HANDLE WITH CARE EVALUATION PROJECT:
IMPACT OF A MENTAL HEALTH PROMOTION TRAINING PROGRAM ON
CHILD CARE PRACTITIONERS’ KNOWLEDGE AND PRACTICES

by

Heidi Kiefer

A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Graduate Department of Applied Psychology and Human Development
Ontario Institute for Studies in Education
University of Toronto

© Copyright by Heidi Kiefer 2013
HANDLE WITH CARE EVALUATION PROJECT:
IMPACT OF A MENTAL HEALTH PROMOTION TRAINING PROGRAM ON
CHILD CARE PRACTITIONERS’ KNOWLEDGE AND PRACTICES

Doctor of Philosophy, 2013
Heidi Kiefer
Department of Applied Psychology and Human Development
University of Toronto

Abstract

This study explored the effectiveness of Handle With Care, a mental health promotion training program for child care practitioners working with children between birth to age 6. Handle With Care program content is based on research evidence. Training units are intended to deepen practitioners’ understanding of how children’s social-emotional development, centre and family connections and positive workplace activities link to children’s well-being and practitioners’ roles in these areas. Fifty-seven front-line practitioners from three different regional groups (Rural, Suburban, Urban) completed Handle With Care workshops and were compared to 56 comparison participants, matched according to region, who were not exposed to training. The evaluation utilized a time series repeated measures design and consisted of mixed quantitative and qualitative measures to determine training outcomes related to practitioners’ mental health promotion knowledge and practices.

Findings indicated that child care practitioners who participated in Handle With Care training demonstrated increased mental health promotion knowledge. In particular, they acquired better comprehension of issues concerning practitioner and child attachment relationships, children’s self-esteem, emotion expression and regulation and peer relationships. Training participants significantly differed from comparison participants in their knowledge of these topics. In terms of practices, training participants also evidenced significantly improved practices relative to comparison participants. These gains were especially observed in relation to
practitioners building trusting relationships with children, fostering children’s sense of self and competence, positive peer interactions and practitioners promoting their own mental health. In contrast, *Handle With Care* training did not show the intended consistent outcomes with respect to practitioners helping children with emotional communication, dealing with diversity, changes and transitions and practitioners building relationships with children’s parents.

Results tended to be discrepant across regional groups, and in some instances, gains in mental health promotion and knowledge were not sustained over time. Overall, the study suggests that *Handle With Care* is a useful way to augment child care practitioners’ capacity to consider the mental health of all children in their care and flexibly implement strategies to help children reach their optimal potential. The study also provides important information concerning regional differences and areas of training content that may benefit from revision.
ACKNOWLEDGEMENTS

A long time ago, when I was in Grade 5, I decided to become a kindergarten monitor. The position involved giving up morning recesses to help look after the children and assist the teacher with preparation tasks and carrying out activities. My main motivation was to gain experience working with a teacher, taking on the responsibilities of activity planning, organization and keeping the kids calm. My advanced age and wisdom led me to feel that actually dealing with the children would be secondary, no big deal. As it turned out, it was a huge deal. Not only did I fall in love with the children, I grew to love the way I thought when around them. All the children were unique, no two were completely alike. They were filled with individual spirit, curiosity, motivation and stories. There were smiles, tears, laughter and rage. No matter how much I tried, I could never quite plot, control or exactly know everything in situations with the kids. Instead, I started to learn how to be flexible, creative and accepting. I appreciated what those kids were able to teach me and those lessons have led the way for me to clinical child psychology and this Ph.D. dissertation.

I have continued to learn so much along the way. My supervisor and mentor, Nancy Cohen, Ph.D., has continuously been an inspiration. I have been so proud to have her keen insight, patience, thoroughness and sensitivity influence my work and life. She is now a voice in my head when I write and the skills I possess in this area, I owe to her. The other core members of my committee, Rachel Langford, Ph.D., and Janette Pelletier, Ph.D., have truly provided me with fresh perspectives and endless enthusiasm and support during the entire research process. Working through the highs and lows and occasional ambiguity, I was fortunate enough to have the tremendous interest and efforts of those who assisted with interviews, coding and keeping me optimistic, including Vivian Lee, Jennifer Kelly, Caroline Fabbruzzo, Angela Huang and Katie
Sussman. This project would absolutely not have been possible without you. Additionally, project results would not have made any sense without the help of Fataneh Farnia, Ph.D., in terms of statistics and comic relief.

I am so lucky to also have some exceptional friends. Melody Ashworth and Katherine Morton have amazed me with their positivity, strength and daring. They have kept me afloat so many times when the weight of graduate studies and this dissertation felt almost too much. Natacha Da Silva, my best friend, has helped me to strive further than I could possibly imagine. Your friendship has taught me more than any other. If I could, I would wrap up part of the happiness, relief and awe I feel while writing this as a gift to share with you as we continue to be each other’s biggest fans. Thank you.

As I reach this milestone, I have been wondering what happened to those young children from my kindergarten monitor days. All of them, and every child I have met since, has had so much potential. More than anything, I hope that the topic of this dissertation, mental health promotion for young children, increasingly resonates with everyone with deals with children. This includes the caregivers, storytellers, researchers, policymakers and the fund-givers. There is so much more to learn and if we do it together, open-minded and collaborative, oh the places we’ll go.
TABLE OF CONTENTS

CHAPTER 1
Introduction .................................................. 1
Theoretical and Practical Relevance .................. 6

CHAPTER 2
Literature Review ........................................... 9
Child Development ........................................... 10
Early Brain Development .................................. 11
Pivotal Role of Emotions .................................. 12
Developmental Trajectories and Outcomes .......... 14
Mental Health Considerations ......................... 17
Mental Health Promotion ................................ 19
Promotion Distinguished From Prevention and Intervention .............. 20
Mental Health as More Than the Absence of Mental Illness ............... 21
Economic Implications .................................... 23
Human Capital ................................................ 27
Child Care in Canada ...................................... 29
Changing Family Circumstances ....................... 30
Growing Need for Centre-Based Child Care .......... 35
Characteristics of Quality Child Care ................ 38
Why Are Child Care Centres Appropriate for Mental Health Promotion? 43
Relational Context of Child Care ....................... 45
Child Care Practitioner Training ....................... 49
Research Literature Concerning the Effects of Mental Health Programs for Children ........................................... 51
Review of Mental Health Consultation Programs for Children .......... 52
Review of Mental Health Promotion Programs for School-Age Children 54
Review of Mental Health Promotion Programs for Early Childhood .... 58
Mental Health Promotion Training for Child Care Practitioners .......... 61
Present Study ................................................. 63
Origin of the Handle With Care Training Program .......... 64
Description of the Handle With Care Training Program .......... 69
Building Block 1: Developing Trust Between Practitioner and Child .......... 71
Building Block 2: Building and Ensuring Positive Self-Esteem .......... 72
Building Block 3: Expressing Emotions .................. 73
Building Block 4: Relationships With Other Children .............. 74
Building Block 5: Respecting Diversity ................. 75
Building Block 6: Change and Transitions ............... 76
Building Block 7: Relationships With Parents .............. 77
Building Block 8: Well-Being of Practitioners .............. 77
Building Block 9: Environment ......................... 78
Purpose of the Current Outcome Study ................ 79
Expanding the Knowledge Base ......................... 80
Handle With Care Logic Model | 84
---|---
Research Questions and Hypotheses | 87
  Hypothesis 1 | 87
  Hypothesis 2 | 87
  Hypothesis 3 | 88
  Hypothesis 4 | 88
  Hypothesis 5 | 88
  Hypothesis 6 | 88
  Hypothesis 7 | 88
  Hypothesis 8 | 89

CHAPTER 3
Method | 90
---|---
  Research Design | 90
  Participants | 91
  Procedure | 93
    Training Participants | 93
    Comparison Participants | 98
    Training Groups | 99
    Comparison Groups | 100
  Measures | 102
    Background Questionnaire | 103
    Child Care Interview | 103
    Child Care Questionnaire | 104

CHAPTER 4
Quantitative Results | 105
---|---
  Data Preparation and Preliminary Data Analyses | 105
  Managing Missing Data | 106
  Child Care Questionnaire Findings | 106
    Hypothesis 1 | 106
    Hypothesis 2 | 107
    Hypothesis 3 | 111
    Hypothesis 4 | 113
    Hypothesis 5 | 114

CHAPTER 5
Qualitative Results | 116
---|---
  Data Organization | 116
  Data Coding and Analyses | 116
  Child Care Interview Findings | 118
    Hypothesis 6 | 118
      Building Block 1: Developing Trust Between Practitioner and Child | 119
    Summary of Findings for Building Block 1 | 136
Building Block 2: Building and Ensuring Positive Self-Esteem 137
Summary of Findings for Building Block 2 . 154
Building Block 3: Expressing Emotions . 155
Summary of Findings for Building Block 3 . 171
Building Block 4: Relationships With Other Children . 171
Summary of Findings for Building Block 4 . 188
Summary of Findings for Building Blocks 1-4 . 190
Hypothesis 7 . 191
Building Block 7: Relationships With Parents . 191
Summary of Findings for Building Block 7 . 204
Hypothesis 8 . 205
Building Block 8: Well-Being of Practitioners . 205
Summary of Findings for Building Block 8 . 219

CHAPTER 6
Discussion . 221
Handle With Care Program and Evaluation Study in the Context of Research 221
Mental Health Promotion Knowledge-Quantitative Data . 225
Regional Differences . 226
Conceptual Ambiguities . 230
Mental Health Promotion Practices-Qualitative Data. . 233
Comparison Between Quantitative and Qualitative Data Findings . 238
Study Implications . 240
Study Limitations . 243
Sample . 243
Study Methodology . 246
Data Collection Measures and Analysis . 247
Future Research Directions . 249
Further Analyses of Handle With Care Evaluation Data . 250
Research Concerning Mental Health Promotion Activities with Children 251
Conclusion . 252

REFERENCES . 254

APPENDICES . 276


**LIST OF TABLES**

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1.</td>
<td>Research Data Collection Schedule</td>
</tr>
<tr>
<td>Table 2.</td>
<td>Demographic Characteristics of Project Participants</td>
</tr>
<tr>
<td>Table 3.</td>
<td>Descriptive Analyses of Questionnaire Scores and Independent Variables</td>
</tr>
<tr>
<td>Table 4.</td>
<td>Pearson Correlations of Independent (Training &amp; Comparison Groups) and Dependent Variables</td>
</tr>
<tr>
<td>Table 5.</td>
<td>Pearson Correlations of Independent (Sector Groups) and Dependent Variables</td>
</tr>
<tr>
<td>Table 6.</td>
<td>ANOVA Results Between Groups Across Sectors on Child Care Questionnaire Totals</td>
</tr>
<tr>
<td>Table 7.</td>
<td>Building Block 1: Question A—How do you think children’s relationships with you affect their development?</td>
</tr>
<tr>
<td>Table 8.</td>
<td>Building Block 1: Question B—In what ways do you help children develop a trusting and secure relationship with you?</td>
</tr>
<tr>
<td>Table 9.</td>
<td>Building Block 1: Question C—What kind of things impact your ability to make children feel safe and secure?</td>
</tr>
<tr>
<td>Table 10.</td>
<td>Building Block 1: Question D—Is there anything in your professional and/or personal life that influences your relationships with children?</td>
</tr>
<tr>
<td>Table 11.</td>
<td>Building Block 2: Question A—In what ways do you help children recognize that they are unique individuals and to feel comfortable being themselves?</td>
</tr>
<tr>
<td>Table 12.</td>
<td>Building Block 2: Question B—In what ways do you help children feel competent and effective in the things they do?</td>
</tr>
<tr>
<td>Table 13.</td>
<td>Building Block 2: Question C—What kinds of things do you do to promote good or positive self-esteem in children?</td>
</tr>
<tr>
<td>Table 14.</td>
<td>Building Block 2: Question D—How do you know children have good self-esteem? What kinds of thoughts, feelings and behaviours (in children) do you associate with it?</td>
</tr>
<tr>
<td>Table 15.</td>
<td>Building Block 3: Question A—What do you feel are some signs that children may not be coping effectively with their emotions?</td>
</tr>
</tbody>
</table>
Table 16. Building Block 3: Question B–In what ways do you help children express position emotions (e.g., excitement, pride, etc.) in an acceptable/appropriate way?

Table 17. Building Block 3: Question C–In what ways do you help children express negative emotions (e.g., anger, sadness, aggression, etc.) in an acceptable/appropriate way?

Table 18. Building Block 3: Question D–How do you think children’s ability to share their feelings changes as they get older (e.g., from infancy to preschool age)?

Table 19. Building Block 4: Question A–What kinds of social skills do you actively promote in children and how?

Table 20. Building Block 4: Question B–How do you support children who have negative experiences (e.g., being teased, conflict) with peers?

Table 21. Building Block 4: Question C–In what ways do you help shy children participate in activities and interactions with others?

Table 22. Building Block 4: Question D–How do you think children’s peer relationships change as they get older (e.g., from infancy to preschool age)?

Table 23. Building Block 7: Question A–How do you think your relationships with parents influence your relationships with their children?

Table 24. Building Block 7: Question B–What kinds of things do you consider when trying to interact with parents?

Table 25. Building Block 7: Question C–How do you handle collaborating with parents in situations in which there may be a poor fit between a family and the centre or when your beliefs are different from a parent’s?

Table 26. Building Block 8: Question A–Do you feel that your own well-being affects the children that you work with in any ways?

Table 27. Building Block 8: Question B–In what ways do you contribute to your own well-being in the centre?

Table 28. Building Block 8: Question C–Do you ever have conflicts with your colleagues or differences of opinion? How do you handle those kinds of situations?
LIST OF APPENDICES

Appendix A. Training Participant Project Information Sheet
Appendix B. Training Participant Informed Consent Form
Appendix C. Comparison Participant Project Information Sheet
Appendix D. Comparison Participant Informed Consent Form
Appendix E. Background Questionnaire
Appendix F. Child Care Interview
Appendix G. Child Care Questionnaire
Appendix H. Codebook for Building Block 1 Questions
LIST OF FIGURES

Figure 1. Funding for mental health efforts relative to proportion of children’s problems.

Figure 2. Handle With Care Logic Model.
CHAPTER 1

INTRODUCTION

There is now widespread awareness and evidence from the areas of neuroscience, developmental psychology, epidemiology, population health, molecular biology and economics that experiences in the early years of life set the stage for development, lifelong health, learning and mental health (McCain, Mustard, & McCuaig, 2011). In particular, the majority of the brain’s neural pathways supporting cognition, communication, social development and emotional well-being grow rapidly from birth to age three (Nelson, 1999). Multiple determinants, including positive stimulation and nurturance, influence the formation of these pathways. Consequently, the period from infancy to early childhood can be considered a critical window of opportunity for enriching environmental input and simultaneously reducing stressors that render children susceptible to mental health problems (The Health of Canada’s Children, Third Edition of the CICH Profile, 2000). Moreover, it is recognized that once behavioural, psychological and health difficulties develop, the prognosis for eliminating their impact on children’s well-being through intervention is far poorer than strategies designed to proactively foster mental health or prevent disorders (Knudsen, Heckman, Cameron, & Shonkoff, 2006).

For these reasons, activities to promote mental health in young children are gaining ground as a paradigm to strengthen lifelong well-being and to help reduce the individual, social and economic burden of mental health problems and illnesses. Recently, The Mental Health Commission of Canada called for mental health promotion approaches to be targeted towards different populations including children, across multiple settings, and fully integrated throughout the mental health system, as well as in broader public health activities and social policy initiatives (Toward Recovery and Well-Being: A Framework for A Mental Health Strategy for Canada, 2009). Drawing on the best available evidence and national input, the Commission’s
strategy document, Changing Directions, Changing Lives (2012) strategy recommends key areas for action include promoting mental health across the lifespan with “efforts in everyday settings where the potential impact is greatest” and mobilizing leadership, improving knowledge and fostering collaboration at all levels.

Centre-based child care has been proposed as one of the optimal sites for mental health promotion activities directed to children (Cohen, Kiefer, & Pape, 2004). The proportion of children spending time in child care outside the home has steadily risen. In terms of care arrangements, the largest increase has been seen in centre usage (Bushnik, 2006). Much research exists to show that children’s development across domains benefits from quality child care (NICHD ECCRN, 2000c, 2001a, 2003c). Many aspects related to quality can be regulated, including the policies structuring centre environments and the training requirements of child care practitioners. As well, child care centres are well-positioned within communities and social service networks to engage families, public health, education and mental health professionals in their attempts to secure children’s well-being.

The present study describes the implementation of a mental health promotion training initiative for child care centre practitioners. Very few initiatives of this nature exist in Canada and beyond; consequently, research is limited concerning the outcomes of such programs. This exploratory study examines the effects of Handle With Care, a training program designed to equip front-line centre child care practitioners with the developmental knowledge and strategies for promoting the mental health of children from the ages of birth to 6 years. In particular, Handle With Care helps practitioners understand how developmental, family and community factors play out in children’s lives and facilitates practitioners developing a mindset for ensuring that mental health promotion is incorporated into all aspects of their centre work. The training program consists of 9 Building Blocks, or workshop units that focus on specific mental health
promotion topics. While the ultimate goal of *Handle With Care* is to enhance children’s long-term mental health, it is first essential to determine whether the training impacts practitioners’ knowledge and practices.

More specifically, this study investigates whether child care practitioners who complete *Handle With Care* training demonstrate changes both in what they *know* about mental health promotion and what they *do* to promote children’s well-being within their work. Child care practitioners play a vital role in development of children’s mental health, yet are typically under-trained in this matter (Farrell & Travers, 2005). Within Canada, there is no uniform approach to child care systems. Provinces and territories independently exert control over funding, regulations and curriculum; importantly, each region also mandates child care practitioners’ educational requirements (Flanagan, Beach, Michal, & Cormier, 2009). Consequently, there is inconsistency with respect to the minimal training needed to work in child care centres across the country. However, research consistently underscores the link between the preparation and education of practitioners and their consequent skill and expertise (Gable & Cole, 2000).

Additionally, there are increasingly higher expectations for knowledge and skills for child care practitioners as they are required to deal with changing family dynamics, cultural sensitivities and child welfare authorities (Beach & Flanagan, 2007). At a time when post-secondary program accreditation has been recommended for the early childhood sector, it has been recognized that having staff with at least one post-secondary credential in early childhood education (ECE) is a key indicator of high quality (Beach & Flanagan, 2007). A survey of key informants in the *Partners in Quality Project* (Kaiser & Rasminsky, 1999a) indicated that a two year program was a minimum academic standard for practitioners. At the same time, most informants viewed community college curricula as inadequate. They perceived a need for more complete articulation of theoretical foundations that address the “why” and “what” of practices, a
better blend of theoretical and practice based knowledge and better mechanisms to incorporate new research and emerging issues into the knowledge base (Kuhn, 1999). More recently, faculty from post-secondary early childhood education and care programs and child care employers expressed concern over disconnect between what the colleges are teaching and what is being practiced in the sector (Beach & Flanagan, 2007).

Ontario currently maintains some of the highest standards for child care practitioner education requirements. At least one staff person for each group of children must hold an Early Childhood Care and Education diploma from a recognized institution or an academic qualification that a centre operator considers to be equivalent (Day Nurseries Act, 1990). However, the content of such training tends to concentrate on building children’s cognitive and language abilities, with a view to promote a narrow definition of school readiness (e.g., academic skills and abilities such as following directions, working independently, early literacy and reasoning skills). Although some provinces and territories explicitly mandate the particular areas (e.g., child growth and development, behavior guidance, program development, health and safety, interpersonal skills/family/community) and minimum hours of study needed within early childhood education requirements, Ontario does not. Rather, Ontario’s standards address learning outcomes and individual post-secondary institutions develop their own courses and timetables to meet the outcomes (Flanagan, Beach, Michal, & Cormier, 2009). As well, the prevalence of research on the impact of quality early care and education on children’s development deals with this view of school readiness (Kamerman, 2008). Less emphasis is placed on children’s social and emotional development, especially within a mental health promotion framework. The Handle With Care program serves to augment child care practitioners’ awareness and understanding in these areas and is delivered as professional development training.
This research is innovative in two important ways. *Handle With Care* represents a unique approach to mental health promotion training, employing a mixture of didactic, experiential and reflective techniques to emphasize how social-emotional development, family and community connections and practitioner well-being contribute to promoting children’s mental health. Currently, there is no other program for child care practitioners in Canada that parallels the comprehensiveness of the *Handle With Care* content. Furthermore, there is an overall dearth of empirical evidence concerning early childhood mental health promotion program outcomes. A review of the research literature finds one sole investigation similar to this evaluation, namely, mental health promotion training geared towards caregivers in early childhood settings (Farrell & Travers, 2005). Studies outside this specific population generally evaluate mental promotion programs directed to children within regular school systems (with older children and adolescents) and/or limited to restricted aspects of mental health (e.g., emotion expression). There remains a gap in our understanding of how mental health promotion efforts work for children in the 0-6 year age range; the stage of development identified as most critical for cultivating positive mental health. Additionally, there is a need for more information about the usefulness of training those in positions to broadly foster mental health promotion in younger children and especially child care practitioners. The latter is the focus here.

For this study, the *Handle With Care* training program was evaluated within three different geographical regions in Ontario. The program was delivered to front-line child care practitioners working in community-based child care centre settings with children under six years of age. A time series repeated measures design consisting of mixed methods approach was used to investigate the outcome of the training. Specifically, child care practitioners’ knowledge and practices concerning mental health promotion were measured prior to training, immediately after the conclusion of the *Handle With Care* program and 6 months following the end of the
program. A comparison group consisting of child care practitioners not exposed to the *Handle With Care* training program was also employed to contrast results.

**Theoretical and Practical Relevance**

This research has both theoretical and practical implications for mental health promotion training and practice of child care practitioners. This is important as child care services play a significant role in the lives of many families with young children. Farrell and Travers (2005) stress that children attending child care “are a captive group whose mental and social development is affected by the environment, and the interaction and nurturing they receive whilst in care”. Outside of parents and extended family members, child care practitioners enact crucial caregiving functions and may share up to 12,500 hours of early experiences with a child before he or she starts school (Farrell & Travers, 2005).

Historically, it has long been recognized that the relationship between a mother and child is essential not only for survival, but also for the psychological growth of the child (Eberhart-Wright, 2002). Due to major societal changes, more children have multiple caregivers, including child care practitioners, and form attachment relationships with these caregivers that strongly influence their social and emotional development. Within this relational context, child practitioners play a role in helping children develop a sense of security, positive self-esteem, resiliency and coping skills, appropriate emotion expression and regulation, healthy peer relationships and cultural sensitivity. Furthermore, the child care environment in which these practitioner-child relationships transpire includes special features that also exert influence on practitioners’ ability to enhance children’s social and emotional development. These include creating collaborations with parents, supporting children through changes and losses unique to child care and maintaining their own well-being within the workplace. It is necessary then to examine whether mental health promotion training increases child care practitioners’ knowledge
related to these factors as well as their application to working directly with children. In this manner, this research adds to understanding of what Baum (1998) calls a systems based approach to the promotion of mental health and wellbeing. This study can help identify whether mental health promotion training of child care practitioners is a necessary first step in enhancing children’s well-being.

Additionally, given the exploratory nature of this study, findings can help pinpoint the strengths and weaknesses of the *Handle With Care* program. In particular, these findings will highlight the overall efficacy of the program in increasing knowledge and perceived practice with practitioners as compared to practitioners who are not exposed to the training. Furthermore, by delivering the program in three different geographical areas, the research will begin to explore the usefulness of the program in different contexts. The study is also structured to investigate the effectiveness of each *Save the Children* training topic or workshop unit independently. Consequently, results will indicate which topics related to mental health promotion *Handle With Care* addresses most and least effectively, as evidenced by change in practitioner knowledge and practices. This will provide important information about continuing education for child care providers and identify further training needs and areas of *Handle With Care* training that might benefit from revision.

More broadly, this study will add to the literature and discussion concerning the value of mental health promotion efforts during early childhood. The *Handle With Care* program represents one kind of endeavour that has the potential to improve the immediate mental health of children as well as contribute to their development into healthier, emotionally resilient adults (Licence, 2004). Currently, there are gaps in the evidence base for mental health promotion in children. The Pan-Canadian Planning Committee for the National Think Tank on Mental Health Promotion (2009) emphasized that there is a need to create an enhanced mental health promotion
and mental illness prevention knowledge base by supporting new areas of research. In particular, the Committee called for work across different sectors in order to increase accessibility and recognize people’s varying needs for support at different times. As well, the Committee suggested mapping existing programs that support mental health so that strengths and gaps may be identified and can guide future action. Investigating the impact of training for child care practitioners is an example of this. The results have potential implications for where Canada must invest its attention, effort and money so that the mental health of all children may flourish.
CHAPTER 2
LITERATURE REVIEW

To provide a clear theoretical rationale and background for the current study, this chapter reviews relevant existing literature. First, the importance of the first six years of a child’s life will be considered from a developmental perspective. Then, research concerning how children’s psychological growth is rooted in early experiences that shape neural connections formed in the brain will be summarized. This information is then elaborated to explain how children’s functioning across domains such as cognitive, academic, social and emotional is interrelated and strongly determined across the lifespan by children’s early development. Emphasis is given to how early development impacts mental health. Then the discussion will turn to defining mental health promotion and distinguishing it from other mental health activities. Related arguments surrounding the human capital and economic implications of mental health promotion are also summarized.

The chapter continues with a look at the current state of child care in Canada, followed by literature supporting the perspective that child care centres are appropriate sites for mental health promotion efforts. This includes review of the capacity of centres to reach large numbers of children at critical ages, as well as research about quality child care that positively impacts children’s development. Examples of relevant research describing the effectiveness of existing mental health consultation and mental health promotion programs are then reviewed.

The chapter concludes with a description of the current outcome study, describing the origins and content of the Handle With Care training program. The evidence base for the unique aspects of the Handle With Care program that support children’s mental health promotion is reviewed. Specifically, how enhancing children’s social and emotional development, building relationships with parents and families in a multicultural context and supporting the well-being
of child care practitioners forms the framework for mental health promotion in child care centres will be considered. Gaps in previous research are highlighted. How the Handle With Care training program and current exploratory evaluation study are innovative and differ from past studies will be described. The purpose of the present project is then summarized, with research hypotheses and specific questions provided.

Child Development

Developmental psychology first concerned itself with theories of stage-like development within the child from early childhood through adolescence (Lerner, 2002). The emphasis tended to fall on cognitive growth and developmental milestones, with a theory typically identifying that development proceeded according to either innate mental structures or learning through experience. Prominent examples include Piaget’s Stage Theory, Vygotsky’s Social Constructivism, Ecological Systems Theory, Social Learning Theory and the information processing framework. With the introduction of research concerning topics such as attachment and temperament, developmental science started to consider the social and emotional features of a child’s growth. It was also recognized that key developmental processes in these areas occur when children are very young and within a direct relational context. Advancements in neurobiological research have provided additional evidence of how the social environment of early life gets “under the skin” in the early years of life to shape learning, behaviour and health across the lifespan (McCain, Mustard, & McCuaig, 2011). Moreover, epigenetic research underscores that a child distinctly contributes to his or her interactions with different social partners, thereby influencing how their development unfolds. Such theories underscore the transactional or interactional nature of child development; a child and his or her important caregivers shape each other’s social and emotional experience in a dynamic, ongoing fashion (Rosenblum, Dayton, & Muzik, 2009).
Growth promoting relationships are based on the child’s continuous give-and-take (serve and return interaction) with a human partner who provides what nothing else in the world can offer—experiences that are individualized to the child’s unique personality style; that build on his or her own interests, capabilities and initiative; that shape the child’s self-awareness, and that stimulate the growth of his or her heart and mind. (National Scientific Council of the Developing Child, 2004).

Adult-child relationships influence development throughout the lifespan. Although there is no scientific evidence to suggest that these relationships are more important at specific stages of a child’s life, it is clear that the impact of such relationships does vary by age and developmental status (Reis, Collins, & Berscheid, 2000). In particular, relationships during the first years of life critically mold how a child grows physically and psychologically.

*Early Brain Development*

In the *Early Years Study* (1999), McCain and Mustard described how epigenetic research, based in molecular biology, shows that genes are not solely responsible for producing an individual’s various traits. Instead, genes function within a “fully co-actional developmental system” involving many environmental factors. Most importantly, McCain and Mustard’s research review articulated that a child’s diverse early experiences affect brain architecture, largely determining gene expression and the biochemistry and physiology of the human body. The consequences of this development mediate a child’s cognitive, emotional and social behaviours.

Research concerning early brain development focuses on how neural pathways are shaped by experience. In normative development, the construction of the brain follows a similar progression for all humans. During the first two trimesters of fetal life, the assembly of the basic architecture occurs. The last trimester and initial few postnatal years are allotted for changes in
connectivity and function (Sheridan & Nelson, 2009). In these early years of development, the brain massively overproduces neural pathways (Shonkoff & Phillips, 2000; Gage 2003). In essence, this represents the brain’s potential to be responsive and adaptive to whatever kinds of stimulation are encountered in the environment. Two integral mechanisms, synaptogenesis and synaptic pruning, shape brain development after birth. Synaptogenesis, or the connecting of neurons, occurs when neurons link together to create neural circuits in which communication is shared in order for the neurons to perform distinct tasks in the brain and body (Itoh, Stevens, Schachner, & Fields, 1995; LeDoux, 2002a; Fields, 2005). Few neural connections are present at birth. Synaptogenesis flourishes during a child’s first years; by six years of age, the number of brain neurons is consistent with that at birth, but there are abundant neural connections (McCain, Mustard, & McCuaig, 2011).

By fourteen years of age the density of neural connections has decreased. This results from synaptic pruning, the process by which connections are consolidated and refined. The lasting power of neural connections is contingent on use. Strong connections are based on repeated stimulation; when connections are under-used, they are lost (Hebb, 1949). Communication in enduring pathways is further made efficient through myelination (Shonkoff & Phillips, 2000), when supportive tissue forms around neuron circuitry, shielding signal transmissions.

**Pivotal Role of Emotions**

How experiences determine which pathways are maintained and strengthened and which are eliminated relates to brain plasticity. Plasticity denotes the brain’s ability to change with learning; all learning is dependent on memory (McCain et al., 2011). Early in life, the quality of stimulation from the environment greatly impacts an infant’s learning about how to respond to stimuli and demands and what is remembered.
Importantly, four neural pathways are shaped by this environmental learning; they form in a hierarchical manner and are established through emotional experiences. Sensory pathways involving vision, hearing, touch and other modalities develop until around 4 years of age. These pathways facilitate most of the brain’s ability to interpret signals that control intellectual, emotional, psychological and physical responses to stimuli (LaDoux, 2002a; Knudsen, 2004; Fields, 2005). Coping pathways simultaneously develop and use sensory stimuli to activate brain and body regions that allow infants to respond to the environment in a way that is adaptive. Adaptive responses are what we consider emotions for an infant; they affect senses, heart rate, breathing and hormones, the rudimentary coping capacities. Repeated instances of coping with stimuli in particular ways strengthen these neural connections. Although initially infants are dependent on their caregiver(s) to help regulate their physiological/emotional arousal, these interactions enable infants to gradually learn how to self-regulate. Sensory and coping pathways provide the foundation for later language and cognitive (third and fourth) pathways, with the latter continuing to develop into adolescence (McEwan, 2002). Therefore, the abilities most associated with intellect and academic achievements are contingent on early emotional learning. Development is optimized within a positive relational environment.

Human brains are specialized for receiving and understanding stimulation from other people (Adolps, 2003). Interactions with adults, especially primary caregivers, are crucial for providing the early stimulation that drives formation of sensory and coping neural pathways (Halfon, 2004). In infancy, adult-child exchanges consist of a range of sensory exchanges (e.g., facial expressions, gaze, body movements, vocalizations) through which infants learn and remember response patterns that underlie their emotional and intellectual functioning (Greenspan & Shanker, 2004). This also influences their capacity to attend to and interact with others (McCain, Mustard, & McCuaig, 2011). When adult-child exchanges are positive and pleasurable,
an infant is only required to cope with minor stresses. The infant develops capacities to manage these stresses. Less than optimal exchanges, marked by misattunement, fear, neglect or trauma create a stressful environment for the child. Prolonged exposures to stressful exchanges compromise the young child’s coping capacities and hinder the formation of relevant neural circuits and pathways (McCain, Mustard, & McCuaig, 2011).

Greenspan and Shanker (2004) further elaborate on how positive, nurturing adult-child exchanges impact the developing neural pathways that underlie the acquisition of a young child’s core competencies. For instance, verbal and nonverbal chains of communication between adult and child promote the child’s ability to engage in purposeful behaviours (e.g., leading a parent to something she wants in the kitchen). Attending to and learning caregivers’ meaningful use of sounds and gestures facilitates the child employing them in problem solving interactions and in representing experiences in symbolic forms (e.g., words, drawings). Furthermore, a child’s capacity to make connections and better understand thoughts, facts and feelings is fostered when caregivers question, challenge, discuss, offer choices and actively engage in play. All these developments rest on the quality of adult-child interactions and the earlier emotion-driven sensory and coping neural pathways.

**Developmental Trajectories and Outcomes**

Knowledge gleaned from increased understanding regarding early brain development has also strengthened the sense of how developmental trajectories are formed. Researchers propose that experiences during early childhood establish brain circuitry, which causes neural pathways to become highly stable and therefore difficult to change (Knudsen, 2004). Relational interactions during the early years consist of the crucial interplay between child and caregiver characteristics that shape these experiences. In the caregiver-child dyad, both partners influence
one another’s social and emotional experience in a dynamic, ongoing fashion (Rosenblum et al., 2009). It is not merely the caregiver affecting the infant’s emotional response; the infant is capable of eliciting certain caregiver behaviours which, in turn, serve to induce the caregiver’s own emotional reactions in particular ways. The quality of exchanges between caregivers and infants powerfully mediates whether an infant’s social and emotional development steers in a direction that builds resilience or one in which the infant will form maladaptive coping mechanisms to deal with stress as they move through child- and adulthood. Thus, within the earliest caregiver-child interactions the child’s sense of the world is established. Whether a child meets a world of love and acceptance or one in which indifference or hostility necessitates rooting and pulling and anxious hypervigilance to have needs met, these earliest relationships form the template for subsequent interactions.

Arriving with a limited capacity for self-regulation, emotion expression in a newborn reflects biologically based signals, evolutionarily designed to engage another to provide care and protection (Rosenblum et al., 2009). Reciprocal sensory stimulation is shared with modalities such as touch, smell, vocalizations and gaze (Greenspan & Shanker, 2004). The infant cues the caregiver, whose contingent responses stimulate positive effects in the infant and are communicated back to the caregiver through the infant’s signals (e.g., facial expressions, body movements, vocalizations, etc.). As a result, both members of the dyad enter into a ‘symbiotic state of heightened arousal’ (McCain, Mustard, & McCuaig, 2011).

The emotional tone of this shared arousal creates the framework within which the infant develops his or her own affective repertoire and very quickly the infant’s experiences grow markedly more complex (Rosenblum et al., 2009). Continuous back-and-forth communication between infant and caregiver allows the infant to find caregiver expressions and responses that are pleasurable and meaningful. Subsequently, the infant will seek these out (e.g., smiling to
evoke the caregiver’s smile). Yet, caregiver-infant interactions can’t always match; infant affective overtures draw out slightly different caregiver responses across various scenarios, allowing the infant to sample subtle differences in the environment. This ongoing process furthers learning that helps the infant’s awareness of differentiation between himself and his caregiver as well as affective discrimination, pattern recognition and increasingly complex and subtle response patterns (Greenspan & Shanker, 2004). Recent research confirms that the neural systems that a child uses to process facial emotion expressions are primarily impacted by the nature of early interactions with the first, primary caregiver (de Haan, Belsky, Reid, Volein, & Johnson, 2004).

Early social interactive experiences are internalized and the young child uses these day-to-day lived experiences to guide responses to current interactions with others. Young children developing in the context of optimally attuned caregiving proceed along a trajectory of greater competence, which is accompanied by increasing feelings of self-efficacy, trust and security (Rosenblum et al., 2009). In contrast, caregivers with mental health (e.g., depression) or substance abuse problems, or have experienced family violence, physical, sexual or verbal abuse negatively influence early caregiver-infant interactions and neurological pathways are altered in order to prepare a child to survive and reproduce in dangerous and/chaotic environments (Teicher, 2002, 2003). Stress can indelibly alter a child’s brain structure, leading learned patterns of emotional signaling and responding within a negative early environment to become the template for how a child deals with future social partners. Dyadic interactions marked by negative emotionality and/or hostility can facilitate problematic moods and behaviours, such as anxiety, depression, aggression, impulsiveness and hyperactivity that are likely to impede positive interactions with others beyond primary caregiver relationships (Teicher, 2002, 2003).
Ineffective, mismatched interactions caused by stressors can foster feelings of low control, negative expectations, self-blame and hopelessness (Denham, 1998).

Negative affect associated with early interaction patterns are often the focus of mental health intervention. However, research suggests that the absence of positive affect may be an even more important portent of problems in the emotional domain (Rosenblum, Dayton, & McDonough, 2006). Consequently, it is crucial to recognize that all of caregivers’ interactions with children are influential in establishing the trajectory for social and emotional development. Early relationships and experiences set the stage for how a child develops social and emotional skills, including managing emotions, coping with difficulties and building and maintaining friendships (Miars, 1995). Learning social and emotional skills mirrors that of learning academic skills in that the effects of initial learning are enhanced over time to help children manage progressively complicated situations (Greenberg, Weissberg, Utne O’Brien, Zins, Fredericks, Resnik, & Elias, 2003). For example, internalizing problems affect up to 20% of children and adolescents and symptoms show substantial continuity from early to mid-childhood (Bayer, Hastings, Sanson, Ukoumunne, & Rubin, 2010). Parent-toddler interactions observed to be mutually responsive predicted fewer internalizing problems in children at five years of age (Calkins, 2007). In contrast, higher levels of maternal depression and negative control when children were toddlers predicted high and increasing levels of anxiety in children tracked from two to ten years (Feng, Daniel, & Silk, 2008).

Mental Health Considerations

There can be adverse consequences in adulthood when children’s emotional and behavioural problems are not adequately addressed by mental health, education and social work services (Fergusson, Horwood, & Ridder, 2005; Scott et al., 2001). Longitudinal studies document the potential long-term impact of childhood mental health problems (Heijmens Visser,
van der Ende, Koot, & Verhulst, 2000). It is especially important to recognize that mental health difficulties in childhood are associated with other aspects of development in cognitive, academic, social and emotional domains. While these functions are often studied separately, they are significantly intertwined with one another (Rosenblum, Dayton, & Musik, 2009). Thus, mental health difficulties exert a powerful stretch across the lifespan and usurp many areas of functioning.

Children struggling with emotional and behavioural problems are more prone to mental health problems in later life and are at higher risk of school exclusion, offending, antisocial behaviour, drug misuse, alcoholism and marital breakdown (Wells, Barlow, & Stewart-Brown, 2001). For example, depression may disrupt several realms in a child’s life resulting in diminished academic performance (Kovacs & Goldston, 1991), poor peer relationships (Connolly et al., 1992), disturbed family relationships (Hamilton, Asarnow, & Tompson, 1997), conduct problems and socialized delinquency (Norvell & Towle, 1986) and suicide (Phillips et al., 2002).

Approximately one in ten children are affected by mental health problems at any time (Ford, Goodman, & Meltzer, 2003) and such problems emerge across both high-income and low and middle-income countries (Cortina, Kahn, Fazel, Hlungwani, Tollman, Bhana, Prothrow-Stith, & Stein, 2008). There is a broad continuum of mental health problems that varies with developmental changes through infancy, childhood and adolescence. The most common disorders in childhood and adolescence include conduct disorder, attention deficit hyperactivity disorder, depression and anxiety disorders (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Many of these are normally distributed within the population, and, as such, cut-off points distinguishing ‘disorder’ and ‘no disorder’ can be considered somewhat arbitrary. Growing evidence suggests that the risk for dysfunction is not confined to those at the higher end of the
psychopathology dimension, particularly in the case of challenging behaviour (Fergusson et al., 2005; Goodman & Goodman, 2009).

Additionally, children displaying social and emotional difficulties may not access mental health interventions according to need, based on a review of trends of characteristics of children served by a federally funded children’s mental health initiative (1994-2007) in the United States. For example, it appears that generally girls reach a higher maximum threshold of problem behaviour before entering (or being referred into) mental health services. In contrast, children of colour are entering services (or being referred) with lower overall problem levels (Walrath, Godoy, Garraza, Stephens, Azur, Miech, & Leaf, 2009).

All in all, the research literature highlights that early mental health difficulties can powerfully impact children’s functioning in various ways over time. Although interventions can target such difficulties, it is far from certain that all children who need these services actually obtain and benefit from them. As well, once trajectories imbued with mental health risk factors and symptoms are set in motion, it is challenging to alter their course. It has been proposed that activities that promote mental health from early on have the potential to improve both the immediate mental health of children and to shape their development into healthy, emotionally resilient adults (Licence, 2004).

**Mental Health Promotion**

The social, emotional and mental health of infants, children and adolescents is essential for effective learning and for sustaining healthy and productive societies. Threats to the mental health of children are recognized worldwide in the form of exposure to violence, malnutrition, poverty, school failure, disrupted families, lack of opportunities for self-sufficiency and mental illness (World Federation for Mental Health, 2007). Beginning early in life, a broad range of
programs from mental health promotion to early intervention, treatment and care can provide resiliency and protection. Mental health promotion efforts most especially target children broadly and use proactive strategies.

Promotion Distinguished from Prevention and Intervention

Mental health promotion encompasses activities that are distinguished from prevention and early intervention. Prevention is geared towards individuals presenting with mental health risk factors. Early intervention targets those already displaying social and emotional difficulties (Pollett, 2007). Mental health promotion efforts are designed to be delivered to the population as a whole as well as to specific populations and settings. Mental health promotion refers to the actions taken to strengthen mental health. The Canadian Mental Health Association asserts that mental health promotion activities seek to enhance mental health and take into account broad psychosocial factors, rather than focusing on preventing or ameliorating clinical phenomena (Willinsky & Pape, 2002). It is important to point out that many of the strategies and outcomes of mental health promotion, prevention and early intervention overlap, despite their different goals. For example, even when a child is at risk of or already displaying some social-emotional problems, promoting mental health can help the problems from becoming more extensive or severe (Magyary, 2002).

One can conceptualize these three categories of mental health activities in the form of a pyramid (Figure 1). At the base are mental health promotion efforts, which are relevant for the entire population. The intermediate part of the pyramid is comprised of prevention activities delivered to those considered to be “at risk” for developing mental health problems. The top of the pyramid consists of specialized interventions and services for children and families with identified mental health difficulties or disorders; these are estimated to occur in one of five children (Public Health Agency of Canada, 2009). Mental health promotion is the critical
foundation for all children and families and relevant for all components of the pyramid. When promotion efforts are inadequate (Pyramid 1), the protective base for enhancing children’s well-being is reduced, resulting in a greater number of children who require mental health interventions. Alternatively, and optimally, effective mental health promotion practices are in place (Pyramid 2) to help ensure that children’s mental health is fostered and the requirement for intervention is narrowed. In fact, it is now recognized that over 50% of all adult mental disorders begin before the age of 14 and many can be prevented through mental health promotion and prevention activities (World Federation for Mental Health, 2007).

*Figure 1. Funding for mental health efforts relative to proportion of children’s problems.*

*Pyramid 1: Non-Effective Promotion Efforts  Pyramid 2: Effective Promotion Efforts*

*Mental Health as More Than the Absence of Mental Illness*

Mental health is not the same thing as the absence of mental illness. Mental health can be thought of as the result of individual resources and experiences, social support, various predisposing factors (e.g. early childhood experiences) and precipitating factors (e.g., stressful life events) (Willinsky, 2003). A core feature of mental health is related to the concept of resilience. Resilience refers to the ability to cope adaptively within adversity or risk. Given what is known about the sequence of brain development in young children, it has become a popular construct in developmental science (Tusaie & Dyer, 2004).
In order to achieve resilience across the lifespan, it is necessary to promote the development of strengths and assets within all children. Childhood is considered a vital time for mental health promotion because it represents the stage of greatest competency acquisition, particularly with regards to language, social abilities and self-efficacy beliefs (Tusaie, 2008). When children are resilient, they can maintain or resume competent functioning even when they must deal with stressors. In fact, the Canadian Mental Health Association describes positive mental health as emotional resilience that enables individuals to enjoy life and survive pain, sadness and disappointment while holding onto an underlying belief of their own and others’ worth and dignity (Willinsky, 2003). Inherent to this perspective is the notion that certain universal protective factors are needed for children’s competence and resilience, such as connectedness at home, school and community and optimism along with a host of other skills (Scales, Benson, Leffert, & Blyth, 2000).

Corresponding to this perspective, the focus of mental health promotion initiatives is not on fixing people’s deficits, but instead on building their capacities and competencies. The American Surgeon General has defined mental health as a “state of successful performance of mental function, resulting in productive activities, fulfilling relationships and the ability to change and cope with adversity” (U.S. Department of Health and Human Services, 1999). In this sense, there is a huge difference between lack of a diagnosis and happiness, productivity and social engagement (Tusaie, 2008). The Canadian Mental Health Association further asserts that mental health is an integral component of overall health; people’s mental health is inextricably linked to relationships with others, environmental and lifestyle factors and the extent to which they can exert control over their lives (Willinsky, 2003).

Therefore, mental health services that strive only to decrease or eliminate psychiatric symptoms in children may not be the best approach to ensuring well-being. A growing body of
literature posits the need for a broad paradigmatic change in relation to children’s mental health issues. This can be attributed to the significant problems that characterize current approaches to children’s mental health as well as emerging efforts to reform, improve and integrate research, practice and policy (Weist, 2003). For example, despite a solid evidence base indicating that mental health and school functioning for children are intertwined, professionals working in these domains traditionally operate in silos, with mental health clinicians directing their efforts toward symptom reduction and educators primarily concentrating on academic functioning (Hunter et al., 2005; Report of the Surgeon General’s Conference on Children’s Mental Health, 2000).

It is essential to get the public engaged in children’s mental health and interested in improving it. A science base does exist to demonstrate that prevention and mental health efforts with children do lead to desired outcomes such as better behavioural and academic performance and decreased costs in public systems (Durlak & Wells, 1997; Greenberg & Kusche, 1997).

However, Clauss-Ehlers and Weist (2002) note that the public remains largely unaware about this, which highlights the challenge of making it accessible and interesting.

**Economic Implications**

Worldwide, there is growing recognition that fostering the mental well-being of the whole population brings social and economic benefits to society (Changing Directions, Changing Lives, 2012). Evidence is mounting to support the argument that funding for mental health promotion activities is more efficacious than for efforts concentrated on individuals who have already developed problems. While Knapp and McDaid (2009) highlight that the “primary aims of a mental health system are prevention of needs arising, alleviation of symptoms and promotion of quality of life if they do arise, support of family carers and improvement of broad life chances”, resource restrictions typically limit the scope of services to observable problems in very young children. To a large degree, such funding choices dovetail with research interests
concerning service effectiveness. It is most prudent to provide financial support for programs that promote mental health and activities that are empirically validated. To this end, services intended to deal with clinical problems in children are most easily studied because there are diagnostic criteria that specify symptoms and kinds of impairment children display and whether these are reduced or eliminated.

Investigating effectiveness of mental health services in this way mirrors the approach taken with treatments for health conditions. What tends to be overlooked is that an accurate assessment of mental health is not so simple and straightforward. For instance, the outcomes of mental health services impact many aspects of functioning. In thinking about adults, Knapp and McDavid (2009) contend that various mental health problems can strongly correlate with difficulties in employment, income, housing, relationships, co-morbid health problems, self-harm, suicidal ideation, stigma and discrimination as well as complicated implications for close family and friends. This is similar to children’s overlapping mental health and learning problems. In essence, poor mental health has high economic and social costs. Consequently, these authors argue that such characteristics of mental health necessitate planning broadly and working collaboratively across a number of different areas of public and private responsibility, various budgets and degrees of involvement of individuals and families (Knapp & McDavid, 2009). In terms of financial burden, it has been conservatively estimated that the costs of poor mental health account for 3-4% of GDP in developed countries (Pelletier & Lutz, 1998). It is much more challenging to figure out the expense involved with the emotional and behavioural struggles inherent to poor mental health. The latter tend to culturally-driven and very personal. Thus, the impact is complex to measure and are deemed by economists to be “intangible” because they are often concealed (Rosenblum, Dayton, & Musik, 2009). What is clear is that if such problems
remain unaddressed, they progressively escalate and swell burdens at individual, societal and family levels (Weist, 2003).

Potentially, there are significant economic benefits to be gained by individuals who experience emotional, psychological or social well-being. Outcomes could be expressed in terms of quality of life improvements, including better participation in everyday activities and increased efficiency and egalitarian distribution of available resources and support (Rosenblum, Dayton, & Musik, 2009). According to U.S research, such people may have the lowest rate of physical activity limitations, work cutback or loss and absences due to sickness (Keyes, 2007). Another analysis from Britain suggests that lifetime costs estimated at 75,000 and 150,000 pounds might be avoided per individual as a result of both effective promotion of mental well-being and effective prevention of mental health problems, respectively (Friedli & Parsonage, 2007). With the advance of mental health promotion efforts, information will be needed on how various options (compared to lack of promotion efforts) impact improved personal functioning, prevention of mental illness symptoms, better quality of life or positive mental well-being.

Investing in promoting children’s mental health is economically sound. Prentice (2009) emphasizes that returns on investments in the early child development period exceed investment in any other stage of human development. Implementing mental health promotion activities into child care is one possible option for fostering children’s mental health in a cost effective manner. A great deal of research has shown that quality early childhood care and educational programs have remarkable potential to enhance a range of social outcomes: reduced grade retention, higher reading and mathematics scores, increased IQ test scores, higher levels of social competence, higher graduation rates, lower teen pregnancy rates, less smoking and drug use, higher employment and income levels and lower crime rates (Brownell, Roos, & Fransoo, 2006). From a financial standpoint, W. Steven Barnett, an education researcher and director of the National
Institute for Early Education Research, documents at least thirty-eight American research studies forecasting positive economic results from early education programs that explored child outcomes at the third-grade level and beyond (Barnett & Ackerman, 2006). Additionally, child care services both represent an economic industry in their own right and enable the rest of the economy to flourish (Prentice & McCracken, 2004). Exploring the projected returns to mothers and children if universal child care services were implemented, Cleveland and Krashinsky (1998b) discovered that the benefits have the capacity to outweigh costs by a factor of 2:1.

Mental health of the next generation is described as “everybody’s business” (World Health Organization (WHO), 2004). Increasingly, leaders from financial and political domains have placed a spotlight on the need for investment in early childhood programming that includes consideration of children’s mental health. Charlie Coffey, the Royal Bank of Canada’s former vice president and a prominent corporate champion for expanded child care services, has argued that “creating innovative strategies for early learning and child care contributes to Canada’s path to prosperity (Coffey & Hargrove, 2003). Meanwhile, the former governor of the Bank of Canada, David Dodge emphasized that “more should be done to convince politicians of the value of investment in early childhood development” (Dodge, 2003). Paul Martin, then Prime Minister, announced in his 2004 Reply to the Speech from the Throne that “a strong, Canada-wide program of early learning and care for our children is the single best investment we can make in their future and in ours” (Martin, 2004). A wealth of economic and population health studies accentuate the consistent message that investing in children makes clear economic sense, considering both immediate and longer-term perspectives (Lynch, 2004; Grunewald & Rolnick, 2006).
Broadening the domain of beneficiaries beyond children and their parents extensively expands a community backing children’s mental health to include politicians, economists, bankers and business leaders (Prentice, 2009). Hay (2006) highlights that this, in turn, “legitimizes and justifies social spending on child care programs through a calculus that erases immediate costs in favour of longer-term profitability, shifting the focus to social returns”.

Beyond improved child outcomes, many countries are realizing that investments in early childhood programs can also ease the burden on public resources, enable higher labour force participation, productivity and economic growth (Joint Economic Committee, 2007).

Human Capital

Within Canada and the US, this economic reframing has led to the human capital approach emerging as one of the primary impetuses for early learning and child care (Friendly, 2006). Increasingly, it is being recognized that mentally healthy infants, children and adolescents are essential for the future well-being of our societies (Declaration of the Consortium for Global Infant, Child and Adolescent Mental Health, 2009). Heckman (2000) advocates that the best evidence directs policy to invest in the very young and enhance basic learning and socialization skills. Considering the same level of investment at different age points, the return is higher in human capital when money is spent on the young as opposed to when it is spent on the old. This is so because the young have a longer time to recoup their investment (Becker, 1964).

