fowler, Schwartz & Atwater, 1991; Janus & Offord, 2007; Rimm-Kaufman, 2004). Rimm-Kaufman (2004) found that kindergarten teachers identified school-ready children as those who were physically healthy, communicative and enthusiastic, while parents focused on academic ability as a sign of readiness. There is controversy about whether the term "school readiness" inappropriately places the onus on individual children to be modified in order to accommodate the rigid confines of the school environment. Thomas and Loxley (2001) refer to this as the school's "need for calm and order" (p.49) which situates teachers' actions in addressing within-child deficits. Alternatively, the operationalization of the term "school readiness" could be an indicator of the diversity of children's learning styles, behaviours and levels of development that must be accommodated by the school environment. Indeed, inappropriate uses of school readiness measurement are those that assess only individual children's competence without considering economic, cultural and contextual inequities in communities and society (American Academy of Pediatrics, 2008).

School readiness is understood by Janus (2007) to mean such competencies as "children's ability to meet the demands of school tasks, such as being comfortable exploring and asking

questions; being able to hold a pencil and run on the playground; listening to a teacher; playing and working with other children; and remembering and following rules" (p. 184). However, these types of abilities may conflict with the approach of many holistic pedagogues and early childhood educators who view child development as a process and are cautious of defining 'readiness' solely in terms of academic preparedness, given that school is an artificial and administrative construct (Mustard & Young, 2007).

Transition issues for children with mental health issues, are particularly complex. Janus, Lefort, Cameron and Kopechanski (2007) conducted systematic reviews of the issues and practices related to school transitions for children with special needs and found key administrative and ideological concerns. In terms of administrative issues, there may be multiple community services connected with the school, and often the onus is on parents to establish those lines of communication; there is often a disconnect between preschool and school diagnostic and designation criteria that can hinder children receiving necessary supports upon entry into school; and assessments may be delayed or repeated. Janus et al. (2007) found that preschool and school environments have different operational philosophies in terms of the purpose of school and school readiness; and teacher training in special education has an impact on teachers' confidence and approaches to inclusive education. Ultimately, the issues of most concern for families related to their exclusion from decisions regarding their children's academic plan (Janus et al., 2007).

The Ministry of Education acknowledges that children beginning school is not just a significant milestone for individual children, but also an experience that involves the family and many additional community partners (2005). Dockett and Perry (2007) state that the process of transitioning to school refers to "many experiences, people and services contributing to the general well-being of children and their families, and hence affecting their preparedness for

school" (p.1). Thus defined, the term "school readiness" serves as one appropriate proxy of an outcome measure that can be assessed for virtually all children as they enter en masse into the institutional learning environment; school readiness is then viewed in relation to children's exposure to a range of programs and supports provided within supportive ecological systems to enhance optimal development and health before children enter school (Janus & Offord, 2007). School readiness, then can be perceived as an outcome indicator of child development actions in a community (Janus & Offord, 2007).

The Ministry of Education has acknowledged the particular challenges involved in the transition for children with special needs through the development of *Planning entry to school: A resource guide* (2005), specifically designed to support schools to develop entry-to-school plans that involve families and community partners to improve transition experiences for children.

The period during which children aged four to six are transitioning to school is increasingly recognized as a key occasion to redress the "critical window into the development and consolidation of serious and long-lasting patterns of maladjustment" (Olson et al., 2009, p. 145). Given that the transition to school is a significant milestone for children, it presents a key opportunity to create the conditions for optimal mental health and coordination across child serving sectors to ensure children and institutions are as prepared as possible to support children for this critical stage in life.

Service Delivery for Children's Mental Health in Communities and Schools

Community-based mental health.

In a recent annual report, the Auditor General of Ontario noted that the composition of community-based children's mental health services in Ontario is a patchwork that reflects thirty

years of community decision-making, with little provincial direction (Auditor General, 2010). Services are not mandatory under the *Child and Family Services Act* (Government of Ontario, 1990) or other legislation, and so are provided to the level of available resources within the existing system. In the late 1970s, responsibility for children's mental health was transferred from the Ministry of Health to the Ministry of Community and Social Services, reflecting an increased focus on a social model-influenced approach to addressing needs through prevention and integrated services in the community rather than through pathologization (Oliver, 1990).

In 2003, MCYS was created to focus the government's priorities on children and families (MCYS, n.d.). In 2006, the government released *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (Framework). The Framework states that all children and their families need a "flexible, broad continuum of timely and appropriate services and supports which meet their changing needs through key age, developmental, academic and sector transitions" (MCYS, 2006, p.ii).

Services provided by community-based service providers offer a continuum from universal prevention programs to intensive treatments for multiple or complex needs (MCYS, 2006). The Framework calls for all child-serving sectors to work together to support a "sector that is coordinated, collaborative and integrated at all community and government levels, creating a culture of shared responsibility" (MCYS, 2006, p.i). Historically, however, ministry priorities related to children's mental health have not been developed jointly. Funding is largely based on historical precedents and priorities of government as a whole, rather than on integrated priorities of child-serving ministries or determinations of children's need for services (Auditor General, 2010).

School-based mental health.

Until recently, children's mental health has been underrepresented in the school system (Kirby & Keon, 2006). New public policy development in Canada and Ontario has led to an increased focus on the role of schools to support optimal mental health and reduce the risk of serious problems that extend through the lifespan (Ferguson & Short, 2009; Kirby & Keon, 2006; Santor, Short & Ferguson, 2009). School-based mental health may include health promotion activities, prevention programs, identification and assessment programs and intervention services delivered in the school setting by school staff or community-based service providers (Santor et al., 2009). Kirby and Keon's (2006) consultations highlighted that schools were the most underused site for the children's mental health service delivery in the country despite being a natural environment for children, and that "development of the school as a site for effective delivery of mental health services is essential" (p.138).

Positive mental health is correlated with a reduced risk of early school leaving and improved achievement (Ferguson, Tilleczek, Boydell, & Rummens, 2005; Santor et al., 2009). Fox, Dunlap and Cushing (2002) caution that children who display challenging behaviors during this transition, even if they have received community-based early intervention services before they enter school, are at increased risk for developing subsequent academic and behavioral difficulties, and systematic supports that bridge between community and school systems are indicated. Stephan, Weist, Kataoka, Adelsheim and Mills (2007) and others have argued that schools are in the best position to play a pivotal role to improve access to both preventive and targeted mental health programs.

Educators across the province have identified the need for support and training to help them recognize mental health issues and respond effectively (Short et al., 2009). Mental health

literacy, that is, the range of knowledge and skills needed to recognize potential problems and respond appropriately, is variable among professionals (Connor & Ferri, 2007; Davies, Garner, Parkin & Short, 2009; Loades & Mastroyannopoulou, 2009; Kelly, Jorn & Wright, 2007). Loades and Mastroyannopoulou (2009) found that teachers were more able to recognize externalizing problems (e.g., behaviour) than internalizing problems (e.g., emotional disorder), which may mean that children with problems that do not disrupt the classroom go unaddressed. This is consistent with research on parents' incomplete understanding of the distress experienced by young children with internalizing disorders in terms of their social participation and motivation (Carter et al., 2010). Janus et al. (2007) found that preschool and school teachers' approaches to treatment and education differ in terms of children with special needs, with the former focusing on life skills or reducing the impact of specific problems, and the latter on interventions relating specific to academic outcomes.

Moreover, teachers' relationships with children and their perceptions of children's behaviour can affect their responses to the mental health or developmental screening tools completed for the children in their classroom. Negative teacher-child interactions may influence teachers' perceptions of children's functioning and lead them to identify certain children with higher ratings of inappropriate behaviour (Feeney-Kettler, et al, 2010). In a presentation to the Scottish government's inquiry into special education and social inclusion in schools, the President of that country's largest teachers' union said that inclusion cannot continue in its current format because "those with behavioural difficulties [are] a serious threat to emotional wellbeing of teachers" (Allan, 2006, p. 121). Teachers' stress and competence are significant issues that must also be considered in the context of the wellbeing of children and their right to equitable access to educational opportunity, which are predicated in large part on their

relationship with their teachers. Educators have identified many significant barriers to inclusion in their practice (Connor & Ferri, 2007; Frankel, 2004; Killoran, Tymon & Frempong, 2007) including fear of dealing with children with special needs. Indeed, when they enter school, children typically start to spend more waking hours in the company of teachers and other children than their immediate families. Children who exhibit self-regulation issues or other behavioural problems that impair transactions in the teacher-student relationship may present classroom management concerns for teachers that can affect their acquisition of foundational academic skills (Morrison & McDonald Connor, 2009). Olson, Sameroff, Lunkenheimer, and Kerr (2009) also caution that teacher-child transactions have a sustained impact on children's development and competence. For example, aggressive, noncompliant children tend to elicit hostile, controlling responses from teachers, resulting in cyclical transactions that exacerbate relationship problems and detract from learning (Olson et al., 2009).

It is widely recognized that schools are one of the most effective mechanisms through which mental health services and supports can be delivered to the greatest number of children (WHO, 2004). Schools can work with community-based organizations to deliver universal prevention programs to the whole school population, as well as targeted programs to at-risk groups or those with identified needs. Despite the mounting evidence of the importance of maximizing the role of schools for prevention, early identification, assessment and intervention, there is widespread acknowledgement of the challenges to educational transformation to focus on more inclusive and responsive educational environments and teachers' reflexivity about their pedagogic values and their relationships with students, due to resistance to change, resource limitations, collective agreements, and other complex factors (Stephan et al., 2007).

Bridging the Systems: Integrated Service Delivery and System Change

Over the last decade or so, there has been much policy articulation internationally and in Ontario to support children and families in the early years, including *Reversing the Real Brain Drain: Early Years Final Report* (McCain & Mustard, 1999) and its successor, *Early Years Study 2: Putting Science Into Action* (McCain, Mustard & Shanker, 2007), the World Health Organization Commission on Social Determinants of Health - final report (CSDH, 2008), and most recently, *With Our Best Future in Mind: Implementing Early Learning in Ontario* (Pascal, 2009). From a societal perspective, the rationale for focusing on early children's physical and mental health and development has been shown to have a significant cost-benefit value, and is highly effective at mitigating socioeconomic and other disparities as children transition to school (Mustard & Young, 2007).

Integrated community-based programs across various domains – physical and mental health, education, and social systems – create the ecological conditions for optimal child development outcomes (Bronfenbrenner, 1994). These are particularly warranted to address inequities for children in poverty or other disadvantages who are further deprived of adequate mental health services due to contextual circumstances. An integrated approach capitalizes on bridging the most important contexts surrounding children – family, school and neighbourhood (Cappella, Frazier, Atkins, Schoenwald & Glisson, 2008).

Borrowing from population-based public health prevention and promotion approaches, models for the delivery of children's metal health services are often depicted by a pyramid, with universal programs or primary prevention at the base to represent core curriculum and population health system programs that serve the greatest number of children, followed by targeted interventions that serve a sub-group of children who have been assessed as being at risk for

problems, then clinical specialized interventions at the tip for a select number of children diagnosed with intensive problems (Sugai et al., 2000).

Santor et al. (2009) have outlined four prevalent models in the literature regarding mental health service delivery in schools: the mental health spectrum model, the interconnected systems model, the social-emotional learning model, and the public health perspective model. The mental health spectrum model is similar to Mrazek and Haggerty's (1994) continuum model, which while leaning towards a medical model of illness treatment, integrates several settings (e.g., home, school, community) and includes universal, selective, and indicated intervention and treatment depending on level of need (as cited in Zeanah, 2009). The interconnected systems model is characterized by the integration of programs as three distinct levels of need driven through pooling of resources across schools and community (Santor et al., 2009). Both these models are focused on prevention and treatment of problems as necessary. The third model, the socio-emotional learning model, shifts the focus from prevention to a more proactive approach geared to fostering positive behaviour and building the capacity for self-regulation, empathy and conflict management (Santor et al., 2009). Finally, the public health perspective model is population-based and grounded in collective responsibility and collection of data across sectors to identify protective and risk factors in communities and focus on environmental conditions that can lead to improved outcomes.

The intersection of core components of the models is found in the conceptualization of schools as a natural environment for integrated services for children and families that focus on the broad social determinants of health and the conditions to support optimal development. Offord, Kraemer, Kazdin, Jensen and Harrington (1998) promote the need for a blend of universal, targeted and clinical programs provided collaboratively across sectors as the ideal

service model to reduce mental health problems in children. Some examples of integrated school-based models that have been implemented in Ontario include: The Algoma model, a partnership among the Algoma District School Board, Huron-Superior Catholic District School Board, and Algoma Family Services, that provides mental health promotion, programs for students at risk, services for complex problems, and crisis intervention (Short et al., 2009); The Wrap Program (Working to Reinforce all Partners) delivered through Bluewater District School Board, Bruce Grey Catholic District School Board and Keystone Child and Youth Family Services that develops individualized service plans provided through school, in the community and at home; and the COMPASS Program (Community Partners with Schools) in Simcoe and York region that perceives schools as hubs for integrated services in the York Region District School Board (Short et al., 2009).

Research consistently points to collaborative relationships as essential to ease transitions for young children. Cross-sectoral collaboration is key to improving the seamless, timely delivery of services through universal, targeted and clinical programs, while optimizing human and financial resources (Spratt, Shucksmith, Philip & Watson, 2007; Adelman, 1993). As mentioned previously, Ontario's children's mental health Framework calls for all child-serving groups and sectors to share a commitment to a coordinated, collaborative and integrated children's mental health system (MCYS, 2006). As Dockett and Perry (2007) explain: "Relationships between schools and prior-to-school settings, among service-providers within communities, between families and schools and among families themselves all play an important role in constructing a context based on collaboration" (p.2).

Recently, Pascal's early learning report (2009) has led to a merging of community-based, child care and early childhood education services which has shown great promise but, in its

infancy, is yet to be assessed. While the school system has been identified as a natural hub to provide a range of services, there are disparities and inconsistencies in policy and practice on the ground (Corter & Peters, 2011). New initiatives specifically supporting integrated approaches to promote positive mental health, earlier identification, mental health literacy and/or increased collaboration with community-based partners in Ontario show promise. These include *Student Support Leadership* and *Working Together for Kids' Mental Health* (Ministry of Education, 2010c). *Student Support Leadership* supports school boards and community service providers to better meet student needs through collaborative planning, service coordination and referrals. *Working Together for Kids' Mental Health* is a provincial pilot in progress that examines decision-making processes and tools that support professionals across sectors (educators, community health workers, hospital staff) to better understand, effectively identify and appropriately respond to mental health concerns.

These provincial initiatives involve alignment across several ministries, communities, sectors and schools, and reflect the movement, however measured, towards integrated system support and early intervention for children aged four to six with mental health problems.

Special Education: Issues for Children's Mental Health Service Provision

Ontario's "functional limitations model" for labeling exceptionalities.

Oliver (1990) citing Hahn (1985) notes that public policy is the vehicle through which disability has been defined in practice. This is particularly true in terms of the system governing special education. As indicated previously, Ontario's education ministry oversees an operational system for addressing children designated with "exceptionalities" to meet these students' instructional needs through accommodations and specialized programs (Ministry of Education, n.d.b). Ontario's special education system is founded on a discourse based on the medical model

of disability, which locates disability as individualized functional deficiencies – deviations from what is considered the "able-bodied norm" - that require medical and institutional solutions (Oliver, 1990).

This approach uses specific designations, and in some cases accompanied by clinical diagnoses, which may be related to various degrees of impairment in functioning, as the gateway to services for children who may have mental health problems (Carter et al., 2010). The operational definition is broad, given that the actual educational needs, as opposed to the clinical diagnosis, may be very different from child to child (Janus et al., 2007). The criteria cover a range of disabilities, however the term does not encompass those children who may be at academic risk due to ecological disadvantages, such as poverty or unsafe or abusive family conditions that may affect their mental health or other determinants of health (Janus, Lefort, Cameron & Kopechanski, 2007). Parents can apply to have their children assessed for physical, learning or developmental problems and children who meet the criteria are eligible for additional supports.

Thus, Ontario's approach to additional supports and services may be seen as a deficit-based, medicalized model used to determine the level of support to which struggling children and their families are entitled. Danforth (2001) has called this type of approach the "functional limitations model" (p. 343), the dominant type of disability model that assumes disability to be to a physical, psychological or behavioral deficit residing in individual children. Parents must declare their children deficient (Slee & Allan, 2001) in order to qualify for additional supports. While this model is designed to promote the development of programs and approaches to support improved functioning and participation for children with an identified 'special need', at the same time, it positions them as inherently defective and unequal in the first place.

In addition, and most important for our purposes, these criteria often exclude children with a range of mental health needs. How are children entering the school system with undiagnosed issues or those who have not been designated as exceptionalities defined in relation to the normative centre? Indeed, how do diverse learning styles, dispositions and behaviours of all types of different children fit into this spectrum? And further, what place does a holistic approach to mental health, understood as not merely the absence of illness, but as environmental circumstances designed to promote optimal health and development (WHO, 2004), have in this approach?

