



Children's Mental Health Ontario
Santé Mentale pour Enfants Ontario

**Children's Mental Health Services
for Children Zero to Six:
*Review of the Literature
and
Practice Guide***

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Children's Mental Health Services for Children Zero to Six: *Review of the Literature and Practice Guide*

EXECUTIVE SUMMARY

Fraser Mustard has presented convincing evidence about the importance of early childhood development for laying the foundation for competence and coping skills throughout life. Researchers such as Michael Rutter and Richard Tremblay have offered equally convincing evidence about the importance of the period from birth to six years on antisocial behaviour and mental health problems later in life. In particular, parenting ability and the influence of the family, community, and socioeconomic environment in the early years are consistently linked to health, learning, and behavioural outcomes.

WHAT ARE EARLY CHILDHOOD MENTAL HEALTH SERVICES?

The following is a working definition of early childhood mental health services, developed through a review of the literature and consultations in Ontario:

Early childhood mental health services consist of multidisciplinary services provided to children from birth to six years of age to identify and treat existing or emerging mental health problems, enhance adaptive parenting and overall family functioning, strengthen competencies, minimize developmental delays, prevent functional deterioration, enhance the ability of other systems to address the needs of young children and their families, and promote child mental health and well-being.

Early childhood mental health services have a key role to play in:

- treating children and families with mental health problems;
- supporting the new child development and parenting centres and existing programs (childcare, kindergarten, perinatal support programs) that address mental health needs; and
- working with communities to increase parenting capacity and reduce the risk factors associated with mental health problems in young children and their families.

The ultimate goal of early childhood mental health services is to enhance the well-being of all children and minimize or avoid behavioural and emotional problems in children with special needs.

RESEARCH INTO EARLY CHILDHOOD DEVELOPMENT

Early childhood mental health is grounded by advances in three areas:

- Biological and psychological research
- Ecological and systems theories
- Early intervention and health promotion

Recent advances in biological and neuropsychological research demonstrate that all organisms adapt to their environment, and neither behaviour nor developmental potential is fixed by genetic factors or limited by strict critical periods. Advances in the understanding of the development of young children show the importance of the ecological context that begins with the family, then widens to include the child's immediate community, and then expands further to embrace the broader socio-cultural-economic environment. Research supports the notion that well-designed early interventions and mental health promotion/prevention activities can enhance the development and well-being of children from all social classes and cultural groups by:

- improving social supports;
- connecting families with resources;
- improving parents' coping skills;
- advocating for families;
- enhancing parent-child relationships and parenting competencies;
- empowering parents; and
- providing services that are responsive to cultural differences.

RISK AND PROTECTIVE FACTORS

Research on risk and protective factors indicates that reducing risk factors and developing protective factors can influence positive child mental health outcomes. Protective factors are characteristics of the child or environment that may protect a child from a poor outcome, or reduce the negative effects created by risk factors. Protective factors include personal strengths (intelligence, relaxed temperament), family strengths (supportive home environment, socioeconomic advantages) and school and community strengths (safe and effective schools, participation in social groups). In contrast, the presence of multiple risk factors is associated with poor child outcomes. Risk factors for early childhood mental health problems include poverty, parental mental health problems, limited parenting skills, problems with attachment, alcohol and drug abuse, premature birth and low birth weight.

KEY ELEMENTS OF EARLY CHILDHOOD ASSESSMENT

For children from birth to 6 years of age, it is important to rule out health and developmental issues before determining that there is a mental health problem. Depending on the individual situation, assessments related to speech and language, occupational therapy, and pediatrics may be warranted.

New approaches to early childhood mental health assessment focus on sources of resilience and identifying the unique strengths of children and families. Five key elements of early childhood assessment include:

- **Target of Assessment:** Traditionally, assessments focused on the child alone. Today, assessments view the child in relation to the family, caregivers and the larger ecosystem.
- **Context of Assessment:** In the traditional approach, assessments of young children took place in structured environments under controlled circumstances. The more recent trend is to assess in familiar ("inclusive") settings that are comfortable, non-threatening and of interest to the child (e.g., homes, daycare, school).
- **Methods of Assessment:** Whereas traditional assessments employed highly specialized procedures and norm-referenced instruments administered in a formal environment, current assessments make use of everyday environments to enable children to demonstrate what they are experiencing.
- **Assessment Personnel:** Current approaches to assessment depart from the traditional model of a client assessed by a single assessment expert. Because children's mental health does not work in isolation, current best practice is multiple assessments by persons representing multiple disciplines.
- **Fusion of Assessment and Intervention:** One of the most significant changes to take place in early childhood assessment in recent years is the fusion of assessment and intervention. This occurs by using assessment tools that obtain assessment information at the same time as they structure interactions that support the child's development.

Family assessment within early childhood mental health has been strongly influenced by ecological, systems, and strengths/empowerment models. The result is an emphasis on family-focused assessment strategies that allow families to conduct their own evaluations of their strengths, resources, and needs. This approach may be used by professionals with little or no formal training in family assessment, and still provide information useful for making referrals and designing interventions.

Research shows that the quality of early parent-child relationships, especially attachment, has important effects on a child's development. Instead of focusing on the assessment of the individual child alone, current early childhood mental health assessment includes assessment of the quality of parent-child interactions.

PROMISING PRACTICES IN EARLY CHILDHOOD MENTAL HEALTH: TREATMENT AND INTERVENTION FOR SPECIFIC DISORDERS

The goal of this review is to identify promising treatments and interventions, within a short timeframe, through a review of existing articles, databases and other materials, and consultations with panels of experts and clinicians working in the field. Although promising practices do exist, the review found serious gaps in the evaluation of the efficacy and effectiveness of treatments and interventions, especially for infants and very young children. These notable shortcomings in the research are likely to be addressed as early childhood mental health attains greater visibility. Therefore, this review of promising practices in early childhood mental health is best viewed as a first step of a work-in-progress for identifying the best possible treatments and interventions for infants and young children in Ontario.

Anxiety Disorders

Anxiety is characterized by a strong negative emotion and an element of fear. A moderate level of anxiety is adaptive and is experienced by most children as they develop. According to epidemiological studies, anxiety disorders are the most common type of mental health problems in children, and are present in 6-18% of the child population. For younger children, the most frequently identified childhood anxiety disorder in clinics is separation anxiety, followed by social phobia, and then by simple phobias (e.g., fear of a specific animal or object). There are clear gender differences for anxiety disorders, with more girls than boys having separation anxiety, phobias, and generalized anxiety disorder.

None of the medications studied to treat anxiety disorders provide definitive evidence of effectiveness or safety for treating young children. Cognitive behaviour therapy (CBT) has proven effective in the treatment of children with severe anxiety disorders, including generalized anxiety disorder, separation anxiety disorder, and social phobia. The addition of a family anxiety management component significantly increases recovery rates. Preliminary evidence indicates that group administration of CBT, with a parent training component, is effective in treating children diagnosed with generalized anxiety disorder, overanxious disorder, and social phobia. There is also early evidence that the combination of group CBT and parent training is effective for preventing anxiety disorders in high-risk children. In addition to the use of CBT, individual behavioural treatments, especially participant modelling and reinforced practice, have been found effective in addressing phobias.

Attention Deficit Hyperactivity Disorder (ADHD)

Children with attention deficit hyperactivity disorder show developmentally inappropriate levels of attention, impulse control, and physical restlessness. ADHD is a chronic and

persistent problem that can interfere with many aspects of normal development and functioning from the preschool years through adulthood. Prevalence studies indicate that approximately 3-5% of all children have ADHD.

The efficacy of stimulant medication for the treatment of children diagnosed with ADHD without any comorbid conditions has received very strong support in the research literature. There is growing concern, however, about the increased use of medication to treat ADHD, especially for children aged 3 and younger. The lack of research on the long-term impact of these medications suggests that psychotropic medication for young children must be prescribed cautiously and side-effects monitored regularly.

Although stimulant medication is the treatment of choice for children with ADHD without any comorbid conditions, behavioural interventions remain the treatment of choice for those children with ADHD and comorbid conditions, such as oppositional defiant disorder or conduct disorder, or when children experience negative side effects from medication. For these young children with ADHD, behavioural parent training has proven effective. For children beginning school (age 6) who are diagnosed with ADHD and comorbid oppositional defiant disorder, social skills training has produced improvements in parent ratings of self-control and teacher ratings of withdrawal, aggression and social acceptance.

Oppositional Defiant Disorder (ODD)

Oppositional defiant disorder (ODD) is a persistent pattern of conduct problems characterized by defiant, hostile, and uncooperative behaviour that cannot be attributed to the child's developmental stage and that impairs a child's functioning, but does not include violations of the law. In the United States, ODD accounts for between one-third and one-half of all referrals to child and family clinics. Younger children usually show ODD through temper tantrums, arguing with adults, and stubborn behaviour. Studies of non-clinic populations show that between 10-15% of boys and girls are described as difficult to control, and 5% have temper tantrums. Follow-up studies show that these problems persist through the preschool and early school years. Gender differences are not significant in preschool children.

Research indicates that behavioural parent training (BPT), such as the Webster-Stratton model, combined with child-focused problem-solving skills training (PSST), is efficacious for improving behaviour at home and at school. Group-based BPT programs that include videotape modelling are as effective and less costly than individually administered BPT programs. Although studies indicate that combined BPT and PSST is more effective than either BPT or PSST alone, if parents cannot engage in behavioural parent training, then children may be offered child-focused PSST on its own. This strategy has proven effective for some children with ODD.

Conduct Disorder (CD)

Conduct disorder (CD) is characterized by a pattern of behaviour that violates the basic rights of others or age-appropriate norms and rules of society. Overall, conduct disorder appears more often in boys than girls, with a rate of 6-10% for males and 2-9% for females. In childhood-onset conduct disorder, biological and psychosocial factors appear to interact to cause the disorder. Disruptive behaviours emerge in the preschool years, usually as negative, hostile, and defiant behaviour characteristic of oppositional defiant disorder. As the child develops, there is usually an escalation to behaviours more characteristic of conduct disorder, especially lying, fighting, and stealing. Although the childhood-onset CD group comprise only 3-5% of children with conduct disorder, they are believed to account for at least half of the offenses committed by young offenders. Children with childhood-onset conduct disorder tend to be mostly male, and incidence is not strongly related to socioeconomic class or ethnic group.

Although some psychiatric medications are used to treat CD youth who have a comorbid disorder (e.g., antidepressants for mood and anxiety disorders, stimulants for ADHD), medication alone is not sufficient to treat conduct disorder. The main evidence-based individual therapy with conduct disordered children is cognitive behavioural therapy (CBT), especially problem-solving skills training (PSST). Some clinicians have successfully added parent management training (PMT) to further improve the effectiveness of PSST. Family intervention is an essential component for treating conduct disorder. For younger children, the family is often the primary target for intervention. Numerous studies support the effectiveness of parent management training (PMT) to improve parenting skills and manage child behaviour effectively without the use of physical punishment. Some researchers have found that group PMT with videotape modelling, combined with group child therapy (CT), are superior to either PMT or CT alone.

