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## **Child and Youth Health: Strengthening Inter-Ministerial Integration**

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Submitted by the OPHA Child and Youth Health Ad Hoc Task Group

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## **Executive Summary**

There is concern in the public health community that child and youth health programs will become fractured and fragmented given the dispersion of programs and services across a number of Ontario government ministries. In addition, the move to program-based service delivery often related to a topic or disease, potentially detracts from focusing on the holistic and comprehensive needs of children, youth and their families. It is the position of the Ontario Public Health Association (OPHA) that it is important to view this population holistically and comprehensively.

To make both short and long-term improvements in the lives of Ontarians, the government must simultaneously support the use of a comprehensive health promotion approach and the provision of direct services for children, youth and families.

Strategies and actions by the OPHA and its partners to support the need for a holistic approach are:

1. Influencing the Ministry of Health and Long-Term Care, Public Health Division, the Ministry of Children and Youth Services and the Ministry of Health Promotion and other ministries such as Ministry of Education to establish integrated mechanisms for comprehensive and collaborative planning, implementation and evaluation of child and youth programs and services.
2. Ensuring that the Ministry of Health and Long-Term Care, Public Health Division release augmented Mandatory Health Programs and Services and that these programs integrate the determinants of health, recognizing the connection between the individual, family, community and environment.
3. Advocating that the Ontario Government take a lead role in re-orienting health services for children and youth, moving the health sector increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. (Ottawa Charter for Health Promotion, 1986).

Two resolutions will be made by the Child and Youth Health Ad Hoc committee of OPHA to carry forward public health's goal to increase the percentage of children and youth who meet physical, cognitive, communicative and psychosocial developmental milestones.

## **Introduction**

The Child and Youth Health Ad Hoc Task Group recommend an integrated approach to planning and delivering services to families. There is extensive evidence to prove the multi-faceted needs of children and youth, and it is the position of OPHA that there needs to be an emphasis on the importance of viewing this segment of the population holistically and comprehensively.

The public health system has recently undergone and continues to undergo extensive review, resulting in significant public health system changes. At the provincial level, the formation of the Ministry of Children and Youth Services resulted in a transfer of accountability for the Healthy Babies, Healthy Children Program and the Early Child Development projects from the Ministry of Health and Long-Term Care, Public Health Division to the Ministry of Children and Youth Services. It has not yet been determined as to whether the Ministry of Health Promotion or the Ministry of Health and Long-Term Care, Public Health Division will be accountable for the remainder of the Family Health mandate under the Mandatory Programs and Services Guidelines. The establishment of a Public Health Agency for Ontario, currently in the formation stage, has not yet considered how they will address child and youth services or how they might be integrated to better meet the holistic needs of this population.

This shift in funding and responsibility requires the development of an integrated mechanism to ensure child and youth health services are provided in a manner that maximizes the potential of the complimentary programs and services offered by the various Ministries. To make both short and long-term improvements in the lives of Ontarians, the government must simultaneously support the use of a comprehensive health promotion approach and the provision of direct services for children, youth and families. Federal and provincial recognition of this truth, as outlined in recent announcements and documents described below, suggests that this is an opportune time to comprehensively evaluate the way in which we serve children, youth and their families.

## **Determinants of Health**

### ***Background***

The World Health Organization defines the determinants of health as the range of personal, social, economic and environmental factors which determine the health status of individuals or populations (World Health Organization, 1998). Recent government announcements and publications indicate an increasing commitment to a population health approach at both the federal and provincial level. In the Public Health Goals for Canada Workbook (2005), the Public Health Agency of Canada states “there is a growing body of evidence that suggests that addressing inequalities in society is key to helping improve the health outcomes of all Canadians” (p.2).

Given this commitment from the government, the evidence supporting child and youth programs is presented here according to the determinants of health, as outlined in the *Public Health Goals for Canada Workbook*. These determinants of health include income and social status, social support network, education and literacy, employment/working conditions, social and physical

environment, personal health practices and coping, healthy child development, biology and genetics, health services, gender and culture.

For the purpose of this position paper, selected determinants of health which impact children and families will be the lens to guide the discussion on the importance of an integrated approach to child health.

### ***Income and Social Status***

Income and social status are well recognized as key factors in determining an individual and family level of health. The more money an individual/family has, the greater are the opportunities to get a good education; purchase adequate food, clothing and housing; buy recreational equipment and take vacations; and generally make the choices necessary to participate in development opportunities (Canadian Institute for Health Information, 2004). As one example, when income is restricted, people often select foods that are higher in sugar and fat because they are among the least expensive foods (Taylor, Evers, and McKenna, 2005). When food is scarce, mothers often sacrifice their own food intake to protect their children from hunger (Raine, 2005).

This determinant, as it relates to children and youth, has been examined in depth by the Ontario Public Health Association (OPHA) Child Health Work Group through its position paper, *Public Health Responds to the Challenge to Reduce Poverty and Enhance Resiliency in Children and Youth* (2004). For further strategies to address child poverty see the 2004 OPHA Child Health Work Group position paper.

In the Canadian National Longitudinal Study of Children and Youth, approximately 30% of children living in families who fall within the bottom quartile of household income experience significant “vulnerabilities” for poor development (these include behaviour disorders, difficult temperaments, low motor and social development, low receptive vocabulary and low mathematic scores). However, each of the successive quartiles shows significant numbers from the other levels of families, with families in the top economic quartile showing a 20% prevalence of vulnerability. In addition to targeted strategies there is also a need for a population-based approach to enhancing parenting capacity, to shift the trajectory of the largest numbers of children in the middle socio-economic status (SES) quartile. If we focused our system of services for children and families *solely* on socioeconomic indicators, we would ignore the greatest number of vulnerable children (McCain and Mustard, 1999; Mustard and Picherack, 2002).