Reallocating human capital investment to the young would improve efficiency at current levels (Heckman, 2000).

In Europe, there also has been considerable examination and conceptualization of how to favourably shift human capital investment. Currently, Europe is undergoing significant demographic and social changes, including aging of the population, falling birth rates and rising immigration. Such changes will have far reaching consequences for all vulnerable groups and
their well-being (Mental Health Europe, 2007). Positive mental health in the Europe population is perceived as a valuable resource, “enabling citizens to realize their full intellectual and emotional potential and to find and fulfill their roles in society, in school, in working life and in retirement” (Mental Health Europe, 2007). Mental health promotion is understood here as a means to help ensure basic levels of citizenship and create new and equal opportunities for everyone. Other locations with aging populations, such as Canada, have also started to reconsider human capital investment strategies. However, the focus in these locations has been on increasing post-secondary education and training/employment opportunities for women and visible minorities (Toronto as a Global City: Scorecard on Prosperity – 2013; Fortin & Lemieux, 2005).

Heckman (2000) argues that current policies around the world concerning education and job training are based on “fundamental misconceptions about the way socially useful skills embodied in persons are produced”. Typically, the focus of education is narrowed to cognitive skills reflected in IQ scores and achievement to the exclusion of self-discipline, social skills and a variety of non-cognitive factors that contribute to life success. Policymakers, educators and families have tended to be preoccupied with cognitive intelligence and academic ‘smarts’, which has caused serious bias in the evaluation of human capital interventions because social adaptability and drive are largely ignored. Rather than just fostering basic cognitive skills, non-cognitive skills and motivation need to be cultivated in children. These abilities are crucial for succeeding in the modern economy and such skill formation is most often shaped by non-institutional environments and families (Heckman, 2000). Therefore, learning starts long before formal education (e.g., infancy, preschool years) and psychological research demonstrates that success or failure at this stage feeds into success or failure in post-school learning (Heckman, 2000). Even enriched early interventions are more important in terms of substantially raising
participants’ non-cognitive skills and social attachment; they do not appreciably alter I.Q. Consequently, a more accurate view is that abilities are created in a variety of learning situations and are cumulative. Learning begets learning, skills acquired early on make later learning easier and more able people acquire more skills and find learning easier (Heckman, Lochner, & Taber, 1998; Heckman, 2000). The focus on the child-to-invest-in positively indicates movement away from the concept of the child as a subject of needs (Prentice, 2009). Instead, the idea of the investable child capitalizes on the notion that children are not at risk but rather are “at promise” (Swadener, 2005). Yet the World Health Organization has documented the absence of social emotional learning and mental health promotion programs worldwide (WHO Atlas, 2005).

Child care settings represent one significant venue in which the kind of social attachment and social and emotional learning Heckman (2000) describes take place. As such, child care centres are appropriate sites for mental health promotion efforts. Large numbers of children attend centres at ages considered critical for social and emotional development. Moreover, a substantial body of research evidence has established that quality child care has a positive impact on all areas of children’s development.

Child Care in Canada

The need for centre-based child care is widely acknowledged. At the same time, the impact of such care on young children, and especially the extensive care of infants, has been controversial. A number of societal shifts concerning children and families have necessitated many parents sharing child-rearing and caregiving roles with others, including, child care practitioners. Given what is known about the importance of the relational context in influencing children’s mental health, these shifts make it crucial to consider how adults and environments outside of the home help shape children’s social and emotional growth.
More specifically, it is essential to understand the psychological implications of shared care for children. To accomplish this, the following section details changes within the social fabric that have modified the way families function, creating a need for centre-based child care. The nature of child care is then more comprehensively examined to show how the quality of care is directly linked to children’s mental health. Finally, an argument is made for considering child care centres to be an optimal venue for promoting children’s mental health and for how practitioners’ training regarding mental health promotion, with programs such as Handle With Care, is needed.

**Changing Family Circumstances**

A myriad of changes related to urbanization, industrialization and immigration have occurred in Canada and the United States over the last century. Such changes have served to alter how families are structured and function. Development of new industries in the mid-19th century transformed these countries’ agriculture-based economies, whereby families lived and worked on farms and mothers and fathers were equally involved in child-rearing and household production of goods (Tan, 2008). Families increasingly migrated to cities in which industrial jobs were provided for men, while women remained at home to care for their children. From this shift, a societal mindset was born that stipulated divided responsibilities for men (“work”) and women (“child care”). Consequently, this ‘domestic ethic’ is strongly associated with our notion of maternal child care as optimal for child development and nonmaternal care as the least favourable, and even perhaps dangerous, resort for poor families that needed mothers to have paid employment (Kessen, 1979). Our perceptions of child care outside the home have been filtered through this legacy of domesticity; as well, this doctrine underlies much of child psychology’s history in conceptualizing the primacy of mother as child-minder (Cahan & Bromer, 2003)
The most dramatic change in families in the past 40 years has been the enormous entry of middle-class mothers into the workforce (Tan, 2008). Beginning in the 1960s, women’s opportunities started to expand to include continuing their education, as well as being married and having children (Wattenburg, 2000a). Falling wages in the 1970s created a need for women, especially married women and mothers, to work (Coontz, 1997). By 1990, there had been a sixfold increase in the number of working mothers, and in 2003 almost 72% of Canadian mothers with children under age 16 were in the labour force working either full- or part-time (Canadian Council on Social Development, 2004). The additional income that these women contribute to their families is typically essential to having a family. Indeed, as Tan (2008) reports, having children is the number one predictor of bankruptcy for a majority of families. More than three out of four Canadian couples with children count on the earnings of both parents (Vanier Institute of the Family, 2004). This change in the workforce has caused recognition of “child care as a need that cuts across traditional lines of social class, race and ethnicity (Cahan & Bromer, 2003).

More specifically, rates of employment for mothers of young children have increased significantly. Recent estimates place the labour force participation rate of mothers with young children at 69% with a youngest child 0-2 years, 75% with a youngest child 3-5 years old and 84% with those whose youngest child is 6-15 years of age (Statistics Canada, 2012).

One of the longstanding myths concerning maternal employment is that children’s development and attachment to their mothers will be disrupted when mothers are in the workforce. This is fuelled by the idea that employment substantially reduces the time mothers spend with their children and consequently stunts the bonding process and interferes with their relationship. Empirical evidence, however, largely disputes this notion. Mothers’ employment per se does not adversely affect children’s adjustment and well-being as assessed on a broad
spectrum of social and cognitive measures (Aube, Fleury, & Smetana, 2000; Aughinbaugh & Gittleman, 2003; Gottfried, Gottfried, & Bathurst, 1988; Hoffman & Youngblade, 1999; Makri-Botsari & Makri, 2003; Tresch Owen & Cox, 1988; Parcel & Menaghan, 1994; Vandell & Ramanan, 1992; Youngblut et al., 2001). Moreover, maternal employment may contribute indirect benefits to their children’s and family’s well-being through enhancement of mothers’ own self-esteem and mental health and increased quality of attention devoted to their needs (Repetti, Mathews, & Waldron, 1989; Scarr et al., 1989). Employment can also serve as a buffer for maternal depression and stress, which have clearly been shown to have negative consequences for the developmental outcomes of children (Downey & Coyne, 1990). Generally, research in this area does not suggest that attending child care in and of itself places children at-risk for developing mental health difficulties.

Other changes in Canadian families are linked to cultural background and structure. There were 9.3 million families in Canada in 2011 (Statistics Canada, 2012). However, there is increasing diversity in terms of the composition of families and their culture and ethnicity. Today, fewer children are being reared in what would be considered ‘traditional’ families. In 2011, 67.0% of families consisted of married couples, 16.7% were common-law relationships and the remaining 16.3% were lone-parent families (Statistics Canada, 2012). Between 2006 and 2011, the number of common-law couples rose 13.9%, more than four times the 3.1% increase for married couples. Lone-parent families increased 8% over the same period; growth was higher for male lone-parent families than for female lone-parent families. Additionally, the 2011 Census counted 64,575 same-sex couple families, up 42.4% from 2006. Of these couples, 67.4% were common-law couples, while the remainder was married couples (Statistics Canada, 2012).

Challenges faced by single parents, such as inadequate economic resources, can impact children’s well-being. Female lone-parents are less likely than women in two-parent families to
be employed. In 2003, 67.9% of female lone-parents with children under age 16 living at home were employed, compared with 72.3% of mothers in two-parent families with children in the same age group. In 2010, roughly 22% of children living in female headed lone-parent families experienced low-income in contrast to just fewer than 6% of children in two parent families. Living in poverty has a proven detrimental effect on children’s mental health (Landy & Tam, 1998).

Numerous children must deal with parental divorce. In 2008, there were over 70,000 divorces in Canada (Human Resources and Skills Development Canada, 2013). Shifting family arrangements constitute major life changes for the children involved. They may have to adapt to relocation, spend less time with one or both parents and adjust to the introduction of new partners in a blended family and possibly step-siblings. The 2011 Canadian Census counted stepfamilies for the first time and found that 7.4% of couples with children were simple stepfamilies; all children were the biological or adopted children of one and only one married spouse or common-law partner. An additional 5.2% of couples with children were deemed complex stepfamilies comprised of at least one child of both parents as well as at least one child of one parent only (Statistics Canada, 2012). Especially significant is the trend that children are experiencing these events at young ages. Marcil-Gratton (1998) described how 25% of children born in the late 1980s would experience parental separation before reaching six years of age as compared to 5% of those born in the early 1960s.

Not only is there a heterogeneous mix of structures in Canadian families, there is also a diverse array of cultures represented. The Canadian Census of 2006 reported that almost 20% of the overall population was immigrants (Statistics Canada, 2009). While European ethnic groups still comprise the largest proportion of Canadian citizens, Asian and Middle Eastern immigrants contribute significantly to the population, with Chinese, South Asian, East Asian and Black
minorities accounting for the largest percentage (Statistics Canada, 2009). Statistics Canada (2011) has predicted that the foreign-born population of the country could increase approximately four times faster than the rest of the population between now and 2031. This agency has projected that Arab and West Asian groups could more than triple, the fastest growth among all foreign groups.

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

Recent estimates indicate that the Aboriginal population is growing faster than the general population, increasing by 20.1% from 2001 to 2006 (Statistics Canada, 2008). Children under 14 years of age account for 29.7% of the overall Aboriginal population, much higher than the corresponding share of 17.4% in the non-Aboriginal population (Statistics Canada, 2008). Many Aboriginal children also have different experiences from the majority of the population. Approximately 35% of Aboriginal children from birth to age 14 live in single parent families and 7% reside with grandparents or other relatives (Statistics Canada, 2008). Aboriginal children are also twice as likely as non-Aboriginal children to live in multiple family households (Statistics Canada, 2008). As well, 40% of Aboriginal children and youth live in poverty, more than twice that national average. They trail the rest of Canada’s children on almost every measure of well-
being, including family income, educational attainment, crowding and homelessness, poor water quality, infant mortality, health and suicide (Macdonald & Wilson, 2013).

**Growing Need for Centre-Based Child Care**

With shifts in maternal employment and family demographics, there has been an explosion in the need for centre-based child care. Approximately 54% of Canadian children ages 6 months to 5 years were in some type of non-parental child care in 2002-2003 (Bushnik, 2006). This represents an increase from 42% in 1994-1995. The overall rise in rates occurred for children from almost all backgrounds, regardless of geographic location, household income, family structure, parental employment or parental place of birth. However, children from higher income households and children with single parents who worked or studied were more likely to be in non-parental child care than others (Bushnik, 2006). Unlike their past counterparts, women are now more highly educated and are employed in more diverse and traditionally male occupations (Aube, Fleury & Smetana, 2000), which has added to the demand for child care. Children who lived in two-parent households where both parents were working for pay or studying saw their child care rates rise from 66% in 1994-1995 to 71% in 2002-2003 (Bushnik, 2006).

In addition to families in which two parents work, the proportion of lone-parent families with young children and growth in the incidence of non-traditional work hours have increased the demand for non-parental care (Doherty et al., 2003). As well, immigrant children are more likely than non-immigrant children to have parents who work more than 50 hours per week (Canadian Council on Social Development, 2002).

In 2010, there were 921,841 regulated child care spaces across Canada, with approximately 50% of centre spaces allocated for children between 0-5 years old (Friendly, Halton, Beach & Forer, 2013). However, there is considerable variation in this allocation.
according to province/territory. This represented an overall average increase of 27,324 spaces in each of 2009 and 2010, the smallest increase since 2001. Still, there are only enough regulated child care spaces to accommodate 21.8% of Canadian children between 0-5 years of age, meaning that the country is still far from supplying all children with mothers in the paid labour force. Across Canada, the biggest increase in non-parental care has been in child care centre usage, rising from 20% in 1994-1995 to 28% in 2002-2003 (Bushnik, 2006). Currently, about 25% of Canadian children who are in some form of child care attend community-based centres (Statistics Canada, 2005).

Certain factors appear to correlate with children being in centre-based care more than other types of non-parental care. For instance, urban children in 2002-2003 were more likely to be in a child care centre (30%) than were rural children (22%) (Bushnik, 2006). The availability of certain types of non-parental child care arrangements may be contingent on the type of community in which a child lives. Compared to families in urban areas, families residing in rural areas may not have the same access to a wide range of child care options (Norris, Brink, & Mosher, 1999). Also, data from the National Longitudinal Survey of Children and Youth (NLSCY; 2010) showed that in 2002-2003, children from the lowest income level were consistently most likely to be cared for in a centre. As well, children in single-parent households were much more likely than children in two-parent households to be in a day care centre (40% versus 28%) (Bushnik, 2006). Furthermore, 53% of children in single-parent households were below the low-income cut-off versus 9% of children in two-parent households (Bushnik, 2006). This may be related to such households tending to have lower incomes than two-parent households; therefore they are eligible for child care centre subsidies (Norris et al., 1999); It also appears that use of centre care for Canadian children varies with age. In 2002-2003, over 30% of children aged two to four years in care were in a centre, compared to roughly 20% of children in
the other age groups (Bushnik, 2006). One reason for this may be in parents’ perceptions regarding centre attendance as preparatory for school entry. Bushnik (2006) highlights that centres seem to be a main conduit into preschools, nursery schools and before or after school programs when children reach ages four and five years. Approximately, 44% of children at these ages were in a child care centre two years previously.

For children in child care centres, this may not represent the sole non-parental care arrangement. In 2002-2003, about three out of every ten children (27%) were in more than one care arrangement. Factors such as convenience, cost and availability influence parental decisions about care arrangements for their children. Multiple care arrangements have implications for both children and parents. The child must adjust to multiple caregivers in a day and the overall time spent in care. Parents have to coordinate schedules, travel time and manage communication among the various caregivers. NLSCY data from 2002-2003 showed that children whose main care arrangement was a centre spent more time there per week, on average, than did children in any other non-parental care arrangement. This was true across time intervals and regardless of age (Bushnik, 2006).

The NLSCY also found that about one in every five children in a day care centre changed their care arrangement at least once. Stability in child care arrangements can be linked to child development. Research suggests that, depending on the child’s age, frequent care changes are associated with reduced mother-child attachment (Owen, 2003), more problem behaviour (NICHD ECCRN, 1998) and poorer peer interactions (NICHD ECCRN, 2001). Importantly, a lack of change in care arrangement in the NLSCY only identified if the type of care arrangement was consistent from one cycle to the next; it did not necessarily indicate that the specific arrangement (e.g., particular centre) or caregiver remained the same (Bushnik, 2006).
Characteristics of Quality Child Care

As more children entered child care, many people questioned its effect on children’s cognitive, social and emotional development (Tan, 2008). Applied research has largely demonstrated that participation is not detrimental to children’s development and is unrelated to mother-child attachment (Silverstein, 1991; Vandell, et al., 2010). Subsequently there has been a shift towards research that explores the complexity of factors that contribute to children benefitting from child care.

Taking a broad perspective, this newer research (emerging in the 1990s) assumes that the effects of child care experience on the child at any age are not simply related to single factors, but the ongoing transactions between characteristics of the child, the family, the child care centre and the larger social and cultural context (Burchinal, Ramey, Reid, & Jaccard, 1995; Deater-Deckard, Pinkerton, & Scarr, 1996). Such factors influence the quality of children’s experiences in child care, which, in turn, affect their development. Significant child variables include sex, temperament and intelligence while family factors consist of such variables as family income, educational level, family composition and place of residence. Characteristics of the family that also shape children’s development, and must be considered when examining child care effects, include attachment security, parental warmth and sensitivity, cognitive stimulation, behavioural guidance strategies, quality of the marital relationship, spousal support and the emotional adjustment of parents (NICHD ECCRN, 1994). These family factors may function as “selection effects” by influencing choice of care, including type and quality (Hungerford, Brownell, & Campbell, 2000).

Measurements of child care ‘quality’ focus on two related aspects of centre settings. “Structural” measures include fixed regulated features of the centre setting such as adult-child ratio, group size, caregiver education, staff turnover and safety and developmental
appropriateness of the environment. “Process” measures are linked more to children’s interactions within the setting, including the nature of child-caregiver relationships and the amount and type of stimulation caregivers provide. Numerous studies indicate that the process quality of child care is especially salient in children’s development (Lamb, 1998). Moreover, research has shown that children’s experiences in child care are not independent of experiences at home (Hungerford, Brownell, & Campbell, 2000). High quality child care is associated with positive effects for children of all backgrounds (Peisner-Feinberg & Burchinal, 1997), but particularly for children from low income families and problematic family environments (NICHD ECCRN, 2002; Votruba-Zrzal, Coley, & Chase-Lansdale, 2004). Indeed, Hungerford et al., (2000) emphasize that child care influences “neither replace nor outweigh family influences; rather, child-care experiences act in concert with and/or complement family experiences in shaping children’s social development, whether it is optimal or problematic.”

What makes for high quality child care is determined by systematic measurement and observation. The Early Childhood Environment Rating Scale (ECERS; Harms & Clifford, 1980) and the Infant and Toddler Environmental Rating Scale (ITERS; Harms, Clifford, & Cryer, 1998), along with practitioners’ self-assessment, have become the standard tools for evaluating the child care environment. These scales describe and measure content areas such as space and furnishings, program structure, personal care routines, language and reasoning, activities, interaction, parents and staff. Research has shown that child care programs that achieve high ratings on these scales produce the best long-term outcomes for children. The Child Care Advocacy Association of Canada (2004) has highlighted 5 key areas that contribute to quality child care:

1) the learning environment – a quality child care setting is one that is child-centered
2) adult to child ratios – the number of adults as compared to the number of children is crucial given that high adult to child ratios enhance the capacity of staff to more sensitively interact with the children and parents and to engage the children in a range of developmentally appropriate activities.

3) qualifications, remuneration and morale of staff

4) public and not for profit delivery

5) legislated standards and capacity for monitoring and enforcement

The National Institute of Child Health and Human Development study of Early Child Care (NICHD ECCRN, 1994) represents the most comprehensive investigation to use a transactional model when considering child care effects. This longitudinal study solicited parents at 10 sites across the United States immediately following their child’s birth and prior to making child care arrangements. Children’s development has since been regularly followed into middle childhood and adolescence (Vandell, Belsky, Burchinal, Vandergrift, & Steinberg, 2010). The length of this project has allowed it to capture many common life scenarios, such as changes in child care arrangements and addresses the fact that child care effects may be different at various points in time (Cohen, Kiefer, & Pape, 2004).

The NICHD research has spurred consideration of how child care features such as type, stability of care, timing and amount of exposure in association with level of quality impact the typical course of development (Lamb & Ahnert, 2006; Phillips, McCartney, & Sussman, 2006). Consequently, this research tells us about whether and under what conditions child care experiences affect early development, or what the risks and benefits are for children (Phillips, Fox & Gunnar, 2011). Evidence supports the conclusion that higher quality of child care enhances positive social skills and emotional adjustment (NICHD ECCRN, 2006; Phillips et al., 2006). As well, children in high quality child care demonstrate higher cognitive performance,
better language ability and school readiness and fewer problem behaviours (Peisner-Feinberg & Burchinal, 1997). In contrast, lower quality child care contributes to elevated, albeit nonclinical levels of externalizing behaviour, including noncompliance, aggression, impulsivity and risk-taking (NICHD ECCRN, 2006; Phillips et al., 2006). Moreover, evidence regarding these effects of child care quality shows such patterns are consistent across ages, up to 15 years (Vandell, Belsky, Burchinal, Vandergrift, & Steinberg, 2010). Type of care, specifically centre-based care, has also been pointed to as a contributor to negative developmental outcomes (Belsky, Vandell, Burchinal, Clarke-Stewart, McCartney, & Owen, 2007). Fabes, Hanish, and Martin (2003) suggest children’s unsuccessful navigation of peer relationships in centre care is a key ingredient leading to such outcomes. Additionally, for low income children, long hours in child care are detrimental to their development when child care quality is low (Votruba-Drzal et al., 2004).

Importantly, only some children display elevated levels of externalizing behaviour in these studies (Crockenberg, 2003). Currently, one line of research is turning its focus to explicating how children’s individual differences interact with features of child care to produce distinct patterns of outcome (Phillips, Fox, & Gunnar, 2011). In this way, findings can highlight how the daily experiences of different children within the same child care environment may lead to divergent developmental outcomes. For instance, studies are exploring how children’s temperamental profile, especially negative emotional reactivity, inhibition and social reticence, can lead to different consequences for children in response to variations in child care factors and quality (Fox, Henderson, Rubin, Calkins, & Schmidt, 2001; Pluess & Belsky, 2010; Watamura, Donzella, Alwin & Gunnar; Phillips, Fox, & Gunnar, 2011). A second line of research is drawing attention to how child care influences may help shape early physiological processes that govern stress regulation (Geoffroy, Cote, Parent, & Seguin, 2006; Vermeer & van IJzendoorn, 2006). Quality of care factors heavily into these interactions insofar as child care practitioners
are able to accommodate individual differences, offer emotional support and buffer children from sources of stress such as conflicts with peers.

In Canada, findings from the You Bet I Care! (2000) study demonstrate that regardless of jurisdiction, the factors that determine quality child care are the same and include appropriate regulations (e.g., educational requirements for practitioners) and higher levels of practitioner remuneration and good practitioner supports. Overall levels of education and specific ECCE training are among the most important, if not the most important, variables in the provision of quality care (Doherty, Lero, Goelman, LaGrange, & Tougas, 2000). Citing both Canadian and American literature, as well as its own findings, the You Bet I Care! (2000) study highlighted that practitioners with appropriate post-secondary education know how to plan educational and caring environments for young children and understand all aspects of children’s development in order to recognize and take advantage of “teachable moments”. Appropriate training deepens a caregiver’s understanding of child development and broadens ideas about the range of developmentally appropriate activities for children (Childcare Resource & Research Unit, 2004).

Most research evidence emerging from investigations from the 1980s and 1990s supported the conclusion that more ECCE-specialized college-level preparation resulted in higher quality experiences for children (Bellm & Whitebrook, 2006). Much of this research demonstrated that highest-quality child care or preschool programs showing long-term positive outcomes for children of low-income families, were staffed by teachers with a BA degree, often with an early childhood focus (Whitebrook, 2003). More recently, a multi-state American investigation of publicly funded preschools concluded that the BA degree was only modestly related to child outcomes and classroom quality, lending some support to those who question the added value of a four-year degree over an associate degree or a lesser number of college courses (Early et al., 2006). It is important to note that this latest study did not distinguish among
Why Are Child Care Centres Appropriate for Mental Health Promotion?

Proponents of mental health promotion argue that child care centres represent one key venue for implementation of activities that foster children’s well-being. For example, the Consortium for Global Infant, Child and Adolescent Mental Health (2009) advocates for diverse sectors and agencies to become more actively involved in supporting children’s social and emotional development. Specifically, the Consortium endorses recommendations to: 1) foster the development of infant, child and adolescent mental health policy as an integral part of education, social welfare, health policy and health reform; 2) recognize and support intersectoral responses to child and adolescent mental health that help address the social, economic and political determinants of mental health and mental illness in children and adolescents (e.g., child care); 3) recognize and intervene at the earliest possible developmental stage to promote positive mental health and to avert the consequences of growing up with conditions which interfere with healthy mental development.

Accompanying the paradigmatic shift from mental health intervention to mental health promotion is the realization that promotion activities have to be implemented in innovative ways. Kaufman and Hepburn (2005) suggest that it is most appropriate to replace a discrete mental health service system for young children with services and supports that can be infused into environments that children are already accessing in their communities. In order to accomplish this, it is important to identify and strengthen collaborative processes across existing systems and
agencies. For children under 6 years of age, this includes early care and education provided in community child care centres. These centres can also play a key role in the continuum of services, from mental health promotion to prevention to intervention, that ultimately reach all children and families. As Edwall (2005) explains the process:

It includes children who will never have a mental health diagnosis, those who may develop a problem at some point and those who have evident problems early on. It relies on a wide range of both professional helpers and ‘natural’ helpers--those grandparents, child care workers, neighbours, church members or others who understand and are willing to support young children and their families. It embraces families as the most important people in their children’s mental health development, but it also acknowledges the importance of the quality of relationships that children begin to establish outside the family during their early years. (p. 32)

Child care centres, then, represent an important part of a coordinated network of mental health services that need to be responsive to the multiple and changing needs of children and their families. Establishing these kinds of mental health promotion services necessitates bridging the perspectives of parents, child care practitioners, other caregivers and mental health professionals. What is called for then, is mutual respect for and understanding of the unique roles and responsibilities of the various parties involved in early childhood mental health (Kaufman & Hepburn, 2005). Accomplishing this requires that partners build trust, agree on core concepts and values, cultivate common language and distinguish shared goals (Kaufman & Hepburn, 2005).

Conceptualized in this way, the responsibility of early childhood mental health rests with all individuals who deal with young children and families. From a systems viewpoint, early childhood mental health is defined as a set of strategies that includes: 1) promoting the emotional and behavioural well-being of all young children; 2) helping families of young children address whatever barriers they face to ensure that their children’s emotional development is not compromised; and 3) expanding the competencies of nonfamilial caregivers and others to
promote the well-being of young children and families (Knitzer, 2000). In their comprehensive review of research concerning systems of care that promote young children’s social-emotional well-being, Smith and Fox (2004), assert the following:

- Challenging behaviour can be prevented when systems support a comprehensive array of services from prevention to intensive intervention.
- Services must be of high quality and, whenever possible, evidence based.
- Services must be comprehensive and provide individualized assistance and supports related to child and family needs, including culture and language.
- In the absence of one comprehensive service delivery system, systems must be developed from interlocking and interconnected services and programs into a system of care.
- Systems should be family centered.
- The early care and education, mental health, and healthy and child welfare work force must have the skills to provide collaborative, comprehensive, individualized, evidence-based services, supports and systems.

Relational Context of Child Care

This latter bulleted point concerning skills stresses a prepared workforce that need a range of skills, including developmental knowledge, clinical sensitivity and expertise, understanding of family dynamics and cultural competence (Cohen & Kaufmann, 2000; Knitzer, 2001). Most importantly, child care practitioners require a mindset that emphasizes the relational context of mental health promotion and services. Early childhood mental health is reflected in children’s relationships with significant others and how they interact with their environments (Kaufmann & Hepburn, 2005). Recognizing the importance of such relationships is essential to
guaranteeing that appropriate practices are in place to support child-caregiver interactions. Such a relationship-based approach to mental health promotion services speaks to several types of practices and interactions in which child care practitioners are engaged. Practitioners must consider their relationships and parallel processes with children and also centre colleagues. In order to offer individualized services for children, practitioners also must form relationships with families and support the family as the constant in a child’s life while respecting and fostering their strengths, capacities and skills. Moving away from the traditional one size fits all approach to mental health services, practitioners must be able to tailor practices with children to facilitate families’ roles as decision makers, team leaders and service effectiveness evaluators (Kaufmann & Hepburn, 2005). To foster and sustain practitioners’ skills in these domains, reflective supervision is recommended as a “safe, nonjudgmental and relationship-based process for staff to share their successes as well as their challenges with an experienced listener” (Kaufmann & Hepburn, 2005).

Situating mental health promotion in the child care centre context has been associated with good practices that foster children’s social and emotional development, build family and community connections and create a positive working climate for those in the child care field (Cohen, Kiefer & Pape, 2004). This translates into practitioners being cognizant not only of factors that are generally important to children’s mental health but how factors specific to the centre context contribute as well. For example, research from a variety of sources has repeatedly indicated that young children can have secure attachments with more than one important person in their lives if such individuals are sensitive and consistent (Eberhart-Wright, 2002). Indeed, studies conducted in Israel and Holland have demonstrated that children benefit most by having relationships marked by three secure attachments – mother, father and nonparental caregiver (van Ijzendoorn et al., 1992). Yet, child care providers are often unaware of how important consistent,
nurturing care is to the overall growth and development of young children in their program or to early signs of mental health problems in young children (Gonzalez-Mena, 2008).

Furthermore, young children participating in group child care must master tasks created by the nature of the centre context such as experiencing separation, sharing their caregiver with other children, and having daily routines slightly different from those they experience at home. Eberhart-Wright (2002) notes that at that stage, in which children need to establish basic trust and form the beginnings of their own identity, they are placed in child care situations frequently marked by little stability, and where they are cared for by an “overwhelming cadre of caregivers with different ways of doing things”. As well, when children experience loss of a preferred practitioner (i.e., due to staff turnover), they must cope with difficult feelings and adapt to new caregivers. The video Together in Care: Meeting the Intimacy Needs of Infants and Toddlers in Groups (Lally et al., 1992) shows the grief of toddlers – and sometimes of caregivers – as children experience new situations where they must once again teach the adults to understand their cues.

Fostering children’s positive social and emotional development within the centre optimally involves practitioners developing collaborative relationships with parents. Indeed, Eberhart-Wright (2002) argues that practitioners who understand children’s development and the importance of their caregiving to healthy development will communicate regularly with parents, learn about children’s needs, cues and expectations through them and attempt to replicate practices as close as possible to the home culture. While practitioners are typically aware that parents are important, they often have minimal training for communicating with them, understanding their culture and determining how to work out disagreements. As well, practitioners may lack awareness of how they can play an emotionally supportive role with parents, whose decision concerning child care for their children can punctuate ambivalence and
loss (e.g., feeling that they are missing out on their children’s important early experiences).

According to Amelia Warren Tyagi (2004), often a mother’s choice to work “comes down to dollars and cents, and the calculation is brutal. In one column sits that big-eyed slobbery youngster, and a mother’s heart beating to be there so she can give him everything”. Without parent-caregiver partnerships, children experience a world that is hard to understand and integrate (Eberhart-Wright, 2002).

Additionally, practitioners’ implementation of practices with children must be influenced by culture in order to augment synchrony between centre and home. It has been suggested that practitioners require a better understanding of the place of culture in both recognizing and ameliorating pathology (Declaration of the Consortium for Global Infant, Child and Adolescent Mental Health, 2009). In 2002-2003, about 21% of children had a parent who was born outside of Canada (Bushnik, 2006). Research suggests that parents born outside of a particular country may have views of child care that differ from those held by parents born within the country (e.g., Canadian born parents are more likely to favour centre based care than immigrant families). This, in turn, may influence their use of certain types of care (Leseman, 2002).

Ultimately, child care practitioners’ own mental health can affect their ability to perform this multitude of roles. Working conditions, pay, benefits job status and professional development influence the well-being of practitioners via job satisfaction and commitment. The Child Care Advocacy Association of Canada (2004) highlights that highly qualified, well-trained, well-paid, well-supported child care staff who experience high job satisfaction are better able to respond to children’s needs, and plan and provide developmentally appropriate programming and offer care that respects and values diversity. Feeling supported at work is often key, and includes positive staff relations, frequent coworker communication, participation in group decision making and role clarity (Doherty et al., 2000; Stremmel, Benson, & Powell,
Practitioners are more satisfied with their work when the people around them are friendly, respectful and collaborative and when staff can be involved in how their work environment is shaped. This allows them to feel more trusted, resourceful and capable (Whitebrook & Bell, 1999). Yet, little consideration and training is given to how practitioners can foster their own well-being in their workplace and contribute to a positive organizational climate.

This is perhaps most pronounced in centre care. A Labour Market Study Update in 2003 found that job satisfaction was lowest among those working in full-day regulated child care centres. The reasons for this cited by staff not only included poor wages and benefits, but also lack of leadership in pedagogy, curriculum and human resources, lack of access to training and professional development, less than desirable quality programs for children and working environments for staff and a working day marked by mainly custodial activities rather than the early childhood practices for which they were trained (Beach & Flanagan, 2007).

More and more, advocates for mental health promotion practices view the workplace as a context for increasing individuals’ well-being. Most adults spend the majority of their waking hours in their workplace settings and this environment “plays an essential part in helping people to attain their full potential” (Mental Health Commission of Canada, 2012). The Changing Lives, Changing Directions 2012 report advised that workplace mental health promotion should consist of efforts to encourage work-life balance, ensuring staff have clear work roles and facilitation of decision-making in how their work gets done (Mental Health Commission of Canada, 2012).

Child Care Practitioner Training

The practitioner is the key influence in the quality of the relationship and interactions with children (Morris, 2002). In order for mental health promotion to be effectively integrated into child care centres, practitioners must be suitably trained. While the majority of Canadian
practitioners hold a two-year ECCE-specific level of education, Morris (2002) emphasizes that this is not a lengthy period in which to cause significant change in personal characteristics that support suitability for the child care field, including “warmth, sensitivity, effective interpersonal communication skills, a love of learning, enthusiasm, patience, high motivation and the ability to enjoy and encourage children” (Saracho & Spodek, 1983).

In the report, *Our Childcare Workforce, From Recognition to Remuneration* (1998), supervisors, managers and owners of centre-based care facilities expressed concern that some ECCE graduates lack a child orientation, respect for children and their families and appreciation for the nature of the work. Researchers from this study also identified particular areas as gaps in practitioner skills, including guiding children with behaviour challenges, culturally sensitive practice and inclusive care for children with special needs (Beach, Bertrand, & Cleveland, 1998).

Moreover, while the expectation of ECCE college programs is that students will be able to work with children from infancy to school-age, graduates themselves indicated feeling unprepared to deal with children from diverse backgrounds. Additionally, graduates highlighted that within the ECCE curriculum, there is a need to distinguish, accept and integrate values, knowledge and practices from non-mainstream cultural contexts (Beach, Bertrand, & Cleveland, 1998).

Although practica are incorporated into ECCE programs to provide the opportunity for ECCE students to link classroom theory with real-life practices, Katz and Goffin (1990) suggest that the focus on interactive skills in child care necessitates better conceptualization and integration of the clinical component. Hinshaw-Fuselier, Zeanah, & Larrieu (2009) recognize that child care practitioners represent a faction of a growing number of professionals that are being expected to work within the relationship context to promote infant mental health, regardless of their preparation to do so. Beach and Flanagan (2007) also point to changing
expectations for child care practitioners, who in addition to working with children and families, “must be part of a team, able to articulate their philosophy and curriculum approach, integrate thoughts and knowledge, work with other professionals and deal with issues related to culture, a range of children’s special needs, family dysfunction and family emergencies”. Mentoring students has been shown to be one effective way to facilitate communication between students and supervisors in a non-threatening way, thereby increasing students’ comfort in recognizing areas for improvement and reflecting on alternative ways to improve their practices (Ferguson, Ferguson, Singleton, & Soave, 2001). Given that children’s mental health issues can lead to contact with most major public serves and health professionals, it is essential that all professionals working with children also have basic skills in the identification and management of minor difficulties. As well, these professionals require knowledge regarding how to access more specialized services for children that need extra support beyond what the professionals can provide (Ford & Ramchandani, 2009; Ford, Hamilton, Meltzer, & Goodman, 2007; Marcer, Finlay, & Baverstock, 2008). Additionally, there needs to be increased awareness for professionals concerning the interdependent link between mental health, learning and life success along with the extensive array of evaluated programs that serve mental health across the continuum (World Federation for Mental Health, 2007).

Research Literature Concerning the Effects of Mental Health Programs for Children

In contrast to the wealth of literature concerning the effectiveness of early childhood interventions in child care centres, research examining mental health promotion programs for children is limited. Investigations have largely dealt with mental health consultation to child care settings, programs implemented in school settings or discrete types of activity based curricula. Across these areas, outcome results have been promising (Maxwell, Aggleton, Warwick, Yankah, Hill, & Mehmedbegovic, 2008). In this section, the research available in these areas is
reviewed. Then, how the current study differs and its purpose in expanding knowledge concerning efforts towards improving children’s mental health is highlighted.

Review of Mental Health Consultation Programs for Children

Similar to mental health promotion activities, consultation efforts can focus on whole population approaches. However, they can additionally include prevention and intervention activities. Furthermore, mental health consultation activities, comparable to promotion, also work towards building the capacity of professionals to promote young children’s social-emotional and behavioural development (Perry & Kaufmann, 2009). Consultation models operate from the perspective that activities intended to support positive health are best implemented in the settings in which children naturally engage (Cohen & Kaufmann, 2005).

Increasingly, mental health consultation has been initiated to foster linkages between mental health professionals and child care practitioners in order to support staff working directly with children at risk for emotional and behavioural difficulties (Alkon, Ramler, & MacLennan, 2003). Effective consultation enables practitioners to incorporate a mental health perspective, addressing developmental, family and cultural needs, to assess children at risk, implement appropriate supports and prevent future emotional and behavioural problems (Knitzer, 2000; Lieberman, 2000; Raver & Knitzer, 2002). The impetus for this kind of collaboration has evolved from the fact that more children are being expelled from preschool than all other grades (Gilliam, 2005) and evidence that child care practitioners can be taught better ways to manage behavior using positive attention, encouragement and praise (Arnett, 1989; Webster-Stratton, 2001). On-site or regular visit mental health consultation typically consists of a partnership between a centre or preschool setting and a mental health organization or profession. Consultation approaches tend to either focus on improving the overall program and practitioner
skills (e.g., program-focused) or developing individual child interventions and referrals for external services (e.g., child-focused).

Studies have shown effectiveness for both program- and child-focused models of mental health consultation to child care centres. Alkon et al. (2003) collected information from 25 San Francisco area child care programs that received program focused consultation services over two years. Overall program quality did not change, but consultation intensity was significantly associated with lower staff turnover. Practitioners reported 41% to 67% of consultation goals had been “very much” met, although only 3 of 13 items measuring teacher self-efficacy significantly improved. Evaluating the effects of a child- and program-focused consultation program used with 76 Connecticut child care centres, Gilliam (2007) found that 8 weeks of 4-6 hour onsite consultation upon request resulted in significant improvements in teacher-rated child oppositional behaviours relative to a control group. However, no changes were found in children’s internalizing behavior (e.g., anxiousness, emotional lability) and social skills or in classroom or teacher quality in comparison to control groups. Importantly, there was no independent observation of children’s behaviour.

A study examining a child-focused model that involved consultation for 3 months to centres, upon request for assistance with individual child behaviors, found significant practitioner-reported increases in individual children’s social skills and decreases in problem behavior (Perry, Dunne, McFadden, & Campbell, 2008). There were no measures of centre or practitioner impact, nor was there a control group.

In another study, findings from a pilot demonstration project to address the needs of children identified with challenging behaviours in preschool classrooms revealed that consultation was associated with significant improvements in classroom aggressive and maladaptive behaviour and growth in adaptive behaviour (Upshur, Wenz-Gross, & Reed, 2009).
Such improvements were associated with total hours of individual child services provided and improvements in child developmental skills (e.g., physical, self-help, social, communication and academic). While this consultation program employed both program- and child-focused approaches, the authors highlight that programs that emphasize practitioners as primary change agents and practitioner skill development may demonstrate more improvement in practitioner skills than specific child outcomes (Williford & Shelton, 2008). However, they suggest that further research should explore the extent to which augmented practitioner skills in such models can benefit a wider population of children beyond only those targeted with significant behavioural issues (Upshur et al., 2009).

Beyond these mental health consultation programs geared towards promotion, prevention and intervention activities, there is strong evidence for the effectiveness of mental health promotion programs in schools. These latter programs are intended to foster the positive social and emotional development and well-being of broader populations of children. However, just as consultation programs varied in terms being program- or child-focused, school-based promotion programs have been quite diverse in their application.

Review of Mental Health Promotion Programs for School-Age Children

Wells, Barlow, and Stewart-Brown (2003) conducted a systematic review of studies investigating a universal approach to mental health promotion and/or in schools. Approximately 17 studies involving 16 promotion programs were included. Most dealt with school populations located in socioeconomically deprived areas and many consisted of a high proportion of children from ethnic minority groups. Studies differed in their focus on programs operating in elementary, junior or high schools. Differences also existed among studies in terms of their classification according to whether they adopted a whole school approach, were confined to the classroom or extended beyond the classroom to some degree to other parts of the school (but did not meet
criteria for being a whole school approach). The programs and studies themselves were diverse in their focus, with most measuring negative aspects of mental health (e.g., depression, antisocial behavior, aggression, conduct problems, suicidal tendencies), fewer exploring the personal and interpersonal behaviours that underpin mental health (e.g., emotional awareness, problem solving, conflict resolution) and a minimal number measuring positive aspects of mental health (e.g., self-esteem, self-concept). Findings pointed to positive evidence of effectiveness for programs involving whole school approaches that were implemented continuously for more than a year and were aimed at mental health promotion rather than mental illness prevention.

These authors concluded that long-term programs that promote the mental health of all students and involve changes to school climate are more likely to be successful than prevention programs situated only in classrooms. They highlight that whole school approaches serve to engage everyone involved in the school system, including children, families, staff and the community and shift the school environment and culture. Necessarily, such programs move beyond thinking just about the mental health or behavior of children; they also require changes in teachers’ beliefs, attitudes and behaviours (Wells, Barlow, & Stewart-Brown, 2003). Additionally, they noted some crucial limitations in the way other studies examined factors that sustain program implementation and map the scope of children’s mental health. For example, most/many studies did not report on how much school staff felt supported during their program participation. Furthermore, the authors emphasized that none of the programs reviewed considered goals such as improving children’s ability to enjoy life, to develop emotionally or spiritually, or make use of children’s own systematic goals, all of which have been suggested as important components of mental health (Weare, 2000; Weare, 2003; Zohar & Marshall, 2000; Holden, 1998).
In a broad review of primary prevention mental health programs for children and adolescents, Durlak and Wells (1997) reviewed 177 outcome studies completed prior to 1991 that targeted youth 18 years of age and under. Primary prevention was defined as a program specifically designed to reduce the future incidence of adjustment problems in currently normal populations. Mental health promotion efforts were included in this. Programs widely varied in their approach to primary prevention; thus, programs were categorized as being either person or environment centered and according to the target population. Programs were identified as being either geared towards all members of an available population, groups considered at risk for eventual problems, or groups about to experience potentially stressful life events or transitions. Using meta-analysis, findings provided empirical support for most categories of programs. In particular, programs that modified the school environment, consisted of individually focused mental health promotion activities and attempts to assist children in negotiating difficult changes were especially effective. The average participant in a primary prevention program was found to surpass the performance of between 59% to 82% of those in a control group. Moreover, most categories of programs that showed dual benefits of significantly reducing problems and increasing competencies. Durlak & Wells (1997) stress that findings reinforce the idea that primary prevention is not a single uniform approach that achieves uniform results. Rather it is a collection of distinct strategies that are likely to vary in outcome based on target population, level of intervention, program objectives and specific circumstances of implementation.

Exploring the effectiveness of school programs designed to improve primary school-age children’s social and emotional health, Green et al. (2005) examined 8 systematic meta-reviews covering 322 studies. They concluded that greater effectiveness was evidenced with a sustained concentration on mental health promotion, self-esteem and coping outcomes in the broad school climate. They highlighted that effectiveness was most associated with creating positive impacts,
as opposed to preventing mental health problems. Authors tempered findings by noting that most studies were short in duration and provided limited details regarding the programs and the relationship between processes and outcomes.

Reviewing 47 school-based programs designed to enhance students’ emotional, social and/or behavioural functioning, Rones and Hoagwood (2000) concluded that while there was no particular right or wrong approach that contributed to effectiveness, a number of common factors informed program development. These included the inclusion of parents, teachers and peers, the adoption of developmentally appropriate program components, consistent program implementation and the integration of program content into general classroom curriculum (Rones & Hoagwood, 2000). More recent school-based mental health promotion efforts found to be effective have echoed these sentiments, advocating for conceptual frameworks that include the elements of security, connectedness and positive regard (Bond, Glover, Godfrey, Butler, & Patton, 2001). Stewart (2008) advocates that sustained mental health promotion in schools can only occur if efforts encompass the school organization, structural issues and organizational practices, including parental involvement. As well, programs increasingly attempt to reinforce positive teacher-student interactions and relationships, change teachers’ attitudes and approach in their role and impact their perceptions of children (Bale & Mishara, 2004; Stewart & Sun, 2007). Results from a study conducted by Lyon et al., (2009) suggest that similar approaches implemented with practitioners in preschool settings have positive impacts on practitioner behaviours and are a promising way to enhance practitioner-children interactions.

Overall, these findings suggest that multi-component and universal school-based programs aimed at promoting emotional well-being and mental health, sustained over lengthy periods of time and through modification of environments are effective (Maxwell et. al., 2008). This knowledge can also be applied to child care centre settings, as a cost-effective alternative to
mental health consultation (Upshur, Wenz-Gross & Reed, 2009). Shifting to mental health promotion models in which a primary component is equipping child care practitioners with the knowledge necessary to impact daily practices can encourage a more comprehensive way of perceiving and attending to children’s well-being.

**Review of Mental Health Promotion Programs for Early Childhood**

In Canada, there have been a handful of notable training programs geared towards helping adults foster positive mental health in children.

The *Reaching IN...Reaching OUT (RIRO)* project, implemented by the Child and Family Partnership, evolved from the Penn Resilience program (PRP; Gillham, Reivich, Jaycox, & Seligman, 1995) and was adapted to train adults to model resilient thinking styles/skills in their everyday interactions with 2 ½ to 6 year olds (Kordich Hall & Pearson, 2004). This training program has been widely implemented with child care practitioners in across Ontario. Training consists of 12 hours of didactic and activity-based presentation of seven resiliency skills including the Adversity-Consequences-Beliefs (ABC) model (Ellis, 1962), Thinking Styles/Thinking Traps, Challenging Beliefs, Detecting Icebergs, Generating Alternatives, Putting it into Perspective and Calming/Focusing (Kordich Hall & Pearson, 2004). The ABC model is based on the notion that one’s beliefs about events mediate their impact on one’s emotions and behavior. The model teaches individuals to detect inaccurate thoughts, evaluate the accuracy of those thoughts and challenge negative beliefs by considering alternative interpretations (Gillham & Reivich, 2007). The other resiliency skills listed are intended to help deal with daily stress, consider the accuracy of their thinking and lead to more flexible conflict resolution, problem solving and effective communication.

In a pilot project (2004-2005) to evaluate the outcome of this training program, ongoing consultation was provided to child care centres by *RIRO* project staff for a period of one year.
Consultation visits concentrated on discussion of practitioners’ completion of structured reflective journaling activities. These helped practitioners conceptually integrate the seven resiliency skills through reflective practice and to provide a structure to try out these skills with children in their care, initially through skill-based observation of child behavior and then through activity templates (Kordich Hall & Pearson, 2004).

Both quantitative and qualitative measures were employed to evaluate the impact of RIRO training on practitioners, children and parents as well as the feasibility of the RIRO model for use with young children in child care centres. Findings indicated that following training, practitioners rated their level of awareness of the importance of promoting resilience in children significantly higher. Additionally, they rated their knowledge of the seven resiliency skills significantly higher. Furthermore, all practitioners reported that the training had an impact on their interactions with children in their care. They rated the level of impact as ‘moderate’ to ‘high’ on interacting with children (94%), understanding their own behavior (91%), understanding child behavior (86%) and increasing teamwork in their rooms (82%). The majority of practitioners indicated that RIRO training also affected their interactions with children’s family members (86%), other practitioners (82%) and personal friends and acquaintances (62%).

According to practitioner report, 100% of those who participated in RIRO training observed changes in child behavior, which they considered attributable to their resiliency training. Such changes were related to children’s enhanced impulse control (65%) and emotional regulation (61%). More specifically, RIRO training resulted in increasing children’s ability to follow rules, calm down after stress, follow through on expected behavior, deal with everyday setbacks without emotional outbursts and experience less upset about making mistakes (Kordich Hall & Pearson, 2004).
Impulse control and emotional regulation are considered two fundamental abilities associated with resilience. Practitioners largely reported that the RIRO training models was useful, user-friendly and developmentally appropriate for the children in their care. They continued to use the RIRO program in their centres two years after their training had been completed. The RIRO research team concluded that such positive outcomes had broad implications for professional practice. The training augmented practitioners’ awareness of their own thinking habits and the impact of their behavior on the children with whom they work through a framework for reflective practice (Kordich Hall & Pearson, 2004).

A post training follow-up conducted in 2005-2006 revealed that 96% of practitioners continued to use the RIRO skills they learned at work. Practitioners indicated that the top three ways in which skills training had helped them related to: 1) reducing their own stress (77%); 2) understanding and being more empathic with children (77%); and 3) modifying their own beliefs about stress and challenge (74%).

Another training program designed to help young children learn to manage stress effectively, called Kids Have Stress Too! Preschool Program (KHST!) was created by the Psychology Foundation of Canada in partnership with the Toronto Public Health Department and the Toronto District School Board’s Stress Management Committee. The KHST! Preschool Program is offered to professionals from the child care community working with children between the ages of 2½ to 5 years of age. Trainees are helped to understand the impact of stress on young children, learn how to recognize and respond to children’s stress, are educated about the key role relationships with parents and caregivers play in helping children learn to manage their stress, learn age appropriate stress management techniques to help children relax and become more resilient and effective ways to promote positive emotional development and self-regulation in young children (Psychology Foundation of Canada, 2012). The KHST! training has
been professionally evaluated with ECCE students, demonstrating that the training increased students’ knowledge and skills and provided them with a greater ability to recognize and comprehend the impact of stress on children (Psychology Foundation of Canada, 2012).

**Mental Health Promotion Training for Child Care Practitioners**

One sole empirical study currently exists in the literature concerning broad mental health promotion training for child care practitioners (rather than specific skills such as resiliency). Farrell and Travers (2005) described the implementation, evaluation and sustainability of the Healthy Start program, which was designed to build the capacity of the child care workforce to promote children’s mental health, their families and staff themselves. Utilizing a capacity building model (Hawe, King, Noort, Jordens, & Lloyd, 2000), researchers focused on equipping child care providers with the knowledge and skills to promote positive mental health as well as an awareness of early intervention to families. Two types of health promotion activities were used: 1) developing the personal skills of child care workers; and 2) producing mechanisms for creating supportive child care environments for children, parents and workers. Healthy Start content was informed by a literature review and results of focus groups conducted with child care workers. Areas of need (for child care workers) identified through the focus groups included more information and strategies concerning behaviour management for children with specific mental health issues, approaching parents and dealing with emotional parents and/or those in crisis. Workers surveyed were found to vary in their attitudes towards parents; some felt parents should be exclusively responsible for children’s behaviour change and some felt taken advantage of by “emotionally demanding” parents.

Training in the Healthy Start program consisted of two components: mental health information training and communication skills training. Mental health information training intended to foster workers’ mental health literacy through two sessions (two hours each) that
dealt with protective and risk factors that impact children’s mental health, conduct disorder, postnatal depression and referral options. This training was facilitated by a project officer and a social worker. Communication skills training was comprised of six sessions (ninety minutes each) and concentrated on communication principles, active listening, recognizing and responding to emotional crisis, discussing sensitive issues with parents, referral services and self-care. This series was delivered by a project officer and a mental health nurse.

The outcome of Healthy Start was investigated through structured telephone interviews completed with participants pre- and post-training as well as 12 months later. Findings indicated that in the short-term, training was effective in increasing the knowledge of mental health protective and risk factors and individual confidence in recognizing and discussing mental health and emotional issues. Specifically, the proportion of workers expressing confidence (fairly/very confident) increased by well over 40% in their ability to recognize the signs of postnatal depression, conduct disorder, two or more risk factors for mental health problems in children and three or more referral options for parents with potential postnatal depression. Especially striking is that the proportion of child care worker able to list two or more recognizable protective factors for mental health increased by 64.6%. In terms of communication skills, there was an increase of 34.4% of child care workers expressing confidence (fairly/very confident) in their ability to discuss a child’s emotional problems with parents and a 40.4% increase in confidence in terms of discussing emotional problems of adults with parents. At twelve-month follow-up, however, gains in skill and confidence were not retained with the exception of recognition of risk factors for mental health problems in children and signs of postnatal depression and confidence in their ability to discuss this latter topic with parents.