Recent studies support the efficacy of prenatal and early childhood interventions (such as family-based home visiting) to reduce behavioural problems and antisocial behaviour in children born to poor families. Although the literature generally does not support the effectiveness of individual psychodynamic therapy with CD children, several studies indicate that an explorative approach or an attachment-based approach may be useful for some CD children. Children with CD may be treated effectively in day treatment programs, but good follow-up and transition planning is necessary if treatment gains are to be maintained in regular preschool and classroom settings.

Childhood Depression

The clinical picture of childhood depression includes features associated with mood changes that are unique to the disorder (e.g., sadness, dysphoria, worthlessness, suicidal ideation). Depression in children under age 7 tends to be less sharply defined than

depression in older children and adults. Depressive disorders are estimated to occur in 2-4% of children, and the prevalence of depression is virtually the same for girls and boys during childhood. Serious depression is fairly rare among preschool children (less than 1%) and school-aged children (about 2%). Major depression in children is usually an episodic disorder with each episode lasting an average of 8 months.

There is mounting evidence that infants can suffer from depressive disorders. During the first year of life, depressive disorders are often related to problems with attachment and mothering, perhaps caused by separation related to death, illness, or other factors. Depressive disorders may also be caused by neglect from a caregiver who is overwhelmed by a lack of resources or supports (e.g., teen parent, single parent), suffers from depression or another mental illness, or is addicted to drugs. Depressed preschool children may suffer from separation anxiety or withdraw from other children in a childcare setting. They also might be aggressive to other children and defiant with adults. Depressed preschool children are often uncooperative, cry frequently, have temper tantrums, look sad, and have sleep and eating problems. Research shows that many depressed preschoolers have suffered from traumatic events (e.g., serious illness, parental divorce) or stressful events (e.g., birth of a sibling), or have experienced abuse and/or neglect. Depressed school-aged children usually show poor self-esteem and self-blame, pervasive sadness, inability to have fun, and either poor school performance or refusal to attend school. About 70% of depressed children complain of headaches and stomachaches that do not have any physical cause.

Given the developmental and psychosocial context of early childhood depression, treatment with medication alone is not sufficient. Overall, there have been very few studies on the use of medications for young children with depression. The pharmacological treatment literature suggests that only those medications targeting the serotonin systems have demonstrated efficacy in treating depression in pre-adolescents.

Research shows that psychoeducation – the education of the parents, child, other family members, and childcare providers or teachers about childhood depression and its treatment – drastically reduces treatment dropout and allows treatment to proceed with less blame of the child or self-blame on the part of parents or caregivers. There is a strong relationship between family factors and depression in children. If a child presents with serious depression, it is important to verify whether the parent is depressed and requires treatment. Untreated parental depression may affect the development of normal parent-child attachment and social, emotional, cognitive and interpersonal skills.

With younger children, clinicians tend to work with both the child and parents in treatment. There is little evidence, however, that parent counselling and family therapy alone are effective in treating child depression. Home-based interventions may work with the family to develop a supportive home environment or reduce the stress at home. Social work intervention may be helpful in dealing with issues related to poverty and

psychosocial stress (e.g., unemployment, homelessness, access to social supports).

Evidence from clinical and controlled studies shows that cognitive-behavioural therapies are effective for treating mild or moderate depression in children, or for treating serious depression when used together with other therapies. For children who have been physically abused, research indicates that interpersonal therapy can be used to combat depression by strengthening social competence. Therapist reports indicate that the principles of psychodynamic therapy are useful for treating children with mild and moderate levels of depression, when integrated with structured forms of therapy such as interpersonal and cognitive-behavioural approaches.

Enuresis (Bed-Wetting)

Enuresis involves repeated involuntary or voluntary urination into the bed or clothes that impairs a child's functioning and is not related to a medical problem. Wetting the bed is a primary concern of parents, although it is quite common for younger children. About 40% of children wet the bed at age 3 and nearly 25% at age 5. A well-established efficacious treatment for enuresis is the bell-and-pad or urine alarm system that has been used for over 60 years. Urine alarms used over a period of 5 to 12 weeks usually eliminate enuresis for 75% of children. Studies have found positive treatment effects for urine alarm programs coupled with other treatment strategies, such as contingency management, retention control training, overlearning, and cognitive behavioural treatment.

Encopresis (Soiling)

Encopresis is the involuntary voiding of stool in underwear or other inappropriate places by children older than age 4. Approximately 1-3% of children suffer from encopresis, and it affects boys 3-6 times as often as girls. Constipation plays a major role in encopresis, as well as in other toileting problems. In the absence of a clear psychopathology, the treatment program of choice is medical. Parent education about encopresis, together with parent training about medical management strategies (enemas, dietary fibre) and behavioural management training (contingency management, contracting), improve encopresis symptoms. These parent education programs have been delivered successfully in both individual and group formats.

Pain Related to Physical Illness

Pain is one of the most common problems related to physical illness in children. Both developmental stage and the experience with pain affect the development of children's reaction to pain. Recurrent abdominal pain occurs in 10-20% of young children. It is most common in the 5 to 12 year age range, and it appears with equal frequency in boys and girls. In the absence of a medical condition or constipation, family-based cognitive

behavioural therapy (CBT) that includes relaxation training and contingency management is more effective than medical care in reducing recurrent abdominal pain.

Headaches are common among children and it is estimated that approximately 10% of children suffer from migraine headaches. Headaches are more common and more severe among girls than boys. About 70% of children experience occasional headaches. Research indicates that progressive relaxation training and biofeedback are efficacious in reducing headache pain, but biofeedback is not as well-established as relaxation training.

A significant proportion of children undergo painful medical or dental procedures each year, ranging from injections and filling cavities to burn treatment, bone marrow aspirations, lumbar punctures, and surgery. Research shows that children do not become accustomed to these procedures, but may become increasingly sensitized and disturbed by them over time. Research demonstrates that cognitive behavioural therapy (CBT) is a "well-established" intervention for treating pain associated with medical procedures. CBT is especially efficacious for managing the pain involved with injections and venipuncture. For more complex procedures, a combination of pain medication and behavioural support produces the best pain management.

PROMISING PRACTICES IN EARLY CHILDHOOD MENTAL HEALTH: TREATMENT AND INTERVENTION FOR ATTACHMENT AND PARENT-CHILD RELATIONSHIP DISORDERS

Therapy with infants and their parents has been strongly influenced by Bowlby's concepts of internal working models and attachment. According to Bowlby, internalized early experiences provide a structural framework to explore attachment-related current emotional events in the context of a therapist-parent relationship.

Attachment theory is the one theory of socioemotional development that is best supported by empirical research. Although the systematic application of attachment theory to clinical issues is still evolving, it has been applied extensively to infant-parent psychotherapy for treating attachment disorders and parent-child relationship problems.

The *Infant-Parent Program* (IPP) provides an illustration of a promising therapy program developed to treat relationship disorders in infants from birth to 3 years of age. The children engaged in the IPP had a wide range of symptoms that various research studies have related to attachment disorders and problems in parent-child relationships. Children's symptoms included failure to thrive, depression, separation anxiety, multiple fears, tantrums, inattentiveness, impulsivity, and anger. A sub-group of the infants and toddlers were formally diagnosed with reactive attachment disorder according to DSM-IV and DC:0-3 diagnostic criteria.

As the program evolved, the original emphasis on the early childhood experiences of the parents was complemented by a focus on individual differences in babies, the parents' perceptions of their children's emotional and behavioural difficulties, and the impact of stressful life experiences on the parents. In keeping with attachment theory, the quality of the parent-therapist relationship is seen as the key factor in therapeutic change. IPP intervention begins with a 6-week assessment process aimed at building a working alliance with each child's parent or caregiver, as well as collecting information about the child and family. During the assessment phase, the child is given a formal neuropsychological assessment. If infant-parent therapy is indicated, then the assessing therapist also conducts the treatment to maintain a positive working relationship and continuity of relationships. The therapy sessions involve the parent and the infant and take place either in the home or in the office playroom.

Both the assessment and treatment sessions are unstructured, with the themes guided by interactions between the parent and the child or by the parents' free-associations. Child observations monitor the child's level and quality of functioning. These observations supplement the formal neuropsychological assessment. The therapist uses a variety of methods (joint play, developmental guidance, emotional support, insight-oriented interpretations) to modify the parent's rigid and distorted perceptions of the child. The aim is to construct a more flexible and developmentally-appropriate set of perceptions and behaviours that will allow the child to become more securely reliant on the parent.

In terms of empirically-supported outcomes, researchers reported significant differences between the intervention and control groups in a randomized treatment outcome study of the IPP. The intervention group showed significant gains on important measures related to attachment, such as maternal empathy and children's avoidance, resistance, and anger toward their mothers. There are a growing number of infant-parent intervention programs that make use of attachment theory. Several of these programs are currently being evaluated for their efficacy and effectiveness with different groups.

1. Introduction

Children's mental health centres in Ontario have had a strong commitment to mental health services for children from birth to 6 years of age. Over the last decade, children's mental health centres have been providing a broad range of services and supports to infants and young children, delivered in the home, school, community clinics and other community settings. Children's mental health centres have also been actively collaborating with other sectors to deliver services to children and their families.

As part of the new initiative to support early childhood mental health programs, the Ministry of Community, Family and Children's Services and the Ministry of Health and Long-term Care have asked Children's Mental Health Ontario to assemble information on best practices, and develop and co-ordinate training for staff working in this specific area.

Because children's mental health centres see clients with complex and serious problems, it is especially important that clinical staff have a clear understanding of the comparative effectiveness of a range of interventions and service models for specific types of clients. Since the body of knowledge about the mental health needs of young children and their parents is evolving so rapidly, this project provides the opportunity for Ontario to develop its programs based on state-of-the-art information. This project proposes to bridge the gaps between knowledge and practice by undertaking a thorough analysis and synthesis of best practices for a range of community-based services for children from birth to age 6 with serious mental health problems, and their families.

The first phase will identify best practices through a literature review and feedback from experts in the field. The second phase will involve input from front-line clinicians, experienced in community-based mental health services for young children, to help translate the practice guidelines into an effective training program. Children's Mental Health Ontario will use this information to develop the *Early Childhood Mental Health Training Program* and resource materials. It will then train children's mental health teams throughout the province in the delivery of these services. The combination of training program and resource materials is intended to enable centre staff to transfer the findings of this study into effective community-based programs across the entire children's mental health system in Ontario.

2. Methodology

The methodology included reviews of the research and practice literature in Canada and elsewhere to identify the key principles and best practices that lead to successful treatment outcomes for infants and young children and their families. The following methods were used:

- (1) Searching computerized databases
- (2) Conducting supplementary hand searches of journals, reviews, books and materials
- (3) Searching relevant Internet resources and websites
- (4) Contacting selected researchers, practitioners, and organizations

Given the mandate of this study, the review gave special attention to:

- the empirical evidence for the comparative effectiveness of various interventions in real-world practice settings;
- the contextual and implementation factors that contribute to the successful implementation of these interventions in a variety of settings (home, school, community); and
- the competencies (knowledge and skills) and training strategies that will build the necessary capacity to deliver effective early childhood mental health programming.

