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A policy analysis of two preschool prevention programs in Ontario

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A Policy Analysis of Two Preschool Prevention Programs in Ontario

BY

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Abstract

The purpose of this research was to examine issues relevant to best practices for preschooler mental health prevention policy so as to inform future prevention policy. Data were gathered through the examination of two preschool prevention programs, Ontario Early Years Centres (OEYCs) and Healthy Babies, Healthy Children (HBHC). These prevention programs were examined with respect to four major issues: (a) the ideology and origins of the program, (b) theoretical underpinnings, (c) research base, and (d) implementation and adaptation issues. To explore these four issues, qualitative methods were used in the form of document reviews (two documents for the Early Years Centres and two documents for Healthy Babies, Healthy Children) and key informant interviews (seven informants for the Early Years Centres and six informants for Healthy Babies, Healthy Children).

The main finding regarding the ideology and origins of the Early Years Centres and Healthy Babies, Healthy Children is that a mixture of values related to both personal well-being and collective well-being was used in the framing of both the problem(s) and solution(s). Furthermore, informants indicated that centres were created by the government in response to both timing (an influx of federal funding for programs for preschool children) and the influences of key people. A key finding regarding the theoretical underpinnings of both programs is that brain-based development theories were used to explain how the quality of early sensory stimulation during critical early periods influences the brain's ability to develop properly. The centres were used to improve the quality of stimulation for preschool children by assisting parents and children through the

use of centre-based programs, whereas Healthy Babies, Healthy Children programs used primarily family-based programs.

Findings for the research base were based on evaluations conducted on both programs. While the evaluation reports suggest encouraging conclusions regarding the effectiveness and efficiency of both programs, the methodologies used in the evaluations of both programs have major limitations. As for best practices with regard to the Early Years Centres and Healthy Babies, Healthy Children, key informants noted the lack of comprehensiveness, accessibility, follow-up assessments, and theoretical basis of the programs and the issue of insufficient dosage of the interventions. Cultural sensitivity was deemed by informants to be a strong aspect of both programs. Key informants also noted that centres are struggling to provide consistent programming across Ontario. Additionally, the Healthy Babies, Healthy Children program's home visitation services lack intensity and may not be effective because this program uses lay home visitors in its primary approach to home visitation.

Findings regarding implementation and adaptation for the centres include a clear message from informants that the ease of implementation was dependent on whether the centre began in a pre-established organization. Additionally, key informants asserted that the extent of community ownership and adaptation varied from centre-to-centre across Ontario. The implementation and adaptation issues faced by Healthy Babies, Healthy Children are evidenced in the lack of pilot projects the program undertook before it was implemented province-wide. This approach led to implementation that was not based in teachings from research evidence or community-based knowledge. While informants

commended HBHC's ability to adapt to the community's needs, the community's sense of ownership of the program is still questionable.

The findings of this research have implications for improving preschool mental health prevention policy in all four categories. These implications include: (a) more thorough framing of the problem(s) and solution(s), (b) a deeper understanding of the research base upon which the greatest program impacts can be achieved, and (c) the need for pilot projects before province-wide implementation.

Acknowledgements

This study was inspired by pivotal research conducted by Dr. Geoffrey Nelson, Dr. Isaac Prilleltensky, Dr. Marie-Claire Laurendeau, and Barbara Powell titled "The prevention of mental health problems in Canada: A survey of provincial policies, structures, and programs." Upon reading this paper and discussing its results and implications with Dr. Nelson, I was motivated to conduct research that would enhance the current and future state of preschoolers' mental health prevention policy.

Throughout this process, Dr. Nelson has been patient, encouraging, and has generously given this research his expertise. He has shared his wisdom, time, and knowledge so kindly and for that I am ever grateful. He creates an environment in which a student can ask openly and challenge herself freely.

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My utmost appreciation goes to my family - your support, loving encouragements, and interest in my work has brought this research to a close for me but hopefully it becomes a starting place for others.

To my dearest husband, without your compromises, love, and listening ear, this endeavour would have been much more difficult. You help make my dreams come true.

With humility I pray that this research becomes a catalyst for change in how preschooler mental health prevention policy is written in the future.

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Purpose

The purpose of this research is to investigate and shed light on issues relevant to the creation of best practices for preschooler mental health prevention policy. The end goal is to have research on best practices in prevention inform prevention policy. This research attempts to gain a better understanding of why prevention programs are not better supported both financially and programmatically. This new knowledge will put prevention programs in a better position to secure funding, credibility, and the political support they deserve and require to flourish. Richer insight into the delicate nature of prevention programs will give policymakers and community planners a deeper appreciation for their long-lasting benefits. The concepts of prevention and policy are on the forefront of the minds of both researchers and decision-makers, as evidenced in recent papers written on prevention (e.g., Dawson-McClure, Spring, Sandler, Wolchik & Millsap, 2004; Long, 2004; Nelson, Westhues & MacLeod, 2003; Reddy, Atamanoff, Springer, Hauch, Braunstein, Kranzler & Reddy, 2004) and policy (e.g., Hartford, Schrecker, Wiktorowicz, Hoch & Sharp, 2003; Sandler, Ayers, Suter, Schultz & Twohey-Jacobs, Maton & Schellenbach, 2004). There is, however, very little theory or research on prevention policy. Recent research focuses on prevention of particular problems and the resulting policy implications of the research (e.g., Cowen & Durlak, 2000; Nation, Crusto, Wandersman, Kumpfer, Seybolt, Morrisey-Kane & Davino, 2003). Two of Ontario's prevention programs for preschool children will be the focus of this research. I begin with a review of the literature on prevention for children and then review the literature on policy.

Literature Review

Prevention

Scope of the Problem and Rationale for Prevention

Eighteen percent (533,000) of Ontario's children under 19 have a diagnosable mental disorder (Offord, 1989). Furthermore, 300,000 of the 18% of children have more than one disorder (Offord, 1989). Albee (1990) highlights that even in a utopian scenario in which therapeutic interventions would be successful 100% of the time, there would never be enough mental health professionals to reach all those in need. This statement is reflected in the current state of affairs for Ontario. The average wait for treatment for children is 21.5 weeks (Children's Mental Health of Ontario, 2004). Furthermore, once children undergo treatment, it costs taxpayers $2,500 a year per child (S.W.A.T., 2003). Moreover, 47.7% of patients with severe mental health issues, both adults and children, in Ontario and 72.3% of moderately troubled Ontarians have never received treatment (Biji et al., 2003). As a result, the federal government has recognized the importance of prevention and has aimed to increase its attention to it. In the 2004 Throne speech, the Governor General stated, "We agree that prevention is the best cure." The values of the government need not only be incorporated in policy creation, but, more importantly, research needs to generate policy-relevant knowledge to guide the creation of effective prevention policy.

Primary Prevention and Mental Health Challenges

Primary prevention includes actions to decrease the number of new cases or incidence of a disorder. For example, Bloom and Gullotta (2003) defined primary prevention as "[involving] actions that help participants (or facilitate participants helping

themselves): (a) to prevent predictable and interrelated problems, (b) to protect existing states of health and healthy functioning, and (c) to promote psychosocial wellness for identified populations of people" (p. 10). Nelson, Westhues, et al. (2003) stated that "primary prevention programs for preschoolers are designed to promote children's competence and well-being and/or to prevent negative outcomes for children" (p. 2).

There is evidence that shows that early childhood age zero to five years, is a period of intense cognitive, physical, and emotional development when specific types of interventions can have considerable impacts (e.g., McCain & Mustard, 1999; Park & Peterson, 2003; Shatz, 1992). Consequently, prevention advocates have argued that prevention efforts must be mounted on a larger scale since research on brain development suggests that positive life experiences in early childhood can have positive impacts on a child's social-emotional, behavioural, and cognitive development (Bruer, 1999; McCain Mustard, 1999). An increasing number of studies have concluded that prevention programs beginning either during the prenatal phase or during the preschool years can have lasting positive effects throughout adolescence and adulthood (e.g., Hertzman & Wiens, 1996; Nelson, Westhues, et al., 2003; Ramey & Ramey, 1998). For example, Nelson, Westhues, et al.'s meta-analysis of preschool prevention programs came to the conclusion that preschoolers who took part in preschool prevention programs experienced definite cognitive, social-emotional, and parent-family benefits compared to disadvantaged children who did not have this opportunity. Durlak's (2003) commentary on Nelson, Westhues, et al.'s research highlighted results supporting the durability of preschool prevention programs on children's school performance, children's and adolescent's social-emotional development and general family functioning. Science-

based research is increasingly showing that prevention programs are benefiting youth by preventing substance abuse, school dropout, adolescent pregnancy, and youth violence (Albee & Gullotta, 1997; Durlak & Wells, 1997; Olds, 2002; Price, Cowen, Lorion, & Ramos-McKay, 1998). In order to develop effective prevention programs for preschoolers, it is reasonable to first examine the sources of mental health challenges with which preschoolers are confronted.

Sources of Preschoolers' Mental Health Problems

Incidence and prevalence. The study of mental health problems involves understanding their epidemiology and etiology. Two main concepts in the field of epidemiology are incidence and prevalence. Incidence refers to the rate of new occurrences of a disorder in a population within a specific time period, whereas prevalence refers to the rate of existing occurrences of a disorder in a population within a time period (Dalton, Elias & Wandersman, 2001). The Ontario Study II determined that the six-month prevalence rate among children 4 to 16 years of age is 18.1% for one or more of either a conduct disorder, hyperactivity, an emotional disorder, and somatization (Offord, 1987). Once the incidence and prevalence of children's mental health problems have been determined, it is necessary to identify risk and protective factors associated with the likelihood of a disorder.

Risk factors. A risk-focused approach to the prevention of mental disorders in children seeks to prevent the onset of mental health challenges by eliminating, reducing or mitigating its precursors (Hawkins, Catalano & Miller, 1992). Fraser (1997) defines a risk factor as "any influence that increases the probability of onset, digression to a more serious state, or maintenance of a problem condition" (p. 10-11). The U.S. Department of

Health and Human Services (1999), along with Fraser's (1997) research, identified a number of risk factors that influence the healthy development of children and adolescents. These include biological influences, psychosocial factors, family and genetic factors, stressful life events, childhood maltreatment, maladaptive peer and sibling influences, violent neighbourhoods, and social injustices which may predispose a child to behavioural, emotional or developmental challenges. For instance, Hawkins, Catalano, et al. state that these risk factors are present before the onset of drug abuse in children. Risk factors are useful in determining which children may be higher in need than others, whereas protective factors can be used to decrease their susceptibility to risk.

Protective factors. A protective factor, on the other hand, can be defined as "an internal or external force that helps a child or adolescent resist or ameliorate risk" (Fraser, 1997, p. 3). Luthar, Cicchetti and Becker (2000) define three types of protective factors: (a) protective stabilizing factors are attributes that provide stability despite increasing risk (e.g., support networks); (b) protective enhancing factors are attributes that build on existing competence (e.g., strategies to increase parent confidence); and (c) protective but reactive factors are those attributes that continue to be protective but less under high stress situations (e.g., coping skills). Common protective factors that assist children in balancing risk factors include self-efficacy, presence of a caring/supportive adult, positive relationships, social support, competence in normative roles, and opportunities for education and growth (Fraser, 1997).

Both risk and protective factors are important for understanding and preventing the onset of mental health troubles. Mental health challenges are the result of complex interactions between genetic endowment and environmental risk factors but can be

affected by numerous reasons not stated above. Environmental factors, such as the family situation, workplace pressures, and the socioeconomic status of the individual can precipitate the onset or recurrence of a mental health issue (Bruer, 1999). Lifestyle choices (e.g., substance abuse) and learned patterns of thought and behaviour can influence the onset as well as the course and outcome of the mental health problem (Health Canada, 2002a). Specifically, the socioeconomic situation of individuals is an area that requires more attention in the prevention of mental health challenges.

Mental health problems and poverty. Several studies find that more mental health issues occur with children living in poverty (Flouri, 2001; Richter, 2003; Rutter, 2003). There are two well-known frameworks that attempt to explain the relationship between poverty and mental health problems: (a) social selection and (b) social causation. The social selection perspective suggests that some individuals may be predisposed to both lower levels of ambition and expectations and, therefore, to mental health challenges. Consequently, individuals attain a lower level of education and occupational achievement, thus leading to a drift towards poverty and mental health issues. On the other hand, social causation implies that the social experience of individuals who are poor increases the likelihood that they may develop mental health troubles (Eaton & Muntaner, 1999). For example, living in poverty may lead to a lack of opportunity and consequently to hopelessness, anger and despair. Poverty may also increase the risk of exposure to chronic or traumatic stress. When combined with a genetic predisposition, such factors may contribute to the development of mental health challenges. This suggests that if one addresses the social causation and social determinants of mental health through

prevention programs, mental health can be promoted and some mental health problems in disadvantaged populations can be prevented (Eaton & Muntaner, 1999).

Prevention science is one way of addressing the adverse consequences of poverty. The focus of prevention programs is on building children's social competencies and support to help children cope with and overcome poverty. However, this person-centered approach is limited in scope. There is no attempt to directly address the issue of poverty, which is one of the root causes of children's mental health problems. Alternatively, social policy could be aimed at reducing poverty through income supports and tax and transfer policies (Peters, Peters, Laurendeau, Chamberland & Peirson, 2001). To reduce children's mental health challenges, researchers support the need for not only mental health prevention policies but also anti-poverty policies and programs (e.g., Conroy & Brown, 2004; Febbraro, 1994).

Types of Early Childhood Prevention Programs

Early childhood prevention programs are typically divided into two major categories: centre-based programs for children and family-based programs. It should be noted, however, that there is considerable overlap between these two types of programs. Nevertheless, some programs tend to emphasize centre-based programs, while others emphasize family-based programs. Centre-based programs include preschool, Head Start, pre-kindergarten, and child care programs, while family-based programs include family support programs, drop-in centres, home visiting, and family strengthening programs, such as Early Head Start (Gomby, Larner, Stevenson, Lewit & Behrman, 1995). The former focuses mainly on children, while the latter tends to focus on parents and families. However, there are some programs that combine the two approaches. I begin by

discussing the nature of these programs, followed by a brief examination of the research underlying their frameworks. Additionally, I present and explain multi-component programs that are both centre-based and family-focused.

Centre-based programs for children: Head Start programs as an example. Head Start is one of U.S.'s most successful prevention programs that was initially created as part of the Kennedy-Johnson era's "war on poverty." Head Start was established in 1964 by the federal government with the intention of helping communities meet the needs of disadvantaged and at-risk preschool children. The program began by launching an eight-week summer program by the Office of Economic Opportunity in 1965, which was designed to help break the cycle of poverty by providing preschool children of low-income families a means to meet their emotional, social, health, nutritional, and psychological needs. Head Start now serves children and their families each year in urban and rural areas in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories, including many American Indian and migrant children (Head Start, 2002).

Head Start programs are federally funded and aim to serve children from zero to five, pregnant women, and their families. Its programs are diverse but must provide comprehensive services in four areas: education, health services, social services, and parent involvement. The overall goal of Head Start is to increase social competence in preschool children from low-income families (City of Phoenix, 2003). Social competence includes cognitive, intellectual and social development, physical and mental health, and adequate nutrition (Devaney, Ellwood & Love, 1997). Currently, the primary goal of Head Start programs, as opposed to when it began in 1964, is to increase school-readiness of children by: (a) enhancing children's healthy growth and development, (b)

strengthening families as the primary nurturers of their children, (c) providing children with educational, health, and nutritional services, (d) linking children and families to needed community services, and (e) ensuring well-managed programs that involve parents in decision-making (U.S. Department of Health and Human Services, 2000). Thus, while Head Start was originally a centre-based program, over time it has become home-based as well. While the primary goal of centre-based prevention programs for preschoolers is to promote school readiness, research has shown that these programs are also successful in preventing long-term problems, such as substance abuse and juvenile delinquency (Yoshikawa, 1995).

Family-based programs: Home visitation program as an example. Home visitation programs have been widely promoted in recent years as promising approaches to preventing health and developmental problems among children. In the literature, there is, however, an emphasis on home visitation as a prevention technique for child maltreatment, given that this is a prevalent social problem with limited success of past prevention efforts. Previous research has demonstrated the efficacy of home visitation as a public health intervention capable of reducing rates of child abuse and neglect (Gomby, Culross & Behrman, 1999; Guterman, 2001; Olds, et al., 1997), as well as improving long-term social developmental outcomes in children and their parents (Olds, Henderson, et al., 1998). More recent research shows little impact of the Hawaii Healthy Start Program home visitation model on child maltreatment and abuse rates (Duggan, Fuddy, Burrell, Higman, Windham, Sia, 2004; Duggan, McFarlane, Fuddy, et al., 2004).

Model home visitation programs initiate services prior to the birth of the child and continue, at a minimum, until the child is two years old. Such programs are designed

to promote healthy child development, prevent child abuse and neglect, and increase positive parenting. Gomby et al. (1999) showed that family-centered programs that use home visitation as the primary intervention for families have demonstrated mixed results in randomized trials. Their review of six model home visitation programs, which used randomized trials, found that home visitation programs did not aid in child development or in decreasing child maltreatment rates. However, they did benefit parenting practices, attitudes, and the knowledge parents held. More recently, there is evidence that programs that produced the most substantial outcomes for children combined parent involvement through programs such as home visitation along with centre-based education services for children (Love et al., 2002; National Research Council and Institute of Medicine, 2000).

The Nurse Home Visitation Program's home visitation model, tested in the Elmira, Memphis, and Denver trials, adapts the frequency of home visits to the prenatal and postnatal phases and is based on the needs of the families. However, within this flexibility, the model details biweekly home visits before and after pregnancy up until the child's second birthday (Olds, O'Brien, Racine, Glazner & Kitzman, 1998; Olds, et al., 2004). The intensity of visits during the prenatal phase in the Elmira and Memphis trials averaged from 7 – 9 visits respectively and an average of 26 visits in Elmira and 26 visits in Memphis from birth until the child reached the age of two. In both trials, the visits lasted approximately 75 – 90 minutes with longer visits observed when mothers had fewer coping resources (Olds, 2002). This program is based on three theoretical foundations: (a) human ecology by involving other family members and referring families to other community services, (b) self-efficacy by helping parents achieve small goals in the hopes that they will gain more confidence and aim for larger challenges, and

(c) attachment between children and parents to increase the child's sense of trust and to also increase their sense of empathy and caring in the future (Olds, 2002).

In a 15 year follow-up of a randomized trial of the Nurse Home Visitation Program, results indicate that there were fewer arrests, convictions, and parole violations for adolescents in the nurse-visited group than for adolescents in the comparison group. Furthermore, youth who lived in low socioeconomic status, single-parent homes in the experimental condition reported significantly fewer incidents of running away, fewer contacts with the juvenile justice system, and fewer days having consumed alcohol in the past six months than did the control group youth (Olds, Henderson, et al., 1998). Unmarried poor mothers in the experimental condition demonstrated significant differences 15 years post-intervention when compared to the control group in the following risk areas: fewer subsequent pregnancies, fewer months on welfare, fewer problems related to substance abuse, and fewer arrests (Olds, Henderson, et al., 1998). Also, this 15-year follow-up study provided the first ever long-term benefits of home visitation programs on the issue of child maltreatment. Results from this study suggest that families that received nurse-visits had half as many child maltreatment reports compared to the control families that did not receive home visits.

Research also suggests that there are differences between nurse-visited or paraprofessional-visited mothers and children (Olds, Robinson, O'Brien, et al., 2002). In Olds, Robinson, O'Brien, et al.'s study, paraprofessionals were able to enhance the mother-child interactions in those circumstances where the mother had low psychological resources. Home visits that employed nurses were able to decrease the mother's prenatal use of tobacco, timing and likelihood of subsequent pregnancies, and increase

participation in the workforce, mother-child interactions, and aid the emotional, language, and mental development of children born to mothers with low psychological resources. Olds, Robinson, O'Brien, et al. also suggests that nurses are seen as more credible and persuasive by families. As well, because of their formal training they are able to address most concerns parents have regarding the healthy development of their child. The Denver trial (Olds et al., 2004) shows that the impacts on mothers visited by a paraprofessional were larger than the impacts on mothers visited by a nurse, whereas the opposite was the case for the effects experienced by children. Children of the nurse visited group showed better cognitive, language, and behavioural test performance scores than children visited by paraprofessionals. Moreover, results show that paraprofessional-visited mothers began to show impacts of visitation two years after the visits ended (i.e., when their child was two), whereas nurse-visited mothers and children showed positive effects during the first two years of visitation and continued to show impacts even two years after the program ended. As concluded in the Olds, Robinson, O'Brien, et al. study, more beneficial impacts were found for nurse visited mothers and children if mothers had low psychological resources. The results of Olds, Robinson, O'Brien, et al. study also concluded that nurse home visitation and paraprofessional home visitation result in different impacts, even with both home visitors using the same home visitation program model. Much research suggests that the impacts of home visitation are modest (Daro, 2004; Kitzman, 2004; Santos, 2005; Zercher & Spiker, 2004). There are a handful of trials that show long-term positive impacts of home visitation, but they are not only limited in number but also in the range of impacts (Olds et al., 1997; Wagner, Spike, & Linn, 2002).

Family support is a central aspect to maintaining the well-being of preschoolers. For example, Dunst (1995) has published a monograph of guidelines for family support practice that summarizes the main principles and best practices involved in quality family support service. By convening family support leaders and soliciting input from practitioners around the country, the Family Resource Coalition has compiled an invaluable resource for other practitioners interested in the provision of quality services. Such a document would greatly facilitate the selection of the best prevention programs in family support. In addition to the prevention science literature, prevention practice reports and guidelines can also facilitate the selection of quality prevention programs. Prevention practice coalitions and organizations are often unaware of what types of programs work best for their particular prevention focus.

Multi-component prevention programs: Early Head Start as an example. Multi-component programs focus on both parents and children, providing both centre-based and family-based programs. For example, the Early Head Start Program, offered to parents of children aged zero to three, provides intensive learning and developmental services directly to children and their families and links to other community services to meet family needs (Tarullo, 1998). The program addresses three key components: (a) intensive child development, (b) parent education, and (c) building self-sufficiency for low-income families. These programs have demonstrated positive outcomes on child development measures (Tarullo, 1998). Typically these programs target low-income parents and oftentimes involve a case manager who informs the family of other services (Gomby et al., 1995).

Currently performance measures for Early Head Start are being developed to address the unique aspects of infant and toddler development. Programs that focus on early childhood developmental needs through parent education and home visitation, but which lack a child development or adult job training or education component, seem to have modest impacts on the child's cognitive development and the parent's life course outcomes (e.g., earning a high school equivalency diploma, delaying subsequent births) (St. Pierre, Layzer & Barnes, 1995). On the other hand, results from Nelson, Westhues, et al.'s (2003) research maintains that programs focused on mothers or both parents impact children as well.