The Healthy Start program, although fashioned as mental health promotion training, actually contained considerable content that could be considered to be more focused on
prevention and intervention. While mental health protective and risk factors were included in training information, emphasis was placed on awareness of signs of mental health problems in children. There was no attention given to enhancing child care providers’ awareness of indicators of positive mental health. Farrell and Travers acknowledged that despite great interest in mental health promotion on the part of child care workers, it was necessary to explain mental health promotion carefully and divert discussions away from behaviour management. Additionally, the researchers identified several methodological limitations in their study including, small sample size, lack of interrater reliability in coding interview responses and no measures to assess how increased mental health literacy may have changed workplace practices. Anecdotally, they indicated that participants felt their skill development had enhanced their role in children’s mental health, decreased work-related stress and feel more comfortable discussing issues with parents. However, no information was presented to indicate whether this reflected an impact on worker’s perceptions, strategies or both. Importantly, one of the lessons learned highlighted by the authors was that developing rapport between researchers and the child care workforce is dependent on clearly linking training to the early childcare role to improve work practices. They suggested that sustained practice changes within centre organizations could be accomplished through centre-based visits, specific action plans, resources and information in a range of formats (Farrell & Travers, 2005).

Present Study

The Handle With Care training program is intended to advance child care centre settings as sites for children’s mental health promotion. Specifically, it serves as a professional development activity to augment child care practitioners’ knowledge and practices concerning how to promote well-being in children from ages 0-6 years. The training program is designed to be appropriate for child care practitioners currently in the field; regardless of their educational
background or degree of experience. *Handle With Care* engages practitioners to think of ways that they can apply their understanding and skills related to mental health promotion. The following section reviews how the *Handle With Care* training was developed and provides a detailed program description. It is then considered how this particular training program and the current evaluation study differ from previous research and add to the evidence base concerning mental health promotion training for child care practitioners. Finally, specific research questions and hypotheses are delineated.

**Origin of the Handle With Care Training Program**

The *Handle With Care* training program was developed as an extension of the Early Childhood Care and Mental Health Project (ECCMHP), completed in 2005 by the Canadian Mental Health Association, National Office and the Hincks-Dellcrest Centre. The purpose of the original project was to explore ways that the mental health of young children from birth to 6 years can be promoted in community-based child care centres. To that end, two lines of research were completed and generated two products. The first line consisted of a comprehensive literature review to provide an understanding about the individual and environmental characteristics that promote children’s mental health in child care settings. Sources of information were compiled through provincial government policy documentation as well as book and journal selections accessed through PSYCHINFO and ERIC database searches. The review resulted in a wide-ranging report entitled *Handle With Care: Strategies for Promoting the Mental Health of Young Children in Community-Based Child Care* (Cohen, Kiefer, & Pape, 2004), that considered the value of implementing mental health promotion efforts in centre-based child care while situating it within the context of the complexity of children’s development, prevalence and persistence of mental health problems emerging in young children and key factors involved in the child care scene in Canada. Such factors included the growing need for
centre-based care, the changing structure and background of Canadian families, factors influencing child care selection, education and professionalism of child care practitioners, government regulations supporting social and emotional development in child care centres and the challenges (e.g., lack of national policy, low wages) central to the child care field. Three primary ways to promote children’s mental health were described: 1) developmental considerations and applications, including attachment security, emotion and behaviour regulation, emotion expression, development of a sense of self, self-esteem and self-efficacy and insuring positive peer relationships; 2) collaborations with families and community resources in a multicultural context; and 3) providing a positive work environment for child care practitioners.

The second research line entailed an extensive environmental scan to collect examples of policies and practices in child care centres relevant to children’s mental health promotion. For the scan, telephone interviews were conducted with both child care practitioners working directly with children and centre directors from 81 centres across Canada. Participating centres were recommended for their reputation for integration of positive practices related to mental health promotion by professionals in important child care consultation and/or education roles. Specifically, practitioners were asked about their strategies for: 1) building trusting relationships with children in their care; 2) supporting children’s individuality and self-esteem; 3) fostering independence and problem solving skills; 4) encouraging understanding and expression of emotions; 5) respecting diversity and the rights of others; 6) building positive peer relationships; and 7) dealing with changes and transitions. Given the developmental needs of children in these areas, responses to the interview questions for infants, toddlers and preschoolers were considered separately.
Additionally, practitioners were asked about ways in which they: 8) interact with parents; 9) support and respect a child’s home language and culture; and 10) receive support themselves in the work environment. Descriptions of centre policies and arrangement of the physical setting considered to underpin mental health promotion for young children were also solicited. Findings from the environmental scan were disseminated through a resource booklet intended for child care practitioners in the field, also entitled *Handle With Care: Strategies for Promoting the Mental Health of Young Children in Community-Based Child Care* (Kiefer, Cohen, & Pape, 2004). It highlights pertinent child development literature and describes practical techniques drawn from the scan interviews that are meant to be useful in all centres.

Including two components (report and resource booklet) in this project created a strong link between the theoretical and practical aspects of mental health promotion. Most importantly, the ECCMHP substantiated mental health promotion in child care centres hinged on evidence-based research and strategies while simultaneously offering concrete demonstrations of how practitioners applied key principles. The resource booklet, in particular, received an overwhelmingly positive response. It was initially distributed nationally through a mailing with the Canadian Child Care Federation’s *Interaction* journal in 2005, reaching an estimated 15,000 subscribers. Additionally, professionals in the child care field were further able to order the resource booklet through the Hincks-Dellcrest Centre. Such professionals reported utilizing its content for consultation work with child care centres, postsecondary education classes in early childhood education and development as well in settings other than child care centres dealing with learning and social and emotional development with young children (e.g., Ontario Early Years Centres).

Informally, the feedback about the *Handle With Care* resource booklet indicated that those working in the child care field believed mental health promotion to be an important topic,
and one that was lacking within the formal education of child care practitioners. Furthermore, although current early childhood care and education (ECCE) programs consisted of more training related to components of mental health promotion than previously, there was still a substantial proportion of child care practitioners who experienced models of ECCE training in which mental health promotion was not an integral component. Additionally, readers of the resource booklet particularly appreciated the concrete ideas presented; they reported that it could be quite overwhelming for ECCE graduates entering the child care field to take their theoretical knowledge and apply it in diverse situations. All in all, the response to the ECCMHP indicated that a gap existed in terms of child care practitioners’ training with regards to mental health promotion principles and practices.

Subsequently, the research team responsible for the ECCMHP initiated a new project with the purpose of designing a training program for child care practitioners to parallel the content of the Handle With Care resource booklet. Supported once again by the Social Development Partnerships Program of Human Resources and Social Development Canada, the Handle With Care training represents the next step in equipping practitioners with ideas and strategies for promoting the mental health of children between ages 0 and 6 years in their centres. To this end, the project adhered to the following considerations:

- Content

The training topics were chosen to mirror those in the Handle With Care mental health promotion resource booklet. Training units are intended to deepen practitioners’ understanding of how social-emotional development, family connections and positive workplace activities link to children’s well-being and their role in these areas. They are meant to cultivate a ‘mental health promotion mindset’ that will foster mental health
promotion strategies that are based on evidence and that are personally and contextually meaningful.

- National Scope

It was also important to deal with mental health promotion issues in a manner that would resonate with child care practitioners across Canada. This meant designing training activities that help practitioners adapt the training to the particular characteristics of their regions, including child and family diversity related to ethnic background, immigration, family structure and patterns, language, religion and socioeconomic status. Additionally, materials were presented in a way that could accommodate the range of educational and experiential backgrounds of child care practitioners from different provinces and territories. This process was facilitated by engaging a steering committee with members representing different professional backgrounds and different geographical regions of Canada. Once a draft of the training package was developed, we conducted pilot workshops with representatives from across Canada. These participants were recommended by the steering committee members as well as through other contacts from the original ECCMHP. Participants worked in a variety of settings associated with child care, including government departments, public health, early childhood care and education training institutions, private child care consultation firms and child care centres. Participants provided us with constructive and insightful feedback that shaped the course of revisions to the training materials and process.

- Sustainability

The research team was especially conscious of the challenge in making a training program widely available and sustainable. For this reason, there are two levels of training. One level of training is directed at front-line child care practitioners. The second
level of training is directed at individuals who are in a position to train the practitioners (facilitators). To this end, facilitator training was developed and is presented using a train-the-trainer format. Two manuals were produced to reflect these two levels: *Handle With Care: Strategies for Promoting the Mental Health of Young Children in Community-Based Child Care – Facilitator Training Manual* and *Participant Training Manual*.

Training qualified individuals involved in mental health and child care consultation to facilitate workshops within the own regions, and to train other trainers, is intended to help the *Handle With Care* training program to reach many child care practitioners. Ultimately, the *Handle With Care* training program may be offered by various organizations and agencies across Canada.

*Description of the Handle With Care Training Program*

The current study focuses on the level of training directed at front-line child care practitioners. Therefore, a description will be provided only of this level of training. For an overview of the train-the-trainer level intended for *Handle With Care* facilitators, information is available on the Hincks-Dellcrest Centre website: [http://hincksdellcrest.org](http://hincksdellcrest.org).

The *Handle With Care* training is divided into 9 units that are called Building Blocks. Naming the units in such a manner is meant to reflect how foundational they are in promoting children’s mental health. They are sequenced to build cumulatively on the learning gained in each one, with earlier Building Blocks representing key topics that are addressed before approaching later Building Blocks. For example, the initial Building Block concentrates on attachment relationships between practitioners and children; from the perspective of the *Handle With Care* training, knowledge and strategies in this area need to be in place before consideration of such subsequent topics as fostering children’s self-esteem and working with parents. In this sense, the units are ordered according to developmental priority. All are interrelated to one
another and, across the training program, units’ content overlaps, both to reinforce important information and to permit workshop units to be presented individually. Training can be delivered as a whole, involving all 9 Building Blocks, or with Building Blocks facilitated individually or mini-sequences (e.g., 2 or 3 Building Blocks), depending on the needs of participants with which they are carried out. In the present study, interest was in evaluating the full *Handle With Care* program delivered in sequence.

The content of all Building Blocks is based on a body of research evidence. Information is sourced from references included in the Early Childhood Care and Mental Health Project materials as well as more recent research obtained through searches completed to develop the training program development. Training workshop units consist of a variety of teaching approaches, including didactic lecture, group discussion and hands-on activities. Within every Building Block, a consistent format is utilized in the Participant Manual and in presentation. Each Building Block begins with a Key Message that indicates the overriding ‘take home message’ of the Building Block topic. An experiential activity initiates the Building Block to engage participants immediately. This is followed by 3-5 Content Topics, in which participants review a mix of information presented through facilitator-led talks, powerpoints and group discussions. A unique feature of the training is a Reflection exercise at the end of each Building Block. This encourages participants to think more deeply about questions related to Building Block issues and to integrate their personal and professional experiences with the material they have discussed in the Building Block. During the Reflection workshop component, participants choose whether or not to share this information with the group.

For facilitators/trainers, each Building Block section also provides background research and additional resources. This material is not included in the Participant Manual and facilitators incorporate it according to their own discretion. It is important to highlight that while the
manuals offer a structure with which to deliver each workshop unit, facilitators are able to tailor their presentation to a certain degree. Thus, facilitators select the background information they want to share with their participants and when to describe it in the context of the Building Block content. As well, variability is likely to occur across facilitators due to the experiences and situations their participants bring with them into workshop sessions. Inevitably, it is participants’ own material that directs group discussions and reflection exercises. Facilitators are required to adapt to the needs of their particular audiences.

At the beginning of each Building Block, there is an Introduction section to the *Handle With Care* training that outlines the goals of the training and contains an overview of what mental health promotion is and why it is crucial in the child care environment. The following is a brief description of the specific Building Blocks.

**Building Block 1: Developing Trust Between Practitioner and Child.**

The key message from this Building Block emphasizes that building trusting relationships and secure attachments with children helps to foster positive social and emotional development. Secure relationships have been shown to provide a sense of security in the child, regulate arousal and affect, promote the expression of feelings and communication and serve as a base for exploration (Goldberg, 2000). Understanding practitioners’ subjective experiences and giving voice to children’s experiences are seen as essential to fully realizing the complexities of the relationship and interactions between practitioners and children (Johnston & Brinamen, 2005).

Training focuses on what an attachment relationship is, how attachment relationships lay the foundation for social and emotional development, differences in the quality of attachment relationships (e.g., secure vs. insecure), how both practitioner and child contribute to the pattern of interactions they experience together and the influence of attachments from more fixed
features of the centre (e.g., practitioner-child ratios). How developmental progressions at various stages are related to children’s abilities for forming attachments is highlighted. Finally, practitioners reflect on their own attachment background and how this may have an impact on their relationships with children, how factors external to the centre (e.g., government policies) contribute to the development of practitioner-child attachments and the impact of a child having an attachment to a practitioner within the context of their other attachment relationships (e.g., with a parent).

Building Block 2: Building and Ensuring Positive Self-Esteem.

This key message of this Building Block highlights that fostering children’s self-esteem involves helping them to recognize and appreciate who they are and what they can do. Children’s self-esteem benefits from supportive relationships, good experiences and positive thinking (Canadian Mental Health Association, 2007). Positive self-esteem has been repeatedly identified as a protective factor that helps to minimize the negative effects of risks (Franck & Raedt, 2007; Masten & Coatsworth, 1995; Rutter, 1987). Consistent with an approach that promotes resilience, scholars suggest that self-esteem serves a crucial function by insulating young children from the stress that stems from negative life events and specifically protecting against depression (Stewart & Sun, 2007). Practitioners are guided to identify how their relationships with children influence the children’s developing capacity to experience the full range of emotions and to regulate interaction, attention and internal states in the formation of a primarily positive view of self and others (Zero to Three Infant Mental Health Task Force, 2002). In particular, it is considered to be important for practitioners to learn how to enhance children’s feelings that they are competent, valued and have an impact on the places and people around them. For example, practitioners can foster these areas by having children help shape rules, manage the environment and solve interpersonal conflicts (Maccoby & Lewis, 2003).
This workshop unit provides an overview of factors contributing to self-esteem development, the issues of temperament and ‘goodness of fit’, cultural considerations and strategies that practitioners use that either help or hinder children’s internalization of self-worth (e.g., different kinds of praise). A special section deals with considerations for enhancing self-esteem in children with special needs. Practitioners are encouraged to reflect on their own level of self-esteem and how it may affect their interactions with children, if there is such a thing as ‘grandiose’ self-esteem in children and if it is possible to nurture positive self-esteem when children’s centre experiences are offset by negative situations outside the centre (e.g., a parent who demeans them).

Building Block 3: Expressing Emotions.

For this Building Block, the key message is that understanding and expressing emotions constructively is essential for children to have their needs met, share experiences and build healthy relationships. Within this section, practitioners gain skills for using daily interactions with children to highlight understanding and expression of emotions. Techniques include labeling feelings and providing emotion-related words, explanations of cause and consequences of emotions and assistance with constructive means of emotion regulation (Brown & Dunn, 1996; Landy, 2002). Activities enhance practitioners’ understanding of strategies for talking to children about their emotions, both about how they make children feel inside as well as how they influence their behavior and impact others (Dunn & Brown, 1993; Laible, 2004).

Content topics deal with children’s capacity to communicate and control their feeling states during different stages of development, cultural variation in emotion expression, consideration of both negative and positive emotions as opportunities for practitioners to help children understand their feelings and how to share them, and emotion regulation. Special emphasis is given to the relationship between emotional development and language. In terms of
reflection, practitioners consider the value of acknowledging versus not acknowledging their own personal negative feelings with children at the centre, parental influences on how practitioners support children’s emotion expression and factors outside of the centre that may impact children’s feelings and the way they express them.

**Building Block 4: Relationships With Other Children.**

*Helping children to have positive relationships and social experiences with peers contributes to their sense of worth, competence and support* is the key message for this Building Block. Research confirms that access to other children and chances to learn from them enhance children’s lives and enables them to learn prosocial skills and interaction strategies (DiLalla, 1998). More research attention has been called to the important role of peer relationships in emotional well-being (Rubin, Bukowski, & Laursen, 2009). Even early friendships offer children benefits and a source of support (Walden, Lemerise, & Smith, 1999). Throughout this section, practitioners gain understanding of the importance of peers to children’s mental health and how to promote social skills and behaviours that contribute to effective interaction and engagement with other children.

This workshop unit presents topics detailing how children’s capacity to learn and use certain social skills depends on age and developmental stage. Further, information highlights how social skills need to be promoted and supported through practice. The unit also considers the development and maintenance of peer friendships and the impact on children’s well-being if they do or do not have friendships or when they lose friendships. Material is presented to link children’s developing theory of mind and perspective taking to meaningful friendships. Another content topic concerns helping children to resolve conflicts with peers. The concluding topic is intended to help practitioners better understand, appreciate and assist introverted and shy children. This latter topic was included to solicit practitioners’ attention to such children in child
care settings where typically extroverted children or those with externalizing behavioural
difficulties garner most of practitioners’ notice and/or concern. This workshop unit concludes
with practitioners reflecting on their own past social experiences and how they shaped their
interaction style, if they can affect the development of altruism in children and how they can deal
with children exposed to negative perspectives (e.g., coming from their parents) about
differences among people.

Building Block 5: Respecting Diversity.

In this Building Block, the key message is that developing a culture of inclusion involves
understanding and respecting diversity. Inclusion, in this respect, is conceived of as the
“convention for dignity and respect for all children whatever their country of origin, regardless
of their abilities, without reference to their family economic status, or their religion or other
differences that distinguish or define them” (Clough & Nutbrown, 2005). This is critical as
Canada is increasingly becoming a nation of many diverse groups. Practitioners’ knowledge,
beliefs and attitudes toward various forms of diversity are examined and linked to appropriate
strategies for teaching children about diversity.

The various types of diversity that exist among children and families are examined with
practitioners. How children become increasingly aware of similarities and differences between
people as they get older and how their growing sense of individual identity is influenced by their
group identities (e.g., racial/cultural, family composition) is considered. Practitioners are
encouraged to recognize their impact on children’s formation of beliefs about diversity and how
to respond to it. Activities allow practitioners to consider how to discuss differences among
people that children notice. Additionally, practitioners think about other individual differences,
specifically learning styles and multiple intelligences and their response to such differences
among children in their care. At the end of the unit, practitioners ask themselves reflection
questions about the relationship between their personal and professional values, how effective fostering respect of diversity can be when diversity is limited in the centre and their role in helping children manage competing messages they may receive about diversity.

**Building Block 6: Change and Transitions.**

Many children in centres will experience stressors related to parental separation and divorce, parent job loss, illness or death of a family member, birth of a new sibling or particular family circumstances (e.g., military families). Children also experience changes within the centre experience, such as child care practitioners and peers leaving. An essential component of mental health promotion is strengthening children’s ability to bounce back from adversity and manage the inevitable challenges presented by life (Willinsky & Pape, 1997). In this Building Block, the key message emphasizes that to support children’s well-being through change and transitions, it’s important to enable them to cope, adapt and successfully recover. Practitioners are guided to foster children’s active style of responding to stress, ability to elicit positive attention, belief in their own capacity to solve problems and skill in handling things autonomously with help seeking when necessary. These are factors that have been identified in developing children’s resilience (Masten & Coatsworth, 1998).

Practitioners work through content topics concerning children dealing with changes and transitions within the centre as well as beyond it, occurring at home or in the community. Activities and discussions guide them to think about factors that can impact how much children are affected by change and transitions and techniques for talking about changes with children and supporting them. In the reflection section, practitioners contemplate about their own kind of response style to changes in their lives, the boundaries that exist in discussing some issues with children and if they feel they possess sufficient skills and resources to help children effectively.
Building Block 7: Relationships With Parents.

There is evidence that good relationships between practitioners and parents are associated with healthy child outcomes (Endsley, Minish, & Zhou, 1993). Consequently, the key message for this Building Block is that actively involving parents and families in meaningful ways create partnerships that promote children’s mental health. This workshop unit cultivates skills connected to building mutual trust and good communication in which both perspectives are valued and both are enabled to understand the whole child (Sussna Klein & Miller, 2003).

To this end, training focuses on helping practitioners understand and be sensitive to family practices, expectations and practices and thinking about how their strategies for dealing with parents impact practitioner-parent interactions. The unit also emphasizes ways in which practitioners and parents can work together to find the best approaches for connecting parents and centres. Importantly, practitioners are encouraged to consider some of the different assumptions about parents and how they can be inaccurate. Family diversity is also examined in relation to practitioner-parent relationships. Practitioners reflect on their personal experience across different life stage affect their interaction with parents, if parents can be too involved in centre activities and the role they play in connecting families to community resources.

Building Block 8: Well-Being of Practitioners.

The key message of this Building Block is that practitioners’ own mental health affects the children they work with and is influenced by their workplace. It is critical for practitioners to maintain positive feelings about their work environment and job commitment. When these are diminished, centre program quality is reduced and linked to negative staff behaviours with children, such as low sensitivity, harshness and detachment (Doherty et al., 2000). Recognition of and techniques for continually engaging in the process of problem solving and finding
solutions that enable centres to be healthy places for both practitioners and children is the key process in this section.

Content topics examine how practitioners’ own mental health affects children, the concept of ‘organizational climate’ in the centre workplace and workplace factors related to practitioners’ well-being. Practitioners are encouraged to problem solve with regard to ways in which they can contribute to their own well-being in their centre, as well as adopt good practices concerning the intermingling of their professional and personal lives (e.g., when a fight with a spouse affects their mood at the centre). The unit concludes with practitioners reflecting on key aspects of their work that promote their job satisfaction, the centre supervisor’s role in promoting the well-being of practitioners and challenges inherent to the child care field (e.g., low wages) that affect practitioner’s mental health.

Building Block 9: Environment.

While previous Building Blocks emphasize the interpersonal environment in which mental health promotion is supported, this section addresses the impact of the physical environment. The key message is that features of the centre setting can bolster children’s and practitioners’ feelings of belonging, individuality, independence and competence. While practitioners are trained to create a safe environment, they also need to understand ways that the environment can be constructed to promote satisfying relationships between children and practitioners as well as practitioners and parents, allow provision of flexible, individualized care and support practitioners’ professional and personal needs (Zero to Three, 1994; Doherty, 1999).

This unit explores how the aspects of the centre physical environment contribute to children’s social and emotional development and create an emotional climate. Such features are further examined in relation to different developmental stages. The centre environment is also viewed as contributing to practitioner’s well-being. Finally, practitioners reflect on what aspects
of their centre environments influence their interactions with others, incorporation of parent and family needs into the centre setting and managing outside influences (e.g., television, negative news event) within the centre.

**Purpose of the Current Outcome Study**

The *Handle With Care* training program’s conceptualization of mental health promotion is comprehensive and transactional in nature. It considers the enhancement of mental health to transpire through three primary avenues: 1) children’s social and emotional development; 2) relationships between child care practitioners and parents; and 3) the well-being of practitioners themselves. In this way, the training parallels many principles inherent to mental health consultation, as well as parent-child psychotherapy. As Johnston and Brinamen (2005) emphasize, when consultants enter child care settings, they cross into an “established community environment of child care providers, parents and children” where the “potential for change is dependent up on the wishes, challenges and abilities of all the participants”

Similarly, *Handle With Care* highlights that it is not possible to promote mental health by solely equipping practitioners with strategies intended to positively impact children’s well-being. Instead, it is necessary to encourage practitioners to appreciate the power of the relationships that exist within the child care centre. Moreover, it is not enough to provide a practitioner with a technique to implement with all children in the centre. Each child possesses varying strengths, weaknesses and needs. These are heavily influenced by interactions with their parents and families, who also bring to the fold their unique set of characteristics and point of view. Further, how practitioners perceive children, parents and families is inextricably filtered through the lens of their own personal knowledge and experience, influencing their interactions with these individuals and groups as well as other practitioners. From this perspective, mental health promotion is an adaptive and systematic endeavour; essentially, for it to be successful with all
children, practitioners need to think about the underlying causes and meaning of behaviour of all centre participants (Johnston & Brinamen, 2005).

Ultimately, the way in which Handle With Care attempts to accomplish these goals is by training child care practitioners to develop a ‘mental health promotion mindset’ for thinking flexibly about children’s development and enabling them to engage in positive problem solving to implement positive promotion strategies. The workshop format provides a meaningful model for this, allowing for interaction, brainstorming and analyzing among participants. The current evaluation explores whether the content and approach of the Handle With Care training impacts child care practitioners’ knowledge about mental health promotion and their use of positive mental health promotion practices. This evaluation can help to close the gap in understanding whether mental health promotion training with professionals dealing with young children can be effective. Similar to research conducted by Farrell and Travers (2005) with a child care practitioner population, the present study examines the effect of training on practitioner knowledge and practices both immediately after Handle With Care training and following a delay of 6 months. This second time point is included to determine if any initial changes in practitioner knowledge and practices are sustained over time.

Expanding the Knowledge Base

Both the Handle With Care training program and the current evaluation study are innovative in comparison to other programs designed to foster children’s positive mental health and the way in which their effectiveness is examined.

Handle With Care represents a unique approach to mental health promotion training, employing a mixture of didactic, experiential and reflective techniques to stress how social-emotional development, family and community connections and practitioner well-being contribute to promoting children’s mental health. Currently, there is no other program for child
care practitioners in Canada that parallels the comprehensiveness of the *Handle With Care* content.

*Handle With Care* employs many crucial ideas identified in the literature as necessary to effective mental health promotion efforts. For example, it is emphasized that child care practitioners are well positioned as significant caregivers in children’s lives to use the relational context they build to enhance children’s social and emotional development. Furthermore, practitioners’ relationships with children occur at a critical period in their development. *Handle With Care* continuously teaches practitioners how their interactions with children influence learning and all aspects of development and can impact future relationships and behavior. Focus is consistently given to how practitioners can consistently build children’s capacity, resilience, optimism and social engagement rather than just how to prevent or curb mental health difficulties. Mental health promotion practices are conceptualized as happening all the time through everyday situations. Finally, the notion of mental health promotion is fostered as operating at many different levels. It’s essential for practitioners to consider individual children’s needs, but also how those needs interact with environmental factors, related to features of families, communities, centres and practitioners themselves.

As such, the training program utilizes many of the best facets of related mental health consultation, mental health promotion programs in schools and early childhood care settings that have been found effective. For example, similar to school-based programs that implemented a ‘whole school approach’, *Handle With Care* treats mental health promotion as a centre-wide effort that concentrates on all children and adults involved. Additionally, the program treats child care practitioners as the primary change agents by directly attempting to impact their understanding and skill set concerning children’s mental health promotion. Reflection, collaboration and attention to practitioners’ own well-being are encouraged to boost their sense
of self-efficacy when dealing with children, families and coworkers and managing challenging situations. Lastly, *Handle With Care* strives to ensure that child care practitioners consider the developmental appropriateness of their approaches with children and to keep in mind how developmental level and the child care environment influence pertinent mental health issues (e.g., pre-theory of mind peer conflict, loss of a child care practitioner, etc.)

Furthermore, there is an overall dearth of empirical evidence concerning early childhood mental health promotion program outcomes. There is one sole investigation similar to this evaluation, namely, broad mental health promotion training geared towards caregivers in early childhood settings (Farrell & Travers, 2005). Studies outside this specific population generally evaluate mental promotion programs directed to children within regular school systems (with older children and adolescents) and/or limited to restricted aspects of mental health (e.g., emotion expression). There remains a gap in our understanding of how mental health promotion efforts work for children in the 0-6 year age range; the stage of development identified as most critical for cultivating positive mental health. Additionally, there is a need for more information about the usefulness of training those in positions (such as child care practitioners) to broadly foster mental health promotion in younger children. The latter is the focus here.

For this study, the *Handle With Care* training program was evaluated within three different geographical regions in Ontario (Rural, Suburban and Urban). Including three regional groups provides the opportunity to examine whether the effectiveness of the training program is universal or possibly influenced in relation to different locations and populations. The program was delivered to front-line child care practitioners working in community-based child care centre settings with children under six years of age. A time series repeated measures design consisting of a mixed methods approach was used to investigate the outcome of the training. Specifically, child care practitioners’ knowledge and practices concerning mental health promotion were
measured prior to training, immediately after the conclusion of the *Handle With Care* program and 6 months following the end of the program. A comparison group consisting of child care practitioners not exposed to the *Handle With Care* training program was also employed to contrast results. Other evaluations investigating the effectiveness of mental health training programs for early childhood care professionals, such as *Reaching IN...Reaching OUT (RIRO)*, *Kids Have Stress Too!* and *Healthy Start* have not included comparison groups.

Previous mental health promotion training program evaluations have used outcome measures that rely on practitioners’ accounts of changes in their knowledge and skills. That is, the practitioners reported whether they believed training had an impact on their understanding of such topics as resiliency and skill implementation. There was no direct measure of specific knowledge or structured questions investigating the types of practices practitioners used. As such, evaluation focuses more on practitioners’ attitudes towards the training. Furthermore, in the case of the *RIRO* training program, practitioners received ongoing consultation support, no doubt reinforcing, strengthening and ensuring adherence to the program principles on which they were originally trained. This consultation is an important component to the efficacy of the *RIRO* training. The current study uses more objective measures (quantitative and qualitative) to directly assess child care practitioners’ knowledge and practices associated with mental health promotion. Furthermore, *Handle With Care*’s impact on knowledge and practices is investigated longitudinally, but without additional training reinforcement following completion of the workshops. Consequently, it offers important information about the effectiveness of the program as a stand-alone training activity.
Figure 2 summarizes the overall logic model for the Handle With Care evaluation. It outlines the program inputs, activities, outputs and outcomes. For the purposes of the current evaluation study, focus is concentrated on the impact on child care practitioners’ knowledge and practices. As such, data sources are limited to measures involving child care practitioners, the short-term outcome related to post-training data from training and comparison group participants as well as the long-term impact of the training program gathered from 6-month follow-up data. The research design and methods used to collect data are thoroughly described in Chapter 3.

The theory of change that describes how the Handle With Care program is intended to produce results is delineated in the set of assumptions and external factors listed in Figure 2. In particular, reasons to expect Handle With Care training to increase child care practitioners’ knowledge and practices concerning mental health promotion are based on evidence-based research (described in the preceding literature review). The training also consists of several teaching strategies, including didactic lecture, group discussion, experiential activities and reflection to enhance multi-modal learning for child care practitioners. Based on prior delivery of Handle With Care workshops and the subsequent feedback and interest from relevant professionals, the training program has been considered beneficial by those who attended the training as well as community stakeholders (e.g., consultants to child care centres, educators from post-secondary early childhood education and care programs).

In terms of external factors, how much Handle With Care training is able to impact child care practitioners’ mental health promotion knowledge and practices may be related to several elements that influence program implementation and the speed and degree of change. This includes training participant demographics, such as age and level of education and child care experience. Additionally, the cultural milieu of child care centres in which training participants
work may influence their openness to and application of *Handle With Care* content. Training participants’ understanding and use of *Handle With Care* principles may also be affected by the community in which child care centres are situated; certain mental health promotion topics may differentially resonate with training participants based on the various populations of children and families with which they work. These factors are examined more in-depth in Chapter 6 following discussion of study findings.
Figure 2: Handle With Care Logic Model

**Program Investment**
- Funding:
  - Alva Foundation
  - Hincks-Dellcrest Centre
- Participants:
  - Rural
  - Suburban
  - Urban
- HR/Staff:
  - Facilitators
  - Research assistants

**Processes (Formative)**
- **Child Indicators**
  - Attachment/trust
  - Self-esteem
  - Expressing emotions
  - Peer relationships
  - Diversity
  - Change & transitions
- **Parent Indicators**
  - Relationships/interactions with child care practitioners
- **Practitioner Indicators**
  - Professional well-being
  - Personal well-being
- **Activities**
  - Training
- **Program Delivery**
  - Number of sessions
  - Length of each session
  - Number of participants in each group

**Data Sources**
- **Input**
  - Child care practitioners
  - Facilitators
  - Community partners

**Output**
- **Direct results after exposure to training**
  - Workshop ratings
  - Post-Training data for training and comparison group participants
  - Facilitator experiences
  - Participant recruiter feedback
- **Goals?**
  - Learning: improved awareness on mental health, changes in skills, knowledge, opinion
  - Action: change of behaviour, practice,

**Outcome/Effectiveness**
- **Short Term**
  - Draft descriptive analyses
  - Sustained effect on learning and action
- **Intermediate Term**
  - 6-month follow-up data
  - Program fidelity info across all stages of program
  - Draft descriptive analyses
  - Sustained effect on learning and action
- **Impact (Summative)**
  - Evaluate program effectiveness in Mental health promotion of young children from birth to 6
  - Evaluate program impact on
    - Society
    - Economy
    - Policy

**Assumptions:** Beliefs we have about the program and those involved such as: Evidenced-based research; Breadth of teaching techniques; community input & interest; Experience with original HWC; HWC activity trial; Beliefs about mental health well-being

**External factors:** Factors that may Influence program implementation, speed and degrees of change, staffing patterns and resources available: Cultural milieu; Economic and community structure; Demographic patterns; Participants’ background and experiences; Media influence
Research Questions & Hypotheses

Based on anecdotal reports from practitioners previously trained through *Handle With Care* workshops, it is hypothesized that training participants in all regions will demonstrate significant gains in mental health promotion knowledge relative to control participants and to their initially measured level of knowledge (Child Care Questionnaire; described in Chapter 3). It is also hypothesized that training participants will provide more positive examples of mental health promotion practices in their work relative to control participants and to their initially sampled practices (Child Care Interview measure; described in Chapter 3).

To examine the impact of *Handle With Care* training on child care practitioners’ knowledge and practices related to mental health promotion, front-line child care practitioners were trained in three different geographical regions (Rural, Suburban, Urban) and compared to front-line practitioners who did not receive *Handle With Care* training matched according to region. Specific hypotheses are as follows:

**Hypothesis 1.**

*Given that training and control groups consisted of participants selected from similar regions and be recruited according to the same eligibility/exclusion criteria, there will not be significant differences between the groups at Time 1 (baseline) in mental health promotion knowledge as measured on the Child Care Questionnaire.*

**Hypothesis 2.**

*Immediately following conclusion of the full Handle With Care workshop series, training group participants will demonstrate a significant increase in mental health promotion knowledge as compared to control group participants at Time 2 (post-training).*
Hypothesis 3.

Significant increases in mental health promotion knowledge will be demonstrated by training group participants as compared to control group participants across all regions (Rural, Suburban, Urban) as measured between Time 1 and Time 2.

Hypothesis 4.

Handle With Care training participants will maintain mental health knowledge gains from Time 2 to Time 3 (6 month follow-up). There will be no significant changes between training participants’ Time 2 and Time 3 knowledge.

Hypothesis 5.

Handle With Care training participants will demonstrate significant mental health knowledge gains as measured between Time 1 to Time 3, reflecting an increase in knowledge resulting from the training workshop series.

Hypothesis 6.

Relative to Time 1, Handle With Care training participants will demonstrate higher quality mental health practices at Times 2 and 3, related to building trusting relationships with children, promoting children’s self-esteem, emotion expression and positive peer relationships.

Hypothesis 7.

Relative to Time 1, Handle With Care training participants will demonstrate higher quality mental health practices at Times 2 and 3, related to their relationships with parents of children in their care.
Hypothesis 8.

Relative to Time 1, Handle With Care training participants will demonstrate higher quality mental health practices at Times 2 and 3, related to enhancing their own well-being.
CHAPTER 3

METHOD

Research Design

The present investigation is intended to empirically explore the impact of the Handle With Care training program on child care practitioners’ knowledge and practices. This training program was developed with funding from Social Development Partnerships Program of Human Resources and Social Development Canada and produced by the Hincks-Dellcrest Centre/Gail Appel Institute. The Handle With Care program is a comprehensive series of mental health promotion training workshops for child care practitioners working directly with children between birth to six years of age. Specifically, this research project focuses on the outcome of training with respect to two main areas. First, it determined whether participation in the Handle With Care training project affected child care practitioners’ understanding of relevant factors involved in children’s mental health promotion. Secondly, it established whether training modifies child care practitioners’ mental health promotion practices in their daily strategies with the children in their care. The project utilizes a time series repeated measures design and consists of mixed qualitative and quantitative measures. Data collection took place between April 2009 and May 2011.

Child care practitioners representative of three regional areas within Ontario, including Rural, Suburban and Urban, were trained with the Handle With Care program. Study measures were administered at three time points: immediately prior to training (Time 1), immediately following training (Time 2) and six months after the end of training (Time 3). A comparison group of child care practitioners, matched for the three regional areas in which training was delivered, was also studied. These comparison participants received no training and completed
study measures at time points that paralleled data collection with training participants at Time 1 and Time 2. No Time 3 data collection was conducted from the comparison group.

Table 1

*Research Data Collection Schedule*

<table>
<thead>
<tr>
<th>Setting</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Baseline</td>
<td>Posttest</td>
<td>6-Months Follow-Up</td>
</tr>
<tr>
<td>Suburban</td>
<td>Baseline</td>
<td>Posttest</td>
<td>6-Months Follow-Up</td>
</tr>
<tr>
<td>Rural</td>
<td>Baseline</td>
<td>Posttest</td>
<td>6-Months Follow-Up</td>
</tr>
<tr>
<td>Control</td>
<td>Baseline</td>
<td>Posttest</td>
<td>-----</td>
</tr>
</tbody>
</table>

Participants

The total overall sample consisted of 113 child care practitioners. Fifty-seven practitioners completed the *Handle With Care* program and were included as part of the training group. These training participants subsumed three regional groups from which they were solicited. These areas were the locations for training participants’ residences, workplaces and provision of *Handle With Care* workshops. 14 participants (all females) comprised the rural training group, 21 participants (19 females, 1 male) comprised the suburban group and 22 participants (19 females, 1 male) for the urban group.

The rationale for dividing the training group into three subgroups representative of different regions was to assess whether the training might produce varying results with child care practitioners exposed to diverse education and populations of children. Although, province-wide, a front-line child care practitioner requires a minimum two-year college diploma in Early Childhood Education and Care, the time and place in which their learning occurred may have impacted the quality of their learning with regards to key topics associated with mental health promotion as contained in the *Handle With Care* training. Furthermore, certain regions may
consist of dissimilar proportions of child care practitioner demographic characteristics, such that some regions may have a greater number of older practitioners who received lesser degrees of education, entering into the field before the current requirements were implemented. Within regions, there may also be different access to professional development opportunities. As well, given that location and size of location can correlate with the cultural and socioeconomic makeup of its population, child care practitioners working in different regions may deal with children for which there are unique factors to consider in relation to their mental health promotion. It is therefore informative to examine if the Handle With Care program, created to be utilized with practitioners across Canada, is in fact, suitable for all practitioners, regardless of their background and where they work.

Inclusion and exclusion criteria were as follows. Child care practitioners needed to be employed in front-line staff positions at child care centres, dealing directly with children. Centre directors were permitted to participate if the majority of their work consisted of caring for children; directors whose main function was administrative were unable to be included in the project. Additionally, practitioners were required to have a minimum of two years education, or the equivalent in the case of mature practitioners. Thus, child care assistants or those working directly with children without a two-year educational background were excluded. As well, practitioners working towards Early Childhood Education and Care degrees, even in demonstration centres where other project participants were recruited, were not eligible. The child care centres in which practitioners worked could either be non-profit or commercial. Practitioners operating or employed in family or home child cares were excluded. Child care practitioners were required to speak English.

Child care practitioners were required to provide voluntary consent for participation as evidenced through their completion of a formal project informed consent form. An incentive of
$100 was offered following the end of project participation. This meant that the incentive was contingent on completing all measures at all study time points (Time 1, 2 and 3 for training participants and Time 1 and 2 for comparison participants). Specific to training participants, eligibility was dependent on their commitment to attend a minimum of 8 out of 9 *Handle With Care* workshops in the series.

Training participants were recruited with the assistance of contacts in the child care field that project investigators had made in the earlier phase of the *Handle With Care* program when the training was originally developed and piloted. Such contacts were either individuals who themselves had participated in the initial train-the-trainer version of *Handle With Care* in 2006 or were part of their larger child care networks. In the case of rural and suburban regions, these contacts held positions in provincially funded organizations and functioned in regulatory and consultation roles with child care centres in the catchment areas served by their agencies.

### Procedure

**Training Participants**

Regional contacts distributed project information sheets (Appendix A) detailing the content of the *Handle With Care* training workshop series, the requirements of project participation and contact information for the researchers. Potential participants independently forwarded a participant agreement form, filling in pertinent information needed to be included in the research and providing their signature to indicate that they had reviewed the project requirements, understood the nature and scope of their participation and agreed to take part in the training and data collection components (Appendix B). This agreement form fulfilled the condition of informed consent. Following the initial contact from potential participants, the
primary investigator telephoned them to ensure they met inclusion criteria and to confirm their participation.

Once informed consent was obtained from training participants, a telephone interview (Child Care Interview) was scheduled and individually administered. Telephone interviews were conducted immediately prior to the commencement (1-2 weeks) of the Handle With Care workshop series. Interviews were arranged to be completed at any time that was convenient for the practitioner prior to the start of training. Some practitioners scheduled telephone interviews during breaks in their working day while others completed them in the evening outside of work hours. Telephone interviews were conducted by one of four trained members of the research team. This included the primary investigator and the project coordinator. The remaining two interviewers were research assistants on the project with a minimum of an undergraduate degree in areas relevant to research psychology and child development. Interviews were scripted and all interviewers were trained how to deliver the interview, including how to field participant questions and troubleshoot to ensure consistency. Telephone interviews were audiotaped so that interviews could be completed in a timely manner, approximately 30 minutes, without having to simultaneously record participant responses. Audiotapes were later transcribed by other members of the project team.

Three Handle With Care workshop series were presented, one for each of the rural, suburban and urban regions included in the project. Every training series took place over 9 consecutive weeks, with one workshop session per week. Each workshop session covered the content of one Building Block and the series provided the Blocks in their consecutive sequence from 1-9, as outlined in the program manual. The introduction concerning mental health promotion was coupled with the first Building Block. Workshop sessions were each three hours in length. Training was held in facilities provided by one of the centres from communities in
which participants were recruited from (e.g., meeting room in a child care centre), or from regional contacts (e.g., meeting room in government operated service building). For rural and urban training groups, sessions were carried out in the evening immediately following conclusion of the work day. Suburban participants completed late-afternoon sessions, receiving work release for the first part of the session that overlapped with their work day and lieu time to recoup personal time. Training was consistently facilitated by the principal investigator and the project coordinator, both of whom developed the *Handle With Care* program and prepared the workshop manuals. For three sessions (two for the rural group and one for the urban group), the principal investigator was unable to facilitate and a substitute facilitator worked with the project coordinator. The substitute was either a co-developer of the *Handle With Care* program or an experienced trainer who had previously observed a complete *Handle With Care* training series and pre-planned delivery of the workshop session with the project coordinator in the regular facilitator’s absence. Participant attendance was taken for each session to document that participants met the inclusion requirement of attending a minimum of 8 sessions.

The Child Care Interview was administered prior to the introduction of *Handle With Care* training in the first session of each workshop series. Participants completed this questionnaire individually and were asked to work silently and not discuss questions with other participants. The research team communicated that questionnaires were intended to capture individual participants’ knowledge and responses. Facilitators also distributed Background Questionnaires to participants and requested that they take them home to fill out and return to facilitators the following week in the second workshop session.

In the initial session of each workshop series, facilitators established a climate of confidentiality and respect among participants and facilitators. It was important to acknowledge that the content of training could lead into some provocative workshop discussions. Participants
were encouraged to be open about their thoughts, feelings, experiences and challenges. Facilitators emphasized that discussions that took place during sessions would not be discussed outside of the workshops. It was also asked that participants attempt to be open-minded and considerate of everyone’s participation. Further to this, participants were assured that discussions would not be shared with participants’ centre supervisors and that their performance during workshop sessions was in no way connected to their work evaluations.

The format of training, one Building Block per week over 9 weeks, was structured so that participation would cause minimal interference to participants’ daily schedules. Within the *Handle With Care* facilitator’s manual, this is one of the recommended formats. A benefit of this mode of deliver is that the time between sessions allows participants to better consolidate what they’ve learned with their prior knowledge and ongoing daily experiences and to have time to reflect on the topics covered and try to apply learning to their practices. Participants were provided with *Handle With Care* participant manual to keep and follow during workshop sessions.

Each Building Block was presented according to the protocol outlined in the *Handle With Care* facilitator manual. Facilitators opened the workshop session with an opportunity for participants to raise questions or comments regarding the previous session’s information. Then facilitators introduced the topic of the current week’s Building Block, describing the Key Message contained in the workshop manual. As much as possible, facilitators extended ideas covered in previous Building Blocks to thread the concept of mental health promotion throughout all topics and to substantiate that each workshop unit successively builds on the information of earlier units. Then facilitators guided participants through the week’s Building Block, including the discussions, powerpoints, highlights, experiential activities and reflection sections from the facilitator manual. Additionally, each Building Block consisted of a
Background/Research section that described pertinent research connected to the unit topics and conceptualizations of why such topics were essential components of mental health promotion for children. Facilitators inserted information from this section throughout the corresponding Building Block.

At the conclusion of each workshop session, training participants were asked to complete an evaluation form to help facilitators gather participants’ perceptions regarding the usefulness of the material presented and the effectiveness with which facilitators imparted it. For the final session, an overall workshop evaluation was administered asking participants to express their views on the Handle With Care workshop in its entirety. Both evaluation forms encouraged participants to make suggestions for improvements to an aspect of the training.

After the last Building Block was delivered, a second version of the Child Care Questionnaire was distributed to participants. They were asked to take the questionnaire home and fill it in on their own time. Once again, it was stressed that participants should complete the questionnaire individually so that their responses reflected their own knowledge rather than collaboration with other child care practitioners. Participants were supplied with a self-addressed, stamped envelope for returning the completed questionnaire to the research team. They also scheduled themselves for a post-training Child Care Interview to be conducted over the telephone. Interviews took place within two weeks following the last workshop session.

To reduce potential bias, workshop facilitators were not involved as interviewers for any of the post-training telephone interviews; the other two trained members of the research team were responsible for administering all training participant interviews conducted after the workshop series had ended. Data collected at this stage represented Time 2.

Approximately 6 months after every regional Handle With Care workshop series ended, the training participants affiliated with that series completed Time 3 data collection measures.
Timing was based on the date at which their Time 2 Child Care Interview was conducted. Participants completed a third Child Care Interview via telephone, as well as two questionnaires that were mailed out to them by the research team. One questionnaire was a version of the Child Care Questionnaire (same format as Time 2). The second questionnaire was a Follow-Up Survey that contained questions requiring participants to acknowledge whether they had been applying the skills and knowledge acquired from the Handle With Care program, to rate the usefulness of each Building Block, list the top five ways in which the Handle With Care program was helping them in their work and describe the principal changes they had observed in the children they worked with as a result of what they were doing differently because of the training program. Participants were asked to fill out the questionnaires independently and were provided with a self-addressed, stamped envelope to forward them to the research team. Once all Time 3 measures were completed, training participants received $100 each as appreciation for the time and effort they had put forth into the project.

Comparison Participants

The same regional contacts which assisted the research team with training participant recruitment also helped to solicit participants to form regional comparison groups. Contacts identified child care centres for distributing project information (Appendix D) to potential comparison participants. While these centres were located in the same districts as centres from which training participants were enlisted, no one centre was used to recruit both training and comparison participants. This was done so that training participants could not communicate content and ideas from the Handle With Care workshops with comparison participants. Project information provided to comparison participants was modified from that shared with the training group. For comparison participants, there was no mention of the Handle With Care workshop series or that their involvement was to fulfill the requirements for a comparison group. The same
process for solicitation and obtaining informed consent was employed for comparison as for training participants (Appendix D). Similarly, the principal investigator confirmed that comparison participants met inclusion criteria and confirmed their participation over the telephone.

Once participation was confirmed, initial Child Care Interviews were scheduled with comparison participants by telephone. Interviews were completed by the same four trained research team members that conducted interviews with training participants. Background and Child Care Questionnaires were individually mailed out to participants who returned them to the research team using self-addressed, stamped envelopes the research team provided in their package. As with training participants, it was emphasized that practitioners should fill in questionnaires independently so that responses reflected their individual knowledge and experience. In all, these measures corresponded to Time 1 data collection for comparison groups.

The Child Care Interview and Child Care Questionnaire were re-administered to comparison participants approximately 9 weeks after completion of the initial telephone Interview. The two measures formed Time 2 data collection and the time gap between Time 1 and Time 2 paralleled the length of the Handle With Care workshop series that training participants attended. The procedures for completing these measures mirrored Time 1. Comparison participants fulfilled their project requirements when Time 2 measures were finished and were forwarded $100 compensation for their participation.

Training Groups

The training group consisted of a total of 57 practitioners (55 female; 2 male; see Table 1). Considered across regions, 14 participants were trained in the rural region, 21 participants in the suburban region and 22 participants in the urban region. The largest proportion of participants fell into the 20-29 year age range (38.6%), with the second largest proportion within
the 30-39 year age range (28%). Substantially fewer training participants fell into older age ranges (19.3% - 40-49 years; 14.0% - 50 or older). Approximately 66.7% of training participants were married, while roughly a quarter of practitioners were currently living with children (27%). Questions regarding practitioners’ children did not distinguish whether participants were parents of the children residing in their household.

In terms of education, the majority of training participants (73.7%) had completed a two-year college program as their highest level of education. Three participants (5.4%) had completed less than two years of post-secondary education. The majority of trainees (87.7%) held a two-year college certificate or diploma in early childhood education. This corresponds to the current Ontario minimum level of education required by at least one child care practitioner for each group of children in a centre. Three participants had received less than this two-year level in early childhood education. Most training participants (87.7%) had completed some form of professional development, including conferences, workshops and courses, in the 12 months leading up to the start of *Handle With Care* workshops.

In their current child care centre positions, 87.7% of training participants identified working with a specific age group. Approximately half of participants (50.9%) worked with children falling in the ‘toddler’ (18-35 months) and ‘preschool’ (3, 4 and 5 years) age range. Substantially fewer participants worked with ‘infants’ (0-17 months; 10.5%) or with children 6 years and older (5.3%). Participants were able to indicate working with one or more of these age groupings. Not all participants’ centres age group classifications aligned perfectly with those asked in the Background Questionnaire.

**Comparison Groups**

The comparison group consisted of 56 practitioners, all female (see Table 2). Within this group, the rural region included 21 participants, the suburban region 18 participants and the
urban region 17 participants. In contrast to the composition of the training group, comparison participants were equally distributed across age ranges, with the largest number (28.6%) between 40-49 years (25% - 20-29 years; 21.4% - 30-39 years; 25% - 50 or older). A large proportion of comparison participants were married (67.9%); approximately half of the comparison group (51.8%) lived with children.

Similar to training participants, the majority of comparison practitioners (62.6%) had at least two years of postsecondary education in any area. No comparison participants held less than this level of education. Three quarters of participants (75%) completed a two-year college program in early childhood education. Most other participants (23.2%) obtained more than two years post-secondary education in this area. One comparison participant (1.8%) had completed less than two years of college level education in early childhood education. As with training participants, almost all comparison participants (92.9%) completed some form of professional development in the 12 months before they began Handle With Care project participation.

With the exception of one participant, comparison participants (98.2%) identified working with a specific age group of children. A large proportion of comparison participants worked with ‘preschool’ children (57.1%). As with training participants, far fewer worked with ‘infants’ (19.6%) and children 6 years of age and older (12.5%).