3. Context of Early Childhood Mental Health Services

3.1 What Are Early Childhood Mental Health Services?

The following is a working definition of early childhood mental health services, developed through a review of the literature and consultations in Ontario:

Early childhood mental health services consist of multidisciplinary services provided to children from birth to six years of age to identify and treat existing or emerging mental health problems, enhance adaptive parenting and overall family functioning, strengthen competencies, minimize developmental delays, prevent functional deterioration, enhance the ability of other systems to address the needs of young children and their families, and promote child mental health and well-being.

This definition emphasizes a number of important characteristics of early childhood mental health services. These services:

- involve multiple disciplines;
- focus on infants and young children from birth to six years of age;
- identify and treat either existing mental health problems, or those that are emerging as a result of risk factors and/or developmental challenges;
- adopt a systems approach that includes the child, family, and community;
- take a strength-oriented and capacity-building approach to prevent or limit more serious mental health problems;
- adopt an ecological approach that views all systems that affect children and families as working together to create a healthy community environment; and
- promote positive mental health and well-being for children and their families.

3.2 Improving Awareness of Early Childhood Mental Health Needs

Attention to the mental health needs of young children and their families has grown rapidly in recent years. Early childhood mental health services are increasingly considered essential as more information becomes known about the emotional and behavioural challenges faced by children from birth to six years of age. In the *Early Years Study*, Fraser Mustard drew national attention to the deleterious effects that stress and other risk factors can have on early brain development and, as a result, on children's mental health (Mustard & McCain, 1999).

How widespread are children's mental health problems? The *Ontario Child Health Study* is generally considered the "gold standard" for estimating children's mental health problems in Ontario and elsewhere in Canada. In this widely respected study, Dan Offord and his colleagues (1987) found that at least one in five children and adolescents have a mental health problem. The research team also found that as many as 40-50% of children with mental health problems have more than one disorder at the same time (Rae-Grant and others, 1989).

Regarding very young children, a recent study in the United States of nearly 4,000 preschool children found that 21% meet the criteria for a psychiatric disorder and 9.1% meet the criteria for a severe disorder (Lavigne and others, 1996).

Evidence indicates that serious disorders such as depression and alcohol abuse/dependence are increasing among younger generations and emerging at earlier ages. Giaconia (1994) and colleagues found that age of onset for serious mental illness varies according to disorder. Early onset of one disorder also greatly increases the risk of being diagnosed with one or two other disorders by 18 years of age. Evidence is mounting, therefore, that early onset of a serious mental health problem is not simply an isolated or transient episode of little developmental importance. Early onset may indicate the start of a continuing pattern, the appearance of coexisting disorders, and poor functioning later in adolescence, especially for disorders such as serious depression, conduct disorder, phobias, and post-traumatic stress disorders.

Sprott and Doob (1998) note that Canadians are becoming more concerned about the aggressive behaviour of very young children, and studies indicate that the origins of criminal behaviour go back to early childhood well before age 12, the age of criminal responsibility in Canada.

Given greater awareness of these needs, early childhood mental health has recently emerged as a distinct field of service delivery, drawing from research and experience with early intervention and related fields. Evidence-based studies found that mental health programs can benefit children with emerging or identified behavioural and

emotional challenges, as well as those having difficulty developing age-appropriate social and emotional skills (e.g., emotional self-regulation) and parent-child relationships. Even so, it is important to know that, compared with other age groups, knowledge about the mental health needs of children under 3 years of age and the most effective treatment interventions is limited. More research and rigorous treatment evaluations must be done to address these limitations.

Early childhood mental health gives special attention to the following populations:

- 1) infants, toddlers, and preschoolers with established mental health problems
- 2) infants, toddlers, and preschoolers with increased environmental risk (e.g., teen parents, substance-abusing parents)
- 3) infants, toddlers, and preschoolers with increased biological risk (e.g., extremely low birth-weight, asphyxia)
- 4) infants, toddlers, and preschoolers who have been abused, neglected or witnessed violence

In addition to treatment for children who demonstrate a problem, studies have also found that early childhood mental health services can benefit families and communities by supporting healthy child development and positive parent-child interactions. Early childhood mental health services have been used to strengthen children's relationships with caregivers and develop age-appropriate social and emotional skills (Knitzer, 2000). Children's mental health interventions are designed to intervene early when emerging needs have been identified, and to increase the skills of parents and other caregivers to improve the well-being of children at risk.

The ultimate goal of early childhood mental health is to enhance the well-being of all children and to minimize or avoid behavioural and emotional problems in children with special needs (Cohen & Kaufman, 2000).

3.2 Research into Early Childhood Development

Early childhood mental health is grounded by research advances in three areas:

- Biological and psychological research
- Ecological and systems theories
- Early intervention and health promotion

Recent advances in biological and neuropsychological research demonstrate that all organisms adapt to their environment and that neither behaviour nor developmental

potential are fixed by genetic factors or limited by strict critical periods. This basic research is bolstered by applied studies that show the effects of early intervention on brain development, resulting in improved cognitive scores and reduced behavioural problems later in life (e.g., Olds, Henderson and others, 1998). It also has been affected by research on the impact of stress on the healthy development of young children and their families, and the value of mental health services to reduce stressors and prevent additional problems.

Advances in the understanding of the development of young children show the importance of the ecological context that begins with the family, then widens to include the child's immediate community, and then expands further to embrace the broader socio-cultural-economic environment. The ecological context provides a framework for all aspects of early childhood mental health, from prevention and identification of developmental concerns, through to assessment, service delivery, program evaluation and the formulation of policy. Rather than focus on the child alone, an ecological framework also includes the mutual transactions among the child, the family and the community.

Advances in early intervention and health promotion underscore the diversity of developmental opportunities and challenges, and the interdisciplinary mix of services and supports required to meet those needs. Research supports the notion that well-designed early interventions and mental health promotion/prevention activities can enhance the development and well-being of children from all social classes and cultural groups. These approaches recognize the cultural and economic contexts of families by improving social supports, connecting families with resources, improving parents' coping skills, advocating for families, enhancing parent-child relationships and parenting competencies, empowering parents, and providing services that are responsive to cultural differences.

3.3 Importance of a Positive Family Environment for Young Children

The field of early childhood mental health has been influenced strongly by Bronfenbrenner's ecological-systems perspective of families (Bronfenbrenner, 1986). His theories provide the framework for research that examines the mutual transactions between child, family, and community. This perspective argues that the behaviour of young children must be understood in the context of age-appropriate developmental tasks and the importance of nurturing environments. The stages of early childhood development are characterized with particular tasks (e.g., developing physical skills through play, acquiring cognitive and social skills, developing language). Nurturing responses by caregivers contribute to competence through the mastery of these tasks. Together with fostering positive attachments, they maximize the potential for healthy development. The capacity of caregivers to nurture healthy development depends on their knowledge of child development, availability of resources to meet their children's needs, and cultural factors. Changing social conditions, such as the growing number of working parents and those in one-parent homes, are increasing the stresses on children and their

caregivers.

The primacy of the family appears in the transaction models of child development (Sameroff, 1993) that view the child as a product of interaction with parents, other family members, and the wider environment. Positive attachments, relationships, and interactions with parents and family members lead to healthy child functioning. Family systems theory also provides a base for identifying the contributions of stresses, coping strategies, and social supports on the behaviours of children and families. Strength-based and family empowerment models show the importance of harnessing the inherent strengths of families and communities to improve the mental health of children and their families.

3.4 Risk and Protective Factors: Implications for Child Development and Early Childhood Mental Health Services

In the early childhood literature, risk refers to a characteristic of a child or the environment that research associates with a negative child development outcome. The "environment" includes both family and community. A risk factor does not cause the negative outcome, but it increases the probability that a negative outcome, such as a behaviour problem, will occur.

In terms of intervention, research on risk and protective factors indicates that reducing risk factors and developing protective factors can influence positive outcomes. It also shows that interventions that target several risk factors have a higher probability of producing positive outcomes. To be effective, however, interventions should address three levels: individual level, family level, and community level. The presence of multiple risk factors is associated with poor child outcomes. Exposure to any combination of three or more risk factors places children at increased risk.

On the other hand, research indicates that some children demonstrate resilience to problems, that is, the ability to overcome stresses posed by risk factors in the environment. Rutter (1985) calls these protective factors, and his research associates protective factors with resistance to psychiatric disorders. Protective factors are characteristics of the child or environment that may protect a child from a poor developmental outcome, or reduce the negative effects created by risk factors. Rutter (2000) argues that a holistic approach is necessary because the same personal quality or environmental characteristic can be either a protective or vulnerability factor, depending on the psychosocial context.

Garnezy (1991) refers to a protective triad that involves the strengths of the individual, the family, and the school and community. Individual qualities include intelligence, high self-esteem, sociable and relaxed temperament, and abilities. Family strengths include a close relationship with a caring parent or caregiver, positive parenting, socioeconomic

advantages, and a supportive home environment. School and community strengths include attendance at safe and effective schools, participation in social groups at the school and in the community, and having adults external to the family who actively promote the welfare of children. Increasingly, early childhood mental health services are emphasizing the strengthening of resilience and protective factors, especially efforts to increase parenting skills and parent-child relationships, advocate for quality childcare and education, expand social supports, reduce poverty and homelessness, and build healthy communities.

The following sections will briefly examine six types of risk factors that are closely associated with early childhood mental health problems. These six types of risk factors are:

- Poverty
- Parental mental health problems
- Limited parenting skills
- Problems with attachment
- Alcohol and drug abuse
- Prematurity and low birth weight

Poverty: According to data from the first phase of the *National Longitudinal Survey of Children and Youth*, children living in families where income is below 75% of Statistics Canada's Low Income Cut-Off have higher rates of behaviour problems and repeat grades in school more often than children living in poverty but whose families have higher incomes (Offord & Lipman, 1996). The *Ontario Child Health Study* reports similar levels of behaviour and school problems related to poverty (Lipman, Offord & Boyle, 1994).

Parental Mental Health Problems: Parental mental health problems are risk factors that affect parenting, and often appear together with other risk factors such as alcohol and drug abuse, exposure to violence, and teen pregnancy. Maternal depression is the mental health problem that research links most closely with poor parenting and strained parent-child relationships that can lead to problems in the adjustment of infants and children (Gelfand & Teti, 1990). Depressed mothers tend to show negative parenting practices such as unresponsiveness, inattentiveness and intrusiveness, as well as erratic disciplining. The interaction styles of depressed mothers, such as being withdrawn-unavailable or hostile-intrusive, are believed to interfere with emotional regulation, and this theory is supported by longitudinal research (Laucht and others, 1994). Maternal depression is also linked to abuse and neglect that, in turn, can lead to serious behavioural and emotional problems later in life (Rogosch and others, 1996). Finally, research shows that depressed mothers have fewer social supports available to them, and social supports are a key protective factor for building resilience.