The answers to these questions are not clear. It is noted that amendments to the *Education Act* in 2008 include a "progressive discipline" approach to recognize the range of underlying needs that may be expressed through "inappropriate" behaviour in the classroom (Ministry of Education, 2010b, p.20). This approach is designed to help schools better respond to challenging behaviour and take into consideration contextual and individual factors (Ministry of Education, 2010).

However, much literature about service delivery models for children with additional needs points to significant flaws in practice (Allan, 2006; Slee & Allan, 2001; Thomas & Loxley, 2001) because they do not account for the actual range of student differences that are present in the classroom, and lead inevitably to the repetition of exclusion for certain students based on their unsuitability to the conforms of the model.

Indeed, there is wide variation across school boards within Ontario about how mental health is addressed within the special education paradigm (Auditor General, 2008; CADDAC, n.d.). In the U.S., most children with mental health issues are not identified as students with special needs (U.S. Public Health Service, 2000). As previously mentioned, 75% of children with

disorders do not receive specialized treatment (Waddell et al., 2007). This places many children with unaddressed mental health issues within the normative group of children whose needs are assumed to be met by the existing environment until their behaviours become unmanageable within the class environment (U.S. Public Health Service, 2000). When the learning environment is not designed to address their needs, children may eventually be labeled as having behaviour exceptionalities or begin to fall behind, charting a course for low academic achievement or early school leaving that compromises their future life chances (CADDAC, n.d.).

However, in Ontario, some children may be identified as fitting into exceptionality categories, such as behaviour, learning disability or developmental delay, if they exhibit behaviours or learning deficits perceived by the IPRC to align with these categories.

Among the categories related to the designation of exceptional students, the behaviour category is the most likely label under which children with mental health problems are placed if children are identified by teachers or parents as exhibiting behaviours that affect their learning or the class environment (Ministry of Education, n.d.b.). Externalizing symptoms such as acting out, ADHD and conduct disorder could be captured by this designation if children's behaviour is sufficiently disruptive, or if these issues are concurrent with another disorder that fits one of the existing categories. However, many mental health issues, such as depressive symptoms, being withdrawn or other internalizing behaviours that may not adversely affect classroom functioning, can go undetected (Loades & Mastroyannopoulou, 2009). Some children with secondary mental health issues may be captured under other categories, such as children with learning disabilities, developmental delays or multiple exceptionalities. Others with transient, contextual, moderate or anomalous mental health issues or problems may not be designated or categorized within the exceptionalities.

When considering this omission, one reasonable remedy is to build on the existing model and expand the definition and labeling of children with special needs in order to include all children with mental health issues (see Kauffman, Bantz & McCullough, 2002); some propose further that these children should be specially labeled to access better educational resources and experiences in segregated classrooms (Cigman, 2007; Landrum, Tankersley & Kauffman, 2003).

Some advocacy groups support this type of redress. For example, the Centre for ADHD Awareness, Canada (CADDAC) has lobbied the provincial government to include ADHD as an officially recognized "disability qualifying students for special needs status under the designation of a medical condition in the Physical/Medical category. School boards must be given direction on where ADHD is to be placed in the categories of exceptionality" (CADDAC, n.d.). Such a revision of the Physical/Medical category addition would allow other neurobiological and mental health disorders to be addressed under this category (CADDAC, n.d.)

Notwithstanding that this model moves more towards a medical than a social approach to the provision of service, this modification could prevent children from being labeled as having deficits based solely on how their behaviour is expressed in the classroom, and in particular, on their teachers' tolerance of perceived inappropriate behaviour. Adding mental health problems as a specific category would more appropriately focus on cognitive challenges or learning difficulties associated with a specific condition as opposed to teachers' subjective perception of inappropriate or disruptive behaviour (Feeney-Kettler, et al, 2010; Olson et al., 2009).

Another perspective: The elimination of labels.

However, adding more labels to improve access to services for children with mental health issues limits improvements to working within the existing framework. Another approach, reflected in Slee and Allan's (2001) reconceptualization, proposes an eradication of all labels

within a new universally designed environment in which no children are "excluded" because no children are "included". More specifically, "[i]nclusive education is not just about... those we describe as having 'special educational needs'. It is about all students. Inclusive schooling is a social movement against educational exclusion" (Slee & Allan, 2001, p.177). This approach assumes a limitless educational setting and framework of inclusion that creates the conditions for optimal mental health for all children. It is based on the right for all children to be equally valued and afforded equitable access to educational opportunity (Thomas & Loxley, 2001).

Inclusive Education in Practice: Children's Rights and the Problem with "Inclusion"

Research has pointed to the proliferation of inclusion models, particularly in school settings, that have in practice resulted in the discriminatory repetition of exclusion for a wide range of children (Allan, 2006; Slee, 2006). Slee and Allan (2001) critique the assumption that conceptualizations of inclusion evolve naturally from the worthy practice of addressing special education needs, as defined within the existing education model. Rather, inclusive education must consider:

> the processes and practices in schooling which compromise the participation of some students....The deconstruction of these barriers is only made possible by a refutation of the liberal reforming project of submerging disabled students in the unreconstructed culture of regular schooling. Inclusive education is not just about... those we describe as having 'special educational needs'. It is about all students. Inclusive schooling is a social movement against educational exclusion. (Slee & Allan, 2001, p.177).

Roulstone and Prideaux (2008) also point out the contradictions between the proliferation of inclusion policies and the actual practices in social and educational settings that have not addressed the systematic social and physical barriers that inherently problematize children with differences and perpetuate exclusion. Allan (2006) states that inclusion initiatives may be perceived as accountable and transparent actions forward in social justice and equity, but may

actually be under resourced, uninspired facsimiles that result in perpetuating exclusionary practice and injustice:

> The standards and accountability culture creates closures, but also catches everyone – policymakers, teacher educators, researchers, teachers, parents and children and young people – in a performance, forced to enact a version of inclusion which is merely about tolerance and management of difference and which leads to a constant reiteration of exclusion. (Allan, 2006, p. 126)

Similarly, Thomas and Loxley (2001) contend that the term 'special needs', if it is to be used at all, must be updated to encompass not just a prescribed set of deficient categories of ability, but to reflect the fluid and dynamic nature of children's development and level of need. In this way, inclusion in the education realm is "about comprehensive education, equality and collective belonging" (Thomas & Loxley, 2001, p. 124), as the education realm is reflected in an inclusive, humane and civilized society that respects children's basic society societal and educational rights, as articulated internationally by the 1989 United Nations Convention on the Rights of the Child (UNICEF, 1989) and the United Nations Educational, Scientific, and Cultural Organization (UNESCO) which states that

> Inclusion is to be seen as part of the wider struggle to overcome exclusive discourse and practices, and against the ideology that each individual is completely separate and independent. Inclusion is about the improving of schooling. Rather than being a marginal theme concerned how a relatively small group of pupils might be attached to mainstream schools, it lays the foundations for an approach that could lead to the transformation of the system itself. (UNESCO, 1999, p.9)

However, diverse interpretations of children's rights, even in Canada, have contributed to unequal access to adequate educational opportunities for all children, including those with mental health issues whose needs are not adequately met in the general educational system.

Devlin and Pothier (2006) have said that a true human rights approach to inclusion involves the rejection of "a hierarchy of disability difference, rejecting a privileging of the

'normal' over the 'abnormal'" (p.11). If policies, programs and classrooms were structured for the most 'marginalized' groups from the start, then no one would be excluded.

Summary and Research Questions

The literature above has pointed to several key issues related to the provision of services for young children with mental health needs who are transitioning to school. Needs are far-reaching and acute, and teachers have identified gaps in their ability to respond appropriately. Despite Ontario's focus on the early years, the research indicates that there is uneven and disorganized integration of school and community supports for young children with mental health issues. In Ontario's current approach, it appears that children's needs, even if they have been previously identified and treated, may not continue to be met once they begin school. Many children with mental health needs are not captured through the labeling of exceptionalities or the current approach to inclusion in school and community settings. In addition, the current provincial model lacks a systematic approach to tracking and monitoring the effectiveness and appropriateness of services in communities and schools based on evidence.

The present study was a secondary analysis of quantitative data about children's mental health services previously collected by MCYS. This study examined the following questions in the Ontario context:

1. What are the mental health needs of children aged four to six?
2. What mental health services are currently provided for children aged four to six?

Results are discussed in the context of the current system, and focus on the implications for supporting the mental health of children aged four to six who are transitioning from community-based services into the school system.

CHAPTER THREE

Methodology

Overview

This study sought to understand the specific mental health needs of children transitioning to school, and the provincial mental health services currently provided to these children. The secondary analysis of numerical and descriptive data collected previously allows for a rich analysis and interpretation that opens a window to further inquiry (Creswell, 2009). To the extent possible within the limitations of the original dataset, I have sought to explore relational questions of variables within the dataset (Williams, 2007). Williams refers to this as a content analysis study in which the data are described, their characteristics are studied, and the results are reported and analyzed to show patterns from which to draw themes and conclusions (Williams, 2007).

Through this study, I generated descriptive statistics about the profile, needs, and services provided to children with mental health problems aged four to six, from a large dataset collected by MCYS from provincially-funded children's mental health service providers about their service provision in 2007/08. A discussion of these results was undertaken in the context of a selected review of government documents and other public documents (e.g., provincial reports, municipal and regional planning documents and reports) and a critical review of the literature, policy and system models related to inclusion and mental health in school and community context, and in light of a reconceptualized model of social inclusion. The following sections describe the methodology in greater detail.

Research Design

Secondary analysis of data is a commonly used method in the social sciences and other fields; for example, much peer-reviewed research relies on census data and other demographic or population-based surveys for its database (Johnson & Turner, 2003). Secondary data analysis, defined generally as the reanalysis of an existing survey using different research questions, has benefits including financial and time resource economy; however, this method may be limited by validity problems (Lewis-Beck, Bryman & Futing Liao, 2004). In the case of the present study, conducting secondary data analysis provided the opportunity to explore further, with a focus on young children, an existing provincial database created through MCYS Mapping. This more focused exploration may be helpful for future policy development regarding young children's mental health in Ontario. The stated limitation has particular relevance in this case, as the original survey questions were not necessarily designed to address my specific research questions. However, the purpose of MCYS Mapping was similar to that of this study, in that it was designed to gain a better understanding of particular populations accessing services and services provided in communities (MCYS, 2009). I have pursued similar insights, but focused on a slice of the original dataset, to look more closely at children aged four to six and the programs serving this group. The original survey provides an extensive collection of data that can be used as a starting point for deeper study and discussion.

The Original Survey

Children's mental health policy framework.

In 2006, the province released *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (Framework). The Framework has four over-arching goals:

1. A coordinated, collaborative and integrated child and youth mental health sector at all levels, creating a culture of shared responsibility;
2. Children and youth have timely access to a flexible continuum of appropriate programs within their own cultural, environmental and community context;
3. Enhanced understanding of, and ability to respond to, mental health issues through the provision of high quality and effective services at all levels of need;
4. An accountable and well-managed sector (MCYS, 2006).

As indicated previously MCYS's articulated position is that mental health is viewed as a continuum from illness prevention and mental health promotion to the prevention and treatment of disorders (MCYS, 2006). The Framework introduced new vocabulary through which different provincial child-serving sectors could discuss children's mental health. Twelve mental health functions that comprise a continuum of services that should be available in a comprehensive children's mental health service system were defined in the Framework (MCYS, 2006). Definitions for these functions are included below.

MCYS Mapping.

As a first step to implementing the Framework, MCYS conducted a mapping exercise related to children's mental health services. Mapping is a process by which information from various sources is collected, integrated, analyzed and displayed in map format and in relation to geographic location (Hillier, 2007). When used in social services, mapping can help support an ecological approach to services delivery and planning: communities and government can identify gaps in service, target high-need areas, and plan services based on integrated information from various relevant sources (Hillier, 2007). The Ontario Healthy Communities Coalition (OHCC, n.d.) has promoted the strengths-based approach to mapping developed by Kretzmann and McKnight designed to inventory the existing assets of communities and build sustainable partnerships and community capacity.

Similarly, the intention of MCYS Mapping was to gather baseline information from funded

service providers that could be combined with other data sources, to provide a "point-in-time" snapshot of what children's mental health services were provided, where and to whom, based on 2007/08 service data (MCYS, 2009). These data sources displayed together could then provide a more comprehensive picture of Ontario's children's mental health system in order to be able to compare it to the idealized model outlined in the Framework. MCYS developed maps using geographic information system software to display the information gathered through the mapping exercise (MCYS, 2009).

In what became known as "MCYS Mapping" (MCYS, 2009), all MCYS-funded service providers that delivered children's mental health services in fiscal 2007/08 completed individual surveys. This information was combined with other data sources, including Statistics Canada demographic information, corporate data from the Ministry of Education and the Ministry of Health and Long Term Care, displayed in map and table format, and shared with service providers in workshops held across the province.

Sample.

A unique survey instrument, or "mapping tool" was developed to capture the nature and distribution of mental health services across the province during the 2007/08 fiscal year (MCYS, 2008). The tool was informed by substantial research into mapping approaches undertaken both in Ontario and across other jurisdictions. Consultation was undertaken with MCYS-funded service providers, academic and clinical experts about the goals of the exercise, and methodology to be employed. Two pilot tests were conducted prior to provincial release.

Data collection occurred in Summer 2008. MCYS-funded service providers completed a survey for each individual mental health program they provided in 2007/08 to describe: what types of mental health programs and services were available and where; who received these

programs and services (target population, levels of need); wait times for service; and sources of funding (see Appendix 1 for Mapping tool questions). Service providers received administrative support from MCYS to facilitate their accurate completion of the tool for each distinct program. Mapping tools were completed by program staff, overseen by executive directors, signed off by the executive signatory of the agency, and approved by MCYS Regional Directors.

Mapping tools were completed by 373 service providers with self-reported data related to 1502 programs, 255,000 children receiving services, reported funding sources and wait times. These data were delivered electronically to MCYS and incorporated into a database for storage, cleaning and analysis by MCYS research and policy staff. The Statistics Package for the Social Sciences (SPSS) was used to store, clean and analyze the original survey.

Target Group: Children Four to Six

The explorative secondary data analysis focused on identifying and analyzing the MCYS survey data collected on programs serving children aged four to six in 2007/08. Using SPSS, the original database was filtered to extract only the data related to services provided to young children up to the age of six. The variables for analysis included: the number and proportions of children served by gender; the level of need of children served and concurrent needs; the ranking of primary mental health functions provided by programs; referral sources; wait times for service; and sources of funding. These were collected and analyzed for the province as a whole as well as according to MCYS regions.

To understand the profile of children served during the 2007/08 fiscal year, secondary data analysis was undertaken to identify the number and proportions of children served, by gender.

To describe the needs of children served, the variables included the level of need of children served, and prevalence and types of additional identified needs. Finally, secondary data

analysis was undertaken specifically to identify the services delivered to children four to six. The variables included specific primary mental health functions delivered by programs serving this age group, geographic location of services, referral sources, wait times, and funding.

Analyzing these data provides insights into the profile and level of need of young children receiving services, as well as the nature, frequency, consistency, relevance and variability of provincially-funded services being delivered in Ontario. Variations in service provision and wait times, and gaps in delivery across the province were identified. The findings are presented in narrative form, or in charts and tables generated by importing the data from SPSS to Excel.

There were some limitations to understanding the needs of children transitioning to school based only on MCYS survey data. The current funding model for MCYS-funded community-based services is not predicated on the demonstration of needs in the community nor is the funding mandated in legislation to provide services which address needs. As the Auditor General notes, "services [are] provided only up to the system's existing capacity, which is determined largely by the amount and allocation of ministry funding rather than by need" (AG, 2010). Specifically, service providers are not required in any contractual way to demonstrate that the services they are providing are responding to community-identified needs. Therefore, the MCYS survey data only reflects the needs of children and families who "walked through the door".

To better understand the mental health needs of children aged four to six, the foregoing literature review included the prevalence of problems, specifically as these present in children who are transitioning to school. In order to understand community drivers for services, a public document review of the grey literature, such as advocacy group submissions, intake and monitoring instrument reports and policy statements that speak to early years services was undertaken with a particular focus on services to support optimal mental health and children's

development. The intersection of data analysis, the literature and other sources, and the differences between provincially-funded services and the needs of children starting school with mental health issues, are discussed in chapter five.

Definitions of Variables

This section provides definitions for the variables analyzed in the secondary analysis. These terms are used extensively in the rest of the paper.

MCYS Regions: MCYS divides the province into nine geographic regions for administrative purposes (MCYS, n.d.b), as described in *Table 1.*

Table 1: MCYS Regions

MCYS Region	Areas Served
Central East	Durham, Haliburton, Northumberland, Peterborough, Simcoe, Kawartha Lakes, York
Central West	Dufferin, Halton, Peel, Waterloo, Wellington
Eastern	Cornwall, Ottawa-Carleton, Prescott & Russell, Renfrew
Hamilton-Niagara	Brantford, Haldimand/Norfolk, Hamilton, Niagara
Northern	Algoma, Kenora, Manitoulin & Sudbury, Rainy River, Sault Ste. Marie, Sudbury, Thunder Bay
North East	Cochrane, Muskoka, Nipissing, Parry Sound, Timiskaming, eastern part of Kenora district along Hudson and James Bay coastline
South East	Hastings, Kingston/Frontenac, Lanark, Leeds & Grenville, Lennox & Addington, Prince Edward County
South West	Middlesex, Oxford, Elgin, Huron, Bruce, Perth, Grey, Essex, Chatham-Kent, Lambton
Toronto	Toronto

Primary (Mental Health) Functions: The MCYS survey (MCYS, 2008) defined twelve mental health functions that form a comprehensive system of services to meet children's mental health needs. Service providers identified and ranked the four primary functions

provided by their program, defined as the program's key purposes (MCYS, 2008).