Chi-square tests of independence were performed to examine the relation between training and comparison group status with demographic variables (see Table 2). There were no significant differences between groups in terms of age, marital status, living with children, highest level of education in any area as well as in early childhood education and professional development activities within the previous 12 months.
Table 2

Demographic Characteristics of Project Participants

<table>
<thead>
<tr>
<th></th>
<th>Training Group</th>
<th></th>
<th>p</th>
<th>Comparison Group</th>
<th></th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 57)</td>
<td>X^2</td>
<td></td>
<td></td>
<td>X^2</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>22</td>
<td>38.6</td>
<td>0.40</td>
<td>14</td>
<td>25.0</td>
<td>0.32</td>
</tr>
<tr>
<td>30-39</td>
<td>16</td>
<td>28</td>
<td>12</td>
<td>21.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>11</td>
<td>19.3</td>
<td>16</td>
<td>28.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 or older</td>
<td>8</td>
<td>14.0</td>
<td>14</td>
<td>25.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Level of Education (in any area)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1.8</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Less than two-year post-secondary</td>
<td>2</td>
<td>3.6</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-year college certificate/diploma</td>
<td>4</td>
<td>73.7</td>
<td>35</td>
<td>62.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than two-year post-secondary</td>
<td>1</td>
<td>21.1</td>
<td>21</td>
<td>37.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Level of Education (in Early Childhood Education)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>3.5</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Less than two-year post-secondary</td>
<td>1</td>
<td>1.8</td>
<td>1</td>
<td>1.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-year college certificate/diploma</td>
<td>5</td>
<td>87.7</td>
<td>42</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than two-year post-secondary</td>
<td>4</td>
<td>7.1</td>
<td>13</td>
<td>23.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status (% married)</td>
<td>38</td>
<td>66.7</td>
<td>36.11</td>
<td>0.00</td>
<td>38</td>
<td>67.9</td>
</tr>
<tr>
<td>Living with children (% with children)</td>
<td>27</td>
<td>47.4</td>
<td>0.16</td>
<td>0.69</td>
<td>29</td>
<td>51.8</td>
</tr>
<tr>
<td>Professional Development in last 12 months (%)</td>
<td>50</td>
<td>87.7</td>
<td>32.44</td>
<td>0.00</td>
<td>52</td>
<td>92.9</td>
</tr>
<tr>
<td>Specific classroom of children</td>
<td>50</td>
<td>87.7</td>
<td>32.44</td>
<td>0.00</td>
<td>56</td>
<td>98.2</td>
</tr>
<tr>
<td>Age of children in group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17 months</td>
<td>6</td>
<td>10.5</td>
<td>11</td>
<td>19.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35 months</td>
<td>29</td>
<td>50.9</td>
<td>21</td>
<td>37.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3, 4 and 5 year olds</td>
<td>29</td>
<td>50.9</td>
<td>32</td>
<td>57.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 years and older</td>
<td>3</td>
<td>5.3</td>
<td>7</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measures

The following measures were identical for both training and comparison group participants. All were designed by the project team for the current study.
Background Questionnaire

A questionnaire was created to obtain information on the background of project participants, including individual demographics (e.g., age, marital status, family composition, education, etc.) and years of experience in the child care field (Appendix E). Additionally, questions were included to gather details regarding child care practitioners’ prior access to mental health promotion information. The question contained items previously used in the environmental scan of the Early Childhood Care and Mental Health Project.

Child Care Interview

A semi-structured qualitative interview was developed by the research team to assess child care practitioners’ daily strategies in the child care centre environment (Appendix F). The information collected through the Interview was intended to answer questions related to practitioner’s mental health promotion practices, or the application of mental health promotion principles in their work with children, parents, families and coworkers. The Interview consisted of the same sequence of instructions and items across data collection points.

The Interview comprised a script to which the interviewers from the research team were trained to adhere. The introduction of the script discussed the kinds of questions to be asked, confidentiality of the information shared by participants and permission to audiotape and later transcribe the interview. All participants agreed to have their telephone interviews recorded. It was emphasized there were no ‘right or wrong’ answers to items to diminish the possibility that participants might feel evaluated. Project interviewers were trained to reiterate this point when participants expressed doubt or anxiety about their responses. Interviewers assured participants that the purpose of the Interview was to obtain their opinions based on the knowledge and experience and that they were the ‘experts’ regarding the topics discussed in the Interviews. Such comments were meant to convey that the interviewer and project team were not judging
participants. Interviewers were instructed not to probe participant responses unless they could not understand what the participant was expressing. When participants requested clarification of questions, interviewers were trained to rephrase questions in a manner that simplified the wording while retaining the meaning.

The Child Care Interview was comprised of a total of 29 questions. Each *Handle With Care* Building Block content was represented in the Interview with 2-4 questions addressing topics that were relevant to content covered within the training workshops and manuals. Questions per Building Block were grouped together for administration. Questions associated directly with children’s social and emotional development (Building Blocks 1-4,) started the Interview, followed by questions concerning more indirect and/or less controllable (by practitioners) factors influencing this area of development (Building Block 6 and 5). Finally, questions concerning practitioners’ interactions with parents (Building Block 7) and then their thoughts and practices related to the perceived impact of their own mental health (Building Block 8) rounded out the Interview.

**Child Care Questionnaire**

One of the major goals of the training program is to improve child care practitioners’ knowledge pertaining to mental health promotion for children in child care centres. A multiple-choice questionnaire was constructed to assess such knowledge, according to material presented within each Building Block workshop and manual unit (Appendix G). Overall, the questionnaire included 43 questions with 4 response options per item. 4-6 items were designed to test content specific to each unit; as well, 2 questions were fashioned concerning broad knowledge about mental health promotion. Questions were randomly sequenced on the instrument. For Time 2 and 3 data collections points, an alternative version of the questionnaire with a different randomized sequence was used.
CHAPTER 4

QUANTITATIVE RESULTS

In this chapter, quantitative concerning data collected from the multiple-choice Child Care Questionnaire dealing with child care practitioners’ mental health promotion knowledge. This chapter begins with a description of how the data were prepared for analysis and preliminary data screening to review assumptions. Subsequently, results are presented corresponding to study Hypotheses 1-5.

Whenever possible, three main comparisons were made for each outcome variable. The first comparison was at the group level, comparing differences between the Handle With Care training group and the comparison group that did not receive training. The second comparison examined within group differences with respect to region, namely the Rural, Suburban and Urban subgroups participants comprised. The third comparison also explored within group differences in terms of time, to determine if mental health knowledge changes over times. For the Handle With Care training group, this consisted of Time 1 (immediately prior to training), Time 2 (immediately following the conclusion of training) and Time 3 (6 months after training completion. Data were collected for the comparison group at two time points, Time 1 (at the time of recruitment) and Time 2 (approximately 9 weeks after Time 1 data collection were compared to parallel the length of the Handle with Care training program).

Data Preparation and Preliminary Data Analyses

Prior to data analysis, the properties of the data, including distribution, skewness and kurtosis, were examined to ensure that criteria were met for different analyses. No assumptions were violated for parametric analyses. The Statistical Package of the Social Sciences (SPSS) was the primary software package utilized for data analyses. Unless otherwise stated, a minimal alpha level of .05 was used as the standard for statistical significance.
Managing Missing Data

To be included in the data analyses, both training and comparison participants had to have Child Care Questionnaire data available for Time 1 and Time 2 data collection time points. Cases in which participants from either group provided only Time 1 information were excluded from the data set. There was some attrition in the training group at Time 3 (6 participants). The default in SPSS is that cases with missing values or scores that are specifically identified as missing values be excluded from computations. This was done rather than imputation of missing data as the attrition did not substantially reduce the sample size for analyses.

Child Care Questionnaire Findings

Hypothesis 1

Given that training and comparison groups consisted of participants selected from similar regions and recruited according to the same eligibility/exclusion criteria, there will not be significant differences between the groups at Time 1 (baseline) in mental health promotion knowledge as measured on the Child Care Questionnaire.

Prior to conducting comparisons involving Time 1 and Time 2 data, a one-way between subjects ANOVA was done to compare the mean total scores on the Time 1 multiple-choice questionnaire for training and comparison participants. The same procedure was used to compare participants included in region groups: Rural, Suburban and Urban. No main effects were found for either training \( F(1, 113) = .03, \ p = .87 \) or region \( F(2, 113) = .14, \ p = .87 \). Finally, effects were examined with a one-way ANOVA to determine if there was any training by region interaction. The overall \( F \) for this one-way ANOVA was also not statistically significant, \( F(2, 113) = 1.17, \ p = .31 \). These results indicate that there were no differences in total scores on the Child Care Questionnaire measure between training and comparison groups prior to the project training. Consequently, these findings support Hypothesis 1.
**Hypothesis 2**

*Immediately following conclusion of the full Handle With Care workshop series, training group participants will demonstrate a significant increase in mental health promotion knowledge as compared to comparison group participants at Time 2 (post-training).*

In considering the structure of the multiple-choice questionnaire, it was deemed important to explore the impact of *Handle With Care* training on participants’ knowledge according to each of the nine Building Blocks (in addition to Total scores). However, given the small number of items per Building Block (2-6), it was decided to combine sections in order for conduct more meaningful analyses. Two groupings of items were established and the mean total scores for each variable grouping were included in analyses. Intrinsic variables represented the first grouping, which combined questions concerning mental health promotion as well as those from Building Block 1-4 inclusive. These items dealt with children’s social and emotional development and were conceptualized as internal factors (developments within the child) involved in mental health promotion. This subsumed issues regarding attachment, self-esteem, emotion understanding and expression and peer relationships.

Extrinsic variables, the second grouping, consisted of items from Building Blocks 5-9 inclusive. This grouping dealt with factors external to the child relevant to mental health promotion, including diversity, life transitions and stressors, practitioners’ relationships with parents, practitioner’s well-being and the physical environment of child care centres. These two groupings conceptually align with the three core features of the *Handle With Care* training’s approach to mental health promotion: 1) developmental considerations (Intrinsic grouping); 2) collaborations with families in multicultural context; and 3) providing a positive work environment for child care practitioners (2 & 3-Extrinsic grouping).
Means and standard deviations of Time 1, 2 and 3 Total questionnaire scores, along with Intrinsic and Extrinsic factor mean totals for each time period are presented in Table 3. Scores were approximately normally distributed and there were no serious violations of the assumption of homogeneity of variance across groups. Correlations among Child Care Questionnaire scores and various participant variables are shown in Tables 4 and 5.

A one-way between subjects ANOVA was done to compare the mean scores for training and comparison participants on Time 2 questionnaire total scores. The overall $F$ for the one-way ANOVA was statistically significant, $F(1, 110) = 6.65, p = .01$. This indicates that training participants possessed more mental health promotion knowledge than comparison participants when assessed immediately following the Handle With Care training. Therefore, findings support Hypothesis 2. However, additional analyses of Intrinsic and Extrinsic variables indicated only a significant difference at Time 2 between the training and comparison groups in terms of Intrinsic variable knowledge, $F(1,111) = 15.4, p < .001$. There was no significant difference between groups at Time 2 for knowledge related to Extrinsic variables.
### Table 3

**Descriptive Analyses of Questionnaire Scores and Independent Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Training Group</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Questionnaire Total</td>
<td>57</td>
<td>30.12</td>
</tr>
<tr>
<td>Intrinsic Factor Total</td>
<td>57</td>
<td>13.11</td>
</tr>
<tr>
<td>Extrinsic Factor Total</td>
<td>57</td>
<td>17.12</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Post-Training Total       | 57 | 32.89 | 4.23 | 56 | 30.30 | 5.73 | 6.64 | .011*
| Intrinsic Factor Total    | 57 | 14.63 | 2.42 | 56 | 12.80 | 2.42 |      |      |
| Extrinsic Factor Total    | 57 | 18.26 | 2.42 | 56 | 17.50 | 3.67 |      |      |
| **Time 3**                |    |       |     |    |     |      |    |      |
| 6-Month Follow-Up Total   | 51 | 32.51 | 4.39 | --- | ---  | ---  |     |      |
| Intrinsic Factor Total    | 51 | 14.59 | 2.43 | --- | ---  | ---  |     |      |
| Extrinsic Factor Total    | 51 | 17.92 | 2.61 | --- | ---  | ---  |     |      |

*a* 43 Total questionnaire items consistent across times  
*b* 20 Intrinsic questionnaire items consistent across times  
*c* 23 Extrinsic questionnaire items consistent across times  

**Significant at the 0.05 level (2-tailed).**

---

### Table 4

**Pearson Correlations of Independent (Training & Comparison Groups) and Dependent Variables**

<table>
<thead>
<tr>
<th></th>
<th>Training Group</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td>2.</td>
</tr>
<tr>
<td><strong>Comparison Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. T1Q_Intrinsic</td>
<td>---</td>
<td>.44</td>
</tr>
<tr>
<td>2. T1Q_Extrinsic</td>
<td>.60**</td>
<td>---</td>
</tr>
<tr>
<td>3. T1QTotal</td>
<td>.84**</td>
<td>.94**</td>
</tr>
<tr>
<td>4. T2Q_Intrinsic</td>
<td>1.00**</td>
<td>.60**</td>
</tr>
<tr>
<td>5. T2Q_Extrinsic</td>
<td>.55**</td>
<td>.80**</td>
</tr>
<tr>
<td>6. T2Total</td>
<td>.62**</td>
<td>.81**</td>
</tr>
<tr>
<td>7. Years/Experience</td>
<td>.24</td>
<td>.20</td>
</tr>
<tr>
<td>8. Age</td>
<td>.11</td>
<td>.09</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed).**  
* Correlation is significant at the 0.05 level (2-tailed).
Table 5

*Pearson Correlations of Independent (Region Groups) and Dependent Variables*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suburban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
Hypothesis 3

Significant increases in mental health promotion knowledge will be demonstrated by training group participants as compared to comparison group participants when considered according to region (Rural, Suburban, Urban) as measured between Time 1 and Time 2.

Further analysis was conducted to determine if the significant impact of Handle With Care training occurred in every region participant group (see Table 6). One-way ANOVAs indicated that of the three regions, only the Suburban training group demonstrated a significant change in questionnaire mean total scores from Time 1 to Time 2. However, when knowledge between time points was also considered in terms of Intrinsic and Extrinsic variables, further significant differences were found. Both Rural and Suburban training groups showed significant differences on Time 2 measures of Intrinsic variable knowledge as compared to region comparison groups. This did not hold true for Extrinsic variable knowledge. Urban groups demonstrated no significant changes in pre- to post-training knowledge with either Intrinsic or Extrinsic variables. Consequently, results only partially support Hypothesis 3.
Table 6

ANOVA Results Between Groups Across Regions on Child Care Questionnaire Totals

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1_Total</td>
<td>Between Groups</td>
<td>25.376</td>
<td>1</td>
<td>25.376</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>801.024</td>
<td>33</td>
<td>24.273</td>
</tr>
<tr>
<td>T1_Intrinsic</td>
<td>Between Groups</td>
<td>.805</td>
<td>1</td>
<td>.805</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>168.167</td>
<td>33</td>
<td>5.096</td>
</tr>
<tr>
<td>T1_Extrinsic</td>
<td>Between Groups</td>
<td>17.143</td>
<td>1</td>
<td>17.143</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>379.429</td>
<td>33</td>
<td>11.498</td>
</tr>
<tr>
<td>T2_Total</td>
<td>Between Groups</td>
<td>53.505</td>
<td>1</td>
<td>53.505</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>629.238</td>
<td>33</td>
<td>19.068</td>
</tr>
<tr>
<td>T2_Intrinsic</td>
<td>Between Groups</td>
<td>31.243</td>
<td>1</td>
<td>31.243</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>115.500</td>
<td>33</td>
<td>3.500</td>
</tr>
<tr>
<td>T2_Extrinsic</td>
<td>Between Groups</td>
<td>2.976</td>
<td>1</td>
<td>2.976</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>275.024</td>
<td>33</td>
<td>8.334</td>
</tr>
<tr>
<td><strong>Suburban</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1_Total</td>
<td>Between Groups</td>
<td>29.280</td>
<td>1</td>
<td>29.280</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1072.310</td>
<td>37</td>
<td>28.981</td>
</tr>
<tr>
<td>T1_Intrinsic</td>
<td>Between Groups</td>
<td>15.048</td>
<td>1</td>
<td>15.048</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>180.849</td>
<td>37</td>
<td>4.888</td>
</tr>
<tr>
<td>T1_Extrinsic</td>
<td>Between Groups</td>
<td>2.347</td>
<td>1</td>
<td>2.347</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>547.397</td>
<td>37</td>
<td>14.795</td>
</tr>
<tr>
<td>T2_Total</td>
<td>Between Groups</td>
<td>188.738</td>
<td>1</td>
<td>188.728</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1224.349</td>
<td>37</td>
<td>33.091</td>
</tr>
<tr>
<td>T2_Intrinsic</td>
<td>Between Groups</td>
<td>80.889</td>
<td>1</td>
<td>80.889</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>293.778</td>
<td>37</td>
<td>7.940</td>
</tr>
<tr>
<td>T2_Extrinsic</td>
<td>Between Groups</td>
<td>22.505</td>
<td>1</td>
<td>22.505</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>451.238</td>
<td>37</td>
<td>12.196</td>
</tr>
<tr>
<td><strong>Urban</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1_Total</td>
<td>Between Groups</td>
<td>1.958</td>
<td>1</td>
<td>1.958</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>650.709</td>
<td>37</td>
<td>17.587</td>
</tr>
<tr>
<td>T1_Intrinsic</td>
<td>Between Groups</td>
<td>2.449</td>
<td>1</td>
<td>2.449</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>179.243</td>
<td>37</td>
<td>4.844</td>
</tr>
<tr>
<td>T1_Extrinsic</td>
<td>Between Groups</td>
<td>.027</td>
<td>1</td>
<td>.027</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>226.332</td>
<td>37</td>
<td>6.117</td>
</tr>
<tr>
<td>T2_Total</td>
<td>Between Groups</td>
<td>1.077</td>
<td>1</td>
<td>1.077</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>772.318</td>
<td>36</td>
<td>21.453</td>
</tr>
<tr>
<td>T2_Intrinsic</td>
<td>Between Groups</td>
<td>1.866</td>
<td>1</td>
<td>1.866</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>177.528</td>
<td>36</td>
<td>4.931</td>
</tr>
<tr>
<td>T2_Extrinsic</td>
<td>Between Groups</td>
<td>.108</td>
<td>1</td>
<td>.108</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>299.892</td>
<td>36</td>
<td>8.330</td>
</tr>
</tbody>
</table>

**p < 0.01  *p<0.05**
Hypothesis 4

Handle With Care training participants will maintain mental health knowledge gains from Time 2 to Time 3 (6 month follow-up). There will be no significant changes between training participants’ Time 2 and Time 3 knowledge.

To evaluate the level of training participants’ mental health promotion knowledge across project time points, a one-way within subjects (or repeated measures) ANOVA was performed with a Greenhouse-Geisser correction. Child Care Questionnaire data across Time 1, 2 and 3 were available for 51 training participants (13 – Rural; 17 – Suburban; 21 – Urban). There were no significant violations of the sphericity assumption. This analysis determined that questionnaire mean total scores were significantly different between time points for the training group overall, Wilks’ Lambda = .60, \( F(2, 47) = 15.99, p = .00 \). Post hoc tests using the Bonferroni correction revealed that Handle With Care training was related to an increase in mental health promotion knowledge from pre-training to post-training (immediately following the conclusion of the 9-week workshop series)\( (p = .00) \). However, the change in training participants’ knowledge from Time 2 to Time 3 was not statistically significant \( (p = .64) \). This is not surprising as no further training was conducted in the 6 months following the end of Handle With Care workshops and it is likely that participants received no additional mental health promotion education. Therefore, the effects of training were maintained.

Examination of plotted scores across time shows a decline in mean total scores from Time 2 to 3 for every region group. Although training participants did not maintain the same level of mental health promotion knowledge as they had immediately following Handle With Care training, it was not a significant decrease. Therefore Hypothesis 4 is supported by these results.
To examine the areas in which training participants’ knowledge was enhanced by the *Handle With Care* workshops, repeated measures ANOVAs were carried out separately for Intrinsic and Extrinsic variable total scores. Analyses indicated that training participants showed gains across time in both these areas: Intrinsic – Wilks’ Lambda = .59, $F(2, 47) = 16.04, p = .00$; Extrinsic – Wilks’ Lambda = .82, $F(2, 47) = 5.13, p = .01$. This is interesting because although there was no significant difference between training and comparison groups on Extrinsic variable knowledge, these results confirm that trainee knowledge concerning such topics was nevertheless significantly enhanced compared to what they knew prior to *Handle With Care* training. When post hoc tests using the Bonferroni correction were completed, participants displayed significant increases in knowledge of Intrinsic variables between Time 1 and Time 2 ($p = .00$), or from pre-to post-training, but not from Time 2 to Time 3 ($p = .77$). This was also the case for Extrinsic variables: Time 1 to Time 2 ($p = .00$); Time 2 to Time 3 ($p = .29$). Furthermore, there were no significant time by region interactions between any time points assessed for either Intrinsic or Extrinsic variables.

**Hypothesis 5**

*Handle With Care* training participants will demonstrate significant mental health knowledge gains as measured between Time 1 to Time 3, reflecting an increase in knowledge resulting from the training workshop series.

Finally, to determine whether *Handle With Care* training impacted trainees’ mental health promotion knowledge (total Child Care Questionnaire scores) across the full scope of the project (from pre-training to the 6 month follow-up), a univariate ANCOVA was performed. This analysis showed an overall significant main effect of time, $F (1, 47) = 34.03, p = .00$, demonstrating that, as a group, training participants’ knowledge increased from Time 1 to Time 3. This held true despite a nonsignificant decline in mean total scores for the training group.
overall from Time 2 to Time 3. As such, these results support Hypothesis 5. Further examination of the data established that there was not a significant main effect for region, indicating that the region participants came from did not distinguish them in terms of their Time 3 total scores. However, analysis did show a significant interaction between region and Time 1 total questionnaire scores, $F(3, 47) = 11.46, p = .00$. This indicates that region groups did not start with the same level of mental health promotion knowledge measured prior to training. Urban training participants, in particular, achieved higher mean total scores on the Child Care Questionnaire as compared to Rural and Suburban training participants. Urban training participants possessed greater awareness and understanding of mental health promotion for children between birth to age 6 before they were exposed to the *Handle With Care* workshop series relative to the other regional training groups.
CHAPTER 5

QUALITATIVE FINDINGS

Qualitative findings are described in this chapter. These findings reflect data collected through the Child Care Interview exploring child care practitioners’ report of their mental health promotion practices. This section initially provides a description of how interview data were organized and then provides an explanation for the coding system used to analyze the data. Then findings are presented in response to study Hypotheses 6-8.

Data Organization

Audiotaped participant Interviews were transcribed verbatim and inputted to NVivo (QSR International, 2010), a software program that supports qualitative research. This software allows in-depth coding of word documents through highlighting of key points. Coding then guides analyses through specific software queries to discover trends and summarize themes. Participant identification was removed from NVivo interview files and replaced with generic labels in order to keep coders blind to the group (training versus comparison), region (Rural, Suburban and Urban) and time (Time 1, 2, or 3) classifications to which Interviews belonged.

Data Coding and Analyses

A coding system was developed to analyze qualitative participant responses. Two types of coding were created to consider the impact of Handle With Care training on participants’ mental health promotion practices. First, descriptive coding unique to each Interview question was generated to identify the various topics discussed by participants. Descriptive coding has been referred to as establishing the “basic vocabulary” of data that forms the “bread and butter” categories for further analytic work (Turner, 1994). Furthermore, descriptive codes collected across different time points are essential for assessing longitudinal participant change (Saldana,
2003, 2008). Given that the current project is exploratory in nature, descriptive coding was considered to be appropriate for capturing the substance of practitioners’ responses.

Secondly, quality coding was developed specific to each Interview question. Quality coding was based on the template of magnitude coding, as described by Saldana (2009), whereby a supplemental alphanumeric code is added to an existing coded datum to indicate evaluative content. In the case of Interview questions, a quality code was assigned to reflect: 1=Low Quality; 2=Adequate Quality; or 3=High Quality. Saldana (2009) suggests that this kind of coding is suitable for social science research that also utilizes quantitative measures as evidence of outcomes; magnitude coding can add texture to more elaborative coding and both types of coding may work in concert to fashion richer answers and corroborate each other. Quality codes were designed in association with descriptive coding; criteria for quality codes typically included explanation of how to use descriptive codes to determine the appropriate quality rating.

A codebook was produced to explain the descriptive and quality coding available to each Interview item (see Appendix H for codebook example). Where necessary, examples were provided. Interviews were coded by four members of the research team. These members included two of the training facilitators as well as two members uninvolved with any other aspects of training.

Following preliminary analyses, it was decided to focus on findings from Building Blocks 1, 2, 3, 4, 7 and 8. Interview data related to content concerning diversity, change and transitions and the environment were found not to be specific or informative. Consequently, Hypothesis 6 deals with Interview responses to questions pertaining to Building Blocks 1 (Developing Trust Between Practitioner and Child), 2 (Building and Ensuring Positive Self-Esteem), 3 (Expressing Emotions) and 4 (Relationships With Other Children). Hypothesis 7 focuses on findings from Building Block 7 Interview questions (Relationships With Parents),
while Hypothesis 8 concerns Building Block 8 Interview responses (Well-Being of Practitioners).

The presentation of findings concerns both the descriptive and quality coding for each Interview item. Quality coding findings are first shown in frequency tables to clearly illustrate the number of Low, Adequate and High quality responses according to Interview question provided by training and comparison participants according to region and time. Missing interview data are noted under these tables. Chi-square analyses were conducted to determine the patterns of frequency counts. Specifically, these analyses were completed in order to examine and report any significant discrepancies between training and comparison groups at Time 1 and Time 2. Then analyses were completed to examine group changes over time, within the training group between Time 1 and Time 2 and, subsequently, between Time 2 and Time 3. The same analyses were also completed within the comparison group between Time 1 and Time 2. Regional differences were not analyzed due to the small frequency counts in cells when data were further broken down in this manner. However, such differences are qualitatively noted. Examples of training participant responses (not comparison participants) are included to depict differences between Low, Adequate and High quality ratings. Subsequently, descriptive code findings (exclusively from training participants) are explained in terms of content trends found in Interview question responses.

Child Care Interview Findings

Hypothesis 6

Relative to Time 1, Handle With Care training participants will demonstrate higher quality mental health practices at Times 2 and 3, related to building trusting relationships with children, promoting children’s self-esteem, emotion expression and positive peer relationships.
Building Block 1: Developing Trust Between Practitioner and Child.

The four questions associated with the Handle With Care’s initial training unit explored participants’ understanding of their attachment relationships with children in their care (See Appendix F: Child Care Interview for questions). Specifically, participants explained how: a) their relationships with children impacted children’s development as well as b) practices they employ to foster trusting and secure relationships with children. Additionally, participants were asked about what they consider to be c) factors that influence their ability to make children feel safe and secure and, more broadly, about d) aspects of their professional and/or personal life that influence their relationships with children. Tables 1-4 present the overall quality code ratings for these questions for both training and comparison participants across study time points.

Table 7

Building Block 1: Question A—How do you think children’s relationships with you affect their development?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>17</td>
<td>8</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>22</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>High Quality</td>
<td>16</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>21</td>
<td>6</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>High Quality</td>
<td>27</td>
<td>4</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>21</td>
<td>7</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>High Quality</td>
<td>27</td>
<td>6</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>
*One participant interview tape cut off this initial question response.

At Time 1, before *Handle With Care* workshops, training and comparison groups demonstrated similar frequency levels with respect to Adequate and High quality responses. The training group provided significantly more Low quality responses ($\chi^2 = 1.23, p < 0.001$) relative to the comparison group.

Following completion of the workshops at Time 2, the training group showed major shifts in quality, with a significant reduction in the number of Low quality responses ($\chi^2 = 20.17, p < 0.001$) and a significant increase in the number of High quality responses ($\chi^2 = 4.48, p < 0.001$) as compared to Time 1. No significant change was observed with respect to the number of Adequate quality responses given by training participants between Time 1 and Time 2. In contrast, the comparison group showed Time 2 quality levels virtually equivalent to Time 1, with no significant changes. Quality shifts that occurred in the training group between Time 1 and Time 2 resulted in this group providing significantly fewer Low quality responses ($\chi^2 = 3, p < 0.001$) and significantly more High quality responses ($\chi^2 = 3.37, p < 0.001$) relative to the comparison group at Time 2.

At Time 3, improvements in quality levels shown overall by the training group immediately after workshops at Time 2 were maintained. The sole significant change was a reduction in Low Quality responses ($\chi^2 = 3, p < 0.001$), accounted for by attrition. However, the three subgroups continued to change even six months after training. The Rural and Suburban subgroups showed more improvements in the quality of their responses. The Urban subgroup differed in not sustaining improvements shown at Time 2; they provided fewer High quality responses and more Adequate quality responses at Time 3.

Prior to *Handle with Care*, a number of training respondents indicated that they did not perceive their relationships with children as particularly important in shaping their development
in any way. Such respondents expressed that children or practitioners themselves possessed characteristics that largely determined the nature of practitioner-child relationship. Responses were coded as Low quality in these instances in which the practitioner inaccurately indicated that practitioner-child relationships have no effect on children’s development. Low quality was also coded when participants did indicate the relationship was important but offered no discussion of its impact on children’s development.

I think at this age group, as long as they feel confident with who they are and feel comfortable that they get the social development that they need and they get the – they know how to bond with people. (Time 1-Low quality)

Um well I think it affects them greatly, because they are with myself and my team partner for 8 hours of the day, some more than that but for our shift it is 8 hours. But I think that my energetic personality, and the encouragement that I give them does affect them. Because if it was a very negative environment, they would not want to come in during the morning. A lot of them do run to me in the morning to greet me which I take as a good sign having done this for so long.” (Time 1-Low quality)

These participants focused on describing relatively short-term impacts that the relationships stimulate and/or noted effects on development that relate to children’s school preparation and rule-following behaviour.

Um (long pause) how it affect their development? Well when you have a good relationship with them, it affects their day, they are happy throughout the day. If they see us frowning or sad, it affects their mood throughout the day too. If we are singing or happy, they are happy and singing and dancing. So it definitely affects their mood. (Time 1-Low quality)

Largely. I guess in the way that they would, in how they respect adults and authority figures, because I guess if we don’t have a good relationship that could continue on with other adults. (Time 2-Low quality)

Adequate quality was coded when participants recognized that the relationship affected children’s development but did not communicate specific examples of areas of development. Responses were coded as High quality when there was description of one or more ways in which
the practitioner-child relationship affected children’s cognitive, social and/or emotional growth. Training participants’ responses subsequent to training increasingly conveyed understanding of how a positive practitioner-child relationship helps to provide a secure social and emotional base that can facilitate healthy development across all areas of children’s functioning (e.g., cognitive, social, emotional). This shift from a ‘Low’ or ‘Adequate’ Quality response to a ‘High’ Quality response is illustrated in these responses given by a Suburban training practitioner prior to *Handle With Care* training (Time 1) and then immediately after training (Time 2). As well, more training participants explicitly indicated that practitioner-child relationships represented ‘attachment’ relationships.

I think that children’s relationships with me affect their development because each and every day that they come to the child care centre, they’re watching me, they’re imitating me, they’re modeling my behaviour during the day in my classroom and they learn off of me and the children need to feel comfortable with me in order for us to have a successful day. The children need to be able to approach me with questions or comments or whatever they might be thinking of and I need to be ready, willing and able to help them out, give them guidance, positive reinforcement, get down to their level and be able to share control with the children in my group. (Time 1-Adequate quality)

I think that children’s relationships with me affect their development because if they are attached to me then I think that they will develop better then if they didn’t have a good attachment with their primary caregiver. They will feel more comfortable with their primary caregiver with a positive attachment and they will be willing to participate more, communicate more and probably be more inclined to do more things at the child care centre or within the group just because of their comfort level and they are probably going to have more self-esteem and just be all around more inclined to grow and develop in the program because they are happy and if they’re happy then they are able to be satisfied. (Time 2-High quality)

Descriptively, training participants noted more developmental areas impacted by practitioner-child relationships than previous to *Handle With Care* workshops. This included children’s self-esteem (e.g., self-worth, confidence, how practitioners make children feel about
themselves), sense of security (e.g., feeling physically and emotionally safe, knowing it is OK to seek assistance from others when needed), willingness to try new activities, explore their surroundings, receptivity to learning (e.g., motivation, being able to attend) and capacity to trust and develop relationships with other adults and peers.

I think it is a big part of their development if they have a close attachment with the primary caregiver, being myself, it enables them to have the confidence to explore new materials, get involved with the other children, also they feel confident in sharing experiences and verbalizing with the other children, that sort of thing. (Time 2-High quality)

I think it affects their development tremendously. I feel like children need to have a trusting relationship with me in order to engage activities, in order to learn how to follow routines and also to trust me that I am guiding them in the right way. I think it affects every aspect of their development not just for them to get to like me, it’s more like how I act with their parents and they see how I act with their parents in a positive way, their parents are their primary caregiver and if they see that the trust is there, they open up and let me in. So I think it affects all aspects of their development. (Time 2-High quality)

I think it’s very important. I think that if children don’t bond and feel secure, that their learning is hindered. Learning in anything. If they always have to feel stressed because they haven’t bonded or they don’t feel secure in the atmosphere then even from wanting to eat or for infants to sleep, toddlers same thing sleep, just generally needs of life and then when you get to preschool if they don’t feel secure then it hinders their learning whatever you want to teach them, the fine motor, the gross motor, all of the stages, it certainly affects them. (Time 3-High quality)
Table 8

**Building Block 1: Question B**–In what ways do you help children develop a trusting and secure relationship with you?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>39</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>5</td>
<td>16</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>3</td>
<td>4</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>42</td>
<td>44</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>High Quality</td>
<td>9</td>
<td>6</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>37</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>High Quality</td>
<td>14</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

At Time 1, the training group presented significantly more Low quality responses ($\chi^2 = 12, p < 0.001$) and significantly fewer High quality responses ($\chi^2 = 1.45, p < 0.001$) relative to the comparison group. No significant differences existed between groups in terms of Adequate quality responses.

From Time 1 to Time 2, the training group showed significant decreases in Low quality responses ($\chi^2 = 12, p < 0.001$), with small, but nonsignificant increases in Adequate and High quality responses. Relative to the comparison group at Time 2, the training group exhibited significantly more High quality responses ($\chi^2 = 1.5, p < 0.001$). The comparison group displayed a significant decrease in the frequency of High quality responses ($\chi^2 = 4.17, p < 0.001$) from
Time 1 to Time 2. No other significant changes in quality were observed for the comparison group between these two time points.

From Time 2 to Time 3, the training group demonstrated a further significant increase in High quality responses ($\chi^2 = 1.79, p < 0.001$). Nonsignificant decreases were also noted for the training group with respect to Low and Adequate quality response frequency.

With respect to how practitioners help children develop a trusting and secure relationship with them, training participants highlighted a number of positive strategies prior to *Handle With Care* workshops. In particular, being responsive to individual needs, supportive (being gentle, not forcing oneself on a child), responsive communication (e.g., getting down to child’s level, eye contact, sound/tone of voice) and assisting with problem solving were frequently mentioned prior to training and maintained similar frequency levels subsequent to training (Time 2 and 3). Additionally, many training participants described using physical affection, disclosure of their own personal information and talking to children constantly prior to their workshop training. Such strategies were deemed vague or nonspecific examples in coding. Following the *Handle With Care* workshops, the frequency of these kinds of responses declined dramatically.

Subsequent to the workshops, training participants increasingly described enhancing children’s trust in them through acknowledgment of feelings and extended conversations about feelings. It is noteworthy that these kinds of approaches were strongly referenced in both Building Blocks 1 and 3. Furthermore, training participants discussed openness and availability (e.g., being there when children need them, helping children to feel as though they can come to practitioners for help and support and to meet their needs) as well as consistency (e.g., in terms of limits, following through with what they say to children, expectations) more after completing *Handle With Care* workshops.
Well now that I have taken the classes like I didn’t know there was as many little things, like before sometimes I would be hesitant or I wouldn’t like talk about so much about like feelings but I have been trying to do it more. It kinda helps because I know in one situation there was a child taking a toy from another child and um that one child had it first but the other teacher didn’t notice. Like they could have actual shared the toy but the teacher just came and said ok no this girl can use it. So I went up to the girl and called the other boy back and said, “Look at his face” and “Do you think he is happy or sad?” And she said “sad”. I said, “Why do you think he is sad?” and then I said, “Tell her, tell her why you are sad”. And he said, “Because we can share but she doesn’t want to.” And I said, “oh okay, how about you tell her, tell her that you would like to share because it is a toy you can share.” And then he told her this and she said okay that is fine. And they played together and that was really nice. (Time 2)

I think just being there to support them in sort of a gentle, I guess I don’t know what the word would be, but I don’t kind of push myself on them, but just kind of be there to support them. Also, building trust in that having a schedule that’s consistent and that we follow basically the same steps. Sometimes of the day may be a little longer or a little shorter but it always follows the same basic steps. And also with that, being that if I tell them something, I am going to follow through with it. An example might be if they ask to have a certain activity for a group the next day and I tell them that I’m going to provide that then I follow through with that so they have that trusting relationship. And the same with if they need redirecting or with limits and expectations. Again, that consistency to follow through. (Time 2)

Although the scope of strategies described by training participants widened following training, and there was a substantial reduction in Low quality responses, training participants largely provided Adequate quality responses across time points. This reflected participants’ ability to describe positive and effective strategies for fostering children’s sense of trust and security with them, but no or limited articulation of how such strategies impact the way in which children individually relate to them. For training participants who offered High quality responses after receiving training, they expressed awareness of how their strategies helped children to feel uniquely accepted and worthwhile, thereby building a sense of trust and security with the practitioner.

I help children develop a trusting and secure relationship with me by my adult and child interactions with the children, so that’s getting down to their physical level, being patient, giving the children a chance to communicate in their own
words, following their lead so going with their interests or what they are talking about and being a good listener, so listening to the children with what they are saying and what they are trying to communicate. Modeling or I guess restating what they are saying to me, so you know “I see that you’re sad or I see that you’re excited” and kind of empathizing with them and showing them that you’re there to help them whether its positive or negative and just being consistent with the children, that helps for children’s relationships. (Time 2-High quality)

Well if the toddler starts let’s say in our room, I have an example. The girl started like a month ago so she’s never been in a daycare before and her relationship with her mom was so close. It was so hard for us even to encourage her to come in activities. She just used to cry and cry and cry. She didn’t used to come to teachers so there was like no relationship, she didn’t feel free. We just started building the relationship by just gently touching her hand, just looking at her eyes, always stay in their level and always keep eye contact. All of a sudden in two weeks, she started looking at us, just keeping eye contact and the relationship just started building. So we are just building all this step by step I don’t know, this foundation of this learning. So the most important thing is always stay at their level and just let them know we are always available, they are all unique, they are all accepted, whatever they do they’re always loved.

Maybe regarding language, it has to be age appropriate, simple, positive, all this kind of stuff. In many ways, you build relationships. (Time 2-High quality)

Well, we get down to their level, make sure that you listen to what they say so that you bring up those things later, so that they do realize that we have been listening and what they say matters. We also take into account that some of the things they say they want to do in activities, we make sure we try to build that into the program as well so that they feel like their input is actually important and mostly I would really say just getting down to their level and making sure that they know they have your time when they’re talking so they feel important. (Time 3-High quality).

Suburban and Urban training participants displayed minimal shifts in the quality of their responses to this particular question across time points. Indeed, Suburban practitioners demonstrated deeper understanding of what they do to promote trusting and secure relationships with the children in their care prior to Handle with Care training; no training practitioners offered ‘Low’ quality responses at Time 1.

I believe it first starts with mutual respect, if you give them the chance to allow them to speak and to voice what they’re feeling and to be careful not to create assumptions with the children. So, allowing them to be themselves and be there to hear them because there are times where I have seen when you don’t kind of
really listen, there is a difference between hearing and listening to them. You are hearing and asking questions and are into the conversation and they know you are sincere. So I think that’s what it comes down to, you are being true and listening and respecting what they are saying and yourself, knowing their interests because that’s an ice breaker too, when you follow up on that they know that they feel that you know them and they are able to share a little bit more of themselves with you and that just creates a cycle, so you know add more, you talk more, and they start to feel more curious about what you are as a person so they will ask questions of you, what you like, what you do. (Time 1-High quality; Suburban participant)

Table 9

Building Block 1: Question C–What kind of things impact your ability to make children feel safe and secure?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>High Quality</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>High Quality</td>
<td>7</td>
<td>13</td>
</tr>
</tbody>
</table>

Both Questions 1C and 1D for this Building Block inquire about a more reflective component associated with attachment relationships between practitioners and children. Question C was intended to query practitioners’ perceptions of broad factors that influence their capacity to help children feel safe and secure with them. Taken from Handle With Care content,
responses were coded for factors such as centre organization (e.g., gradual entry policies when children first started care), environmental factors (e.g., centre safety features, appropriate materials for children’s developmental level), practitioner education and professional development (e.g., affecting knowledge about fostering secure attachment), children’s home lives, parent relationships with the centre/practitioner, practitioners’ well-being, practitioners’ personal emotions/biases and enjoyment of children. Responses for both Questions 1C and 1D could have been phrased positively or negatively (e.g., something that can get in the way of a practitioner helping a child to feel safe and secure).

Overall, training participants demonstrated significantly more Low quality responses ($\chi^2 = 9.09, p < 0.001$) and significantly fewer High quality responses ($\chi^2 = 4.5, p < 0.001$) at Time 1 relative to comparison participants. The number of Adequate quality responses was similar between training and comparison groups at Time 1.

There was a significant reduction of Low quality responses ($\chi^2 = 6.75, p < 0.001$) provided by the training group at Time 2 following training. Moreover, the number of Low quality responses diminished across training subgroups. Additionally, there was a significant increase in High quality responses ($\chi^2 = 6.4, p < 0.001$) between Time 1 and Time 2 for the training group. The number of Adequate responses remained constant for this group from Time 1 to Time 2. The pattern shown by the Suburban subgroup at Time 2 differed from the one shown by the overall training group. Although Suburban participants provided fewer Low quality responses at Time 2, their level of High quality responses did not increase. Instead, the Suburban subgroup provided more Adequate quality responses.

Similar quality shifts were not observed in the comparison group. No significant change in quality levels was demonstrated by the comparison group from Time 1 to Time 2. The training group showed significantly more High quality responses ($\chi^2 = 2.67, p < 0.001$) relative to the
comparison group at Time 2. There were no significant differences between the training and comparison groups in terms of the frequency of Low and Adequate quality responses at Time 2.

At Time 3, the training group maintained quality levels consistent with that at Time 2, both overall as a group and across regional subgroups. No significant changes in quality were demonstrated.

Descriptively, there was minimal mention by training participants of personal enjoyment of children and personal emotions/biases across time points. Consistent decreases were noted across time points in responses that indicated nothing affected training practitioners’ ability to help children feel safe and secure or didn’t appropriately address the question. As well, participants made less mention of their professional education/training and professional development. In contrast, training practitioners increasingly referred to children’s home lives, personal experiences, personal well-being, centre organization and environment subsequent to their *Handle With Care* training.

When participants’ responses reflected no recognition of any factors that impact their ability to make children feel safe and secure, they were coded Low quality. The shift from Low quality responses to Adequate or High quality tended represent practitioners broadening their understanding of how both practitioners and children bring something to their attachment relationship. Low quality responses often suggested that there was some sort of characteristic that the practitioner possessed that made it easy for children to feel safe and secure with them.

I think it just comes naturally from being around them and working with them. Just making them feel safe. (Time 1-Low quality)

Practitioners who gave Adequate quality responses offered examples of factors that impact their ability to make children feel safe and secure without description or specificity as to how the factors affected the children. When participants exclusively discussed centre
organization or environment factors with no mention of more personalized factors connected to the practitioners, child or family, responses were also coded as Adequate quality.

Alternatively, High quality responses frequently contained comments about how there are often issues external to the practitioner, related to either the centre itself or to events in their lives that impacted their availability to children, which in turn influenced children’s sense of trust and security. Some practitioners also described specific kinds of past experiences with children that bolstered their understanding of how to respond to children in a manner that was very individual to their history and needs.

Well, unfortunately I was away, I had a death in the family and I had just been away for a week and my kids really missed me like one child started to act out negatively, scratching other children and stuff like that because I wasn’t there and apparently he missed me so we developed that bond and I wasn’t there when he needed me so he had to find other ways to get attention from other people. So when I’m away that impacts care. (Time 2-High quality)

I think that I’m a patient person. I have empathy for children, I have raised a few foster kids and got them through college and things. Even though a child can say hurtful things, they can get angry, but you have to learn they’re hurting and not take it to heart, and still say, “I’m here for you, I know you are hurting, I know you are angry, can I help you?” It just depends on the age of the child. If it’s a younger child you have to be able to think on your feet to be able to help that child. I never like to see a child get angry because I think that’s starting another pattern if a child gets angry because they are frustrated, you are starting another roll of behaviours. (Time 2-High quality)

In some cases, training participants continued to show further reflection on this topic. For example, one training participant acknowledged that parental relationships with the centre played a role in the practitioner’s ability to make a child feel emotionally safe, but 6 months after the training at Time 3, this same practitioner better articulated the reason for this factor’s impact:

Certainly the environment, you know having everything prepared and everything that we need in order to make the day go smoothly and also I think the parents have an impact on that as well. If the parents aren’t enjoying the daycare or if they’re not trusting of me then that certainly makes an impact as well. (Time 2-Adequate quality)
Um, I would think probably the relationship we would have with their parents. If they see that their parents don’t want to talk to me or I am ignoring their parents, they are probably getting the vibe that I am not a safe person. The environment can certainly have an effect on that as well if there are things that are unsafe then they are not going to trust me to be able to provide the safe environment for them. (Time 3-High quality)

Table 10

*Building Block 1: Question D–Is there anything in your professional and/or personal life that influences your relationships with children?*

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td>N=54</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td>N=51</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>High Quality</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Question 1D asked participants more specifically about professional and personal factors that influence practitioners’ relationships with children. This related directly to a reflection question within *Handle With Care* training content. Responses were coded for such personal aspects as upbringing, having kids, past experiences with children (e.g., foster parent), personal issues experienced beyond the centre (e.g., family difficulties, illness). Professional aspects included centre curriculum, the changing nature of the child care field, staff support, supervisor
support, work enjoyment, history of working with children, educational background and professional development.

At Time 1, the training group presented significantly fewer Adequate quality responses ($\chi^2 = 1.63, p < 0.001$) and significantly more High quality responses ($\chi^2 = 2.67, p < 0.001$) relative to the training group. The frequency of Low quality responses was comparable between groups.

Training participants, overall, demonstrated large positive shifts in the quality of their responses across time points. From Time 1 to Time 2, the training group exhibited a significant decrease in the number of Low quality responses ($\chi^2 = 14.40, p < 0.001$) and a significant increase in the number of Adequate quality responses ($\chi^2 = 9, p < 0.001$). There was no significant change in High quality responses between Time 1 and Time 2. The training group showing significantly fewer Low quality responses ($\chi^2 = 4.26, p < 0.001$) and significantly more High quality responses ($\chi^2 = 40.5, p < 0.001$) relative to the comparison group at Time 2.

The comparison group exhibited a significant reduction in High quality responses ($\chi^2 = 8, p < 0.001$) between Time 1 and Time 2. No other significant changes in quality levels were observed.

At Time 3, six months post-training, training participants showed a further significant reduction of Low quality responses ($\chi^2 = 9.0, p < 0.001$) and a significant rise in High quality responses ($\chi^2 = 1.07, p < 0.001$). The frequency of Adequate quality responses remained similar to that at Time 2. These positive changes in response quality were demonstrated in all training regional subgroups. Continued shifts at Time 3 suggest further improvement of reflective practices related to attachment relationships with children.

Quality codes were similar to those in Question 1C. Responses were coded as Low quality when participants failed to recognize that any aspect of their professional and/or personal
life influences their relationships with children. Low quality was also coded when participants did mention some aspect but did not indicate how it affects their relationships. In many instances, Low quality responses suggested a dichotomy between their professional and personal lives that needed to be maintained. Consequently, the level of reflection in response to the question was practically nonexistent. These types of responses conveyed the sense that the practitioner’s demeanour was essentially static when with the children, unchanged by anything happening inside or around her.

I’ve always worked with children, always been working with them since I’ve been old enough. I don’t really see myself doing anything else. (Time 1-Low quality)

Honestly now and then it does but you have to shove that aside because your focus is right where you are at the moment, like on your job, so that’s where you need to be right now and not bring your issues to work. (Time 1-Low quality)

Well, we’re always told to sort of leave things at the door, our main priority or my main priority I guess would be to make sure their needs are met so anything that may be personally affecting me, I try to just leave it out there and a lot of the time when I come here, I’m so caught up in them and being happy and smiling, you almost put it on the backburner, you almost forget and then in that way, it just helps me cope in a sense. (Time 1-Low quality)

I think you learn a lot of that from your schooling and I think that you need to leave your personal stuff at home so it doesn’t impact, so it doesn’t come out against the children. (Time 1-Low quality)

Within Adequate quality responses, participants explained one or more specific examples of factors from their professional or personal lives, but offered limited insight into how such factors shaped the interactions they have with children in their care. These participants communicated recognition that there are factors from their backgrounds or current circumstances that contribute to structuring their understanding and approaches to children in their care.

Well even just the things that we do in our own family life, any kind of religion or culture that is in our own life would definitely impact what we do in the classroom as well, or what kinds of things we can do, have the knowledge to do. (Time 2-Adequate quality)
There’s lots of things. My values and the way I was brought up. What I learned over the years, kind of the person I am and the ways I’ve brought up my children and things like that. (Time 3-Adequate quality)

I would say definitely. In the professional aspect, it’s definitely the support that you receive from other coworkers and the supervisor. Home-life definitely I think your upbringing or what type of home-life that you have, whether it’s two parent, one parent, just your past experiences definitely help too. (Time 3-Adequate quality)

I find that I’m a very motivated person. I still like to attend a lot of workshops where I like to learn things. I read a lot of material whether it be High Scope or child development material and I usually like to come back to the childcare centre and impact other staff with it and usually apply what I’ve learned in workshops so it’s always a continuing education sort of thing. (Time 3-Adequate quality)

High quality responses highlighted a reflective capacity on the part of participants that made them sensitive to how specific professional and/or personal aspects of themselves or their lives shaped their practices and, in turn, how children experienced them. In the following example, the training participant integrated content from Building Block 1 with Building Block 2, in which concepts of temperament and goodness of fit were considered.

In my professional life, just having I guess a goodness of fit with the children, I guess that might influence. If you have a different temperament as far as the children go, usually if somebody has the same temperament as the child I guess they tend to connect with the child a little bit more but definitely just to be aware of that and to know that all children are different and we all have different temperaments and just to be I guess conscious of that and to know that they’re just being who they are. (Time 2-High quality)

In terms of professional or personal aspects mentioned by training participants in their responses, the changing nature of the child care field and centre curriculum (e.g., centre using a mental health perspective) were minimally described across time points. Prior to Handle With Care workshops, training participants predominantly included having their own kids as a factor that strongly influenced their work relationships with children. However, at Time 2 and 3, the frequency with which having kids was included in responses declined markedly. Instead, practitioners started focusing more on how their own personal upbringing, personal attributes
(e.g., openness, mood, etc.) and history of working with children led to them to relate to children in certain ways. Such factors could be thought of as foundational to how practitioners interact with children generally, be it at the centre or with their own kids. Certain professional aspects, such as practitioner education, professional development, work enjoyment and staff and supervisor support were also increasingly mentioned across time points, although more minimally than with the aforementioned factors that were more personal in nature.

Well, again, I’m in an environment that is a healthy environment so that we all are supported by our supervisor and our opinions matter and that we are able to build relationships with the family, being a family-centered daycare, it’s important to build relationships not only with the children but with the families because we are taking care of their children so having that is important and it betters the relationship I have with the children. (Time 3)

**Summary of Findings for Building Block 1.**

Findings from Interview responses to Building Block 1 questions established that training participants provided significantly higher quality responses immediately after *Handle With Care* workshops. Moreover, this change was relative to their pre-training response quality as well as to the quality of comparison group responses. This indicates that training was associated with better understanding and practices related to building trusting relationships between practitioners and children. Training participants demonstrated enhanced recognition of specific areas of development that are affected by practitioner-child relationships as well as improved strategies for developing a sense of trust and security in children. Furthermore, training participants grew increasingly reflective about professional and personal characteristics that can influence how they interact with children as well as additional external factors (e.g., centre environment) that also shape the nature of these interactions. Six months following *Handle With Care* workshops, training participants either sustained such positive shifts or continued to advance their insight and skills with respect to trusting practitioner-child relationships.
After *Handle With Care*, more training participants perceived their relationships with children to be attachment relationships that offer a context in which to better understand children and their behaviour. They also conveyed greater awareness of these attachment relationships contributing to how children learn and form relationships with others. Responsiveness to individual children’s needs, practitioner openness and availability, extended conversations about emotions and consistency were highlighted more by practitioners after training as strategies for developing children’s sense of safety and trust with them. Additionally, greater reflective capacity following training led practitioners to become better at discerning how their personal upbringing and attributes, previous experiences and relationships with coworkers and children’s parents help shape their relationships with children.