Disenfranchised children are exposed to several difficulties that increase their probability of experiencing a number of developmental problems in both the short and long-term (McLoyd, 1998; Yoshikawa, 1994). Preventive interventions designed to address the needs of children in the social services system must be multi-systemic since no childhood problem exists in isolation at any one system level (Fraser, 1997). Key principles that emerge from this perspective include support for continuity of care across the service delivery system instead of fragmented services, cross-system collaboration instead of single-system responses, community-based services over out-of-home care for children, and culturally-competent services that incorporate varying racial, ethnic, socioeconomic, and regional values.

Summary. In summary, centre-based prevention programs emphasize programming that educates children with little involvement of parents in the process. On the other hand, family-based programs involve parents in their children's development and strengthen parenting skills. They are based on the assumption that when parents are

provided with the necessary skills through parent education and support, positive outcomes for children will be enhanced. Activities include conducting weekly or monthly home visits, and offering classes and a drop-in centre for parents. There is a third type of program, which combines centre-based and family-based prevention programs called multi-component or "two-generation" programs (St. Pierre et al., 1995). These programs serve children and parents simultaneously using a three-pronged approach. Activities promote child development and school readiness, enhance parenting skills, and provide economic self-sufficiency services for parents. Children's programs and services are linked with adult-oriented services for parents such as job training and adult education.

Theoretically, multi-component programs should produce the strongest effects on preschoolers and parents since the wide range of program goals encompasses risk and protective factors at multiple ecological levels of interest along while taking into consideration the factors that impact the onset of mental health problems. When implemented though, multi-component programs may not be offer sufficient program intensity to deliver positive results (McLennan, MacMillian & Jamieson, 2004). Service delivery has increasingly focused attention on addressing the individual, family, neighbourhood, and broader contextual conditions that may cause childhood problems (Fraser, 1997). An ecological framework focuses on both the child in need of social services and on the context (e.g., family, school, peers, and neighbourhood) (Bronfenbrenner, 1979). This perspective requires those who work with children and their families to look holistically at the child, the family, their roots, and their culture as well as the social services delivery system. No matter what type of prevention program is chosen, scientists and service providers must collaborate in their efforts in understanding,

planning, implementing, and evaluating prevention programs. Following is an examination of this particular issue of collaboration that also happens to be at the forefront of prevention policy.

Decreasing the Gap between Research and Practice

The sustainability of some prevention programs is becoming an important issue (Durlak & Wells, 1997; Ennett, Tobler, Ringwalt & Flewelling, 1994; McLennan et al., 2004; Zigler, Taussig & Black, 1992). Outcome studies show that some programs have resulted in minimal effects that can be partially explained by the obstacles community interventionists face. These obstacles include a lack of funding and resources, the complexity of the problem addressed, a lack of community buy-in, and inadequate implementation (Elliott & Mihalic, 2004). McLennan et al. also mention that there is "a strong desire to implement programs that are not resource-intensive. Yet most proven prevention programs are intensive and are provided over a relatively long period" (p. 1070).

Furthermore, and possibly most importantly, the success of a prevention program depends on the use of prevention science in the planning and implementation of the program. For a variety of reasons, including lack of time, interest, or resources, practitioners do not consistently base the framework of prevention programs on science, which sometimes can result in minimal effects (Morrissey, Wandersman, Seybolt, Nation, Crusto & Davino, 1997). There needs to be a dialectic relationship between science and practice. This should include feedback to the scientific community about the utility and the feasibility of developing science-based programs on a community-wide scale (Morrissey et al., 1997). In order to decrease the gap between prevention practice

and prevention research, researchers are devoting more time in examining and writing documents that reflect best practices in particular prevention areas (Gomby, et al., 1999; Head Start, 2002; Nation et al., 2003; Olds, O'Brien, et al., 1998).

There have been many approaches suggesting how to narrow the gap between science and its practice. Backer, David and Soucy (1995) advocate the *technology transfer approach* which works to improve the transfer of knowledge between science and practice through education, training, and dissemination of information. This transfer can be done through conferences, journal articles, and reports. A second approach, *participatory research*, highlights the importance of researchers and community members collaborating to outline community issues, designing the project, and analyzing the data (Altman, 1995). A third approach, the *practice-centred approach* is presented in Morrissey et al.'s (1997) review. This approach states that to maximize the impact of community-based prevention programs, there needs to be emphasis put on the continuous improvement of the program through the use of evaluations. In efforts to narrow the gap between science and practice, science must begin by sharing its knowledge regarding effective prevention programs with the intention of helping practitioners in providing successful prevention programs. The practice-centred approach emphasizes a dialectical relationship between science and practice to inform one another.

Characteristics of Effective Prevention Programs

Morrissey et al.'s (1997) review examined the components required for effective prevention programming in the areas of ATOD (alcohol, tobacco, and other drugs), teen pregnancy, AIDS, juvenile delinquency, and academic problems. Nation et al. (2003) also studied prevention programs dealing with issues of substance abuse,

sexual behaviour, school dropout/failure, delinquency, and violence and identified similar components. Both reviews acknowledged that comprehensiveness, defined as "an array of interventions to address the salient precursors or mediators of the target problem" (Nation et al., 2003, p. 451), is an essential factor in successful programs. Nation et al. outlined two types of comprehensiveness: (a) multiple settings and (b) multiple interventions. The former involves engaging multiple systems (i.e., families, peers, schools, etc.) that directly impact the individual in hopes that changing the social environment will, in turn, lead to supporting the preferred behaviour (Dryfoos, 1990, Hawkins & Catalano, 1992a). The latter refers to having a variety of prevention programs addressing the problem such as: increasing information and awareness, promoting skill development, and teaching coping mechanisms.

Second, Morrissey et al. (1997) and Nelson, Westhues, et al. (2003) both identified "sufficient dosage/intensity" as a crucial component. Programs need to provide enough of the intervention to produce the desired effects. The more intensive the program, the greater the likelihood that there will be positive effects (Mulvey, Arthur & Repucci, 1993). Nelson, Westhues, et al. also identified program length, intensity, and timing as crucial factors in program effectiveness. They found that the longer and more intensive the program was for children, the greater were the impacts on children. Third, theoretically-based programs that recognize multiple factors and are based on accurate and empirically-supported rationales have been shown to be most effective (Henggeler, 1992). Fourth, reviews have also concluded that programs that take into account varied teaching methods that are tailored to the needs of the participants are most effective (Morrissey et al., 1997; Nation et al., 2003). Programs should then provide interactive

instruction and hands-on experience, bearing in mind the age, ethnicity, and the needs of the participant. Fifth, programs need to be appropriately timed to have the maximum impact on the life of the child.

The last overlapping primary concern discussed by Nation et al. (2003) and Morrissey et al. (1997) is the socio-cultural relevance of the program to the participant. The program should not only be tailored to the cultural needs and norms of the participants, but also modifications should be made to increase the participants' responsiveness to the intervention. One important component that Morrissey et al. describe is sufficient follow-up, meaning that programs should incorporate a follow-up assessment, provide booster sessions to remind participants of the skills they learned, and provide participants with the opportunity of not only maintaining their current skill set but learning new skills as well. Nelson, Westhues, et al. (2003) also found that preschool programs with a follow-up educational component provided to children in elementary school show stronger cognitive impacts from kindergarten to grade eight than programs that lack this component.

Morrissey et al.'s (1997) review acknowledges that prevention programs that are consistent with the above mentioned components do not guarantee success. There are other issues to which attention should be paid. Having community involvement or buy-in in all phases of the research (planning, implementation, analysis, and evaluation) and therefore support for the prevention program is central to program success. Another major concern for service-providers is the lack of stable, long-term funding. Many prevention programs begin as pilot projects with short time frames, causing quick start-up times. Service-providers do not always have the time needed to develop all short and

long-term goals, identify target populations, and appreciate the "values" and theory that frame the objectives of the program (Morrissey et al., 1997). Rigorous, continuous evaluations of the program will help in bridging this gap between prevention science and the needs of the community to what is actually implemented. Collaborations with partnerships such as universities, local agencies, and different levels of government help the program evolve in response to new research, inform the program on how to adapt to local contexts, and provide ongoing funding respectively. These partnerships work together in informing one another of best practices and the community's needs - together they can create a program that is effective in gaining continuous funding.

A meta-analysis of reviews on the effectiveness of preschool prevention programs found that programs that include a direct teaching component for children have short-term impacts on the cognitive development but that in the long-run, these effects diminish slightly by the time these children enter elementary school (Nelson, Westhues, et al., 2003). As seen in evaluations of Head Start programs, children's cognitive skills improved over short periods. While the gains shown by Head Start children from fall to spring were relatively modest, they fell within the range that has been deemed "educationally meaningful" (Rosenthal & Rosnow, 1984). These findings are in line with earlier findings on the immediate effects of Head Start on children's intellectual performance (Haskins, 1989; McKey, Condelli, Ganson, Barrett, McConkey, & Plantz, 1985). Other longitudinal studies of Head Start program have found positive outcomes for school achievement beyond third grade and reduced rates of grade retention, enrolment in special education, and delinquency (Barnett, 1995; Devaney, et al., 1997; Yoshikawa, 1995). The Head Start program effects were greater in model program sites

where there were high ratios of staff to children, small group sizes, and well-supervised teachers (Barnett, 1995; Devaney, et al., 1997). Parent involvement through home visitation, classroom participation, and parent group meetings produced more long-term positive outcomes for the Head Start children than programs where parent involvement was minimal (Yoshikawa, 1995). Frede (1995) also examined characteristics of effective early care and education programming and found that all had the following elements: (a) small class sizes with low ratios of children to teachers; (b) teachers who received support to reflect on and improve their teaching practices; (c) a concentrated or long-lasting intervention; (d) ongoing, child-focused communication between home and school; and (e) use of some curriculum content and classroom processes that are similar to what children encounter in traditional schooling.

Furthermore, Nelson, Westhues, et al. (2003) also discuss the crucial implications of their research on policy issues. For instance, their analyses showed that programs less than one year in length and with fewer than 300 sessions have minimal impacts on children. Prevention policies must be based on research evidence such as Nelson, Westhues, et al.'s results to guide programs to success.

Below is a table adapted from Nation et al.'s (2003) research showing some of the characteristics of effective preschool prevention programs that must be taken into consideration.

Table 1

Characteristics of Effective Prevention Programs

Principle	Definition
Comprehensiveness	Multicomponent interventions
Varied teaching methods	Programs involving diverse teaching methods
Sufficient dosage	Programs provide enough dosage to produce the desired effects
Theory driven	Programs have a theoretical justification, are based on accurate information, and supported by empirical research
Appropriately timed	Programs are initiated early enough to have an impact on the development of the problem behaviour
Socioculturally relevant	Programs are tailored to the community and cultural norms of the participant
Ongoing and outcome evaluation	Programs have clear goals and objectives
Community "buy-in"	The program is designed and implemented to promote community ownership
Conducting follow-ups	Calling program participants to discuss how their needs can after the program be further meet, what benefits they experienced from the program

Source: Nation, M., Crusto, C., Wandersman, A., Kumpfer, K., Seybolt, D., Morrissey-Kane & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist, 58*, 449-456.

A goal of prevention science is to provide information about what type of program works best for a particular type of problem within a particular type of

population. Knowledge generated by research determining what works in prevention is helpful in answering the question of what program to select. To be effective, programs need to be based on a theory of the target problem and be tied to current and relevant research (Brady, Goldman & Wandersman, 1994). After research has concluded the most effective types of programming, the risk and protective factors, and the characteristics of effective prevention programming, governmental action can be taken in the form of mental health prevention policy development.

Summary. The word prevention encompasses many important concepts as evidenced by the prevention literature discussed above. The differing types of prevention programs such as, centre-based and family-based programs should reflect best practices to be effective in improving the mental health of preschoolers. Furthermore, the characteristics of programs identified by evidence-based research such as its comprehensiveness, intensity, its basis in theory and its cultural-sensitivity seem to clash at times with what in actuality is implemented. There is a gap between research and practice that has the ability to impact all areas of prevention programs ranging from the program's emergence to implementation, adaptation, and effectiveness. In the next section, the concept of policy will be examined to illustrate and understand its impact on program creation.

Policy

Policy signifies both a position or a stance and a course of action. Pal (1992, p. 2) defines public policy as "a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems." In other words, a policy is intended to determine and influence decisions and actions and shape programs.

Furthermore, Pentz (2000) describes policy as statement that represents public agreement about a course of action regarding a specific concern. According to Pentz, policy can be categorized into two broad types: (a) regulatory and (b) programmatic. For example, regulatory policies for increasing early childhood well-being can be through anti-poverty policies, or income supports, or tax and transfer policies. However, programmatic policies increase well-being through the implementation of centre-based or family-based early child development prevention programs.

In the 1990's there was devolution of funding, specifically to health care, from the federal government of Canada to the provinces, and from the provinces to local communities (Health Canada, 2002b). Provinces and local communities are reinventing the ways in which they coordinate, plan, produce, and evaluate policies; they have shifted from a focus on process and inputs (what programs do) to a focus on outcomes. For example, organizations are requesting program logic models and evaluations of the program to be outlined and conducted before initial and future investments in the program (Caputo, 2003; Naylor, Wharf-Higgins, Blair, Green & O'Connor, 2002). Now more than ever, practitioners are encouraged to be an integral part of the policy-making process (Gregrich, 2003; Kirby, 2004; Petersen, 2004). It is important to note, however, that psychologists and mental health professionals are not of a single mind regarding policy recommendations (Cowen & Durlak, 2000). Each professional assimilates facts differently, through a different value-based lens that is guided by a variety of experiences. Even with the increasing trend towards accepting mental health prevention programs as opposed to treatment, there is a continuum on which practitioners fall with respect to the optimal prevention activities provided. On one end of the continuum, some advocate for

strengthening at risk children (Coie et al., 1993), whereas on the other end, there are calls for universal programs that seek to build and maintain psychological wellness from the start for all children in hopes of building protective factors for the future (Cowen, 1994).

There are a variety of general policy issues in prevention that I aim to discuss. First, it is important to examine if there is an adequate knowledge base from which prevention policy can be developed. Prevention research stresses the complex interaction of many factors in the development of social and psychological problems; thus making research in prevention more complex as well (Plaut, 1980). Furthermore, for some advocates of prevention, it appears that a "double-standard" is being applied in relation to the adequacy of the knowledge base for action. That is, more evidence regarding effectiveness seems to be required before prevention programs are supported than is the case of treatment activities (Weissberg, Kumpfer & Seligman, 2003). This being said, prevention is accepted in principle, but when resource allocation choices are made, more resources are allocated to treatment services (Nelson, Prilleltensky, Laurendeau & Powell, 1996). Moreover, due to the lack of funding for prevention programs, successful pilot prevention programs that receive initial funding are also vulnerable to being discontinued (Elias, 1987).

Policy Frameworks

Since the definition of the issue is the heart of policy, new policies on prevention must come to grasp with an accurate view of the "why" of problems (Pal, 1992). Ideologies used to understand the problems can be categorized by the values they address. For example, Nelson and Prilleltensky (2005) describe three categories of values: (a) personal well-being, (b) relational well-being, and (c) collective well-being.

Nelson and Prilleltensky define personal well-being as "values that serve the needs of the person," such as self-determination, caring and compassion, and personal health (p. 56). Relational well-being values include respect for differences, acceptance and inclusion, and facilitation of meaningful involvement in decisions affecting one's life. Collective well-being is described as "values [that] complement individual aims, for the attainment of personal objectives requires the presence of social resources," such as support for community structures, social justice, and accountability (p. 58). Relational well-being values serve to bridge personal and collective well-being values. In this research, I have chosen to concentrate on personal and collective well-being values.

There are many frameworks from which policy can be analyzed. Kelley's (1975) change-related approach is one of the most parsimonious frameworks for analyzing policy. The three criteria of Kelley's analysis are adequacy, effectiveness, and efficiency. Kelley defines these terms as follows: (a) adequacy is the "extent to which a specified need is met if the program objectives are carried out," (b) effectiveness is the "extent to which the outcomes obtained are a result of policy intent and program activity," and (c) efficiency is defined as the "measure of goal attainment in terms of the expenditure of the least amount of resources" (cited in Flynn, 1985, p. 35). All proposed or actual policies that are subjected to analysis must be addressed in terms of the three criteria. Furthermore, for my interests, it is important to note that Kelley also recognizes two sub criteria called "identity" and "self-determination." With respect to mental health prevention policy, the impact of the policy or subsequent program on the self-image or "identity" of the recipient or target population must be considered along with the right of the consumer to have a voice in the determination of the policies that may impact them.

Kelley's (1975) framework is perhaps slightly simple, not providing a comprehensive analysis. Gilbert and Specht (1974) have proposed a two-level framework for policy analysis. The first level deals with the major "parameters of choice," major values at odds in the policy, the explicit or implicit theories giving rise to the policy issues, and the overarching alternatives that are possible. The second level is called "dimensions of choice." These elements are labeled as: (a) bases of social allocations, (b) type of social provisions, (c) strategies for delivery, and (d) modes of finance. In essence, this second level examines who gets what (e.g., target population), through what delivery mechanism (e.g., preventative, habilitative, or rehabilitative), and how the program will be financed (mode and manner of finance). It is important to note that neither Kelley's change-related approach nor Gilbert and Specht's two-level framework emphasize the process of policy.

Ross and Staines' (1972) explanation of policy-making stems from what goes on in the community's agenda-making or agenda-setting process. The analysis and definition of the social problem occurs in a political context. Ross and Staines maintain that certain institutional actors, such as the media, officialdom, and members of private groups, are vehicles for the movement of ideas and for raising awareness of long-standing problems. On the other hand, the sequential/incremental model is described by Lindblom (1977) as "social policy change comes about as a result of a process of successive comparison in the play of power" (p. 45). In other words, gradual changes arise out of the exercise of influence and expertise. Therefore, every new proposal is just a new variation of what use to be. In the end, Lindblom believes that the process of policy is merely a comparison of what used to be, what is, and what might be in the future.

Similarly, resource mobilization theory asserts that societies possess the resources (money, political influence, access to media, and workers) to mobilize a variety of change efforts, but that power and power struggles determine which change efforts will be successful. Authors such as Tilly (1978) and McCarthy and Zald (1977) emphasize that resource mobilization focuses upon the goals, organization and leadership of movements, the resources and opportunities available to them, and the strategies movements employ. Different ideological perspectives will have different degrees of success depending upon the prevailing context. Hunter and Staggenborg (1986) state, "mobilization of resources is seen as a necessary antecedent to action, and the types, amounts, and sources of the resources are seen to structure the form, content, and likely outcomes of that action" (p. 4). Another key aspect besides resource mobilization that has been shown to have an impact the success of prevention programs is the concept of program implementation.

Program Planning and Implementation: Policy into Practice

The quality of prevention program implementation is a central factor in influencing program outcomes (Durlak, 2003). There are a variety of factors that enhance program success - the training and support given to teaching staff, community buy-in, barriers to participation, and the flexibility of the program to meet the needs of different cultural populations.

Nelson, Pancer, and Kissin (2003) identified three stages in the life-cycle of community-based prevention programs: (a) planning, (b) implementation; and (c) sustainability. Their research outlines two major components of program planning: (a) starting with a firm prevention program model, and (b) building community ownership of the program through forming collaborations. First, a sound program model should be

based on the "why" of a problem and then outline the "how" of a program. In other words, the model should specify what and how activities will lead to the desired outcomes. Second, gaining community or stakeholders' trust and partnership is essential to the success of any prevention program. Nelson, Amio, Prilleltensky, and Nickels (2000) have observed that there is at times discord between the evidence-based practice approach and the community development approach to prevention. The former emphasizes program planning and implementation based on previous empirical research, whereas the latter emphasizes planning and implementation of programs based on the knowledge, wants, and needs of community members.

The second phase in the life-cycle of prevention programs is the implementation of the program. Nelson, Pancer, et al. (2003) define implementation as "how well the program components are put into practice." Bartunek and Betters-Reed (1987) have identified "implementation" as a stage in their model of organizational creation. This stage is characterized by the ideas generated in the planning stage into actuality as concrete organizational features of a program. During this stage, issues that can arise are: the lack of resources, the use of resources, the relationships between the leader, the planners, and organizational members.

Historically, there have been two categories of implementation: (a) fidelity and (b) adaptation. Fidelity is characterized by adapting program innovations as close as possible to the original model, whereas adaptation suggests that differing organizational and community contexts demand on-site modifications of the innovation (Blakely, et al. 1987). Berman (1981) advanced the fidelity-adaptation debate when he proposed a model that stated that different strategies were acceptable within different settings. For example,

the fidelity perspective would be the likely choice when the innovations were well-specified and well-structured, whereas the adaptation perspective is more appropriate with less structured innovations. However, Hall and Loucks (1978) did clarify adaptation in saying that adaptation or reinvention was acceptable up to a "zone of drastic mutation." In other words, if a program is adapted beyond this zone, the program's integrity and effectiveness would be compromised. Results from Blakely et al.'s research suggest that high fidelity to the innovation does not necessarily result in higher effectiveness. Rather, adaptation or reinvention of the innovation contributed to effectiveness only when the adaptation took the form of additions to the model. Improvements that took into consideration the local context when reinventing the program actually increased program effectiveness. Research suggests that when programs are complex, they are less likely to be implemented. The more flexibility a consumer has to modify the program to meet those needs, the greater the likelihood that a program will be adopted, implemented, and institutionalized (Berman & McLaughlin, 1976).

Current research in this area focuses on two competing aims as well: (a) to develop universal prevention interventions and implement them with fidelity and (b) to design prevention interventions that are responsive to the cultural needs of a local community (Castro, Barrera, & Martinez, 2004). This latter aim emphasizes the adaptation concept similar to Blakely et al. (1987) in saying that community involvement in a program is highly reliant on the assimilation of the program's cultural sensitivity to the needs of the community. Nonetheless, model programs that conflict with local participant needs are culturally mismatched and may require program adaptation. The participants of a prevention program demonstration may be quite different from

participants from communities to which the program is disseminated. This could threaten program efficacy despite high fidelity to program implementation. Major sources of mismatch are: (a) group characteristics, (b) program delivery staff, and (c) administration/community factors. When present, it is recommended that these sources of mismatch should be addressed in an a priori strategic plan for program adaptation that comes before program implementation.

Stemming from these mismatches, there are two forms of adaptation that can be considered: (a) modifying program content and (b) modifying the form of program delivery. Modification of content may be necessary if a consumer group needs or wants certain programmatic content not offered by the original model program. On the other hand, modifying the delivery refers to presenting the same program content albeit as delivered with changes in: (a) characteristics of the delivery person(s) - lay health workers rather than health educators, (b) channel of delivery - internet delivery rather than school classroom, and (c) location of delivery - church or community-based organization rather than school classroom, etc. (Castro et al., 2004).