Service providers were required to adhere to the definitions in *Table 2* below.

Table 2: Definitions of MCYS Mental Health Functions

Function Name	Description
Assessment	Assessments include: evaluating the strengths, needs and resources of children and families; communicating findings; and seeking relevant information from other service providers.
Early Identification	Activities involving the early detection of the potential development, or occurrence of, a mental health problem.
Early Intervention	Activities involving early intervention in response to the identification of the potential development.
Emergency/ Crisis Intervention	Provides urgent response through a range of mechanisms to the mental health needs of children / youth in a crisis situation.
Family / Caregiver Support	A broad range of information, education, and support for families, targeted at enhancing their capacity to respond effectively.
Intervention/ Treatment	Elements of this function include: informing children and families about intervention/ treatment options and the likely benefits and risks to safety and well-being; negotiating goals, timeframes, methods and arrangements for service delivery; coordinating and integrating multiple interventions/treatments where possible; communicating and reviewing plans in a manner tailored to support the understanding of children and families;
Mental Health Promotion/Illness Prevention	Mental health promotion empowers people and communities to interact with their environment in ways that enhance emotional and spiritual strength. Prevention seeks to avert problems through universal or targeted activities geared at reducing risk factors.
Navigation/ Service Coordination	Navigation is the process of supporting children and families through system. Service coordination is the process of coordinating and/or integrating the plan across service providers.
Professional Training	Focus on enhancing the ability of a professional to effectively meet the mental health needs through a range of formal mechanisms, including training, education and consultation.
Public Education	Providing information, tools and other resources for schools and other community organizations interested in working on addictions and mental health issues.
Referral	Includes referrals for follow-up services to health, mental health, education, Children's Aid Societies, youth justice, social services, recreation, Friendship Centres, Aboriginal community service providers, Aboriginal healing lodges, and volunteer sectors.
Social/ Community Supports	Community and social supports include education, recreation, training, employment, income benefits and programs that support connection or reconnection with family, friends and others with whom they can develop or nurture relationships.

(MCYS, 2008)

Level of Need: Service providers estimated the level of need of the target population their program served (MCYS, 2008). As described in *Table 3*, levels of need were defined for the MCYS Mapping survey as follows:

Table 3: Levels of Need

Continuum of Needs	Target Population
Level 1:	Not at risk/not experiencing mental health problems
Level 2:	At risk or experiencing some mental health problems/illness
Level 3:	Experiencing significant mental health problems/illness
Level 4:	Experiencing most severe, complex, diagnosable mental illness

(MCYS, 2008)

Children with Additional Need: Service providers estimated the number of children who, in addition to having a mental health issue, also had an additional identified need including: substance use problem, eating problem/disorder, developmental disability, learning problem/disability, or other identified need (MCYS, 2008).

Referral Sources: Service providers identified the sources from which referral were received to their program, as well as number of referrals to their program. These included schools, health sector, community organizations, children's aid societies, access mechanism (central intake point for services in community), and "other", which included faith-based organizations, recreation facilities, and other various sources.

Wait Times: Service providers reported the wait time for their program. Wait time was defined as the period from referral to when children began receiving the program, in days (MCYS, 2008). For the purpose of this secondary analysis, wait times were analyzed based on the primary functions, i.e., for a program that identified a particular function as a primary function, the wait was calculated for the program.

Funding for Services: Service providers indicated the total amount of funding received for each program. For this secondary analysis, a mean cost per child was calculated by

dividing the total amount of funding for each program by the total number of children served in the program. Given that the mean is highly sensitive to some large differences in program costs, the median cost per child was obtained by ordering all the values of cost per child from smallest to largest and identifying the middle point.

Original Mapping Survey: This refers to the original survey conducted and data collected by MCYS in 2008 from which secondary data analysis is being conducted in the current study. In the total database, there were 1502 survey records, representing distinct children's mental health programs that were delivered by MCYS-funded service providers in 2007/08 to serve children and youth (MCYS, 2009). While the mandate of MCYS is to serve children up to age 18, many programs continue to serve youth who have transitioned out of MCYS's mandate. Youth up to the age of 21 are also included where they are receiving services as provided under the *Child and Family Services Act, Ministry of Correctional Services Act* or *the Youth Criminal Justice Act.* (MCYS, 2008).

Secondary Data Analysis

Secondary analysis was undertaken using SPSS to filter the data into three overlapping groups referred to as the Children four to six subset, Children zero to six subset and Total Dataset.

The Total Dataset was created by filtering the original mapping survey data and selecting only those programs that served partially or exclusively children aged zero to six. Thus, the Total Dataset included any programs that served any number of children zero to twenty one. Programs in this group could have served a minority of children zero to six and a majority of children aged seven to twenty one. There were 588 programs serving 148,029 children in the Total Dataset.

There were 35,550 children aged zero to six and 22,580 children aged four to six were served by these programs.

The Children zero to six subset was created by removing the programs that indicated that children zero to six constituted less than 50% of their children served. I assumed, for the purpose of analysis, that these programs were either specifically targeted to the zero to six age group, or were serving a minimum of 50% children aged zero to six. If these programs were targeted to young children or serving young children primarily, then these programs likely consider their main priority to be children zero to six. This type of specialization is defined operationally as the expression of an organization's 'core business' or essential activity (Kotler, Keller & Cunningham, 2006). Differences were apparent when the Children zero to six subset was compared to the Total Dataset, where young children were not the "core business". There were 143 programs where 50% or more of the children served were aged zero to six. The total number of children zero to six served by these programs was 21,098.

The Children four to six subset was created by filtering the data to analyze wherever possible only the programs serving a majority of children aged four to six, and these children's needs. This decision was made in order to gain a better understanding of the profile of children served at this specific age group which coincides with the typical ages that children are transitioning to a formal school setting – junior kindergarten, senior kindergarten, and grade one. There were 79 programs where 50% or more of the children served were aged four to six. The total number of children four to six served by these programs was 6,563.

Limitations and Generalizability

A limitation of the research is that the original Mapping data is restricted only to the data collected on children aged four to six who "walked through the door". These data do not

sufficiently elucidate the unmet needs in populations, communities or the status of children and families who do not access services. Another limitation is that determining the effectiveness of mental health services provided to children aged four to six is beyond the scope of the original Mapping data and this subsequent secondary analysis. It is not possible from the data to know how Ontario's children transitioning to school with mental health needs are doing when they access MCYS-funded programs, or whether their transition to school is improved upon receiving services.

There were some specific limitations associated with the original MCYS Mapping dataset. Some provincial exclusions were agreed to across MCYS Regions (e.g., programs funded through MCYS's envelope for individual children with complex special needs, developmental services, autism services, child abuse programs, could be excluded). In addition, at the discretion of MCYS Regional Directors, some specific programs and services may have been excluded in certain regions or communities (e.g., programs provided in First Nations communities or early intervention programs delivered in Best Start locations or Early Years Centres). Given that some programs may have been eliminated where the four to six age group represented their core business, I reviewed other sources in order to paint a more comprehensive picture of the current state of the system. I conducted a public document review of MCYS and Ministry of Education legislation, policy statements, websites and service information related to community-based and school-based services that were in existence in 2007/08 and that are in practice today to address this limitation.

While MCYS Mapping provides a snapshot of MCYS-funded services it was not designed to provide information on specific presenting needs of individual children, supply versus demand of services, or local geographic factors that may explain apparent overlaps or gaps, informal

supports, effectiveness of service provision or outcomes for children.

The data are further limited by two issues related to the number of children served in the original Mapping data. The first issue relates to the definition of "children served". MCYS reported that 255,000 children and youth were served in distinct "episodes of service". However, a specific number of actual children and youth served is unknown, since children accessing community-based services are not individually identifiable through a unique identifier such as an Ontario Health Insurance Plan (OHIP) card. In the original MCYS Mapping survey, MCYS reported the total number of children served in terms of episodes of services, since individual children may have been served by more than one program, or more than once in the same program (MCYS, 2008). For the sake of clarity, "children served" is used in this paper.

The second issue relates to a flaw in the original survey design. Service providers were asked at different points in the survey to provide counts of the number of children served, for example according to gender, age group, and level of need. In some cases these counts did not reflect the same total. For example, the number of children served by age did not agree with the number of children served by gender. During analysis, these different datasets were compared using SPSS to see how different they actually were, once the data were cleaned. Differences were compared between the totals by age and the totals by gender. There were some very small inconsistencies. For example, the total by gender was 148,246 children served, while the total by age group was 148,029 children. This is a difference of 217 children, which amounts to only a minor 0.15% difference considering the total number of children served.

Despite the limitations outlined above, the original MCYS Mapping Dataset provides a rich starting point that allows for relevant exploratory analysis of the needs of young children and the services provided to them.

CHAPTER FOUR

Results

This section describes the findings of the secondary analysis conducted on data filtered from the original MCYS survey results (MCYS, 2009). Findings describe the profile of children served and answer the research questions. These findings are primarily focused on the Children four to six subset; findings related to the other datasets are included where they enhance the understanding of the Children four to six subset findings.

Profile of Children Served

The profile of children aged four to six is described based on the number of children served, their proportion in relation to other age groups served in programs, and the gender distribution of children served.

Number of children served.

As indicated in *Figure 1* below, the Total Dataset was comprised of 588 programs that included children zero to six (as well as other age groups). 148,029 children and youth were served in these programs. Of the Total Dataset, 24% (35,500) were children aged zero to six. Fifteen percent (22,580) were children four to six. Sixty-four percent of children in the zero to six age group were children aged four to six.

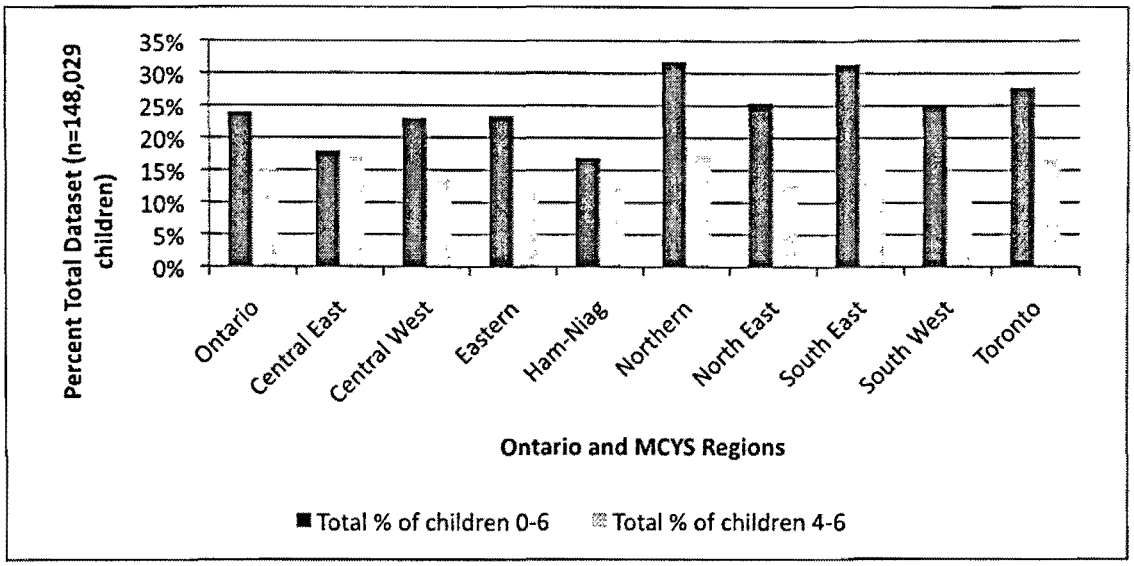


Figure 1: Percent of Children in Total Dataset Age 0-6 and 4-6

Number of children served in programs targeted to their age group.

As indicated in *Table 4* below, 29% of children aged four to six were served in programs that were targeted to their age group (in which children four to six constituted 50% or more of children served); consequently, seventy one percent of children four to six were served in programs that are not specifically targeted to their age group. By comparison, 59% of children zero to six were served in programs that were targeted to their age group (in which children zero to six constitute at least 50% of the children served), while 41% of children zero to six were served in programs in which children zero to six constituted less than 50% of children served. In the zero to three age group, 45% of children were served in programs targeted to their age group while 55% were served in programs that were not targeted to their age group. It appears that the vast majority (97%) of children aged seven to twenty one were served in programs targeted to their age group; less than 3% were in programs that were not targeted to their age group.

Table 4: Percent of Children in Programs Targeted to their Age Group

	Total Dataset (n=588 programs)			Proportion of children being served in programs targeted to them (more than 50% children in their age group)			Proportion of children being served in programs not targeted to them (less than 50% children in their age group)		
Age	Children served	% Total children served	Programs	Children served	% Within age Group	% Total children served	Children served	% Within age Group	% Total children served
0-6	35,500	24%	143	21,098	59%	14%	14,452	41%	10%
0-3	12,920	9%	48	5,789	45%	4%	7,131	55%	5%
4-6	22,580	15%	79	6,563	29%	4%	16,017	71%	11%
7-21	112,529	76%	448	109,602	97%	74%	2,927	3%	2%
Total (0-21)	148,029	100%	588	121,954	-	82%	26,075	-	18%

Gender distribution.

As illustrated in *Table 5*, in the Total Dataset, 57% of children served were boys, and 43% were girls. In the Children zero to six subset, there were 54% boys and 45% girls. In the Children four to six subset, there were 66% boys and 34% girls.

Table 5: Gender Distribution, Ontario

Dataset	Boys (%)	Girls (%)
Total Dataset	57%	43%
Children 0-6 Subset	54%	46%
Children 4-6 Subset	66%	34%

There were some pronounced regional variations. For example, in the Children zero to six subset, Central East had 76% boys and 24% girls, and South East had 63% boys and 37% girls. Eastern and Northern had more girls and than boys. In the Children four to six subset, as indicated in *Table 6*, Central East had 77% boys and 23% girls. South East had the smallest difference, with 59% boys and 41% girls.

Table 6: Gender Distribution, Children 4-6 Subset, Ontario and Regions

Region	Boys	Girls
Ontario	66%	34%
Toronto	65%	35%
Central East	77%	23%
Central West	63%	37%
Eastern	63%	37%
Hamilton-Niagara	66%	34%
Northern	62%	38%
North East	66%	34%
South East	59%	41%
South West	67%	33%

Question One: What are the mental health needs of children aged four to six?

The first question asked through this secondary analysis of the Original Mapping Dataset was intended to better understand the profile and needs of children served who are aged four to six. The findings provide information about the number and gender of children served, children's level of need (level 1 representing lowest level, and level 4 representing highest level), and the prevalence and types of additional needs, as reported by service providers.

Level of need.

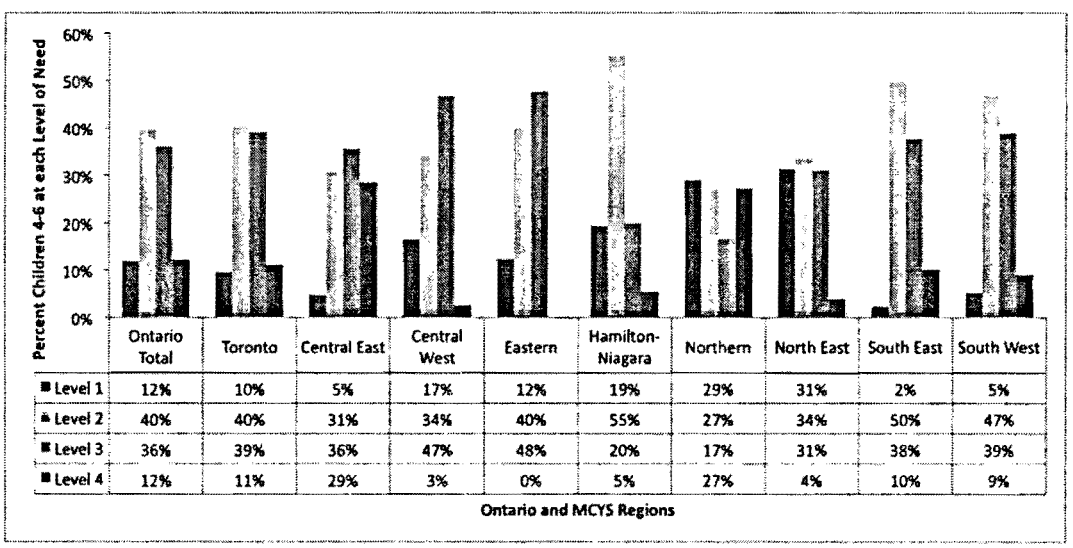
Table 7 below shows the percentage of children served in Ontario by each of the four reported levels of need.