**Building Block 2: Building and Ensuring Positive Self-Esteem.**

The second unit from *Handle With Care* training, asked participants about their practices to help children to: a) develop a positive sense of individuality, including being at ease around others and b) feel capable and successful in their activities. More broadly, participants were asked about: c) strategies they use to promote good or positive self-esteem with children. This question was included to gather practitioners’ insights into other ways in which they enhance children’s self-esteem beyond that discussed in the first two questions. Finally, participants were asked to identify: d) children’s thoughts, feelings and behaviours that demonstrate they possess good self-esteem. (See Appendix F: Child Care Interview for questions). Within the *Handle With Care* workshop, self-esteem was considered within the context of attachment relationships, temperament characteristics, goodness of fit between practitioners and children and cultural factors. Additionally, the workshop addressed how to help children develop and internalize a
realistic sense of identity and self-esteem. Tables 5-8 present the overall quality code ratings for these questions for both training and comparison participants across study points.

Table 11

**Building Block 2: Question A—In what ways do you help children recognize that they are unique individuals and to feel comfortable being themselves?**

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td>N=55</td>
<td></td>
<td>N=54</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>10</td>
<td>2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td>12</td>
<td>14</td>
<td>41</td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td>N=54</td>
<td></td>
<td>N=54</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>37</td>
<td>14</td>
<td>15</td>
<td>43</td>
</tr>
<tr>
<td>High Quality</td>
<td>15</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td>N=51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>33</td>
<td>7</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>13</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Prior to *Handle With Care* training, at Time 1, significant differences were observed in the quality levels of training and comparison group responses. The training group displayed a significantly higher number of Low quality responses ($\chi^2 = 2.67, p < 0.001$) and High quality responses ($\chi^2 = 5.14, p < 0.001$) relative to the comparison group. In contrast, the training group presented significantly fewer Adequate quality responses ($\chi^2 = 1.98, p < 0.001$) than the comparison group at Time 1.
At Time 2, the training group exhibited significantly fewer Low quality responses ($\chi^2 = 32, p < 0.001$) as compared to Time 1. There were small increases from Time 1 to Time 2 in the number of Adequate and High quality responses provided by the training group, but these were nonsignificant. These shifts were most evident within the Rural and Urban subgroups, with little change in the Suburban training group.

Relative to the comparison group at Time 2, the training group presented significantly fewer Low quality responses ($\chi^2 = 3.57, p < 0.001$) and significantly more High quality responses ($\chi^2 = 30.25, p < 0.001$). The training group also demonstrated fewer Adequate quality responses than the comparison group, but this difference was nonsignificant. The sole significant change for the comparison group from Time 1 to Time 2 was a reduction in the number of High quality responses ($\chi^2 = 2.25, p < 0.001$).

By Time 3, the number of Low Quality responses had significantly increased for the training group ($\chi^2 = 1.8, p < 0.001$). There were no other significant changes in quality levels, although slight decreases in the number of Adequate and High quality responses given was observed. This suggests that for some participants, the impact of Handle With Care workshops on their practices in this area was not sustained over time.

Low quality responses were coded when vague approaches were described and/or included at least one incorrect strategy as determined a priori by the research team in coding development (e.g., “telling children what to do”). Such responses lacked insight into how enhancing children’s feelings of uniqueness might require practitioner approaches that are tailored to individual children rather than ‘blanket’ activities used with all children.

In everything we do every day. We have a lot of um, well one thing that we do, we have a calendar that every day everybody has a special helper. There is a special person for the day, so they know at least one day during the week they are going to be the special person. Um, they um, what else do we do? I don’t know, I am at a loss right now. (Time 1 –Low quality)
Just by accepting everything that they do. I know that not every child develops at the same rate so they are praised and congratulated at every task and milestone that they do. (Time 1-Low quality)

We talk about it all the time, we just talk about expressing feelings and stuff. If there’s a situation where two children are upset, I would encourage them to use their words before anything else and just express because ‘you took my toy’ or vice versa and direct them in the sense that we can use our words first before we use our hands. (Time 1-Low quality)

Adequate quality responses consisted of one or more strategies, but lacked reasoning about how or why such strategies bolster children’s sense of individuality and comfort in being themselves. High quality responses offered one or more strategies as well as explanation around the strategies’ impact on children feeling like unique individuals and comfortable being themselves. These latter responses offered specificity suggesting that practitioners are interacting in distinctive ways with each of the children in their care. They also conveyed the sense that in order to do this, practitioners needed to be working within the context of a trusting and secure relationship that allowed them to really get to know the children and appropriately support and respond to them.

Just really to accept their mood, accept their temperament, accept how their feel, accept that children in the morning need a few more extra minutes to just cuddle with a soft cuddly toy on the couch, or they need that extra hug when their parents leave them. They still need to get that energy out, so there are areas, the block area, and other areas that they can get the energy out. So basically again just know my children well and to accept the mood that they will be in during the morning and to provide them with that experience to let go of their emotions so that they are ready to work. (Time 2-High quality)

Um, in our centre we don’t use praise, but I always encourage them. Any little thing they do, I let them be aware of it and give more encouragement. I think that is the bond I build with them and let them feel they feel that you know I appreciate who they are and know what they do. Accept them for who they are … I feel that makes a big influence into their life, I do recognize or acknowledge anything they do or whatever they read or whatever anything builds their confidence and self-esteem. In our open relationship... they always feel they are going to hear something positive. Positive feedback is really helping them. (Time 3-High quality)
I think sitting down with them and talking about experiences and letting them know that they’re an individual and they’re unique and there’s nothing wrong with following what they like and what they enjoy and you’re doing that through a discussion with them and things that they create within the classroom, through observation and the activities that we set up within the classroom. Just show them that for example within my age group when they go somewhere and come back, say ‘hey this is what I did this weekend’. If they want to share that with the group, then when it’s sit down time, okay guys this child has something that they would like to share with you or has something that they made over the weekend and may want to show the group how to make it. So it makes them a part of the planning and makes them a part of the learning environment. So you know what you do here, what you bring to the classroom is important to everyone. (Time 3-High quality)

You just treat the child the way you think they want to be treated and you read the signals and they’re doing something and you acknowledge what they are doing so we don’t praise in our school but just being there for that child and giving that child a certain amount of time of your day. I guess the biggest gift you can give a person is your time. So letting them know that they’re unique and special by just spending time with them. Letting them know that they are worth spending time with. That’s how I do it. (Time 2-High quality)

Descriptively, training participants spoke more about acknowledging what children say and do, showing an interest in a child, telling and/or acknowledging that children are special after receiving Handle With Care training. Participants also increasingly mentioned discussing or acknowledging differences, incorporating elements of children’s home, culture and language into the centre environment, promoting children’s success in activities and tasks (e.g., by setting things up at an appropriate developmental level) and conveying the message ‘you are worth it’ to children (e.g., showing children that they are important to the practitioner). Across time points, training participants maintained similar frequency in mentioning strategies such as acknowledging or mirroring children’s feelings, accepting or respecting individual needs and observing children’s interests or needs or skill levels. Training participants minimally spoke about strategies such as connecting to children’s home environment (e.g., considering situations that a child experiences at home and with family), parent involvement, individual spaces and materials for children, praise, proving opportunities for choices and decision making, open-ended
activities and separating behaviours from the child both prior to and following *Handle With Care* training.

Table 12

**Building Block 2: Question B**—*In what ways do you help children feel competent and effective in the things they do?*

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>High Quality</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>High Quality</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

Training and comparison groups’ quality rating levels were quite similar at Time 1, with the majority of responses falling in the Adequate level. The training group did provide significantly more Low quality responses ($\chi^2 = 2.25, p < 0.001$) and significantly fewer High quality responses ($\chi^2 = 1.13, p < 0.001$) relative to the comparison group.

At Time 2, the training group demonstrated a significant decrease in Low quality responses ($\chi^2 = 36, p < 0.001$) and a significant increase in High quality responses ($\chi^2 = 4.92, p < 0.001$) compared to Time 1 frequency levels. There was no significant change in the number of Adequate quality responses offered by the training group at Time 2. Both the Rural and
Suburban training subgroups demonstrated relatively marked gains in the number of High quality responses, while quality levels for the Urban subgroup remained consistent with Time 1.

In contrast the comparison group did not show positive shifts. The only significant change observed was a significant increase in Low quality responses ($\chi^2 = 2.78, p < 0.001$) at Time 2 as compared to Time 1. Comparing groups at Time 2 revealed that training participants offered significantly fewer Low quality responses ($\chi^2 = 7.11, p < 0.001$) and significantly more High quality responses ($\chi^2 = 5.14, p < 0.001$). The number of Adequate quality responses was comparable between groups at Time 2.

Six months following the end of the workshops at Time 3, the training group displayed a significant increase in Low quality responses ($\chi^2 = 1.33, p < 0.001$) and a significant decrease in High quality responses ($\chi^2 = 1.78, p < 0.001$). However, the actual numbers in each of these quality levels were quite low. Overall, these shifts did not significantly alter the consistently large number of Adequate responses in the training group across time points.

There was minimal change in the frequency of strategies mentioned by training participants for Question 2B. The one exception was that more practitioners described listening to children and acknowledging their feelings at Time 2 relative to Time 1. However, by Time 3, this strategy decreased in frequency, to below the level displayed at Time 1. Beyond that, encouragement and praise were the two most frequently mentioned strategies across time points. Providing support when needed, promoting children’s success at activities and tasks, promoting children’s interests and following children’s lead and scaffolding children’s learning or skills were strategies consistently identified by training participants across time points, though markedly less often identified than encouragement and praise. Offering accessible materials, acknowledging changes in a child’s skills, deflecting failure/disappointment/reassurance, displaying children’s work, having children role model and talk to other children, peer assistance
and open-ended activities (including chances for choices and decision making, emotion expression, idea expression, time for experimentation) were strategies minimally mentioned by training participants at all time points.

Criteria for the Low, Adequate and High quality coding levels for Question 2B matched those for Question 2A. Low quality responses tended to be vague or contain an ambiguous approach to fostering children’s feelings of competence and effectiveness, implying that practitioners were at all times promoting these areas. Such responses failed to display any kind of conscious effort with individual children or indicate that practitioners actively thought about these as strategies to help children develop positive appreciation for their abilities.

Um high fives, hugs, smiles, verbal, nonverbal communication, very enthusiastic facial expressions. (Time 1-Low quality)

Well, let them do what they want to do and just watch and ask them if they want help and try and guide them through that way. (Time 1-Low quality)

In contrast, Adequate quality response demonstrated greater specificity in strategies and with respect to the children and situations in which they are used. Frequently, this included mention of children’s willingness to try new things and dealing with situations in which children make mistakes and/or fail.

Encouragement, encouraging anything they do and making sure that they feel that they have done a good job and also showing them if they’re not feeling like they’ve done, maybe they don’t feel like they’ve done it right, or whatever, just making sure that they know that everybody does things differently and just a lot of encouraging and positive reinforcing. (Time 2-Adequate quality)

I definitely by encouraging them and by offering praise. You want them to know that if they have tried something new that it is great and you are proud of them for trying something new. They might have not had success, but they did try something new and went out of their comfort zone. A lot of praise and, um, praise. (Time 3-Adequate quality)

Training participants who shared High quality responses to Question B often pinpointed one-on-one conversations between practitioners and children as an important context for
strategies they used. These kinds of conversations seem to offer an opportunity for practitioners to engage children on a more moment-to-moment basis, not just when children accomplish something or are explicitly attempting to achieve. Practitioners described themselves as authentically interested in the child, with a curious and accepting stance. Once again, High Quality responses given for this question suggested that attachment relationships between practitioners and children are a necessary foundation from which practitioners can foster children’s positive development in this area.

Just to acknowledge what they are doing. Even for instance say I am working with the red blocks and they are working with green, I’m not going to say no those are green blocks, so just to accept what they are doing, sit down and work alongside, use the materials the same way they’re using them, ask open-ended questions, you know can you tell me how you made those blocks, you look like you worked very hard, I wonder how you got those blocks so high? So just encourage conversation with them, show them you are really interested in what they are doing and that you are genuine about it. And by doing that and getting down to their level, and using the materials the same way and having conversations with children. (Time 2-High quality)

For us when a child does something, instead of saying “Oh good job” it’s Talk to me about what you did, why you did it, why is it important that you’ve done certain things the way you’ve done it?” Once again you are having that discussion, talking to them about why they did it, helping them to problem solve through certain situations, these are little things that show the competency for them. (Time 2-High quality)

It is noteworthy that by and large across time points, training participants predominantly associated children feeling competent and effective with concrete tasks, most often learning and goal-oriented activities. Across time points, virtually no practitioners linked children’s competence to more social and emotional kinds of situations, such as interacting with peers, emotion expression or recognition and acceptance of their own strengths and weaknesses. It is unclear why this may be so (e.g., cultural inclination to assume individual achievement when thinking about competence). However, it does offer important commentary that after attending a comprehensive workshop devoted to mental health promotion, these child care practitioners still
did not seem to link encouragement and reinforcement for children’s own mental health promotion strategy use (e.g., sharing with someone that they are feeling frustrated) to building their self-esteem.

Table 13

Building Block 2: Question C—What kinds of things do you do to promote good or positive self-esteem in children?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>42</td>
<td>14</td>
</tr>
<tr>
<td>High Quality</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

The distribution of quality response ratings was similar between training and comparison groups at Time 1. Both groups exhibited a very high number of Adequate quality responses. The training group displayed significantly more High quality responses ($\chi^2 = 4.5, p < 0.001$) than the comparison group, though the numbers were quite small for both groups.

At Time 2, the training group offered significantly fewer Low quality responses ($\chi^2 = 27, p < 0.001$) and significantly more High quality responses ($\chi^2 = 1.78, p < 0.001$) relative to their
Time 1 levels. Most changes occurred with Rural participants, followed by Suburban participants. Urban participants demonstrated minimal changes in the quality levels of their responses. Still, training participants predominantly gave Adequate quality responses at Time 2.

However, these shifts were paralleled by the comparison group as well. The comparison group similarly demonstrated a significant decrease in Low quality responses ($\chi^2 = 1.45, p < 0.001$) and a significant increase in High quality responses ($\chi^2 = 1.8, p < 0.001$) relative to their Time 1 levels. At Time 2, the training group exhibited significantly fewer Low quality responses ($\chi^2 = 5.82, p < 0.001$) and significantly more High quality responses ($\chi^2 = 3.2, p < 0.001$) relative to the comparison group.

At Time 3, the training group displayed a significant increase in Low quality responses ($\chi^2 = 1.5, p < 0.001$) and a significant decrease in Adequate quality responses ($\chi^2 = 1.4, p < 0.001$) relative to Time 2. There was no significant change in frequency of High quality responses. This suggests that the impact of training for the few participants who demonstrated change in this area was not sustained over time.

Although Question 2C was intended to gather examples of ways in which child care practitioners promote good or positive self-esteem in children beyond that discussed in Questions 2A and 2B, many participants did not make the distinction between these questions in their responses. Many participants reiterated practices they described to help children recognize that they are unique individuals and to feel competent and effective in the things they do. Unlike earlier questions, there were only minimal increases in the frequencies of some specific strategies, such as allowing independent problem solving, creating security in the centre environment, individual attention, encouraging children to use their words, helping children to work through difficult feelings and promoting children’s self-help skills. Many strategies mentioned as responses to Questions A and B were consistently mentioned across time points by
training participants, including promoting children’s interests or following their lead, praising efforts and acknowledging and accepting feelings.

Low quality responses conveyed vague or inaccurate information (e.g., helping a child to feel that he can do anything). Adequate quality responses consisted of one or more strategies for promoting good or positive self-esteem in children.

You talk to them about, I don’t know. You encourage them not to make comments about other friends or that everybody is different and you praise their qualities. (Time 1-Low quality)

Um, well, we acknowledge all their behaviours, for example when the kids are playing in the room if we see one of the children playing on their own we encourage them to come on over and interact with the other kids. I know they are young, but we still encourage that to build their self-esteem. (Time 1-Low quality)

Um, self praise. Whenever they do a good job, it is praised. If they are not on the right track, I help them get there and every upgrade is praised. (Time 1-Low quality)

High quality responses included one or more strategies (as in the Adequate level) but also suggested that the practitioner takes into consideration individual children’s temperaments, needs or situations.

Encourage them. Make sure that they feel that they’re special, that they do matter, they don’t get lost in the group. Make sure I talk to them about how they feel and if something’s bothering them. Make sure I talk to their parents, see if there is something I can maybe help them with. If they’re maybe feeling sad or down about something, try to find out why. Basically try to encourage them and make them feel important. (Time 2-High quality)

The kinds of things I do to help children gain positive self-esteem is just being respectful of each and every child. Realizing that not everyone is the same and they have different ways of approaching situations. Getting the child to use their own language and tell me how they feel, maybe about themselves, or if they notice something about someone else, just commenting on that and talking about that in a positive way. Trying to be very inclusive, we have a very inclusive environment here. We accommodate children of different cultures, different learning abilities, we have special needs children in our rooms, so we have a really nice quilt or mesh of individuals at our centre so they recognize that each and every one of them is different. In terms of self-esteem, providing them with positive reinforcement, so it could be something as simple as smiling at the child or comforting them if they’re
sad, so hugs or we will allow them to have a cuddle toy or something, or photo albums from their family and things from their home so they can have a chance to look at all those things and feel better about themselves. (Time 2-High quality)

Again, for me it’s giving the child the time right, acknowledging what they say and what they do. Brushing them off is going to make them feel horrible so you know if they want to talk to you about their day or something that they just did, give them that time. Or if there is a problem, a “fight” or an argument, then say sorry I can’t listen to you right now over here but I will come back and for god’s sake please make sure you go back because if you don’t go back to talk to them, then they’re going to feel bad like they are not important. So if you say you are going to go back, do what you say. If you say you are going to do something, do it. Because then they build that trust and then that again goes with the self-esteem. Again, we don’t praise because we don’t want their feeling good coming so much from us, we want their feeling to come from inside themselves so they can feel good about what they are doing without a need for other people to tell them “Oh you’re such a good girl.” You know you hear that all the time so we ask them “You painted this picture, you seem excited, how do you feel about it? Tell me about this picture. What did you do?” Get them talking about it and then they know that you’re genuinely interested and you’re giving them your time. (Time 3-High quality)

Again, it’s giving them encouragement and accepting the way they use materials and their interaction with other children. Again, looking at their child development, just being – have reasonable expectations of them. Always the encouragement is very, very, important I find and it helps them to be self-directed, self-regulated, and it allows them to make really good choices. (Time 3-High quality)
Table 14

Building Block 2: Question D—How do you know children have good self-esteem? What kinds of thoughts, feelings and behaviours (in children) do you associate with it?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td>N=55</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>High Quality</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td>N=54</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>High Quality</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td>N=51</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>High Quality</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Question 2D differed from other questions pertaining to Building Block 2 in that it did not explicitly query about practitioner practices. Rather, this question sought to gather information about how practitioners identify that the children in their care seem to possess positive self-esteem. However, practitioner perceptions about the kinds of child thoughts, feelings and behaviours that are associated with good self-esteem are likely foundational for how they respond to children and support (in practice) their self-esteem, and more broadly, social and emotional development.

At Time 1, prior to Handle With Care training, the training group presented a significantly higher number of Low quality responses ratings ($\chi^2 = 1.23, p < 0.001$) relative to the comparison group.
Following the training at Time 2, there was a significant reduction in the Low quality responses \( (\chi^2 = 112.5, p < 0.001) \) offered by training group participants as well as a significant increase in the number of High quality responses \( (\chi^2 = 11.53, p < 0.001) \) relative to Time 1. Moreover, these changes occurred across Rural, Suburban and Urban subgroups. There was no significant change in the frequency of Adequate quality responses provided by training participants from Time 1 to Time 2.

These shifts were not mirrored in the comparison group, which displayed no significant changes from Time 1 to Time 2. The training group provided significantly fewer Low quality responses \( (\chi^2 = 8.33, p < 0.001) \) and significantly more High quality responses \( (\chi^2 = 65.33, p < 0.001) \) than did the comparison group at Time 2.

At Time 3, the training group did not sustain the number of High quality responses evidenced at Time 2. This group showed a significant decrease in High quality responses \( (\chi^2 = 28.8, p < 0.001) \) as well as a significant increase in Low quality responses \( (\chi^2 = 2.67, p < 0.001) \). This shift was most prominent within the Urban subgroup. The training group also displayed an increase in Adequate quality responses at Time 3, although nonsignificant. It is noteworthy that although the number of Low quality responses provided by the training group rose at Time 3, they did not return to the higher level seen at Time 1.

Discerning between different quality ratings linked to how directly participants answered the question and could explain how features of good self-esteem relate to children’s sense of worth, control and competence. For example, Low quality responses detailed only child thoughts, feelings and behaviours that participants believe are associated with low self-esteem and/or contained inaccurate information (e.g., children with high self-esteem are usually leaders in their groups).
They’re really sociable. They will come in or they are playing and they’re not afraid to do anything. (Time 1-Low quality)

Look what I did, look what I did!!” They are constantly wanting teachers’ praise for something, it’s almost like they have to be perfect at whatever it is they’re doing and we have had a couple of children that are like that, it’s almost as though they’re a perfectionist at doing things because they’re part time at daycare and part-time in school off the reserve. So it’s two different environments and I’ve seen that. The ones that always want to be, if they’ve got high self-esteem, they want to always be the leaders, they want everybody to do what they do, that’s what I see. Whether it’s just because of they’re trying to please everybody because there are some, there’s a couple of our little friends that seem like they’re trying to be high self-esteem just to please themselves and not really be at a level that they normally are at. (Time 3-Low quality)

A more advanced Adequate quality rating was given to participant responses that consisted of one or more thoughts, feelings or behaviours that practitioners observe in children to indicate they possess positive self-esteem.

I think they would definitely when they come to the centre you would see them more involved in the program, happy, expressive, their communication would be more positive and they would express themselves, they would not be withdrawn, they participate in the program and activities, they would be more willing to talk to the teacher, talk to others and interact with other children. (Time 2-Adequate quality)

Strong self-esteem, it’s different for different children. When they do something and they can talk to you about what they are doing and they’re comfortable with themselves in sharing their ideas with you and when other people within their environment, that shows that they are comfortable in what they are doing and in expressing themselves. (Time 2-Adequate quality)

Um, I associate them being well adjusted, you know they are happy… they seem content with themselves and they are eager to go off and play, they don’t need to be stuck right to my leg the whole time. You can just see them out exploring and coming into their own and they are not totally dependent on an adult to go every step of the way with them, they are comfortable enough to do some exploration themselves. (Time 3-Adequate quality)

Well they’ve got good self-esteem, they are willing to go ahead and do something, they are willing to try something new, they’re willing to venture out different things. Not saying ‘I can’t do it’ or say ‘I don’t want to do it’. They are willing to venture out and try. (Time 3-Adequate quality)
High quality responses went beyond the kind of information provided in an Adequate response to also suggest that children with positive self-esteem are resilient (e.g., able to recover from upsets or challenges), flexible (e.g., can adapt to different situations, persistent) and have a sense of self-worth. This particular information was stressed in *Handle With Care* training content.

Well, just because they're quiet or they're isolated on their own doesn’t necessarily mean it (they don’t have good self-esteem), some children just need that time to be on their own. As well as able to, when it’s time to do a group thing and they want to be part of it, able to contribute and they don’t feel like they don’t have anything worthy to say or anything like that. But I find that if a child is able to build relationships with other children or is able to have their own time alone, someone who is confident in all those areas, I think that is a child with good self-esteem who doesn’t necessarily always have to be beside somebody or get acknowledgment from other people, who is confident in their abilities, can have their alone time and is able to function within a group as well. (Time 2-High quality)

I find that children with high self-esteem are very empathetic, they understand children’s feelings and needs and are open to help another child. The children as well do a lot of encouraging of other children and celebrating their goals and seeing what’s different about them. As well as just overall their demeanor being happy, how they’re more open to trying different things and knowing that it’s okay if things don’t go the way that they should. (Time 3-High quality)

I think children who are persistent that can kind of work things out on their own before not even trying it themselves and going straight to an adult and asking them to do things for them for whatever. If it’s tying your shoe or whatever or trying to write a certain letter. If they’ve tried themselves a couple of times and knowing that they can’t and they go and ask a teacher, I think is a good sign. Being independent, making their own choices and decisions and following through on that is a good sign. Even if they’ve changed their mind, being able to recognize that, saying ‘I change my mind, I don’t want to do this, I thought I did but now I’m going to do that instead’. Children who can problem solve, sometimes even having the teacher’s help is okay too, like if they’re able to say ‘so-and-so is not listening to me, I need your help is okay as well’. (Time 3-High quality)

In terms of specific thoughts, feelings and behaviours training participants associate with good self-esteem in children, training participants more frequently described children being expressive (e.g., with ideas), feeling good about themselves, resilient, at ease with following routines and displaying open emotion expression, competence and independence and positive
peer relations subsequent to the *Handle With Care* workshop. Additionally, training participants increasingly mentioned that these children had secure relationships with adults and were more willing to approach and accept others. Across time points, training participants maintained similar frequency levels in discussing children’s willingness to try things, positive and helpful behaviours, positive interactions with child care practitioners, involvement in centre activities, and assertiveness as further indicators of good self-esteem. After *Handle With Care*, training participants less frequently identified happiness and initiative taking as signs of good self-esteem in children.

*Summary of Findings for Building Block 2.*

Across questions pertaining to the self-esteem content in Building Block 2, training participants generally displayed positive and significant changes in their practices. Generally, this tended to be shown only immediately following training, with quality levels not sustained six months after training had concluded. Significant differences in the quality level of responses prior to *Handle With Care* were noted between training and comparison groups for all questions. This suggests that the two groups were not truly on par with their practices to promote self-esteem at this initial time point. Training participants evidenced improvement in practices related to helping children recognize they are unique individuals and to feel comfortable being themselves. But most shifts occurred in the reduction of Low quality responses rather than a significant increase in High quality. This suggests that training practitioners could describe specific positive strategies they used but their responses lacked insight into why such strategies were beneficial. For those participants that did, they increasingly showed insight that strategies were effective because they offered attention and interest to the unique qualities of individual children. Additionally, these participants expressed that the centre environment needed be
responsive to children’s unique qualities. Training participants also often referred to secure attachment relationships and ideas related to ‘goodness of fit’ between themselves and children.

Similarly, although training participants demonstrated significant positive shifts regarding practices to help children feel competent and effective in the things they do and to promote good and positive self-esteem more broadly, they predominantly provided Adequate quality responses across all time points. This suggests that training practitioners were implementing useful techniques related to these aspects of mental health, but remained limited in their appreciation and responsivity to children’s individual differences, and how relationships and reciprocity between practitioners and children can help children foster and internalize a sense of self-worth and self-efficacy. Immediately after *Handle With Care*, training practitioners also became more cognizant that resilience, adaptability and a sense of self-worth are characteristics indicative of children with positive self-esteem. However, six months following the conclusion of the workshops, training participants conveyed a more basic understanding of characteristics of positive self-esteem, and offered lower quality responses.

*Building Block 3: Expressing Emotions.*

To investigate the impact of Building Block 3 on participants’ awareness and practices related to children’s emerging emotion understanding and expression, four questions were included in the Child Care Interview. (See Appendix F: Child Care Interview for questions). Participants were asked about: a) signs that they recognize to be symptomatic of children not coping effectively with their emotions. Additionally, questions explored how participants help children express: b) positive emotions and c) negative emotions in acceptable and appropriate ways. The final question was more knowledge-based in nature, asking participants about how they believe: d) children’s ability to express their feelings develops as they advance cognitively,
socially and emotionally. Tables 9-12 present the overall quality code ratings for these questions for both training and comparison participants across study time points.

Table 15

**Building Block 3: Question A – What do you feel are some signs that children may not be coping effectively with their emotions?**

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td>14</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>12</td>
<td>9</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>8</td>
<td>13</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Very little evidence of change across time was demonstrated in training participants’ quality of responses with respect to Question 3A. Across time points, responses that were classified as Low quality responses accounted for the largest proportion of participants in the training and comparison groups.

At Time 1, the training group displayed a significantly higher number of High quality responses ($\chi^2 = 24.5$, $p < 0.001$) relative to the comparison group. The frequency of Low and Adequate quality responses was comparable between groups.
From Time 1 to Time 2, the training group demonstrated no significant change in Low quality responses. In contrast, this group displayed a significant increase in Adequate quality responses ($\chi^2 = 1.23, p < 0.001$) and a significant decrease in High quality responses ($\chi^2 = 1.5, p < 0.001$).

Across all quality levels at Time 2, the training and comparison groups significantly differed in response frequencies. The training group gave significantly fewer Low quality responses ($\chi^2 = 1.17, p < 0.001$) and significantly more Adequate ($\chi^2 = 1.78, p < 0.001$) and High quality responses ($\chi^2 = 3, p < 0.001$) than the comparison group. There were no significant changes in quality levels for the comparison group from Time 1 to Time 2.

At Time 3, quality levels for the training group remained largely the same as those immediately after workshops at Time 2. The only significant change was found with a significant decrease in Adequate quality responses ($\chi^2 = 1.78, p < 0.001$), which is accounted for by participant attrition.

Low quality responses were coded when a participant indicated that a child displays some type of ‘negative behaviour’ and/or listed examples (e.g., tantrums) but made no reference to the frequency and/or intensity of behaviours.

They can be off by themselves, they may act out, looking for attention. (Time 1-Low quality)

Um well sometimes I have had experience biting and hitting are huge in the toddler room, but I think that communication is key there because some of them don’t use their words. So those are two things that stand out for me. (Okay.) I don’t understand why they do it, sometimes it because yes they want something and they want it now, it could be teething, it could be because they are angry, if they cannot use their words to tell me, then sometimes I just kind of have to make a guess and if they are hurting someone I just kind of take them out of the situation. (Time 1-Low quality)

In behaviour, negative behaviour. Most likely hitting, hurting other children, biting sometimes, crying or tantrums I find. (Time 1-Low quality)
An Adequate quality response reflected the participant indicating one or more ways in which children may not be coping as well as referencing the frequency and intensity of their behaviors. Unlike participants who provided Low quality responses, those offering Adequate quality answers often acknowledged that there were a range of behaviors that could be associated with poor emotional coping. Rather than exclusively focusing on oppositional and disruptive behaviour, these participants also mentioned internalizing behaviours, such as withdrawal and low mood. Within *Handle With Care* training, emphasis was placed on recognizing the variety of signs that children might display (e.g., ‘holding it all in’ versus ‘letting it all out’). Adequate quality responses also commonly described pervasiveness to children’s difficulties across situations.

Excessive crying, sometimes that can be a really long process. Refusing to participate in an activity although I don’t see that often. The child could be a new child starting and we usually give them a week or two to adjust and then the occasional being sad is fine...No matter what you do for the child, it’s hard to comfort them. They don’t want any social interaction or comfort. Sometimes to help this child along, we have certain strategies that we can use. For instance, taking pictures of their mom and dad. They can carry their pictures around or carry a special cuddly toy that they brought from home. Sometimes ask another child to help the child that’s sad or upset, that might help because sometimes they might not want the adult to interact with them but they might accept a younger child interacting with them. (Time 1-Adequate quality)

If they are crying all the time, if they’re screaming, if they’re not happy to come to school, if they’re not happy to go to home, if they’re not eager to participate in any activities, if they are always angry and never want to have fun with their friends. (Time 3-Adequate quality)

Usually, for some children it could be withdrawing from the environment or the activities going on so a child may sort of shut down or they may just go off on their own. We may also see not only that, just not getting involved in the routines. You may see it the other end of the spectrum where they have outbursts of either aggression or anger that they are not coping. (Time 3-Adequate quality)

High quality responses were considered more advanced than Adequate responses in that the participant recognized a change in children’s behaviour that was out of the
ordinary or different from the norm compared to other children. Often, participants implicated attachment relationships with children by suggesting that they really needed to know children and their cues in order to be effectively able to interpret their behaviour.

There’s children that won’t eat, there’s children that won’t sleep, if they’re not coping well, there could be a great deal of silence, there could be withdrawal. Like I had one little girl that was doing really well and then all of a sudden she kind of withdrew and one guy that was talking and then all of a sudden he’s not talking and then you have the one child that all of a sudden just starts hitting everybody and you don’t think they’re doing it maliciously but you go ‘ok, they’re trying to figure out how that person is going to react’ but it’s still inappropriate. A child that’s not coping well, who might be toilet trained, is suddenly having accidents all of the time. There could be so many different reasons for that, but there’s something going on that they are unable to cope with, so these are usually tell-tale signs. (Time 1-High quality)

Again, it depends on the individual child I think. For instance, one child this week because I was away started scratching another child in the face and that’s how he was dealing with it. My other little guy that I was just speaking to, he’s Polish, he used to go sit in the corner just quietly by himself and just sort of watch but the tears would be running down his eyes so you just try to sit close to him or give him a hug, things like that. Some children sort of retract back into themselves and some children burst out into this like little devil and try to get whatever attention they can, it doesn’t matter if it’s negative or positive, it’s just please somebody look at me because I need help somehow. It depends on the child, you just have to really know them and watch them carefully. (Time 2-High quality)

With respect to the actual signs that children are not coping well with emotions mentioned by training participants prior to and following Handle With Care workshops, some were consistent in frequency across time points. These included difficulty coping with daily routines, biting, not talking about emotions, poor social interactions and temper tantrums (listed in order from least to most mentioned). Across time points, training participants rarely indicated individual signs such as children hurting themselves or that a variety of behaviours can occur, depending on the individual child. Following training, training participants more frequently mentioned children being upset or withdrawn a majority of the time and aggression than they did
before the workshops. This corresponded with a decrease in frequency of participants describing children crying and hitting between Time 1 and 2.

Table 16

**Building Block 3: Question B—In what ways do you help children express position emotions (e.g., excitement, pride, etc.) in an acceptable/appropriate way?**

<table>
<thead>
<tr>
<th></th>
<th><strong>Training Participants</strong></th>
<th></th>
<th><strong>Comparison Participants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>15</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>10</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At Time 1, there was one notable discrepancy between training and comparison groups. Training participants provided significantly more High quality responses.

There were very minimal changes in the quality of responses given by training participants from Time 1 to Time 2. The training group exhibited a significant decrease in Low quality responses ($\chi^2 = 2.5, p < 0.001$) and a nonsignificant increase in Adequate quality responses. The frequency of High quality responses remained relatively consistent between time points.
The comparison group did not show any significant changes in quality ratings from Time 1 to Time 2. The training group provided significantly fewer Low quality responses than the comparison group at Time 2. Consistent with Time 1, the training group continued to offer a significantly higher number of High quality responses ($\chi^2 = 12.5, p < 0.001$) relative to the comparison group.

At Time 3, the distribution of quality levels for the training group remained similar to Time 2, with no significant changes. Overall, this suggests that *Handle With Care* training had little impact on child practitioners’ strategies related to helping children express positive emotions in acceptable and appropriate ways.

To be coded as Low quality, participant responses consisted only of practitioners acknowledging children’s feelings without mention of specific strategies to help children express those feelings. Additionally, a response obtained a Low quality code if the participant indicated that expressing positive emotions is never problematic and/or the participant does not need to use specific strategies for assisting children in expressing these kinds of emotions.

Being a teacher I get just as happy as they do, I get just as excited with them and share that with the same laugh and enthusiasm that they will have. (Time 1-Low quality)

Adequate quality responses, those that made up the large majority of responses across time points for both training and comparison groups, included one or more general strategies for dealing with a group of children.

Well again, I don’t tell them that they can’t do it, I will get the entire group involved with a celebration or whatever and we will jump around a bit and make it like a circle time at that point, depending when it comes up. Other than that just tell them, say “Right now it’s snack time and after snack we get to go outside and do all of this exciting stuff then. (Time 2-Adequate quality)

Well through their play, through games, I guess a lot of it, showing appropriate means of where they should be using excitement and louder voices. I guess they take by example so if we were to show them when somebody does something
really well at a game and we are all clapping then that would be showing them that is the proper time to use that kind of behaviour and emotion. And then again through our scheme units even just dealing with emotions, being able to show them where or when some people feel sad or when some people feel happy, why they feel happy, why they feel sad. We do things also through our different table toys, the table toys that we make anyway, matching games, any kind of thing that have to do with happy faces, sad faces. Dramatic play again, being able to show some excitement and I guess they figure that from when they all get excited at the same time but just again making sure when is too much. (Time 3-Adequate quality)

When participant responses were geared towards dealing with an individual child or circumstances more than the general population of children and described more than just group activities for expression of positive emotions, they were coded as High quality. Such responses tended to emphasize that dealing with positive emotions was as much a ‘teachable’ moment as it is for negative emotions, which often garner more attention from practitioners in child care settings because they can be disruptive. High quality responses also recognized that positive emotions can also dysregulate children at times and it is important to help children develop awareness about what makes them feel good and how to create and manage those feelings in themselves. Within Handle With Care training content, such an approach considered strategies as helping children identify body sensations associated with positive feelings, providing outlets for expression and extended conversations about their feelings.

Um, usually we do it probably the moment they come into the room. And um, if they are not having a good day but usually most of the time they are having a great day, like they are excited to come to the room, to come to the school and stuff like that. They always have a smile on their face, ‘Oh you are so happy!’ So, it depends on the tone of voice and your posture and how you express it towards that child. With me, I am known to be loud here and I always recognize the children that are very excited, that are always jumping up and down. We are like, “Oh you are so happy!” And we will always ask them, “Why are you so excited?” And they will be like, “Because I am so happy”. We try to ask them questions, we try not to get just the yes or no so that they think about ‘why I am happy’ rather than just saying ‘yes I am happy. (Time 2-High quality)

It could be as simple as “Let’s draw a picture about how excited you are” or as elaborate as in “Let’s express this, we can dance to some music and talk about how
we’re feeling.” For example, a little boy was told that – his mother told him on his way to school that he was going to Cuba and he came in and he was so excited, he was like, “I’m going to Cuba. I’ve never been to Cuba.” He doesn’t know much about Cuba but he’s just so excited, so I’m like, “I wonder if AJ would want to know that you’re going to Cuba. I wonder how we could tell the children.” Just being excited and carrying on that excitement and enthusiasm makes the children feel as if they are appreciated and someone else understands their excitement and their emotions. (Time 3-High quality)

There were no particular trends in the frequency of specific strategies mentioned by training practitioners in response to Question 3B across time points.

Table 17

Building Block 3: Question C–In what ways do you help children express negative emotions (e.g., anger, sadness, aggression, etc.) in an acceptable/appropriate way?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td>Time 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>High Quality</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Time 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>High Quality</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Time 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>High Quality</td>
<td>19</td>
<td>4</td>
</tr>
</tbody>
</table>

There were no significant differences in quality ratings between training and comparison groups at Time 1. It is noteworthy that both groups offered few Low quality responses, with the
majority of responses falling into Adequate and High quality levels. This suggests that before
*Handle With Care* workshops, most practitioners maintained good practices in terms of helping
children to express negative emotions in acceptable and appropriate ways.

At Time 2, the training group offered significantly fewer Low quality responses ($\chi^2 = 4.5,$
p $< 0.001$) and significantly more High quality responses ($\chi^2 = 1.39,$ p $< 0.001$) relative to Time
1. A small decrease in Adequate quality responses between time points was non-significant.

The comparison group showed a significant increase in Adequate quality responses ($\chi^2 =$
1.32, p $< 0.001$) and a significant decrease in High quality responses ($\chi^2 = 3,$ p $< 0.001$) from
Time 1 to Time 2. There was no significant change in Low quality responses. At Time 2, the
training group offered significantly fewer Low quality responses ($\chi^2 = 1.8,$ p $< 0.001$) and
significantly more Adequate quality ($\chi^2 = 3.27,$ p $< 0.001$) and High quality responses ($\chi^2 =$
16.33, p $< 0.001$) relative to the comparison group.

At six months post-training (Time 3), the training group did not maintain Time 2 quality
levels. At Time 3, the training group offered significantly fewer High quality responses ($\chi^2 =$
7.11, p $< 0.001$). The frequency of Adequate quality responses increased compared to Time 2,
but the change was not significant.

Due to the higher degree of attention and responsivity to children’s negative emotions
(compared to positive emotions) given by child care practitioners, the quality coding for
Question 3C differed from 3B. Within Low quality responses, participants described
acknowledging children’s feelings without mention of a specific strategy used to help children
express negative emotions. Indeed, virtually all participant responses indicated
acknowledgement of feelings. Low quality responses also were coded when participants
suggested that children needed to be disciplined in some way for expressing negative emotions
or told children that the manner of their expression was wrong.
Well sometimes the children that I work with, there’s this one where it always has to go his way, so it’s very hard for him to be in that transition because he’s never been in daycare before, so whenever he thinks that its ok that my way goes and we have that little argument because you know he’s going to cry, he’s going to be upset, but what I do is, “You know until you’re done and you understand that’s when you can continue doing what you were doing, but you know what you did was wrong.” I will show you what you’re supposed to be doing or I will help you and I will encourage help if after being told once or twice or a third time and they still don’t understand. I will encourage the help that they need so that they understand whether they are upset or not, so long as they understand that ‘ok clearly I’m doing something wrong so what do I have to do to fix the problem?’

(Time 1-Low quality)

By correcting their wrong or negative response. If the child is crying for attention, first you give the child attention but if you know that they are demanding it, then you kind of do a little bit of both. You do a little bit then you go back and then you do and then you go back. The child may learn that if I cry like this, I may not get it from them, I need to stop and do this to get what I need to get so that’s helping the child with positive emotions. (Time 1-Low quality)

When responses included one or more general strategies for dealing with a group of children, they were coded as Adequate quality. Within Adequate quality responses, participants either directly or implicitly communicated that it is acceptable for children to feel negative emotions and that practitioners’ role should be helping children to recognize their feelings and guide them in how to cope with them.

Just by talking with them and letting them know that it is ok to express anger and sadness, maybe show them or talk with them about some ways that are more appropriate to show it, but just letting them know that it is ok to be sad sometimes. (Time 2-Adequate quality)

Lots of options for children, maybe pounding on play-dough or punching a pillow or talking things out through a puppet that sort of thing. Some children can be settled in a quiet area, they can read a book to calm their body. Again, labeling those emotions and feelings. (Time 2-Adequate quality)

High quality responses were coded when participant answers were geared towards dealing with an individual child or in circumstances that went beyond dealing with the general population of children; responses described more than just group activities. In this sense, participants who provided High quality responses thought broadly about emotion understanding
and expression, often considering individual children’s temperaments and self-esteem, the context of the practitioner-child attachment relationship, topics all integrated in *Handle With Care* training.

We allow them to express those emotions because it is important that they express that. For example, we have 6 steps of problem solving with the children, that children learn how to express their emotions and we acknowledge their emotions, whether they are positive or negative, it’s very important to acknowledge their emotions and let the children know that you see that they’re upset and that something is upsetting them, but through problem solving they work through the problem and the number one step is to stop the negative behaviour. When a child is calm and ready to solve a problem, they would let the other child know “I feel sad or I feel angry because…” If the child is not ready to solve a problem because they might be really angry then we allow them to have that calm time to calm their body in the quiet area where they can sit down and relax and calm their behaviour, calm their emotions and we also teach them techniques through breathing, maybe having something soft and cuddly in their arms or just relaxing by themselves in the quiet area. Also we read books that relate to that too about how we express our emotions and how we cope with those emotions. (Time 2-High quality)

A lot of times I’ll take them aside. Sometimes they just need that space away from children. If there is a conflict between them, I definitely will intervene and help them calm down and approach the situation differently. I find with preschoolers sometimes those emotions can be all over the place so sometimes they just need the direction from an adult to encourage them to breathe or if they are very angry, maybe hitting a pillow so they can get rid of that anger and regroup. (Time 3-High quality)

Similar to Question 3B, there were no particular trends in the frequency of specific strategies mentioned by training practitioners in response to Question 3C across time points. Interestingly, despite participants providing a higher baseline quality response to this question relative to other interview questions, the scope of the responses was limited. For the most part, participants thought of frustration and anger expressed through aggression and acting out behaviour as the primary kind of negative emotions, rather than feelings that might be more understated such as sadness, fear, embarrassment, guilt or shame. Additionally, participants predominantly focused on use of language to assist children with expression of negative
emotions, with much less mention of nonverbal approaches, even with younger children (e.g., infants and toddlers).

Table 18

**Building Block 3: Question D—How do you think children’s ability to share their feelings changes as they get older (e.g., from infancy to preschool age)?**

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Low Quality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 1</td>
<td>N=55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td>N=53*</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>High Quality</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td>N=50*</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>High Quality</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

*One response to this question missing for Suburban participant in Time 2 and for Urban participant in Time 3*

Prior to *Handle With Care* training, the training group presented significantly more Adequate quality responses (χ² = 1.12, p < 0.001) relative to the comparison group at Time 1. There were no significant differences between groups in terms of Low and High quality responses at this time point.

At Time 2, both groups demonstrated a shift in the frequency of quality level responses. The training group demonstrated a significant decrease in Low quality responses (χ² = 24.5, p <
0.001) and a significant increase in High quality responses ($\chi^2 = 4.77, p < 0.001$) relative to Time 1. There was no significant change in the frequency of Adequate quality responses between these time points. The comparison group also displayed a significant decrease in Low quality responses ($\chi^2 = 2, p < 0.001$) from Time 1 to Time 2. However, unlike the training group, comparison groups provided significantly more Adequate quality responses ($\chi^2 = 1.26, p < 0.001$) and significantly fewer High quality responses ($\chi^2 = 1.29, p < 0.001$) compared to their Time 1 levels.

The training group presented significantly fewer Low quality responses ($\chi^2 = 4.5, p < 0.001$) and significantly more High quality responses (14.29, $p < 0.001$) than the comparison group did at Time 2.

At Time 3, the training group’s changes in quality were not maintained. The training group exhibited a significant increase in Low quality responses ($\chi^2 = 1.8, p < 0.001$) and a significant decrease in High quality responses ($\chi^2 = 7.11, p < 0.001$) relative to Time 2. There was a small decrease from Time 2 to Time 3 in Adequate quality responses, but this change was nonsignificant.

In terms of coding different quality levels, Low quality responses reflected participant answers that indicated no recognition of the developmental progression of how children are able to share their feelings as they get older. These kinds of responses were also coded if participants focused just on one age group when answering this question. Great focus in training content was given to how advancements in children’s language, perspective-taking, internal strategies for regulating emotions and assertion of autonomy influenced their capacity to share their feelings. Low quality responses from training participants suggested that this information did not impact their knowledge.
I don’t know, I don’t really remember myself. Like when they get older I think they really share, they always remember to give the teacher hugs and stuff. They, just again at the physical level, they feel their love no matter what the teacher says, they feel love and they share and this is very important for the future I guess, regarding their future children. I don’t know, I think they always share and remember and appreciate the love they got in early years. (Time 1-Low quality)

In contrast, Adequate quality responses focused just on language development and how that affects children’s ability to share their feelings as they get older. The decision to restrict Adequate level quality to this one type of child development was determined in response to examination of participant answers during coding creation. Such a high proportion of participant answers dealt solely with this topic that it was felt be to a minimal type of knowledge concerning children’s developmental progression related to emotion expression. Language advancement is the most explicit type of growth that enables children to talk about their emotions; thus it is most noticeable to child care practitioners.

To be considered a High quality response, participants had to describe two or more ways in which children’s ability to share their feelings changes as they get older. Such responses could include language as one feature. Due to the widespread mention of language for this question, High quality responses were thought to reflect training participants’ knowledge being more impacted by the Handle With Care workshop. Often, these kinds of responses also mentioned factors that help shape how children negotiate emotional situations, such as temperament, attachment with a child care practitioner and sociocultural values and norms.

A lot. Just with the language development, they are able to express themselves a little more. I find sometimes as they get older they do have a lot more ways of expressing. I find some of the children get a little frustrated because there are so many ways they can express it and they’re not sure which way to go with it. So it changes a lot in different aspects but I think it’s all to do with how they have been shown how to express it in their family and even with their religion and culture, how they are allowed to show it. So, yeah I definitely think it’s harder for them as they get older, a little bit more confusing as they get older. Infants they can just cry and show you how they truly feel but then it gets a little more difficult, and they
start to realize maybe I shouldn’t feel this way. I think it gets harder as they get older. (Time 2-High quality)

Well they express it more when they get older because they have more language skills and they understand more, so when they’re younger it’s also part of their development. When they are younger and everything revolves around them, so it’s very difficult for them to understand other children’s feelings and other children’s emotions but as they get older they realize there is another person and they are also feeling sad and they are also feeling angry and this way they are able to recognize their emotions. When they get older they have more language skills and they are able to express it more and they are able to communicate through their words. (Time 2-High quality)

The most obvious one would be that they can express it verbally, and I think that they’re more aware of it, maybe not stop that feeling if it’s a negative one but, they can verbalize it, they’re more aware of how they’re feeling and maybe that they can know that what will be something that bothers them so before it escalates to anger or aggression, they can remove themselves from that situation, eventually, maybe it’s more of a kindergarten thing. (Time 3-High quality)

With respect to descriptive frequencies, training participants across all time points predominantly mentioned increased language as a sign of children’s progressing ability to share their feelings as they advance in age. Minimal increases were noted from Time 1 to Time 2 in participants identifying more ways to express emotions (e.g., younger children might cry to convey a number of emotions such as anger, sadness, etc., while older children can share emotions more specifically with language and/or nonverbal expressions), perspective taking (e.g., younger children are more egocentric and think more about themselves while older children consider others more and how to share their emotions with others), social influences (e.g., younger children might imitate others’ expressions such as ‘contagious crying’ while older children might actually feel the same way someone else does because they are able to empathize or sympathize), internal strategies for regulating emotions, immediacy (e.g., younger children will tend to convey feelings right away as they experience them while older children can also hold onto feelings and experience them over time) and assertion of autonomy.
Summary of Findings for Building Block 3.

Overall, findings from questions pertaining to Building Block 3 contents indicate that *Handle With Care* training had minimal impact on practitioners’ practices in the area of emotion expression and regulation. Participants had quite discrepant levels in the quality of their skills related to these areas prior to training. For instance, training participants demonstrated higher quality practices in helping children express negative emotions relative to the lower quality practices they described in helping children express positive emotions. Such differences tended to continue across time points. Before *Handle With Care*, training participants predominantly provided low quality responses concerning their understanding of signs that children are not coping effectively with their emotions. This reflects training participants’ consistent beliefs that ‘negative behaviour’ represents coping problems without considering such behaviour in the context of what is known about individual children. As well, training participants typically failed to think about the intensity and pervasiveness of behaviours. The sole area in which training participants displayed significant shifts relative to their pre-training responses and the comparison group was in recognition of the developmental progression of emotion expression. Exposure to *Handle With Care* content was associated with greater awareness that increasing language, social influences, burgeoning assertion of autonomy and internal self-regulation strategies affect growing children’s emotional life. However, these positive shifts in quality were not sustained through to six months after training.

Building Block 4: Relationships with Peers.

To examine participants’ strategies and knowledge with respect to children’s peer relationships, four questions pertaining to Building Block 4 were included in the Child Care Interview (See Appendix F: Child Care Interview for questions). In particular, participants
described: a) what kinds of social skills in children they try to help them to develop and the ways in which they do this; and the manner in which they: b) support children who experience negative peer situations, as well as: c) support shy children in the social child care centre environment. Finally, participants explained their understanding about: d) how children’s peer relationships change developmentally over time. Tables 13-16 present the overall quality code ratings for these questions for both training and comparison participants across study time points.

Table 19

**Building Block 4: Question A-What kinds of social skills do you actively promote in children and how?**

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>High Quality</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>23</td>
<td>12</td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Prior to *Handle With Care* workshops at Time 1, both groups presented higher proportions of Low and Adequate quality level responses than High quality responses. The training group provided a significantly higher number of Low quality responses ($\chi^2 = 1.14$, $p <$
0.001) than the comparison group. There were no other significant differences between the groups at this time point.

At Time 2, the training group showed minimal shifts in the quality of their responses. The group demonstrated a significant decrease in Low quality responses from Time 1 to Time 2. Most of the change in the training group was accounted for by the Rural and Urban participants. Although the group displayed increases in Adequate and High quality responses, these changes were not significant.