Recently a set of *program adaptation guidelines* has been proposed (Backer, 2001), which emphasizes balancing program fidelity and adaptation as a best strategy for improved prevention program outcomes. It is this research's aim to examine the implementation of the preschool prevention programs chosen in hopes of identifying and examining the level of fidelity and adaptations made by the programs by using Backer's program *adaptation guidelines.* Backer's has identified 12 guidelines from which the following are examined in this research: (a) the program's theory of change, logic model, and core components, (b) determining the needed resources of the prevention programs,

and (c) examining if and how the program includes fidelity/adaptation issues in their program evaluation. The other nine steps in Backer's guidelines detail assessments and considerations that should be made prior to implementation (i.e., assessing community concerns, consulting with the program developer, considering available training etc.) and therefore will not be used in this study's analysis.

Summary. The ways in which policy can be analyzed has been examined by many different frameworks as detailed above. For this analysis, I will focus on Nelson and Prilleltensky's (2005) personal and collective values of well-being when describing the ideology behind the two prevention programs examined. Kelley's (1975) criteria and sub-criteria of effectiveness, efficiency, adequacy, identity, and self-determination will be used when analyzing the policy of both programs as well. The extent to which the environment, (i.e., political, media, financial, etc.) in which the two prevention programs emerged, played a factor will be assessed through the resource mobilization theory. As for examining implementation and adaptation issues, Nelson, Pancer, et al.'s (2003) program planning and implementation stages will be reviewed in light of both the Early Years Centres and the Healthy Babies, Healthy Children program. Issues, such as the extent of fidelity and adaptation raised by Blakely et al. (1987) in regards to implementation fidelity to the original model will be discussed as well. The sensitive nature of adaptation as discussed by Blakely et al. (1987) and Castro et al. (2004) will be used to shed light on the nature of adaptation in the Early Years Centres and the Healthy Babies, Healthy Children program.

An Integration of the Literature Review and a Framework for the Study

Considering the vast amount of literature on the effectiveness and impacts of prevention programs, these programs still seem to be the poor cousin of treatment programs. This research will examine why there is a lack of resources put towards these programs. This new-found understanding can then be used to guide and alter funding practices. Furthermore, the knowledge gained can also be applied to the writing of prevention policy that best reflects the complex and valuable nature of prevention programs. In this section, I aim to synthesize the information presented in the literature review. There seem to be four overarching themes that can be extracted from the literature review. First, the issues of *ideology and origins of the program* are considered. In other words, questions such as the framing of the problem by the policies, the values that underlie the policy, questions regarding the emergence of the policy at a particular time, the amount and adequacy of funding for the policy, and the impact of stakeholders and leaders on the policy, are considered. More specifically, the research by Lindblom (1977) and the ideas in resource mobilization theory compose this first theme in the research. Second, I investigate the *theoretical underpinnings* of the policies along with identifying the sources of the problem. This is where this research attempts to answer Gilbert and Specht's (1974) level one questions relating to parameters of choice (i.e., major values at odds in the policy, the explicit or implicit theories giving rise to the policy issues, and the overarching alternatives that are possible), along with issues dealing with risk and protective factors and the type of programming chosen by these policies. Third, *the research base* upon which these policies are established in, Kelley's (1975) change-related approach for analyzing policy, and the fidelity of programs to

established research are studied. In other words, the identified best practices for prevention programs are examined in terms of the adequacy, effectiveness, efficiency, and fidelity of the programs. Fourth, *implementation and adaptation issues* along with Gilbert and Specht's level two questions that deal with dimensions of choice (target population, what delivery mechanism, and mode of finance) are examined.

Table 2

Research Questions

Category	Issues/Questions
Program Ideology and Origins	- how and why did the prevention program emerge at this time? - what were the underlying values and assumptions of the policies? - who were the major players in the process?
Theoretical Underpinnings	- what are the theoretical underpinnings of the program? - who does this program serve? - what type of prevention program is it? - what are the risk and protective factors addressed?
Research Base	- what is the extent of the program's fidelity to research/its program logic-model? - does the program adhere to best practices in prevention?
Implementation and Adaptation Issues	- what is the funding for the program? - was there community ownership and local adaptation? - were the training and program guidelines given to staff adequate? - what are the major changes that have occurred overtime?

Background

Children's Mental Health Prevention Policy in Ontario

Children's Mental Health of Ontario (CMHO, 2002) has written on the current state of children's mental health services for children zero to six years of age. The working definition of children's mental health services provided by CMHO through a literature review and consultations in Ontario is as follows:

> 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. (CMHO, p. 2)

The McGuinty government's commitment to children's mental health can also be seen through the creation of the Ministry of Children and Youth Services in 2003. On a national level, under the *Multilateral Framework on Early Learning and Child Care,* the federal government committed $900 million to provinces and territories over five years. Ontario's share of this funding was $9.7 million in 2003/04 and $29.1 million in 2004/05, growing to approximately $137.3 million by 2007/08 (Ontario Early Years, 2004). Even though both the Early Years and Healthy Babies, Healthy Children programs pre-date the new ministry and the current Liberal government, they are still central initiatives with the aim of helping give children the best start in life by providing prevention/intervention programs for children and their families.

Research Context

In this study, two Ontario-based preschool prevention programs are examined: Healthy Babies, Healthy Children and the Ontario Early Years Centres. These two programs offered this study an opportunity to examine a breadth of preschool prevention and policy issues that could be used to strengthen all current and future preschool mental health prevention policy. Healthy Babies, Healthy Children is a province-wide, early intervention/prevention initiative that helps families promote healthy child development along with helping their children achieve their fullest potential (Ontario Ministry of Child and Youth Services, 2004). The Ministry of Health and Long-Term Care (MOHLTC) launched Healthy Babies, Healthy Children in 1998. The program offers all families with new babies information on parenting and child development and delivers extra help and support to those families who would benefit. Delivered by the province's 37 public health units, Healthy Babies, Healthy Children provides a range of services. These services include screening/assessment for pregnant women and families with children up to age six, a phone call from a public health nurse to all new mothers offering information and a home visit, referrals to services in their communities, a home visit to families that would benefit from a public health nurse or a lay home visitor and lastly, service planning and co-ordination services. The program also encourages more communication among community services to help make it easier for all families with young children to get the services they want and need (Ontario Ministry of Child and Youth Services, 2004). HBHC is funded by one ministry, supported by another, managed provincially, and co-ordinated locally. This complex interdependence gives rise to a dynamic, diverse, and wide-ranging program as long as all sectors fulfill their roles and responsibilities. On the

other hand, this interdependence becomes a jigsaw puzzle of sorts, potentially making administrative roles more time-consuming and improvements to the program more challenging to implement.

The Ontario Early Years Centres, which is one program out of many under the Early Years Initiative, was created in response to a study commissioned in April of 1999 by Premier Mike Harris and the Minister Responsible to Children, Margaret Marland. This study titled Early Years Study was conducted by Dr. Fraser Mustard and the Honourable Margaret Norris McCain in 2001. As a result, several Early Years Centres have been established since then in response to the Early Years Study. In 2003, 42 Ontario Early Years Centres opened in 17 communities across the province. Furthermore, in 2004, 61 more Centres opened throughout Ontario. An Ontario Early Years Centre is a place for parents and caregivers of children, up to the age of six, to get information about their children's development and about services to support healthy development (Ontario Early Years, 2004). Programs enhance child development in five developmental domains including cognitive, language, physical, social, and emotional (Ontario Early Years, 2004). Parents get the opportunity to take part with their children in a range of program and activities, talk to early years professionals, as well as other parents and caregivers in the community.

Methodology

Stakeholders and Participant Involvement and Utility to the Setting

The stakeholders in this research include policymakers, researchers in the field of policy, and service-providers and clients of both the Early Years Centres and the Healthy Babies, Healthy Children program. Participants were asked to contribute to this

study by being key informants and discussing their views with regard to either the Early Years Centres or the Healthy Babies, Healthy Children program.

Methods to Collect Data

Patton (2002) describe qualitative research as using three different types of methods of collecting data: (a) interviews with open-ended questions, (b) observations of people and/or group processes, and (c) analyses of documents such as program reports or document reviews. These methods are collectively referred to as fieldwork and the data acquired through these methods are referred to as field notes. To produce findings in qualitative research, the content of all field notes was analyzed by searching for emerging themes, patterns, and/or insights. The qualitative data gained from these field notes provided an in-depth understanding of the phenomenon of interest. As Patton (2002) states, qualitative types of inquiry allow for the gathering of detailed, in-depth information. This research began with a document review to get a general understanding of the programs and then followed-up with interviews to gain more in-depth knowledge. Methods such as detailed interviews helped this research understand the meanings behind the acquired documents. A semi-structured interview guide using open-ended questions was used, covering each of the four central topics outlined in the research questions section (see Appendix A).

Document review. Nelson, Ochocka, and Lord's (2000) research examined mental health reform in terms of the underlying policies and programs employed. A review of documents provided the researchers with a broad range of information, critiques, recommendations, and an accurate representation of the current policies and programs. A document review was undertaken for this study as well. The documents that

were reviewed to examine the Early Years programs include: *Reversing the real brain drain: Early years study* by McCain and Mustard (1999) and the Harry Cumming and Associates (HCA) evaluation (2004) of the Early Years Centres. The documents that were reviewed to examine the Healthy Babies, Healthy Children program include: the HBHC consolidated guidelines provided by the partners involved with the program and the Applied Research Consultants (ARC, 2003) preliminary evaluation of the HBHC program. The initial research questions were revised to reflect the knowledge that was gained from the document review before key informant interviews were conducted. To ensure consistency in the analysis of the documents, a protocol for analyzing the documents was outlined (see Appendix B). Documents were analyzed by grouping recurring themes together under the four categories listed above. For example, when reading the Early Years study (McCain & Mustard, 1999), the universality of programs was repeatedly mentioned as a key aspect of any early years prevention program. Universal programming became a theme that I categorized under the theoretical underpinnings category. The emerging themes in the document reviews help set the foundation for the key informant interview questions.

Key informant interviews. Coupled with the document review, Nelson, Ochocka, et al. (2000) also conducted key informant interviews which provided their research the depth it required. These informants, using their experiences, shed light on issues that lay the foundation of the policy documents. In other words, "these interviews were conducted to probe beneath the surface of the rhetoric of government documents to determine what changes people believed had occurred" (Nelson, Ochocka, et al., 2000, p.8). This current study used a similar approach. The interview guide was created with the help of the

themes that were emerging from document reviews. Additionally, questions were formulated to reflect the prevention and policy topics that were covered in the literature review. As informant interviews were being conducted and new issues were arising, the interview guide was adapted to accommodate these new areas. A consent form was given and signed by each informant. The consent form detailed the purpose and procedure of the project, any potential benefits and risks of involvement, the voluntary nature of involvement, the confidential and anonymity of interviews, and permission to tape-recorded and quote informants. Interviews were coded using the four categories as well. For example, I took all interviews that were conducted for the Early Years Centres and categorized them under the four categories – thus creating four new documents. Each document had all the opinions expressed regarding one of the four major categories. Therefore, the theoretical underpinnings document had all that was said by informants about this category. Then, I further analyzed each document for recurring themes such as issues pertaining to the universality of the centres. Furthermore, I kept a separate record of information that was recurring but that did not fall into one of the four major categories. For example, the role of the business sector was an unforeseen issue but that was mentioned by several informants and therefore is discussed in the findings section.

The sampling of informants for the interviews took the form of snowball sampling as information-rich cases were required. Informants were chosen based on their knowledge and experience with the history, creation, implementation, and sustainability of both prevention programs. Furthermore, informants recommended other informants that would shed more light or be able to discuss unique aspects of research questions. To provide the research with informants that had diverse positions within the programs,

informants were government officials, researchers, or service providers. For the present research, the key informants came from the following areas: (a) one government representative involved with the Early Years program; three government representatives involved with the Healthy Babies, Healthy Children program. (b) two service providers from the Early Years program and two service providers from the Healthy Babies, Healthy Children program; and (c) three researchers who examined the Early Years program and one researcher who examined the Healthy Babies, Healthy Children program

Analysis and Verification of the Trustworthiness of Data

Analyzing key informant interviews and document reviews involved finding the themes, concepts, and patterns that are consistent across the two methodologies. To verify the trustworthiness of data, I used data triangulation. Data triangulation was used to study the concepts of prevention and program implementation in Ontario using a variety of differing data sources such as document reviews and key informant interviews.

Along with using triangulation to ensure trustworthiness of data, Lincoln and Guba's (1985) also outlined four verification criteria: (a) credibility, (b) transferability, (c) dependability; and (d) confirmability. Credibility was achieved by taking the data and interpretations to the source from which they were drawn and asking the key informant participants whether they believed or found the results plausible. For example, the Early Years study (McCain & Mustard, 1999) advocated for universal programming and therefore, the centres were mandated to be universally available. During the interviews, I asked informants if they would categorize the centres as universal. This question would result in informants discussing issues relevant to universal programming and their beliefs

about the extent of universality the centres demonstrate. The transferability of results to a variety of different contexts and populations is important. Therefore, I provided readers with enough descriptive data so to be able to determine if the transfer of the results of this research to other settings is possible. Dependability refers to the consistency of the findings and this was tested through the document reviews and key informant interviews. After reading key Early Years Centre documents I reached a point of saturation as all documents were resulting in the same type of themes. This pattern of saturation also occurred for the key informant interviews. Confirmability refers to the objectivity of the data, such that there would be agreement between two or more key informants about the data's meaning or interpretation. I noticed confirmabilty between the same types of informants. For example, service providers would tend to agree and have similar perceptions of program ideology, research base, adaptation issues, etc., but their perceptions on the same issues were at times different than those of government representatives.

Findings

Early Years Centres

Research Question 1: What Are the Ideology and Origins of the Program?

Document review. An interest from Ontario's Children's Secretariat in early child development was rekindled at the time the Early Years study (McCain & Mustard, 1999) was announced because of evidence on early childhood intervention and growing research on healthy brain development. Scientific-based research expanded the understanding of long-lasting effects of parental nurturing in the early years, specifically

the first three years, on children's ability to learn, demonstrate positive behaviour, to regulate emotions, and minimize the risk for disease later in life.

Lindblom's (1977) ideas on resource mobilization theory stress that every new proposal is just a variation of what used to be. This is true in the history of healthy child development. The Early Years study (McCain & Mustard, 1999) highlights historical efforts in support of parenting centres to improve early child development. The history of early child development is one that spans more than 40 years. Some have advocated for Ontario to create centres, such as the Early Years Centres, in elementary schools. Over the years, others have attempted to change the notion of daycare towards more holistic approaches, including support services such as parent and child-oriented programs. Therefore, McCain and Mustard's recommendations do not call for extreme and radical policy changes but rather for variations in the existing policies concerning the relationship between daycare and early child development. Unlike past recommendations, the Early Years study (McCain & Mustard, 1999) gives the power primarily to communities and the private sector. It does this by giving the responsibility of guiding the creation of the centres to stakeholder groups composed of community members and business representatives. Therefore, along with governments, communities and the private sector are recognized as possessing the needed resources to change the face of early child development.

The principles upon which the Early Years Centres were established lie in the recommendations outlined in the Early Years study (McCain & Mustard, 1999). This study outlines a variety of strategies that can improve the state of healthy child development including the following: supporting healthy parental interactions, increasing

paternal and maternity leave and benefits, and developing community information networks. McCain and Mustard envisioned a community-based approach to the creation of the centres. In this study, there is a clear underlying view that child developmental problems are attributable to both person-centred and social environmental factors. The central problem identified by this study is the lack of adequate brain stimulation in the healthy development of children. The authors of the study stated, "We know now that development of the brain in the early years of life, particularly the first three years, sets the base of competence and coping skills for the later stages of life" (McCain & Mustard, 1999, p. 2). Furthermore, McCain and Mustard asserted that "this new evidence expands our understanding of how nurturing [positive stimulation] by parents in the early years has a decisive and long-lasting impact on how people develop..." (p. 5). Positive parental interactions early on in life are crucial in setting the foundation for competence, positive coping skills, good health and quality of life, and success in the labour market later on in life. These outcomes focus on values for personal well-being as they serve the needs of an individual. The impact of changing social environmental factors on the healthy development of children is also evident by the following quote "How economies create and distribute wealth affects early childhood, and early child development affects the health and competence of populations throughout the life cycle" (McCain & Mustard, 1999, p. 53). These outcomes focus on values for collective well-being as they emphasize an equitable distribution of wealth and power. Socioeconomic inequalities are indeed discussed in the study in terms of supporting the need for universal programming. Furthermore, McCain and Mustard also advocate for increased maternal and paternal leave and benefits, family-friendly workplaces, and tax incentives to private sectors to

engage in creating early child development and parenting centres across Ontario. While the causes of the problem addressed by McCain and Mustard focus on both brain stimulation and socioeconomic gradients, thus reflecting values for both personal and collective well-being, respectively, the solutions chosen by the Conservative government only focus on promoting brain stimulation, thus concentrating on a micro level solution. Furthermore, collective well-being was valued to the extent that the centres were universally available. This idea of mixed ideologies is a theme that was identified through both document reviews and key informant interviews.

Another major theme in the McCain and Mustard study (1999) is the idea that an early investment by all - government, private and community sectors of society - in children's lives will pay-off, resulting in a population of individuals with better competence and coping abilities. This early investment is deemed to be much more cost-effective than paying for rehabilitation or remediation services later in life. Inadequate brain stimulation is rooted in the lack of services and supports for *all* parents, caregivers, and children. Therefore, financing centres that provide a continuum of support and are available for all parents and children to engage in play-based and problem-solving learning and parenting programs are the essential factors in the healthy development of children. For this reason, McCain and Mustard advocate for both a public and private sector understanding of the short and long-term importance of early child development centres. In ensuring that centres are available and accessible in all sectors of society, government support is seen no differently than private and community sector support. Government, the private sector, and communities are urged to be responsible for the creation of a new "first" tier of programming for children aged zero to six with the use of

the best knowledge about brain stimulation and early child development to maximize children's potential in the future. Furthermore, private sector involvement also entails providing leadership, financial support, and the acknowledgement of early child development issues in the workplace. The private sector is strongly encouraged to increase its resources to provide quality early child development and parenting centres accessible to all of Ontario's families. There is recognition, however, that if there is little responsibility assumed by the private sector to ensure that communities have the funding necessary to establish the centres, then more public resources will be needed to fill this gap. The ideology of community and private sector responsibility along with government responsibility is in line with the Conservative government at that time.

The McCain and Mustard study (1999) states that the initiatives cannot be considered universal in the terms that it is government-mandated and government-funded. Rather, universal signifies that the program should be available and accessible to all families.

Key informant interviews. Key informants provided many different perspectives on how and why the Early Years program emerged at this particular time in history. Many stated that it was not one single factor that led to the program's introduction. Rather the time was ripe for a program such as the Early Years Centres. At this time, there was a body of sound research indicating the importance and benefits of investing in early childhood development. Furthermore, this knowledge attracted people both from the human services sectors (i.e., early childcare providers, early childhood service providers, etc.) and the private sectors (i.e., banks, economists etc.). Along with sound research and the broad range of interested sectors, one key informant highlighted that

there were also many more women in the workforce then than ever before. This trend led to more children in the daycare system, thus raising concerns about the quality of childcare.

Key informants also noted that the emergence of the program was based on economic reasons. Informants expressed that the business sector was becoming increasingly interested in investing in early child development, as evidence by Charles Coffey's involvement with the Early Years study, because of its apparent benefits in doing so (i.e., ensuring a more competent workforce). Furthermore, informants mentioned that politically, there was a need to stay internationally competitive. As a result, there was a push towards initiatives that invested in early childhood development. Consequently, these Early Years Centres would help in the government's efforts to remain internationally competitive by developing a population that had strong coping skills, good social skills, and strong academic achievement.

Key informants also stressed that the idea of Early Years Centres would not have come about if it were not for the prominent people that supported its creation. One key informant said, "Not only content but also because who was saying it. McCain and Mustard were both very influential people who had the ear of Harris [the Premier of Ontario] - a relationship with Mike Harris personally." Additionally, how McCain and Mustard chose to convey the report also supported the creation of these centres. One key informant said, "It was not particularly new ideas, the messaging was very attractive to politicians because they used this early brain development messaging to sort of say to politicians, 'look you're backing a sure-fire winner here.'"

Another theme that emerged was the idea of political opportunity. One informant expressed that the development of the Early Years Centres was a politically expedient way in which the government at the time could respond to the recommendations made by the Early Years study (McCain & Mustard, 1999). Some also said that the program emerged since the province of Ontario, along with all provinces, was promised federal money if first they spent a certain sum of money on early childhood. With the Early Years study (McCain & Mustard, 1999), Ontario Premier Mike Harris was left with other viable options, as recommended by the study, than the childcare solution. One key informant said:

> I don't think that it was particularly a strong philosophical underpinning. I think that government had no choice but to do something for early years because they had this money from the feds and I think Mustard gave them a way of doing it that was easy and unlikely to get in the way of their other agenda items and unlikely to attract much criticism and allowed them to do nothing for childcare.

Along with McCain and Mustard playing pivotal roles in bringing the research to light, others brought their experiences and skills to the forefront as well. The private sector played a role in both the Early Years study (McCain & Mustard, 1999) and in the demonstration projects set around the province. In the study members of the private sector participated in the form of being reference group members by bringing their experience and knowledge to the study. In demonstration projects, they were stakeholders in committee meetings as well. Premier Mike Harris also had a major role in the inception of the Early Years Centres, and public servants helped in coordinating and planning the program. For some time, the childcare sector and children's mental health

services had been advocating for a program such as the Early Years Centres, and it was at this time that their work came to fruition. The childcare sector was also involved with planning the program. One key informant said, "Classically the major daycare providers were the initiators. Major daycare providers played a huge role in developing the Early Years proposal with the input of child and youth services in the communities in a more general sense." One key informant's perspective was that researchers, businesses, and community members were not involved with the introduction of the Early Years Centres. Instead, the major players were government and the Premier's office political staff.

There was consensus amongst informants that the Early Years study (McCain & Mustard, 1999) was very much the backbone of the centers rather than any specific government policies. However, key informants also pointed out that the centers did not fulfill McCain and Mustard's entire vision of how to best provide for early child development. One informant noted, "The research would not have been done without policy support from the province. The province supported the Early Years baseline study." In this informant's view, first came government support for research in the early child development area, then came the study leading to further government support through the creation of the Early Years Initiatives, one of which is the centres. Another key informant stressed that the Early Years Centres did not stem from the McCain and Mustard study, but that they were a response to the provincial government's need to spend some money within a certain time frame on children.