Table 7: Level of Need, Ontario

Dataset	Level 1	Level 2	Level 3	Level 4
Total Dataset	13%	27%	36%	22%
Children 0-6 Subset	21%	41%	28%	10%
Children 4-6 Subset	12%	30%	46%	12%

In the Children four to six subset, the majority of children were identified as having Level 3 needs (46%) and Level 2 needs (30%). Twelve percent of children were identified with Level 1 and Level 4 needs, respectively.

As can be seen in *Figure 2* below, there were some marked regional variations. For example, in the Children four to six subset, Hamilton-Niagara and South East had a higher number of Level 2 children than the Ontario average, at 55% and 50%, respectively. There were 48% children identified as Level 3 in Eastern and 47% in Central West. There were no Level 4 children identified in Eastern Region, but in Northern Region, 27% in the Children four to six subset were Level 4.



	Ontario Total	Toronto	Central East	Central West	Eastern	Hamilton-Niagara	Northern	North East	South East	South West
Level 1	12%	10%	5%	17%	12%	19%	29%	31%	2%	5%
Level 2	40%	40%	31%	34%	40%	55%	27%	34%	50%	47%
Level 3	36%	39%	36%	47%	48%	20%	17%	31%	38%	39%
Level 4	12%	11%	29%	3%	0%	5%	27%	4%	10%	9%

Figure 2: Percent of Children at Each Level of Need, Children 4-6 Subset, by Region

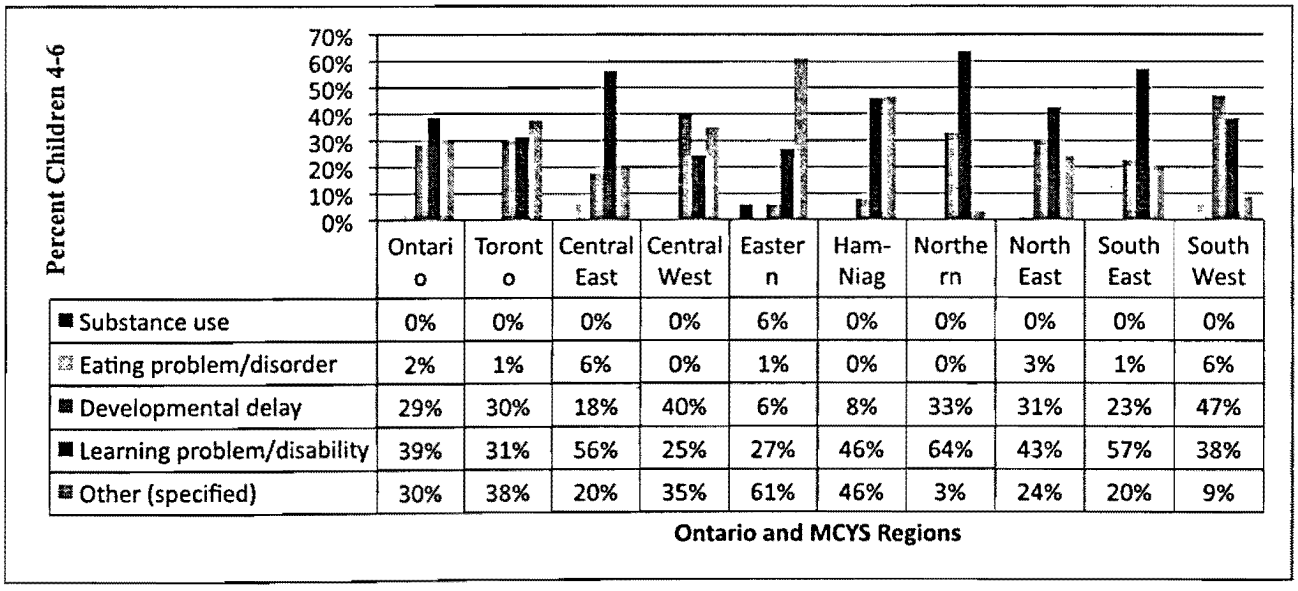
Children with additional needs.

Table 8 below shows the levels of additional needs in all datasets for children served across the province.

Table 8: Level of Additional Need (selected), Ontario

Dataset	Total	Learning Disorder	Developmental Disability	Other
Total Dataset	53%	40%	15%	24%
Children 0-6 Subset	29%	31%	27%	31%
Children 4-6 Subset	14%	39%	29%	29%

As indicated in *Figure 3*, 14% of children (n=3,107) were identified with additional needs in programs in the Children four to six subset. Thirty nine percent of these had a learning disability; 29% had a developmental delay; 2% had an eating disorder, 0.3% had a substance use problem; and 29% had another identified need under the category "other" some of which were identified as: Autism and ASD, attachment disorder, medical (unspecified) FASD, complex needs, ADHD, anxiety, family distress, victims of abuse, and speech and language, and others.



	Ontario	Toronto	Central East	Central West	Eastern	Ham-Niag	Northern	North East	South East	South West
Substance use	0%	0%	0%	0%	6%	0%	0%	0%	0%	0%
Eating problem/disorder	2%	1%	6%	0%	1%	0%	0%	3%	1%	6%
Developmental delay	29%	30%	18%	40%	6%	8%	33%	31%	23%	47%
Learning problem/disability	39%	31%	56%	25%	27%	46%	64%	43%	57%	38%
Other (specified)	30%	38%	20%	35%	61%	46%	3%	24%	20%	9%

Figure 3: Children with Additional Needs in Children 4-6 Subset

Question Two: What mental health services are currently provided for children aged four to six?

The second question examined through the secondary analysis of the original Mapping dataset was designed to analyze the types of services provided to children aged four to six. Findings included information about the primary mental health functions of each program, wait times, referral sources and funding for programs.

Primary functions serving children aged four to six.

Figure 4 below shows the percentage of programs that included the particular function as their first primary function, as well as the percentage that included the function as any one of their four primary functions. In the Children four to six subset, the most common first primary function was intervention, which was ranked as first primary function in 48% of programs (n=38). This was followed by early identification at 20% (n=16), then assessment at 19% (n=15), and finally early intervention, at 10% of programs (n=8).

In addition to looking solely at the first primary function, the data were analyzed to identify service providers' top four ranking functions. This provides a different identification of the most frequently provided functions. In the Children four to six subset, family/caregiver support was identified as among the top four functions in 80% of programs, followed by intervention/treatment (71%), assessment (68%) and early intervention (46%).

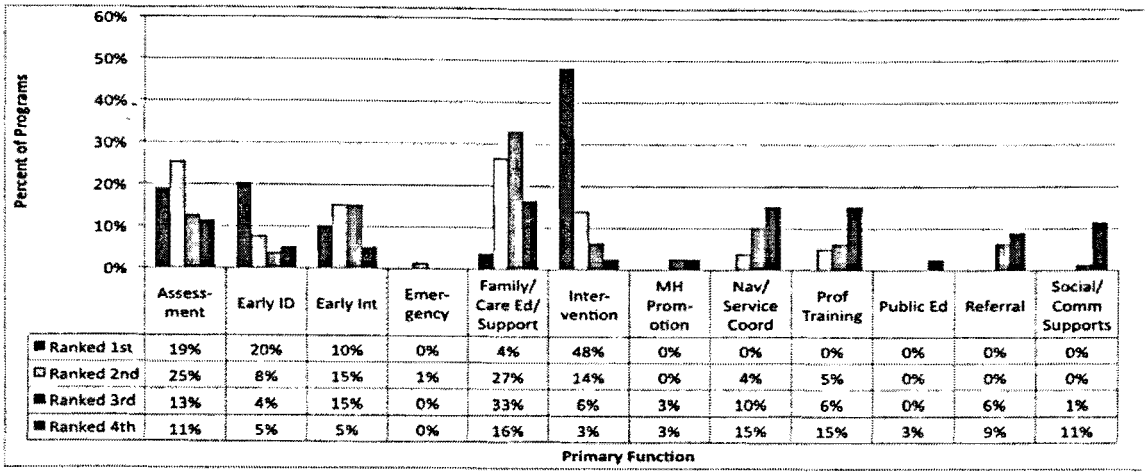


Figure 4: Programs with Primary Functions, Children 4-6 Subset, Ontario

Referral sources to programs.

As indicated in *Table 9* below, the Children four to six subset included a wide variety of referral sources across regions. For all Ontario service providers in this subset, 37% of referrals came from family/self, 17% from the access mechanism, 11% from health care/hospital. Programs in Hamilton-Niagara received all their referrals through the access mechanism, and family/self was the most common other referral source across regions.

Table 9: Percent of Referrals by Source, Children Four to Six Subset, by Region

Region	ON	Toronto	CE	CW	Eastern	H-N	North	North East	South East	South West
Health Care Provider/Hospital	11%	30%	4%	20%	5%	0%	1%	8%	3%	6%
Youth Justice	0%	0%	0%	0%	3%	0%	0%	0%	0%	0%
Family/Self	37%	17%	54%	17%	60%	0%	8%	26%	74%	62%
Access Mechanism	17%	0%	1%	36%	3%	100%	62%	0%	0%	1%
Community	5%	4%	16%	1%	1%	0%	0%	12%	1%	9%
School	9%	29%	4%	0%	12%	0%	15%	3%	5%	2%
Child care	8%	9%	16%	5%	1%	0%	12%	19%	7%	6%
Children's Aid	6%	5%	1%	7%	8%	0%	3%	22%	8%	7%
Other	6%	6%	4%	14%	6%	0%	1%	10%	2%	8%

Wait times.

Table 10 below displays the average length of time that children four to six waited to receive service for selected primary functions. Across Ontario children waited an average of 89 days for programs in which intervention/treatment was identified as a primary function, 72 Days for assessment, 81 days for family/caregiver support, 46 days for early identification, 53 for early intervention, 48 days for referral. Toronto, Hamilton-Niagara and Central-West had the longest wait times for most functions.

Table 10: Mean Wait Time (Days), Selected Primary Functions, Children 4-6 Subset

Primary Function	ON	Toronto	CE	CW	Eastern	H-N	North	North East	South East	South West
Assessment	72	109	66	90	94	110	65	16	33	58
Early ID	46		45	146		100	33	12	57	47
Early Int	53	69	52	93	50	100	32	25	48	45
Family/Care Ed/Support	81	143	53	97	129	106	36	17	97	57
Intervention/Treatment	89	127	69	55	128	110	87	18	127	56
Referral	48	20	60	120	10			15	21	120

Note: blank fields indicate that no program in the region identified the function as one of its primary functions

Funding for services.

The total amount of funding for programs in the Total Dataset was $225,755,386. *Table 11* shows the provincial cost per child based on mean and median measurements. In Ontario, the mean cost per child in the Children four to six subset was $4,543, and the median was $2,497.

Table 11: Cost per Child – Mean and Median, Ontario

Dataset	Mean	Median
Total Dataset	$3,916	$1,678
Children zero to six Subset	$4,242	$1,996
Children four to six Subset	$4,543	$2,497

As seen in *Figure 5* below, there is significant variation in mean cost per child across regions. Toronto is very high compared to others, at $10,677 per child in the Children four to six subset. The next highest was Eastern, at $5,345. The lowest was in South West, at $2,413.

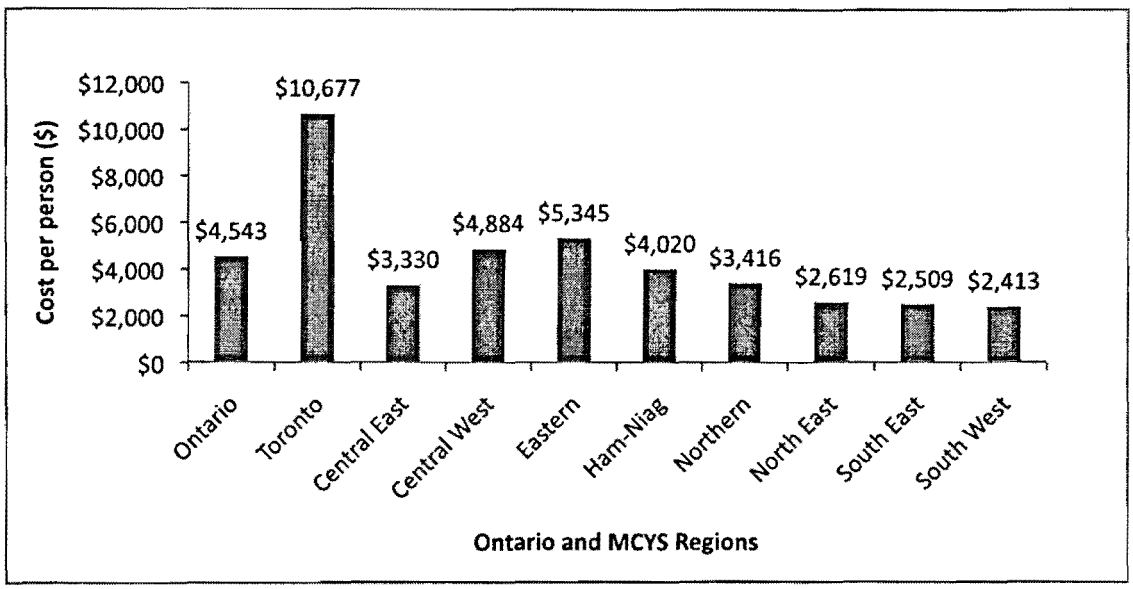


Figure 5: Mean Cost per Child, Children 4-6 Subset, by Region

Summary of Findings

The findings identified the profile and needs of children served aged four to six, including the number and gender of children served, children's levels of need and additional needs. Additionally the findings revealed the types of services received, including primary mental health functions of each program, wait times for specific functions, referral sources, and program costs per child. Age group specific and regional variations were identified.

Overall, the findings indicate that children four to six are a unique population receiving a wide range of services to meet a continuum of needs. Significantly more boys than girls are receiving services. The profile of children receiving services, types and frequency of mental

health programs and functions delivered, wait times and funding spent per child all vary considerably across regions. These findings will be discussed in the next chapter.

CHAPTER FIVE

Discussion

The purpose of this study was to conduct a secondary analysis of the MCYS Mapping Dataset in order to examine the following questions in the Ontario context:

1. What are the mental health needs of children aged four to six?
2. What mental health services are currently provided for children aged four to six?

The results identified the profile and needs of children served aged four to six, including their number and gender, level of need, and the prevalence and types of additional needs, as reported by service providers. The results also identified the range of services provided to children aged four to six with an emphasis on primary mental health functions of each program, wait times, referral sources and funding for services

Data was analyzed for the province as a whole and broken down by MCYS Regions. In general the findings show that there are thousands of young Ontario children receiving a wide range of services to meet a continuum of needs, the majority of which are at higher levels of need that include moderate or significant impairment at home, school, and/or in the community. Significantly more boys than girls are receiving services. The profile of children receiving services, types and frequency of mental health programs and functions delivered, wait times and funding spent per child all vary considerably across regions.

Key Themes

The following sections examine key themes that emerged from the findings, their relation to theory and practice as outlined in the literature presented, and the potential for additional data sources to help provide further insights. The key themes are:

1. Children four to six have needs that span a continuum of severity and complexity, and show significant variations across regions.
2. Mental health services and functions may not match the needs of children four to six and their families or the demand for services, and show significant variations across regions.
3. Many sectors are involved in meeting the needs of young children with mental health problems.

1. Children four to six have needs that span a continuum of severity and complexity, and show variations across regions.

Number of children served.

A significant number of young children are served by MCYS-funded mental health services. The group of 35,500 children aged zero to six constituted 16% of all children and youth served by MCYS-funded services in the Original Mapping exercise (MCYS, 2009). Children aged four to six represented the majority (64%) of young children zero to six served in programs targeted to children zero to six. A total of 22,580 children aged four to six were served by MCYS-funded mental health services in 2007/08.

Despite these numbers, the findings suggest that MCYS-funded programs are not serving as many young children as would be expected based on prevalence data. If 15 to 21 percent of children in kindergarten may have mental health problems, this suggests a range of 35,835 to 50,169 children who may have mental health needs in the 2007/08 academic year (Ministry of Education, 2010). As we have seen through this secondary data analysis, 22,580 children aged four to six were served. Taking into account that the definition for "children served" includes children who may have received more than one service, there are potentially thousands of

children whose needs have not been identified or treated though MCYS-funded services.

The findings highlight the need for additional information to better understand the number of children accessing services, the number who may not be accessing needed services despite having mental health needs, and the other sources of support that children and families may be accessing in their communities, such as health care professionals and privately-funded services.

Gender distribution.

The findings revealed significant gender differences. According to each of the datasets, boys dominated service use. These gender differences, 66% boys compared to 34% girls, were especially pronounced for Ontario children aged four to six. Some regional variations were particularly notable. For example, in Central East, boys represented 75% of all children served in the Children zero to six subset, and in North East and South East Regions, boys comprised over 60% of children.

The literature review supports these findings. Preschool-aged boys tend to be diagnosed with externalizing conditions more frequently than girls (Carter et al., 2010; Egger & Angold, 2006) and boys with externalizing conditions tend to be more frequently referred to services (BCFPI, 2008). While MCYS-funded services are responding to a significant need for boys accessing services, what remains unclear from the findings is whether boys are accessing the appropriate service for their level of need.