In contrast, the comparison group demonstrated a significant increase in Low quality responses ($\chi^2 = 2.13, p < 0.001$) from Time 1 to Time 2. As well, the comparison group exhibited a significant decrease in Adequate quality responses ($\chi^2 = 3.37, p < 0.001$) between these time points. The frequency of High quality responses offered by comparison participants remained constant. The training group displayed significantly fewer Low quality responses ($\chi^2 = 3.33, p < 0.001$) and significantly more Adequate quality responses ($\chi^2 = 4.26, p < 0.001$) than the comparison group at Time 2.

The training group exhibited minimal change from Time 2 to Time 3. The sole significant shift was a decrease in Adequate quality responses ($\chi^2 = 1.09, p < 0.001$). Urban participants, in particular, failed to maintain gains shown in Time 2; their number of Low quality responses returned to the Time 1 level, coupled with a decrease in Adequate responses.

Coding responses for Question 4A intended to capture both what kinds of behaviours (social skills) participants were encouraging in children as well as the strategies or practices they used to accomplish this. Low quality responses were coded when participants did not refer to building social skills (e.g., talked about promoting self-help skills) or were nonspecific with regards to what social skills they were encouraging and actual strategies used to promote them.
Probably I like to see them – interact with other ages too right? Once they start playing together as a group, I think it’s good to bring a child in that’s struggling at these areas and play with them for sure and show them the appropriate way to interact. (Time 1-Low quality)

Socializing with their peers, not so much parallel play but more group play and inclusion, like including everyone. (Time 1-Low quality)

Um social skills, ah … language development, using their words, um sitting them to a quiet activity if they can’t get along with others, I promote through activities if they can’t seem to get what they need out, there is colouring, there is play dough, there is water play, even getting them outside, running around, getting that anger out. Just if I see that they are getting frustrated, we go outside, we play, they run it off. I try to promote it through positive activities and developmentally, socio-emotional, physically, cognitively, try to sit down and do one-on-one but it is hard when you are running a program. (Time 1-Low quality)

In contrast, Adequate quality responses included mention of both one or more specific social skills participants attempted to promote in children and particular strategies used for this purpose.

Cooperation, I mean we do a lot of things where we have to work together as a group and they’re expected to problem solve, you know you don’t leave a problem unsolved. We have our 6 steps to problem solving to do that. Respect I guess too is a social skill, for each other, for people in general and for the environment and I guess that’s really through modeling and showing them how to do that and that everyone’s opinions are valued and respect for when someone is talking and that kind of thing. (Time 2-Adequate quality)

Working together is one of the best things. Working with the materials in your environment, like with the younger kids how to share materials in the classroom, we do have multiple materials but sometimes you still have the challenges of children wanting to use the same materials even though you have multiples of the same material so you encourage them to talk it out, you know how are you going to use the material? How is this material going to be shared amongst you? If they decide they want to do an activity together, working in the hallway area together, talk to them about what they’re going to do and who is going to be what, you know sometimes I want to be the mommy or you want to be the mommy, so let’s talk it through. It’s all about having that conversation and opening it up for them to communicate with each other and once again giving them some of the verbal cues as to, if you’re not liking something that someone is doing how do you have that discussion with them letting them know that you’re not liking that or if you are liking something that someone is doing and you want to interact with them how do you go about asking them, you know I want to play with you or I want to do what you’re doing as well. Things like that. (Time 2-Adequate quality)
Much training time for Building Block 4 was spent considering the developmental appropriateness of promoting certain social skills (e.g., sharing) at various ages. Due to this, a High quality response for Question 4A was coded when a participant described specific social skills they promoted, particular strategies used to do this and also acknowledgement of age appropriateness for the social skills discussed. Generally, very few training participants provided High quality responses, both before and after Handle With Care workshops.

With regards to the toddler, really egocentric, so just I guess labeling, “I’m using that” or “That’s mine” so the child understands that they can’t have it right now at the moment and in our program, we have multiples of items. So you wouldn’t just have to have two cars, you would have to have five cars so that there’s always enough for all of them. I guess lots of role modeling, taking turns, give and take, ‘It’s your turn now’; ‘It’s my turn.’ (Time 2-High quality)

Some of the social skills are working together because I have older kindergartens and school agers, working together, problem solving together, talking about your feelings, going back to that when things come about how to use the work environment whatever area that you’re working in, how to use that environment with other people. One of the things is sharing. One of the big things that we have in our program is that children feel that they have to do this because you have to share. That’s not what sharing really means. Sharing means when I’m finished with it, then you can use it not because you want it now you have to share it and give it to me. For example, we talked to them about the importance of working together and using materials together and problem solving if you both want the same material at the same time, how are you going to work around that and deal with that. (Time 3-High quality)

Descriptively, training participants were very limited in terms of the specific social skills and strategies they discussed in response to this question. Sharing was by far the most mentioned social skill participants indicated they were trying to encourage and this was consistent across time points. Teamwork or collaboration, problem solving and politeness were also consistently mentioned both prior and subsequent to Handle With Care workshops, although much less frequently than sharing. At Time 2, training participants increasingly discussed expressing emotions to others and turn taking in contrast to Time 1. Some social skills were mentioned less often than they had been at Time 1. These included respect, empathy and helping others. Conflict
resolution, consideration, recognizing social cues, listening to others, sympathy and comforting were virtually ignored by participants across time points in their responses. With respect to strategies employed by training participants to foster these social skills in children, role modelling, turn-taking games, providing opportunities for children to work or play together, group activities, facilitating emotional language and encouraging/reinforcing polite language were described more at Time 2 than they were prior to training. Other strategies such as facilitating peer modelling and assistance, encouraging role-playing and perspective taking were minimally mentioned across time points.

Table 20

**Building Block 4: Question B—How do you support children who have negative experiences (e.g., being teased, conflict) with peers?**

<table>
<thead>
<tr>
<th>Time 1</th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Low Quality</td>
<td>N=54</td>
<td>7</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>26</td>
<td>9</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Time 2</td>
<td>N=54</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Low Quality</td>
<td>25</td>
<td>9</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>14</td>
<td>8</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Time 3</td>
<td>N=51</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>
There were no significant differences in quality ratings between training and comparison groups at Time 1.

The training group exhibited a significant decrease in Low quality responses ($\chi^2 = 2.4, p < 0.001$) between Time 1 and Time 2. Additionally, this group showed a significant increase in High quality responses ($\chi^2 = 2.57, p < 0.001$) between these two time points. There was no significant difference in the number of Adequate quality responses.

The comparison group showed no significant changes in quality levels from Time 1 to Time 2. One sole significant difference existed between groups at Time 2; the training group provided significantly more High quality responses ($\chi^2 = 1.6, p < 0.001$) at this time point.

Further shifts also continued at Time 3 for the training group. This group displayed a significant decrease in Low quality responses ($\chi^2 = 1.46, p < 0.001$) as well as a significant increase in Adequate quality responses relative to Time 2. However, the training group also demonstrated a significant decrease in High quality responses between these time points ($\chi^2 = 1.53, p < 0.001$). This suggests some training participants made additional gains in the quality of their practices in this area six months after the workshops, while others failed to sustain prior gains from Time 2.

Responses that were inaccurate, vague, and/or focused primarily on dealing with the ‘aggressor’ child were coded Low quality. These kinds of responses neglected consideration of the ‘victim’ child experiencing the impact of the conflict or teasing. Most strategies concentrated on managing the ‘aggressor’s’ behaviour.

It’s always hard to deal with children that have conflicts with peers or are teased ‘cause I find that they tend to shut down and don’t want to discuss it or approach the conflict because they are afraid of what will happen after. It’s always hard, that’s one of the challenges that I’m still trying to overcome. It’s hard to understand children too and you don’t want to make any assumptions. (Time 1-Low quality)
Just by talking. Talking to the peers that are doing the teasing and helping them understand what they are teasing at and helping the child understand they’re teasing and what they shouldn’t be doing. (Time 1-Low quality)

For negative behaviours is more open in the toddler room with pushing, hitting or biting so for that case we say biting hurts. We also have circle time, we teach them teeth are for biting food. If they are teething and really want to bite something, you can bite the white cloth but you don’t bite the people. So we don’t encourage biting each other or biting the toys. As they get older, we say you want to bite, bite something that isn’t hurting people. If we are hitting or pushing others, we say we are gentle, you want to push, push the car, you want to hit, okay tap the table, you can hit the table. So something that changes the way they are doing it so they don’t hurt each other. (Time 1-Low quality)

When a participant provided a response that consisted of one or more strategies used with ‘victim’ child, it was coded Adequate quality.

We’ll spend a lot of time with that child and try to get them comfortable in the environment and then we’ll invite other friends to come and join and play with us while we’re still there and we can monitor what’s going on and what’s being said and if something, if there’s still a problem then we’ll talk to the children about teasing and how you should treat your friends. (Time 3-Adequate quality)

To reflect content emphasized in Building Block 4, High quality responses were coded when the participant described one or more specific strategies used with the victim child and included specific mention of acknowledging or helping to voice that child’s feelings and reasons for feeling a certain way. High quality responses typically illustrated the practitioner helping the child to contain difficult emotions and working to ensure that the child feels secure in themselves and around others.

You could talk to them and ask them how they are feeling about it, it makes them sad. I would probably bring in the peers that are in the daycare centre you can more or less bring them in and talk to them with the other child there and asking them how do they think this child feels or get the child who is feeling sad and upset to express his feelings to the other child, so the other child can get some empathy, because sometimes at this age, they are getting to know what they are doing and yet sometimes they really don’t know either. (Time 3-High quality)

We encourage them to speak about what happened, regardless if it is hard. Sometimes we even relate our own issues to them, listen you know so and so likes, I am moving or when I was young I moved schools too. If they are having trouble
from moving one school to another you can relate your issue to them also letting them know that they are not alone. That it is okay to be sad, they do not have to be happy all the time. I understand why you are upset and it is okay to be upset. Just letting them know that they are not alone and that other people feel this too. (Time 2-High quality)

Training participants most frequently indicated that they guide problem solving between children across time points. They also consistently, though less frequently than the aforementioned strategy, described comforting the victim, disciplining the aggressor and encouraging the victim to use language to tell peers to stop. Following the Handle With Care workshops, training participants increasingly detailed such strategies as acknowledging or empathizing with the victim child’s feelings, group discussions about bullying or teasing, encouraging perspective taking, guiding the aggressor to acknowledge the victim child’s feelings, highlighting the problem and offering assistance and encouraging language to express feelings. Although several training participants reported trying to minimize the impact of conflict and/or teasing on children’s feelings at Time 1, the frequency sharply diminished at Time 2 and 3. Guiding the aggressor to apologize, encouraging the victim to ask the practitioner for help, promoting the assertiveness of victims and informs parents of either child were minimally discussed across time points.
Table 21

**Building Block 4: Question C—In what ways do you help shy children participate in activities and interactions with others?**

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>9</td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>36</td>
<td></td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>N=54</td>
<td></td>
<td></td>
<td></td>
<td>N=54</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>30</td>
<td>14</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td>14</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>N=54</td>
<td></td>
<td></td>
<td></td>
<td>N=54</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td>8</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>11</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>N=51</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At Time 1, the training group presented significantly more Low quality ($\chi^2 = 1.23, p < 0.001$) and High quality responses ($\chi^2 = 2.67, p < 0.001$) relative to the comparison group. In both groups, Adequate quality responses predominated across time points.

Following *Handle With Care* workshops at Time 2, the training group demonstrated significant frequency decreases in Low quality ($\chi^2 = 9.14, p < 0.001$) and Adequate quality responses ($\chi^2 = 1.89, p < 0.001$) relative to Time 1. Additionally, the training group exhibited a significant increase in High quality responses ($\chi^2 = 6.04, p < 0.001$) at this time point. Such shifts were especially evident in the Rural and Urban training subgroups.

Such shifts were not observed in the comparison group, with no significant changes in quality levels from Time 1 to Time 2. The training group provided significantly fewer Low
quality responses ($\chi^2 = 6.25, p < 0.001$) and significantly more High quality responses ($\chi^2 = 33.8, p < 0.001$) than the comparison group at Time 2.

However, by Time 3, the training group displayed quality levels equivalent to that which they presented at Time 1. Training participants showed a significant decrease in High quality responses ($\chi^2 = 4.46, p < 0.001$), coupled with nonsignificant increases in Low and Adequate quality responses. This suggests that improvements in practices seen immediately following training were not sustained.

Low quality responses for Question 4C were coded when participants gave answers that were inaccurate, vague or only focused on having shy children participate in group activities. Such responses lacked sensitivity to the shy child in that approaches did not consider the child’s individuality, comfort level and/or were intrusive.

Um well we go on over and we encourage them to come play with the group and we sit down, what we do is we sit down in a little group of a circle. Let’s say if there are animals out, we could always ask the kids to ask that child um, “Can you ask so and so what sound this animal makes?” To build their self-esteem so they are not too shy around their peers. (Time 1-Low quality)

For the shy child, I remember that I was shy … for the shy child you know I help the child to participate by you know following around the child and saying okay, “Show me the car in the book” and or “What colour is the car?” Some children are shy and don’t want to talk unless you call up on them. So just call them up and help them to participate. (Time 1-Low quality)

When participant responses contained mention of one or more specific strategies for helping shy children participant in activities or interactions with others, they were coded as Adequate quality. Additionally, if a response simply indicated that the participant did not ‘force’ shy children into situations that are uncomfortable for them, an Adequate quality code was also given. In the latter case, participants were considered to be mindful of shy children’s comfort level, but failed to explain any additional tactics to assist these children in fostering peer interactions.
I usually try to help them maybe join in an activity or first I will play with them and get to know them so that when we do join the group I know something about that child and hopefully it makes it easier for that child to make friends and interact with others. (Time 2-Adequate quality)

I will try to start an activity with them, themselves and then fully bring the rest of the group over to do something or slowly I will invite that child to come and play with whatever I’m doing with the other children. I won’t force them to play with them if they don’t want to, if they’d rather do something on their own then that’s fine too. (Time 3-Adequate quality)

I like to have that child kind of come with me or we will approach a group of children and ask if I can play and the shy child will be there as well and I will introduce the child and make sure that everybody knows who everybody is and get some turn taking going on or we may also, you know myself and the child, start a game and get the others to come and join us. (Time 2-Adequate quality)

To be coded as High quality, a response included one or more specific strategies for helping shy children participate in activities and interactions with others and also provided some indication that that practitioner had to follow the children’s lead (e.g., by reading the child’s cues and accommodating them) and that it was a gradual process. Frequently, High quality responses discussed practitioners being better able to facilitate shy children’s comfort level and peer engagement within the context of a positive and secure attachment relationship (between practitioner and child).

I think it’s important to build that trusting relationship with the child and communication with the child cause if a child is shy, they might not always want to be involved with other children right away, they more likely will play alone sometimes and so it’s important that you help that child and you build that trusting relationship with them and you as a practitioner, you give them that one on one attention and you spend time with them and play with them, work with them together and invite them to work with other children gradually, when they are ready then you invite them and when they are ready you go with that child and help them get settled. Invite them into the program and guide them through that process, be there for them and when you see them making a step and they made a connection with one child then it’s already progress and maybe you step a little bit back and give them the opportunity to continue and you observe them and help them through it and if you see them doing well then great and if they still need more assistance then help them and be there for them. (Time 2-High quality)
Um, I just kind of look and play with that shy person and see what their interests are. And again try to implement it into my program and maybe gain their interest and curiosity that way. Definitely I don’t push anything on them because I think it can turn into something negative. Just do side-by-side play, and just kind of gradually invite them into activities if they would like to join. Again if they don’t want to join, that is okay too. (Time 3-High quality)

Shy children, once again it all depends on the child. Some kids come in and right away you know that they want to be left alone and they want to slowly work their way into things. The kids who are approachable and you see that they want to get involved and just doesn’t know how to, I sit with them and do an activity with them and invite another child over and talk to the other child about what he or she is doing and try to get them involved in what the other child is doing as well. A lot of time that kind of works, sometimes it does and sometimes it doesn’t, you just keep working with them. (Time 3-High quality)

Well, I get at their pace. I don’t want to force too much on them right away. Sometimes they get more comfortable. Sometimes it’s just a new room, new environment; it could be just the personality altogether but I don’t want to push too much on them. I do it at a slow pace and I follow their lead when they’re ready to sit with teacher direction or get another buddy, maybe somebody that they’re comfortable with to help. (Time 2-High quality)

Like sometimes with like shy children you could like, um, like, start out small. It might be like two children playing together and sometimes you can increase it. Or if you notice the shy child has some activity they really love you kind of bring it into a group setting so the child can express themselves and be more open out it. For example, there was a shy child who really liked bubbles, like they really love bubbles and because he really loves it, I brought it into a group setting. We had lesser kids, it wasn’t as busy but it was like in the evening time when it was a little bit calmer. We weren’t doing ten things. It was a time when there wasn’t that many transitioning or things like that. And I brought the bubbles out and you could see the expression, he was like, ‘my turn...can we all have a turn?’ He was talking a lot more and participating a lot more. Cause of the way we had done it, it wasn’t a busy time so I could give him all my attention and then fully I kind of walked away and kind of stood back and watched from far away to see how they were playing with it together and they were giving each other a turn. And it was really sweet. Yah, so I try to find out his interest sand you kind of expand out on that. (Time 2-High quality)

Prior to Handle With Care workshops, a relatively large number of training participants discussed encouraging peers to notice and respond to shy children in positive ways as a strategy they use. Following the workshop, there was a significant increase in the frequency with which participants discussed such strategies as not forcing a shy child into situations that are
uncomfortable for him, getting to know the shy child’s interests, highlighting and reinforcing the child’s strengths, incorporating the child’s interests into the environment and pairing a shy child with another child for activities and interactions. Across time points, training participants often described accompanying shy children into groups and gradually withdrawing and initially spending one-on-one time with shy children and building rapport as tactics they use. Encouraging shy children to interact with those they are naturally drawn to, practitioners modelling skills for joining a group and interacting and acknowledging the shy child’s feelings were very minimally, yet consistently, talked about by training participants across time points.

Table 22

**Building Block 4: Question D—How do you think children’s peer relationships change as they get older (e.g., from infancy to preschool age)?**

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td>N=54</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>High Quality</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td>N=54</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>High Quality</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td>N=51</td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>High Quality</td>
<td>18</td>
<td></td>
</tr>
</tbody>
</table>
There were no significant differences in quality ratings between training and comparison groups at Time 1.

Following *Handle With Care* workshops at Time 2, the training group evidenced significant decreases in Low quality ($\chi^2 = 9.14, p < 0.001$) and Adequate quality responses ($\chi^2 = 1.89, p < 0.001$) relative to Time 1. Additionally, the training group demonstrated a significant increase in High quality responses ($\chi^2 = 6.04, p < 0.001$) between these two time points. Quality improvement was especially noted for Suburban and Urban participants. In particular, the Urban participants showed the largest increase in High quality responses.

The comparison group demonstrated a significant decrease in High quality responses ($\chi^2 = 1.23, p < 0.001$), coupled with a significant increase in Adequate quality responses ($\chi^2 = 1.75, p < 0.001$) relative to Time 1 frequencies. At Time 2, the training group presented significantly fewer Low quality ($\chi^2 = 2.78, p < 0.001$) and Adequate quality responses ($\chi^2 = 2.89, p < 0.001$) than the comparison group as well as significantly more High quality responses ($\chi^2 = 17.31, p < 0.001$).

Six months subsequent to the workshops at Time 3, the reduced level of Low quality responses offered by the training group was sustained. However, the level of High quality responses was not and there was a significant decrease in these responses ($\chi^2 = 5.56, p < 0.001$) as well as a significant increase in the number of Adequate quality responses ($\chi^2 = 1.44, p < 0.001$).

Responses that consisted of only inaccurate or vague ideas were coded as Low quality. As well, when practitioners indicated in their answers that they only knew about one age group of children with respect to peer relationships and could only speak to that, a Low quality code was applied. Low quality responses typically focused on internal changes within children but lacked description regarding how such changes impacted peer interactions.
Just their social skills, their vocabulary, their knowledge on the different toys, they just come in and do it. (Time 1-Low quality)

They see that as they get older they see their personality change, what they like changes. Say for example “I like Spiderman and not Dora anymore.” They get to see the things they have in common with other children which kind of changes their social aspect. (Time 1-Low quality)

In contrast, Adequate quality responses included one change in peer relationships and referred to the idea of developmental progression. During preliminary analysis of participant responses to this question, it became evident that most practitioners mentioned language development as a key component in the evolution of peer relationships as children age at all time points. However, within Handle With Care content, much emphasis was placed on additional cognitive and social developments that influence the nature of children’s interactions with one another. As such, language development was considered a modicum level of knowledge in this area.

I believe they are more knowledgeable, they are more aware of things, so they build the relationships as they get older. They might have a friend at that time with somebody that they can relate to more, rather than playing with a group of children but when they get older they build strong communication and strong relationships with another child. (Time 2-Adequate quality)

Um, definitely see a difference from infants to toddlers. Toddlers, they don’t have the verbal skills to interact, so when you get to the preschool room they do have the skills to use their words. And so I would encourage them to use their words with each other. (Time 3-Adequate quality)

When participants provided responses that mentioned more than one change in peer relationships and specifically referred to age or younger children versus older children, a High quality code was given. Within High quality responses, participants could discuss language development in addition to other changes in peer interactions.

Quite a lot. By I find by the time they are preschoolers, you know infants they don’t know that there’s other children on the planet for a few months, and then a lot of parallel play, and then toddlers, they don’t like anybody around them, they don’t want to share anything, it’s all mine, and by the time preschoolers, I find
even two and a half or so are definitely starting to notice children around them and friendships are made with children that they are around every day usually and then by the time they get to preschoolers there’s really strong bonds. I find that the bond is a lot stronger once they hit preschool. Friends are very important at that stage I think. (Time 2-High quality)

Definitely I think the verbal communication is huge. I think from infancy or the toddler age, it’s all mine, it’s no one else’s. Whereas they learn to show a lot of empathy and sharing skills as they get older so that they’ll play together and role model and role play different things that they have been through and that’s how they’ll deal with those things. (Time 3-High quality)

Well infants and toddlers are a little more egocentric so they kind of only think of themselves and then as they get older they are kind of more aware of how other people are thinking and how other people are feeling. Like the older children are aware, if they’ve upset someone, or they might worry about what other people are thinking about. (Time 2-High quality)

Well in infancy it’s basically them and their caregiver. With other children, it’s just parallel play for toddlers. But as they get older there’s a real sense of they choose who they want their friends to be and there’s always that connection with them. They want to sit next to them, they want to play with them outside, they want to play inside, they tend to save the spot next to them. They’re able to express their needs and wants to the child and they’re able to become elaborate. They can role-play a lot more with the children and pretend to put on their hats and purses and shoes and pretend to go shopping and what things are you going to buy. So their play becomes a lot more elaborate. (Time 3-High quality)

I would say they start to build relationships around preschool because they have that language development there, they are able to communicate with each other, expressing how they are able to collaborate with play, whereas a younger group of toddlers or in infancy, they are not able to sit down and socialize so much, it’s more of sitting beside each other, they can see each other, but there won’t be so much back and forth kind of communication, they will be more in their own little worlds. I think more when they are in preschool they start to understand the needs of other children and how to compromise with their own needs as well. I believe that’s where they will be able to understand the concept of relationships. (Time 2-High quality)

Well, they become, I guess, more reciprocal. They engage in cooperative play, where I guess in infancy, like I said, it’s just more, “hey you’re here, you have eyes, I have eyes,” that kind of a thing, they’re sitting side by side and, in the toddler room, I know, I used to be a toddler teacher so they’re starting to form that, sort of, you can see that, sort of, who they play close to, and in preschool of course they start to fill those bonds, common interests and you can start to see the division between the boys and the girls so I think it just becomes more back and forth between the, as they get older. (Time 3-High quality)
Well, infancy, preschool, they don’t focus too much on whether they have friends but as they get older, it’s an important part because they want to be accepted by their peers so it becomes more of a “I need to do what it takes to get liked by other people.” I find that especially at this age they’re doing a lot of things that they otherwise wouldn’t do as long as it’s cool with their friends, they start to do it. So being accepted by others is more important. (Time 2-High quality)

A significant portion of Building Block 4 reviewed ‘theory of mind’ research and considered it (specifically the capacity to engage in perspective taking) within the context of children being able to develop friendships. This seemed to impact training participants’ ideas around how children’s peer relationships change as they get older. Following Handle With Care workshops, training participants more frequently discussed children establishing friendships, their increased perspective taking, cooperative play and development of pretend play than originally at Time 1. Across time points, participants consistently, and very frequently, conveyed that increased social engagement (e.g., being egocentric at younger ages and then more collaborative at older ages) and better communication skills allowed peer relationships to advance when children develop. Although mentioned minimally, children developing concern over standards of behaviour and increased gender roles came up consistently across time points.

Only one aspect of children’s changing peer relationships decreased in the frequency with which it was mentioned. At Time 1, some training participants discussed children displaying more sympathetic and helping responses as they advance in age. At Time 2 and 3, this was virtually no longer mentioned.

Summary of Findings for Building Block 4.

Findings concerning responses to Building Block 4 Interview questions were varied. Following Handle With Care workshops, training participants described greater skill in helping shy children engage in interactions and activities with others as compared to their pretraining responses and the comparison group. Similarly, training practitioners demonstrated significant
change in their understanding of developmental considerations in children’s peer relationships. These participants showed increases in the quality of their responses immediately after training and relative to the comparison group. Despite positive results regarding two peer relationships topics, gains were generally not sustained by training practitioners at Time 3. Although training practitioners shared improved practices with respect to supporting children through negative peer experiences (e.g., teasing) relative to their Time 1 responses, there was minimal difference between this group and comparison participants at Time 2. However, further significant shifts in quality occurred in the training group at Time 3. Six months after Handle With Care, some training participants’ skills in this area continued to be enhanced while other training participants failed to maintain the level of skill quality they had evidenced immediately after the workshops were completed. Finally, Handle With Care workshops appeared to have minimal impact on practitioners’ ability to promote social skills. Training participants maintained relatively high levels of Low and Average quality responses across time points and showed little difference from the comparison group immediately after workshops.

These findings suggest that Handle With Care workshop content concerning peer relationships enhanced training practitioners’ recognition and relevant practices in a developmentally appropriate ways. The training expanded practitioners’ perceptions of what changes over time for children, in cognitive, language and social domains, in order to shape the nature of peer interactions. With respect to specific instances in dealing with shy children, training practitioners increasingly described being responsive to the individual needs of the children, attentive to and respectful of their comfort level. These practitioners also tended to indicate that secure attachment relationships (related to Building Block 1) between practitioners and children created an important context in which practitioner could assist shy children with their peers. As well, more training participants discussed helping children to engage in emotion
expression, perspective taking and problem solving during times of conflict after exposure to *Handle With Care* content. Regardless of these gains, training had minimal impact on the social skills practitioners attempted to promote in children and the repertoire of strategies for fostering such skills.

*Summary of Building Blocks 1-4.*

Hypothesis 6 was only partially supported by findings from Interview responses for questions from Building Blocks 1 to 4. Specifically, relative to Time 1, training participants clearly demonstrated higher quality mental health practices at Times 2 and 3 related to building trusting relationships with children. Training participants evidenced higher quality mental health practices following *Handle With Care* workshops regarding promotion of children’s self-esteem at Time 2, but this was not sustained at Time 3. Findings were mixed regarding change with practitioner practices to support emotion expression and regulation and positive peer relationships. Moreover, any positive shifts in quality were not sustained at Time 3. Consequently, the *Handle With Care* training program was inconsistently associated with higher quality practices related to enhancing children’s social and emotional development.
Hypothesis 7

Relative to Time 1, training participants will demonstrate higher quality mental health practices at Times 2 and 3, related to their relationships with parents of children in their care.

Building Block 7: Relationships with Parents.

Unlike the previous sets of questions for Building Blocks 1-4, that focused on aspects of enhancing children’s social and emotional development, questions pertaining to Building Block 7 dealt with a separate component of mental health promotion. Three questions inquired into participants’ understanding and approach to their relationships with the parents of the children in their care (See Appendix F: Child Care Interview for questions). Participants were asked to describe: a) in what ways their relationships with children are influenced by their connection to children’s parents, as well as: b) factors important to practitioners’ ways of interacting with these parents. Additionally, participants offered: c) strategies they use for dealing with situations in which conflicts or differences in beliefs and opinions arise between themselves and parents. Tables 17-19 present the overall quality code ratings for these questions for both training and comparison participants across study time points.
Table 23

Building Block 7: Question A - How do you think your relationships with parents influence your relationships with their children?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>22</td>
<td>8</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>High Quality</td>
<td>23</td>
<td>11</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>16</td>
<td>4</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>High Quality</td>
<td>34</td>
<td>13</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>35</td>
<td>10</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

There were no significant differences in quality ratings between training and comparison groups at Time 1. The comparison group displayed no significant shift in the quality of their responses from Time 1 to Time 2.

In contrast, the training group demonstrated a significant decrease in the number of Low quality responses ($\chi^2 = 5, p < 0.001$) and Adequate quality responses ($\chi^2 = 2.25, p < 0.001$) from Time 1 to Time 2. The training group also showed a significant increase in High quality responses ($\chi^2 = 3.56, p < 0.001$) between these two time points. At Time 2, the training group provided significantly fewer Low quality responses ($\chi^2 = 4.08, p < 0.001$) and significantly more High quality responses ($\chi^2 = 3.24, p < 0.001$) relative to the comparison group. There were no
significant differences at Time 2 between groups with respect to the frequency of Adequate quality ratings.

Quality levels remained relatively stable six months after Handle With Care at Time 3 for the training group. However, a significant decrease in Adequate quality responses was observed from Time 2 to Time 3, which was most likely accounted for by participant attrition.

Within the training content for this Building Block, emphasis was placed on how children’s relationships with practitioners are strongly influenced by the nature of the rapport between their parents and practitioners. In cases where participants provided Low quality responses, they failed to acknowledge this and, instead, suggested that dealing with parents should not affect their relationships with children. Additionally, responses were coded as Low quality when participants focused solely on dealing with difficult parents and therefore did not directly answer the question.

I wouldn’t have to say that you know we have good communication with all of our parents, but I’ve never had an instance where I’ve had a disagreement with parents, I would never let that go into the classroom on that way, how to deal with that person’s child. I think once they’re in our room, those kids are totally different from when they are outside of the room and I try and keep that separate just because I don’t think if you have a disagreement with a parent or a parent doesn’t get along with you I don’t think that’s fair to let that go onto the children at all. So, I kind of keep it separate but at the same time you need to make sure that the parent is telling you everything about the child. (Do you think your relationship with the parents affects your relationship with the kids?) I don’t think so, no. We get our own relationship with the children in the classroom and that’s where that relationship is and then it’s a relationship with the parents as well. (Time 1-Low quality)

I more or less think that I would build that relationship with the children then the parent because I am dealing with the child on a daily basis. It does reflect your relationship with the parent but it’s nothing that would make you second guess the parent. It’s always positive and you always stay positive and support the parent but a lot of parents live fast paced lives. So it’s always about building relationships with the children then with the parents. (Time 1-Low quality)
Responses that acknowledged practitioner-parent relationships impact practitioner-child relationship without describing how were coded as Adequate quality. Adequate responses lacked depth with respect to understanding practitioner-parent relationships can set the tone for establishing positive attachments with children that influence practitioner’s capacity to build trust with children and effectively meet their developmental needs.

Well, it makes it a whole lot easier when you have a really good relationship with the parent because then that way the lines of communication are open and you always know kind of what’s going on in the family life versus here and you are able to feel comfortable coming to that parent if there are things that are going wrong. (Time 2–Adequate quality)

It does a lot because if a parent is upset about something that you did, you would see it in the child because the child is an emotional magnet so they can sense that there is something between the parent and the teacher. We try to keep the communication as open as we can and always be positive and if there any conflict to resolve it as fast as we can. So far, I’ve had very good relationships with parents. (Time 2–Adequate quality)

High quality responses were characterized by discussion of how positive or negative practitioner-parent interactions can bolster or hinder feelings of security in children. Such responses were coded also when the practitioner considered how relationships with parents enable them to meet children’s needs more optimally and/or assist the practitioner in knowing children better.

Well, the children see how you act with the parents, like if you have a good relationship with the parents and you are open with them and you have that trust with them the kids see that and they know that you are the one that their parents trust and they are safe with you and if it’s a negative relationship then they can probably pick up on that and they are probably a little more hesitant or scared to be there. (Time 2–High quality)

If a parent does not feel comfortable with you in the baby room, then the baby is not going to feel comfortable with you. If the parents are very nervous about leaving their child with you, the baby will know, they will feel it. So I believe having a good relationship with the parents and the parents feeling comfortable about coming to you about anything and trusting decisions that we make is very important. That’s what I try to do with all the parents that come in the door. (Time 2–High quality)
I believe that it influences them greatly. If there is a parent that is difficult sometimes you can look at the child that they may be difficult ones too or high maintenance is another word that you tend to think of. I think it’s very important and I do take note, especially when taking this course, that you do have to separate the two and realize that you are with this child everyday and you have to support them, whereas the parents basically you are seeing them at the end of the day and the beginning of the day but you still have to feel like you are on the same page with the parents so the child feels that too. (Time 2–High quality)

A lot. If I have a close relationship with parents and the children see that, I have a good relationship with children as well. That’s what is important to me too, if you have a good relationship with parents, you’ll have a good relationship with the children and I shouldn’t be using the word good, I’m trying to think of a different word to describe the relationship other than the word good. Because I can communicate and talk with all the parents that come into the daycare centre and I find that I’m friendly and open and their response to me is the same and I’ve even had a couple of parents that have been upset when they come in and have voiced what they’ve been upset about and they know it has affected their child, which is good that I know that, that has affected their child. That’s why sometimes that child seems to cling to me a lot more, once I know the reason why. I feel I’ve always had a good relationship with all parents that come in to our centre. (Time 3–High quality)

Oh it has a big influence I believe. If the children don’t believe that you know mom and I get along or dad and I get along, why are they going to make an effort to feel secure and be happy with me? You know if I am somebody that mom doesn’t like, then they maybe are beginning that attitude, no I don’t want you either. It is important for me to be open and honest with the parents and I like to have that dialogue so that they can see that we do get along and that we do care about how the child’s day has gone and that we are both invested in their day. (Time 3–High quality)

After Handle With Care workshops, training participants increasingly discussed how the nature of practitioner-parent relationships influences whether children trust practitioners. They recognized that if practitioners have tense or difficult experiences with parents, then children may develop negative interaction patterns with practitioners because they don’t feel safe. Additionally, training participants more frequently indicated that communication about the child is bolstered when they have a rapport with parents, enabling them to know the child better and be more effectively responsive. Across time points, training participants consistently discussed how practitioner-parent relationships can make children feel secure and indirectly impact children’s
rapport with practitioners by fostering a positive atmosphere and helping practitioners to know children better. Less frequently, training participants consistently suggested across time points that they and the parents model getting along, problem solving and conflict resolution to children. At Time 1, training participants frequently indicated that practitioner-parent relationships allow parents to know more about their children’s centre experiences, which can indirectly strengthen children’s security with practitioners. However, at Time 2 and 3, this was mentioned much less as training participants increasingly focused on directly elaborating about parents’ sense of trust with them forming the foundation for their children’s trust in practitioners.

Table 24

*Building Block 7: Question B—What kinds of things do you consider when trying to interact with parents?*

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>

*Missing question data for one urban participant*
There were no significant differences in quality ratings between training and comparison groups at Time 1.

Unlike the previous question for Building Block 7, Question B revealed minimal shift in the quality of responses offered by the training group following *Handle With Care*. At Time 1, the training and comparison groups exhibited virtually identical distribution of quality level responses. Following the workshops, small but significant increases in the number of High quality responses were demonstrated by both the training ($\chi^2 = 2.25, p < 0.001$) and comparison groups ($\chi^2 = 1.14, p < 0.001$). Slight decreases in Adequate quality responses were also observed for both groups, but were not significant. There was no true difference between groups at Time 2, indicating that training did not impact participants’ understanding, consideration or reflection on factors that influence their interactions with parents (as framed by this question). At Time 3, the training group maintained the same number of High quality responses. Moreover, the training group showed a significant increase in the number of Low quality responses ($\chi^2 = 1.13, p < 0.001$) as well as a significant decrease in Adequate quality responses, ($\chi^2 = 1.33, p < 0.001$), suggesting that some gains made by participants after training were not sustained. Across time points, the majority of responses for both groups fell into the Adequate quality level.

Participants who provided Low quality responses gave either vague answers or indicated that they do not actively think about their approaches to parents. Typically, this latter kind of response was offered within the context of participants not experiencing difficulties in their interactions with parents.

Um, when they arrive and depart, we basically discuss how their night went, and their day. And all that stuff. Just so we can get a feel for how the day is going to be for the child. (Time 1 – Low quality)
When participants could describe one or more factors that they consider with working with parents, responses were coded as Adequate quality; however, such responses did not include explanation of why such factors are important in interactions.

Being positive, even if it is something that has gone wrong during the day, that the child has done. Always making sure you begin with a positive and end with a positive. Letting them know ways to deal with the situation, always making them feel welcome. Not ignoring them, listening to their concerns. To be just as open to them and welcoming to them as you are to the children. (Time 3 - Adequate quality)

High quality responses consisted of elaboration about how factors could influence the tone of interactions between practitioners and parents, in turn affecting such aspects of the relationship as trust building, information sharing and parent satisfaction with the care their children were receiving. Responses coded as High quality typically conveyed a strong sense of perspective taking on the part of the practitioner, who tried to be cognizant of the parents’ background and current mood and functioning as well as how parents may perceive the practitioner, both verbally and nonverbally.

Culture. Some cultures have different ways of communicating. Certainly the language is important. Sometimes even the age of the parent. You want to make sure that when you are communicating you’re not using a lot of jargon and you’re trying to use language or communicate with them that’s understandable. You always want to have that respect and if they’re not able to or if they don’t want to talk about something in particular, then you put it off, you always want to make it convenient for them and be honest with them. (Time 3 - High quality)

I try to consider my body language, my facial expression, I just want to be as open and approachable as possible, so the parents get a sense that, you know, I am a good, ardent, kind caregiver and if they see me be very standoffish they’re not gonna want to leave their child in my care for the whole day, so I just try to be as prudent as possible and just listen to them, try to help them as much as I can, make them comfortable when they leave their child in our care. (Time 3 - High quality)

Because of the community that I work in, I have to consider first and foremost the culture and how they relate to and how they communicate with and the level of communication. I have to also consider what their needs are and what they’re looking for, what their stresses are because some parents come in and they don’t have a job, they just lost their job and they’re looking for a job or they’re going to school because they can’t find a job and they’ve been looking for a long time, what
are their stress points is so important for you to understand and better for you to meet their needs as well. Because when families come in and they're bringing in their child, you're actually servicing the whole family as a unit. It's not just about the child so finding out about what those stress factors are is really helpful. (Time 3 - High quality)

I consider their day at work for example. Like when parents come in, you do not know what happened to them prior to them coming. I consider how they were feeling, like if I see a parent coming flustered and you know you can see it has been a hard morning, trying to get the child up, they missed the bus, they did this, you don't know what happened. So you don't want to drag things out but you want to take into consideration their feelings and what they are going through. So you know just asking them, "Are you feeling okay? Is there anything I can do?" In that pick up time when they come for their child, if you see that they are just a little bit overwhelmed and they are so happy just to go home, you can give them a light snack to take with them so they don't have to worry right away when they get home to prepare a meal. So taking into consideration the little things and the little responsibilities a parent has to do, it can be so overwhelming at times and making sure they feel that consideration when it comes to parents because it is hard. It is hard raising a child, so. (Time 3 – High quality)

Two categories were established for descriptive codes: participants considering things from: 1) parents’ perspectives, and 2) practitioners’ perspectives. In terms of parents’ perspectives, training participants were consistent in the frequency with which they mentioned considering the language parents use, parents’ comfort level in discussing personal issues, parents’ time constraints and whether parents had a bad day across time points. Additionally, both prior to and following workshops, training participants consistently identified that they try to recognize the best times to communicate with individual parents and don’t communicate about important issues when parents are rushed. Certain factors increased in frequency following training, including participants thinking about parents’ beliefs, experiences and life situations and parents’ perspectives of the centre. Other factors, such as parents’ interaction patterns (e.g., typically shy and reserve or sociable and open), whether parents were going through difficult personal issues as well as the nature of parents’ relationships with their children were generally not mentioned across time points although they were factors considered within \textit{Handle With}}
Care training.

At Time 1, a large number of training participants mentioned promoting open communication and being positive about the child as factors from the practitioners’ perspective when communicating with parents. However, at Time 2 and 3, the frequency of these factors largely diminished. Instead, practitioners more often discussed the language they used (e.g., no jargon), their level of professionalism and providing a variety of communication options than they did at Time 1. Rarely, but consistently across time points, training participants discussed nonverbal body language and trying to balance positives and negatives when talking about children as other factors they consider when interacting with parents.

Table 25

*Building Block 7: Question C—How do you handle collaborating with parents in situations in which there may be a poor fit between a family and the centre or when your beliefs are different from a parent’s?*

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th>Comparison Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>High Quality</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
At Time 1, training and comparison groups displayed dissimilar quality levels. The training group exhibited significantly fewer Low quality responses ($\chi^2 = 4.27$, $p < 0.001$) and a significantly higher number of High quality responses ($\chi^2 = 1.78$, $p < 0.001$) relative to the comparison group. This reflects the training group presenting overall higher quality responses prior to *Handle With Care* workshops.

From Time 1 to Time 2, the training group demonstrated minimal shifts in the quality of their responses; none were significant. Significant differences between the training and comparison groups continued at Time 2 for Low ($\chi^2 = 8$, $p < 0.001$), Adequate ($\chi^2 = 1.96$, $p < 0.001$) and High quality ($\chi^2 = 2.27$, $p < 0.001$) responses. There were no significant changes between Time 1 and Time 2 for the comparison group.

At Time 3, the training group showed a significant reduction in High quality responses ($\chi^2 = 16.67$, $p < 0.001$), coupled with a significant increase in Low quality responses ($\chi^2 = 3.77$, $p < 0.001$) as compared to Time 2 frequencies. Across time intervals, the majority of training group responses were consistently coded as Adequate quality. This suggests that *Handle With Care* training had little impact on how training participants handled conflictual situations with parents as assessed by this question.

Descriptive coding revealed that training participants frequently indicated open communication, empathizing with parents’ feelings or ways of thinking and trying to set up their collaboration with parents for success were strategies they used to prevent or resolve difficult situations with parents at Time 1. However, the frequency with which these same strategies were mentioned at Time 2 and 3 significantly diminished. In contrast, training participants increasingly spoke more about attempting to meet the meets of both parents and children,
presenting their own ideas and opinions and involving the centre supervisor following *Handle With Care* workshops.

It is noteworthy, that there was a great deal of variety in the response content that consisted of involving centre supervisors. While some training participants used this as a sole strategy and their responses reflected little problem solving or open-mindedness when dealing with parents, other participants indicated that involving the supervisor typically was the last step or resort after attempting many approaches to collaborate with parents in a positive manner.

At both Time 1 and Time 2, training participants frequently mentioned considering parents’ perspectives. At Time 3, this strategy was discussed much less often. Across time points, participants minimally yet consistently discussed arranging meetings with parents, referring to centre policies and procedures and always listening to parents’ ideas or opinions as strategies they employ. Other strategies that were coded included arranging centre visits for parents, consistent check-ins with parents, having another staff deal with parents or mediate difficulties, maintaining consistent interest in children and families, not making assumptions about parents based on culture, past experiences, etc., presenting a variety of options to parents and staff teamwork. However, these strategies were very minimally discussed by training participants and no trends in frequency were observed across time points.

Low quality responses were characterized by vagueness or the participant describing talking with the parent and then turning the matter over to their supervisor. As well, a response was coded Low quality if the participant suggested that a lack of a good fit between family and centre necessitated parents changing child care arrangements for their children (e.g., placing them in a different centre). These kinds of responses were considered to lack a problem solving or reflective approach to the situation, something that was emphasized in the *Handle With Care* workshops. They also suggested there wasn’t much a practitioner could do to achieve resolution.
Usually then we would involve our supervisor and just let her know what is going on and what our beliefs are and what the parents’ beliefs are and what the situation is and ask the supervisor to intervene and see what we can figure out. (Time 3 – Low quality)

In contrast, Adequate quality responses included one or more strategies used by participants to work through issues with parents, but did not describe why they found such strategies to be beneficial.

I just had a little incident not too long ago about a child who is having a little bit of a hard time adjusting and so I showed the parent, again I did the pictures, this is our daily routine, just little things like to help out. Now the child is preschool and at home he is still sitting in a high chair, therefore during lunch the child had a hard time sitting at the table and the child kept running away from me because he wasn’t attached to the chair, so just going back and forth and mentioning these things to the parents, just making them aware that these little things impact the child’s life at daycare. So discussing the problems and just seeing how we can sit down together and come up with strategies that will work here and at home. (Time 2 – Adequate quality)

High quality responses were richer than Adequate responses in that that included one or more strategies participants employ to work through issues with parents and also conveyed the reasoning behind their problem solving approach. Furthermore, these responses communicated a sense of neutrality on the part of practitioners; they did not describe themselves or parents as being right or wrong or suggest that parents needed to simply conform to centre policies. Participants that provided High quality responses also considered working with parents, not just the children, to be an important part of their work role.

Well if my beliefs are different, first of all I’m not there to tell that person otherwise that this is what I believe and this is what you should believe. You need to recognize that parents might have different beliefs and to support that as much as you can. Definitely you do want to support them. If there is a situation that they are not happy with then you definitely ask them how you can support them or what you can do for them and what is it that they’re not happy with. We have surveys for the parents that they can express what they are feeling and how happy they are with the centre and what are the areas we need to improve on and when we see that we do work on that and make the changes throughout the centre but at the same time as a teacher in the classroom you would ask the parent how you can support them and what you can do and then you provide the resources necessary to help the parent so there is no bad situation. You work through that. (Time 2–High quality)
I hate to say this but--I don’t know if it was based on the fact that right from the beginning I let myself out there so I know I’m available for them. Again, back to these particular parents, when I first started, everybody warned me to leave the parents but I said I’m going to be open, if she doesn’t want to talk, she doesn’t need to talk to me. I go based on that as long as you are open communicating with these parents and they feel that you are open and listening to what they have to say, whether good or bad. I mean I’ve never experienced parents where they said “I don’t like you or the centre” or anything like that. There’s always been a way to resolve it. I’ve never really had an experience to say, thirteen years and I’ve never really had that. (Time 2–High quality)

Summary of Findings for Building Block 7.

Findings from Interview responses related to Building Block 7 support only some components of Hypothesis 7. Training participants did present significantly improved quality in their responses relative to the comparison group and their own Time 1 responses when they considered how their relationships with parents affect relationships with children. Moreover, they increasingly conveyed understanding that building trust with parents fosters the same in children, models positive collaboration strategies for children and allows both practitioners and parents to have a fuller knowledge of the children. These positive changes for training participants were maintained 6 months after Handle With Care training. In contrast, training participants were not better able than comparison participants following training to discuss factors they consider when interacting with parents or positive practices related to conflicts or ‘poor fit’ situations with parents. Additionally, the quality of training participant responses associated with these topics tended to decline at Time 3. Most often, training participants concentrated on parental factors that influence interactions, such as language issues, communications strategies, without giving thought to their side of interactions (e.g., body language, potential biases) or the ‘goodness of fit’ between parents and themselves. The majority of training participants could indicate one or more strategies for dealing with conflictual
situations but most lacked insight into how to achieve a flexible problem solving approach, espoused in *Handle With Care* content.

**Hypothesis 8**

*Relative to Time 1, Handle With Care training participants will demonstrate higher quality mental health practices at Times 2 and 3, related to enhancing their own well-being.*

**Building Block 8: Well-Being of Practitioners.**

The three questions pertaining to this training unit queried child care practitioners’ perceptions about how their own mental health can affect their use of mental health promotion practices with the children in their care. In particular, participants indicated: a) if they feel their own well-being affects the children they work with in any ways; b) ways in which they contribute to their own well-being in the centre; and c) how they handle conflicts or differences of opinion with colleagues in their workplaces. (See Appendix F: Child Care Interview for questions.) Tables 20-22 present the overall quality code ratings for these questions for both training and comparison participants across study time points.
Table 26

Building Block 8: Question A–Do you feel that your own well-being affects the children that you work with in any ways?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>N=54</td>
<td></td>
<td></td>
<td>N=54</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>11</td>
<td>13*</td>
<td>7</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>15</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>22</td>
<td></td>
<td></td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>12</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>14</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>High Quality</td>
<td>18</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Missing question data for one urban participant

Prior to workshops at Time 1, training and comparison groups were significantly different with frequency of Low quality ($\chi^2 = 2.56, p < 0.001$) and High quality ($\chi^2 = 6.25, p < 0.001$) responses. The training group offered significantly more Low quality and significantly fewer High quality responses.

From Time 1 to Time 2, training participants demonstrated a significant reduction in Low quality responses ($\chi^2 = 5.5, p < 0.001$) and a significant increase in High quality responses ($\chi^2 = 8, p < 0.001$). In contrast, the reverse pattern was found with comparison participants; at Time 2, they were found to provide significantly more Low quality responses ($\chi^2 = 2.38, p < 0.001$) and significantly fewer High quality responses ($\chi^2 = 3.6, p < 0.001$). There was no significant change in Adequate quality responses between these time points for either group. Across all quality
levels, training and comparison groups significantly differed from each other. Training participants provided fewer Low quality responses \( (\chi^2 = 4.23, p < 0.001) \) and more Adequate quality \( (\chi^2 = 1.6, p < 0.001) \) and High quality responses \( (\chi^2 = 6.4, p < 0.001) \) relative to comparison participants.

At Time 3, training practitioners evidenced further significant decrease in Low quality responses \( (\chi^2 = 8, p < 0.001) \) and generally maintained similar Adequate and High quality levels as at Time 2. This suggests that their understanding of this topic continued to grow and/or was sustained 6 months following the workshop.

Low quality responses indicated that the practitioner did not believe their well-being affected children in their care and/or worked to ensure that their well-being didn’t impact their relationships with children. As well, a Low quality response could reflect that the practitioner simply agreed that their well-being did affect children but offered no elaboration. Many Low quality responses suggested that although practitioners might experience negative things in their professional or personal lives, it was necessary to ‘leave it at the door’ and maintain a positive, cheerful disposition. As well, practitioners minimized how their physical or psychological well-being influenced children’s experiences.

Oh, of course, for sure. There will be a day that I come in and I had a really good night sleep, I am on top of the world, we do awesome activities, I got the energy to do extra little things whereas another day I might come in not so energetic and I just basically lay low and let the kids do what they want to do. (Time 1-Low quality)

Just sort of like I mentioned before, if it’s emotional well-being, if I’m having a bad day, I just sort of cheer up when I get here. One, because I have to, and two, because they force me to because they are just so happy all the time, I can’t help but smile at them. In terms of health, I don’t come when I’m sick, when I know I’m not well enough and I’m not one hundred percent, I look at my day and say okay am I going to be able to fulfill all my duties and give kids what they need. If I can’t, if I say no to that, then I stay home. (Time 1-Low quality)
I think maybe on a day-basis. I guess my well-being physically of course I try to stay healthy especially because I’m lifting children often. Mentally I said earlier too that if I’m not feeling good at home, coming to work actually makes me forget about it so in a way they are helping me which is nice. Then in turn, I am in a better mind frame to be taking care of them. (Time 1-Low quality)

Yes. Like I said before, if I’m tired, it hinders the day I guess a bit. And I’m upset about something from home, it can as well. I try to leave it at the door like I said but it kind of comes in with you, it doesn’t necessarily affect how I take care of the children but maybe how interactive I am with them that day. (Time 2-Low quality)

Um, sometimes because I do, I do suffer from back and neck pain a lot and sometimes I feel like I cannot do certain activities with them like running. I can walk but I cannot run and I kind of feel bad. But in the same time, I don’t think that it affects them that much because they like still will try and come get me but I am walk fast but certain things I cannot do as much. Like jumping jacks or jumping up and down. In that terms or something like when I am upset or whatever, I might be irritable faster. But I try to prevent it, like I try not to do so much. (Time 2-Low quality)

Adequate quality responses consisted of the practitioner describing that children do in fact observe or ‘sense’ characteristics of their well-being (e.g., mood) and are inevitably affected. However, there was no further elaboration about how interactions with children may be subsequently impacted.