Limited Parenting Skills: Research shows that mothers with limited parenting skills, especially teen mothers, place their children at risk for mental health problems. Mothers with limited parenting skills are more likely to engage in poorly regulated patterns of interaction (e.g., child cries and mother yells at child for crying). These negative patterns of interaction and parenting styles support the finding that the children of adolescent mothers are at higher risk for developing insecure and disorganized attachment relationships. This may contribute to the poorer social and emotional outcomes observed in the children of teen mothers and others who have limited parenting capacity. These mothers are generally less responsive to their infants, and initiate verbal interactions less often. As another result, their children tend to be raised in limited cognitive environments, which makes them less prepared for school as they grow older (Osofsky, 1996).

Problems with Attachment: Through the attachment process, the parent and child form an emotional bond that provides the child with a secure, consistent base to explore and learn about his or her environment (Waters and others, 2000). Starting in the first year of life, the evolving attachment relationship helps the child to engage with the world and regulate behaviour and emotions, especially under conditions of stress. A combination of theoretical work and empirical findings (see Carlson & Sroufe, 1995 for a review) indicate that problems with insecure or disorganized attachment can result in a wide range of possible negative outcomes, such as conduct problems, depression, anxiety and phobias, psychosomatic disorders, sleep and eating disorders (including failure-to-thrive), and personality disorders.

Alcohol and Drug Abuse: There is an extensive body of literature about the detrimental effects of alcohol and drugs on a child when they are introduced early in life. Before birth, the use of alcohol and drugs may result in birth defects and developmental problems, including difficulties in information processing, disturbance of attention, and decreased interactions. Mothers who abuse drugs also show much lower levels of interaction with their infants, and a lack of ability to parent effectively given their preoccupation with drugs, neurological impairments caused by long-term drug use, and often high rates of depression (Mayes, 1995). Living with an addicted parent can affect a child's development of trust, attachment, autonomy, self-esteem, behavioural control and regulation of emotions (Kaplan-Sanoff, 1996).

Prematurity and Low Birth Weight: Both prematurity and low birth weight are associated with a variety of developmental problems. With regard to mental health issues, these infants are seen as more difficult to parent and less responsive to parental interaction, less able to regulate distress, and at higher risk for behavioural and emotional difficulties (Achenbach and others, 1990). Klaus Minde and colleagues (1989) followed 77 premature children and found that, at 4 years of age, 43% of the children showed a likelihood of having a behaviour disorder. This is four times higher than a non-clinical

preschool group. The most frequent problems were eating difficulties, settling difficulties and overactivity, as well as temper tantrums, demands for attention, and problems with self-regulation. A wide variety of intervention programs have been developed to address the needs of premature/low-birthweight infants and their families, ranging from remediation programs for infants to home visiting programs, to parent education programs.

4. Assessment of Early Childhood Mental Health Concerns

4.1 Key Elements of Early Childhood Assessment

For children from birth to 6 years of age, it is important to rule out health and developmental issues before determining that there is a mental health problem. Depending on the individual situation, assessments related to speech and language, occupational therapy, and pediatrics may be warranted.

New approaches to early childhood mental health assessment focus on sources of resilience and identifying the unique strengths of children and families. According to Meisels and Atkins-Burnett (2000), there are five elements of early childhood assessment based on recent research findings:

1. Target of assessment
2. Context of assessment
3. Methods of assessment
4. Assessment personnel
5. Fusion of assessment and intervention

Target of Assessment: Traditionally, assessments focused on the child alone. Today, assessments view the child in relation to the family and caregivers and the larger ecosystem. For example, considerable research shows that effective mother-child interactions are linked to positive child outcomes, and the mother-child relationship mediates risk. These assessments are likely to include composite risk-indexes such as those used in the *Canadian National Longitudinal Survey of Children and Youth* and the *Readiness to Learn at School* research.

Context of Assessment: In the traditional approach, assessments of young children took place in structured environments under controlled circumstances. The more recent trend is to conduct assessments within familiar settings that are comfortable, non-threatening and of interest to the child (e.g., homes, daycare, school). In keeping with the ecological framework, assessment strives to be "culturally competent" by considering ethnic and cultural factors in the process and "context sensitive" by assessing children in familiar environments.

Methods of Assessment: Whereas traditional assessments employed highly specialized procedures and norm-referenced instruments administered in a formal environment, current assessments make use of everyday environments to enable children to demonstrate what they are experiencing. Much of the change in methods of assessment reflects dissatisfaction with conventional psychometric tests, given problems such as lack of agreement across measures, unreliability, circularity of criterion measures, and not providing information that is useful to guide intervention.

Assessment Personnel: Current approaches to assessment depart from the traditional model of a client assessed by a single assessment expert. Since children's mental health does not work in isolation, current best practice is multiple assessments by persons representing multiple disciplines (multidisciplinary assessments). Other trends include developmental monitoring (closely watching a child's development without implying a specific process or technique), developmental screening, deliberate attention to parents' expression of concern regarding their children's psychosocial and developmental problems, and greater reliance on systematic clinical judgment or judgment-based assessment (Neisworth, 1990).

Fusion of Assessment and Intervention: According to Meisels and Atkins-Burnett (2000), the most significant change to take place in early childhood assessment in recent years is the fusion of assessment and intervention. This approach to assessment has its roots in the early childhood field. It is based on the ideas that knowing a child is a far more dynamic process than learning about objects and events, assessment is ongoing, and the hypotheses generated by the initial assessment will be tested and refined during intervention. As a result, a new class of assessment tools has been generated, such as the *Infant-Toddler Developmental Assessment*, the *Transdisciplinary Play-Based Assessment*, and the *Ounce-of-Prevention Scale*. These tools obtain assessment information while helping structure interactions that support the child's development.

4.2 Age of Onset and Gender Factors in Child Assessment

Giaconia (1994) and colleagues found that early childhood mental health problems generally have onset at different ages, and onset also varies according to gender. Simple phobias are most likely to have onset in infancy and early childhood and to decrease by the time children reach 8 years of age. Social phobias also show early onset for some children in infancy and onset increasing steadily through early adolescence. Post-traumatic stress disorder (PTSD) begins onset as early as age 4-5 years and peaks at age 16-17 years. Early onset PTSD is associated with interpersonal problems later in adolescence. Major depression shows early onset at age 6-7 years and increases throughout adolescence. Alcohol abuse/dependence has onset as early as age 8 and drug abuse/dependence as early as age 10. Both increase sharply to peak levels in mid-adolescence (14-15 years of age).

Gender differences are important when assessing risk for early onset of disorders. Although gender differences in rates of psychiatric disorders have been studied for adolescents and adults, only recently have gender differences in ages of onset been examined for children. In terms of the disorders reported in Giaconia's (1994) study, females tend to have earlier onset for serious depression, simple phobias, social phobias, and post-traumatic stress disorder. Children with childhood-onset conduct disorder tend mostly to be male.

4.3 Family Assessment

Family assessment within early childhood mental health has been strongly influenced by ecological, systems, and strengths/empowerment models. The result is an emphasis on family-focused assessment strategies that allow families to conduct their own evaluations of their strengths, resources and needs. This approach may be used by professionals with little or no formal training in family assessment, and will still provide information useful for making referrals (e.g., to psychiatrist for depressed mothers) and designing interventions. It stands in contrast to the more traditional family assessments based on theories of child development, family development and adaptation by the caregiver (Simeonsson and others, 1995).

The essential domains for useful family assessments are:

- Values, attitudes, beliefs
- Patterns of relationship within the family
- Ecology of the family
- Specific family needs
- Family resources
- Existing and potential sources of support
- Current expressions of family stress

The current approach to family assessment first requires that practitioners develop a respectful stance toward the family that emphasizes partnership and shared understanding. Beckman and others (1996) identified six specific skills needed for establishing a positive assessment relationship with the family. These are:

1. Joining with the family (listen without judging)
2. Active listening (listen to what is said and how it is said)
3. Effective questions (balance between open- and closed-ended questions)
4. Reflect and clarify parent comments
5. Provide information
6. Reframe (redefine problems or information in a positive way)

4.4 Assessment of Parent-Child Relationships

Research shows that the quality of early parent-child relationships has important effects on a child's development. Instead of focusing on the assessment of the individual child alone, current early childhood mental health assessment includes assessment of the quality of parent-child interactions.

Research over the last three decades has identified the important elements of parent-child relationships. These elements include the behavioural responses of both the parent and child, and the reciprocal relationship that develops through interactions over time.

From the mental health perspective, considerable research has explored the parent-child interaction in families at risk for environmental reasons. In this context, environmental factors include characteristics of the mother (low intelligence, low educational achievement, teen mother, depression, low self-esteem) and family (large family size), and socio-economic factors (poverty). Children exposed to multiple risk factors are especially vulnerable to developing behavioural and emotional disorders.

In families with identified risk factors, assessment has focused more on identifying parental behaviour patterns rather than the child. For example, studies find that mothers from disadvantaged environments generally are less stimulating, less responsive, and more controlling than mothers from middle-class environments. In contrast, studies of children's resiliency show that positive parent-child interaction and attachment lead to greater resilience.

In terms of best practices for assessment of parent-child interaction, Mahoney and others (1996) cautioned that standardized assessment measures are not sufficiently developed to be included in the assessment process, and might lead to false conclusions about the parent-child relationship. Because of the importance of understanding the parent-child relationship, Kelly and Barnard (2000) developed the following recommendations for obtaining assessment information:

- Recognize the importance of the parent-professional relationship
- Determine what assistance is needed
- Assess individual parent and child characteristics and reciprocity
- Respect individual values and preferences
- Use an approach that allows the parent to remain in contact with the child
- Use a joint parent-professional assessment process
- Emphasize the positive
- Make assessment an ongoing process

The *Parent-Child Early Relational Assessment* (Clark, 1985) is an example of a

standardized tool for assessing parent-child relationships. The major concept behind the assessment is that maternal affect serves as a regulator of the infant's social development. The scale was developed for use with parents with psychiatric problems, but it is applicable to other populations. The procedure involves videotaping four specific episodes of interaction in a 20-minute sequence. The episodes include feeding, an age-appropriate structured task, free play with toys, and a brief separation and reunion of parent and child. The four situations provide sufficient data to assess parenting strengths as well as vulnerabilities. A training manual assists in the objective assessment of the four episodes. Research supports the ability of the scale to discriminate between high-risk and well-functioning mothers and between securely and insecurely attached infants.

5. Methodology for Identifying Promising Practices in Early Childhood Mental Health Treatment and Intervention

The purpose of this section of the review is to summarize the findings about the most promising treatments for infants and young children, using the best information available. The primary focus of the review is treatment programs for young children with established mental health problems, because in Ontario, children's mental health centres have the mandate to serve children and families with very serious problems. The review concentrates on psychosocial treatment and interventions rather than medical or psychopharmacological treatments. Given the close relationship between neurobiology and early childhood problems, medical assessment and treatment should be considered on an individual basis.