Another way to look at this disproportionate prevalence of boys in services is to consider whether current structures and supports for boys are pathologizing normal boy behaviour at this age. Are boys being identified as problematic for externalizing behaviours that push the boundaries in certain home, school or community environments? The literature supports this

possibility, particularly in institutionalized settings such as early learning environments and preschools, where, as Thomas and Loxley (2001) have reported, the teacher's need for organization and structure in a class of twenty students tends to focus deficits on "inappropriate" children rather than on the environment as a whole. Indeed, despite the debate about the intent of school readiness theories and practice, focus continues to be place on the need for children to be modified through clinical intervention in order to accommodate their environment or the expectations of their teachers and caregivers (Egger & Angold, 2006).

In addition, we cannot theorize about the reasons for increased prevalence of boys in services without wondering about another gap in the findings - where are the girls? The literature underlines that many young children, particularly girls, experience higher levels of internalizing disorders, yet they are not accessing services. It may be that their problems are not considered to be disruptive enough at home, in preschool or in the community to be considered by teachers to warrant intervention.

However, based on the findings alone, it is unclear why there are such pronounced provincial and regional gender differences. The findings of this study do not address access issues or questions of unmet needs that may be experienced by children who are not accessing services. More information is needed from additional sources to better understand the extent of this potential gap in service.

Levels of need and concurrent needs.

The majority of children aged four to six accessing services were identified as having moderate or significant mental health problems that affected their functioning at home, school or in the community. In Ontario overall, 76% of children aged four to six had needs identified by service providers as Level 2 or Level 3 (experiencing moderate or significant mental health

problems/illness), and 12% were identified with Level 4 needs (experiencing the most severe, complex, diagnosable mental illness).

However, there were other significant regional variations in terms of levels of need. For example, the percent of children four to six with Level 4 needs across regions ranged from 0% in Eastern to 27% in Northern and 29% in Central East. Similarly, the percent of children four to six with Level 1 needs ranged from 2% in South East to 29% in Northern.

Although the original Mapping survey asked service providers to identify the level of need of children accessing services, there is a significant gap in the data as a result of the fact that service providers reported only the *additional* needs, not the first problems that brought children into services. Other data sources are required in order to better understand the presenting problems.

Additional needs were shown to be prevalent in younger children receiving MCYS-funded services. Provincially, 14% of children in the Children four to six subset were identified by service providers as having an additional need to the mental health need that brought then in for service. The most common additional needs identified were learning disabilities (39%) and development delays (29%). While the data do not provide a reason for these additional needs being prevalent, these findings may be correlated with the extent to which assessment and early identification tools are being applied depending on the region. However, there are substantial variations in the types and occurrence of additional needs across regions. For example, 25% of children in the Children four to six subset in Central West were identified with learning disabilities, while 64% were found in Northern. Similarly, only 6% of children in the Children four to six subset were identified with development delays, while the percentage in South West rose to 47%. These variations may indicate regional inconsistencies in the frequency and nature

of assessments that direct young children to the appropriate service. "Other" additional needs identified in the Children four to six subset were also wide-ranging, spanning from 3% in Northern, all the way to 61% in Eastern. These needs included environmental factors, such as housing, family distress, victims or witness of violence, and other factors, which demonstrate the extent to which young children with mental health needs are products of their ecological conditions and environment.

The findings related to the profile and needs of children aged four to six show significant variations across the province. The data presented cannot provide explanations for these variations. Additional information is needed in order to understand the factors that impact the presenting needs of children accessing services, or variations in the timeliness of appropriate assessments in order to begin addressing needs at the right level of service.

2. **Mental health services and functions may not match the needs of children four to six and their families or the demand for services, and show variations across regions.**

   Programs targeted to age group and level of need.

Young children are being served in programs where the majority of children are older, or in programs for whom their age group is not the program's "core business" - defined as programs in which children of the age group constituted at least 50% of the children served by the program. The findings show that mental health services are not designed for younger age groups: 71% of children four to six in Ontario are being served in programs which are not targeted to them; and similarly, 41% of children zero to six are being served in programs that are not targeted to them. By comparison, only 3% of children seven to twenty one are served in programs that are not targeted to them. What implications might this have for the quality, appropriateness or specificity

of programming to serve this unique population? It is conceivable that children aged four to six are receiving universal prevention programs provided to all age groups at once, rather than targeted interventions, despite the fact that the majority of children four to six accessing services (76%) are experiencing moderate to significant mental health issues warranting specific services.

These findings are particularly notable in light of the literature on school readiness that highlights the significant and unique challenges encountered by young children starting school (Janus, Lefort, Cameron & Kopechanski, 2007). Notwithstanding that there are additional provincially-funded prevention services, such as Early Years Centres, providing some early intervention services in communities, it appears from these findings that most children aged four to six with moderate and significant mental health needs are being served in mental health programs that are not targeted to their age or level of need. The inference can be made that most children who are transitioning to school settings with needs that warrant targeted services are not receiving them.

This is reinforced when we compare the Children four to six subset and the Total Dataset. The majority of children in the Total Dataset were assessed at Level 3, that is, children who are experiencing significant mental health problems/illness. There were few children assessed at Level 1 (not at risk/not experiencing mental health problems). The expectation is that more targeted, intensive interventions must be delivered in order to serve the higher level of need. It was noted that, throughout the datasets, intervention/treatment was the most common primary function. The question that emerges, then, is how young children with Level 2 and Level 3 needs (moderate or significant mental health problems/illness) are being adequately served in intervention/treatment programs whose target population includes children ranging from zero through to 21 years of age. This is particularly problematic in terms of the literature that has

identified the complexity and range of issues for children transitioning to school particularly for those with special needs (Janus et al., 2007).

Again, it must be noted that there were significant variations in levels of need across regions, but these data on their own do not explain why. It may be that what service providers identify as their "core business" is where they direct most of their resources, what they do most effectively, and that specialization in a particular age group or level of need is an appropriate way to organize specialized service delivery. On the other hand, many service providers that provide services in less populated, rural or remote areas, may best meet the diverse needs of children and families through the provision of integrated services in their communities. More information is needed to better understand the distribution of services in different communities and regions of the province, and local decision-making related to service provision.

Wait Times.

The findings indicated that there is a high demand for services across the province. In some regions, children are waiting over four months for primary functions such as assessment and intervention/treatment. In the Children four to six subset, for the Ontario average, children waited an average of 89 days for programs in which intervention/treatment was identified as a primary function, 72 days for assessment, 81 days for family/caregiver support, 46 days for early identification, 53 early intervention, 48 days for referral. While there were no programs that identified emergency services as one of their primary functions for Children four to six, Children zero to six, however, are waiting on average 23 days for emergency services.

Regional variations were remarkable. In Central West, children four to six needing early intervention waited 146 days on average. In Toronto, children four to six waited an average of 109 days to be assessed, then another 127 for intervention/treatment and 143 for family/caregiver

support programs. Similarly in Hamilton-Niagara, children four to six waited 110 days for assessment, then 110 days for intervention/treatment, and at least 100 days for early identification, early intervention or family/caregiver support programs. In contrast, no North East wait times for functions exceeded 25 days: children waited only 16 days for assessment and 18 days for intervention/treatment in that region.

Some regions have similar wait times across all their primary functions; for example, in Hamilton-Niagara, the wait times for all primary functions range between 100 to 110 days for children four to six. Others vary significantly. For example, in South West, the average wait time for children four to six for programs whose primary function is assessment is a relatively short 33 days; however, once they have been assessed, children must wait 127 days for intervention/treatment.

The findings in themselves cannot explain the intra- and inter- region variations. More information is needed in order to better understand regional pressures that result in longer wait times and the impact that these wait times have on young children's health and development. Other data sources may also help identify whether children in this age group are receiving services from other sources, such as emergency services from primary health care (hospitals or clinics).

Additional questions related to wait times require consideration. The determination of what are reasonable wait times, how long is too long to wait, whether children in this age group should ever have to wait for any service or function, are all questions that must be addressed when considering how best to meet the needs of young children with mental health issues.

Cost per child.

As with all the other findings, there were wide variations in cost per child across the province. The Ontario mean was $4,543, which spanned from South West at $2,413 to Toronto at $10,677. Toronto's comparatively high costs suggest the subset was skewed by a few programs with very large costs. When the costs are analyzed in terms of the median, the Ontario median was $2,497, which is closer (but still much higher) to the Ontario mean of $1,398 calculated in the Original Mapping Exercise (MCYS, 2009).

While the variations are striking, the data do not provide insights into the reasons for such dramatic differences in costs. It is conceivable that higher costs in some regions are due in part to the proliferation of specialized services in urban areas, or the existence of academic centres, hospitals or specialized programs that serve out-of-region children. There are many more questions that emerge, however, including: Why are there such great variations across regions to deliver similar programs? What is the right amount of spending? Are the regions spending less money per child providing lower quality services, while those with higher spending are providing better quality? Is it equally possible that those spending more are overspending, while those spending less are at the right level to deliver appropriate services? More information is needed in order to establish benchmarks for costs.

3. Many sectors are involved in meeting the needs of young children with mental health problems.

The findings related to the types of primary mental health functions provided, as well as the range of referral sources to MCYS-funded service providers drew out the importance of the ecological environment surrounding children four to six with mental health needs.

Primary functions.

In terms of primary functions, the findings suggest that, though intervention provided directly to individual children may be assumed to be the most important service provided by MCYS-funded service providers, intervention alone cannot adequately support families whose children have mental health needs, especially in the early years. For example, while the intervention function was identified by service providers as the predominant first ranked function for children four to six (48% of programs identified Intervention as their top ranking function), overall across the top four functions, family/caregiver support programs were the most common function provided to young children and their families (80% of programs identified family/caregiver support as among their top four ranking functions). Family/caregiver support programs were defined as those "providing a broad range of information, education, resources and support for families, targeted at facilitating growth and enhancing their capacity to support children/youth with mental health problems/disorders by responding effectively to their needs" (MCYS, 2008). Similarly, assessment, which was only the third most common top ranking function at 19%, was ranked among the top four functions by a much larger 68% of programs. It may be inferred that many different service providers are providing a range of services, including assessment and intervention, as opposed to specializing in providing specific functions. Further study would help to identify whether there are duplications or gaps in service provision in particular communities that could merit restructuring or integration to maximize the use of limited resources in those communities.

Referral sources.

Findings related to referral sources help indicate the degree of effectiveness of cross-sectoral collaboration. For example, in Central East the most important referral source is schools indicating close working relationships between service providers and schools to build effective referral patterns and protocols as children transition to school and throughout their primary and secondary schooling. One way of looking at this is that Central East Region's Community Planning Table support of Community Partners with Schools (COMPASS) effectively links community mental health service providers and supports to schools to enhance healthy child and youth development, support effective school transitions, and reduce social, emotional, or behavioral barriers to learning. (Short et al., 2009). However, an opposing critical view could be that Central East has failed to establish equally effective referral patterns with other key partners, such as those from the health sector.

Similarly, the data showed that Family/Self referrals are most common in most regions in the Children four to six subset, for example in South East (74%), South West (62%) and Eastern (60%). On one hand, these patterns suggest that service providers and communities have made successful efforts to ensure that families are aware of services and are able to access them. On the other, this could be interpreted as a lack of coordination among sectors because referrals are not coming from other child serving sectors such as community partners, educators and primary health professionals who are in regular contact with children aged four to six.

While these regional variations may demonstrate the extent to which communities have maximized their strengths or prioritized their relationships with other sectors, would it not be reasonable to expect all regions to have strong, effective referral practices in place across all sectors? And, perhaps the more important consideration, in the end, is not how many different

referral sources are at work, but whether the kids that need to be referred are being referred competently and appropriately. This highlights the need for collaboration across all sectors.

More Questions Than Answers

Perhaps the most revealing finding in this secondary data analysis is not how much we have learned, but rather how much we do not know about needs and services for children age four to six in Ontario. Provincial policy must take into account regional differences, gaps and strengths. In order to plan and fund effectively, policy makers need to know what underlies the regional discrepancies. Are they for instance due to variations in access to services, community reticence to seek help or lack of comprehensive assessment tools? More robust information would point the way to meeting the demands for service and creating the systemic conditions so that communities build on their strengths and focus on areas for improvement with some local flexibility.

Further, what conclusions can be made about the amount of variability across the province? On the one hand, these data may be demonstrating the effective ways that regions are adapting and responding to the presenting needs in their communities, building relationships with certain sectors to respond to these needs, and maximizing the use of limited resources. However, if we were creating a children's mental health system from scratch, would we plan for this type of variability? Or would we expect achievement of minimum standards in all areas in an idealized model?

Suggestions for Further Research

It is not possible to know from this data how Ontario's children aged four to six starting school with mental health needs are doing when they access MCYS-funded programs, or whether their transition to school is improved upon receiving MCYS services. Combining survey

data from service providers with other data sources, such as provincial intake and outcome data for children aged four to six, would shed light on specific areas of interest and concern, such as the pronounced disproportion of boys receiving services, the lack of information about specific presenting needs, and the regional and age variations in levels of need. Finally, additional data sources are required to understand the total population of children starting school in Ontario, not just those who have accessed services, to gauge how well communities and schools are supporting their mental health and development. These will be discussed in the recommendations following.

Key Recommendations

Pragmatic recommendations for improvement include a focus on a province-wide system that is based on knowledge and data, led by MCYS and supported through and for communities. With a focus on improved early identification and assessment mechanisms, it is possible to ensure that children transitioning to school have access to the supports they need when they need them. With enhanced use of schools and improved capacity of schools to work in collaboration with communities, an integrated service delivery system that can be monitored and measured in communities will provide the necessary local and provincial knowledge. These are technical challenges that could be addressed within a short time frame to immediately improve the quality, effectiveness and accountability of MCYS-funded services.

Recommendation 1: "What gets measured gets done": Improve provincial and community-based knowledge and reporting about transition-aged children

This secondary analysis has shown that the province has incomplete information about its services, the mental health needs of children transitioning to school, the unmet needs of children who may not be accessing services, and the effectiveness of programs to improve outcomes.

MCYS must lead the way in the children's mental health sector to create and nurture the conditions for the regular and rigorous collection of data about its funded programs, the children it serves, and the children who may yet be accessing needed services. In 2007/08, MCYS spent approximately $502 million on children's mental health in the province (Auditor General, 2008). It is unclear to what extent provincially-funded services are accountable to the public as a whole and to the children and families they are designed to serve.

Mandate intake and outcome tools to better understand children's presenting needs and measure how well children are doing in service.

The province should develop mechanisms for continuous monitoring of the appropriateness, effectiveness and outcomes of MCYS-funded services to better enable provincial and community decision-making based on evidence. The mandated use of standardized instruments by all MCYS-funded service providers is one key step.

An example of such a tool is the Brief Child and Family Phone Interview (BCFPI), a standardized intake and assessment tool that is currently used by MCYS-funded service providers accredited by Children's Mental Health Ontario. The BCFPI provides information on the nature and severity of mental health problems faced by the children accessing services. It is administered through interviews with parents or teachers at the time of referral and throughout the course of treatment (Cunningham, Pettingill & Boyle, 2006). Specifically, the BCFPI allows

parents to describe the nature of the issue and helps determine the impact on child functioning, the parent's mental health and functioning, and the family functioning as a whole. The tool also gathers basic demographic information about the child's environment, including family and socio-economic status. The BCFPI situates children's presenting problems within the ecological environment to better understand the risks and protective factors that may influence child and family outcomes.

Currently, the BCPFI is used at intake for children aged 6 to 18; children outside this age span are grouped as "other" in the publicly available annual reports (BCFPI, 2008). However, a review of the 2008 report for children aged 6-18 shows the potential for BCFPI to illuminate the profile of young children accessing service. BCPFI can provide key information on the impacts of children's issues on the family functioning, the socioeconomic status and education level of parents, their readiness to engage in intervention services, and the prevalence of parental depression and stress (BCFPI, 2008). The report shows that 281 girls and 609 boys aged 6 entered services in 2008; 51% were boys and 45% were girls presenting with oppositional defiance disorder; parental depression was associated with 26% of new cases, and parents cited that the child's presenting problem caused them difficulties in terms of family comfort, social participation and engaging in family activities (BCFPI, 2008). A customized report from 2009 displayed parent/caregiver reasons for referral for children aged zero to five during the July to September 2008 period, indicating that behaviours that brought parents to seek mental health services for their children were aligned with oppositional defiance disorder and ADHD when the children were boys, and anxiety disorders for girls (BCPFI, 2009). These few examples demonstrate the potential for a standardized intake tool to provide rich data regarding children accessing services that can be compared over time and associated with other data sources.

Linking intake data about parent and family functioning, socioeconomic and other demographic information, with information gleaned from the secondary analysis underlines the appropriateness of service providers' majority focus on providing the function of family/caregiver support to address young children's mental health, given that children's mental health problems affect the whole family and are related to their ecological environment.