When informants were asked why more emphasis was given to brain stimulation than the socioeconomic factors to the healthy development of children in McCain's study (1999), many key informants interpreted this question differently than I intended.

Informants defined the word "socioeconomic" in two different ways: (a) the social factors that impact on the economic situation of families and (b) how an early investment in children has long-term economic benefits. Some informants stressed that Dr. Mustard needed the brain stimulation research to sell the economic side of the issue. When speaking about the lack of emphasis given to the socioeconomic factors that impact on child development, some key informants stated that this was so because brain stimulation became a palatable means of framing this complex set of issues. Using brain stimulation as the selling feature of the McCain and Mustard study was another theme that emerged in the interviews. Using brain stimulation was strategic in the way that it led Conservatives to feel comfortable distributing funds to children rather than creating programs and policies that strive for a more equitable societal distribution of wealth. One key informant said:

> I think he [Dr. Mustard] was very clever in messaging it in a way that was palatable, and I think he was really thinking about the systemic issues but what are the levers I have access to that I can pull that will make a difference and at the end of the day, redistribution of wealth and change social assistance rates he didn't think had the potential to change the same way, that putting money in the first few years did.

A criticism of the view above was that McCain and Mustard were trying to "push an individual level type of intervention." In other words, if parents did not take the responsibility of stimulating their child before the age of three, then parents were to blame for their child not growing to his/her fullest potential. On the other hand, some key informants also believed that the McCain and Mustard study (1999) valued personal well-

being since it called for improving the individual through a network of service and supports and educating parents and childcare workers about the important role of brain stimulation.

One key informant believed that the McCain and Mustard study (1999) also valued collective well-being as it "very much recognized the impact of social and economic circumstances on child development outcomes." This informant went on to explain that the "Early Years study took very much into account socioeconomic factors and looked at brain stimulation against the socioeconomic gradient." The problem, as assessed by this key informant, was that McCain and Mustard recognized the vulnerabilities that lie across all social classes. The majority of children who are having difficulties live in middle class, two-parent families. This informant's view was that the brain stimulation research and the socioeconomic factors were complementary rather than incompatible perspectives. This is evidence that the problem and solutions are founded on mixed ideologies as some informants discussed the problem in terms of valuing personal well-being and others highlighted how the problem values collective well-being.

Key informants shared their understanding of the underlying values and assumptions of the Early Years study (McCain & Mustard, 1999). Some identified educating parents and caregivers as a central value. One key informant said, "The underlying value is that all parents need, want and would benefit from access to greater knowledge on good [parenting] whether they are delivering it or a caregiver on their behalf is delivering it." Another underlying value is the emphasis the study gave to developing and relying on community, business, social, and government sector strengths and partnerships.

Another informant argued that an underlying assumption was that through the creation of the readiness-to-learn measure or the Early Development Index (EDI), one could determine if the Early Years Centres were benefiting the early development of children. The EDI is a measure that assesses a child's preparedness for school and ability to learn in school. To determine children's school readiness, teachers are asked to rate children in five developmental areas: (a) physical health and well-being, (b) social competence, (c) emotional maturity, (d) language and cognitive development, and (e) communication skills and general knowledge. This baseline measure would also show the progress each community was making in supporting early child development. A criticism of this approach is that test scores of the EDI do not take into account the family - changes in family structure, employment, income, and health. Low test scores are attributed to a lack of stimulation and not to possible changes in the child's environment. Furthermore, children's cognitive test scores do not directly assess either brain stimulation or levels of parental stimulation of children.

A central value is that an investment in a child's early years is a good investment because, as Mustard notes, what happens in the first few years shapes a child's academic and social well-being later in life. Additionally, one informant said, "We wouldn't go anywhere unless government is there and early child development is a key factor." This quote highlights that there needs to be a certain level of political understanding of the importance of early childhood development before funds are contributed to research. Moreover, one key informant stressed that the McCain and Mustard study (1999) would not have been commissioned if the federal government did not accept the importance of early development.

A key informant also stated that an important assumption found in the McCain and Mustard study (1999) is its emphasis on the centres' ability to adapt and mold to the specific needs of communities. The centres should "link up with others and be a resource for other services, and servicing parents and families." Another key informant expressed that an underlying value is the universalism of early child development and this value recognizes that far more middle-class than poor children are headed for behavioural problems and trouble in school.

Summary. Both the document review of the Early Years study (McCain & Mustard, 1999) and key informant interviews showed that the central reasons the Early Years Centres emerged were both the available research and most importantly the federal money that had surfaced. Evidence of the socioeconomic impacts and the lasting effects that parental nurturing has on healthy child and brain development early on in life proved to be a powerful means of getting people to understand the importance of investing early in children. Furthermore, this investment was needed and acknowledged by all sectors - government, businesses, and the social services sectors. Even though the pay-off of overall healthier citizens was recognized by all sectors, the McCain and Mustard study emphasized the need for the private sector to take more responsibility. A key informant believed that the centres were a politically expedient way of spending the money allocated for children and therefore, researchers, businesses and the community were not involved in the inception of the centres. On the other hand, other informants asserted that Honourable Margaret McCain, Dr. Mustard, Premier Mike Harris, public servants, the childcare sector, and children's mental health services were involved in different phases of the centres.

Some key informants thought that the Early Years study (McCain & Mustard, 1999) needed the brain stimulation research to frame the issue and believed that if it focused on other causes, such as socioeconomic factors and improving the values for the collective well-being of the community, the study would have not succeeded in gaining Premier Harris's support. On the other hand though, one informant believed that the brain stimulation research and the socioeconomic factors worked hand in hand. Underlying values and assumptions of this program include: the universalism of the centres, parent education, community diversity, the need of community partnerships, the importance of the Early Development Index (EDI), and using existing community strengths.

Research Question 2: What Are the Theoretical Underpinnings?

Document review. Along with many other researchers mentioned in the literature review (e.g., Bruer, 1999; Hertzman & Wiens, 1996; Nelson, Westhues, et al., 2003; Shatz, 1992), McCain and Mustard (1999) also underline the benefits of primary prevention. The central theoretical underpinnings are micro-centered theories that range from how to improve parenting skills to the impacts of brain stimulation on child development. The Early Years study (McCain & Mustard, 1999) emphasizes how research on brain development needs to be used in future prevention efforts. McCain and Mustard observed that Ontario children have lower performance scores on vocabulary and math tests when compared to other children across the country. The source of the problem, according to the authors, is due primarily to the inadequacy of support given to preschoolers and parents in the early stages of life. They advance the "zero to three" theory that a large part of a person's behaviour into adulthood is based on his experiences in the first three years of life.

The knowledge gained from brain research can have critical and lasting effects on learning, behaviour, and health throughout life. According to the authors, there is widespread evidence that a large portion of brain development occurs between conception and age three. This is seen through the active interplay of sensing pathways with the basic genetic structure of the brain that together influence the "wiring" of the nerve cells and neural pathways of the brain during this early stage. Theories postulate that inadequate nutrition and stimulation through touch, vision, smell, sound, and taste in the early period of development reduces and at times eliminates neurons and synapses that are not used. Scientists (e.g., Cynader & Frost, 1999; Doherty, 1997) have identified critical periods in which some functions of the brain such as vision, emotional control, peer social skills, and cognitive skills, develop more intensely than at other ages or periods of brain development. If positive stimulation is provided during these critical periods then the development of these functions strengthens brain capacity whereas inadequate or negative stimulation can lead to unsatisfactory development. Once these windows of opportunity have passed, it is still possible for the brain to develop capacity to compensate for poor development but it may be difficult for the brain to achieve its original full potential. Therefore, brain development is much more vulnerable to environmental factors than previously suspected.

McCain and Mustard (1999) assert that nature interacts with nurture rather than taking the position that either nature or nurture is of primary importance. The interplay between nature and nurture is seen through the statement "genetic potential is necessary, but DNA alone cannot teach a child to talk" (BrainWonders, 2001). Genes and environment interact at every step of brain development, but they play very different

roles. Genes lay the basic foundation for forming the neurons and general connections between different brain regions, whereas one's environment fine-tunes these connections. Our brains are programmed to recognize human speech, to discriminate subtle differences between individual speech sounds, to put words and meaning together, and to pick up the grammatical rules for ordering words in sentences. However, the particular language each child masters and the size of his or her vocabulary is determined by the social environment in which he or she is raised. Experience has the potential of changing the actual structure of the brain that can impact on how the sensory, motor, emotional, and cognitive circuits are put together. Every experience - whether good or bad, excites specific neural circuits and leaves others inactive. Those neural circuits that are consistently active will be strengthened, while those less active may be pruned or dropped away. Pruning is a process by which children's neural processes are streamlined, making the remaining circuits work more quickly and efficiently. Without synaptic pruning, children would not be able to walk, talk, or even see properly.

Similarly, attachment theory (Bowlby, 1980) denotes that a child's social-emotional development depends on a positive, nurturing attachment to a primary caregiver. This is based on the higher frequency of serious behavioural problems among children who were severely neglected during the first year or more of life. Comparable problems emerge among monkeys who are reared in isolation, and neuroscientists are beginning to understand how the lack of attachment in infancy alters development of emotional areas of the primate brain.

McCain and Mustard (1999) rely on Bronfenbrenner's bioecological systems theory to emphasize the impact a child's maturing biology, his or her family and community

environment, and the societal landscape have on steering his or her development (Bronfenbrenner, 1990). Bronfenbrenner's theory acknowledges that there are layers to one's environment, each having an effect on development. Changes or conflict in any one layer will ripple throughout other layers. A child's development then is not only affected by his or her immediate environment, but also through the interaction of the larger environments as well. Bronfenbrenner sees the instability and unpredictability of family life we have let our economy create as the most destructive force to a child's development. Children do not have the constant mutual interaction with important adults that is necessary for development. According to the ecological theory, if the relationships in the immediate microsystem break down, the child will not have the tools to explore other parts of his or her environment (Bronfenbrenner, 1990).

McCain and Mustard (1999) also call for universal programming. They argue and firmly believe that through their analysis of data gathered from both the National Longitudinal Survey of Children and Youth (NLSCY) and Statistics Canada, that there is no socioeconomic threshold above which all children do well. From their observations, as one goes up the socioeconomic ladder, children seem to have fewer and fewer learning or behavioural issues. They note, however, that at each socioeconomic level, from the highest to the lowest, families and children still experience a number of difficulties. McCain and Mustard describe this phenomenon as a gradient - more families at the lowest level have problems and fewer families at the highest socioeconomic level are faced with issues. Therefore, since all are faced with varying difficulties, the need for universal programming is understandable and potentially beneficial. In addition, according to the NLSCY data, only one-third of all parents from different socioeconomic

backgrounds demonstrated an authoritative parenting style (considered to be the most positive and enriching parenting approach). This implies that all parents could benefit from parenting programs, since the authors claim that positive parenting skills are weakly associated with socioeconomic status.

The Early Years study (McCain & Mustard, 1999) also advocates for both parent and child-oriented programming that can enhance a variety of protective factors as outlined below. With the new understanding of brain development, McCain and Mustard describe how from conception to one and a half years of age, parents direct their child's brain development. Therefore, parent-oriented programs need to teach parents how to adequately feed and provide play-based stimulation for their children which subsequently leads to their children learning how to problem-solve in a safe and nurturing environment. Programs must also be child-oriented and provide a safe venue for children to interact with other children. As well, programs need to increase children's capability in literacy, language, numeracy, behaviour, emotional control, and social skills. Home visitation was listed as an important support for parents as well. Home visitation provides outreach support for parents in their own home and links them to other social supports in their communities.

Other provinces across the nation have implemented alternative solutions than the ones McCain and Mustard (1999) recommended and have used their funding towards subsidizing childcare. Childcare or daycare is seen by many as providing child-oriented programming but without the parent-oriented component. However, at odds with the main suggestions recommended by McCain and Mustard is their emphasis on the

importance of non-parental care services. McCain and Mustard stress the value of full-time, part-time, and occasional childcare given to children at these centres.

Key informant interviews. Overall, the interviewees strongly believed that the theoretical underpinning of the Early Years Centres prevention program was the recognition of brain stimulation for healthy brain development. This general belief led one key informant to say, "I don't think it was holistic in the sense that it looked at all the variables that could impact a family." Nevertheless, the centres have become a viable, community-based, family intervention for parents and caregivers for aiding in healthy child development. Another central underpinning mentioned by most informants was the assertion that universal programming is more beneficial and needed than targeted programming. Furthermore, informants said that there was an understanding that programming should not be "going out on the basis of assumptions about what the particular needs are in the community but they should base it on the scientific analysis of the EDI [Early Development Index]." In other words, programming at the centres should not and is not implemented with a "one-size fits all" mentality. Rather it should be based on the particular needs of the community. One informant stated that the theoretical underpinning of the Early Years Centres is political expedience. In other words, the provincial government was told that if it wanted federal money funneled into its health care system, it needed to spend some of the funds given on early childhood; therefore, Premier Harris lifted and implemented parts of the Early Years study (McCain & Mustard, 1999) as a means of assuring continuous federal money.

Most key informants indicated that the Early Years Centres are universal, centre-based programs. However, some agreed that even though the intent was to have the

centres universally available, with the lack of funds, the universality of the centres is limited. For example, with the centres being scattered in each riding, and no funding to open up more centres, transportation becomes a barrier to accessibility. One key informant also stated that the type of programming delivered depends heavily on the type of programming the centre delivered before it became an Early Years Centre. Therefore, there lies much diversity in the types of programming, modes of service delivery, and outreach across centres. One key informant said:

> I think a lot of people would say that it serves, bored, sophisticated, middle-class housewives because it's not an intensive, street-level outreach kind of service, it's like a store front and you have to drive there and it's available from 9-5 so its serving middle-class, stay at home parents....some of them are doing excellent things but some of them it's true - they are serving those that are easy to serve - preaching to the choir.

Furthermore, one key informant highlighted that the centres are providing services that increase and support parent-child bonding, as recommended by the Early Years study (McCain & Mustard, 1999). On the other hand, another key informant stressed that, unfortunately, the centres remain as drop-ins for young children, families, and caregivers, whereas McCain and Mustard also strongly suggested providing non-parental care services for families as well.

As mentioned by many key informants, centre services vary based on the historical roots of the program and how the original program viewed their role in the community. This variation across the province also impacts the risk factors and protective factors affected. For example, one informant said:

> Some were Family Resource Centres and viewed their role as being very holistic - looking at the whole family. If there are issues of unemployment, or homelessness, violence in the family, health issues whether that is mental or physical health issues or the physical well-being, they will look at and refer and make the connections for the family or bring in supportive services into the centre. If you're a brand-new [centre] and never done this before, I think you stay very close to the child-focused [approach], ensuring the child was developing and meeting the milestones, a very much developmental focus, getting ready for school and that sort of focus. You may not worry so much about the parent except in their role as a parent and feed off parent education related to the needs of the child.

Another key informant said:

> They [the Early Years Centres] haven't to date become integrated with the rest of the program pieces of early child development so instead of being an integrated force they have effectively have been one more piece of program fragmentation at a systems level - so they haven't moved in towards the system.

When generally speaking about the protective and risk factors, key informants mentioned that centres:

- improve social health and physical development
- identify issues earlier through referral services
- improve school readiness
- improve coping skills
- improve prenatal health
- offset the risk of a lack of parental or caregiver knowledge about early child development by providing more information

- increase and improve maternal-infant bonding, and
- reduce parental isolation

One key informant said, "Which risk factors are most important varies around the province and I think there is a fairly good understanding and everybody would believe that different Early Years Centres need to target different kinds of risk factors." This informant applauded the use of the Early Development Index (EDI) in saying that centres create and deliver programming according to community needs. For example, if children in a community scored low on the language skills component of the EDI, some centres would use this information and increase its supports in the area of language. The use of the EDI, as expressed by the informant is a reactive measure - it takes a rather individual focus of the issue instead of attributing low language scores to issues such as poverty. In other words, the "EDI is showing particular way in which poverty is hurting kids in your area so you can sort of react."

Summary. The primary document that was reviewed to examine the theoretical underpinnings of centres was the Early Years study (McCain & Mustard, 1999). In it, the authors describe and suggest solutions to improve the low achievement scores of Ontario's children in light of brain research that supports the nature and nature interaction theory, Bowlby's (1980) attachment theory, and Bronfenbrenner's bioecological theory (1990) in supporting parental nurturing. As well, the authors make a case for universal, parent and child-oriented programming by using data obtained from the National Longitudinal Survey of Children and Youth (NLSCY) and Statistics Canada. Informants acknowledged the intended underpinnings listed above but also shed light on the reality of many centres which, due to circumstances, deviate from these theoretical underpinnings. With the exception of Bronfenbrenner's ecological theory, the theories

discussed are person-centred in that they focus on parenting skills and brain stimulation. Even though the risk and protective factors vary across centres, informants believe that centres are having positive impacts.

Research Question 3: What Is the Research Base?

Document review. Kelley's (1975) change-related approach examines the adequacy, effectiveness, and efficiency of policy. Kelley defines these terms as follows: (a) adequacy is the "extent to which a specified need is met if the program objectives are carried out," (b) effectiveness is the "extent to which the outcomes obtained are a result of policy intent and program activity," and (c) efficiency is defined as the "measure of goal attainment in terms of the expenditure of the least amount of resources" (cited in Flynn, 1985, p. 35).

In all the documents reviewed, there is no discussion of the adequacy of the Early Years Centres. The Harry Cummings and Associates (HCA, 2004) consulting firm was hired in 2004 to conduct a review of Early Year Centres, and this firm highlighted three key issues, two of which are program effectiveness and efficiency. The evaluation encompassed three major areas: (a) program effectiveness, (b) program efficiency, and (c) program equity. The evaluation design aimed to ask the nature of implementation of the centres through examining the delivery of core and other services and their impacts on the community. To examine these areas, an evaluation of the process was undertaken by HCA through the use of questionnaires, key informant interviews, and focus groups.

To examine effectiveness and efficiency, the intents and goals of the McCain and Mustard study (1999) are compared with the results obtained in the Harry Cummings's evaluation. The HCA evaluation (2004) defines effectiveness as: (a) the extent to which

the program produced its expected results and thereby achieved its objectives and contributed to its goal and (b) program efficiency as the extent to which program inputs were supplied and managed and activities organized in the most appropriate manner at the least cost. Harry Cummings and Associates (2004) categorize program effectiveness as follows: (a) parents/caregivers and children 0-6 years, (b) the service-provider community, (c) the community at large, and (d) program management. The overall effectiveness of the Early Years Centres in producing the intended outcomes that are outlined in the Early Years study (McCain & Mustard, 1999) is fairly high according to HCA (2004) evaluation results.

The methodology used by the HCA (2004) evaluation was limited due to tight timelines. For instance, a data profile consisting of two parts was sent to all 103 centre data coordinators, but because of a lack of time, the evaluation analysis focused solely on part one questions. Part two questions that were left out of the analysis included program specific information, such as the effectiveness and efficiency of the types of activities, accessibility, and of operational resources. Additionally, due to time constraints, analysis relevant to effectiveness and efficiency were gathered from 45 centres instead of all 103 centres. Furthermore, focus group participants were not randomly selected. Rather executive directors of each centre, through criteria provided by HCA (2004), chose which parents would be involved in focus groups. It is important to note that the participation rate for the executive director interviews, staff interviews/survey, focus groups, pre-focus group questionnaire, and the parent/caregiver questionnaire was 100%. However, the participation for the planning table members (local members that identify service gaps and duplication) was the lowest at 27%, community champions (selected and appointed

by the Ministry to work with community partners to select planning table members and to determine a planning process to guide the creation of the OEYC in their area) and community advisory boards in the 40% range, and regional supervisors at 90%. Moreover, as stated by HCA (2004):

> The methodology used was basically the methodology prescribed by the Ministry in its request for resources. While this methodology provides valuable insight into the implementation of the Ontario Early Years Centres initiatives, it does not produce data which can be ascribed a specific level of statistical certainty. (p 12)

Most outcomes described in Tables 3, 4, 5, and 6 can be directly linked to recommendations made in the Early Years study (McCain & Mustard, 1999). It is important to keep in mind that the program logic-model has the same components as the intended program objectives from the Early Years study (McCain & Mustard, 1999) as detailed in Tables 3, 4, 5, and 6.

However, HCA (2004) did observe both negative and positive unexpected outcomes. There are a handful of negative outcomes that surfaced during the evaluation that directly stem from the McCain and Mustard study (1999). The Early Years study (McCain & Mustard, 1999) called for the use of existing community supports and resources in the development of the centres. Therefore, some satellite locations that had previously provided Early Years support found it difficult to adapt to the new policies and procedures that the Early Years Centres brought with it. Furthermore, it was difficult for some parents that perceived the centres as being drop-ins to adjust to more structured programming once the centres got up and running. On the other hand, some centres experienced such high levels of interest in parent and child-oriented programming that it

has been necessary for parents to register for some of these programs - leading to long waiting lists. Lastly, McCain and Mustard advocated for a clear and detailed relationship between early development programs and the public school system whereas staff at the Early Years Centres also expressed uncertainty of where and how the centres fit into Ontario's education agenda.

On the other hand, due to McCain and Mustard's vision, the Early Years Centres have experienced some unanticipated positive outcomes as well. The number of participants, referrals, and community partnerships is higher than expected. The desire parents express for early childhood development information is higher than predicted along with more frequent positive feedback from parents. Centres are also becoming and providing a venue for support and friendship for all parents in general and specifically for new immigrants as well.

Table 3

Program Effectiveness for Parents/Caregivers and Children 0-6 Years

Intended Program Objectives from the Early Years Study[1]	Results from the HCA evaluation[2]
To increase access by all children to services that promote healthy child development	Based on Phase I Centres, Centres are enabling more and more children access to environments that promote this objective.
To increase parent/caregiver knowledge in the area of supports available and child development	Increasing number of parents/ caregivers are participating in OEYCs. Participants are finding that the knowledge they are gaining to be useful and is improving their care-giving skills.

To improve maternal and child health well-being	Participants believe that their involvement has resulted in positive changes to both themselves and even more to their child(ren).
To develop/improve social networks amongst other parents/caregivers	89% of parents and caregivers surveyed made new friends.
To increase volunteer participation from parents/caregivers in early year activities	The volunteerism rate was 23.7%. 57.8% percent of those volunteered over an hour a week whereas 15.6% gave over four hours a week.

Source[1] McCain, M., & Mustard, F. (1999). *Reversing the real brain drain: Early years study-final report.* Toronto: Ontario's Children Secretariat.

Source[2] Harry Cummings and Associates Inc, (2004). *Ontario Early Years Centres Implementation Review:* Ministry of Children and Youth Services. Submitted to Early Years Program Branch, Policy Development and Program Design Division.