I think it does because for example maybe I’m having a lot of problems at home or I’m having other types of problems other than work, or maybe sometimes even at work, I think the children feel it even though we don’t have to tell the children usually how we’re feeling, the children can read some cues, body language, or something for them to see that something different is going on. (Time 2-Adequate quality)

I do, I mean, we are told to leave our issues and anything that may be festering in our minds or problems or whatever at home, leave them at the door. Work is work and home is home, which is valid, however, sometimes you can’t help but be emotional to certain situations, you know, a death in the family, a difficult time in your life, things like that, and it is gonna take a toll on these individuals sometimes, we’re only human so it’s really hard to kind of mask that, and I find the kids are really attuned to it, they know when you’re having a bad day and the last question sometimes, they’ll just push those buttons cause they know they can. (Time 3-Adequate quality)
It does. Again, as a professional, you can’t let that affect the way you work with the children. But we’re only human and for example if someone is not feeling valued at their workplace, then that will reflect on your mood and how you are everyday you come to work. I feel good so it’s the way I’m being treated at work and how I feel valued. But yes, some people would be affected and it could affect the children. You just have to be aware of your behaviour and your moods around the children. (Time 2-Adequate quality)

High quality responses represented recognition on the part of the practitioner that his or her well-being affects children in their care and offered insight into how practitioner-child interactions may be influenced. Additionally, such a response could include an explanation of how children’s well-being may be impacted (e.g., sense of security with the practitioner, child feeling that he is the reason for the practitioner being in a bad mood, etc.). Such responses were aligned with content from earlier Building Blocks 1 and 2 in explicating that practitioners themselves bring something into their attachment relationships with the children in their care; the reciprocal nature of these relationships plays a significant role in children’s mental health.

Oh completely. Completely. You know I personally have some medical problems and when I am in a great deal of pain, but still struggling to get into work because you know, “Why are you off so much blah blah blah “… you get it from higher ups you know. It totally affects the kids because I am not mentally there for them. I need to be physically in good shape to work this job with them, get down on the ground with them, jump with them, swirl with them, do what they are doing but I also need to mentally be there and in some situations I am not. I am no good to them on days like that. I am just sort of a warm body filling the space. My mentally and physically, yah it affects them and they know it. They ask , “Are you okay?” And they kind of get down and anxious because they don’t know how to act around me when I am like that to be honest. You can just tell that they know something is wrong but they don’t know how to deal with it and they are having a hard time. And that is when some behaviours come out and I understand that I am somewhat part of the cause behind it. (Time 3-High quality)

Yes, I guess if I am sick or not feeling well, I guess it would affect the children because they pick up on that if I am extra quiet or not my usual self, then they notice it and they pick up on it. I’m pretty good about emotional stuff and I have a lot of support here. If I really needed to talk to somebody, there’s always somebody here or if I just needs a few minutes alone to collect my thoughts, there’s that support too. Definitely if I’m really upset, kids would pick up on it. They would probably feel a little bit more insecure because they don’t understand why I’m behaving the way I am. (Time 2-High quality)
Yes. So if I am having a bad day, like today, and I am not having a good day, and … one of the kids said to me while we were doing washing routine, “Why aren’t you smiling?” And I said, “Well I am feeling sad”, and she noticed clearly and asked about if it was because of her and I said no. I am just feeling sad inside and it has nothing to do about you. And she said, “Okay” and she gave me a hug. So, clearly I did not notice I was not smiling and she did and it obviously plays a factor. (Time 2-High quality)

Oh yes sometimes if I am having an off day I get irritated faster. That is important. I try not to, but sometimes you cannot help it right- I mean you -just there is a day where you are like ‘okay how many times do I have to talk to you about this’ because you are having an off day. Sometimes I will tell them, ‘You know I am not feeling too good today. I have a headache, can you keep your voices down a little bit?’ Usually they are like, ‘Oh are you okay?’ and give me a hug. It does affect a little bit but in general usually I am in a good mood. The other thing is that when the supervisor is at me, then I kind of feel like pressured and it changes, not on purpose, my relationship with the children and my mood changes, I kind of feel more stressed. I try to feel okay with the kids all the time but I am pretty sure it affects me and I maybe become a little bit more distant. You know with the children. Not generally, but sometimes. (Time 3-High quality)

Descriptively, training participants more frequently mentioned their mood, personal issues, stress levels, feeling good about themselves and relationships with colleagues as aspects of their well-being that affected children in their care after attending Handle With Care training. As well, these practitioners increasingly noted (following training) that children notice changes in practitioners and that their own well-being directly impacted the amount of attention they paid to children, children’s behaviour changes and children feeling that they are responsible for practitioner mood and behaviour.
Table 27

Building Block 8: Question B–In what ways do you contribute to your own well-being in the centre?

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>10*</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>10*</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>1*</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td>N=54</td>
<td></td>
<td></td>
<td>N=54</td>
</tr>
<tr>
<td>Low Quality</td>
<td>17</td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>7</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>31</td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>8</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>High Quality</td>
<td>6</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td>N=51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Missing question data for one urban participant

No significant differences between training and comparison groups in the frequency of quality levels existed at Time 1, with the exception that the training group demonstrated a significantly higher number of High quality responses ($\chi^2 = 3$, p < 0.001). However, the frequency of High quality responses for both groups was relatively low at this time point.

From Time 1 to Time 2, the training group presented a significant decrease in Low quality responses ($\chi^2 = 3.77$, p < 0.001) and a significant increase in Adequate quality responses ($\chi^2 = 2.01$, p < 0.001). The frequency of High quality responses remained consistent between Time 1 and Time 2. Relative to the comparison group at Time 2, the training group offered significantly fewer Low quality responses ($\chi^2 = 2.04$, p < 0.001) and significantly more High quality responses ($\chi^2 = 1.44$, p < 0.001). No significant difference was found between groups...
with respect to High quality responses at Time 2. The comparison group did not demonstrate any significant change in quality levels between time points.

At Time 3, training participants displayed some further shifts in quality; at the 6 month follow-up to *Handle With Care*, training participants displayed a significant increase in High quality responses ($\chi^2 = 1.6, p < 0.001$), with significantly fewer Adequate quality responses ($\chi^2 = 1.44, p < 0.001$). Such change at Time 3 implies training practitioners’ awareness and practices concerning how to bolster their own well-being in their workplaces continued to advance following the workshop.

Question 8B was intended to tap into the effect of Building Block 8 training had on practitioners’ perceptions that they could contribute to the organizational climate of their centres and, consequently, enhance their sense of empowerment and feeling valued. In training, it was emphasized that this concept paralleled ideas considered in relation to children’s mental health promotion, most especially increasing feelings of personal control, self-determination and capacity for problem-solving, which greatly influence well-being. Low quality responses reflected ambiguity on the part of the practitioner in recognizing that he or she did anything in this regard, lacked mention of any specific strategies and/or detailed only physical strategies for maintaining well-being in the centre. Additionally, responses that only described strategies structured by the centre were also coded as Low quality. Essentially, Low quality responses suggested that the practitioner did not perceive him or herself as an active agent in promoting personal well-being. *Handle With Care* content strongly considers both the physical and emotional demands of the role of practitioners, so exclusive consideration of how to attend to physical well-being neglected how practitioners foster their psychological health.

Um, just like, when it comes to the area and my well-being, I try to leave it on the side and come in here like someone different. I just forget the rest and continue with the day. (Time 1-Low quality)
Um, just making sure that you are staying healthy. Taking vitamins so that you are not being ill. Um, making sure that you are following procedures in terms of hand washing and things like that, because that is one thing easily helps you to stay healthy. In terms of eating habits and staying fit and working out so … that helps me at least to stay energized. (Time 1-Low quality)

Well I try to like, like to take things lightly. I don’t stress on things too much if I don’t have too. I just take things like you know if it not important I cannot let it bother me cause then it is not worth it. I laugh off a lot of stuff, like ‘okay, whatever’. I like to laugh a lot with the children too cause like if you make them have fun, they feel good and that is going to solve problems and make them feel good about themselves and laugh and tickle them to get a laugh out and they are like do it again, do it again. Take things lightly and shake it off. (Time 3-Low quality)

In turn, Adequate responses included describing one or more strategies that practitioners use to contribute to their own well-being in the centre, but did not elaborate on the impact of such strategies on practitioners, coworkers and/or children.

How I look after myself is that what you are sort of saying there? I take a break and I go away from the centre, away from where the children are, so you are out of the earshot of hearing the kids and you are sort of do some inhaling and exhaling and just relax and shut my eyes for a little while. And for my personal well-being, I work out three times a week, I go to Curves. You have to do things for yourself to make you well, that you can work with the children because I think working with children is, everybody just says you are babysitters but they have no idea. (Time 2-Adequate quality)

I have lunch breaks and I just relax. We have a staff room, I go in there, have coffee and relax, and if somebody is in the staff room, I chat with them, I find more resources that I can use in dealing with troubling behaviour or I need new ideas or I just want to know more about one topic because we have access to the internet too. Even though I’m not computer literate, I’m still learning. There are different ways that I try and improve myself. And plus, when I come home from work, I take time to just chill out. (Time 3-Adequate quality)

Responses coded as High quality consisted of one or more strategies used by practitioners to enhance their well-being as well as explanation of the impact of these strategies on themselves, their colleagues or the children in their care. The majority of High quality responses took both physical and emotional well-being into consideration (holistically) and suggested that a number of practices, rather than just one, are needed to address these areas. These responses also
generally displayed awareness and normalization of the fact that child care practitioners do have mental health needs that should be acknowledged by themselves, their workplaces and colleagues.

Well, we need to take care of ourselves definitely. Working as a team, doing all kinds of activities for ourselves, doing lunch or maybe an event, multicultural lunch where we’ll bring something from their own culture and we’re going to share that food with each other and socialize so we have different things happening. We go out sometimes with the staff for outings or for celebrations or we have potlucks sometimes for different occasions. It’s important to recognize each other and respect each other and respect each other as a team player and recognize the accomplishments or celebrate with them different occasions or things that happen in their life. They feel more valued. As well, we have wellness… I’m actually the wellness rep and we have things for the staff to get involved in for their well-being whether we have videos for yoga that they can do during lunch or they can do outside of work. They can take it home and do it. We have also ‘walk of the wellness’ where staff are encouraged to walk or do all kinds of exercises or different things for their well-being. We have websites they can go on for answers to their questions or we also have helpline if there are any issues or difficulty they are having in their life, they can call and receive help. There’s a lot of things that we do here in the centre to help for our well-being. (Time 3-High quality)

Being here for so long, I develop relationships with other staff so if ever I am feeling stressed, I can always count on another staff that I am close to, to help me out and vice versa. There are things that I do like if I need the help then I will ask for the help and at this centre I feel comfortable doing that. I feel like my coworkers are understanding and they will reciprocate. We work together to work on anything that I need to work on…That almost makes it easier to come to work knowing that there are people there that you can speak to if something were to happen, that they are positive and they want you to come to work. It makes for a better atmosphere and a better work time. (Time 2-High quality)

Enjoying my break and not running around like crazy, just taking some down time when needed. If I need more down time or having a moment where I need to get off the floor because something is bothering me, I make sure I call and ask someone to come and let me off for a few minutes instead of just staying there and getting more upset or more worked up about something. (Time 3-High quality)

Oh yeah, for sure … taking this Handle With Care program. I think especially being ten years in this field has made relook at some of things I need to focus on. I bring that into the centre and I bring that into my room. It has rubbed of onto the people that I work with too so I think that is a positive impact. And just trying to take care of myself and make sure that if I know I need a break, I need a break. I just think that is a huge part of my well-being. (Time 3-High quality)
In terms of specific strategies highlighted by training participants in their responses, coding broke down practices into those are were intrapersonal (mental/emotional strategies practitioners used individually and/or within themselves), interpersonal (mental/emotional strategies practitioners used in collaboration with others or through relationships), physical (focused on physiological health) and participatory in the centre (practitioners individually seeking out supports and resources through their workplace). Following *Handle With Care*, training participants more frequently identified intrapersonal strategies such as relaxation exercises, taking breaks at work, ensuring their preparation for the activities of the day and interpersonal strategies such as accepting help from and relying on coworkers, engaging in team building and collaboration with staff. Furthermore, training practitioners increasingly noted physical strategies such as exercising, sleeping well, participating in extracurricular activities (e.g., sports leagues) and taking sick days from work when they weren’t feeling well. Finally, in terms of participation in centre activities, training practitioners rarely indicated engaging in such strategies to promote their own well-being, though small increases were noted for participating in group staff physical activities arranged by centres and celebrations to mark special life events in staff’s lives.
Table 28

**Building Block 8: Question C—Do you ever have conflicts with your colleagues or differences of opinion? How do you handle those kinds of situations?**

<table>
<thead>
<tr>
<th></th>
<th>Training Participants</th>
<th></th>
<th>Comparison Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Suburban</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>7</td>
<td>6</td>
<td>9*</td>
<td>8</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>19</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>High Quality</td>
<td>4</td>
<td>8</td>
<td>7*</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6</td>
<td>5*</td>
<td>5</td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>19</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>High Quality</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>8</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td><strong>Time 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Quality</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Adequate Quality</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>11</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

*Missing question data for one urban participant

There were no significant differences in quality ratings between training and comparison groups at Time 1.

Following workshops at Time 2, the training group exhibited a significant decrease in Low quality responses ($\chi^2 = 3.27, p < 0.001$) and a significant increase in High quality responses ($\chi^2 = 2.45, p < 0.001$) as compared to Time 1. The frequency of Adequate quality responses remained consistent between all time points. The training group provided significantly fewer Adequate quality responses ($\chi^2 = 3.45, p < 0.001$) and significantly more High quality responses ($\chi^2 = 32.67, p < 0.001$) relative to the comparison group at Time 2. The comparison group also exhibited shifts in quality levels from Time 1 to Time 2. However, the comparison group demonstrated an overall decrease in quality, with a significant reduction in High quality.
responses ($\chi^2 = 10.67, p < 0.001$) and a significant increase in Adequate quality responses ($\chi^2 = 2.79, p < 0.001$).

At Time 3, the training group exhibited a further significant decrease in Low quality responses ($\chi^2 = 6.13, p < 0.001$) from Time 2. Although there was a slight increase in the number of High quality responses from Time 2, the change was not significant.

Question 8C was included in the Child Care Interview to gain information concerning participants’ appreciation for their capacity to help develop a constructive work environment that supported their well-being. Conflicts or differences of opinion between centre colleagues represented one type of situation related to this. Such a situation, when dealt with positively, invites practitioners to express their thoughts, ideas and feelings, engage in perspective taking and problem solving and reflect on possible biases. Additionally, they could consider the impact on children how such situations were worked through and resolved. Essentially, conflict resolution between practitioners and colleagues parallels the process by which children in child care are encouraged to deal with peer difficulties.

Low quality responses for Question 8C were coded when practitioners did not acknowledge that any conflicts or differences of opinion occurred and/or provide strategies. As well, responses were coded Low quality if practitioners simply indicated that they sought out supervisor assistance in such situations. An Adequate quality response was coded when a practitioner detailed one or more strategies that he or she used to resolve issues with colleagues.

I myself am pretty easy going. I am pretty much set in my ways though, I have been around the block a few times. Um, but I am very easy going and flexible, you have to be. You have to be. Yeah, cause with the amount of people you work with. (Time 1-Low quality)

Do you really want me to be honest? I’m not very good at confrontation and within our centre you always, well, this was like I said you’re going back quite a few years, you’re always told that if somebody’s not doing their job appropriately, you should tell them, but I don’t believe it should be coming from me if they’re not
doing their job appropriately so I'll communicate that to the supervisor and I will have him follow through with it. Yeah, I'm a little wuss. Yeah, I don't need confrontation, you know what I mean, and like I said, I don't think it's my job to tell somebody else how to do their job and that's where my conflicts would be because my main thing is the kids and if it's not being done right, it really bothers me, it irks me, actually, I dream about it, it's so bad. (Time 2-Low quality)

High quality responses also consisted of a description of a strategy but further articulated a problem solving attitude in which the practitioner considers the perspective or well-being of themselves, their coworkers or the children in their care. In this sense, practitioners that provided High quality responses conveyed an active approach, whereby their input was crucial to resolving difficult issues and maintaining a positive environment and well-being.

There will always be differences of opinion, everyone has different styles, different approaches, different ways of thinking, it’s important to respect someone else’s opinion as well as voicing your own if there was a conflict….It’s based on talking to each other and seeing if we can come to an agreement together and if not, I’ve never had to go past that, it always works out, usually you can also take things, step away and look at it from a different point of view when you get a chance to and come to an agreement, what would work for both partners, being understanding of each other. (Time 2-High quality)

I don’t think there is ever a situation where it’s always perfect. There will always be conflicts regardless of either how big or how small but it’s always in how you approach it and how you handle it. I always want to have it resolved right away. My philosophy is if I have to be with you every single day or work with you every single day, I certainly don’t want tension or animosity or anything bothering our working relationship. That’s not my belief. So I always want to kind of put it out there and be able to discuss it with the person or persons about whatever it is bothering them or me or whatever the situation is. So just being honest and trying to work together, if it’s trying to compromise on something, trying to provide suggestions to make it work but also not just with us, if it has an impact on the children, then always trying to let the children’s interests come first before us. (Time 3-High quality)

Well so far, I just started working with a new team partner in September and we haven’t had any conflicts, but I guess if I think back in the past it would be trying to discuss and trying to understand the differences of opinions and I always try and use the problem solving process, even with parents or co-workers or whoever, cause I think it really helps people express their emotions appropriately. So just kind of acknowledging feelings, gathering the information, asking for suggestions, offering suggestions, that type of thing. (Time 2-High quality)
Yes, I do. Just actually a few weeks ago that happened, there was a particular situation or something happened and I might have been, in my approach, not appropriate, however, the reaction to it was also not appropriate. So, kind of, two wrongs don’t make a right, and immediately I just approached my co-worker, asked them if they had a minute, and we discussed it in private, and how we were both feeling and how we could both make that situation better, but I don’t like to leave things festering cause I just find it just makes for an even more awkward working environment. I’m the type of person where the situation happens, you take a step back, you re-evaluate it, you take a deep breath and then just try and work through it as opposed to any continue and build. Once it’s dealt with, you can move on from it, learn from it, and know for next time. (Time 3-High quality)

With respect to particular strategies identified by training participants in their responses, primarily interpersonal approaches were increasingly highlighted following *Handle With Care*. More specifically, training practitioners referenced initiating discussion and acknowledging conflict, expressing thoughts and feelings, listening to others and joint problem solving. Some intrapersonal strategies also showed some minimal increase in frequency post-training, including considering other perspectives and reflection on personal opinions and biases.

*Summary of Findings for Building Block 8.*

Across Interview questions related to Building Block 8, training participants consistently demonstrated significant changes in awareness and practices concerning their own well-being. This included recognition that practitioner mental health affects children’s mental health as well as gains in positive strategies to contribute to their own well-being in the centre workplace and manage conflictual situations or differences of opinion with colleagues. Not only did training practitioners show significant improvements in their quality of responses relative to their initial responses prior to *Handle With Care* and to the comparison group immediately after training, they continued to show improvement in quality at Time 3. This suggests that *Handle With Care* training was associated with practitioner well-being led training participants to further develop
beneficial thinking and practices in this area well after workshops had ended. Consequently, findings uniformly support Hypothesis 8.

Following *Handle With Care*, training participants were increasingly attuned to how their own well-being cannot simply be ‘left at the door’ as they enter their workplaces. There was greater recognition by training participants that their own mental health inevitably influences children, something that they cannot always consciously control. Furthermore, after workshops, training practitioners described more holistic ways of enhancing and maintaining their own well-being, both in professional and personal settings and with a variety of relationships (e.g., coworkers, loved ones). More training practitioners described self-efficacy in resolving difficulties with colleagues through use of flexibility, self-awareness, perspective taking and collaborative problem solving. There was more insight into how all aspects of their lives are interlinked, just as in the case with children’s various developmental domains.
CHAPTER 6
DISCUSSION

This exploratory study was undertaken to examine the effects of Handle With Care, a mental health promotion training program for community-based front-line child care practitioners working with children between birth to 6 years of age. Specifically, the study investigated whether practitioners who complete the training program demonstrated positive changes in their mental health promotion knowledge and practices. This study is intended to broaden the research literature concerning mental health promotion efforts directed toward early childhood populations. The vast majority of research on mental health promotion has focused on older children and/or settings other than child care centres. Additionally, no other mental health promotion programs have been as comprehensive in the scope of content as Handle With Care. Furthermore, the study provides important information about the value of training child care practitioners, who are in a prominent position to foster children’s mental health.

In this final chapter, the current study is considered in the context of existing mental health promotion programs and associated evaluation research. Additionally, study implications are outlined and include the practicality and benefits associated with implementing the Handle With Care training program with child care practitioners. Limitations of the study are acknowledged in order to provide a sense of their reliability and validity. Finally, recommendations are made for future research and a concluding summary.

Handle With Care Program and Evaluation Study in the Context of Research

Epigenetic and neurobiological research has made it clear that experiences in the early years shape life-long outcomes (Sims, Davis, Davies, et al., 2012). In particular, children confronted with chronic stress during early childhood are at increased risk for long-term mental
health problems (Stanley & Siever, 2010; Swain, 2006; Twardosz & Lutzker, 2010). However, when young children receive nurturing and responsive care, they are provided protection from environmental risks (Noriuchi, Kikuchi & Senoo, 2008; Sims, 2009). This knowledge has resulted in the call for mental health programs geared towards population-based approaches that promote the well-being of all children. Effective programs involving mental health promotion efforts have primarily focused on children in school settings. Such programs do not target children in the critical period of development between birth to 6 years of age. The *Handle With Care* program differs from these other programs by focusing on this important early childhood time period.

The comprehensive content of the *Handle With Care* training is unlike that covered by other existing mental health promotion programs. Moreover, *Handle With Care* concentrates exclusively on evidence-based mental health promotion activities. As well, many factors relevant to children’s mental health are considered rather than attending to just one concept, such as resilience or coping with stress, as do programs such as *Reaching IN... Reaching OUT* (RIRO) and *Kids Have Stress Too*! (KHST!).

Child care practitioners are in a position to engage large numbers of children on a daily basis and influence children’s developmental trajectories. Yet, there are few programs geared towards mental health promotion training for child care practitioners or include this in their education. There is also little research that evaluates the effectiveness of training professionals, such as child care practitioners, about mental health promotion for children (Farrell & Travers, 2005; Kordich Hall & Pearson, 2004; Psychology Foundation of Canada, 2012). The current study provided information related to these topics.

To examine whether *Handle With Care* training had an impact on child care practitioners’ knowledge and practices related to children’s mental health promotion, two types
of information were collected and analyzed. Both assessed concepts and practices considered to be central to the *Handle With Care* program framework for advancing mental health promotion in child care centres. This framework consisted of practitioners enhancing children’s social and emotional development through development of trust between themselves and the child, building children’s self-esteem, encouraging emotion understanding and expression and fostering peer relationships, as well as building positive relationships with parents and practitioners ensuring their own well-being within the centre workplace.

The first type of information was quantitative, and obtained from the Child Care Questionnaire, comprised of multiple choice questions to ascertain study participants’ knowledge about mental health promotion concepts. Due to the small number of items associated with each specific mental health promotion concept, two groupings of variables, Intrinsic variables and Extrinsic variables, were formed to perform more meaningful analyses. Intrinsic variables consisted of questions related to Building Blocks 1-4. Questions related to the Building Blocks dealt with mental health promotion and with children’s social and emotional development, including attachment relationships, self-esteem, emotion understanding and expression and peer relationships. These topics were conceptualized as internal factors (development within children) involved in mental health promotion. Extrinsic variables consisted of questions related to Building Blocks 5-9. These questions concerned factors external to the children which are relevant to mental health promotion, including diversity, life transitions and stressors, practitioners’ relationships with parents, practitioner’s well-being and the physical environment of child care centres.

The second type of information was qualitative, and obtained from the Child Care Interview, which comprised open-ended questions designed to gather details about participants’ mental health promotion practices related to those described in *Handle With Care* training. These
two types of information produced two data sets and results, which are discussed independently below and then in combination.

The methodology of the current study sets it apart from previous evaluations of mental health promotion programs. Unlike evaluations completed for RIRO (Kordich Hall & Pearson, 2004) and by Farrell and Travers (2005), a comparison group was included. Ways in which training program effectiveness is assessed also differs from such previous research. In particular, this study is innovative in using an objective measure created for the study (Child Care Questionnaire) to determine changes in practitioners’ mental health promotion knowledge. Previous evaluations have relied on measures that focus more on practitioners’ individual confidence in recognizing and discussing mental health and emotional issues and/or practitioner-reported behavioural changes in children (Farrell & Travers, 2005; Kordich Hall & Pearson, 2004).

Additionally, the current study is the first of its kind to use a qualitative measure to have child care practitioners describe specific strategies they use to promote children’s mental health. Open-ended interview questions provided the opportunity to see what naturally came to practitioners’ minds when thinking about how they enhance various areas of children’s social and emotional development, build connections with parents and families and promote their own well-being. Responses illustrated the quality of practitioners’ understanding of what they do with children. More specifically, low quality responses demonstrated a vagueness in practitioners’ understanding and application of mental health promotion principles. In most cases, this corresponded to a one-size-fits-all approach to dealing with various children and situations. Little flexibility, reflection and problem solving were evident. Increased quality of responses demonstrated that practitioners understand mental health promotion better and could effectively apply this knowledge. Higher quality responses also implicitly conveyed that practitioners
recognized their important role in promoting children’s mental health and possessed a fair degree of confidence in taking this role on.

This study was also longitudinal in nature. It collected information prior to and immediately after *Handle With Care* workshops. Similar to research conducted by Farrell and Travers, this study also evaluated child care practitioners’ knowledge and practices six months subsequent to training. This allowed investigation into whether any changes in knowledge and practices demonstrated immediately after training were sustained long-term.

**Mental Health Promotion Knowledge-Quantitative Data**

Overall, study findings established that *Handle With Care* training resulted in a significant increase in training participants’ overall knowledge of mental health promotion relative to comparison participants immediately following workshop completion. Six months following completion of *Handle With Care* workshops, this increase was sustained. However, regional training subgroups were found to differ in the areas of mental health promotion knowledge that increased after *Handle With Care*. In-depth analysis according to region, and using the Intrinsic and Extrinsic variable groupings, revealed that both Rural and Suburban groups displayed significant increases related to Intrinsic variables associated with mental health promotion. No significant change was evident for the Extrinsic variables. The Urban group failed to show significant change in their mental health promotion knowledge after attending training. However, these results are tempered by the fact that training participants significantly differed according to region prior to training in terms of the level of their knowledge of the components of mental health promotion included in the workshops. Urban training participants, in particular, displayed a greater understanding of the concepts reviewed in *Handle With Care* before they attended the workshops. These discrepancies among regional subgroups are a crucial finding that
may be attributable to both the characteristics of the regions and their participants as well as the concepts presented in training.

**Regional Differences**

Various factors may be associated with regional subgroups that affect participants’ receptivity and capacity to understand and apply concepts described in mental health promotion training. Such factors may include participants’ age, prior education and background experience working with children. Although information about these factors was collected from participants in this study in order to describe the sample, analysis of their relationship to Child Care Questionnaire scores was not completed. Such analysis was not done in this stage of the project because it could not be comparably completed with the qualitative data from the Child Care Interview.

Additionally, participants in the three regions may differ in terms of the exposure they have to materials and resources concerning children’s mental health promotion. For example, the level of diversity in children and families enrolled in Urban child care centres may result in greater amount of training and support related to certain mental health topics for practitioners in these regions. For example, in Urban regions with higher numbers of newcomers to the country, practitioners may deal with specific issues related to attachment (i.e., if separation from primary caregivers occurs), transition and trauma (i.e., children coming from countries in conflict). Furthermore, regional characteristics and the population practitioners work with may ‘filter’ their attention to mental health promotion topics based on what they consider especially relevant. For example, in *Handle With Care* workshops conducted prior to this study, training was completed with practitioners primarily dealing with military families in which parents are often gone for extended periods of time. Such practitioners reported finding attachment topics in the training very important for the children and families with whom they worked. In the current study, Rural
training participants spoke about the challenges inherent in mental health promotion approaches geared towards Aboriginal families in their area. As well, most families worked for one predominant company which significantly influenced peer and family relationships among those in the centre, according to practitioners. Many families were very familiar with each other outside of the centre and had established opinions regarding one another. These kinds of circumstances can influence practitioners’ perceptions of and professional relationships with parents.

The varied impact of training across regions suggests that a one-size-fits-all approach may not be an appropriate mental health promotion strategy. Indeed, European researchers have argued that individual, societal and environmental aspects must be considered when developing and implementing targeted mental health promotion strategies (Kalra, Christodoulou, Jenkins, et al., 2011). These researchers contend that those implementing mental health promotion efforts be aware of their target audience. This involves considering the needs of healthy communities, members’ ability to deal with the social environment (e.g., colleagues, parents) and members’ personal capacity to deal with their internal psychological world (Kalra et al., 2011). They recommend tailoring mental health promotion efforts with a ‘nested approach’ that places the individual at the heart of the intervention, surrounded by family and by society at large (Kalra et al., 2011). In essence, this conceptualization mirrors Handle With Care’s ideas about children’s mental health. Promoting the mental health of a child cannot be effectively done without consideration and collaboration of the individuals who shape and support the child, such as the parents/family and child care practitioners. The training workshops emphasize that mental health promotion is a process that optimally occurs within a relational context and requires a flexible mindset to be responsive to the individual needs of children and families. However, the regional
differences in terms of outcomes suggests that *Handle With Care* requires further consideration of how to tailor training to meet the needs of various target audiences.

The mindset of child care practitioners and the ‘climate’ of their centres and regions prior to training also likely influenced the impact of *Handle With Care* workshops. Organizational literature describes ‘mental models’ of the world that individuals possess and contain in long-term memory. These mental models ultimately direct short-term perceptions people apply to their everyday reasoning (Zoellner, 2009). It has been proposed that differences between people in terms of their mental models account for many of the difficulties encountered in evidence-based programs that are introduced to school settings (Zoellner, 2009). Senge (1992) asserts that:

> Our mental models determine not only how we make sense of the world, but how we take action. Two people with different mental models can observe the same event and describe it differently, because they have looked at different details. (p. 164).

When individuals come together as a group, a shared mental model develops as its culture (Stacey, 1996). Consequently, preliminary site assessments and self-assessments are crucial prior to initiating mental health programs in order to determine whether the program ‘fits’ the individual setting or community and to identify potential obstacles (Firth et al., 2008; Mihalic et al., 2004). Given this study’s findings, it seems likely that some aspect of the ‘culture’ of regional groups with which *Handle With Care* workshops were presented may have mediated participants’ uptake and perceived relevance of various mental health promotion topics.

For example, Rural and Suburban training groups made significant improvements with respect to knowledge of Intrinsic variables of mental health promotion but not Extrinsic variables. There are a number of factors that may contribute to this. It is possible that these groups were better able to see the link between fostering children’s social and emotional development and promoting their well-being than the link between issues such as diversity and
practitioner-parent collaborations and children’s well-being. This discrepancy might be attributable to such things as the homogeneity of community cultures or level of parent involvement in centres. These factors can shape practitioners’ mental models regarding what is relevant to promoting children’s mental health. Moreover, at Time 1, the Urban training group possessed significantly more mental health promotion knowledge than the other two training groups. This, again, may point to group differences in what is considered significant to children’s mental health promotion that were present prior to training. The Urban group was also recruited from ECCE college demonstration child care programs in which ECCE students are trained. This could influence how much focus practitioners give to children’s mental health and the scope of factors they view as influential and address (e.g., cultural differences/diversity).

It is noteworthy that the Intrinsic variables grouping was the only one in which training participants showed significant gains in knowledge. This variable grouping focused on enhancing aspects of children’s social and emotional development, which are all inherently interrelated. As well, social and emotional development tends to be conceptually aligned with mental health constructs in the literature.

In contrast, the Extrinsic variables group, which consisted of varied mental health promotion factors (e.g., diversity, change and transitions, relationships with parents, well-being of practitioners and environment) were held together solely based on their being ‘external’ to the child, all still related to mental health promotion. It’s unclear if this was an appropriate composite. Due to the small number of questionnaire items per Building Block, analysis at this level could not be completed. As such, the lack of impact of Handle With Care training demonstrated on practitioners’ knowledge following these workshops may be related to the diverse nature of factors contained in the composite. Alternatively, factors in the Extrinsic variables grouping may have resonated less with mental health promotion ideas for training.
practitioners, resulting in more inconsistent learning about these factors. If this was the case, it suggests that these Extrinsic variables do not play as important a role in children’s mental health promotion as the *Handle With Care* training posits and certainly not relative to the Intrinsic variables. However research indicates that this is not the case. Another possible explanation may be that practitioners simply did not make the links between these external factors and children’s mental health promotion. The importance of these Extrinsic variables may not be so obvious given the context of ECCE training which is focused more on Intrinsic variables. This implies that revision of these *Handle With Care* Building Blocks (5-9) is necessary to make such links more explicit. Factor analysis would also be useful to explore other Building Block composites.

**Conceptual Ambiguities**

It is important to highlight that the key components to promoting children’s mental health (children’s social and emotional development, building relationships with parents and ensuring the well-being of practitioners) in the *Handle With Care* training forms a framework unique to the workshop. Such components were included based on empirical research and literature, which associated them with positive outcomes for children. As such, testing of study participants’ knowledge concerning mental health promotion is solely based on the definition of mental health promotion described in the training. Whether this conceptualization and definition of mental health promotion is accurate, and especially in the context of community child care centres remains to be seen.

Cutcliffe and McKenna (2011) suggest that if large amounts of time, effort and funding are placed into mental health promotion activities, “then in the epoch of evidence-based practice, their underpinning theories need to be as unshakeable as possible”. These authors argue that at the root of conceptual difficulties in mental health promotion is that the scientific and mental health care community is unable to even advance a definitive view of mental health. In
particular, they outline how mental health promotion efforts should not be analogous to broad health promotion strategies that target illness prevention as ideal outcomes. Several authors have pointed out that many mental health problems are problems of everyday living, which constitute such problems as an unavoidable part of the human condition (Barker, 1999; Cutcliffe, 2008; Keen, 1999; Szasz, 2007). For Cutcliffe and McKenna (2011), this perspective indicates that the experience of mental health problems can help lead to a pathway of personal growth and development. This suggests that “mental health challenges and problems can thus be mental health promoting experiences in and of themselves (Cutcliffe & McKenna, 2011).

The seemingly contradictory notion that mental health challenges should not necessarily be something people need to avoid is made more complex when considered in relation to children. Mental health as a concept is even vaguer for young children, who are in the process of developing through significant cognitive, language and social and emotional phases. This can confuse how to interpret children’s emotions and behaviours. Are difficulties developmentally appropriate and likely to naturally fade or do they reflect significant problems? Does the absence of observable difficulties (e.g., externalizing behavior) indicate children are experiencing positive mental health? Infants and toddlers, in particular, have traditionally not been thought able to have mental health problems because they lack mental life (Tronick & Beeghly, 2011). However, increasingly, it is clear that even young infants react to the meaning of others’ intentions and emotions based on their own rudimentary intentions and motivating emotions. Tronick and Beeghly (2011) assert that “infants make meaning about themselves and their relation to the world of people and things.” Such ‘meaning-making’ can go ‘wrong’ and lead to development of mental health problems. In contrast, what is lacking from these and other researchers’ discussions is how to know when ‘meaning-making’ goes right. Does it involve
complete absence of mental health difficulties? Or do challenges experienced by the child offer
the opportunity to create the foundation for resilience?

Perhaps one of the most important questions in relation to children’s mental health and
mental health promotion is how do important caregivers shape children’s ‘meaning-making’
through their interpretations of children’s behaviour? For instance, a child care practitioner who
perceives a toddler’s aggressive outbursts as both challenging and an expression of the child’s
experience of a challenge is likely to respond to these differently than a practitioner who
considers such behavior simply as problematic to those around the child. Similar to medical
conditions, the signs (objective) and symptoms (subjective) of mental health difficulties in
children both play a role in how caregivers attend to children’s psychological life. Being able to
integrate the two well may influence whether a caregiver considers a child’s disruptive behaviour
something that needs to be extinguished and forgotten or an opportunity for a child to learn
coping and problem solving skills and gain a sense that he can handle the upset, even if it arises
again. It is noteworthy that *Handle With Care* training participants, particularly in the Urban
regional group, often expressed disappointment that facilitators were not going to provide them
with concrete behaviour modification strategies to reduce disruptive behaviour.

No two children are alike. Their uniqueness is significantly influenced by the individuals
in their lives that guide and support their growth. As children develop socially and emotionally,
it seems logical that child care practitioners’ interpretations of their behavioural signs and
symptoms would be impacted by practitioner-parent relationships as well as practitioners’
experiences. Yet, the emphasis in creating effective mental health promotion programs that are
grounded in theory and research remain biased toward internal child factors and child
development (Weare, 2010). Additionally, it is often not clear to child care practitioners that
dealing with parents and taking care of themselves are interconnected to what is going on with
children or affects their ability to enhance children’s well-being. Indeed, although building relationships with parents has been identified as important in creating children’s feelings of psychological safety in child care (Sims & Hutchins, 2011), practitioners have frequently indicated this is a problem for them (Sims, Davis, Davies, et al., 2012). As well, practitioners have been found to be better at attributing children’s mental health problems to parents (e.g., poor parenting) rather than acknowledging how stress impacts parenting ability (Champagne, 2008; Zubrick, Smith, Nicholson, et al., 2008).

In terms of practitioner well-being, researchers in the field have asserted that “staff need to explore their own feelings, examine how to promote their own well-being, and feel cared for and about, before they are likely to see this work as part of their role with children” (Weare, 2010). These external factors, reflected as part of the Extrinsic variables measured in the study, thread through practitioners’ awareness and understanding of children’s mental health and can be further cognized when definitions of mental health and thus, mental health promotion are clearer.

Mental Health Promotion Practices—Qualitative Data

Results from interview data coding of content and quality revealed that Handle With Care training was associated with variable changes in child care practitioners’ mental health promotion practices both compared to pre-training quality levels of Child Care Interview responses and to the comparison group. Similar to the results related to the quantitative data, there were frequently differences between regions in terms of quality of responses. Additionally, there were inconsistencies six months subsequent to training with respect to training participants’ response quality.

The most uniform positive impact associated with Handle With Care training was demonstrated on interview items considering attachment and practitioner well-being topics (Building Blocks 1 and 8 respectively). Training participants, overall, showed substantial
increases in the quality of their responses from pre- to post- training when discussing how their relationships with children affect the children’s development, factors that impact these relationships, and aspects of their professional and personal lives that influence how they build the relationships. Additionally, training participants provided richer answers to questions about how their own well-being affects the children they work with, how they promote their own well-being in the centre workplace and how they manage interpersonal conflicts with centre colleagues. Moreover, these increases were consistent across regions. Six months after training, the increases were either sustained or further positive changes in quality levels were noted.

Changes in response quality from pre- to post-training were more mixed in relation to \textit{Handle With Care} content dealing with children’s self-esteem and peer relationships (Building Blocks 2 and 4, respectively). In particular, positive shifts in quality of responses were divergent across regional groups. For example, Rural and Urban training participants demonstrated the greatest increase in beneficial practices used to help children feel unique and comfortable being themselves and to help shy children interact with peers. These participants displayed the most appreciation for acknowledging and accommodating individual differences among children. Urban training participants did not demonstrate comparable shifts.

It is difficult to ascertain why such regional differences were observed. Many of the aforementioned interpretations pertaining to the quantitative data also apply to these qualitative data. Although children’s self-esteem and peer relationships are crucial aspects of their social and emotional development and relevant for all children, it may be that participant audience characteristics influenced which topics resonated with practitioners. In particular, practitioners with different educational backgrounds and years of work experience may have developed different perceptions about these topics that influenced their receptivity to the ideas presented in \textit{Handle With Care} training. Additionally, the groups of children that practitioners work with may
influence how in-depth practitioners consider these topics. For example, practitioners who deal with children who predominantly display good self-esteem may be less likely to actively think about how to enhance children’s sense of competence. The need to do this may seem unnecessary or practitioners may already be employing such strategies but be less aware of what or how they are doing so.

Six months after *Handle Care* training, changes in response quality were not sustained for strategies to foster children’s self-esteem. This was also true for some strategies related to establishing positive peer relationships. Positive changes in the quality of responses provided by training participants after *Handle With Care* workshops that were not maintained six months later suggest that participants might benefit from workshop ‘refreshers’. Such ‘refreshers’ could serve to keep practitioners attentive to their practices concerning children’s self-esteem and peer relationships. Additionally, ‘refresher’ workshops could provide a venue for practitioners to discuss and troubleshoot around barriers to their understanding or implementation of positive and effective practices.

*Handle With Care* was associated with minimal changes in quality levels in responses to questions concerning content about children expressing emotions and practitioners’ relationships with parents (Building Blocks 3 and 7, respectively). Across time points, training participants demonstrated almost no change in the quality of responses describing emotional regulatory difficulties in children, assisting children to express positive and negative emotions, awareness of factors that affect their interactions with parents and management of poor ‘fit’ between centres and families.

However, there were a couple of areas assessed by questions for these Building Blocks that did have an impact on practitioners. Participation in *Handle With Care* workshops was associated with a positive shift in the quality of responses in which training participants
recognized aspects of the developmental progression by which children share their feelings. However, this shift immediately after training was predominately accounted for by Urban region participants and changes were not sustained six months after training. By and large, training participants talked about language development representing a significant advancement for children to share how they feel, with little mention of the other developments in cognitive and emotional domains with respect to internal regulatory capacities, perspective taking, sociocultural influences, etc. This suggests that training participants gained little from *Handle With Care* content in understanding how young children’s emotional life develops at various stages. Instead they continued to concentrate on the most ‘observable’ development for children in the form of language and thought less about internal changes within children, such as perspective tasking. In terms of Building Block 7, training participants demonstrated increased quality in responses describing the link between practitioner-parent relationships and practitioner-child relationships following *Handle With Care* workshops.

Dealing with parents was commonly identified by training participants as one important aspect of their jobs for which they lacked prior training. Thus, it may be that training participants need further reinforcement and practice with these ideas in order to modify their actual practices when interacting with parents. As such, training participants’ baseline understanding and appreciation of factors that influence their interactions with parents might be much lower than other mental health promotion content areas included in *Handle With Care* (e.g., fostering children’s social and emotional development). In a sense, this is not unexpected because there is also evidence that collaborating with parents receives less attention in ECCE college curriculum and practica (Flanagan, Beach, Michal, & Cormier, 2009). Consequently, training participants might benefit from proportionately more focus in workshops on issues regarding their relationships with children’s parents to positively impact the quality of their relevant practices.
Additionally, training participants did not describe using better strategies after workshops for handling a ‘poor fit’ between families with the centres and practitioners. Training participants predominantly described some strategies they used in these situations but displayed limited problem solving capacity or insight into why the strategies might be effective. Much of what can be done in these kinds of situations parallels approaches used during conflicts with colleagues. Although training participants did demonstrate a higher quality of practices in resolving problems with their coworkers following *Handle With Care*, the limited change with parents may reflect greater tentativeness and less confidence when dealing with parents. This may signal issues that practitioners have to grapple with, such as status or age differences between practitioners and parents. Greater support for practitioners to work with parents is likely needed.

These findings correspond with other research concerning practitioner and teacher perceptions of their ability to work with parents. Investigating child care practitioners’ understanding of child and parental mental health, Sims and colleagues (2012) found that practitioners reported that they typically did not having enough time to interact with parents. Yet, practitioners also acknowledged that one of the best ways to promote children’s mental health was to build relationships with parents so that parents would trust and confide in them. In the same study, practitioners conveyed the inflexible perspective that ‘this is how things are’ when barriers hindered practitioner-parent relationships and when they felt parental stress negatively impacted children’s well-being. These researchers argued that this practitioner mindset and their lack of working towards change equate with an implicit acceptance that such problems are just par for the course (Sims, Davis, Davies, et al., 2012). Consequently, they recommend increased centre support and training to help practitioners to work with parents, best offered on-site, through a mentoring or coaching process (Fiene, 2002; Waniganayake et al., 2008). Weare (2010) also indicates that while parental involvement has consistently been an essential
ingredient of successful mental health promotion programs in schools, getting that kind of teamwork started is difficult. Thus, engaging parents is not a problem unique to child care practitioners.

Comparison Between Quantitative and Qualitative Data Findings

It is worth highlighting the lack of comparability of trends from the findings of the quantitative and qualitative data sets. Quantitative results revealed that training participants overall demonstrated gains with respect to Intrinsic variables associated with mental health promotion knowledge after Handle With Care workshops. However, this did not consistently correspond with practitioners describing higher quality practices in these same areas.

Specifically, this discrepancy concerned practices used to enhance children’s self-esteem, emotion expression and peer relationships. Additionally, despite quantitative results indicating that training participants’ knowledge of Extrinsic variables in mental health promotion was not affected following Handle With Care workshops, the qualitative results revealed some opposing results about practices. Training participants consistently described substantial gains following training in how they understood and worked on their own well-being in centre environments. In contrast, training participants did not show changes in their knowledge relevant to this topic on the quantitative measure.

The discrepancies between findings suggest that there may be differences in what training participants know and what they do with respect to mental health promotion. In a sense, this parallels the gap between research communities and practice communities, a phenomenon described in knowledge translation literature and across numerous fields (Rynes, Martunek and Daft, 2001). This literature shows that advances in research knowledge can take a long time to be implemented into, or change, practice (Oborn, Barrett and Racko, 2010). Conceptually, this holds relevance for considering how individuals acquire new knowledge and then use it to
inform what they do. In particular, training participants’ capacity to assimilate and apply new knowledge may be related to overlap with their prior knowledge. However, it may also be dependent on training participants’ skills in dealing with the tacit component of new knowledge in a way that allows them to modify it to fit the context in which they practice. Key to this is the capacity to learn and solve problems, especially when this involves recognizing and combining incongruent forms of knowledge or information to arrive at a new understanding that can create new initiatives (Zahra & George, 2002). In turn, it may be that this capacity is a prerequisite for child care practitioners to ultimately develop the flexible ‘mental health promotion mindset’ encouraged in the Handle With Care workshops to put positive and effective practices into action. These are all factors that likely contribute to practitioners’ uptake of training ideas and skills. In the context of child care, it may then be necessary to explore how practitioners can be further supported in seeing the relevance of mental health promotion knowledge in everyday scenarios. A crucial component to this that would also enable practitioners to implement useful mental health promotion strategies is developing cognitive flexibility. Such flexibility could enhance practitioners’ skills in generating a range of ways to interpret, respond to and monitor mental health issues.

Further follow-up to training with practitioners might be needed. For example, practitioners may need on the job support for developing and sustaining new practices. An aspect that could be essential for practitioners to fully implement strategies for mental health promotion in child care is support in building and monitoring the personal skills needed to effectively carry out positive strategies. Weare (2010) suggests that practitioners are not likely to take an interest in promoting the mental health of children “if they feel their own mental health needs are not met or have the confidence to operate in what is often a difficult, sensitive and possibly threatening area without personal skill development”. Such skills would include feeling comfortable with
emotional issues, developing a broad and flexible repertoire of responses and recognizing their own reactions and impulses (Weare, 2010). As such, it is recommended that staff development be fostered through colleague support, coaching and mentoring so that practitioners feel that mental health promotion is part of their normal workload and not an extra burden (Weare, 2010).

Study Implications

The positive outcomes associated with *Handle With Care* training suggest that it is a valuable approach to enhancing the mental health promotion knowledge and practices of child care practitioners working with children under the age of six years. Findings from this study contribute to the limited data base concerning the effectiveness of training directed at child care practitioners and other early childhood professionals. Moreover, this study provides information concerning what parts of *Handle With Care* content currently resonate with child care practitioners and which parts require revision to create more impact in what practitioners know and do. Ultimately, the goal of training is to bolster children’s mental health. Results from this study, undertaken as an intermediate step to ensure the training is absorbed by child care practitioners, indicate that investigating actual child mental health outcomes is a next, important, logical step.

The current study also has implications for the methods involved in evaluating mental health promotion programs. Findings illustrate the complexities of designing, implementing and evaluating broad mental health promotion efforts. Increasingly guidance around development of mental health promotion has emphasized that even universal programs (i.e., addressed to the whole population) still need to be tailored to the needs of target audiences (Kalra et al., 2011). In effect, one size does not fit all. Attention needs to be given to the individual, societal and environmental aspects of audiences and intended benefactors. Kalra et al. (2011) recommend that essential parts of this process include identifying the mental health needs of the population to be
worked with, prioritizing needs, strengthening social ties, developing healthy habits and respecting cultural diversity.

In many respects, the *Handle With Care* program follows this train of thought. It established crucial components of children’s positive mental health through the evidence based literature that described social and emotional development, collaborations between children’s caregivers and the psychological well-being of those offering care. Attachment issues, in particular, were considered to be the foundational component to be addressed initially in the training. The relational approach of *Handle With Care* is also intended to enhance children, families’ and practitioners’ sense of care, support and belongingness. An emphasis is placed on helping these same people effectively manage daily life, cope with obstacles and bounce back from adversity while feeling valued at an individual and group level. *Handle With Care* content strives to consider these issues in a developmentally appropriate way. Still, despite these targeted mental health promotion efforts, discrepant findings across regional groups used in this study suggest that more needs to be done to tailor content to be relevant and meaningful across various practitioner audiences.

At the same time, further tailoring *Handle With Care*’s delivery with specific audiences complicates the evaluation process. Currently, the preference in social sciences for creating and implementing programs that are ‘evidence based’ is “highly seductive and strongly supported” (Zoellner, 2009; Turner & Sanders, 2006; Mihalic et al., 2004). However, actually establishing such an evidence base is difficult (Coalition for Evidence-Based Policy, 2003). In order to achieve the highest standard of evidence, a program’s capacity to be effective in real-world circumstances is typically diminished. Yet, methods of evaluation intended to build a credible evidence base are often subject to negative critical review (Zoellner, 2009). There are significant consequences to this dilemma. Evaluation findings tend to be the basis on which policies are
made, but this can be problematic because outcome evaluation traditionally lacks focus on process as well as null and unintended consequences (Solin & Lehto, 2011).

Consequently, the case is being increasingly made for acknowledging the validity of disparate practice cultures and research methods in fields such as health and education (Rowling, 2008). For example, in the school system, it has been recognized that the effectiveness of implementation of externally developed mental health promotion programs is highly influenced by school leadership and organizational climate (Zoellner, 2009). Both are unique, often idiosyncratic and always based in a local context (Robinson, 2007; Mullford et al., 2008). In turn, Zoellner (2009) argues that no clear ‘right ways’ exist to achieve specific outcomes from a single course of action. Additionally, no single program, however strong the evidence base, is guaranteed to produce intended changes or sought-after outcomes. To tackle these limitations in implementing and evaluating mental health promotion initiatives, it has been proposed that mental health promotion activities engage school staff to be involved in breaking down, interpreting and accounting for differences in perspective between program material and the school setting (Zoellner, 2009). More varied and complex ways to measure outcomes reflecting evidence of program effectiveness are also recommended (Lea, 2008; Rowling, 2008; Patton, 2002). Although the current study did employ useful and meaningful outcome measures, more could be done to involve child care practitioners in the content, structure and delivery of Handle With Care training. Additionally, systematic consideration of the organizational climate and leadership characteristics of child care centres in which Handle With Care ideas and strategies are introduced would be worthwhile prior to workshop delivery.

In keeping with this idea of tailored Handle With Care workshops for different child care practitioner audiences, subsequent consultation (as seen in RIRO program implementation) might be a valuable adjunct to training. Once Handle With Care training is completed, child care
practitioners would likely benefit from consultation from the program developers/facilitators in order to reflect on their learning processes when faced with real-life scenarios and to troubleshoot. New knowledge and practices might be better reinforced so that long-term retention of the benefits of Handle With Care can be achieved.

Study Limitations

Findings from the current study need to be considered within the context of several significant limitations. Such limitations relate to the sample, study methodology and data collection measures and analysis and are discussed in this section.

Sample

Recruitment of community child care practitioners for study participation was a difficult process. It necessarily entailed connecting with professionals in the child care field who could effectively communicate information about the study to child care practitioners and arrange practical supports (e.g., time at work to complete questionnaires and/or telephone interviews, lieu or paid time to attend workshops) to make participation possible and convenient. As a result, the recruitment was not random and differences existed between the three regional participant groups (Rural, Suburban and Urban).