5.1 Methodology for Identifying Promising Treatment and Interventions

The review takes two approaches to identifying promising treatments. The first is to apply a criterion-referenced approach using the evaluation of studies reviewed by the *Lonigan and Elbert Task Force on Empirically Supported Psychosocial Interventions for Children* (Lonigan and others, 1998) and other published scientific literature reviews. These reviews commonly apply the stringent criteria of the *APA Task Force on Psychological Intervention Guidelines (Barlow Task Force)* and the *APA Task Force on Promotion and Dissemination of Psychological Procedures (Chambless Task Force)* to identify empirically supported treatments.

Since this review serves as the foundation for a provincial training initiative, the findings concerning the effectiveness and feasibility of treatments and interventions are of particular importance in terms of their:

- 1) treatment effects in real-world settings;
- 2) acceptability to clients;
- 3) ease of training staff; and

4) the costs of the implementing the treatment modality or intervention.

The standards for ranking treatments used by the *APA Task Forces* are based only on efficacy (i.e., strength of a treatment as observed in well-controlled evaluation studies) rather than including the effectiveness criteria (i.e., how well the treatment works in the "real world") proposed by the *Barlow Task Force*. As a result, simply disseminating lists of promising treatments based on efficacy does not ensure that quality services will be delivered to children and their families. Thus, a second approach was added that included a review of available materials to determine their effectiveness and feasibility in real-world settings.

5.2 Limitations of the Review of Promising Treatments and Interventions

This review was conducted within a very tight timeframe, and therefore had to draw upon existing articles, databases, reviews, and other available material. The goal of this review is to identify promising treatments and interventions. In many respects, the research into efficacious and effective early childhood mental health treatments and interventions is just beginning. Although promising practices exist, the review identified serious gaps in the evaluation of treatments and interventions, especially for infants and very young children.

One contributing factor is that the treatment research literature tends to adopt a conventional model of treatment based on symptoms and problems diagnosed by applying specific criteria. There is considerable controversy among mental health researchers and practitioners about the applicability of DSM-IV or alternative diagnostic criteria (e.g., ICD-10, DC:0-3), especially for infants and very young children (e.g., Zeanah, 1996). The result is a paucity of high-quality, empirically-based studies on the efficacy and effectiveness of interventions that address the full range of early childhood mental health problems (e.g., infant-caregiver relationships, maladaptive patterns of development, disorganized attachment). These notable shortcomings in the research are likely to be more adequately addressed as early childhood mental health attains greater visibility. This review of promising practices in early childhood mental health, therefore, is best viewed as a first step of a work-in-progress for identifying the best possible treatments and interventions for infants and young children in Ontario.

6. Promising Practices in Early Childhood Mental Health: Treatment and Intervention for Specific Disorders

The following sections present promising practices for specific disorders, typically diagnosed using DSM-IV criteria.

6.1 Anxiety Disorders

Anxiety is characterized by a strong negative emotion and an element of fear. A moderate level of anxiety is adaptive and is experienced by most children as they develop. The following anxieties are developmentally appropriate for infants and young children (Klein & Last, 1989):

- 0-6 months – anxiety or fear at the loss of physical support or the sound of a loud noise
- 7-12 months – anxiety with strangers
- 12-18 months – separation anxiety and concerns over toileting
- 2-5 years – fear of animals, machines, dark rooms, anxiety over separation from caregivers, and concerns about physical harm
- 6 years – anxieties about spirits/ghosts/monsters, dark places, staying or sleeping alone, and bodily injury

An anxiety disorder may be present when a child experiences excessive and debilitating anxiety to the point of significantly impairing the child's functioning. According to epidemiological studies, anxiety disorders are the most common type of mental health problems in children and are present in 6-18% of the child population (Castellanos & Hunter, 1999). For younger children, the most frequently identified childhood anxiety disorder in clinics is separation anxiety, followed by social phobia, and then by simple phobias (e.g., fear of a specific animal or object). There are clear gender differences for anxiety disorders, with more girls than boys having separation anxiety, phobias, and generalized anxiety disorder.

Other disorders can appear at the same time (comorbid) as an anxiety disorder. The most frequent comorbid disorder is another anxiety disorder – about half of clinic samples show a comorbid anxiety disorder. The other most common comorbid disorders are depressive disorders and disruptive behaviour disorders, especially attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD).

6.1.2 Treatment of Anxiety Disorders with Medication

None of the medications studied provide definitive evidence of their effectiveness or safety for treating anxiety in children. These include tricyclic antidepressants, SSRIs, benzodiazepines, and Busipone. Moreover, some of these medications put children at risk for serious side effects and possibly life-threatening physical problems (Velosa & Riddle, 2000). Because of these potential dangers, non-medical interventions are the treatment of choice.

6.1.3 Psychosocial Treatment for Anxiety Disorders

In general, well-designed studies that evaluate the efficacy of treatment interventions for anxiety disorders focus on children who are age 5 or older. Although some of the following interventions appear promising for younger children, it is important to note that their efficacy has not been demonstrated.

Cognitive behaviour therapy (CBT) is proven effective in the treatment of children with severe anxiety disorders, including generalized anxiety disorder, separation anxiety disorder, and social phobia. CBT is effective for anxious children with and without comorbid disorders such as ADHD or depression (Kendall and others, 1997). These CBT programs are built on the original treatment manuals developed by Kendall, including the *Coping Cat Workbook* (Kendall, 1992) and the Australian variation called the *Coping Koala Workbook* (Barret and others, 1991). During the early phases of the treatment program, behavioural techniques such as modelling, role playing, shaping and social reinforcement are used to build the children's basic coping skills. During the later phases, children practice their coping skills when they are exposed to imagined and actual feared situations.

In a subsequent study, Barrett and colleagues (1996) added a family anxiety management component that teaches parents anxiety management, contingency management for reinforcing positive behaviours and extinguishing anxiety-related behaviours, and skills for coaching and communicating effectively with their children. The addition of this component increased clinically significant recovery from 57% with the individual CBT treatment program alone to 84% of cases, and this recovery rate rose to 96% a year later.

Preliminary evidence indicates that group administration of CBT with a parent training component is effective for treating children diagnosed with generalized anxiety disorder, overanxious disorder, and social phobia (Silverman and others, 1999). There is also early evidence that the combination of group CBT and parent training is effective for preventing anxiety disorders in high-risk children (Dadds and others, 1999).

6.1.4 Psychosocial Treatment for Specific Phobias

Many of the children who received cognitive behavioural therapy also had specific phobias, and these appear to have improved as a result of CBT. In a recent review, Ollendick and King (1998) found CBT "probably efficacious" for children with specific phobias as a primary diagnosis. Kanfer and colleagues (1975) found that CBT self-instructional training is effective in reducing the fear of the dark in 5-6 year olds. Graziano and Mooney (1980) supported this finding and discovered that self-instructional training, when combined with relaxation training and parent training, leads to a rapid reduction in fear of the dark.

More recently, King and colleagues (1998) used a version of Kendall's CBT to treat school phobia in children as young as age 5. The program also included parent training

and teacher training in contingency management and strategies for improving school attendance.

In addition to the use of CBT, individual behavioural treatments effectively address phobias. In their review, Ollendick and King (1998) stated that participant modelling and reinforced practice are "well established" efficacious treatments, and systematic desensitization (both visualized and in real situations) is "probably efficacious" in treating specific childhood phobias. These individual behavioural treatments gradually expose the child to the feared object, and this principle is also at the heart of Kendall's CBT program.

6.2 Attention Deficit Hyperactivity Disorder (ADHD)

Children with attention deficit hyperactivity disorder show developmentally inappropriate levels of attention, impulse control, and physical restlessness. ADHD is a chronic and persistent problem that can interfere with many aspects of normal development and functioning from the preschool years through to adulthood (Cantwell, 1996). Prevalence studies indicate that approximately 3-5% of all children have ADHD, and one-third of children with ADHD have the type of disorder that makes sustaining attention difficult (inattentive type of ADHD). Treatment research has focused primarily on medication and psychosocial interventions for ADHD.

6.2.1 Treatment of ADHD with Medication

The efficacy of stimulant medication for the treatment of children diagnosed with ADHD and without any comorbid conditions has received very strong support in the research literature. Anastopoulos and colleagues (1992) indicated that over 70% of children with ADHD who take psychostimulant medications show improvements in behaviour, attention, and academic performance. There is growing concern, however, about the increased use of medication to treat ADHD, especially for very young children. In a study of over 200 children diagnosed with ADHD who were aged 3 years and younger, Rapley and colleagues (1999) found that over half of these very young children received medication for ADHD. Overall, recent studies report a rapid increase in the use of psychotropic medications to treat behaviour problems in preschool children (Zito and others, 2000). The lack of research on the long-term impact of these medications suggests that psychotropic medication for young children must be prescribed cautiously and side-effects monitored regularly.

6.2.2 Psychosocial Treatment for ADHD

Although stimulant medication is the treatment of choice for children with ADHD without any comorbid conditions, behavioural interventions remain the treatment of choice for those with ADHD and comorbid conditions, such as oppositional defiant

disorder or conduct disorder, or when children experience negative side effects from medication.

For young children with ADHD, behavioural parent training (BPT) has proven effective. To illustrate, Pisterman and colleagues (1992) found that 65% of preschool children (ages 3-6 years) with ADHD increased their compliance with parental requests at follow-up, after their parents received 12 sessions of group-based behavioural parent training. Parent-child interactions also showed a significant improvement compared to children in a control group. Likewise, Anastopoulos and colleagues (1993) found that children in the BPT group improved on the ADHD rating scale and on the parent and child domains of the *Parenting Stress Index*. The parents also improved on an index of parenting effectiveness.

For children beginning school (age 6) who are diagnosed with ADHD and comorbid oppositional defiant disorder, social skills training (SST) has produced improvements in parent ratings of self-control and teacher ratings of withdrawal, aggression and social acceptance (Frankel and others, 1997). Carslon and colleagues (1992) found that although medication was essential for improved academic performance, medication in combination with school-based contingency management had a positive impact on classroom behaviour, including observations of on-task behaviour and disruptive behaviour.

6.3 Oppositional Defiant Disorder (ODD)

Oppositional defiant disorder (ODD) is a persistent pattern of conduct problems characterized by defiant, hostile, and uncooperative behaviour that cannot be attributed to the child's developmental stage, and that impairs a child's functioning. It does not include violations of the law. Younger children usually show ODD through temper tantrums, arguing with adults, and stubborn behaviour. ODD often occurs with people familiar to the child (e.g., parents, caregivers) and in specific settings (e.g. home, childcare). ODD typically occurs during the preschool years and can evolve into conduct disorder and antisocial disorder later in life. Studies of non-clinic populations showed that between 10-15% of boys and girls are described as difficult to control, and 5% have temper tantrums. Follow-up studies showed that these problems persist through the preschool and early school years. Gender differences are not significant in preschool children, but school-aged boys have higher rates of externalizing behaviours. In the United States, ODD accounts for between one-third and one-half of all referrals to child and family clinics. ODD can occur together with other mental health problems, such as anxiety disorder, depressive disorder, and communication disorder. However, it is most likely to precede early-onset conduct disorder (CD), although most children with ODD do not develop CD.