Table 4

Program Effectiveness for the Service-Provider Community

Intended Program Objectives from the Early Years Study[1]	Results from the HCA evaluation[2]
To increase knowledge of early years services/supports and gaps	Of the 18 OEYCs visited, staff are familiar with other services in the community and refer one third of their parents to these services.
To increase collaboration among children's service provider	Of the 45 OEYCs that were randomly selected, directors indicate that they are collaborating with a broad range of other services such as speech, health, language, and child care areas.
To train service providers	Based on a fairly small sample, respondents see merit in the training provided and do seek training when needed.

Source [1] McCain, M., & Mustard, F. (1999). *Reversing the real brain drain: Early years study-final report.* Toronto: Ontario's Children Secretariat.

Source [2] Harry Cummings and Associates Inc, (2004). *Ontario Early Years Centres Implementation Review:* Ministry of Children and Youth Services. Submitted to Early Years Program Branch, Policy Development and Program Design Division.

Table 5

Program Effectiveness for the Community at Large

Intended Program Objectives from the Early Years Study[1]	Results from the HCA evaluation[2]
To increase the awareness of the importance of early years and healthy	OEYCs seem to be increasing community awareness of this objective. Word of mouth, child focused community events, and referrals are effective in increasing awareness. However, the effectiveness of such things like the local press, flyers, and posters seem to be debatable.
To increase the awareness of the Services	There is a growth in the number of families using the services, the number of referrals being made, and the number of requests for information.
To increase community participation in early years activities, including the business sector.	Based on a fairly small sample, respondents say that their OEYC pursues a variety of initiatives to increase community participation.
To increase family-friendly workplace practices within the community	18 of the centres visited strive to foster a family-friendly workplace. However, none are actively promoting family-friendly work places within their service areas.

Source [1] McCain, M., & Mustard, F. (1999). *Reversing the real brain drain: Early years study-final report.* Toronto: Ontario's Children Secretariat.

Source [2] Harry Cummings and Associates Inc, (2004). *Ontario Early Years Centres Implementation Review:* Ministry of Children and Youth Services. Submitted to Early Years Program Branch, Policy Development and Program Design Division.

Table 6

Program Effectiveness for Program Management

Intended Program Objectives from the Early Years Study[1]	Results from the HCA evaluation[2]
To record, track and report data on OEYC programs and outcomes.	Staff identified the following as the most important information to be collected: number of visits by parents, number of visits by children, number at individual programs, participant, participant feedback and satisfaction surveys, and number of referrals.
To increase the capacity to assess effectiveness of early years programming	Progress is slow in increasing the OEYCs program's capacity to assess its effectiveness. A coordinated effort, involving all the key stakeholders, is needed if changes are to be made and an appropriate system of effectiveness measurement is to be put in place.

Source [1] McCain, M., & Mustard, F. (1999). *Reversing the real brain drain: Early years study-final report.* Toronto: Ontario's Children Secretariat.

Source [2] Harry Cummings and Associates Inc, (2004). *Ontario Early Years Centres Implementation Review:* Ministry of Children and Youth Services. Submitted to Early Years Program Branch, Policy Development and Program Design Division.

To measure the degree of program efficiency, HCA (2004) asked questions of directors, supervisors, community/champion planning table members, advisory board members, and Early Years Centres staff. Many of the centres have been able to reduce or

entirely avoid the duplication of services due to their integration and collaboration with other service providers. However, several directors of Early Years Centres suggested that the Ministry of Children and Youth Services has been inconsistent in providing interpretations on policy and core funded services. Other directors also suggested that there should be one funding mechanism and reporting system for both the Early Years Centres and the Family Resource Centres since managing both is quite an administrative burden. Staff at Early Years Centres would also like to see a more integrated and standardized approach to data collection and reporting that will satisfy the interests and needs of all funders. With regard to the funding model, many directors and supervisors disagreed with funds being allocated by electoral ridings. The catchment areas for many Early Years Centres are not consistent with the catchment areas of established organizations including health units and municipal governments. Many directors voiced a concern with regards to the inadequate level of funding for their core programs. Furthermore, they stress that the demand and use of the programs is increasing while the funding for their core programs remains the same. Directors would also like greater flexibility in determining the operating hours of the centre based on hours of other community supports and the needs of the community.

With regard to support services from regional program supervisors, most of the 18 directors interviewed indicated that they have strong, supportive relationships with the regional program supervisors. However, directors expressed that better communications between regional program supervisors and the Ministry is needed. Both directors and supervisors addressed the need for maintaining a consistent and locally based program supervisor. This, they said, enables regions to build a knowledge and expertise base and

promotes consistency across the region and timely sharing of best practices and innovative approaches.

When speaking about the local programs and activities provided by Early Years Centres and satellites, directors expressed the importance of having the authority in deciding how, where, and when programs and services are offered. Due to the current levels of funding, Early Years Centres are not able to provide similar programming across Ontario.

Kelley (1975) also suggested examining two sub criteria when analyzing policy called "identity" and "self-determination." When examining "identity," it is important to observe the impact of the policy or subsequent program on the self-image or "identity" of the recipient. The McCain and Mustard study (1999), as previously discussed, is macro in nature but also person-centered as it holds the parent or caregiver responsible for the healthy development of her/his child. However, since this is a universal program, the identity of the recipient is safeguarded from any misconceptions and stereotypes of parents of different races, ages, or socioeconomic class. When examining the "self-determination" nature of the policies, it is clear through the Early Years study (McCain & Mustard, 1999) that a knowledgeable, expert, and interested reference group was used to confirm, share, and discuss the process and outcomes of the study. Members of the reference group were: Charles Coffey, Mary Gordon, Janet Comis, Dan Offord, Julie Desjardins, Terry Sullivan, Richard Ferron, Clara Will, Florence Minz Geneen, and Robin Williams. The reference group visited many community programs, met with many individuals and groups, and were assisted by many reviewers and researchers throughout the process. Furthermore, the Harry Cummings and Associates (HCA, 2004) evaluation

does highlight the fact that the Early Years Centres have community/champion planning table members and advisory board members that aid in the creation and planning of the development of the Early Years Centres.

With regards to best practices and the fidelity the program activities have to research, much is debatable. Some recommendations made by McCain and Mustard (1999) and the resulting program characteristics are similar to one another. It is important to note though that currently no centre offers a home visitation and non-parental component (i.e., daycare services). These services are seen by McCain and Mustard as critical to providing a comprehensive parent and child-oriented program. Furthermore, McCain and Mustard also recommended that due to ease of accessibility, the public school system keeps school sites as a viable option in which Early Year's initiatives can be resourced. Unfortunately, school sites are not currently being used to bridge the gap between the early years and the public school system. Additionally, McCain and Mustard urged the school boards and the government to make kindergarten part of the early child development network. This again was not fulfilled through the creation of the Early Years Centres. Due to the variety of services offered throughout all centres across Ontario, it is difficult to identify the extent to which all services are culturally sensitive, multi-component, intense, theoretically-based, and comprehensive. This lack of consistency across the province is one of the main struggles of the Early Years Centres.

Key informant interviews. Key informants were asked to share their perspective on the research base they believed was used in establishing the policies that gave rise to the Early Years Centres. Most informants agreed that the research base that was used to devise the program stemmed from research outlined in the Early Years study (McCain &

Mustard, 1999). On the other hand, one interviewee stated "There is certainly no universal research base being used across the program to target programming." This key informant expressed the need for more standardized, training-based, and evaluated programs such as child behavioural programs across all centres. On the other hand, other key informants mentioned that the Early Development Index (EDI) is a research-based index that helps to monitor and direct future programming. These informants appreciate the diversity of programming the EDI allows for across communities versus standardized programs that may not take into account the specific needs of the community.

One key informant said that the Mustard and McCain study, describes "a lot of research to show that there is worth to do something in the early years." The idea behind this quote is that choices such as childcare versus parent-education, school space versus community agencies, integrated services versus non-integrated services that underlie and form the centres, are not researched at all. Overall, this key informant believed that, "There is great research on what the problem is but not great research on what the solution is."

The general idea that was articulated when informants were asked to share their views on how well the centres abide by best practices was that the answer varies drastically centre-to-centre. The variations have "very little to do with this particular policy initiative" but rather on, the location of the centre, the historical roots of the original centre, the centre's values and beliefs, and the readiness of the community to take on the planning and coordination necessary. One key informant noted that there was a large participatory movement within each community while developing individual proposals for the creation of centres, yet this large participation also led to inconsistencies

in program delivery across the province. Some informants mentioned that the centres have an air of rigidity to them that is not sensitive to the needs of all parents. One key informant said, "How are you going to promote access to a service when there are these rigid restrictions put on and what do you do with your 1 and 2 [year old children], unless they were going to provide childcare."

Key informants applauded the heightened sensitivity of centres to recognize the different cultures that are present across the province. One key informant said, "Some of our money went into hiring cultural linguistic workers so hiring staff with many languages who are also newcomers themselves to help families navigate the system." To make the centres as comprehensive as possible, some centres still meet with their community partners and stakeholders to address issues that arise in their community and to plan responsive programs accordingly. One other key informant commented on the comprehensiveness of the centres and mentioned "No, none of them are everything a program needs to be - none of them include non-parental care. Without that critical piece they are not early child development centres." Table 7 shows a comparison between the best practices advocated by Nation et al. (2003) and the results from the document review and key informant interviews. As outlined in Table 7, there is clearly a discrepancy between the principles needed to create a successful prevention program and what is actually implemented in the centres. This gap between research and practice is wide and will continue to widen if rigorous evaluations are not conducted examining pre/post results with a control group. The principles of best practices are reflected at different extents in each centre because the importance of these principles is not inherent in the program's logic-model.

Table 7

Comparison of Nation et al.'s (2003) principles of best practices with the Early Years Centres

Principle	Centre results from document reviews and key informants
Comprehensiveness	No
Varied teaching methods	Varies centre-to-centre
Sufficient dosage	Varies centre-to-centre
Theory driven	No
Appropriately timed	Varies centre-to-centre
Socioculturally relevant	Yes
Ongoing and outcome evaluation	No
Community "buy-in"	Varies centre-to-centre
Conducting follow-ups	No

Summary. The document review assessed Harry Cummings and Associates (HCA, 2004) evaluation of the Early Years Centres using Kelley's (1975) change-related approach to policy analysis. The evaluation's results with regards to effectiveness are compared with the program's logic model. Comparisons indicate that effectiveness levels with parents/caregivers and children zero to six years, the service-provider community, the community at large, and the program's management are rather high with a few areas in need of improvement. However, it is important to keep in mind the limitations, such as time constraints that affected the number and depth of analysis and that focus group

participants were not randomly selected, in the evaluation's methodology when reading the comparison table above. Additionally, there are no control groups used in the evaluation that could provide us with a more accurate understanding of the centre's benefits. As for the level of efficiency the centres demonstrate, the evaluation describes the suggested improvements voiced by respondents in areas such as funding, planning, decision-making, and data collection. Based on the document review, both of Kelley's sub-criteria for analyzing policy, "identity" and "self-determination," are positively reflected in centre policies. The HCA (2004) evaluation also sheds light on some unforeseen negative and positive outcomes. Positive outcomes include: an overwhelming response by parents for programs, an increased desire from parents to learn about early childhood development, and providing support and friendship to parents. It is important to note here that all of the unforeseen positive outcomes do not impact children directly. On the other hand, some of the negative outcomes include: a lack of partnership between early child development and the school system, difficulties in adjusting to centre guidelines for pre-established organizations, and long waiting lists for parents wanting to register for certain centre programming. These unforeseen outcomes exist because the Early Years policy was implemented without an evaluation design to inform and strengthen its outcomes.

Some key informants described the research base as inconsistent and lacking standards whereas one other informant mentioned that the Early Development Index (EDI) was a solid research base shaping the future of centres. Others note that the Early Years study (1999) provides sound research supporting the need for services and supports

in the early years, whereas it does not provide the research on the type of services and supports most beneficial to development in the early years.

With regards to best practices such as cultural sensitivity, intensity, being multi-component, and theoretically based, document reviews are still inconclusive primarily due to the vast differences amongst centres. As per document reviews, the centres are not comprehensive. Key informants were encouraging about the centres' cultural sensitivity whereas all other best practices were, as results from the HCA (2004) state, still open for debate.

Research Question 4: What Are the Implementation and Adaptation Issues?

Document review. Through the HCA evaluation (2004), outcome findings of Phase I centres show that there are some implementation and adaptation issues. For example, the organizational structure of the Early Years Centres is largely dependent on whether or not the centre was hosted by a pre-established organization. If so, the implementation of the Early Years Centres strategies and activities was enhanced through the pre-established programs and through the use of existing networks and partnerships with other service providers and organizations. Furthermore, building on existing services was noted as much easier than developing altogether new services. However, if an Early Years Centre did not have a pre-established network, the time frame to develop partnerships with community stakeholders was too short and led to limited community involvement. Centres experienced challenges in their attempts to implement all core activities required within the centre's first year throughout all centres in their catchment area. Advisory board members also stated that centres in remote areas also had difficulties in implementing activities due to the cost of traveling. Overall, early learning activities and

parent/caregiver services were ranked as the most needed in each region whereas establishing a speakers' bureau and focusing on volunteer recruitment/coordination was seen as less important.

The funding source of the Early Years Centres is primarily the Ministry of Children and Youth Services. In 2003, approximately 51% of the 45 centres sampled received all of their funding from the Ministry. Approximately 34% of the centres received 5% of their total funding from other sources such as the municipal and federal government, other donations and user fees, whereas 15% of the centres receive 10% of their total funding from these other sources. Most centres receive in-kind donations such as meeting space, office supplies and equipment, toys, professional services, and refreshments from organization and businesses. Since 2002, the Ontario government has put more than 100 million dollars into the development, implementation and maintenance of the Early Years Centres.

The 18 centres that were sampled are meeting the needs of all community members by being open all year around. Eighty-three percent of the centres are providing information in the languages that are most common to their community's demographics. To increase the ease of accessibility, centres also strive to offer programming in a variety of locations. For instance, in 2004, 45% of centres were planning to offer programs in 4-10 different locations, 41% of centres in 11-20 different locations, and 14% in more than 20 different locations.

Key informant interviews. With regards to benchmarks for implementation, many informants said they could not adequately discuss this for a variety of reasons, including their lack of experience with the early history of the centres. However, one key informant

said, "There is no large system in place for the program, so there are no benchmarks in large part. There is nobody evaluating. There is some monitoring data which is supplied but no central coordination function for evaluation." One key informant highlighted that categorizing the centres as prevention programs "suggests the kind of framework they were put in - a prevention/intervention continuum - not in early child development and parenting centres context."

Some informants discussed the program-logic model that was created for the Early Years Centres. One key informant said:

> I don't think it was guided by a strong logic-model in the sense that it wasn't an initiative that talked a lot about its intended outcomes, and which activities were supposed to lead to those outcomes, and what the underlying validity assumptions were so, technically, yes there was a logic-model but really it wasn't a living, vibrant kind of thing.

Furthermore, this informant stressed that a working program-logic model would have guided community activities and outcomes, but, at the same time, it would have allowed for community diversity and flexibility to be present as well. Additionally, this informant stated that along with a program-logic model, the presence of continuous, strong leadership is essential in changing communities. This informant said, "My belief is that if you can do something that causes communities to care, the service solutions will sort of come." Similarly, another key informant shared that the implementation of the centres does reflect the program-logic model. Moreover, this informant believed that what is lacking is an examination and comparison between the effects of the centre activities and the desired effect listed in the program-logic model.

Informants said that local adaptation was encouraged through the use of local community groups or champions, as they called them, which worked with the community to meet their specific needs. Each centre also "composes a unique service delivery plan for Early Years education..." In other words, centre programming and supports disseminate early year information based on the specific needs of parents. Informants mentioned that community ownership of the centres was developed through community meetings regarding the potential use of the centres, to create community-based guidelines for the centres, through community-oriented working groups, and when identifying which pre-established agencies could house Early Years Centres.

Once again, the theme of variation came through from informants. For example, even though each centre was urged to reach out to their community in the planning process, they all employed different processes. Some "just stuck to few of the major players or [and some] actually went and involved other key players in the community." One key informant said:

> It resulted in stakeholder buy-out because only one organization could get the money- there was a competition to get the money. And if you weren't the lucky recipient, you would be pissed off. In communities where it was very clear that there was only one lead organization and the others were clearly minor players, it wasn't so much of an issue but in communities where there was that competition for that lead, there was some dissent.

Key informants applauded communities for using the existing resources to help establish the centres. For example, many centres are housed in pre-established family

support centres, employ existing staff, and use existing space. However, one key informant mentioned:

> This was not part of the Early Years Centre roll-out. It was sort of parachuted in on top of other things with very little connect with childcare centres and schools. As it rolled out in communities, and it varies again community to community but in some communities, yes, they did in fact integrate with existing schools and childcare centres and there is probably more of that happening now than two or three years ago.

Through a contract with MotherCraft, a Canadian leader in healthy child development, training was available to new staff that gave them some practice guidelines of the program. With new money being funnelled in under the Early Years Centres initiative, pre-established organizations now had the resources to send their staff to training instead of allocating all their resources to staff salaries. One key informant said, "I think there was no common curriculum for staff and coordinators and centres - that was a weakness." Some key informants mentioned that the province has ongoing conferences at which centre staff discuss their activities and are supported by others centre's experiences and knowledge. One key informant said:

> One of the things they did that I thought was really innovative and good - they sort of communicated - added a skill set to the mix to doing this kind of work that I don't think was there before. This idea of needs assessment community research - they actually have people called data-analysis-coordinators that the province hired that go along with all the Early Years Centres and that person's job is to do the EDI, [Early Development Index] do community research and come up with these maps that say where there are needs and where there are gaps and everything and bring that to the

table for planning purposes. I think that was kind of a really great skill set that didn't exist around communities in the province before...

Key informants were asked to discuss their perceptions of the major changes that have occurred overtime with the Early Years Centres. Some said that the foundation of the centres is growing, developing strong networks, has higher community visibility, and has an air of permanence in the community. Some pinpointed the differences in Phase I and Phase II centres in saying that the process employed in Phase II is more flexible and adaptable to community needs. Phase II centres originated in pre-established organizations and, consequently, one key informant said, "Early Years funding allowed them [staff] to gain stability and spend less time writing proposals for funding and focus more on programs delivered...and that doesn't not happen...the first year the key is the length of time the organization has been receiving funding." Another key informant criticized the centres' development and said, "I think the single biggest one is the shift from true notion of a hub to a much more traditional social service, service delivery." The intent of the centres was not to be the place for referrals but, as noted by McCain and Mustard (1999), was to be the heart of early child development activities for parents, caregivers, and children.

Summary. As stated in the Harry Cummings and Associates (HCA, 2004) evaluation of centres, implementation and adaptation issues were positively affected if centres were introduced in pre-established organizations. The centres are sustained primarily by government funding and the 18 sampled in the HCA review use this funding to provide programming all year around, in a variety of locations, and in diverse languages. Key informants noted a lack of a central coordination effort for evaluating

programming and the weak link between the desired outcomes listed in the program logic-model and the actual outcomes. Informants also believed that local adaptation and community ownership was a priority throughout the planning and implementation phases of the centres but vary across the province. As for training, informants recognize than an effort was made to provide training to staff. The major changes informants perceive occurring with the Early Years Centres overtime is the increased attention they receive from their community, their increased flexibility, and the changes to its structure and programming.

Healthy Babies, Healthy Children

Research Question 1: What Are the Ideology and Origins of the Program?

Document review. Similar to the Early Years Centres, the foundation of Healthy Babies, Healthy Children (HBHC) lies in the research of the Early Years study (McCain & Mustard, 1999). Additionally, the program components also stem from the emerging research results in the field of home visitation (McCain & Mustard, 1999; Olds et al., 1997). The HBHC program credits its existence to the McCain and Mustard study even though HBHC emerged in 1998. Initially, the HBHC program targeted its services to high risk families and children whereas after the McCain and Mustard study, it expanded its program to serve all families and children. Furthermore, the first year of the program focused on providing HBHC staff with tools for screening and assessing high risk families, budget guidelines, and guidelines for recruiting, selecting, and training lay home visitors. However, after the McCain and Mustard study, the program expanded its access and type of services based on the study's recommendations. The new information on the impacts of early interactions and experiences on children's emotional, behavioural, and

intellectual development coupled with home visiting services provide parents with the skills needed to foster early healthy development.

As for Lindblom's (1977) resource mobilization theory, no documentation related to HBHC describes past findings, suggestions, and actions in supporting parents. This is not to say that HBHC is a novel program to Ontarians. However, in documents, it is presented as a novel program. The closest reference to a program similar to HBHC was presented in the Advisory Committee on Children's Services Report titled "Children First" (1990), that called for a partnership between parents, the Ontario government, service providers, and all others that impact children's lives to develop a public agenda to ensure that the entitlements of children are met. This agenda would guide the actions of all ministries that directly or indirectly influence the supports and services provided to children. Unfortunately, there is no discussion of whether this program was implemented or not. Past reports, such as "Children First" (1990), may have contributed to the origins of HBHC as its resources, both financial and knowledge-based, are shared amongst many different levels of government, the social sectors, and families.

The HBHC program is designed to improve the early experiences and development of children through parent-oriented programming, such as prenatal and postpartum screening, early childhood screening, assessment and monitoring, postpartum support services, referrals, home visits, and service co-ordination. The ideology behind all program components is based primarily on personal well-being values, as they aim to increase children's optimal potential through increasing parenting ability, parent awareness of the value of early child development, and parent knowledge of the range of community support services available to them, and decreasing factors associated with the

risk of parenting problems. The program also values collective well-being but to a much lesser extent as it only focuses on providing the program universally. Child-oriented programming, such as play-based learning, interactions with other children, and learning how to read services, does not have a place in HBHC ideology and program goals. It is solely through parent-centred programming that HBHC attempts to improve the behaviour and lifestyle of children. However, HBHC does recognize that in the healthy development of children, other factors impact on children and families such as psychosocial factors. Therefore, to provide comprehensive care for children, HBHC complements and works in a system with other effective prevention and early intervention services. Other services support families in improving not only their behaviour and lifestyles, but also the economic and psychosocial factors that affect them and their children. As the consolidated guidelines state:

> The Healthy Babies, Healthy Children Program is not a stand-alone program. It is designed to link and integrate with all other related initiatives, build on the success of other programs and services, and foster new partnerships with the volunteer, charitable, and business communities. The results on an integrated delivery system must improve outcomes for individuals and families. (Early Years and Child Development Branch, Integrated Services for Children Division, Ministries of Health and Long-Term Care & of Community, Family and Children's Services, 2003, p. 6)

Key informant interviews. Similar to Early Years Centres key informants, HBHC program informants also believe that HBHC emerged due to a variety of factors. Factors included sound, evidence-based research in early child development such as McCain and

Mustard's study (1999) that also proved to be logical to both the human service and the business sector. Not only was research on home visitation, such as the Hawaii Model (Duggan et al., 1999) emerging, but the Ministry was also getting increased feedback and pressure from the field to re-incorporate home visitation in its mandate. Key informants also noted that at this time there was a need for more service coordination and an integration of services. Additionally, there was also a trend towards focusing on the concept of return on investment. In other words, sectors understood the cost-benefits of investing in early child development to ensure that citizens reach their full potential emotionally, physically, mentally, and socially. Additionally, there was also a strong political agenda for developing successful, healthier Canadians. One key informant stated:

> At the same time the government of the day was interested in forming targeted services ... instead of providing a lot of universal services. I think they [the government] were looking for efficiency and trying to be extra careful with tax dollars and not spend money on people they thought didn't need it.