Despite its potential, the BCFPI is currently used by fewer than one third of MCYS-funded service providers, and reports do not provide a breakdown of children under six. The use of a standardized intake and assessment tool, such as BCFPI or an equivalent instrument, should be mandated for use by all MCYS-funded service providers at the beginning of service, through service planning, and at the end of service, for all age groups that MCYS funds.

Similarly, the Child and Adolescent Functional Assessment Scale (CAFAS) is a standardized outcome assessment tool that is currently in use by a small number of community-based mental health service providers in Ontario. CAFAS assesses the degree of functional impairment in children aged six to eighteen receiving services based on eight scales related to: School/Work, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behaviour, Substance Use, and Thinking (CAFAS, 2009). The CAFAS is optimally designed for use at the beginning and end of treatment, as well as during the course of treatment to monitor how well children receiving services are doing. For example, the 2008 report indicated that 26,974 cases (or children aged six to eighteen) were treated in that year, with more boys than girls receiving services (57% versus 43%). Of the cases that included an exit CAFAS, 74% of children showed improved functioning by the end of service (CAFAS, 2009). However, despite the evidence that measuring outcomes leads to improved treatment and provides evidence of

quality and appropriateness of services (CAFAS, 2009), outcome data is currently available for less than 5% of MCYS-funded services (MCYS, 2009).

Given its potential to monitor outcomes, the use of a standardized outcome measurement tool such as CAFAS, PECFAS (Preschool and Early Childhood Functional Assessment Scale), or an equivalent instrument, should be mandated for use by all MCYS-funded service providers at entry to service, through service planning, and at the end of service, for all age groups.

Conduct community needs and assets analysis that supports children and families in the ecological environment, through the lifespan.

Programs to address the mental health needs of young children transitioning to school must be informed not only by MCYS service providers through mandated tools, who identify children coming through the doors or waiting on their wait lists, but also on data gathered from other sources that screen for potential problems at a population level. The combination of these data helps to describe the environment and ecological factors that have an impact on school readiness for many children, including those with mental health problems.

Mustard and Young (2007) have stated that tools with the most potential for assessing the outcomes of early childhood and areas of vulnerability are those that are science-based and intended for population-level analysis. An example of an effective, psychometrically sound, population-based measure of school readiness is the Early Development Instrument (EDI). Since 1999, EDI has been used to collect data on the readiness of children for school at entry into grade one. The EDI is a population-based tool designed to assess early development in five domains related to school readiness: physical health and well-being; social knowledge and competence; emotional health/maturity; language and cognitive development; and general knowledge and communication skills (Janus & Offord, 2007). Senior kindergarten teachers complete child-

specific questionnaires halfway through the year, and data are then aggregated at community level to provide a snapshot of how a community is doing. EDI data has been combined with other population-level data, such as the existing inventory of community resources, socioeconomic indicators, and other contextual data, to better understand the ecological context and put in place protective factors where warranted (Hertzman & Bertrand, 2007). For example, the Region of Peel, which includes Mississauga, Brampton and Caledon, discovered through EDI scores that 30% of their children were not ready for school based on vulnerabilities in several domains. In response, they developed a social risk index for all Peel communities that included socio-economic, employment, education level, housing, linguistic, immigration and family structure indicators to help map vulnerabilities and plan services (Grieve, 2009). By combining many data sources, including EDI scores, actions were identified, including the implementation of Early Years hubs, Best Start locations and Parenting and Family Literacy Centres, a Kindergarten Intervention Program and other supports.

Further research is required to understand potential limitations, however. For example, EDI's perception of school readiness includes measures to assess children's ability to sit quietly in class and follow instructions: implications exist for pathologizing children rather than adapting settings to accommodate learning styles. This may be particularly problematic in situations where personality conflicts in the teacher-child dyad affect teachers' bias in completing the EDI. However when viewed as a proxy measure for children's capacity for self-regulation, which is an important predictor for later adjustment, the EDI provides some valid information about the potential disconnect between the classroom environment and children's readiness to be there.

Despite this potential limitation, the EDI is a powerful population-based tool for schools and communities to collect important data on the weakest areas of school readiness for children

in their neighbourhoods and communities, and inform their decision-making on the development of community programs to improve early development. Provincial implementation of such a tool must be viewed as one of several indicators of community health and of the community's shared responsiveness to meeting the developmental needs of all children that help reduce inequities in access to good educational opportunities for all children.

The province need not, and indeed, should not, do this alone. Evidence-based information about the specific needs in communities and the quality and effectiveness of funded services can be collected from multiple sources, with communities working together to build on strengths and focus on areas of improvements that meet the needs of children and families in communities.

Some communities are doing this already. Halton Region, which resides within MCYS's Central West region, has developed a *Vision for Children in Halton Report Card* (Halton, 2009) using many data sources to describe the well-being, challenges and community supports in the region. The report card is the work of Our Kids Network, a multi-sectoral collaborative planning and working table that represents Halton's commitment to the healthy development and well-being of all children in the community. The report card is designed to provide an inventory of Halton-specific information to help identify areas of vulnerability and strength in the population of young children, indicate where service changes may be needed, and serve as a measuring tool to track improvements over time (Halton, 2008). Data sources include the results from the EDI, Kindergarten Parent Survey (KPS) which is completed by parents during the kindergarten year, Education Quality and Assessment Office (EQAO) tests, the Halton Youth Survey, Halton public health department, Children's Aid Societies, and Statistics Canada census data to paint a comprehensive picture of how children are doing from the prenatal period to adolescence. Baseline data were collected in the 2004 version of the report card, and the 2008 report provides

evidence of progress and areas for improvement. For example, comparing the Halton region EDI results over time showed the domains in which children's vulnerability increased, and could be compared with Statistics Canada data on demographic trends, such as increased population growth, including new immigrant families living below the low income cut-off. Through its ongoing monitoring and assessment, Halton was able to identify that Oakville has seen a significant increase in the percent of developmentally vulnerable children, and Acton and West Milton are neighborhoods that continue to have children experiencing more difficulties overall. Considering EDI scores alongside Statistics Canada census data identified significant demographic growth in these areas. School-specific EDI profiles have been provided to schools for school-level planning purposes.

The findings in the present study are reinforced in the literature that confirms that risk factors for children's achievement and wellness comprise variables in their community context, including socioeconomic status, family structure, child health, parental health and family involvement in literacy development (Janus & Duku, 2007). The Halton report card is an exemplar of a region increasing its capacity to respond to contextual trends and pressures, and supporting its communities to share responsibility for addressing the needs of young children through integrated service delivery, the use of appropriate assessment and measurement tools, and a focus on research and evidence to inform service planning based on needs.

Thus, communities and their planning tables working together with the provincial government can make evidence-informed decisions that distribute responsibility for children across all sectors, monitor the impact of investments and services over time, and increase the knowledge-base to improve outcomes for children aged four to six.

Recommendation 2: "Intervene early in children's natural habitats: communities and schools": Improve early identification and assessment practices for transition-aged children with mental health issues

There has never been a better, nor a more necessary, time, to put in place provincial standards and expectations for early identification and intervention services for young children and their families to improve the match between needs and services. Since September 2010, thousands of young children have entered full-day kindergarten at age four and five, and full provincial implementation is on track for completion by 2014. Recent figures indicate that over 242,000 children enrolled in junior or senior kindergarten in 2008-09 (MCYS, 2010). At the same time, provincial EDI reports have indicated that 27% of kindergarten children may be at risk in at least one domain related to readiness for school (Offord Centre, 2010). The present study has confirmed that 76% of children aged four to six receiving mental health services have moderate or significant mental health problems. Prevalence data indicate that as many as 75% of children with disorders never receive treatment (Waddell et al., 2007).

With this context in mind, it is essential to increase the focus on mental health as an integral responsibility of schools and educators in Ontario. Schools remain one of the best hubs through which public health promotion and prevention strategies can be implemented for entire populations of children. As full-day kindergarten for children aged four and five becomes a provincial reality, more than 240,000 kindergarten-aged children could have access to appropriate prevention and identification programs in the school setting where they spend so much of each day.

Schools provide an ideal setting within which to identify mental health issues in young children and respond appropriately through differentiated instruction for all children whether or not they have individually identified needs, universal design principles in classrooms and curricula to ensure that some children are not systematically left behind, ongoing screening and identification practices, and referral protocols for identified children who can be best supported with additional supports in the community or health sectors.

Additionally, before school entry, there is an opportunity to build on existing community and public health infrastructure to help equalize opportunities for children aged four to six to be ready for school. One simple way is through the expanded community Best Start Child and Family Centres currently being developed in the province, which are designed to bring together various provincial early child support programs under a single operational system (OCBCC, 2009). In addition to existing early detection and intervention services for blindness and low vision, hearing, preschool speech and language and overall infant and early childhood development, among others, comprehensive screenings and more targeted assessments for mental health issues could be provided in this setting. The 18-month well-baby visit currently in place in communities also provides an opportunity for screening for mental health issues early. In addition to offering the *Nipissing District Developmental Screen* for ages zero to six (completed by parents and health/child care professionals) population-based mental health screenings and specialized assessments for children who may be at risk could be incorporated with little disruption. Screening for children's mental health could also happen through primary health care professionals in tandem with the immunization schedule. Funding for this would come through the establishment of a new OHIP code, similar to that put in place for physicians to administer the *Nipissing* at the18-month well-baby visit.

Maximizing the use of existing contact points – in community early years programs, in school and at pediatric check-up points - helps to ensure that every child has the same access to services regardless of their individual or family circumstances (Santor et al., 2009).

The suggestions so far for system-wide improvements are largely "technical challenges" (Heifetz & Linsky, 2004) that require child-serving sectors to build on the existing model with practical, logical improvements. Some practices can be changed through additional investments, tools, protocols and policies designed to improve community and school reliance on evidence, remedy disjointed policy and practice in the province, improve monitoring and reporting activities, and show that services are making a difference to children aged four to six. If decisions are made to redirect funding and resources, and implement these recommendations, they will go some way to improve the current system supporting children with mental health needs as they enter school.

Recommendation 3: "Think outside the label": Reconceptualize the practice of inclusion for children with mental health needs

The original MCYS Mapping survey and this secondary data analysis were respectable attempts to glean new knowledge about the state of the current system in order to serve children and families more adequately through existing mechanisms. However, tweaks to the status quo will only go so far without a significant shift in social policy development leading to a systemic transformation in the practice of inclusion in Ontario.

Thus, the final recommendation is a far more reaching "adaptive change" that resides, as Heifetz and Linsky (2004) describe it, in transforming society's values, and pushing people to change their beliefs, habits, and approaches to their practice. Rather than continuing to add

patches to the system, what would a truly transformed vision for equal rights for children with special needs look like in Ontario? What are the barriers to implementing a social inclusion model to address optimal mental health in children transitioning to school?

The new 'normal'.

Recall the proposal in the literature that children with mental health needs need their own label, or at minimum, revised criteria so that they can be adequately addressed in the current labeling. Building on the existing model both in policy and in practice would help ensure that more children with issues are appropriately identified and provided with specialized consideration. However, the alternative approach proposed by Oliver (2009), Slee and Allan (2001) and others would eradicate the current special education model operating in schools in large part because there is no place for the concept of "special education" in the radically changed society of the future. Citing Kuhn's influence (1970), Oliver describes how, rather than viewing social policy transformation as a process of evolution, the accumulation of structural irregularities and contradictions in the existing paradigm render it unsustainable, and must lead inevitably to a radically new paradigm over time. Oliver views this as the transformative shift from special education to inclusive education, citing numerous structural anomalies to prove this point. Firstly, the labels used to categorize children continue to be based on a medicalized model that situates disability as the problem of the individual. Second, systemic biases in the application of special education labels has led to the overrepresentation of certain groups, such as minorities and those of lower socio-economic status, that are not inherently represented in these populations, and so must be produced by the system itself. Third, Oliver argues that the current special education model is not devised primarily to support children with special needs but rather to serve political and economic constraints (Oliver, 2009).

The new paradigm, Oliver argues, is not one in which the perpetuation of a complex, costly infrastructure required to manage children with special needs continues to co-exist alongside the education and preparation of 'regular' children to adopt their rightful economic and civic agency in society. Rather, Oliver contends that changes in social, educational and economic ideology are inevitable and assume an essential contributing role in the global economy for all persons, including those with disabilities. For Oliver, "nothing short of a radical deconstruction of special education and the reconstruction of education in totality will be enough – even if it takes us another hundred years" (Oliver, 2009, p. 71).

Oliver's perspectives present new possibilities for reform to Ontario's current special education delivery in practice as it relates to mental health. The current focus on children labeled with designated exceptionalities takes the focus away from mental health promotion and illness prevention, results in unequal access to supports and services, and causes significant disadvantage for children beginning school with unaddressed mental health issues. Current practice perpetuates exclusion for certain children aged four to six based on their inability to conform in the regular classroom. Rather than fit children with mental health needs under the labeling umbrella (Ministry of Education, n.d.b.), a new vision can be realized by focusing on social justice and educational equity, an approach that opens up new possibilities for considering educational inclusion policy from a holistic, life course perspective.

The potential of universal design.

An emerging approach in equitable education practice is one of universal design that adapts the educational environment to provide the best supports for all children within a common setting, regardless of ability and where they fall on the spectrum (Darragh, 2007). As opposed to defining children by their disability first, Darragh (2007), Hehir (2002) and others see universal

design as supporting equity for all children by placing all children along a continuum of (dis)ability rather than creating special categories for those that deviate too far from a socially and politically constructed 'norm'.

Mounting evidence shows that universally designed inclusive settings have benefits for all students. Ruijs, Van der Veen and Peetsma (2010) found no adverse effects on academic or social functioning for 'non special needs' students in an inclusive classroom. Further, the benefits to inclusive practice are not just felt by those who have been labeled 'special needs' but by all children in the community (Killoran et al., 2007; Underwood, 2006). This is a paradigm shift towards true inclusion that frees special education from its ideological "straightjacket" (Slee & Allan, 2001, p. 177). Where pre-service philosophy, educator and teacher training and classroom practice move beyond the status quo to incorporate inclusion through universal design, and not as a management system for those who do not fit the 'norm', the strategies for inclusion are the same for all children regardless of disability or special need.

Evidence of this shift can be found already in Ontario, including the Hamilton-Wentworth Catholic District School Board (HWCDSB) which has stated it is "opposed in general to the use of labels to identify students" (HWCDSB, 2006, p.7) and has pioneered inclusive education practice and ideology in Ontario through universally designed classrooms and differentiated instruction. New Brunswick and all three territories have made similar ideological shifts and statements in policy (Bunch, 2011). As McLeskey and Waldron (2007) explain, "general education classrooms are transformed into places where difference becomes ordinary" (p.165). Teaching is individualized, whether it is designed for 'special' education or not, learning incorporates family, and schools integrate with the community. The ensuing developmental trajectory for children then reflects the confluence of educational, family,

community and economic systems working in concert, in a positive ecological environment that promotes health and health equity for all throughout life.

Changing the ethos.

Oliver (1996), describes the "old views of integration" as those that attempt to accommodate children with special needs through special departments, support services in schools and communities, and prescriptive policies:

> ...[T]hese things are undoubtedly necessary but, in themselves, they are not enough. There must also be changes in the ethos of the school which must mean that the school becomes a welcoming environment for children with special needs; that there is no questioning of their rights to be there and that the organizational changes are part of an acceptance and understanding of the fact that the purpose of schools is to educate all children, not merely those who meet an increasingly narrowing band of selection criteria (Oliver, 1996, p.87).

But changing an ethos, or as Fullan (2007) states, sharing a "moral purpose" – that is a collective sense of responsibility to the greater social good - is much harder than changing a label. Heifetz and Linsky (2004) have described the challenges for teachers and other professionals to make the adaptive changes required to alter their values, beliefs and practices related to inclusion in fundamental ways for true sustainable reform. Fullan (2007) points to the complexity across layers of government with time-limited mandates that attempt to "muddle through" complex decision-making as efficiently as possible, taking incremental baby steps along the lines of Lindblom's (1959) branch theory of policy making to tweak the status quo rather than undertaking the planned re-invention of social policy. As a result, child serving sectors suffer from misalignment and social policy decisions remain constrained by short-term political and economic outcomes.

Reconceptualizing the practice of inclusion for children with additional needs means an adaptive change (Heifetz & Linsky, 2004) in governmental, societal, educational and community 'ethos' – to build our knowledge base, develop professional capacity, strengthen relationships,

and change beliefs and practices related to inclusion and children's diverse learning and development styles. As Oliver (1996) states: "what is needed, according to the new view of integration, is a moral commitment to the integration of all children into a single education system as part of a wider commitment to the integration of all disabled people into society." (p. 89). Correspondingly, UNESCO has stated that true social inclusion lays the foundation for "...the transformation of the system itself" (UNESCO, 1999, p.9).