Research indicates three types of risk factors that increase the probability that ODD will evolve into serious conduct problems later in life (Lehmann & Dangel, 1998). The first

factor includes child characteristics of aggressiveness, impulsivity, and inattention. The second factor involves parenting practices that do not provide sufficient parental supervision and reinforcement for prosocial behaviours or consequences for violating family rules. The third factor is problems in family organization, such as a high level of stressors, low levels of social supports, substance abuse, domestic conflict and violence, and parental mental health problems.

6.3.1 Psychosocial Treatment for ODD

To address ODD and the risk factors contributing to ODD, research indicates that behavioural parent training (BPT) combined with child-focused problem-solving skills training (PSST) are efficacious for improving behaviour at home and at school. Each program should involve 10-20 sessions over a period of 3 to 6 months. Although studies indicate that combined BPT and PSST is more effective than either BPT or PSST alone (Webster-Stratton & Hammond, 1997), if parents cannot engage in BPT, then children may be offered child-focused PSST on its own. This strategy is proven effective for some children with ODD.

A body of evidence is mounting that group-based BPT programs that include videotape modelling are as effective and less costly than individually administered BPT programs (Webster-Stratton and others, 1989). All of these studies made use of Webster-Stratton's training videotapes and manuals (Webster-Stratton, 1987) and most of the studies were conducted by Webster-Stratton's research team.

For single parents and caregivers with little social support from their partners, including a component to enhance social support may greatly improve the effectiveness of BPT (Dadds & McHugh, 1992).

6.4 Conduct Disorder

Conduct disorder (CD) is characterized by a pattern of behaviour that violates the basic rights of others or age-appropriate norms and rules of society. Overall, conduct disorder appears more often in boys than girls, with a rate of 6-10% for males and 2-9% for females. Children with childhood-onset conduct disorder tend to be mostly male, and incidence is not strongly related to socioeconomic class or ethnic group. Although the childhood-onset CD group comprise only 3-5% of youth with conduct disorder, they are believed to account for at least half of the offenses committed by young offenders.

Risk factors for CD include early age of onset (higher risk for onset during preschool and early school years), conduct problems that occur in multiple settings (home, school), frequency and intensity of conduct problems, diversity of conduct problems and covert problems (lying, firesetting, stealing) at younger ages, and family and parent characteristics (e.g., depressed mother, parental history of antisocial behaviour, substance

abuse).

6.4.1 What is Childhood-Onset Conduct Disorder?

Biological and psychosocial factors appear to interact to cause childhood-onset conduct disorder. Disruptive behaviours emerge in the preschool years, usually as negative, hostile, and defiant behaviour characteristic of oppositional defiant disorder. As the child develops, there is usually an escalation to behaviours more characteristic of conduct disorder, especially lying, fighting, and stealing. These children are more likely to have attention deficit hyperactivity disorder (ADHD), learning disabilities, and poor academic achievement. In terms of developmental progression, ADHD tends to be followed by oppositional defiant disorder (ODD) and then by conduct disorder. The association between ADHD and CD is especially strong for boys, although girls show a higher risk than boys of developing CD if they have ADHD. A consistent finding in the research is that CD children with ADHD are likely to have persistent conduct problems that extend into adulthood.

Children with early-onset conduct disorder may also show neuropsychiatric and neurobiological differences, such as low CSF serotonin levels and abnormal dopamine β -hydroxylase (DBH). These factors lend support to the idea that childhood-onset CD is more constitutional and neurobiologic in origin than adolescent-onset conduct disorder. As early-onset children grow older, their offenses tend to become increasingly severe (e.g., break-and-enter, stealing valuable goods, forced sex). They have a high incidence of substance abuse, erratic employment and marriage histories, and physical abuse of their spouses or partners and children.

Moderate and severe CD often involve comorbid disorders that require treatment (e.g., ADHD, developmental disabilities, substance abuse disorder, anxiety disorder, mood disorders). Chronic CD, usually the childhood-onset type, requires early intervention, extensive treatment in multiple domains, and long-term follow-up (Offord & Bennett, 1994).

6.4.2 Treatment of Conduct Disorder with Medication

Psychotropic medication alone is not sufficient to treat conduct disorder. Although some psychiatric medications are used to treat CD youth with a comorbid disorder (e.g., antidepressants for mood and anxiety disorders, stimulants for ADHD), this treatment is recommended only on the basis of clinical experience, since there are inadequate efficacy studies to support their use (Ritchers and others, 1995).

6.4.3 Psychosocial Treatment for Conduct Disorder

The main evidence-based individual therapy with conduct disordered children is

cognitive behavioural therapy (CBT), especially problem-solving skills training (PSST) based on the model originally developed by Spivak and Shure (1978). This form of therapy targets both antisocial behaviours and prosocial functioning. PSST helps the child manage the cognitive deficiencies believed to contribute to antisocial behaviour by improving communication skills, problem-solving skills, impulse control, and anger management. Kazdin successfully added parent management training (PMT) to further improve the effectiveness of PSST. For example, a recent large-scale prospective study on the treatment of children with CD (ages 2-14 years) found that child, parent, and family functioning improved over the course of combined PSST and PMT treatment. In addition, this treatment produced large effect sizes on child outcome measures (Kazdin & Wassell, 2000).

Family intervention is an essential component for treating conduct disorder. For younger children, the family is often the primary target for intervention. Numerous studies support the effectiveness of parent management training (PMT) to improve parenting skills and manage child behaviour effectively without the use of physical punishment. Webster-Stratton and Hammond (1997) found that group PMT with videotape modelling, combined with group child therapy (CT), are superior to either PMT or CT alone at one-year follow-up. When used alone, CT is superior to PMT for improving the children's problem-solving and conflict resolution skills with other children.

Recent well-designed experimental studies support the efficacy of prenatal and early childhood interventions (such as family-based home visiting) to reduce behavioural problems and antisocial behaviour in children born to poor families (Olds and others, 1998).

Although the literature generally does not support the effectiveness of individual psychodynamic therapy with CD children, several studies indicate that an explorative approach (Fonagy & Target, 1994) or an attachment-based approach (Moretti and others, 1994) may be useful for some CD children. If for no other reason, these approaches help to establish a therapeutic relationship that effectively engages the child in therapy.

Children with CD may be treated effectively in day treatment programs, but good follow-up and transition planning is necessary if treatment gains are to be maintained in regular preschool and classroom settings. Two common school-based treatment approaches for CD children that have research support are contingency management (Abramovitz, 1994) and the use of token economies (Kazdin, 1977) to reinforce positive behaviour and reduce negative behaviours. For children ages 3 to 7, the *Home Chip System* applies the principles of token economies to help parents and caregivers manage a range of mild-to-moderate problem behaviours in the home setting (Christophersen and others, 1981)

6.4.4 Strategies for the Prevention of Conduct Disorder

Some of the more promising strategies for the prevention of conduct disorders involve preschool children. Webster-Stratton (1998) showed improvements in conduct problems, compliance, and affect with high-risk 4-year-old children in a Head Start program by using videotapes to teach their mothers effective parenting skills, positive ways to discipline, and methods for strengthening their children's social skills. In a Canadian study, Cunningham and colleagues (1995) reported positive results for large-scale community-based parenting programs for families of preschool children.

6.5 Childhood Depression

The clinical picture of childhood depression includes features associated with mood changes that are unique to the disorder (e.g., sadness, dysphoria, worthlessness, suicidal ideation). Depression in children under age 7 tends to be less sharply defined than depression in older children and adults (Cantwell, 1990). Younger children are less likely to make serious suicide attempts. However, they are more likely to demonstrate symptoms of depressed appearance, anxiety (e.g., separation anxiety), irritability and frustration (often accompanied by tantrums and behavioural problems), apathy and disinterest, lack of cooperation, withdrawal from family and friends, physical complaints (e.g., headache and stomachache), and auditory "hallucinations."

6.5.1 Depression in Infants, Preschool Children, and School-Aged Children

There is mounting evidence that infants can suffer from depressive disorders. During the first year of life, depressive disorders are often related to problems with attachment and mothering, perhaps caused by separation related to death, illness, or other causes. Depressive disorders may also be caused by neglect from a caregiver who is overwhelmed by a lack of resources or supports (e.g., teen parent, single parent), suffers from depression or another mental illness, or is addicted to drugs.

Depressed preschool children may suffer from separation anxiety or withdraw from other children in a childcare setting. They also might be aggressive to other children and defiant with adults. Depressed preschool children are often uncooperative, cry frequently, have temper tantrums, look sad, and have sleep and eating problems. Research shows that many depressed preschoolers have suffered from traumatic events (e.g., serious illness, parental divorce), stressful events (e.g., birth of a sibling), or have experienced abuse and/or neglect (Kashani and others 1986). Researchers hypothesize that some depressed preschoolers may have trouble with emotional regulation of negative emotional states. Depressed preschoolers may have trouble with the regulatory skills needed to manage emotions, such as recognizing changes in moods and the circumstances leading to mood change, setting goals to change moods, and implementing effective coping responses (Kazdin & Marciano, 1998).

Research indicates that early identification and treatment of depressive symptoms in

preschool children should be a priority. There is evidence of biological changes, such as decreased vagal tone and right frontal EEG asymmetry, that are associated with affective symptoms in high-risk infants and preschool children. These changes occur before the appearance of overt depressive symptoms (e.g., Field and others, 1995). Research also shows that there is treatment resistance for depressive syndromes after age 6. These findings suggest exploring promising clinical interventions or prevention at an earlier stage of central nervous system and emotional development is more important than the current treatment efficacy literature indicates.

Depressed school-aged children usually show poor self-esteem and self-blame, pervasive sadness, inability to have fun, and either poor school performance or refusal to attend school. About 70% of depressed children complain of headaches and stomachaches that do not have any physical cause. School-aged depressed children may demonstrate a variety of anxiety disorders, including social anxiety and specific phobias. Some children may have recurrent morbid fantasies.

Depressive disorders are estimated to occur among 2-4% of children, and the prevalence of depression is virtually the same for girls and boys during childhood (Fleming & Offord, 1990). Serious depression is fairly rare among preschool children (less than 1%) and school-aged children (about 2%). Major depression in children is usually an episodic disorder, with each episode lasting an average of 8 months. More than 90% of children recover from an episode within 1 to 2 years (Emslie and others, 1997), whereas the remaining 10% suffer from chronic depression following their first episode.