With all of the above factors together, the government's solution was the Healthy Babies, Healthy Children initiative.

Key informants clarified that initially, all funding came from provincial bodies and absolutely no money came from federal authorities. This statement reflects the ideology of the program, as it is more micro-focused and based in personal well-being values rather than in collective well-being values. Even key players such as Premier Harris, the Honourable Margaret Marland (Minister Responsible for Children), Jessica Hill, Dr. Fraser Mustard, the Sparrow Lake Alliance (an alliance that aims to ensure that

the conditions necessary for all Ontario children and youth to have the best start possible in life are provided), the Laidlaw Foundation, and the Offord Centre all advocated for the enhancement of personal well-being values.

Key informants also shared their thoughts on the role of businesses in the planning and coordination of HBHC. One informant mentioned that the guidelines of HBHC "required all sectors to be involved in the program but not the planning of the program." This informant implied that the business sector did not participate in the development of HBHC. One key informant acknowledged that the relationship between the social services sector and the business sector has progressed and strengthened, but that there is still a fair amount of work that needs to be done to foster this relationship.

The values and assumptions that underlie the HBHC are found in the HBHC consolidated guidelines. One key element that informants highlighted was that the program was planned and implemented to "ensure it always has to be a voluntary program." It respects the rights of families in asking them to give their consent and cooperation throughout every step of the program. Additionally, informants stressed that the planning committee also recognized that "a lot of expertise lied in the community and we wanted [a] community-wide planning and implementation process and involve the organizations and agencies that serve families of interest in the community." Along with valuing community capacities, the underlying values were created by evidence-based approaches to planning and implementation processes. An informant also said that an underlying assumption is that people are in need of targeted services. Therefore, planners recognized that effective targeted services are contingent on good screening and assessment strategies.

The HBHC program was initially a targeted program for at risk families and presently still holds a strong targeted character. In saying this, informants agreed that the program was consistent with the vision and values of the Conservative government because this government focuses predominantly on personal well-being values in its social policies. Furthermore, the HBHC program focused on investing early to save potential larger treatment costs in the future. This investment was disseminated through comprehensive and integrated programming which was also consistent with the approach of the Conservative government.

Summary. Document reviews and key informants recognized that the HBHC program expanded due to the findings described in the Early Years study (McCain & Mustard, 1999), the research in the field of home visitation, and the interest shown by both the social and business sectors. Healthy Babies, Healthy Children ideology focuses primarily on parent-oriented services in aims of improving the future of children. By working with its partners in early child development, it seeks to provide a comprehensive set of services that range from child-oriented activities to parent-oriented services and supports. Key informants also thought that HBHC was supported by a variety of people - provincial civil servants, private researchers and public childcare workers. Informants highlighted that every HBHC program is guided by a number of assumptions and values such as its voluntary nature, its recognition of community expertise, and the need for targeted services.

Research Question 2: What Are the Theoretical Underpinnings?

Document review. The Early Years study (McCain & Mustard, 1999) advocates for a partnership between all sectors of society in aims of bringing the most care to children

across Ontario. The use of existing services, resources, and community strengths underpins one of the central recommendations made by McCain and Mustard (1999). With the help of these community supports, the health of children is enhanced by not only examining parent's health, but also by educating parents on the factors affecting healthy child development. Healthy pregnancies increase the probability of full-term, uncomplicated, average birth weights, and healthy brain development. Consequently, the health of the mother can have vast impacts on the pregnancy - the healthier the mother, the healthier the pregnancy and baby. The McCain and Mustard study stressed that brain development begins *in utero* meaning that stimuli such as the mother's smoking, drinking, drug, and food consumption habits during pregnancy impact pre-term births and low birth weights. There is also research presented on the benefits of breastfeeding. The advantages of breastfeeding are twofold: (a) providing optimal nutrition and (b) providing optimal sensory stimulation. Breast milk provides children with the needed nutrients to foster optimal brain and body growth whereas the act of feeding provides children with skin-to-skin touch and smell stimulation. The main theoretical base of the HBHC program is improving parenting skills in hopes of increasing the healthy development of children. The theories that lie under the HBHC program are similar to the theoretical underpinnings discussed for the Early Years Centres such as Bowlby's attachment theory, the interplay of nature and nurture, and Bronfenbrunner's bioecological theory.

As discussed in the findings section for the Early Years Centres, issues such as universalism and the need for parent and child-oriented programming apply to HBHC policy issues as well. The HBHC program is not universal. Screening, a brief assessment, and postpartum services are universally provided, whereas its home visiting and service

planning and co-ordination services are targeted to families with children at high risk for child developmental problems. In light of the recommendations made by McCain and Mustard (1999), the HBHC program has included home visitation as a key component to their service as well. In HBHC documents, there is no mention of why the blended model of nurses and lay home visitors was chosen, how the frequency of visits was determined, and how the most effective ratio of lay home visits to nurses was determined.

The HBHC program works within a strengths based model and therefore only protective factors are discussed in their literature. Consolidated guidelines list a variety of desired outcomes such as:

- improving behavioural and lifestyle issues
- improving child health and development
- increasing parent confidence and knowledge
- decreasing parental stress
- increasing parental support
- decreasing family isolation
- increasing integration of services that support healthy development

An alternative solution to the HBHC program is to leave the responsibility of identifying high risk families to pre-established early development centres, primary caregivers, hospital staff, and prenatal and postnatal support services.

Key informant interviews. As for the theoretical underpinnings of the program, key informants mentioned that the program recognizes that childhood experiences and parenting needs are two major areas of concern. Early experiences mold the health and well-being of children, and therefore funding public support resources to invest early can have critical effects on children's future. As well, all parents can benefit from services and supports, such as home visitation, that enhance their parenting skills and knowledge.

There are also some families "because of the context in which they live, their family environment, their income, education, their level of social supports - may put their children at risk for healthy child development." Therefore, the program aims to provide additional support for families at higher risk as well through home visitation and service coordination services. Furthermore, one key informant stressed that all screening methods and instruments used are supported with evidence-based research.

Informants said that the program has some universal and targeted components to it. The program serves all consenting mothers of newborns by screening all families at the hospital for risk factors and all receive a phone call within 48 hours of delivery. This phone call offers a single postpartum home visit to families that do not demonstrate the need for continuous care. However, one informant said, "In years past there might have been four or five home visits and that would have been universal." Additionally, one key informant said:

> I think there are some fairly universal components, but they may be limited in some areas. For example in some communities they are not doing the postpartum home visit based on the resources they have available to them. There are others that have made the decision to target specific families for specific things because they just do not have the resources to do the whole shebang.

The province is funding an exclusive home-based initiative for newborns through HBHC, but the home-visitor makes families aware of other services offered in the community. The health unit in the community may be providing a variety of services to families but does so out of the HBHC umbrella.

As for the risk factors HBHC is offsetting, an informant highlighted that the program focuses on "the risk that a child may not reach his or her full potential." The program offsets this risk by providing more awareness of and access to services, supports, and knowledge to parents to help develop an environment for their child that allows them to achieve their optimal development. Furthermore, one key informant said, "The research shows that the children that live in poverty are no more at risk than children who don't [aren't] if they have the same sort of loving supporting environment and good parenting." For parents, HBHC becomes a strengths-based approach to enhancing their skills. Strengthening and passing on new skills gives parents the tools and skills necessary to provide an environment that can offset a lot of negative environmental factors. For example, those parents that lacked a positive role model growing up can now learn the knowledge and skills to demonstrate good role modeling to their children.

Some key informants discussed the negative effects of social isolation in saying that the HBHC program offsets this issue. It does so by engaging, for example, newcomers with their cultural group, with other mothers in the community, and with other agencies that help work through cultural barriers. One key informant said, "You will see that in every one of our instruments, social support and physical and social isolation are there." Furthermore, lay-home visitors "offer an incredible strength in terms of asset building and befriending the clients."

One key informant's perspective was that HBHC is the central place where new mothers can get information regarding breastfeeding, information on reading to their child, or information on the Early Years Centres with just one phone call. Through this information, parental awareness and understanding of the importance of the early years

develops. The service coordination element to HBHC "is a real bonus if they [parents] are experiencing challenges or wanting some help navigating the system effectively for them. The research demonstrates that it increases parents' confidence."

Other key informants said that the HBHC program offsets a wide-range of issues, such as "the physical safety of kids and they're concerned about nutrition, health, good feeding practices, concerned about potentially damaging family dynamics, a failure to look after their child's developmental, intellectual, stimulation needs."

Summary. All program components are based in theories such as the nature and nurture interaction theory, Bowlby's attachment theory, and Bronfenbrenner's bioecological theory that emphasize the need to increase parenting skills so as to enhance the early development of children. Documents focusing on the theoretical underpinnings of HBHC suggest that prenatal and postpartum care is crucial to the healthy development of a child. Components of care are both universal and targeted. All services, except for the in-depth assessment, intensive home visitation, and service coordination, are universal. The HBHC consolidated guidelines list a variety of desired outcomes, such as increasing parental support, strengthening parental skills, and increasing the integration of child healthy development services.

Key informants emphasized the relationship between parenting skills and early childhood experiences. Furthermore, informants recognized that HBHC provides additional support for families with higher needs through its targeted services. Informants also highlighted that across the province health units offer differing community services. Moreover, HBHC delivers its core services differently, and the frequency of programming differs as well.

Research Question 3: What Is the Research Base?

Document review. Kelley's (1975) change-related approach to analyzing policy, as discussed in the Early Years Centres document review, focuses on three main components: (a) adequacy, (b) effectiveness, and (c) efficiency. The Applied Research Consultants (ARC, 2003) conducted an evaluation titled "HBHC Report Card" in 2002 that shed light on if the program was achieving its goals and if its services are helping children and families. Similar to the Early Years Centres, the adequacy of the HBHC programs is not discussed in the documents either. The methodology used in this process evaluation is not discussed at length, since the "HBHC Report Card" gives a brief overview of the results and not an in-depth review of the evaluation. From what is described, the methodology included on-site research, key informant surveys, in-depth studies, family surveys, and the examination of extracts from the Integrated Services for Children Information System (a database to collect client information, document ongoing activities and outcomes of the program). The methodology does not detail the participation rate and, therefore, the results below need to be read with this in mind. The ARC report (2002) outlines the effectiveness of the program in Ontario by stating the following:

- In 2001, 88% of mothers with new babies consented to be screened before or shortly after the baby's birth.
- More than 80% of families with new babies also received a phone call from a public health nurse shortly after leaving the hospital
- Seven percent of the 80% of families that were called were identified as potentially benefiting from additional (e.g., home visitation) supports and services.

- In 2001, HBHC staff made 31,479 formal referrals to 14,378 families who would benefit from other community services and 88,704 informal recommendations to services.
- Community services are more integrated, communicating, coordinating, and planning services more than before the HBHC program can about.

In terms of the efficiency of the program, the ARC Report Card (2002) compared HBHC home visited families with families that did not receive home visiting. It is important to note that the results do not indicate the extent to which the goal was attained in terms of the expenditure of the least amount of resources. Results show that home visited families in Ontario:

- have children that scored higher on most infant development tests (e.g., fine and gross motor skills and language development)
- parents felt more confident with their parenting skills
- parents used community resources more along with making more contact with the public health nurse and early development experts

Within Kelley's (1975) change related approach for HBHC, the sub-categories called "identity" and "self-determination," are similar to those of the Early Years Centres. Additionally the ARC Report Card (2002) concluded that 88% of families that use HBHC services felt that they had a reasonable level of influence over the services they received. Similar to the Early Years Centres, the HBHC did not use control groups, nor did it have an evaluation design to learn from.

Regarding the question of whether HBHC follows best practices, issues such as programming type, cultural sensitivity, comprehensiveness, and intensity should be examined. One of the strengths of the HBHC program is its continuous growth in terms of the range of services it offers. For example, the HBHC program added a Postpartum

Enhancement program to serve all families in Ontario rather than only providing this service to children who are at high risk. As for cultural sensitivity, the ARC Report Card (2002) concluded that all but four health units across the province said they could provide HBHC services in all languages they needed to for their community.

As for the comprehensiveness of the program, HBHC is predominantly a parent-oriented program seeking to enhance parenting skills and knowledge. The program itself does not provide child-oriented programming. However, program staff has in-depth knowledge of and connects parents to programs that can benefit children directly. As for intensity, HBHC acknowledges that home visitation is best if it is frequent, comprehensive, long-term, integrated with other services, and flexible. However, it does not actually list the schedule of home visitation as per Olds, O'Brien, et al. (1998) in its service delivery guidelines. Therefore, the number of visits parents get varies. Additionally, documents also recognize that home visitation success varies according to the age of the child - one-on-one visitation is best for children under age three, whereas supporting families in connecting to community services along with home visitation is best for children between the ages of three to six. However, the documents do not list the activities nurses or lay home visitors engage in with families of children of varying ages or why benefits of visitation are impacted by the age of the child.

Key informant interviews. Informants expanded on the research base upon which the HBHC policies are established. They focused on prevention research in child development, the impacts of early experiences, and the benefits of intensive home visitation as the catalysts for HBHC policies. Furthermore, they stressed that the biological research behind the workings of the brain became more explicit and used more

precise technology to measure the synaptic changes in the brain. Informants went on to say that people understand now more than ever before how the brain is wired, how a child forms relationships with the world, and the impacts caregivers have on development. An informant also mentioned that there now exists more research supporting the tools the HBHC program uses to identify and assess children and families at risk.

Another key informant mentioned the following as crucial research that shaped the HBHC program: The McCain and Mustard study (1999), Hertzman's *Developmental Health and the Wealth of Nations* (1999), *Health of Canada's Children*, the Canadian Institute of Children's *Health Profile*, some of the research conducted by Dr. D. Olds on home visitation, and the HBHC evaluation conducted by the Applied Research Consultants (2003).

All key informants were positive in their opinions regarding the level at which HBHC works within best practices. One key informant said:

> Well, compared to other programs like it, the HBHC program is, superior. For example, if I compare the Infant Development Program with HBHC, the type of intervention they have, based on the delivery of the program, the components of the program, HBHC is superior.

Informants working directly with HBHC pride themselves with offering HBHC in several languages, training lay-home visitors on the specific cultural needs of their target population, and hiring lay-home visitors and nurses based on the specific cultural demographics in the community. One key informant mentioned that the HBHC lay-home visitor concept in his/her community is a reflective process. Meaning, it is "a reflective process that is deliberate and we also use opportunities to share that information; they

[lay-home visitors] even do cultural sensitivity training to the department so we see them as really valuable resources for the program and for public health services in general."

HBHC also uses theoretical knowledge in planning and implementing each component of their service. Informants felt that choosing to provide services during the prenatal phase, offering postpartum screening, deciding what assessment measurements to use, and when to use targeted services, are all based in theory. One key informant said, "Best practices are set out in the guidelines."

Furthermore, the intensity of the program is in its targeted home visitation services and not in the universal postpartum screening, call or home visit. The consolidated guidelines describe that home visitation "is most effective when it is frequent, long-term, comprehensive, well integrated with other community services, and flexible in responding to the unique needs and strengths of each family" (Early Years and Child Development Branch, Integrated Services for Children Division, Ministries of Health and Long-Term Care & of Community, Family and Children's Services, 2003, p. 32). In response to this, informants stressed that intense home visitation is based on the needs of the family. The HBHC evaluation concluded that on average, each participating family received 13-15 home visits in the time they were in the program. One key informant said:

> Overall the programs use a 3 to 1 ratio- three visits by a lay-home visitors and one from a public health nurse... but there is the recognition that families might need a one-to-one with a nurse for a period of time before a lay home visitor can come in.

As far as being comprehensive, one informant said, "We need to maximize our available resources. We have to get good at being a piece of the pie instead of the whole pie." The HBHC program is in a position where it is but one crucial component in an entire continuum of care. The program's comprehensiveness lies in its networking potential along with the breadth of services other agencies in the community provide. A key informant highlighted that it is not enough to deliver an intervention but that there also needs to be community support in all of the other areas that impact on a child's development and parents' ability to parent well.

HBHC is multi-component to the extent that it is connected and connects parents to other community services. There are multiple components to the programs such as the "prenatal, at birth, postpartum and early ID [identification] so that is across time, there are assessments, postpartum visits, in-depth assessments, ongoing service coordination and health teaching, and family visiting program..." One informant said, "Does it have all the components needed to support early child development? No and we couldn't do that without the rest of our community." Table 8 shows a comparison between the best practices advocated by Nation et al. (2003) and the results from document reviews and key informant interviews. Similar to Table 7, the comparison of best practices with the Early Years Centres, there is also discrepancy with the HBHC program and best practices. HBHC activities suffer from a lack of theory-driven focus that makes them weak in key program characteristics. Additionally, the gap between research and practice, here again, has resulted in minimal adherence to best practices that are required to create a successful prevention program.

Table 8

Comparison of Nation et al.'s (2003) principles of best practices with the Healthy Babies, Healthy Children program

Principle	Centre results from document reviews and key informants
Comprehensiveness	No
Varied teaching methods	No
Sufficient dosage	Varies family-to-family
Theory driven	No
Appropriately timed	Varies program-to-program
Socioculturally relevant	Yes
Ongoing and outcome evaluation	No
Community "buy-in"	Varies program-to-program
Conducting follow-ups	No

Summary. The Applied Research Consultants (ARC, 2003) evaluated the effectiveness of HBHC and overall, HBHC scored fairly high. As for its efficiency, ARC compared a control group that did not receive home visiting with ones that did. Results show that home visited children and parents are healthier than the control group. As noted above, it is important to keep in mind that the participation rate in the methods used to report on the effectiveness and efficiency is unknown. Therefore, the results and the description of the methodology used of the long-term evaluation, which will shortly be

available, should be examined before any concrete conclusions can be drawn. As for best practices, documents state that HBHC has developed a comprehensive, culturally sensitive network of services. As for intensity, the consolidated guidelines acknowledge best practices, but these practices are not specified in program delivery.

Key informants believed that the research base that was integral to the HBHC is in the prevention arena of early child development, home visiting, and brain development. Informants were pleased with the HBHC program in terms of its comprehensiveness, cultural sensitivity, multi-component nature, and home visitation intensity.

Research Question 4: What Are the Implementation and Adaptation Issues?

Document review. Through the examination of documents pertaining to the Healthy Babies, Healthy Children's program, there is very limited discussion of implementation and adaptation issues. The program is currently undergoing an in-depth evaluation by the Applied Research Consultants (ARC, 2003) that should shed more light on these issues. Table 6 lists the change history, adaptations, the target population, and the source of funding for HBHC.

Table 9

HBHC History and Adaptations

Jan-May 1997	Ontario Government introduced HBHC Phase I to serve families with children from prenatal to the age of 2 at *high risk.* Boards of Health are responsible for managing and delivering the program.
April 1998	Train the Trainers (of lay home visitors) Workshop for HBHC program.
May 1998	Ontario Government announced enhancement of HBHC program to budget:

	- increases of $10 million in 1998/99, $20 million in 1999/00, $10 million in 2000/01, for a total commitment of $50 million by 2000/01. - enhancement allows expansion of program for First Nations communities.
July 1998	HBHC Early Identification Process – Background Paper issued.
March 1999	Ontario Government announced additional $17 mission for HBHC Postpartum Enhancement and expanded program to serve *all families* with children under 6.
March 1999	Family Screening, Review and Assessment Manual issued.
May 1999	HBHC Implementation Guidelines – Phase 2 issued.
May-June 1999	Levels of family Support Tool training provided by Middlesex-London Health Unit.
June 1999	Regional Training on use of Family Assessment Tool.
June 1999	Provincial Stakeholder Workshop held to develop an effective early identification initiative for children not identified during the postpartum period.
May 1999	First stage of the Integrated Services for Children Information System (ISCIS) launched; Boards of Health implemented ISCIS Stage IA in July 1999.
October 1999 November 1999	Boards of Health implemented Postpartum services. Request for proposal for Evaluation of HBHC Program issued.
March 2000	Short term evaluation of HBHC is implemented.
April 2000	Aboriginal Healing and Wellness takes responsibility for managing the First Nations component of HBHC for both on reserve and off reserve communities.
July 2000	Early childhood (early identification) screening added to provide a way to identify children after the postpartum period and up to age 6 who may benefit fro HBHC services.
October 2000	Prenatal Guidelines issued.

October 2001	Updated Policy Statement on Home Visiting issued.
January 2002	Policy statement on HBHC universal screening and assessment of children postnatal to age 6 issued.
April 2002	Early Child Development funding provided to enhance HBHC universal screening and assessment.
April 2002	Short term evaluation of HBHC completed.
June-Oct 2002	Evaluation results disseminated.
October 2003	Consolidated Guidelines for HBHC released.
October 2003	Complete Guide to Screening and Assessment released.

Source: Early Years and Child Development Branch, Integrated Services for Children Division, Ministries of Health and Long-Term Care & of Community, Family and Children's Services, (2003). *Healthy Babies Healthy Children: Consolidated guidelines.* p.3.

Key informant interviews. Originally, when the program was launched, a key informant said that it was developed "on the fly." Now, it has "more structure and they [HBHC programs] have gotten more comprehensive..." The Ministry of Children and Youth Services requires health units to annually identify targets within the HBHC mandate to work on year around. As well, the Integrated Children Services Information System (ICSIS) database, created by the Ministry of Children and Youth Services, helps HBHC keep track of what activities were done or not done, along with providing some information on the impacts these activities have had. However, it is the combination of the information from ICSIS and the commissioned evaluations that show the depth and breadth of all impacts. For example, ICSIS provides statistical information on such things as the number of clients, while the evaluation captured information such as details about the advisory committee, the roles and responsibilities of committee members, if phone calls were being made within 48 hours, how many clients were getting a brief assessment,

how many were getting in-depth assessments, how many home visits did clients get, how many people were being screened, etc. One informant mentioned that these types of in-depth questions are not captured on a continuing basis but rather when province-wide evaluations of the program are conducted.