Conclusion

It is in this focus on systemic and social transformation that children's mental health in Ontario is at a crossroads. Within the existing model serving children with mental health needs, there is a disconnect between prevalence, services and approaches to address the unmet mental health needs of young children transitioning into school. As presented above, even moderate alterations to existing practices could more effectively focus on prevention, earlier identification and intervention to help children feel and do better, improve educators' self-efficacy and knowledge, and integrate community support systems to mediate risk factors. Addressing mental health as early as possible, in children's natural settings at home, in communities and in school, helps create the systemic conditions for success through the lifespan. An ecological system (Bronfenbrenner, 1994) focused on equitable child development would ensure that every "differently equal" (Moosa-Mitha, 2005, p. 369) child has the right to a decent standard of living, a good education and a hopeful future (Luxton, 2002). This is what Lynch and Baker (2005) simply call "equality of condition'' for "everyone to have roughly equal prospects of a good life" (p.132).

True reform remains a work in progress, however, with one of the greatest challenges being "mainstream society's unwillingness to adapt, transform, and even abandon its 'normal'

way of doing things" (Devlin & Pothier, 2005). The real touchstone is an ethical one. A fundamental acceptance of our moral duty to respect the education rights of all children through an active commitment to social inclusion dissolves ideological, political and social differences. This calls for "a leap of imagination" to dream what is possible (Allan (2006, p. 122).

This paper has shown that the mental health needs of children aged four to six are serious, numerous and, if unaddressed, harmful to life outcomes. There are disparities between services provided and the needs of young children, and a lack of integration across sectors. A comprehensive understanding of children's needs and the services that best suit them cannot be gleaned from the data the province currently collects. But in a reconceptualized approach to children and families, the necessary knowledge resides not in collecting data as we have in the past, but rather in measuring the value communities place on their most vulnerable citizens, through the life span. A real commitment to equity of opportunity for all children is one that reconceptualizes social inclusion in school and community, as it should in society itself.

APPENDIX 1: MCYS Mapping Tool [excerpts]

Ministry of Children and Youth Services

Implementing *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health*

April 2008

I. SERVICE PROVIDER INFORMATION

1. Service Provider Name:
2. Identify the MCYS region(s) in which this services provider is located: Central East, Central West, Eastern, Hamilton-Niagara, Northern, North East, South East, South West, Toronto
3. Service Provider's head office contact information:
4. Please indicate whether this Agency provides French Language Services:

II. PROGRAM INFORMATION

1. Contact Information: Please identify a contact person in the event follow up questions or clarification are required regarding the Program for which this Mapping Tool is being completed:

2. Please specify this program name:

3. Please provide a description of this program:

4. Indicate whether this program is ongoing or time-limited

5. Please identify whether this is a "generic" mental health program or whether it focuses on addressing specific presenting behaviours/disorders (specify):

6. For 2007/08, please provide the number of referrals to this program directly received from each of the following sources: Child/youth self-referral; Family/caregiver referral; Single Point of Access Mech; Coordinated Access Mech; Other Health Care Providers; Children's Treatment Centres; Friendship Centres; Primary Health Care; Hospitals; Health Access Centre; Child Care Centre; School; Children's Aid Society; Child and Youth Mental Health Service Provider; Youth Justice Probation Officers; Youth Justice Facility; Court/Crown; Police; Faith Based Organizations; Community Care Access Centres; Other (specify); Youth Justice Other (specify)

7. For each of the child and youth mental health program components directly delivered by this program, please select the frequency with which they were provided in 2007/08:

Function	Mental Health Program Components
Assessment	Court-Ordered; Diagnosis Assessment; Eligibility Assessment; Functional Assessment; Health Screening; Intake Assessment; Intake Assessment Tools; Professional Observiation/Consultation; Specialized Assessment; Other (specify)
Early Identification	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Cultural Services and Supports – other; Educational/School Based Supports; Health Screening; Public/Primary Health Care Services; Outreach Services; Pre-Post Natal Supports; Other (specify)
Early Intervention	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Cultural Services and Supports – other; Educational/School

	Based Supports; Educational Supports/Resources; First Episode Psychosis Services; Outreach Services; Health Screening; Public/Primary Health Care Services; Restorative Justice/Mediation; Other (specify)
Emergency Response/Crisis Intervention	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Crisis Assessment/Triage; Crisis Lines; Crisis Residential/Emergency Shelters/ Crisis/Support Counselling; Cultural Services and Supports – other; Mobile Crisis Services; Professional Observation/Consultation; Trauma Stabilization/Crisis Intervention; Other (specify)
Family/Caregiver Education and Support	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Advocacy Services; Cultural Services and Supports – other; Drop-in/Resource Centre; Educational Supports/Resources; Help Lines; In Home Respite Services; Out of Home Respite Services Parenting Supports; Pre-Post Natal Supports; Support Networks; Other (specify)
Intervention	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Brief Therapy; Cultural Services and Supports – other; Day Treatment; Evidence based interventions; Family Counselling/Therapy; Group Counselling/Therapy; In-patient Services; Individual Counselling/Therapy; In-patient Services; Individual Counselling/Therapy; Open Detention/Custody; Intensive Case Mgmt/Service Coordination; Intensive Home-based Interventions; Medication Monitoring; Outpatient/Outclient Services; Play/Art Therapy; Residential Treatment; Secure Detention/Custody; Secure Treatment; Skills-based Supports; Specialized Interventions; Treatment Foster Care; Wraparound; Other (specify)
Mental Health Promotion/Illness Prevention	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Cultural Services and Supports – other; Drop-in/Resource Centre; Educational/School Based Supports; Educational/Supports Resources; Help Lines; Parenting Supports; Public Education Efforts; Public/Primary Health Care Services; Pre-Post Natal Supports; Recreational Serivces; Other (specify)
Navigation/Service Coordination	Aboriginal Cultural Services and Supports; Aboriginal Health Access Centre; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Cultural Services and Supports – other; Drop-in/Resource Centre; Case Resolution; Case Conferencing; Help Lines; Parenting Supports; Multi-professional Teams; Transition/Discharge Planning; Other (specify)
Professional Training	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Cultural Services and Supports – other; Knowledge Transfer and Exchange; Professional Observation/Consultation; Professionals Training/Education; Other (specify)
Public Education	Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Cultural Services and Supports – other; Drop-in/Resource Centre; Educational/School Based Supports; Educational Supports/Resources; Parenting Supports; Public/Primary Health Care Services; Public Education Efforts; School based Anti-stigma and Anti-racism Initiatives; Other (specify)
Referral to	Aboriginal Community Service Provider; Aboriginal Cultural Services and Supports; Aboriginal Health Initiatives; Aboriginal Traditional Medicine; Aboriginal Healing Lodge; Aboriginal Health Access Centre; Children's Aid Society; Cultural Services and Supports – other; Educational/School Based Supports; Friendship Centres; Mental Health Service Provider; Parenting Supports; Public/Primary Health Care Services; Restorative Justice/Mediation; Support Networks; Telepsychiatry; Volunteer Services; Other (specify)
Social/Community Supports	Access Mechanisms; Community Directory; Drop-in/Resource Centre; Educational/School Based Supports; Educational Supports/Resources; Help Lines; Outreach Services; Public/Primary Health Care Services; Recreational Services; Support Networks; Volunteer Services; Other (specify)

8. Please rank (1-4) the four top primary mental health functions provided by this program.
   Function # 1: Function # 2: Function # 3: Function # 4:

9. Please complete the following table for each service delivery site at which this program is delivered: Number of sites: Program Name by Site: Address:
   Catchment Area [Census subdivision drop down menu]
   Please identify the number of days per year this site is in operation:
   Identify the language(s) in which this program is routinely delivered:
   Which primary mental health functions identified in question 8 are available at this site?

10. Provide the total number of individual (i.e. distinct) children and youth served by this program – and, f these, the estimated number who received a mental health component:

11. Please identify the age eligibility for this program (check all that apply):
    0;1;2;3;4;5;6;7;8;9;10;11;12;13;14;15;16;17;18;19;20;21+

12. Provide an estimated breakdown of the age(s) of those children/youth who were actually served by the mental health component(s) fo this program:
    0;1;2;3;4;5;6;7;8;9;10;11;12;13;14;15;16;17;18;19;20;21+

13. Please identify which of the following gender(s) this program is specifically designed to served: Male; Female; Transsexual/Transgendered/Intersex/Other; All:

14. Based on 2007/08 fiscal, provide an estimated breakdown of the gender(s) of those children/youth who were actually served by the mental health component(s) of this program: Male; Female; Transsexual/Transgendered/Intersex/Other; All:

15. Using the *Continuum of Needs-based Services and Supports* please indicate which mental health "target population(s)" this program is designed to serve:

Target Population	Children and youth not currently identified as being at risk of, or who are experiencing, mental health problems that affect their functioning in some areas, such as home, school and/or in community		Children and youth identified as being at risk for, or who are experiencing, mental health problems that affect their functioning in some areas, such as home, school and/or in community		Children and youth who are experiencing significant mental health problems/illness that affect their functioning in some areas, such as home, school and/or in community		Children and youth experiencing the most severe, complex, rare or persistent diagnosable mental illness that significantly impair their functioning in most areas, such as home, school and in the community	
Program designed to serve	Y	N	Y	N	Y	N	Y	N

16. Provide an estimated breakdown of the number of children/youth by target population who actually received the mental health component of this program:

Target Population	Children and youth not currently identified as being at risk of, or who are experiencing, mental health problems that affect their functioning in some areas, such as home, school and/or in community	Children and youth identified as being at risk for, or who are experiencing, mental health problems that affect their functioning in some areas, such as home, school and/or in community	Children and youth who are experiencing significant mental health problems/illness that affect their functioning in some areas, such as home, school and/or in community	Children and youth experiencing the most severe, complex, rare or persistent diagnosable mental illness that significantly impair their functioning in most areas, such as home, school and in the community
Number				

17. For fiscal 2007/08 please provide the estimated number of children/youth who also had: substance abuse problem; eating problem/disorder; developmental disability; learning problem/disability; other (specify):

18. For those children/youth who started receiving service from the mental health component(s) of this program in 2007/08 please indicate the average wait time experienced after referral to begin receiving the mental health component(s) of this program (days):

19. If children/youth or their family/caregiver(s) are provided supports while waiting for the start of the mental health component(s) of this program, please indicate the type and frequency of these: Educational/Supports/Resources; Support Networks; Parenting Programs; Drop In/Resource Centre; Advocacy Services; Other (specify):

20. For fiscal 2007/08, if applicable, please indicate the total number of individual (i.e., distinct) professionals who have received formal child and youth mental health training/education/consultation for this program:

21. In column 1, indicate the total funding received, by funding source, for this program. In column 2, indicate the amount of funding received from each funding source, the amount that was spent on the mental health component of this program.

Source	2007/08 Total funding received for program	1007/08 Total funding spent on mental health component of program
Ministry of Children and Youth Services		
Ministry of Community and Social Services		
Ministry of Education (including school boards)		
Ministry of Health and Long Term Care (including LHINs)		
Ministry of Health Promotion		
Federal (specify)		
Municipal		
Fundraising		
Voluntary Sector		
Other (specify)		
TOTAL		

References

Allan, J. (2006). The repetition of exclusion. *International Journal of Inclusive Education, 10*(2-3), 121-133.

American Academy of Pediatrics. (2008). School readiness. *Pediatrics, 121*(4), e1008-1014. Technical paper available at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;121/4/e1008.pdf

Anderson, R. (1997). *Thematic content analysis: Descriptive presentation of qualitative data.* Retrieved from: http://www.wellknowingconsulting.org/publications/pdfs/ThematicContentAnalysis.pdf

Adelman, H.S. (1993).School-linked mental health interventions: Toward mechanisms for service coordination and integration. *Journal of Community Psychology, 21* (4), 309-319.

Auditor General of Ontario. (2008). Annual report of the office of the Auditor General of Ontario (special education). Retrieved June 25, 2011 from http://www.peopleforeducation.com/specialed/auditorgeneral08

Auditor General of Ontario. (2010). Annual report of the office of the Auditor General of Ontario (children's mental health). Retrieved June 25, 2011 from http://www.auditor.on.ca/en/reports_health_en.htm

Boyle, M.H., & Lipman, E.L. (2002). Do places matter? Socioeconomic disadvantage and behavioural problems of children in Canada. *Journal of Consulting & Clinical Psychology, 70*, 378-89.

Bronfenbrenner, U. (1994). Ecological models of human development. *International Encyclopedia of Education,* vol. 3. Oxford: Elsevier. Reprinted in: Gauvain, M & Cole, M.

(Eds.). *Readings on the development of children.* (1993), pp. 37-43). NY: Freeman. Retrieved November 12, 2010 from http://www.psy.cmu.edu/~siegler/35bronfebrenner94.pdf

Bunch, G. (2011). *Disability – Education – Inclusion: A collection of blogs, articles, thought pieces.* Toronto, ON: Canadian Association of Inclusive Educators.

CAFAS in Ontario. (2009). Ontario's children with mental health needs 2008 report. Toronto, ON: Hospital for Sick Children. Retrieved June 30, 2011 from http://www.cafasinontario.ca/reports.asp#annual

Canadian Council on Learning. (2007). *Report on the state of early childhood learning in Canada.* Ottawa, ON: Canadian Council on Learning.

Canadian Council on Learning. (2009). *Looking to the future: Measuring child and youth well-being in Ontario. A profile of Ontario's children and youth.* Toronto, ON: Ministry of Child and Youth Services.

Cappella, E., Frazier, S., Atkins, M., Schoenwald, S., & Glisson, C. (2008). Enhancing schools' capacity to support children in poverty: An ecological model of school-based mental health services. *Administration and Policy in Mental Health, 35,* 395-409.

Centre for ADHD Awareness, Canada. (n.d.) Current situation in Ontario for students with ADHD. Retrieved July 8, 2011 from http://www.caddac.ca/cms/page.php?124

Cigman, R. (2007). A question of universality: Inclusive education and the principle of respect. *Journal of Philosophy of Education, 41*(4), 775-793.

Carter A.S., Wagmiller, R.J., Gray, S.A., McCarthy, K.J., Horwitz, S.M., Briggs-Gowan. MJ. (2010) Prevalence of DSM-IV disorder in a representative, healthy birth cohort at school entry: sociodemographic risks and social adaptation. *Journal of the American Academy of*

Child Adolescence and Psychiatry, 49(7), 686-98.

Children's Mental Health Ontario. (2011). *Children's Mental Health Ontario Pre-budget submission 2011*. Toronto: CMHO. Retrieved Feb. 8, 2011 from http://www.kidsmentalhealth.ca/documents/Res_cmho_final_prebudget_submission_2011_final.pdf

Children's Mental Health Ontario. (2008). *Brief Child and Family Phone Interview Annual Implementation Report 2008.* Retrieved October 25, 2010 from: http://www.kidsmentalhealth.ca/parents/BCFPI.php

Commission on the Social Determinants of Health (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

Connor, D.J., & Ferri, B. A. (2007). The conflict within: Resistance to inclusion and other paradoxes in special education. *Disability & Society, 22*(1), 63-77.

Corter, C. &. Peters, RDeV. (2011). Integrated early childhood services in Canada: Evidence from the Better Beginnings, Better Futures (BBBF) and Toronto First Duty (TFD) projects. *Encyclopedia on Early Childhood Development* [online]. Montreal, QC: Centre for Excellence for Early Childhood Development.

Cunningham, C., Pettingill, P., & Boyle, M. (2006). The Brief Child and Family Phone Interview: A computerized intake and assessment tool interviewer's manual. Retrieved June 30, 2010 from http://www.bcfpi.com/bcfpi/downloads/manual/en/ENIntMan.pdf

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Danforth, S. (2001). A pragmatic evaluation of three models of disability in special education.

Journal of Developmental and Physical Disabilities, 13(4), 343-359.

Darragh, J. (2007). Universal design for early childhood education: Ensuring access and equity for all. *Early Childhood Education Journal, 35*(2), 167-171.

Davies, S., Garner, S., Parkin, C., & Short, K. (2009). School-based mental health learning forum – Feasibility pilot: Final Report to the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. Retrieved July 1, 2011 from http://www.hwdsb.on.ca/e-best/kmlab/?page_id=21

Devlin, R., & Pothier, D. (2006). Introduction: Towards a critical theory of dis-citizenship. In D. Pothier (Ed.), *Critical disability theory: Essays in Philosophy, Politics, Policy and Law.* Vancouver, BC: UBC Press.

Dockett, S., & Perry, B. (2007). The role of schools and communities in children's school transition. In Tremblay, R.E., Bar, R.G., Peters, RDeV., Voisin, M. (eds). *Encyclopedia on Early Childhood Development* [online]. Montreal, QC: Centre for Excellence for Early Childhood Development, 1-7.

Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: Presentation, posology, and epidemiology. *Journal of Child Psychology and Psychiatry, 47*(3), 313–337.

Feeney-Kettler, K.A, ,Kratochwill, T.R., Kaiser, A.P., Hemmeter, M.L.,1 & Kettler, R.J. (2010). Screening Young Children's Risk for Mental Health Problems: A Review of Four Measures. *Assessment for Effective Intervention, 35*(4), 218–230

Ferguson, H.B., Tilleczek, K., Boydell, K.M., & Rummens, J.A. (2005). *The lived experience of early school leaving.* Toronto, ON: Ontario Ministry of Education. Retrieved Nov. 1, 2010 from http://www.edu.gov.on.ca/eng/parents/schoolleavers.pdf

Fowler, S.A., Schwartz, I., & Atwater, J. (1991). Perspectives on the transition from preschool to kindergarten for children with disabilities and their families. *Exceptional Children, 58*(2), 136-145.