Most children suffering from depression also have other disorders. Anxiety disorder is the most common comorbid disorder, and is present in about one-third of the children with serious depression. The type of anxiety disorder tends to vary with the age of the child. In younger children, separation anxiety appears most frequently. Dysthymia (depressed or irritable mood for at least one year) occurs in nearly one-third of depressed children. This is called "double depression" and may indicate the onset of recurrent mood disorders. Conduct disorder is also frequently comorbid with childhood depression.

There are strong associations between childhood depression and parental depression, as well as indicators of adversity (e.g., poverty, homelessness, chronic stress, family disruption). Social supports, interpersonal skills, consistent relationship with an adult, and other protective factors may reduce the negative effects of adverse circumstances, but generally there is little empirical research on this topic for depressed young children.

6.5.2 Treatment of Childhood Depression with Medication

Given the developmental and psychosocial context of early childhood depression, treatment with medication alone is not sufficient. Overall, there have been very few studies on the use of medications for young children with depression. The

pharmacological treatment literature suggests that only medications targeting the serotonin systems demonstrate efficacy in treating prepubertal depression (Emslie and others, 1997). These drugs may be useful for treating children with certain forms of serious depression that impede psychological treatment, or when the child does not respond to psychotherapy. A major concern, however, is the practice of prescribing combinations of medications ("drug cocktails") without sufficient evidence of their efficacy. Another questionable practice is prescribing medication for childhood depression without sufficient monitoring or professional support from an experienced child psychiatrist.

6.5.3 Psychosocial Treatment for Childhood Depression

Treatment interventions for serious childhood depression have not been empirically tested in systematic treatment evaluations with infants and preschool children. Further efforts are needed to develop and validate treatments and interventions for infants and younger children. As a result, comments regarding treatment interventions should be interpreted with caution.

Research shows that psychoeducation – education of parents, child, other family members, and childcare providers or teachers about childhood depression and its treatment – drastically reduces treatment dropout, and allows treatment to proceed with less blame of the child or self-blame on the part of parents or caregivers.

There is a strong relationship between family factors and depression in children (Kovacs, 1997). Depression in parents and family members, family history of psychiatric illness, substance abuse, marital discord, parent-child conflict, parental abuse and neglect, and stressful or chaotic family environments have been linked to childhood depression. If a child presents with serious depression, it is important to verify whether the parent is depressed and requires treatment. Referral for treatment of parental depression should be a priority, because it may affect the development of normal parent-child attachment and social, emotional, cognitive and interpersonal skills.

There is little evidence, however, that parent counselling and family therapy alone are effective in treating child depression. With younger children, clinicians tend to work with both the child and parents in treatment. Home-based interventions may work with the family to develop a supportive home environment or to reduce the stress at home. Social work intervention may be helpful in dealing with issues related to poverty and psychosocial stress (e.g., unemployment, homelessness, access to social supports).

Evidence from clinical and controlled studies shows that cognitive-behavioural therapies are effective for treating mild or moderate depression in children, or for treating serious depression when used together with other therapies (Harrington and others, 1998). Cognitive-behavioural therapy is based on the premise derived from cognitive theory that

depressed children have distorted views of themselves and their environment that contribute to their depression, and these views can be modified. Themes addressed in therapy sessions include distinguishing different emotions and linking them to precipitating events, self-monitoring thoughts and feelings, self-rewarding positive behaviours, strengthening social skills, problem-solving, and modifying thinking patterns.

Interpersonal therapy is based on the strong association between interpersonal problems and depression. For children who have been physically abused, research indicates that interpersonal therapy can be used to combat depression by strengthening social competence (Flisher and others, 1996).

Therapist reports indicate that the principles of psychodynamic therapy are useful for the treatment of children with mild and moderate levels of depression when they are integrated with structured forms of therapy, such as interpersonal and cognitive-behavioural approaches. Psychodynamic approaches are used to help school-aged children understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behaviour, interact more effectively with others, and cope with ongoing and past conflicts (Bemporad, 1994).

6.6 Enuresis and Encopresis

6.6.1 Enuresis (Bed-Wetting)

Enuresis involves repeated involuntary or voluntary urination into the bed or clothes that impairs a child's functioning and is not related to a medical problem. Most children develop bladder control gradually over the first 5 years of life. Wetting the bed is a primary concern of parents, although it is quite common for younger children: about 40% of children wet the bed at age 3 and nearly 25% at age 5. Approximately 6% of children wet during the day, and some wet both day and night, but the majority (over 60%) of children wet during the night. Although a wide number of causes have been proposed, no cause has been confirmed. While enuresis has behavioural and emotional effects, it is not considered to be primarily a psychopathological disorder.

A well-established efficacious treatment for enuresis is the bell-and-pad or urine alarm system that has been used for over 60 years. Urine alarms used over a period of 5 to 12 weeks usually eliminate enuresis for 75% of children. Relapses may require the procedure to be repeated. A listing of enuresis alarms and their manufacturers may be found in Cendron (1999).

Van Londen and colleagues (1995) found that 97% of the children who used a urine alarm plus immediate contingency management remained continent, compared with 84% who used a urine alarm plus delayed contingency management, and 73% who used a urine alarm program alone. With contingency management, the child is rewarded for not

wetting the bed or waking to urinate. Other studies have found positive treatment effects for urine alarm programs coupled with other psychological strategies, such as retention control training (child is rewarded for postponing urination while awake after drinking), overlearning (child who has achieved continence consumes extra liquid before bed until 14 additional dry nights are attained), and cognitive behavioural treatment. A review by Houts and colleagues (1994) found that children benefited more from psychological treatments, such as urine alarm and contingency management, than from drug treatments, such as imipramine.

6.6.2 Encopresis (Soiling)

Encopresis is the involuntary voiding of stool in underwear or other inappropriate places by children older than age 4. Approximately 1-3% of children suffer from encopresis, and it affects boys 3-6 times as often as girls. Encopresis is called the "hidden disease" because of the lack of articles on the subject in the popular literature for parents. Although originally considered to be a psychiatric disorder, biological factors are increasingly being associated with encopresis. For example, there is now a known relationship between constipation and referral for encopresis: as many as 95% of children referred for treatment of encopresis have functional constipation. Constipation plays a major role in encopresis as well as in other toileting problems. Some children who suffer from encopresis also have a rectum with fewer nerve endings that is less sensitive to the presence of stool, and therefore, the onset of a bowel movement. With the implication of biological factors, a thorough medical assessment with special attention to constipation is warranted for suspected cases of encopresis.

In the absence of a clear psychopathology, a medical treatment program is the treatment of choice. Recommendations for treatment of infants and children may be found in Baker and others (1999). Parent education about encopresis, together with parent training about medical management strategies (enemas, dietary fibre) and behavioural management training (contingency management, contracting) are important in improving encopresis symptoms (Stark and others, 1997). These parent education programs have been delivered successfully in both individual and group formats. In a recent study, Cox and colleagues (1998) compared intensive medical care and toilet training (including intensive medical care plus instruction, modelling, and reinforcement), and biofeedback (including intensive medical care plus biofeedback to teach tensing and relaxing the muscles used to defecate). They found that intensive toilet training and biofeedback produces superior comparable results to intensive medical care alone.

6.7 Pain Related to Physical Illness

Pain is one of the most common problems related to physical illness in children. The development of children's reaction to pain is affected by both developmental stage and experience with pain. Prior to 18 months of age, children can indicate that they are in

pain by crying, but they cannot conceptualize or express different levels of pain. At 18 months, children can verbalize that they are in pain and specify the location of their pain. At 2 years of age, children can describe their pain and attribute it to external causes. By 3 years of age, children are aware of strategies to cope with pain, such as being hugged by a parent. Between 5 and 7 years of age, children can distinguish between various levels of pain and identify their level of pain using pictorial scales (e.g., "face" scales that express different levels of pain).

6.7.1 Recurrent Abdominal Pain

Recurrent abdominal pain occurs in 10-20% of young children. It is most common in the 5 to 12 year age range, and it appears with equal frequency among boys and girls. Fritz and colleagues (1997) found that family-based cognitive behavioural therapy (CBT) that includes relaxation training and contingency management is more effective than medical care in reducing recurrent abdominal pain. Edwards and colleagues (1991) found that non-constipated children improve with relaxation training, but constipated children respond to increased dietary fibre alone.

6.7.2 Headaches

Headaches are common among children and it is estimated that approximately 10% of children suffer from migraine headaches. Headaches are more common and more severe among girls than boys. About 70% of children experience occasional headaches. Progressive relaxation training and biofeedback are efficacious in reducing headache pain (Hermann and others, 1995), but biofeedback is not as well-established as relaxation training (Holden and others, 1999).

6.7.3 Pain Related to Medical Procedures

A significant proportion of children undergo painful medical or dental procedures each year, ranging from injections and filling cavities to burn treatment, bone marrow aspirations, lumbar punctures, and surgery. Research shows that children do not become accustomed to these procedures, but may become increasingly sensitized and disturbed by them over time. Research shows cognitive behavioural therapy (CBT) is a "well-established" intervention for treating pain associated with medical procedures (Powers, 1999). CBT is especially efficacious for managing the pain involved with injections and venipuncture (Lander & Fowler, 1993). Distracting children with cartoons, balloons, music and other strategies also produces positive results. For more complex procedures, a combination of pain medication and behavioural support produces the best pain management. For example, children's distress associated with bone marrow aspirations and lumbar punctures (Ellis and others, 1994) was significantly reduced by these methods. Kuttner and colleagues (1988) found that children between 3-7 years who received hypnosis had significantly lower distress scores.

7. Promising Practices in Early Childhood Mental Health: Treatment and Intervention for Attachment Disorder and Infant-Parent Relationship Problems

Consultation sessions with members of the expert panels and experienced early childhood mental health clinicians identified the importance of describing promising practices for the treatment of attachment disorder and infant-parent relationship problems. However, according to Zeanah and Boris (1999):

There have been no formal efforts to evaluate interventions for clinical disturbances or disorders of attachment to date. The definitional obstacles we have described in this chapter have meant that diagnosis of attachment disorder has been problematic. Thus, studies of intervention after diagnosis of attachment disorder do not yet exist. (p. 365)

The panel of experts felt, nonetheless, that the combination of theoretical work and empirical studies argues for the inclusion of promising practices for addressing attachment disorder and infant-parent relationship problems. Some key findings regarding promising practices are outlined below.

Therapy with infants and their parents is strongly influenced by Bowlby's concepts of internal working models and attachment. According to Bowlby, internalized early experiences provide a structural framework to explore attachment-related current emotional events in the context of a therapist-parent relationship (Zeanah & Benoit, 1995). Attachment theory emphasizes the importance of real-life events in shaping child development and influencing present functioning. In keeping with contemporary developmental research, attachment theory considers infants to be closely tied to their immediate experiences. The premises of attachment theory also place a great deal of importance on the observation of behaviour as an indicator of a child or parent's emotional response.