Informants were asked to share their thoughts regarding the adequacy of the Implementation Guidelines. There were guidelines written for Phase I components of HBHC in 1997 and the new Phase II components of HBHC in 1999, followed by consolidated guidelines written in 2003. Informants said that the guidelines provided the guidance communities needed at that time. The guidelines allowed for flexibility in how ready the community was to implement the program, in the advisory committee it formed, and the types of relationships the program had with its community partners. One key informant said:

> HBHC program has very specific, very clear guidelines. This is a very huge accomplishment in Health Units. Having clear guidelines does not mean that they are strict. The HBHC program it looks the same everywhere in Ontario - that is rare for a program.

One key informant mentioned that regardless of funding, there are times "you get more than you put in to some units [health units] and not as much in others." This informant believes that the outcome differences that exist across health units are not due to different interpretations of the guidelines but can rather be attributed to the particular characteristics of the health unit (experience of staff, strength of community partnerships etc.) delivering the program. One key informant said that the guidelines are adequate, but that the programs struggle to fulfill all the detailed requirements. It was this informant's

perception that this struggle gives programs something to strive for and staff an opportunity to figure out what minor adjustments are needed to increase the program's efficiencies in delivery. One informant also stressed that the guidelines alone do not give rise to a successful program but do in combination with a rigorous computer system (Integrated Services for Children Information System) that evaluates both the processes and outcomes of the program.

Local adaptation and community ownership were encouraged to meet community needs through many different values as noted in the planning and implementation guidelines. HBHC was intended to be designed in collaboration with community partners. A variety of community stakeholders were involved such as Public Health, Ministry of Communities of Social Services funded agencies, schools, and childcare representatives. Each HBHC is also mandated to engage the participation of specific local agencies and service coordinators in the area. This mandate allows for both an increase in community ownership and the program to mold to the community's unique needs and features. For example, some HBHC programs contract some of their services, such as home visitation, to longstanding organizations that have been offering the same services in the community for years. The pre-established program has advantages over HBHC, since it is already familiar to the community and has trained lay-home visitors. A key informant said that home visitation services can adapt to community needs. For example, one key informant described that "there is a group of Mennonite women that get together for home visiting because they are more comfortable with this instead of the lay-home visitor coming into their house." As for how HBHC was staffed, one key informant said that HBHC had flexibility. Some "set it up as a distinct staffed unit within the Health

Unit and others spread the Healthy Babies work amongst all of the public health nurses so that they all shared in doing some of the Healthy Babies work." One key informant said that in regards to community ownership:

> I think it was mostly the health units. I don't know to what extent the community felt they owned it. I think the community saw it as a health unit initiative and in fact they I think in most cases appreciated that the health unit wanted their input from them but they saw it as them helping the health unit instead of them owning the program.

Key informants said that the training for the program was conducted using a train the trainer model. Obstetrical nurses and managers were trained by training educators and then went back to their hospital and trained all nurses. Invest in Kids, a training research organization, was hired to develop and implement training models. Ongoing training to nurses and lay-home visitors is the responsibility of health units, whereas Invest in Kids still provides "highly intensive training across the province." The cost of the training is expensive and health units also have a high turnover rate for public health nurses and therefore most health units cannot fund the intense training. Consequently, some nurses go to the extensive training and, upon return, they update the internal training packages.

One key informant said that since the program was developed "on the fly," the province "provided some initial material some of which was valuable, some of which wasn't so valuable and some of which left some holes for local communities to figure out how to address." Initially, the province left the planning of the guidelines to the individual community, whereas now the province is becoming much more directive on what needs to be included in the program. The changes required do not always

complement the community's needs. In saying this, the communities would prefer sharing their experiences and learning with the government in hopes of shaping a more mutually beneficial model for guidelines and training.

When informants were asked to share what they perceived to be the most major change in the history of the HBHC program, there were a variety of answers. One key informant mentioned that the focus on the universal postpartum home visitation has lessened in order for the program to provide more of the intense, targeted home visitation to at high risk families. This key informant said:

> The home visitation family service is going to be more intensive and that part of the program cannot be compromised in order to be a universal postpartum home call. Our postpartum home visits are going down, but our intensity of home visiting is going up, and I think that is a good thing.

Other informants understood the program to be more comprehensive in its services now than what it first offered in 1998. New, structured components have been added to the program, such as the postpartum component making it a better continuum of care. One key informant also said that HBHC is now a more: "holistic approach to healthy child development and family supports." Additionally, because of HBHC, community agencies are now providing more programs to supplement and complement HBHC services. Some informants highlighted that it is through the use of the ICSIS database that the program can identify what services to provide.

Other key informants mentioned that HBHC now has linkages and a foundation in the communities. Over time, citizens are not only more aware of its culturally-sensitive services but are also accepting of the type of services it offers. For instance, initially

when home visitation used to be offered, before the HBHC program, it only catered to high risk families. Consequently, when HBHC began offering home visitation, nurses had to overcome the negative perception families expressed when receiving the postpartum call offering the universal postpartum visit. This key informant said: "So we went to less than 20% that said they wanted a visit to well over 50% and still heading up. That has taken significant time and promoting the program and demonstrating results etc. to make that happen."

Summary. Implementation and adaptation issues are not thoroughly discussed in documents. Table 10 above describes some of the program implementations and changes that have occurred overtime. Key informants mentioned that the program was not implemented using an in-depth planning process. Presently though, the program has gained a lot more structure as detailed in the consolidated guidelines issued by the ministries involved with the program. The Integrated Children Services Information System (ICSIS) database helps to provide some tracking information, whereas its ability to provide more in-depth assessments is still lacking. Informants praised the program's ability to be adaptable to its community's needs along with using a variety of methods to gain community ownership. Informants said that intensive training was and still is available but comes at a high cost. Therefore, some health units find it difficult to send all their nurses for training. Informants also discussed their perceptions of the major changes that have occurred with HBHC, such as more emphasis on the intensive home visiting aspect, its increased comprehensiveness, and its increased networks with other community organizations.

Discussion

This study was carried out to examine two current prevention programs with the purpose of identifying best practices for mental health prevention policy for preschoolers. To accomplish this purpose, I employed document reviews and key informant interviews to gather data on four aspects of the prevention programs: (a) the ideology and origin of the program, (b) the theoretical underpinnings, (c) the research base, and (d) the implementation and adaptation issues.

Early Years Centres

Research Question 1: What Are the Ideology and Origins of the Program?

Pal (1992) claims that the definition of the problem is the core of policy and, therefore, new policies on prevention need to accurately understand the "why" of issues. The ideology behind the Early Years Centres is one that rests on improving both brain development and the socioeconomic status of individuals. The ideology of the problem, as framed by the McCain and Mustard study (1999), values both what Nelson and Prilleltensky (2005) define as values for personal well-being and collective well-being. Regarding personal well-being, the study values increasing a person's feelings of self-efficacy, control, attachment, attention, love, emotional, and physical well-being, whereas from a collective well-being standpoint, support for community structures, social justice, and accountability are emphasized. Therefore, the ideology of how the problem is framed is a mix of personal and collective well-being values. As for the solutions to the problem addressed, the Conservative government decided to take a mixed approach as well. Centres are universal in nature and therefore follow a collectivist ideology; however, this collectivist approach is micro in nature. In other words, the centres are universal supports

designed to provide formal support in the form of social and health services, but they do not target socioeconomic inequalities. On the other hand, solutions also value personal well-being in that they target individual families with the aim of improving emotional and physical well-being one person at a time.

The authors of the study used brain research as a way to market their work to the Conservative government headed by Premier Harris. Furthermore, according to Gilbert and Specht's (1974) framework for policy analysis, the explicit theory giving rise to the Early Years policy initiatives was research on brain stimulation and its resulting impacts on early child development.

As stated by Peters et al. (2001), focusing on the need for poverty-reduction policies, such as income supports or tax and transfer policies, may lead to a reduction in mental health challenges in preschoolers. However, this approach would have been too incompatible with the Conservative government and too dissimilar from their person-centred Conservative vision. Similarly, according to Pentz's (2000) research, the Early Years Centres' policy can be categorized as programmatic rather than regulatory; meaning that the focus is on prevention education and programs instead of making larger scale changes through policy regulations. Therefore, in view of the fact that the Early Years study (McCain & Mustard, 1999) was commissioned by the Harris Conservative government, the solutions that were brought to light were consistent with the values and vision of the government of the time. According to Eaton et al. (1999), the social causation theory states that living in poverty may lead to increased exposure to chronic stress, thus increasing the probability of developing mental health or psychosocial problems. Reducing poverty or changing social class to prevent the social causation of

mental health problems is not a recommendation made by the authors of the Early Years study (McCain & Mustard, 1999).

Furthermore, the authors of the Early Years study (McCain & Mustard, 1999) emphasized the economic benefits of investing early by stressing the obligation of the private sector and the school system to take more responsibility for early child development. This took away from the government's responsibility for providing a solid infrastructure integral for the planning, implementation, and evaluation of the centres. As well, the importance put on the participation of the business and school sectors overshadowed the greater need for action in the social justice arena in terms of social equality policies. In conjunction with mental health prevention programs for preschoolers, there is also a need for substantial anti-poverty policies and programs. Together, both prevention policies and anti-poverty policies can reduce mental health problems and developmental difficulties in children (Conroy & Brown, 2004).

There was also recognition by informants that the people involved in the writing of the Early Years study (McCain & Mustard, 1999), including the members of the reference group, were influential in the centres' inception. Supporting Gregrich's (2003) and Kirby's (2004) claims, major players from a variety of sectors, including practitioners, gave this study the weight it needed to be sold not only to Premier Harris but to all those invested in early childhood development as a whole. Furthermore, as stated by Ross and Staines (1972), it was the culmination of many forces coming together and raising consciousness about particular issues that led to the emergence of centres that assist with the development of preschoolers.

Using existing community capacities, relying on centres to shape to the uniqueness of their community, and increasing parental knowledge in the area of early childhood development were all deemed pivotal to the success of the centres. However, there was not a consensus as to why and how the centres emerged. Some informants believed that the centres were introduced because the federal government had agreed to give money to all provincial health systems with a condition that a certain amount of the funding be put towards early childhood. Parts of the Early Years study (McCain & Mustard, 1999) were thus used by Premier Harris to justify how the money was being allocated to early childhood. This is in line with resource mobilization theory (Lindbolm, 1977) that states that society possesses the resources to mobilize change efforts, such as the Early Years Centres, but power determines which efforts will materialize.

The readiness-to-learn measure was discussed as reflecting the underlying assumption that a measure was needed to assess the benefits centres have on children. The readiness-to-learn measure would provide Ontarians with a benchmark to assess the cognitive, emotional, and social improvements of children that engage in Early Years Centre programming. Taking the measure alone as a reflection of the well-being of children is once again adopting a person-centred approach to early child development. The environment in which the child functions should also be taken into consideration (Gomby 2005; Olds et al., 2004). Unfortunately, the measure only assesses physical health and well-being; social knowledge and competence; emotional maturity; language and cognitive development; and general knowledge and communication skills. The test results are based on a population level and therefore tell the community and the centres the areas in which their children are strong and those in which they need improvement.

Regrettably, the test results do not measure such issues as: healthy family functioning, adequate parental support, adequate parental knowledge regarding the importance of the early years, and the socioeconomic factors and changes that may negatively impact child development. Since family support systems are integral to the well-being of preschoolers (Dunst, 1995), a measure that incorporates this aspect in its assessment would be a logical and valuable addition.

Research Question 2: What Are the Theoretical Underpinnings?

The major theoretical underpinning, as stated in documents and by informants, is the knowledge gained from brain development theories. The literature on brain development (Bruer 1999; Park & Peterson, 2003; Shore, 1997) supports the creation of more prevention programs for children aged zero to five years because of the social, emotional, cognitive, physical, and behavioural impacts centre-based programs report having (Hertzman & Wiens 1996; Nelson, Westhues, et al., 2003). Findings suggest that there are critical or sensitive periods in which brain development occurs. Inadequate stimulation in these critical periods leads to weak neural connections. Conversely, positive stimulation gives way to strong neural development capacities. This knowledge is the foundation of the centres as parents learn how to positively stimulate their child during critical periods, children get the opportunity to engage in play-based problem solving with other children, parents receive information regarding good nutrition, and most importantly, activities focus on parents interacting with their children. All of these centre-based activities stimulate early brain development through the sensing pathways during the critical periods between the ages of zero to six. The impact of these interactions and stimuli are long lasting. For example, children whose behavioural and

cognitive skills are poorly development in early periods of life have difficulty in school. This can lead to higher rates of antisocial behaviour, crime as a teenager and young adult, and delinquency (Tremblay, Pihl, Vitaro &. Dobkin, 1994) Furthermore, Cynader and Frost (1999) conclude that if positive stimuli are provided early on in life, children show more control with regards to regulating their emotions.

Under Gilbert and Specht's (1974) framework of policy analysis, brain development and its impacts on children's overall well-being is the problem that is targeted by this policy. Furthermore, the primary beneficiaries of this policy are children, caregivers, and families, while secondary beneficiaries include the business sector, communities, and the government (Gilbert & Specht, 1974). Nevertheless, as reported by Bruer, environmental factors can also be the source of onset for mental health challenges. The Early Years Centres do not aim to improve or take into consideration issues such as stressful life events, childhood maltreatment, violent neighbourhoods, and social injustices, which may also predispose a child to behavioural, emotional or developmental challenges as well (Mustard, 1997; The U.S. Department of Health and Human Services, 1999). The centres seem to be rather micro-centred in their approach to improving the well-being of children.

The document review revealed that the Early Years Centres were intended and mandated as universal programs accessible and available to all. Therefore, under Gilbert and Specht's (1974) policy analysis framework, universalism was the chosen strategy for delivery. However, due to the limited funding available and the high interest that some programs have generated, there are waiting lists at some centres. Moreover, due to limited funding, centres were dispersed throughout political ridings, and therefore, are not

accessible and universally available to all parents and children in the province. As well, the centres do not have a standardized method of collecting data on the numbers of parents or caregivers that use the centres. Consequently, evaluators have a difficult task of accurately identifying the number of clients the centres are serving. From a policy standpoint, the centres intended to increase and maintain the well-being of *all* children (Cowen, 1994). However, because of funding issues, the centres are neither universal nor targeted but rather an inconsistent mix of the two that differs from centre-to-centre.

The document review suggested that McCain and Mustard (1999) advocated for both centre and home-based approaches for an ideal preschooler prevention program. McCain and Mustard's view is similar to other literature that supports a holistic, multi-systemic prevention initiative that takes into account both the child's needs and his/her social context (Bronfenbrenner, 1979; Fraser, 1997; Love et al., 2002; National Research Council and Institute of Medicine, 2000; St. Pierre et al., 1995). Unfortunately, as noted by key informants, centres do not provide all components of multi-component, two-generation programs. The key aspects that are missing in all centres include home visitation and non-parental care programs. Both aspects are crucial to increasing the well-being of children. Home visitation, for example has been extensively researched and some findings support its value in terms of reducing child abuse (Green, Mackin, Tarte, Cole, & Brekhus, 2004; Olds, et al., 2004) and increasing the likelihood that children and parents will develop better socially as well (Olds et al., 2004). Non-parental care, as stated by McCain and Mustard (1999), responds to the needs of parents and children by providing care that engages children in play-based, problem-solving activities.

Key informants mentioned the Early Development Index (EDI) is a scientific-based tool that provides a snapshot of the actual needs of a community. This tool gives researchers the opportunity to use the participatory research style as supported by Altman (1995), since it uses community members in decision-making regarding centre programming and issues. Key informants believed that the diversity found in programming centre-to-centre and the history of the pre-established organization have bearings on which risk and protective factors are addressed. Overall, however, the benefits of increasing protective factors and decreasing risk factors, as stated in the literature (Fraser, 1997; Hawkins et al. 1992b; Luthar, et al., 2000), are reflected in the centres, as mentioned by informants.

Research Question 3: What Is the Research Base?

The Harry Cummings and Associates (HCA, 2004) evaluation did not examine the adequacy of the centres, which Kelley (1975) suggests is important for analyzing policy. Kelley (1975) defines adequacy as the "extent to which a specified need is met if the program objectives are carried out" (cited in Flynn, 1985, p. 35). Reflected by both the documents and informants, the adequacy of the centres is difficult to assess since the centres suffer from vast differences in their planning, implementation, programming supports, and tracking systems across the province. Based on comparisons made with the intended objectives as listed in the McCain and Mustard study (1999), and the results from the Harry Cummings and Associates' evaluation (2004) of the centres, the evaluation shows that centres are effective and efficient. However, respondents believe that there is a lack of sufficient funding for core programming, and that they do not have enough authority in deciding what programs to offer. Respondents also mentioned that

the centres need much more of a standard approach to the daily functioning, recording, tracking, and reporting of outcome data and core services offered at centres. It is important to note that the evaluation did use small samples when assessing some aspects of effectiveness, such as merit in training and increasing community participation (including the business sector). Consequently, the results of this small sample may not be generalizable to the perceptions of all Early Years Centres staff. Moreover, the evaluation did not use an evaluation design that permitted any causal inferences about program effectiveness nor did it measure the extent that universal programming is effective. The documents and interviewees both stated that centre-to-centre there is so much variance with regard to their adherence to best practices that it is virtually impossible to give an overall assessment.

To some extent, there are some characteristics that are consistent across the province and therefore can be assessed. As noted by Nation et al. (2005), comprehensiveness of the centres can be assessed through their use of multiple settings and multiple interventions. Centres do engage children and their parents in programming, but do not involve schools, peers, siblings, etc. in the aims of changing the child's social environment. As for offering multiple interventions, centres do increase parent awareness and skill, and social interaction through child-oriented programming and informational brochures, but do not offer home visitation or non-parental care services.

As for the cultural sensitivity of programs, both Nation et al. (2003) and Morrissey et al. (1997) urge prevention programs to be customized and accommodating to the cultural needs of their clients. Overall, informants believed that this characteristic was adhered to and endorsed in most centres. The elements that informants said greatly

varied across centres were the relationships between the centres and theoretically-based knowledge, and whether participants were receiving enough "dosage" to have sufficient effects. As supported by Henggeler (1992), theoretically-based programs that recognize the complexity of issues and are based on accurate and empirically-supported rationales have been shown to be most effective. Additionally, follow-up treatments, which are not conducted at the centres, as noted by Morrissey et al. (1997), are deemed important to refresh gained knowledge and provide a venue for accessing more knowledge.

Research Question 4: What Are the Implementation and Adaptation Issues?

As reported in the Harry Cummings and Associates (HCA, 2004) evaluation and in interviews with informants, the process by which centres were introduced varied across the province. Some centres were introduced in pre-established, networked organizations, while some others struggled with the growing pains of developing a new community centre. The centres strived to increase accessibility and meet the needs of their clients by operating all year around at various locations and in diverse languages. Informants stressed the lack of evaluation, centralized data coordination, and the centres' inadequate program logic-model. The development of a program logic-model, as suggested by Nelson et al. (2003), is one of the components in the planning phase of the life-cycle of successful community-based prevention programs. The problem with the OEYC's logic-model was that it did not detail the desired outcomes of its activities.

As emphasized by the McCain and Mustard study (1999) each unique community needs to create unique child development centres and parenting supports to account for the diversity in language, ethnicity, and cultural characteristics found in the families of the community. Therefore, communities must also take a lead role in deciding what

works best for them, where and how to build on existing strengths and acquiring resources instead of developing a range of centres through a centralized, technical, and bureaucratic model. Furthermore, parents should have choices. There should be options for parents and their children as opposed to a "one-size fits all" program that would be developed by governments. The McCain and Mustard study (1999) also states that a program that grows through community initiatives and support tends to engage leadership and the kind of broad community support, buy-in, and understanding that is necessary for the initiative to thrive.

From a policy standpoint, the mobilization of resources such as money and leadership was central to the planning and implementation of the centres (McCarthy & Zald, 1977; Tilly, 1978); whereas now, in the maintenance and sustainability phase of some centres, both of these resources need to be increased. Planners, however, made it a priority to use existing space and community knowledge and expertise when planning and implementing the centres (McCarthy & Zald, 1977; Tilly, 1978).

Informants concluded that local adaptation, community ownership, and training models were encouraged and developed throughout the planning and implementation process, but, once again, the level of each differs centre-to-centre. According to Nelson, Pancer, et al. (2003), forming trusting relationships with stakeholders is another aspect of the planning phase in the life-cycle of successful community-based prevention programs. Informants said that over time the centres have demonstrated unique networking and adaptability to community needs. On the other hand, centres were intended to be a continuous place for care across the service delivery system, whereas now they are seen more as providing referrals and information.

Implementation, as described by Nelson, Pancer, et al. (2003), is how well each and every aspect of the program is put into practice. According to Blakely et al. (1987), there are two implementation strategies: fidelity and adaptation. It was the intent of centres to reflect, as closely as possible, the characteristics of prevention programs as outlined in the Early Years study (McCain & Mustard, 1999). However, some of the characteristics detailed in the study recommended centres to adapt to community contexts and needs. In actuality, the centres did not remain faithful to major features, such as home visitation, non-parental care services, and the use of school space, the original model in McCain and Mustard's study suggested. This led the centres to adapt past the zone of drastic mutation and therefore, as described by Hall and Loucks (1978), may lack the effectiveness and integrity they intended to demonstrate. A positive adaptation that is at the forefront of centre staff and has contributed to its effectiveness is the heightened sensitivity to cultural diversity found in communities.

The Harry Cummings and Associates (HCA, 2004) evaluation and key informants made similar comments with regards to why centre results may be minimal. These minimal effects can be attributed to limited funding, a disregard for the complexity of the issue and its solutions, and inconsistent implementation across centres (Elliott & Mihalic, 2004). As well, according to Morrissey et al. (1997), the achievements of prevention programs are closely related to their use of prevention science in all facets of the planning and implementation process. Consequently, the negative outcomes experienced by the centres, as reported in the HCA (2004) evaluation, may be due to the lack of adherence to prevention research. The centres are struggling in areas that have been documented by Nation et al. (2003) as being crucial to successful prevention programs, such as

comprehensiveness, intensity, being theoretically-driven, conducting ongoing outcome evaluations, and conducting follow-up assessments. Other factors that contribute to the success of prevention programs, such as support to staff, community ownership, accessibility, and culturally-sensitivity (Durlak, 2003), all vary in strength from centre-to-centre.

Modifying program content, as described by Castro et al. (2004), is a form of adaptation that is necessary if the original model does not offer specific programming as needed by the community. With regards to the Early Years Centres, they were given core areas to focus on, such as teaching parenting skills, helping parents teach their child how to read, and offering referrals. But, the activities and programs centres chose to undertake to fulfill these core requirements were not outlined by the provincial government. Consequently, program delivery, the second form of adaptation as described by Castro et al. (2004), varied based on the program or activity offered. Furthermore, the location of delivery in pre-established or new Early Years buildings is also adapted from McCain and Mustard's (2001) recommendation of using school space.