More specifically, the Suburban training group had previously received comprehensive training in the High Scope early education approach prior to the Handle With Care study. They actively used this philosophy and associated strategies in their work with children. These participants continually referenced the High Scope approach during Handle With Care workshops. Concepts central to the High Scope approach include: 1) providing a learning environment divided into well-defined interest areas; 2) active learning for children involving direct, hands-on experiences; 3) key developmental indicators, including social and emotional
development that child care practitioners keep in mind when setting up the environment, planning activities and observing child behaviours; 4) daily routines that follow a predictable sequence of events; 5) adult-child interaction consisting of shared control; and 6) a six-step conflict resolution process (Holt, 2010). Some of the Handle With Care training content overlapped with what these Suburban participants had learned during their High Scope education and likely contributed to higher quality responses on the study Child Care Interview. In effect, these participants entered the study with a deeper understanding of the key mental health promotion topics presented in Handle With Care as compared to Rural and Urban group participants. However, in a few situations, Suburban participants expressed that Handle With Care content was at odds with components of the High Scope approach. For example, during Handle With Care’s Building Block 2: Building and Ensuring Self-Esteem, there is discussion around the differential impact on children’s developing self-esteem when practitioners deliver ‘general’ versus ‘specific’ praise to them; many Suburban participants noted that ‘praise’ is a strategy particularly advised against overall within the High Scope philosophy. Since Suburban participants were committed to the High Scope approach, it is unclear how they processed Handle With Care training information that diverged from their prior training (e.g., considered it supplemental, disregarded it as incorrect). Anecdotally, from the perspective of Handle With Care workshop facilitators, the Suburban training participants represented a group whose adherence to the High Scope philosophy seemed to interfere with taking on the flexible mental health promotion mindset espoused by Handle With Care workshops. Certainly, it would have been useful to debrief with these participants at the end of the study to explore their viewpoints on Handle With Care content in relation to the High Scope approach.
Another limitation in the study sample concerns the composition of the regional training groups. Once again, due to lack of randomization and reliance on professionals within the child care field to assist with recruitment, there was variance across training groups with respect to how many child care centres were represented. In the Rural training group, a large proportion of participants were employed at one centre, with a smaller number of participants coming from three other centres. Recruitment of Suburban training participants involved limiting two participants per centre, thereby resulting in a large number of centres in that particular group. Finally, in the Urban training group, four centres were represented, with a large proportion of participants employed at two of the centres and a smaller proportion of participants working at the other two centres. Such difference in the composition of training groups creates another important discrepancy between them. When training participants attend Handle With Care workshops with colleagues, this opens the potential for discussion of the material between the training sessions, support with learning and collaboration with respect to implementing mental health promotion practices considered in the training. In contrast, training participants attending workshops with only one colleague may have been at a disadvantage in terms of reflecting on the Handle With Care material and putting it into practice. Further, it may be more difficult to retain and apply learning in a workplace in which coworkers have not been exposed to the same training. It is also unclear if more coworkers attending workshops together impacted the sustainability of Handle With Care ideas in centres up until the 6-month follow-up. It is beyond the scope of this study to determine whether there is a correlation between the impact of training on practitioners’ knowledge and practices and the number of colleagues with whom they attended workshops. Exploring participants’ perceptions about the relationship between colleague participation and Handle With Care learning and application would have been useful.
Finally, recruitment of comparison participants was also problematic for many of the same reasons described with training participants and not random. Although the two participant groups were not significantly different from each other in terms of mean age, there was a substantially higher proportion of comparison participants over age 40 (53.6%) as compared to training participants (33.3%). Inclusion of 6-month follow-up data collection with comparison participants would have also been useful to analyze relative to earlier data time points (within-group) and the training group (between group).

*Study Methodology*

Training with each regional participant group was facilitated by the study’s principal investigator as well as this doctoral candidate. Both originally developed and drafted the *Handle With Care* workshop content and training process. Consequently, these facilitators are intimately acquainted with workshop key information and activities and are skilled in answering relevant participant answers, guiding discussion to pertinent ideas and troubleshooting when discussions grow heated or argumentative. In some respects, having these facilitators represents the ‘ideal’ delivery for *Handle With Care* workshops, helping to ensure reliability. At the same time, it also reduces the external validity of this evaluation. Although study findings demonstrate training effectiveness with respect to many areas of child care practitioner knowledge and practices, there is limited generalizability. This study cannot conclude whether the *Handle With Care* workshop would be effective had training been delivered by different facilitators. Indeed, another relevant line of inquiry is needed into the effectiveness of the *Handle With Care* train-the-trainer workshop that trains facilitators and subsequent effectiveness of *Handle With Care* workshops with front-line child care staff when delivered by these facilitators.

Completing the Child Care Interviews by telephone was also a time-consuming process for project participants. When training participants completed the interview at Time 3, six
months following the end of their attendance in *Handle With Care* workshops, it was the third time that they answered the same set of questions. It also represented the final data collection point before participants received their cash incentive. Overall, it was noticed that Time 3 responses tended to be briefer in comparison to Time 1 and 2 responses. It is unclear if this reflected study ‘fatigue’ on the part of training participants or if responses accurately described participant practices at that stage. In many cases, the brevity of responses corresponded to lower quality and lack of sustained impact gained through the training and demonstrated at Time 2. Whether this correspondence was truly attributable to lack of sustained impact or was affected by participants’ motivation, interest and engagement in responding to interview questions for the third time is not known.

As well, it is difficult to ascertain whether the interview process itself may have impacted changes in child care practitioners’ reporting of mental health promotion practices. It is possible that the type of questions asked caused practitioners to reflect more on their practices and either actually modify their practices in a positive manner and then report them in later interviews or just be better at reporting. On some interview items, comparison participants displayed improvement in the quality of their responses. It is worth investigating if simply thinking about and responding to interview questions contributed to this change.

*Data Collection Measures & Analysis*

Due to a limited timeline to complete the study there was no opportunity to pilot measures. Consequently, this did not allow the research team to review and revise any questions that were confusing to participants and/or relatively ineffective in eliciting specific responses. For example, two questions in the Child Care Interview associated with Building Block 1: Building Trust Between Practitioner and Child (Question C: What kind of things impact your ability to make children feel safe and secure? and Question D: Is there anything in your
professional and/or personal life that influences your relationships with children?) were intended to investigate different issues. The first was meant to explore practitioners’ awareness of broad daily factors that shape how they work with children (e.g., centre policies, ratios, children’s temperament and attachment to their parents), while the latter was intended for practitioners to reflect about particular aspects of themselves (e.g., working relationships with centre colleagues, their own attachment/cultural background) that guide their perceptions and practices when working with children. Although the wording of these questions was considered by the research team to be general enough to allow practitioners to bring up a wide variety of factors, it is clear from the actual responses that the language did not help practitioners distinguish between these issues. As a result, many practitioners gave the same responses for both questions.

All measures in the study were self-report. This is problematic particularly in the case of the Child Care Interview. The interview process was very language-dependent. It required participants to think about their practices in hindsight and find a way to articulate what they do. Not all participants may have been able to thoroughly communicate and elaborate on their mental health promotion practices. For participants providing lower quality interview responses, it is impossible to know if, in fact, the training failed to make an impact on what they do with children or if they just could not explain what they do. Indeed, lower quality responses tended to also have a lower word count, although that was not part of the quality coding criteria. Observational measures would have been a valuable adjunct to the project data collection. Additionally, for some participants, English is their second language. This kind of demographic information was not collected in the Background Questionnaire, yet may have confounded the coding of interview answers.

The coding system used to analyze the Child Care Interview responses was created by the doctoral candidate and implemented by her with the assistance of three other coders. Although
time was spent during coder training to establish interrater reliability, there was no more formal
test to determine the level of interrater reliability after the interview coding had been completed.
During the course of analysis, NVivo software’s capacity to do this proved to be very limited and
not very meaningful with the type of coding that was employed by the research team. The
educational background and familiarity with _Handle With Care_ workshops varied among coders
and may have influenced the consistency of coding. Future evaluations would benefit from using
coders who possess a more uniform knowledge concerning early childhood development and the
(Handle With Care) training program and were not involved in the facilitation of workshops and
possess.

**Future Research Directions**

Although there has been increasing emphasis on the importance of early childhood for
setting the stage for long-term well-being, mental health promotion approaches for the 0-6 year
old age group remain limited. Indeed, even thinking about mental health in relation to infant and
toddler age groups is a relatively new phenomenon, largely confined to the context of parent-
child relationships. However, the changing demographics of Canadian families and lifestyle
shifts mean that young children engage in significant relationships with caregivers and
professionals beyond their immediate families. These relationships exert a powerful influence on
children’s mental health. It is essential for these individuals dealing with young children to be
cognizant of their role and equipped with an understanding and skill set of how to foster positive
mental health. _Handle With Care_ represents a unique type of training in this regard, intended for
child care practitioners. The present evaluation study demonstrates the training’s impact on
practitioners’ knowledge and practices. However, there is still much that future research can
explore with respect to mental health promotion approaches with young children. It would be
both useful to examine the current study’s dataset in novel ways as well as to initiate new lines of investigation concerning mental health promotion training.

*Further Analyses of Handle With Care Evaluation Data*

Overall, the data collected in this project were analyzed with the purpose of exploring between-group trends (both between training versus comparison groups and between regional subgroups within the training group) related to the effectiveness of Handle With Care. However, there remain many more ways of organizing and analyzing these data to provide details about factors correlated with effectiveness and the ideas and strategies practitioners acquire through the training.

Both the quantitative and qualitative data collected have the potential to offer further information about the impact of Handle With Care on training participants. In particular, the data could be analyzed to determine if child care practitioner characteristics mediate the impact of training. Within-subject analysis across time points would also indicate if certain practitioners benefit more than others after attending Handle With Care workshops. For example, a training participant that tends to demonstrate Adequate quality responses on interview questions at Time 1 may be more likely to provide High quality responses following training than a training participant who typically offers Low quality responses at Time 1. Factors such as educational background, experience and workplace satisfaction may contribute to a child care practitioner’s capacity to consider and reflect on mental health promotion strategies prior to training. In turn, such practitioners may be more open and willing to integrate Handle With Care content into their daily approaches with children in their care. Such information could reveal whether the Handle With Care workshop differentially engages various kinds of practitioner audiences.

More case-by-case analysis could also be conducted to determine the correlation between training participants’ performance on the Child Care Questionnaire and the practices they
describe in interviews. It would be useful to know if training participants impacted by *Handle With Care* workshops demonstrate consistent gains with respect to both their knowledge and practices. Alternatively, there may be a discrepancy between improvements in knowledge and practices. In turn, it would be valuable to ascertain if participant characteristics, again, mediate such variability and/or if factors related to the training format (e.g., attending training with one centre colleague versus many centre colleagues) may have also played a role.

Finally, the qualitative data were analyzed using a largely quantitative approach. In order to explicitly evaluate if specific *Handle With Care* training content was learned by training participants, the coding system focused on frequencies and quality levels, established through counting specific ideas and situations mentioned. The training content created the framework for what was considered to be useful in participant responses to test hypotheses. Another approach to coding interview data would be to operate in the reverse fashion, employing a grounded theory method. This would involve reviewing the data without predetermined hypotheses in an open-ended manner to note key points, marked with a series of codes, extracted from participant responses. Subsequently, the codes could be grouped into similar concepts and then broader categories that describe the data and form the basis for the creation of a theory. This ‘bottom-up’ approach to analysis of interview responses could reveal participant perspectives and knowledge gained through training that the research team had not considered.

*Research Concerning Mental Health Promotion Activities with Children*

Further work should be undertaken to replicate and extend the current findings with improvements to study methodology. Future studies would benefit from larger sample sizes and more information and analysis with respect to child care practitioner characteristics that mediate the impact of training. Additionally, more outcome measures could be added to the research protocol, such as direct observation of child care practitioner practices with centre children. This
would provide a more objective source of information about how training might impact the strategies practitioners’ use to foster children’s mental health. It would also diminish the language-heavy demands of qualitative type interview formats for gathering this data.

Given that ‘mental health’ remains relatively poorly defined in terms of adults, more focus needs to be given to conceptualization of what mental health is across various developmental stages. The rapid and complex advancement of cognitive, social and emotional capacities during the 0-6 year old age period might necessitate further differentiation of mental health promotion activities for child care professionals dealing with infants and toddlers and those working with preschoolers. Certainly, consideration of developmental level might shift what knowledge and skills to prioritize in training practitioners.

Finally, mental health promotion efforts geared towards professional caregivers in community child care should be implemented system-wide with all centre staff and supervisors. Opportunities for changes to promote children’s well-being need to be taken advantage of not only with individual practitioners but with those shaping centre policy and the relational climate in centres. If only one or two practitioners benefit from mental health promotion training, their efforts are unlikely to be sustained unless their colleagues share the same perspectives and work with them to attend to and prioritize children’s mental health.

Conclusion

Implementing mental health promotion training with child care practitioners dealing with children between the ages of 0-6 years can be a valuable strategy. This exploratory study demonstrated that the Handle With Care training program demonstrated positive impact on practitioners’ knowledge with respect to helping children to build trust with them, and fostering positive self-esteem, emotion expression and peer relationships. As well, the program was related to practitioners’ use of certain higher quality practices in these same areas as well as in
bolstering their own well-being. These findings were not consistent across all region groups (Rural, Suburban, Urban) studied. However, common element across participants who did demonstrate positive shifts in mental health knowledge and practices was application of a relational approach, supporting children, families and coworkers in a manner that appreciates individual differences and improves awareness of the ways in children cope with difficulties. Participants who benefitted from *Handle With Care* also gained a deeper understanding of how components of mental health promotion (e.g., children’s social and emotional development, practitioner-parent relationships and practitioner mental health) are interrelated. Areas in which training had no impact (e.g., practitioners’ relationships with parents) provide indications of possible content revision and redesign of how training is delivered and evaluated. Overall, *Handle With Care* shows promise as a way to help children reach their optimal potential.
REFERENCES


Hawe, King, Noort, Jordens & Lloyd (2000). Indicators to help with capacity building in health promotion.


Smith, B., & Fox, L. (2002). *Systems of service delivery: A synthesis of evidence relevant to young children at risk for or who have challenging behavior*. Center for Evidence Based Practice: Young Children with Challenging Behavior.


World Health Organization. (2004). *Promoting mental health: Concepts, emerging evidence, practice: summary report.* World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne.


Appendix A

Training Participant Project Information Sheet

Handle With Care: Strategies for Promoting the Mental Health of Young Children in Community-Based Child Care is a comprehensive training program for front-line child care practitioners who work with children from birth to 6 years in community-based child care centres. The training aims to equip practitioners with ideas and techniques for creating a centre setting that promotes the mental health of children. It is based on the Handle With Care resource booklet and consists of nine workshop units, or Building Blocks, including:

- Developing trust between practitioner and child
- Building and ensuring a child’s positive self-esteem
- Expressing emotions
- Relationships with other children
- Respecting diversity
- Dealing with changes and transitions
- Relationships with parents
- Fostering the well-being of practitioners
- Creating appropriate physical environments

A training project, developed by the Hincks-Dellcrest Institute (Toronto, Ontario; http://www.hincksdellcrest.org) and funded by the Alva Foundation is being initiated to understand how the Handle With Care program impacts practitioners’ awareness and strategies concerning mental health promotion. The training uses an active learning approach including lecture, group discussion, small group process and experiential activities. We are looking for child care practitioners to participate in this training project. Practitioners must be full-time centre staff with a minimum two-year ECE education or equivalent. This does not include centre supervisors or assistants.

**Participants will receive:**

- 9 free training workshop sessions, based on each Building Block. Training will be delivered once a week. Snacks will be provided.
- A Participant Manual that contains all the material covered in the workshop units.
- **$100** following completion of all project components.*

**Participants will complete:**

- A Background Questionnaire during the first workshop session.
- Workshop evaluations at the end of every session.
- 3 telephone interviews prior to and immediately following training completion and one 6 months after the end of training. Interviews will take approximately 1-1.5 hrs *(including all 9 workshop sessions, workshop evaluations, Background Questionnaire and 3 telephone interviews)*

To participate in this project, please complete the attached contact/participation agreement sheet.
HANDLE WITH CARE PROJECT

CONTACT/PARTICIPATION INFORMED CONSENT FORM

First Name: ________________________________
Last Name: ________________________________
Child Care Centre: __________________________
Town/City Location of Centre: ________________
Home Telephone: ____________________________
Work Telephone: ____________________________
Email: ________________________________

I have read the attached outline of the Handle With Care Project and am willing to complete all project components. In particular, I agree to attend a minimum of 8 Handle With Care training workshops in the series I will be participating in. All information that I provide in the project will be kept confidential and will not be shared with anyone outside of the project team. I may discontinue my participation in this project at any time I choose without repercussion. I may withdraw from the project by contacting the Project Coordinator (Heidi Kiefer) by phone, email, mail or face-to-face. If I choose to discontinue participation, it is up to my discretion whether to allow project researchers to continue to use my project information or have it destroyed. I understand that receiving $100 upon the conclusion of my project participation is contingent on completing all project components. All participants that fully complete the project will receive a written summary report of project findings when the research has concluded.

I realize that benefits of this research include: 1) Receiving free, comprehensive training concerning mental health promotion in community-based child care centres with children from birth to age 6; and 2) Contributing to the knowledge-base and research related to mental health promotion in community-based child care centres. I realize the risks of this research include: 1) Possibly feeling uncomfortable in responding to telephone interview questions; and 2) Possibly feeling uncomfortable in participating in training workshops. All participant responses and participation are valued and confidential.

This research is part of a doctoral thesis project being conducted by Heidi Kiefer, a Ph.D. candidate at OISE/University of Toronto in the School and Clinical Child Psychology Program. If you have any questions or concerns about this research please feel free to contact Ms. Kiefer or her research supervisor, Dr. Nancy Cohen. Contact information is provided below.

Signature
________________________________________

Date
________________________________________
Heidi Kiefer, the project coordinator, will contact you to arrange interviews. If you would like further information about the project, please contact her at 416.972.1935 ext. 3337 or hkiefer@hincksdellcrest.org.
Dr. Nancy Cohen may be contact at 416.972.1935 ext. 3312 or nancy.cohen@utoronto.ca

This form gets returned to the Handle With Care project team. Please fax to: 416.924.9915 Hincks-Dellcrest Institute, 114 Maitland Street, Toronto, ON M4Y 1E1

If you have any complaints or concerns about how you have been treated as a research participant, please contact: Rachel Zand, Director, Office of Research Ethics, University of Toronto, rachel.zand@utoronto.ca or 416.946.3389.
Appendix C
Comparison Participant

HANDLE WITH CARE PROJECT
Project Information Sheet

This project, developed by the Hincks-Dellcrest Institute (Toronto, Ontario; http://www.hincksdellcrest.org) and funded by the Alva Foundation, is being initiated to better understand child care practitioners’ awareness and strategies concerning mental health promotion. We are looking for child care practitioners working with children from birth to age 6 in community-based child care centre settings to participate in this project. Practitioners must be full-time staff with a minimum two-year ECE education or equivalent. This does not include centre assistants.

What do we mean by mental health promotion? Mental health promotion is reflected in the way caregivers interact with infants and young children during daily routines and classroom activities to build and nurture relationships that support their social and emotional development. It also relates to how caregivers collaborate with parents and coworkers. We would like to talk with practitioners about how they deal with issues in the centre context such as:

- Developing trust between practitioner and child
- Children’s self-esteem
- Expressing emotions
- Peer relationships
- Diversity
- Relationships with parents
- Well-being in the workplace

In order to collect as many examples of knowledge and practice as possible, we would like to discuss these issues with practitioner participants across two different time points.

**Participants will complete:**
- A Background Questionnaire; to be returned by mail.
- 2 telephone interviews and knowledge questionnaires separated by approximately 2-3 months.

**Participants will receive:**
- $100 following completion of all project components.

To participate in this project, please complete the attached contact/participation agreement sheet. Participants should keep this sheet for their own records.
Appendix D

Comparison Participant Informed Consent Form

HANDLE WITH CARE PROJECT

CONTACT/PARTICIPATION INFORMED CONSENT FORM

First Name: ______________________________________________________

Last Name: ______________________________________________________

Child Care Centre: ________________________________________________

Town/City Location of Centre: ______________________________________

Home Telephone: _________________________________________________

Work Telephone: _________________________________________________

Email: __________________________________________________________

I have read the attached outline of the Handle With Care Project and am willing to complete all project components. All information that I provide in the project will be kept confidential and will not be shared with anyone outside of the project team. I may discontinue my participation in this project at any time I choose without repercussion. I may withdraw from the project by contacting the Project Coordinator (Heidi Kiefer) by phone, email, mail or face-to-face. If I choose to discontinue participation, it is up to my discretion whether to allow project researchers to continue to use my project information or have it destroyed. I understand that receiving $100 upon the conclusion of my project participation is contingent on completing all project components. All participants that fully complete the project will receive a written summary report of project findings when the research has concluded.

I realize that benefits of this research include: 1) Contributing to the knowledge-base and research related to mental health promotion in community-based child care centres. I realize the risks of this research include: 1) Possibly feeling uncomfortable in responding to telephone interview questions. All participant responses are valued and confidential.

This research is part of a doctoral thesis project being conducted by Heidi Kiefer, a Ph.D. candidate at OISE/University of Toronto in the School and Clinical Child Psychology Program. If you have any questions or concerns about this research please feel free to contact Ms. Kiefer or her research supervisor, Dr. Nancy Cohen. Contact information is provided below.

_______________________________________________________________
Signature

_______________________________________________________________
Date

Heidi Kiefer, the project coordinator, will contact you to arrange interviews. If you would like further information about the project, please contact her at 416.972.1935 ext. 3337 or hkiefer@hincksdelcrest.org.
Dr. Nancy Cohen may be contact at 416.972.1935 ext. 3312 or nancy.cohen@utoronto.ca

This form gets returned to the Handle With Care project team. Please fax to: 416.924.9915 Hincks-Dellcrest Institute, 114 Maitland Street, Toronto, ON M4Y 1E1

If you have any complaints or concerns about how you have been treated as a research participant, please contact: Rachel Zand, Director, Office of Research Ethics, University of Toronto, rachel.zand@utoronto.ca or 416.946.3389.
Appendix E

Background Questionnaire

Handle With Care Evaluation Project

Participant # ____________

BACKGROUND QUESTIONNAIRE

This questionnaire is intended for front-line child care practitioners who are working directly with children under age six. It consists of questions about your education, experience, current work in child care and your feelings about your centre and the child care field in general.

All the information that you provide will be treated confidentially. If you have any questions, feel free to contact Heidi Kiefer at 416.972.1935 ext. 3337 or hkiefer@hincksdellcrest.org

Contact Information

First Name: ___________________________ Last Name: ___________________________

Name of Child Care Centre: ________________________________________________

Centre Address: __________________________________________________________

Work Phone #: ___________________________

Home/Cell Phone #: ___________________________ Email: ___________________________

Section A: Education

A1. What is the highest level of education that you have completed in any subject area?

- Some high school
- High school diploma
- One-year college certificate
- Two-year college certificate
- One-year college diploma
- Two-year college diploma
- Three-year college diploma
- Post-diploma certificate
- Bachelor’s degree
- Post-graduate certificate
- Post-graduate degree

A2. What is the highest level of formal education that you have completed specifically related to child care provision, early childhood education and/or child development?

- None
- Provincial government course lasting less than one year
- One-year college certificate
- Two-year college certificate
- Two-year college diploma
- Three-year college diploma
- Post-diploma certificate
- Bachelor’s degree
- Post-graduate certificate
- Post-graduate degree
When did you complete this last level of education? __________________

A3. During the past 12 months, have you participated in any of the following types of professional development activities? Please indicate yes or no if these activities involved social-emotional development issues in early childhood or child care? (please check all that apply)

<table>
<thead>
<tr>
<th>Participated In</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No professional development activities in the past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-credit course at a post-secondary institution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit course at a post-secondary institution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-service training/consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting other education and care settings for ideas on improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section B: EXPERIENCE

B1. Which age groups of children have you worked with in your experience as an early childhood professional? (please check all that apply)

- Infants (0-17 months old)
- Toddlers (18-35 months old)
- Preschoolers (3-5 years old)
- School-age children (6 years and older)

B2. How many years of employed child care experience do you have? Years
   Working at this centre (in total) ________
   At other child care centres ________
   In child care homes ________
   In other fields related to child care ________

B3. Please rate how much the following sources have informed your awareness and understanding of children’s social-emotional development?

<table>
<thead>
<tr>
<th>Source</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing education (professional development)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work experience (within child care settings)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work experience (in other areas of child care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre policies/initiatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleague consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation with community/social service agencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B4. Where do you look for information about children’s social-emotional development? (please check all that apply)

- I haven’t looked for information on social emotional development
- Early childhood and education associations
- Books, journals and magazines
- Consultation with community/social service agencies
- Internet
- Consultation with medical/developmental specialists
- Workshops and conferences
- Networking with other child care professionals
- School or community courses
- Other (please specify)
B5. Please list any early childhood educator or child care associations to which you currently belong.

Section C: WORKING AT THE CENTRE

C1. Do you spend most of your day with a specific classroom or group of children in your centre?
   - No (skip to C3)
   - Yes

C2. What are the ages of the children in this group? (Please indicate all options that apply).
   - 0-17 months old
   - 18-35 months old
   - 3, 4 and/or 5 year olds
   - 6 years and older

C3. In a typical work week, how many hours are you regularly scheduled to work?
   ____________ hours per week

C4. In years and months, how long have you worked at this centre? (Include leave of absence, e.g., maternity leave)?
   ____________ years and
   ____________ months

C5. In years and months, how long have you held your current position at this centre? (Include leave of absence, e.g., maternity leave)?
   ____________ years and
   ____________ months

C6. In addition to caring for children, approximately how often you do the following activities in a typical work week?
   Please indicate either DAILY, WEEKLY, OCCASIONALLY or NEVER.
   _________________ planning and preparation (e.g., assembling materials for an activity)
   _________________ interaction with parents (e.g., conversation, phone call)
   _________________ meal and/or snack preparation and clean-up
   _________________ receiving supervisory guidance or feedback
   _________________ staff supervision (e.g., supervising assistants)
   _________________ supervising practicum students (students on placement)
   _________________ collaborating with coworkers (e.g., staff meetings, team planning)
   _________________ administration (e.g., ordering supplies) and/or maintenance
   _________________ other (please specify) __________________________
C7. Does your centre work with any of the following resources and individuals concerning children’s social-emotional development? (please check all that apply)

- Mental health agencies
- Public health
- Early childhood development/education associations
- Child welfare organizations
- Medical professionals
- Developmental specialists (i.e. psychologists, speech and language pathologists)
- Community centres
- Hearing and dental screening
- Family resource centres
- Community colleges
- Libraries
- Schools
- Churches
- Organizations providing consultation to day care
- Other (please specify) _______________________

Section D: PERSONAL BACKGROUND

D1. What was your age on your last birthday?

- Under 20
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50 or older

D2. What is your marital status?

- Married or living with partner
- Single (includes separated, divorced or widowed)

D3. How long have you lived in your present town or city?

- Under one year
- One to two years
- Three to five years
- Over five years

D4. How many children (birth, adopted, foster or stepchildren) in each age group live with you full- or part-time?

- No children living with me
- __________ children 0 to 17 months old
- __________ children 18 to 35 months old
- __________ children 3 to 5 years old
- __________ children 6 to 12 years old
- __________ children 13 to 18 years old
- __________ children over 18 years old
Section E: FEELINGS ABOUT YOUR CENTRE

E1. Indicate ALL of the following that describe how you feel about your relationship with most of your co-workers most of the time.

If you are working in a small centre where there is only you and your director (or employer), fill in this box and skip to E2.

- My colleagues support and encourage me
- I enjoy the company of my colleagues
- My colleagues are hard to get to know
- My colleagues share personal concerns with me
- My colleagues are critical of my performance
- I feel I can’t trust my colleagues
- My colleagues are not very helpful
- My colleagues share ideas and resources

E2. Indicate ALL of the following that describe your relationship with the person who supervises you.

My supervisor:

- Encourages my to try new ideas
- Supervises me too closely
- Provides support and helpful feedback
- Sets high but realistic standards
- Makes me feel inadequate
- Trusts my judgement
- Is unavailable
- Appreciates the difficulties of balancing work and family responsibilities
- Is hard to please

E3. Indicate ALL of the following that describe how you feel about your working environment.

- The centre is a bright and attractive place to be in
- I always know where to find the things I need
- I need some new equipment and materials to do my job well
- We need a separate room where staff can relax during breaks
- I can’t find a place to carry on a private conversation
- It is too noisy
- The conditions meet my standards of cleanliness
- Staff have a place to store personal belongings

E4. Fill in the box that best reflects how each statement describes your feelings about your work situation most of the time.

<table>
<thead>
<tr>
<th></th>
<th>Never or Not at all</th>
<th>Rarely/to a minor degree</th>
<th>Occasionally</th>
<th>Good part of the time</th>
<th>Usually/feel strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>The work I do is stimulating and challenging</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel physically exhausted at the end of the work day</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>My work gives me a sense of accomplishment</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>There is too little time to do all that needs to be done</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel emotionally drained at the end of the day</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I make a positive difference in the children’s lives</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Centre policies and procedures are well-defined</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel frustrated by this job</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I have reasonable control over most things that affect my satisfaction with my job</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
I feel my job makes good use of my skills and abilities O O O O O O
I take pride in my centre O O O O O
I know the centre could be providing a better service but there is nothing I can do about it O O O O O
My centre could be providing a better service but there is nothing I can do about it
My centre provides a well-rounded program for the children who attend O O O O O
My centre really supports the families of the children who attend O O O O O

E5. Indicate ALL of the following that apply to how decisions are made at your centre most of the time.

- People are encouraged to be self-sufficient in making decisions
- The director likes to make most of the decisions
- People don’t feel free to express their opinions
- Everyone provides input on the content of staff meetings
- Practitioners make decisions about things that directly affect them
- Practitioners are seldom asked their opinion on issues
- The director values everyone’s input for major decisions

E6. What do you consider to have been the THREE most pressing problems facing your centre this past year?

1. ___________________________ most pressing problem.
2. ___________________________ second most pressing problem.
3. ___________________________ third most pressing problems.

E7. Are there currently any issues concerning social-emotional development that centre staff are being challenged by? (e.g., certain issues among staff keep coming up)

E8. Have you ever seen or read the Handle With Care booklet? Yes O No O

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
Appendix F

Child Care Interview

CHILD CARE INTERVIEW

Participant ID: 

Participant Name: 

Child Care Centre: 

Interviewer: 

Date: 

Interview

Hi, my name is _______________ and I am calling to complete telephone interview for the Handle With Care project. Today I am going to ask you for examples of what you do with infants, toddlers and/or preschoolers in your child care centre. These may be techniques, strategies or activities that you have used with either individual children or with groups. There are no right or wrong answers. The examples you provide can be general or from a specific scenario that you’ve encountered.

Information you share with us will not be discussed with others from your centre and, when reported, will be compiled with other respondents so that you will not be identified. I also want to let you know that I am taping our call so that I do not have be writing everything down as we talk. Interview audiotapes will be destroyed following dissemination of the project findings. Is that OK with you?

First, I’d just like to know:

Which age group of children do you primarily care for at your centre?

- Infants
- Toddlers
- Preschoolers
- Both infants/toddlers and preschoolers

I will assume that you are talking about that age range when you’re answering my questions, unless you say otherwise.

To start off, I want you to think about the relationships you have with the children in your care.
**Building Block 1: Developing Trust Between Practitioner and Child**

a. How do you think children’s relationships with you affect their development?

b. In what ways do you help children develop a trusting and secure relationship with you?

c. What kind of things impact your ability to make children feel safe and secure?

d. Is there anything in your professional and/or personal life that influences your relationships with children?

That leads us into thinking more about children’s social and emotional development and what you do to support children. These next questions will focus on issues surrounding children’s self-esteem, expressing emotions, peer relationships and dealing with change and transitions.

**Building Block 2: Building and Ensuring Positive Self-Esteem**

a. In what ways do you help children recognize that they are unique individuals and to feel comfortable being themselves?

b. In what ways do you help children feel competent and effective in the things they do?

c. What kinds of things do you do to promote good or positive self-esteem in children?

d. How do you know children have good self-esteem? What kinds of thoughts, feelings and behaviours (in children) do you associate with it?

**Building Block 3: Expressing Emotions**

a. What do you feel are some signs that children may not be coping effectively with their emotions?

b. In what ways do you help children express positive emotions (i.e., excitement, pride, etc.) in an acceptable/appropriate way?

c. In what ways do you help children express negative emotions (i.e., anger, sadness, aggression, etc.) in an acceptable/appropriate way?

d. How do you think children’s ability to share their feelings changes as they get older (e.g., from infancy to preschool age)?

**Building Block 4: Relationships With Other Children**

a. What kinds of social skills do you actively promote in children and how?

b. How do you support children who have negative experiences (e.g., being teased, conflict) with peers?

c. In what ways do you help shy children participate in activities and interactions with others?

d. How do you think children’s peer relationships change as they get older (e.g., from infancy to preschool age)?
Building Block 6: Change and Transitions

a. Children may become upset when they begin child care, leave child care to go to school or change child care arrangements. In what ways do you help children deal with the stress of making these kinds of transitions?
b. Children may experience major changes in their lives due to parent separation and divorce, parent illness or death, birth of a new sibling, immigration or loss of a special child care staff. In what ways do you support children through these events?

Diversity issues are often a major topic, given the various cultures, religions, ethnicities, family structures and socioeconomic status that children may come from. So I would like to talk with you about that.

Building Block 5: Respecting Diversity

a. How would you describe your centre: are most children and families alike or is there diversity? (If yes) What kinds of diversity exist?
b. In what ways do you help children respect beliefs, values and practices of people from diverse cultures or of people who seem different from them?
c. Are there challenges that you experience in trying to handle diversity as a practitioner?

Let’s think now more broadly about the centre environment and how that may affect children. By environment I mean the physical layout and arrangement of the centre space.

Building Block 9: Environment

a. What aspects of your centre space do you feel affect children in their daily life (socially and emotionally) at the centre?
b. In what kind of ways do you structure the centre environment so that children have feelings of belonging, individuality, independence and/or competence?

Beyond working with children, another part of your role in the centre is to communicate and collaborate with parents.

Building Block 7: Relationships with Parents

a. How do you think your relationships with parents influence your relationships with their children?
b. What kinds of things do you consider when trying to interact with parents?
c. How do you handle collaborating with parents in situations in which there may be a poor fit between a family and the centre or when your beliefs are different from a parent’s?
Now I’d like to shift gears. We’ve focused really on the children and families that you work with. But I’d like to ask you about what it is like for you in the centre and how your own well-being may factor into the work you do.

Building Block 8: Well-Being of Practitioners

a. Do you feel that your own well-being affects the children that you work with in any ways?

b. In what ways do you contribute to your own well-being in the centre?

c. Do you ever have conflicts with your colleagues or differences of opinion? How do you handle those kinds of situations?

Thank you for taking the time to share your ideas with me.
Appendix G

Child Care Questionnaire

CHILD CARE QUESTIONNAIRE

Handle With Care Questionnaire

Participant # ____________

First Name: ____________________  Last Name: ____________________

Name of Child Care Centre: ____________________

Date: ____________________

The following questionnaire contains multiple choice questions. Please read carefully through each item and circle the letter of the response you choose. Even though it may seem that more than one response is correct, please choose the BEST answer. Be sure to note that some questions are phrased in the negative (e.g., Which of the following is not...?). The term ‘practitioner’ is used to refer to you in your role as a front-line child care professional. When the term ‘early childhood’ appears in questions, it means infant, toddler and preschool children. Please complete the questionnaire individually and do not work with others.

1. The child care centre environment should be shaped around the fact that children:
   A) always like colourful settings
   B) need different spaces depending on personality and mood
   C) typically want to be around other children all of the time
   D) should be occupied with a range of activities

2. Children’s cognitive and social skills benefit most when:
   A) children and practitioners have the same ethnicity
   B) practitioners are sensitive and stimulating
   C) mothers’ and practitioners’ child-rearing beliefs are similar
   D) children learn about the cultural practices of the majority of centre children

3. A sign of high self-esteem in children is:
   A) feeling they are the best in a particular activity
   B) acting in a way to get positive attention from others
   C) enjoying age-appropriate challenges
   D) working hard to be perfect

4. A quality practitioner-parent partnership is built on:
   A) giving parents clear information on centre expectations
   B) good communication and mutual trust
   C) assuming that the practitioner is the expert on child development
   D) parents being involved in the centre as much as possible
5. Children’s social skills:
A) emerge automatically as they get older and progress through developmental stages
B) need to be promoted and supported through practice
C) are not influenced by how practitioners interact with others in the centre
D) develop easily when they are surrounded by other children

6. When practitioner and parent child-rearing beliefs are different:
A) children’s mental health suffers
B) parents and practitioners will never have a positive relationship
C) practitioners should try to consider and accommodate family values
D) parents need to conform to centre policies

7. Which one of the following is not a sign of secure (positive) attachment (in children)?
A) acting confidently
B) playing independently
C) having good relationships with other children
D) wanting to be close to an attachment figure all the time

8. The best way practitioners can help children to recognize and show their feelings is to:
A) use a ‘time-out’ area when children show negative emotions
B) help children to develop strategies to hold in negative emotions
C) pay attention to children only when they show positive emotions
D) accept emotions, both positive and negative

9. Dealing with change and transitions:
A) is not a big deal for younger children
B) should be handled by parents rather than practitioners
C) is impossible when change and transitions occur outside the centre (e.g., parental separation)
D) affects how children feel about themselves

10. Practitioners’ own well-being:
A) is not as important as children’s mental health in the centre setting
B) affects their relationships with children in their care
C) should be good or they should not work with children
D) is beyond their control in the centre workplace

11. It’s not developmentally appropriate to expect toddlers to:
A) help others occasionally
B) be independent with simple tasks
C) share with other children
D) use language to start interactions

12. Most often, the greatest barrier to inclusion (in terms of culture, abilities, religion, etc.) in child care centres is:
A) practitioners’ attitudes and experience
B) lack of money and resources
C) practitioners’ willingness to include all children
D) difficulty in accommodating individual needs
13. Children with low self-esteem:
A) are born that way and won’t likely change over time
B) may have a hard time believing there are good things about them
C) do not show different behaviours from children with high self-esteem
D) lack the ability to interact with peers positively

14. A positive “organizational climate” in a child care centre:
A) ensures that practitioners have proper work and rest spaces
B) includes good pay and benefits
C) conveys respect and value for practitioners’ work
D) offers children structure and limits

15. Qualities of the indoor child care environment:
A) can have a powerful impact on mental health
B) should be focused only on the needs of children
C) are less important than a good playground
D) are most important for children’s learning

16. As infants, children’s emotions:
A) are complex and reflect internal experiences
B) are shaped by culture
C) signal survival needs (e.g., food) and social arousal
D) are simple to figure out

17. Preschoolers’ capacity to form friendships is strongly tied to:
A) going along with what playmates want to do
B) their ability to consider the perspectives of different adults and children
C) peers becoming more important to them than adults
D) their capacity to engage in more complex games

18. Children develop attachment relationships with:
A) adults who meet their physical and emotional needs
B) positive and warm caregivers who spend lots of time with them
C) their mother immediately following birth
D) their primary caregiver in child care

19. Mental health promotion:
A) involves a set of specific activities
B) focuses on fixing people’s deficits
C) applies to all people
D) is the same as prevention and intervention

20. The best way to teach that different cultural perspectives are equal in worth is to:
A) celebrate holidays from different cultures
B) ignore the differences between children of various backgrounds
C) focus on correcting children who express negative attitudes
D) weave diversity into daily activities and conversations
21. When a child is leaving the centre to start school, it is best to:
A) emphasize the positive, such as the new friendships he or she will make
B) leave it to the parents to explain and support the child
C) deal with it with the child right before the transition
D) help the child know what to expect and understand it is okay to have mixed feelings

22. Which one of the following does not impact children’s mental health when considering parent-practitioner relationships?
A) conflict between parents and practitioners
B) practitioners’ competence to think flexibly and deal with potentially loaded topics
C) parents feeling confident and supported by practitioners
D) the type of communication parents and practitioners use (e.g., phone calls vs. meetings)

23. Fostering children’s healthy self-esteem involves:
A) praising what and how they do things as much as possible
B) ensuring that they always feel capable of doing anything they want to
C) making sure they can do what’s expected of them at the centre and fit in with other children
D) helping them to have accurate perceptions about their strengths and weaknesses

24. Conflicts and negative experiences with peers should:
A) be acknowledged and treated as a learning opportunity
B) always involve practitioners acting to resolve them
C) be discussed in a way that highlights which child is in the wrong
D) be treated differently when they are physical vs. verbal

25. When it comes to arranging the centre surroundings:
A) the centre supervisor should be in charge
B) children should play a role and participate in decision-making
C) basic safety issues are the only consideration
D) the greater the number of activity centres the better

26. The most important strategy for practitioner well-being at work is:
A) providing a staffroom and individual storage areas
B) having funds to buy the best resources and materials
C) inviting practitioners’ input about the work environment
D) ensuring that there are not conflicts among co-workers

27. Children are more likely to empathize, share and deal with conflicts when practitioners:
A) help only when problems between children arise
B) label children’s feelings
C) highlight that children should use appropriate behaviours
D) guide extended conversations about emotions

28. In early childhood, children typically do not:
A) become increasingly aware of similarities and differences between people
B) make comparisons between themselves and others
C) have complex questions or biases about diversity
D) use inappropriate words in relation to diversity
29. Which of the following is most likely to influence the quality of attachment relationships between practitioners and children?
A) whether there are appropriate staff:child ratios in the centre
B) practitioners’ ability to interpret children’s behaviours and respond to their needs
C) parents’ adherence to the centre orientation when children start at the centre
D) children’s skills at getting practitioners’ attention and support

30. One thing that does not help children with a difficult situation (e.g., adjusting to new practitioner) is:
A) modeling coping skills
B) modifying expectations of the children
C) setting fewer limits
D) giving feedback about how they are managing

31. A child who is popular in the centre:
A) is well-liked by many children
B) can easily confide their thoughts and feelings to others
C) will experience no social or emotional difficulties
D) has a lot of close friends

32. In a child care centre, considering mental health is most important with:
A) infants and toddlers
B) preschoolers and school-age children
C) children with behavioural difficulties
D) children of all ages

33. It is best to begin building a trusting parent-practitioner relationship:
A) once the child has settled into the centre routine
B) before the child starts child care
C) at a group meeting with all parents and practitioners
D) when a parent shows an interest in doing so

34. A child’s difficult temperament is most likely to elicit conflicts with a practitioner because:
A) the practitioner’s temperament is mismatched to the child’s
B) the child’s behaviours are problematic and need to be corrected or improved
C) there are very few positive characteristics of the child
D) the child’s behaviour disrupts the centre schedule

35. When a practitioner has a fight with her spouse before starting the day at the centre, she:
A) should be aware that her upset mood may be noticed by children
B) ought to acknowledge to children that she’s acting a bit differently but not explain why
C) needs to act as though nothing is wrong in front of the children
D) should talk about it with her coworkers to relieve her frustration

36. When children bring up cultural or religious issues that practitioners are unfamiliar with, practitioners should:
A) learn everything they can about the topics before responding
B) model respect and acknowledge their own learning process
C) limit the conversation until they can find out more
D) involve other staff who may know more than them
37. Children who do not share their feelings:
A) are not able to cope with emotions effectively
B) need practitioners to label his or her feelings for them
C) have few strong emotions
D) have good self-control and are not easily upset

38. Creating an environment that is considerate of practitioners’ work and comfort needs:
A) promotes their job satisfaction and well-being
B) is impossible in older centres and those with few resources
C) always comes second to children’s centre spaces
D) is less important than good pay and benefits

39. Children who are introverted:
A) fear embarrassment, humiliation and criticism in social situations
B) enjoy solitude and require private time to recharge their energy
C) become that way over time through bad experiences they’ve had
D) are shy and lack the self-esteem necessary to interact effectively with others

40. When developing a relationship with a child, practitioners’ own personal life and background:
A) is never as important as what is learned through their education and training
B) only limits their ability to work with children from different cultures
C) can influence their interactions with and expectations of different children
D) is not an important consideration

41. If a preschool child’s parents are going through a divorce, practitioners need to:
A) assume that he or she will not understand the situation or have strong feelings about it
B) expect that he or she will be very upset and have a hard time dealing with it
C) keep him or her engaged in pleasurable activities and with friends
D) observe him or her closely and provide opportunities to share his thoughts and feelings

42. When there is a poor fit between parents and the centre:
A) positive practitioner-parent collaborations can ease parent concerns
B) parents should enroll their child in a different centre
C) contact with parents should just be handled by the centre director
D) children are not affected because it doesn’t involve them

43. Accommodating children’s different learning styles:
A) is not necessary because all children basically learn the same way
B) interferes with their ability to learn like everyone else
C) makes children stand out as different from others
D) can bolster their self-efficacy
Appendix H

Codebook for Building Block 1 Questions

CODING

BUILDING BLOCK 1: DEVELOPING TRUST BETWEEN PRACTITIONER AND CHILD

*Quality ratings are based on an item response in its entirety. A response may consist of elements that would receive different quality ratings (e.g., part of the response may qualify for a rating of 1, while another part of the response may qualify for a rating of 2). When rating the overall response, award the highest rating reflected.

a. How do you think children’s relationships with you affect their development?

Descriptive

- Relationship is not important
- Relationship is important
  - Affects development in all areas
  - Closeness
  - Reciprocity (e.g., sharing things between each other)
  - Familiarity (e.g., getting to know child, knowing where child is developmentally)
    - Openmindedness
    - Receptive to learning
  - Consistency
    - Preparation for school
    - Dealing with routines
  - Trust
    - Listening skills
    - Compliance (e.g., follow what you ask)
    - Easier to get along with (e.g., between interactions, “everything becomes easier” in terms of activities with the child)
    - Level of participation
    - Follow adult’s lead
    - Positively responsive (socially with practitioner)
    - Comfortable
  - Positivity (e.g., affecting children’s mood, helping them to become positive individuals)
  - Willingness to try/explore
  - Sense of security (e.g., children having a better sense of security in themselves)
  - Promotes self-esteem (e.g., affecting children’s sense of self-worth, how practitioners make children feel about themselves)
  - Learning (e.g., children can build on their learning, affects motivation and wanting to achieve)
• Sociability/interactiveness (e.g., children being more sociable or interactive with adults and/or peers)

Quality*

1- Low Quality
• Inaccurate response such as practitioner-child relationships having no effect on children's development.
• Indication that the practitioner-child relationship is important but no discussion of its impact on children’s development

2- Adequate
• Recognition that relationship affects child’s development with no specific examples about areas of development.
• E.g. “I would say quite a bit. So the relationship that we have, if it’s a positive relationship I think that would affect them positively, their development”.
• In this question, “positive individuals” is considered a vague description related to children’s development.

3- High Quality
• Describing one or more specific ways in which the relationship affects child’s development in the domains of cognitive (e.g., learning), social or emotional growth.
• Examples can be phrased either positively or negatively (e.g., “If we don’t have a good relationship, it could stop them from trying new things”).

b. In what ways do you help children develop a trusting and secure relationship with you?

Descriptive

• Responsive to needs (e.g., physical and emotional)
• Pay attention to interests (e.g., notice child’s interest, fashion centre activities around child’s interests)
• Nurturing
• Acknowledging feelings
• Extended conversation about feelings
• Respect
• Gather personal information (either from children or parents)
  • Interests (e.g., what they like to do)
  • Disinterests (e.g., what they don’t like to do)
• Supportive (e.g., being gentle, not pushing oneself on a child, supportive communication)
• Responsive communication (e.g., way they talk to children, eye contact, at child’s level, sound/tone of voice)
• Parent communication
  • Family activities (e.g., things the family does together)
  • Family communication (e.g., how parents talk to their kids)
• Reassurance
• Disclose personal information (e.g., interests)
• Physical affection
• Role-model/set good example (for practitioners and other children)
• Get down to their level
• Talk to them constantly
• Encouraging words
• Consistency (e.g., in terms of schedule, ways of handling things, etc.)
  o Follow-through (e.g., doing what you say you are going to do)
  o Limits
  o Expectations
• Openness/availability (e.g., being there when they need you, children feeling that they can come to practitioner for help or support or whatever)
• Assistance with problem solving
• Allowing independence (e.g., “allowing them to problem solve themselves”)
• Positive and welcoming

Quality*

1- Low Quality
• Inaccurate response such as practitioner has no ability to help children develop a trusting and secure relationship with them.
• Response is vague in that practitioner acknowledges that they do something to promote security and trust but does not describe how or what the impact is on children and/or the relationship (e.g., “I try in every way. Like the way I read a book to them or play with them.”)

2- Adequate
• Response includes one or more specific examples of strategies or approaches that the practitioner uses with children to help develop trusting or secure relationships with them.

3- High Quality
• Response includes one or more specific examples of strategies or approaches (as described in the Adequate quality rating) but further describes or explains how the strategies/approaches are important and/or impact the relationship with children (e.g., “Talking to the children about their preferences and communicating encouragement for their strengths shows that I’m really interested in them (children) and want the best for them.”)

c. What kind of things impact your ability to make children feel safe and secure?

Descriptive

• Nothing/Didn’t answer question
• Environment
  o Safety (e.g., awareness of where children are, potential dangers, what is safe and what isn’t, children’s developmental level, etc.)
  o Comfort
  o Child-size materials
  o Soft materials for quiet time
  o Appropriate toys
• Centre organization
  o Ratios
  o Supporting co-workers (staff support)
  o Supervisors
• Parents and/or parent/family-centre relationship (e.g., if the relationship is strong or weak)
• Child’s home life (e.g., issues with child at home, parent-child relationship, etc.)
• Professional education/training/professional development
• Personal enjoyment of children
  o Caring
  o Interest
• Personal well-being
  o Ability to concentrate on children (e.g., “definitely if something is going on in my personal life, I try to keep it aside so that I can give my full self to the children.”)
• Personal emotions
  o Affect interactions with children

**Quality**

1- Low Quality
  • No recognition that anything impacts their ability to make children feel safe and secure.
2- Adequate
  • Response includes one or more examples with no details/description or specificity as to how or what they do affects children
  • Response includes only examples related to the centre environment or organization with no mention of other more personalized factors connected to the practitioner, child or family
3- High Quality
  • Response includes one or more examples related to personalized factors connected to the practitioner, child or family and description as to how or what they do affects children.

d. **Is there anything in your professional and/or personal life that influences your relationships with children?**

**Descriptive**

• Nothing
• Professional
  o History of working with children
  o Educational background
  o Professional development
  o Changing nature of the child care field (referring to new knowledge and strategies).
  o Staff support (e.g., good relationships with colleagues)
o Work enjoyment
  ▪ Responsive to needs
o Supervisor support
o Centre curriculum
  ▪ Mental health perspective
  ▪ Thinking about attachment
  ▪ Genuine/specific praise
• Personal
  o Learning from children (e.g., “I’m learning from them as well to make me a better person and a better teacher”)
  o Personal attributes
    ▪ Social
    ▪ Open/relatable
    ▪ Comfortable
    ▪ Happy
  o Enjoying children
  o Quality time for children (e.g., practitioner trying to do her best to make children comfortable and cared for)
  o Upbringing (e.g., number of parents, parents working outside the household, brought up by extended family)
  o Past experiences with children (excluding experiences as a parent)
  o Having kids
    ▪ Safety considerations
    ▪ Similar strategies/approaches
    ▪ Empathize with parents
    ▪ Gender differences (e.g., using different strategies)
    ▪ Similar demeanour with children (e.g., using similar strategies or being the same with their own kids as the kids in child care)
  • Rapport-building

Quality*

1- Low Quality
• No recognition that any aspect of their professional and/or personal life influences their relationships with children.
• Mention of a professional and/or personal aspect but no indication as to how it influences their relationships with children (e.g., “I’ve always worked with children, always been working with them since I’ve been old enough. I don’t really see myself doing anything else.”).

2- Adequate
• Response may include one or more specific examples of aspects of the practitioner’s professional and/or personal life that influences their relationships with children.
• No or limited insight into how such aspects influences their relationships with children or directly affects the children (e.g., “I just have always enjoyed children, so I guess that would be the personal aspect.”)

3- High Quality
• Response includes mention of specific examples of aspects of the practitioner’s professional and/or personal life that influences their relationships with children and has insight into how these aspects influence the relationships.