As identified in a review by Belsky and Cassidy (1994), attachment theory is the one theory of socioemotional development that is best supported by empirical research. Although the systematic application of attachment theory to clinical issues is still evolving, it has been applied extensively to infant-parent psychotherapy for treating attachment disorders and parent-child relationship problems (Lieberman & Zeanah, 1999).

The following synopsis of the *Infant-Parent Program* (IPP) provides an illustration of a promising infant-parent therapy program. The IPP was established by Fraiberg to develop and test infant-parent psychotherapy for relationship disorders in infants from birth to 3

years of age. The original emphasis of the program was the early childhood experiences of the parents. As the program evolved, the original direction was complemented by focus on individual differences in babies, the parents' perceptions of their children's emotional and behavioural difficulties, and the impact of stressful life experiences on the parents. In keeping with attachment theory, the quality of the parent-therapist relationship is seen as the key factor in therapeutic change.

The children engaged in the IPP had a wide range of symptoms related by various research studies to attachment disorders and problems in parent-child relationships (Carlson & Sroufe, 1995). Children's symptoms included failure to thrive, depression, separation anxiety, multiple fears, tantrums, inattentiveness, impulsivity, and anger. A sub-group of the infants and toddlers were formally diagnosed with reactive attachment disorder according to DSM-IV and DC:0-3 diagnostic criteria.

IPP intervention begins with a 6-week assessment process aimed at building a working alliance with each child's parent or caregiver, as well as collecting information about the child and family. During the assessment phase, the child is given a formal neuropsychological assessment. If infant-parent therapy is indicated, then the assessing therapist also conducts the treatment to maintain a positive working relationship and continuity of relationships.

The therapy sessions involve the parent and the infant and take place either in the home or the office playroom. Both assessment and treatment sessions are unstructured, with the themes guided by interactions between the parent and the child or by the parents' free-associations. Child observations monitor the child's level and quality of sensorimotor, social, and emotional functioning. These observations supplement the formal neuropsychological assessment. The therapist uses a variety of methods (joint play, developmental guidance, emotional support, insight-oriented interpretations) to modify the parent's rigid and distorted perceptions of the child. The methods also help the parent construct a more flexible and developmentally-appropriate set of perceptions and behaviours that will allow the child to become more securely reliant on the parent.

In terms of empirically-supported outcomes, Lieberman and colleagues (1991) reported significant differences between the intervention and control groups in a randomized treatment outcome study of the IPP. The intervention group showed significant gains on important measures related to attachment, such as maternal empathy and children's avoidance, resistance, and anger towards their mothers.

In their review, Lieberman and Zeahah (1999) also briefly describe a number of infant-parent intervention programs that make use of attachment theory. Several of these programs are currently being evaluated for their efficacy and effectiveness with different populations. These model programs include:

- *Steps Towards Effective, Enjoyable Parenting*: Minnesota Program
- *Attachment Theory and Transactional Approach*: Rochester Program
- *Relationship-Based Intervention for Maltreated Infants and Toddlers*: New Orleans Program
- *Attachment and Cognitive-Behavioral Parent Training*: Seattle Approach
- *Attachment and Interaction Guidance*: Ann Arbor Approach

These programs encompass a wide variety of therapeutic models (e.g., insight, therapeutic relationship, transactional, cognitive-behavioural), client groups (e.g., first-time mothers, mothers at risk for abuse/neglect, mothers of maltreated toddlers in foster care, hard-to-reach families), and service-delivery locations (e.g., home visits, human service agency, clinics with playrooms, hospitals). They employ principles and interventions, such as interaction guidance (McDonough, 1995), that are important for promoting positive early parent-child relationships and treating attachment disorders.

8. Training Staff to Work in Early Childhood Mental Health

8.1 Core Knowledge and Skills for Early Childhood Mental Health

The most far reaching shift that has taken place in early childhood treatment and intervention is a reconceptualization of the role of the family. The new paradigm places families in the centre with services revolving around them. It focuses attention on family meanings and on individual family coping and adaptation styles. The growing recognition of family diversity also requires the development of cross-cultural competence through self-awareness, knowledge of information specific to different cultures, and effective application of this knowledge and sensitivity in successful interactions (Chan, 1990). The paradigm shift has had a profound impact on the nature of parent-professional relationships, and has clear implications for training.

The "fix-it" approach to disability that makes the individual child the passive recipient of adult controlled interventions has been replaced by a developmental approach that emphasizes the transactional nature of development, the responsive quality of early relationships, and the social nature of learning (Sameroff & Emde, 1988). Within the new paradigm, professionals share their knowledge within the context of respectful, collaborative relationships so that child and family competency is strengthened (Dunst and others, 1991).

Another recent trend is to deliver early childhood mental health services in inclusive (or naturalistic) settings, such as the home, childcare and preschool environments. The goal of inclusive settings is to have the child become a fully contributing member of the group, while meeting the child's individual needs. The move toward family-centered interactive approaches in inclusive settings has significantly influenced the preparation of

professionals (Beckman, 1996; McBride & Botherson, 1997). The focus on family-centered services demands skills in:

- Collaboration
- Support
- Negotiation
- Self-knowledge and reflective practice
- Active listening
- Identifying and respecting the family's goals

Involving families as partners in training is one of the most effective ways for promoting the importance of families and for modeling parent-professional collaboration. Jivanjee and Friesen (1997) recommend involving parents and family members in training professionals for family-centered practice. Kirk Bishop and others (1993) provide examples of programs that use family-professional collaboration for training for early childhood mental health services. Central to a family-centered model is the assumption that strengths exist within the family, and the goal is to match interventions to those capacities. Problems and vulnerabilities are seen as one facet of the complete picture. To deliver a family-centered model, staff must have the following skills:

- Familiarity with the literature on family strengths
- Listening for strengths
- Asking questions that reveal strengths
- Case planning that recognizes both vulnerabilities and strengths
- Applying systems thinking to relate current issues to the overall family situation and take advantage of the skills and resources of all family members

Research links higher quality early childhood programs with higher levels of training and higher self-ratings of knowledge and skills (Buysse and others, 1999). Gallacher (1997) notes that supervision, mentoring, and coaching opportunities are necessary components of early childhood training programs. Parents can also serve as mentors and coaches for professionals (McBride and others, 1995). The role of the child has also changed in the new paradigm. The developmental approach places each child's developmental progress on a continuum and has relevance for children with identified problems as well as those at risk. The developmental perspective considers the child's current functioning in relation to ordinary/normative expectations of developmental skills in all domains.

The move to more inclusive intervention requires that professionals learn to consider what is important to the child when conducting assessments and planning interventions. The child's viewpoint is an essential feature of the intervention planning process. Inclusive intervention requires the capacity to engage children effectively, first individually and then in small groups, often at the nonverbal level. Knitzer (1995) advises

professionals to have child development and family systems knowledge, together with clinical and multidisciplinary practice skills and the ability to work with organizations.

Since identifying and treating mental health problems in young children requires the skills of multiple disciplines, the multidisciplinary approach is a cornerstone of early childhood mental health services. The values and skills of multidisciplinary coordination are essential to apply the integrative nature of development in practice. Multidisciplinary training can take many forms, such as guest lectures, co-teaching, multidisciplinary team-based training, and shared practicums. It should also involve community providers and parents, administrators, and peers who have worked collaboratively together.

To be effective, the training process needs to engage real-world problems through active learning methods, such as role-playing, field application, case studies, guided reflection, self-analysis, and clinical supervision (Bricker & Widerstrom, 1996).

8.2 Specialized Training for Working with Infants

Although there is general agreement on the core areas of knowledge, there are strong opinions that professionals working with infants require information and skills different from those working with preschool children, and that training should reflect those differences (Bricker & LaCroix, 1996). Thorp and McCollum (1994) proposed that those working with infants have additional training in the more specialized disciplinary content related to the infancy period, and in a "common infancy core" required by all disciplines working in early childhood intervention.

8.3 Specialized Training for Working with Children 3-6 Years of Age

Those working with children 3-6 years of age concentrate on the characteristics and behaviours of the preschool child. Within this framework, professionals learn strategies to work with children who have identified problems and those who are at-risk, work in inclusive settings, participate on interdisciplinary teams, and plan/implement individualized interventions. A developmental orientation that reflects an integration of recommended practices from knowledge bases described in the *Guidelines for Preparation of Early Childhood Professionals* (NAEYC, 1996) provides a sound foundation for identifying the content of training for mental health professionals working with preschool children.

8.4 Assessing Training Content

According to Snyder and Wolfe (1997), determining training content should be based on the following:

- Needs assessments of potential participants

- Consideration of the special setting in which training activities will occur
- Interviews with staff and families
- Use of innovative approaches identified in the research literature
- Broad range of experienced and highly regarded practitioner and parent presenters
- Primary follow-up activities to support transfer of training from the workshop, especially peer support groups (including electronic support networks) and coaching
- Secondary follow-up strategies that include assignments and plans for implementing learning in the workplace, job aids, handouts, refresher sessions, follow-up telephone calls and e-mail, and follow-up newsletters and information
- Clearly specified evaluation strategies to assess the effectiveness of training and determine how it can be improved

8.5 Findings of the *Invest in Kids Foundation Knowledge Gap Survey*

The *Invest in Kids Foundation* (Kulkarni & Crill Russell, 2000) commissioned a survey of experienced early childhood professionals in Ontario to determine the knowledge gap in child development between reported level of importance of each topic and reported level of knowledge about the topic. The participants included children's mental health psychologists and social workers, infant development specialists, early childhood educators, public health nurses, child welfare workers, speech and language therapists, and family support workers. For children's mental health professionals, the survey found that the two largest gaps were in the areas of knowledge about brain development and parenting capacities. Knowledge of brain development was the area with the largest gap for the other professions as well.

The survey also asked early childhood professionals to list the topics that would help them do the best possible job of supporting healthy child development in their profession. In rank order of preference, respondents identified the following topics:

Rank Order	Topics
1	Assessing and dealing with parenting skills and capacities
2	Appropriate age and development milestones
3	Risk factors and risk assessment
4	Staff boundaries and issues regarding work environment
5	Assessment and intervention for children with special needs
6	Infant development
7	Providing family support and dealing with family dynamics
8	Attachment and bonding
9	Community resources and collaboration
10	Brain development and the early years
11	Cultural issues and cultural sensitivity

9. Concluding Remarks

There is convincing evidence about the importance of early childhood development for laying the foundation for competence and coping skills throughout life (Mustard & McCain, 1999). There is equally convincing evidence about the importance of the period from birth to six years of age on antisocial behaviour and mental health problems later in life (Rutter and others, 1998; Tremblay, 1999). In particular, parenting ability and the influence of the family, community, and socioeconomic environment in the early years have consistently been linked to health, learning, and behavioural outcomes. Early childhood mental health services have key roles to play in:

- treating children and families with mental health problems;
- supporting the new child development and parenting centres and existing programs (childcare, kindergarten, perinatal support programs) to address mental health needs; and
- working with communities to increase parenting capacity and reduce the risk factors associated with mental health problems in young children and their families.

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APPENDIX I

Project Advisory Committee

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