Healthy Babies, Healthy Children

Research Question 1: What Are the Ideology and Origins of the Program?

The conclusions discussed for the Early Years Centres with regard to why the policy was developed and the mix in ideological perspectives are similar for the Healthy Babies, Healthy Children's program. The problem of poor early childhood development is framed using Nelson and Prilleltensky's (2005) values for personal well-being. The solution is also framed in terms of values for personal well-being, as the program is a micro-based intervention, geared towards helping one family at a time. To fit within the

values of the Conservative government, HBHC is predominantly targeted in its approach. However, some HBHC services are offered universally – thus endorsing collective well-being values. Another issue behind HBHC is the home visitation research. Much like brain stimulation, as examined in the Early Years Centres discussion, home visitation does not change the socio-economic status of individuals. The impacts of anti-poverty policies combined with home visitation services may together lessen the rates of mental health challenges in lower socio-economic status citizens. The HBHC was devised by a wide-range of stakeholders - governmental ministries, high-level civil servants, researchers, early child development advocates, and at times, the business sector. The Ministries responsible engaged in resource mobilization by using leaders in the early child development arena as a strategy in getting this issue on the political agenda (McCarthy & Zald, 1977; Ross & Staines, 1972; Tilly, 1978).

Research Question 2: What Are the Theoretical Underpinnings?

Similar to the Early Years Centres, the HBHC program acknowledges the importance of positive stimuli to healthy brain development. However, unlike the centres that improve brain development through centre-based programs, HBHC focuses primarily on home visitation to create an environment for positive stimulation to impact healthy brain development. In the early years, a child spends the most time with his or her parents. Therefore, home visitation services educate, train, and encourage parents to participate in the development of their child. Furthermore, home visitation programs can reduce parental stress and improve outcomes for parents. McCain and Mustard (1999) emphasize that "people who are reared in poor early parenting circumstances are more likely to be poor parents and repeat the cycle" (p. 45). Parents that were poorly nurtured

in their early days find it more of a challenge to model positive parenting. Therefore, home visitation can assist parents in impacting their child's brain development through parenting supports.

Informants discussed the differences found in the HBHC program with regards to its universality. Over the years, there has been a shift, due to funding constraints, from offering four to five postpartum, universal home visits to some programs offering one to none. The HBHC program has universal services that give parents the information and support they may need to help their child get a healthy start. This aspect is intended to maintain and increase the overall well-being of children in anticipation of building protective factors (Cowen, 1994). In contrast, Coie et al. (1993) advocate for targeted, intensive services and supports for high risk children in hopes of strengthening their coping skills, which is the approach taken by HBHC.

HBHC's home visitation service is an example of a partial model home visitation program since it begins support during the prenatal phase and continues into the postnatal phase (Gomby et al., 1999). HBHC is an example of a family-based program for parents with the aims of strengthening parenting skills and knowledge. Parents receive supports from nurses or lay home visitors in the form of early assessments, parenting training, home visitation, and referrals. HBHC also directly acknowledges the benefits of centre-based programs for children, as it incorporates referrals and information to programs such as the Early Years Centres.

The HBHC program operates from a strengths-based perspective. The HBHC program satisfies Luthar et al.'s (2000) categorization of protective factors by providing protective stabilizing factors (i.e., increased parental support), protective enhancing

factors (i.e., increased parental confidence and knowledge), and protective factors that lessen in stressful situations (i.e., improving behavioural and lifestyle issues). However, as described by Fraser (1997), protective factors that help to balance risk factors, such as increasing a child's self-efficacy, social supports, and opportunity to gain knowledge, are not outcomes of the HBHC program. Considering that strengthening parents, decreasing parental stress and isolation are the primary focus of the HBHC program, it gives the parents the tools necessary to offset risk factors, but it is questionable if the program activities give children these same tools.

Research Question 3: What Is the Research Base?

Similar to the Early Years Centres, the results obtained by the Applied Research Consultants (ARC, 2003) evaluation with regard to HBHC effectiveness and efficiency were positive. Additionally, informants agreed that the HBHC program shows consideration for participants' identity and self-image as skilled parents and also empowers them to help shape the program. Therefore, when analyzing HBHC policy with regards to Kelley's (1975) sub-criteria of "identity" and "self-determination," it is clear that these two criteria are given considerable importance. It is important to keep in mind that the ARC (2003) process evaluation provided preliminary, short-term results, as the long-term evaluation is still in progress.

As briefly mentioned in the theoretical underpinnings section, there is some tension between the evidence-based approach and the community development approach to this prevention program. The tension lies in the fact that there was no examination of community knowledge, wants, and needs before developing this program. As stated by some key informants, the HBHC program did not employ any pilot projects or

comparison groups to gather information on best practices for this specific program. There was no empirical-based research specific to the population of Ontario that was used in determining the core services and the mode of service delivery. Additionally, as McLennan, MacMillian, and Jamieson (2004) state, the HBHC program "received no controlled evaluation prior to its province-wide dissemination" (p. 1070). As reported by Morrissey et al. (1997), prevention programs do not base the prevention program on prevention science because of a lack of time, interest, or resources, which can consequently lead to minimal impacts - which is the case for the HBHC program.

Home visitation services offered through HBHC vary in intensity. According to Olds et al.'s Elmira, Memphis, and Denver trials which yielded overall positive impacts, having biweekly visits during the prenatal and postnatal phases, until the child reaches the age of two, is as an effective model. Gomby's (2005) meta-analysis of home visitation studies suggests that the effect sizes of home visitation on child healthy development, parenting skills, and rates of neglect and child abuse are extremely small. Furthermore, and more importantly, Gomby states:

> The mixed and modest results, however, illustrate just how fragile an intervention home visiting can be. The most intensive national models are slated to bring about 100 hours of intervention into the lives of families. More typically, programs deliver perhaps 20 or 40 hours of intervention over the course of a few years.

Both Daro (2004) and Zercher and Spiker (2004) state that research on home visitation show modest effects on maternal behaviours with low psychological resources, but do not show large impacts on children. As well, both argue that programs that are designed and implemented with rigor and retain their commitment to this model will result in more

positive outcomes. However, HBHC visits the family depending on the family's needs and wants and not by a prescriptive, detailed schedule. Therefore, the benefits that are reported in other studies, however small, may not occur with the home visitation services HBHC delivers. Furthermore, research shows (Layzer et al., 2001; Love et al., 2002; National Research Council and Institute of Medicine, 2000) that programs whose primary intervention is home visitation, as is the case with HBHC, do not impact on children's development as much or as long as programs that are multi-faceted in their approach (i.e., home visitation and centre-based programs).

Longitudinal studies, such as Olds, Henderson, et al.'s (1998) 15-year follow-up study of the Nurse Home Visitation Program, concluded that child maltreatment rates for the intervention group were half that of the control group. Unfortunately, these results may not be reflected in the HBHC program, since HBHC uses a blended model of both lay home visitors and nurses whereas the home visiting program examined by Olds, O'Brien, et al. (1998) only employed nurses. The ratio of lay home visitor visits to nurse visits as mandated by the HBHC guidelines is 3:1 to 6:1. Additionally, it is important to note that the HBHC guidelines do not justify its use of the blended home visitation model and these ratios with any research base. Conversely, research conducted by Olds, Robinson, et al. (2002) shows significant differences in children who were visited by nurses and those by lay home visitors - with those visited by nurses reporting higher overall well-being. A more recent follow-up of the Denver study shows that paraprofessionals produced benefits of only about half the magnitude of those produced by nurses in outcomes such as deferral of second pregnancies, maternal employment in the second year of the child's life, and mother-infant interaction. Moreover, both

paraprofessional and nurse-visited families had improved home environments, but only nurse-visited children had better test performance (Olds, Robinson, et al., 2002).

As for best practices, the ARC (2003) evaluation and informants stressed that the HBHC program is not comprehensive as it primarily offers home-based programs. Even though HBHC provides information to parents on other community services that are centre-based, this information is given out when asked or if home visitors feel it is needed. However, as detailed in the Early Years study (McCain & Mustard, 1999), engaging in early play-based learning is beneficial to the overall emotional, physical, and social well-being of *all* children. Furthermore, the results are mixed with regards to improving early development needs through home visitation and parental education. As reported by St. Pierre et al. (1995), without a child development and parental job training or education aspect, there seems to be minimal effects of home visitation programs on the cognitive development of children. On the other hand, Nelson, Westhues, et al. (2003) found that parent-oriented programs have positive effects on children as well. In terms of Nation et al.'s (2003) types of comprehensiveness (multiple-settings and multiple interventions), the HBHC program only engages the families with newborns through parent-oriented programs. Therefore, HBHC does not seem to offer multiple interventions in multiple systems to prevent the onset of mental health challenges in preschoolers.

In terms of the multi-component nature of the universal aspect of the program, it offers screening, assessments, and postpartum services. The targeted components of the program only offer referrals and information, home visitation, and the service planning and co-ordination of supports. The universal screening and assessment services are

offered during the prenatal and postnatal phases as well as throughout different times in the child's early years. The universal services are offered at critical times in a child's early development, and therefore the probability that at risk children will be identified as early as possible is increased. Nelson, Westhues, et al. (2003) identified program timing as one of the crucial components to successful prevention programs. The postpartum services are not intended to be intense, as they consist of one phone call from a nurse, with the goal of giving parents access to information and support, and an offer of a home visit.

The targeted services differ in intensity since the frequency of home visits is dependent on the family and not embedded in HBHC guidelines. Mulvey et al. (1993) state that the more intensive programs are, the greater the chance is that there will be positive impacts. Therefore, the impacts of home visitation offered through HBHC can vary from family to family. As reported by Henggeler (1992), theoretically based programs are most effective when they have a sound and accurate empirical knowledge foundation. The HBHC program is theoretically-based in terms of its understanding of the importance of early development in protecting children against mental health challenges. The early identification component also uses scientifically valid screening tools as prescribed in the screening process. But, the theory behind the blended visitation model, the use of lay-home visitors, the ratio of lay home visitors to nurse home visitors, and the frequency of home visits is unsupported. From a policy standpoint, as reported by Nelson, Westhues, et al. (2003), programs that are less than one year in length and offer less than 300 sessions have minimal effects on children. More specifically, MacLeod and Nelson's (2000) meta-analysis of the impact of home visitation on family wellness and

child maltreatment concluded that programs had to be longer than six months in duration and have more than 12 visits to be effective.

Furthermore, the HBHC program emphasizes that it is not a stand-alone program but rather networks with other initiatives to provide the best care and outcomes for families. In saying this though, it is important to note that only parents of at risk children are referred to other services, whereas Cowen (1994) suggested that all children can benefit from programs that help to maintain overall wellness.

The importance of programs being culturally-sensitive is discussed by Morrissey et al. (1997) and reflected by informants and the ARC evaluation of HBHC. HBHC not only shapes to the cultural norms and languages of its participants but also modifies its program by hiring lay-home visitors that fit the community's needs. Overall, both the evaluation and the key informants that I interviewed found HBHC to be leader in the area of cultural sensitivity. The HBHC program does not have a follow-up component to its universal or targeted services and, therefore, as reported by Morrissey et al., participants are neither reminded of the skills they learned nor do they have the opportunity to learn new skills. The HBHC program is currently undergoing an extensive evaluation. The knowledge gained from the evaluation should be used, as described by Morrissey et al., to decrease the gap between science and practice through the practice-centered approach. This approach emphasizes the use of evaluations to inform research with the aim of improving the HBHC prevention program.

Research Question 4: What Are the Implementation and Adaptation Issues?

As described in Table 6, HBHC has a history of making positive changes in its programming and availability. HBHC is committed to providing better care as seen

through broadening its Postpartum Enhancement component to a universal service, the issuing of valuable information regarding assessments to HBHC staff, and requesting an evaluation of the program toward the goal of enhancing its services. HBHC upholds the expertise found in the community and fosters the strengthening and use of partnerships by all of the health units that offer the HBHC program. According to Nelson, Pancer, et al.'s (2003) research, developing community ownership through collaboration is important in the planning phase of the life-cycle of a successful community-based prevention program. Informants agreed that originally, HBHC staff were not given many standards or benchmarks for implementation, whereas now, more structure and direction is given as seen through the consolidated guidelines. Informants commented on the strengths of the HBHC consolidated guidelines (Early Years and Child Development Branch et al., 2003) in being prescriptive but flexible enough to adapt to community needs. However, as mentioned by informants, changes do not always take into account community needs, experiences and knowledge before being implemented. As Elliott and Mihalic (2004) describe, the minimal effects of some prevention programs can be directly due to barriers. One of the barriers HBHC faces is a self-imposed barrier of inadequate implementation, as the program was developed and implemented without the community's needs or wants taken into consideration. Furthermore, inadequate funding is reflected in the program's inability to offer all home visits by professional nurses, to continue to offer universal postpartum home visits, and to train and retain all home visitor staff. As described by McLennan et al. (2004), using lay home visitors, and reducing the duration and intensity of interventions, will reduce costs. However, this may also result in no impacts and therefore no long-term savings. Informants applauded HBHC's ability to adapt the

program to the community, but there is still debate regarding the community's sense of ownership of the program. As reported by Morrissey et al. (1997), community ownership is developed in the planning, implementation, and evaluation phases of the program. Consequently, it is understandable why and how the HBHC program lacks community buy-in.

The HBHC consolidated guidelines and informants value voluntary programming, community expertise, the evidence-based approach, and understand that the program assumes a targeted approach when planning and implementing the program. As per Nelson, Pancer, et al. (2003), an evidence-based approach focuses on previous research when planning and implementing new programming. Furthermore, Nelson, Pancer, et al. also state that at times there can be some conflict between this approach and the community development approach.

Additionally, as expressed by informants, the history of the health unit has effects and influences on the HBHC program as well. More experienced and active health units have better HBHC outcomes. The Integrated Services for Children Information System (ISCIS) is also deemed as a useful tool in documenting ongoing activities and outcomes of the program. Both the HBHC consolidated guidelines (Early Years and Child Development Branch et al., 2003) and the ISCIS database are proof of the emerging trend of inventing effective ways in which to coordinate, plan, produce, and evaluate programs (Caputo, 2003; Naylor, et al., 2002).

Informants perceive the major changes of the program to be: (a) an increased intensity of targeted home visitation at the cost of less universal postpartum visits, (b) more comprehensiveness as the program now provides the universal postpartum

component and has the ICSIS database, (c) an increase in other agencies providing services to fill-in the gaps, and (d) more familiarity to the community and therefore is more welcoming to participants. The first two changes are examples of what Castro et al. (2004) describe as content-adaptations. As well, the ICSIS database helps the program identify how well the implementation of core services is taking place, but only provides programs with limited information on how best to adapt to the needs of their community. Some HBHC programs underwent changes to the ratio of lay-home visitors to nurses, group home visits instead of one-to-one family visits, and more targeted home visits in place of universal postpartum visits. Castro et al. (2004) would categorize these adaptations as program delivery modifications.

In terms of Blakely et al.'s (1987) categories of implementation, HBHC compromises its fidelity to the consolidated guidelines because of limited resources (i.e., financial, lack of nurses etc.). This forces each health unit to adapt to its unique circumstances and modify the guidelines. The lack of research base upon which the program is established, along with limited resources supporting the program, leads to adaptation beyond a zone of drastic mutation, as reported by Hall and Loucks (1978). Some of the program changes, such as adapting to the community's cultural needs increase the effectiveness of the program, but others, such as using lay-home visitors instead of nurses, take away from its effectiveness (Blakely et al., 1987).

Lessons Learned

At the beginning of this research process, my belief was that preschool mental health prevention policy was written with research from both the evidence-based and community development approaches as its main cornerstones. Furthermore, my

assumption was that the health of our youngest Ontarians was fulfilled by different levels of government because of the short and long-term social, physiological, and economic benefits prevention programs can provide. However, I have come to believe that our children and their health are used as a guise to leverage power and gain political popularity. The emergence of the two programs that I examined was due to issues such as timing, money, and the influence of dominant people instead of results from pilot tests, needs assessments, evidence and community-based research, and outcome evaluations. The implementation of programs was done in a rush, compromising and at times bypassing essential program principles such as comprehensiveness, theoretically driven activities, and intense programs. I have come to understand McLennan et al.'s (2004) statement stating that policymakers believe that "a little is better than nothing," when in fact "a little" may result in no impact and no long-term savings (p. 1070). In the end, politics takes precedence over evidence-based research and community needs. This is not smart policy-making.

Another lesson concerns the implementation of universal programs. If universal programming is mandated, there needs to be a commitment of sufficient funds to maintain services and supports to all. Evaluations need to determine if and the extent to which the universality of programs is being compromised and effective. There is a middle ground between universal and targeted approaches, one that involves giving priority to high risk communities. The Early Years Centres should have been universally available, but low income communities should have been targeted first as research suggests that mental health issues occur more in disadvantaged populations. Only when funding

became available, should the centres have expanded their services to more middle income communities.

Best practices in prevention programs need not only be acknowledged, but there needs to be an understanding of how adaptations of the program model could lead to minimal effects. For example, current and future planners and program staff need to understand how comprehensive or intensive programs must be to have the desired effects. This lesson stems from the lack of comprehensiveness, follow-up, intensity, ongoing outcome evaluations, and emphasis on community buy-in the programs experience.

Another lesson concerns the role of pilot studies. Neither program was subjected to rigorous pilot investigations before they were implemented on a wider scale. Furthermore, there should be a commitment towards gathering baseline data that can be used later to provide a comparison for assessing program impacts. Use of some type of control or comparison groups would also be helpful in understanding how effective the prevention program is. Additionally, program logic-models should incorporate the explicit and implicit models giving rise to the activities. There was no systematic examination of the blended home visitation program model before implementing it wide scale. Both programs lack a standardized method of delivery of all their activities. Furthermore, the centres do not even have a set of core programs that are offered at all centres province-wide. It is time for centres to implement prescriptive standards, guides, and benchmarks, while allowing some room for flexibility to the community's needs. Diversity in the program should exist to the extent that the local context is taken into consideration and the core program is unchanged. However, HBHC has left too much room for flexibility as witnessed by its use of lay home visitors and the low frequency

and intensity of its home visitation services – this too ought to be reassessed by policymakers.

There is concern regarding the tension between the evidence-based approach and the community development approach to planning prevention programs. This is why the time is ripe for more collaboration and communication between science and the community it serves. Science can take into account the diverse needs, knowledge, and history of the community and with this information, identify best practices that would result in greater program impacts for the community. As the community changes, it shares this information with researchers that then share their informed opinion with policymakers. This communication can be done through recurring outcome evaluations. Government, researchers, and service providers need to collaborate in the design and implementation of prevention programs to the extent that all have equal say, involvement, and influence. Through my learning in this process, I have come to understand that prevention programs are not resourced enough, as compared to treatment programs, because of the lack of commitment towards understanding the extent to which best practices are the backbone of influential prevention programs. A three-way partnership between government, researchers, and service providers is important for effective and sustained prevention programs – all three stakeholders working together can give preschoolers the best start in life.

Appendix A

Interview Guide for Key Informant Interview Participants:

Early Years Centres

1) Values and Politics
- How did the Early Years program emerge at this particular time in history?
- What was "the problem" addressed by the policies from which the Early Years Initiative stem?
- What were the underlying values and assumptions of the policies? What is your understanding of the key features and elements of the policy that the Early Year Centres stem from?
- How were these policy initiatives consistent with the vision and values of the prevailing government?
- How much financial and personnel resources are dedicated to this program?
- How was the policy that guided the planning and implementation of this program devised?
- Who were the major players in initiating, coordinating, and planning the program?

2) Theoretical Underpinnings
- What are the theoretical underpinnings of the Early Years prevention program?
- Who does this program serve? In other words what type of prevention program does this program fall under (universal, selective, or indicative)?
- What risk factors is this program offsetting?
- What protective factors is this program enhancing?

3) The Research Base
- Upon what research base are these policies established?
- With regard to best practices such as: multi-component programs, comprehensiveness of program, intensity, culturally sensitivity, and theoretically-based programs, how do this program fit with each program characteristic?
- Is there a logic-model for the Early Years prevention programs?

4) Implementation and Adaptation Issues
- What were the guidelines, parameters, or benchmarks for implementation of these policies?
- How was local adaptation encouraged to meet community needs?
- How was community ownership (buy-in) developed and stakeholder participation encouraged?
- What type of training, support, and practice guidelines was given?
- With regard to this particular program, what changes have occurred over time?
- Does this program undergo evaluations, if so, how are results used to change program aspects?
- How is the program financed (mode and manner of finance)?

Interview Guide for Focus Group Participants

Health Babies, Healthy Children

1) Values and Politics
- How did the Healthy Babies, Healthy Children program emerge at this particular time in history?
- What was "the problem" addressed by the policies from which the Healthy Babies, Healthy Children Initiative stem?
- What were the underlying values and assumptions of the policies? What is your understanding of the key features and elements of the policy that the Healthy Babies, Healthy Children program stem from?
- How were these policy initiatives consistent with the vision and values of the prevailing government?
- How much financial and personnel resources are dedicated to this program?
- How was the policy that guided the planning and implementation of this program devised?
- Who were the major players in initiating, coordinating, and planning the program?

2) Theoretical Underpinnings
- What are the theoretical underpinnings of the Healthy Babies, Healthy Children prevention program?
- Who does this program serve? In other words, what type of prevention program does this program fall under (universal, selective, or indicative)?
- What risk factors is this program offsetting?
- What protective factors is this program enhancing?

3) The Research Base
- Upon what research base are these policies established?
- With regard to best practices such as: multi-component programs, comprehensiveness of program, intensity, culturally sensitivity, and theoretically-based programs, how do this program fit with each program characteristic?
- Is there a logic-model for the Healthy Babies, Healthy Children prevention programs?

4) Implementation and Adaptation Issues
- What were the guidelines, parameters, or benchmarks for implementation of these policies?
- How was local adaptation encouraged to meet community needs?
- How was community ownership (buy-in) developed and stakeholder participation encouraged?
- What type of training, support, and practice guidelines was given?
- With regard to this particular program, what changes have occurred over time?
- Does this program undergo evaluations, if so, how are results used to change program aspects?
- How is the program financed (mode and manner of finance)?

Appendix B

Protocol for Analyzing Documents

Each document, when applicable, will be analyzed and coded using the themes used in the interview guide. The four overarching themes that will be coded when analyzing the documents are: 1) Values and Origins; 2) Theoretical Underpinnings; 3) the Research Base; and 4) Implementation and Adaptation Issues.

Template for document reviews

Name of document	Relates to which category?	Relates to which theme?	Quotation and page of interest	Other data of interest

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