Fox, L., Dunlap, G., & Cushing, L. (2002). Early intervention, positive behavior support, and transition to school. *Journal of Emotional and Behavioral Disorders, 10*(3), 149-157.

Frankel, E. (2004) Supporting inclusive care and education for young children with special needs and their families: an international perspective, *Childhood Education, 80*(6), 310-316.

Fullan, M. (2007). *The new meaning of educational change*. New York, NY: Teachers College Press.

Government of Ontario. (1990). *Child and Family Services Act.* Retrieved Feb. 5, 2011 from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c11_e.htm

Graham, L.J. & Slee, R. (2008). An illusory interiority: Interrogating the discourse/s of inclusion. *Educational Philosophy and Theory, 40*(2), 277-293.

Grieve, J. (2009). Research in the real world: EDI and EQAO – Informing program planning and implementation. Presentation by Director of Education, Peel District School Board for *Research in the Real World: Large-scale assessment: EDI and EQAO in Ontario.* Ontario Ministry of Children and Youth Services, May 6, Toronto, ON.

Halton Region. (2009). *A vision for children in Halton region report card.* Our Kids Network. Retrieved June 27, 2011 from http://www.halton.ca/cms/One.aspx?portalId=8310&pageId=54256

Hamilton-Wentworth Catholic District School Board (Jim Hansen). (2006). *Each belongs: The remarkable story of the first school system to move to inclusion.* Toronto, ON: Inclusion Press.

Heifetz, R. A., & Linsky, M. (2004). When leadership spells danger. *Educational Leadership, 61*(7), 33-37.

Hehir, T. (2002). Eliminating ableism in education. *Harvard Educational Review, 72*(1), 1-32.

Hertzman C., & Bertrand J. (2007). Children in poverty and the use of early development instrument mapping to improve their worlds. *Paediatrics and Child Health, 12*(8), 687-92.

Hillier, A. (2007). Why social work needs mapping. *Journal of Social Work Education, 43*(2), 205-221.

Institute of Health Economics. (2010). *The Cost of Mental Health and Substance Abuse in Canada: A Report to the Mental Health Commission of Canada.* Edmonton, AB: IHE.

Janus, M. (2007). In *Early child development from measurement to action: A priority for growth and equity*, M. E. Young & L.M. Richardson (Eds.). p. 183-201. Washington, D.C.: The World Bank.

Janus, M., Cameron R., Lefort J., & Kopechanski L. (2007). Starting kindergarten: Transition issues for children with special needs. *Canadian Journal of Education, 30*(3), 628-638.

Janus, M., & Duku, E. (2007). The school entry gap: Socioeconomic, family and health factors associated with children's school readiness to learn. *Early Education and Development, 18*(3), 375-403.

Janus, M., & Offord, D. (2007). Development and psychometric properties of the Early Development Instrument (EDI): A measure of children's school readiness. *Canadian Journal of Behavioural Science, 39*(1), 1-22.

Johnson, B., & Turner, L. (2003). Data collection strategies in mixed methods research. In *Handbook of mixed methods in social & behavioral research*, A. Tashakkori, C.Teddlie (Eds.) Thousand Oaks, CA: Sage Publications.

Kauffman, J.M., Bantz, J., & McCullough, J. (2002). Separate and better: A special public school class for students with emotional and behavioral disorders. *Exceptionality, 10*(3), 149-170.

Kelly, C.M., Jorn, A.F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia, (187)*7.

Killoran, I., Tymon, D. & Frempong, G. (2007). Disabilities and inclusive practices within Toronto preschools. *International Journal of Inclusive Education, 11*(1), 81-95.

Kirby, M.J.L., & Keon, W.J. (2006). *Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada.* The Standing Senate Committee on Social Affairs, Science and Technology. Retrieved from: http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/pdf/rep02may06high-e.pdf

Komesaroff, L.R. & McLean, M.A. (2006). Being there is not enough: Inclusion is both deaf and hearing. *Deafness and Education International, 8*(2), 88-100.

Kotler, P., Keller, K. & Cunningham, P. (2006). *Marketing management.* Toronto: Pearson Prentice Hall.

Landrum, T.J., Tankersley, M., & Kauffman, J.M. What is special about special education for students with emotional and behavioral disorders? *The Journal of Special Education, 37*(3), 148-156.

Lewis-Beck, M.S., Bryman, A., & Futing Liao (Eds.) (2004). *The Sage encyclopedia of social science research methods* (vol. 3). Thousand Oaks, CA: Sage Publications.

Lindblom, C.E. (1959). The science of "muddling through". *Public Administration Review, 19*(2), 79-88.

Loades, M.E, & Mastroyannopoulou, K. (2010). Teachers' recognition of children's mental health problems. *Child and Adolescent Mental Health, 15*(3), 150–156.

Luxton, M. (2002). Feminist perspectives on social inclusion and children's well-being. *Working paper series*. Toronto, ON: Laidlaw Foundation. Retrieved November 12, 2010 from http://www.laidlawfdn.org/working-paper-series-social-inclusion

Lynch, K., & Baker, J. (2005). Equality in education. An equality of condition perspective. *Theory and research in Education, 3(2),* 131-164.

McCain, M., & Mustard, F. (1999). *Reversing the real brain drain: Early years study.* Toronto, ON: Government of Ontario.

McCain, M., Mustard, J.F. & Shanker, S. (2007). *Early Years Study 2: Putting Science Into Action.* Toronto, ON: Council for Early Child Development.

McLeskey, J., & Waldron, N. L. (2007). Making differences ordinary in inclusive classrooms. *Intervention in School and Clinic, 42*(3), 162-168.

Ministry of Children and Youth Services (n.d.) About the Ministry. Retrieved Feb. 10, 2011 from http://www.children.gov.on.ca/htdocs/English/about/index.aspx

Ministry of Children and Youth Services (n.d.b) Regional Offices. Retrieved July 6, 2011 from http://www.children.gov.on.ca/htdocs/English/about/regionaloffices.aspx

Ministry of Children and Youth Services (2006). *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health.* Retrieved Oct. 6, 2010 from http://www.children.gov.on.ca/htdocs/English/documents/topics/specialneeds/mentalhealth/framework.pdf

Ministry of Children and Youth Services. (2008). MCYS Mapping Tool. Toronto: Ministry of Children and Youth Services

Ministry of Children and Youth Services. (2009). *MCYS-funded agency mapping results* (unpublished). Toronto: Ministry of Children and Youth Services.

Ministry of Children and Youth Services. (2011). *Improving Mental Health Supports for Ontario Kids and Families.* Retrieved June 27, 2011, from http://news.ontario.ca/mcys/en/2011/06/improving-mental-health-supports-for-ontario-kids-and-families.html

Ministry of Education. (n.d.a) Ministry of Education Special Education Update February 2011. Retrieved March 12, 2011 from: http://www.edu.gov.on.ca/eng/general/elemsec/speced/SpecialEd_Update2011.pdf

Ministry of Education. (n.d.b) An Introduction to Special Education in Ontario. Retrieved March 12, 2011 from: http://www.edu.gov.on.ca/eng/general/elemsec/speced/ontario.html

Ministry of Education. (2000). *Standards for school boards' special education plans.* Toronto, ON: Queen's Printer.

Ministry of Education. (2005). *Planning entry to school: A resource guide.* Toronto, ON: Queen's Printer.

Ministry of Education. (2008). *Managing Information for Student Achievement.* Information on website regarding Ontario School Information System (OnSIS), 2006-07. Retrieved 2010 from http://www.edu.gov.on.ca/eng/policyfunding/misa/

Ministry of Education. (2009). *Realizing the Promise of Diversity: Ontario's Equity and Inclusive Education Strategy.* Toronto, ON: Queen's Printer.

Ministry of Education. (2009). Including students with exceptionalities. *What works? Research*

into Practice. A research-into-practice series produced by a partnership between the Literacy and Numeracy Secretariat and the Ontario Association of Deans of Education. Retrieved from http://www.edu.gov.on.ca/eng/literacynumeracy/inspire/research/Bennett.pdf

Ministry of Education. (2010a). Quick Facts: Ontario Schools 2007–08. Toronto, ON: Queen's Printer.

Ministry of Education. (2010b). Caring and safe schools in Ontario: Supporting students with special education needs through progressive discipline, kindergarten to grade 12. Toronto, ON: Queen's Printer.

Ministry of Education. (2010c). Memo April 20, 2010 from Barry Pervin to Directors of Education regarding Student Support Leadership. Retrieved from http://www.edu.gov.on.ca/eng/policyfunding/memos/april2010/studentLeaderInitiative.pdf

Morrison, F.J., & Connor McDonald, C. (2009). The transition to school: Child-instruction transactions in learning to read. In *The transactional model of development: How children and contexts shape each other*, Sameroff, A. (Ed), (2009). Washington, DC, US: American Psychological Association.

Moosa-Mitha, M. (2005). A difference-centred alternative to theorization of children's citizenship rights. *Citizenship Studies, 9* (4), 369-388.

Mustard, J.F., & Young, M.E. (2007). Measuring child development to leverage ECD policy and investment. In *Early child development from measurement to action: A priority for growth and equity*, M. E. Young & L.M. Richardson (Eds.). Washington, D.C.: The World Bank.

Offord Centres for Child Studies. (2010). School Readiness to Learn Ontario SK Cycle 2 EDI Results. Retrieved July 1, 2010 from http://www.offordcentre.com/readiness/pubs/2010_06_21_Ontario_Cycle_2_Report.pdf

Offord, D.R., Boyle, M.H., Racine, Y.A., Fleming, J.E., Cadman, D.T., Blum, H.M., Byrne, C., Links, P. S., Lipman, E.L., MacMillan, H.L., Grant, N.I.R., Sanford, N.M., Szatmari, P., Thomas, H., & Woodward, C.A. (1992). Outcome, prognosis, and risk in a longitudinal follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 916–923.

Offord, D. and E. Lipman (1996). "Emotional and Behavioural Problems." *Growing Up in Canada: National Longitudinal Survey of Children and Youth.* Ottawa: Human Resources Development Canada and Statistics Canada .

Oliver, M. (1990). *The politics of disablement.* New York, New York: St. Martin's Press.

Oliver, M. (1996). *Understanding disability: From theory to practice.* New York, New York: St. Martin's Press.

Oliver, M. (2009). *Understanding disability: From theory to practice* (second edition). New York, New York: Palgrave Macmillan.

Olson, S., Sameroff, A., Lunkenheimer, E., & Kerr, D. (2009). Self-regulatory process in the development of disruptive problems: The preschool-to-school transition. In S. Olson & A. Sameroff, (eds.) *Biopsychosocial regulatory processes in the development of childhood behavior problems.* New York, NY: Cambridge University Press.

Ontario Coalition for Better Child Care. *What is a Best Start Child and Family Centre?* Summer 2009, Bulletin # 4. Retrieved July 8, 2011 from http://www.childcareontario.org/?p=1882

Ontario Healthy Communities Coalition. (n.d.). Tool: Mapping your community assets. Retrieved July 8, 2011from http://www.ohcc-ccso.ca/en/courses/community-development-for-health-promoters/module-two-process-strategies-and-roles/tool-mapp#_ftn1

Ontario Human Rights Commission. (1990). Ontario *Human Rights Code.* Retrieved June 8, 2011 from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h19_e.htm

Ontario Human Rights Commission. (2004). *Guidelines on accessible education.* Retrieved June 8, 2011 from http://www.ohrc.on.ca/en/resources/Policies/AccessibleEducation/pdf

Pascal, C. (2009). With our best future in mind: Implementing early learning in Ontario. *Report to the Premier of Ontario by the Special Advisor on Early Learning.* Toronto, ON: Government of Ontario.

Penn, H. (2008). *Understanding early childhood: Issues and controversies.* Berkshire, UK: Open University Press.

Rimm-Kaufman, S. (2004). School transition and school readiness: An outcome of early childhood development. In: Tremblay, R.E., Barr, R.G., Peters, R.DeV, (eds.) *Encyclopedia on Early Childhood Development* [online]. Montreal, Quebec: Centre of Excellence for Early Childhood Development. Retrieved Feb. 2, 2011 at: http://www.child-encyclopedia.com/documents/Rimm-KaufmanANGxp.pdf.

Romanow, Roy J. QC. (2002). *Building on Values: The Future of Health Care in Canada.* Final Report of the Commission on the Future of Health Care in Canada. Ottawa: Queen's Printer.

Roulstone, A., & Prideaux, S. (2008). More policies, greater inclusion? Exploring the

contradictions of New Labour inclusive education policy. *International Studies in Sociology of Education, 18*(1), 15-29.

Ruijs, N.M., Van der Veen, I., & Peetsma, T. (2010). Inclusive education and students without special educational needs. *Educational Research, 52*(4), 351-390.

Sameroff, A.J. & Emde, R.N. (1989). *Relationship disturbances in early childhood: A developmental approach.* New York, New York: Basic Books.

Sandler, I. (1985). Children's environments and mental health: Opportunity and responsibility. *American Journal of Community Psychology, 13*(4), 335-337.

Santor, D., Short, K., & Ferguson, H.B. (2009). *Taking mental health to school: A policy-oriented paper on school-based mental health for Ontario.* Ottawa, ON: The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

Select Committee on Mental Health and Addictions. (2010). http://www.ontla.on.ca/committee-proceedings/committee-reports/files_pdf/Select%20Report%20ENG.pdf),

Short, K., Ferguson, H.B., & Santor, D. (2009). *Scanning the practice landscape in school-based mental health.* Ottawa, ON: Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

Slee, R. (2006). Critical analyses of inclusive education policy: An international survey. *International Journal of Inclusive Education, 10*(2-3), 105-107.

Slee, R., & Allan, J. (2001). Excluding the included: A reconsideration of inclusive education. *International Studies in Sociology of Education, 11*(2), 173-191.

Special Education Advisory Committees (n.d.) Unit 1: An Historical Overview of Special Education in Ontario. Retrieved from http://seac-learning.ca/unit1.htm

Spratt, J., Shucksmith, J., Philip, K., & Watson, C. Embedded yet separate: Tensions in

voluntary sector working to support mental health in state-run school. *Journal of Education Policy, 22*(4), 411–428.

Statistics Canada. (2010). *Population by sex and age group, by province and territory.* Retrieved February 10, 2011 from http://www40.statcan.gc.ca/l01/cst01/demo31a-eng.htm

Stephan, S.H., Weist, M., Kataoka, S., Adelsheim, S., & Mills, C. (2007). Transformation of children's mental health services: The role of school mental health. *Psychiatric Services, 58*, 1330-1338.

Sugai, G., Horner, R., Dunlap, G, Hieneman, M., Lewis, T., Nelson, C., Scott, T., Liaupsin, C., Wailor, W., Purnbull, A., Turnbull, H., Wicham, D., Wilcox, B., Ruef, M. (2000). Applying positive behavior support and functional behavioral assessment in schools. *Journal of Positive Behavior Interventions.* 131-143.

Thomas, C. (1999). *Female forms: Experiencing and understanding disability.* Philadelphia, PA: Open University Press.

Thomas, G., & Loxley, A. (2001). *Deconstructing special education and constructing inclusion.* Open University Press: Buckingham, United Kingdom.

United Nations Educational, Scientific and Cultural Organization (UNESCO). (1999). *Salamanca Five Years On: A Review of UNESCO Activities in the Light of The Salamanca Statement and Framework for Action on Special Needs Education.*

United Nations Educational, Scientific and Cultural Organization (UNESCO). (2008). Inclusive education: The way of the future. UNESCO International Conference on Education, November 25–28. Geneva: Author. Retrieved from: http://www.ibe.unesco.org/National_Reports/ICE_2008/brazil_NR08.pdf

UNICEF. (1989). Convention on the Rights of the Child. Retrieved Nov. 22, 2010 from http://www2.ohchr.org/english/law/crc.htm

U.S. Public Health Service. (2000). Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services. Retrieved June 30, 2011 from http://www.surgeongeneral.gov/topics/cmh/cmhreport.pdf

Underwood, K. (2006) The case for inclusive education as a social determinant of health. *Comparative Program on Health and Society, Lupina Foundation, Working Paper Series, 2005-2006.* Munk International Centre Briefings, University of Toronto. http://webapp.mcis.utoronto.ca/resources/MCIS_Briefings/Oct2006-LupinaBriefing.pdf

Waddell, C., McEwan, K., Peters, RDeV., Hua, J. M., & Garland, O. (2007). Preventing mental disorders in children: A public health priority. *Canadian Journal of Public Health, 98(*3), 174-78.

Williams, C. (2007). Research Methods. *Journal of Business & Economic Research, 5*(3), 65-71.

World Health Organization. (1946). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. Retrieved Feb 2, 2011 from http://www.who.int/about/definition/en/print.html

World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options.* Geneva, Switzerland; WHO.

World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social*

Determinants of Health. Geneva: WHO.

Zeanah, C.H. (Ed.) (2009). *Handbook of infant mental health*, (3rd ed.) New York: Guilford Press.