### ***Social Support Networks***

The social environment includes the family, friends, schools, and communities in which children and youth play, learn and live. Healthy social environments and strong support networks promote the emotional and physical well being of children and youth. Research indicates that a significant number of Canadian children demonstrate behavioural problems, including emotional disorders and psychological disturbances which have a potential for lifelong consequences (Offord and Lipman, 1996). This comes at significant cost not only for children and their

families, but to the provincially funded systems of education, child welfare, children's and family's health among others. Later in life, studies indicate that these children may be at increased risk for tobacco use, substance abuse, suicide as well as factors that impact their ability to succeed (Wilms, 2002). To address these public health issues related to child mental health consideration of family support and security is needed.

### ***Family Support***

A significant aspect of early childhood is the attachment with a significant caregiver or "attachment figure" that provides protection for the infant (Bowlby, 1969). The nature of the parent's response determines the kind of attachment relationship with the infant. When a mother experiences depression, she may not be capable of responding to her infant's emotional needs for safety that could contribute to an insecure attachment relationship and potentially long term child behavioural problems (Beck, 1995). The prevalence of postpartum depression is a growing public health concern among women (Watt, Sword, Krueger and Sheehan, 2002).

In order to provide a supportive family environment and build the healthiest relationship with their children, parents themselves need an environment that fosters their knowledge, growth and confidence. The identification, referral, and support of the infant and his or her family are necessary to prevent child mental health problems. One of the key factors that influence the development of behavioural problems is the parents' style of parenting. The two most critical aspects of parenting are parental warmth, (as opposed to hostility or harshness) and consistency (Deater-Decard, Dodge, Bates and Pettit, 1996; Olweus, 1980).

There are a number of other factors that influence the development of emotional and behavioural problems in children. Evidence indicates that child mental health results from interplay among the child, the family, the immediate environment, society, the economy, and culture (Thomas, Boyle, Micucci and Cocking, 2002). Some disturbing trends influencing the normative development of children include the impact of computers and television on the cognitive and physical development of children which links to obesity and the effects of chronic stress within families on the parenting of children (Couchman, 2002). However, on a positive note, a systematic review of effectiveness studies indicate that parenting group programs are effective when they teach parents a range of skills and to recognize, describe, observe, and respond to problem behaviour in new ways (Thomas et al., 2002).

### ***Security***

The amount of violence in the lives of children and youth has a significant influence on their health and well being. A feeling of security will positively affect the overall development of children and youth. As noted in the OPHA resolution on *Physical Punishment of Children* (2004), "There is cumulative and consistent evidence that physical punishment places children at risk of physical injury, physical abuse, impaired mental health, a poor parent-child relationship and increased childhood and adolescent aggression and antisocial behaviour. Physical punishment in childhood has also been associated with negative outcomes in adulthood such as aggression, poor mental health and an increased risk of abusing one's own child or partner" (p.3). For further strategies to address violence in the family see the 1997 OPHA resolution *Violence: A Public Health Issue*.

### ***Education and Literacy***

Education of both the individual and his or her primary caregivers equips children and youth with knowledge and skills needed to solve problems, gain access to information that can keep them healthy, build self-esteem and, as adults, find meaningful employment. As one example, lower educational status of parents has been associated with lower dietary quality, including higher fat and lower micronutrient intakes in children. Furthermore, parents' nutritional knowledge may affect nutritional quality of foods purchased, and therefore their availability, as well as the size of portions served to the child (Taylor, Evers, and McKenna, 2005).

In addition to the learning opportunities provided through child care, community networks and schools, these environments must also support the child or youth as a whole. Programs and curriculum that offer information and support for parenting skills, child development, early intervention, conflict resolution, and social skills development are important in ensuring a healthy social and learning environment for children and their families (Health Canada, 1999).

#### ***Child Care, Early Learning and Community Based Programs and Services***

The Ontario government, through initiatives such as Healthy Babies, Healthy Children (HBHC), Best Start, Child Health and Reproductive Mandatory Health Programs, has recognized the need to address the broader determinants of healthy development. This government-wide priority is based on an abundance of research on the importance of prenatal and early childhood stimulation and support, including accessible child care. The well-accepted and frequently quoted *Reversing the Real Brain Drain: Early Years Study* by McCain and Mustard (1999) points to the need for increased sensitivity and responsiveness of local communities, with central components including early child development and parenting activities; home visiting; and early problem identification and intervention. These approaches along with population-based approach working with individuals, families and communities as mandated in the public health through child and youth health promotion programs will ensure multiple approaches to enhance the developmental of children and support and strengthen families. Over time, this investment will be much more cost effective than paying for remediation later in life, such as treatment programs and supportive services for problems that are rooted in poor early development (McCain and Mustard, 1999).

Other approaches of importance include the role public health plays in early identification and intervention. The goal of early identification and intervention is to prevent or minimize the physical, cognitive, emotional, and resource limitations of young children disadvantaged by biological or environmental risk factors (Blackman, 2002, p.11). Early intervention programs are devoted to enhancing development, minimizing developmental delays, and providing instruction, support, and assistance to those children and their families (Cantu, 2002, p.47). There is no more important period in human development than conception through early childhood in maximizing the potential for living fully.

#### ***School-based programs and services***

The health knowledge, attitudes and behaviours established in the child and youth years can have tremendous beneficial or harmful effects in adult life. Investing in public health staff to engage children and youth, parents, teachers, administration, and other such partners as the Ministry of

Education in action to create healthy school communities, strengthens and reinforces curriculum messages. Supportive school environments that foster resilience and focus on asset development, protective factors, and social connectedness reduce the risk of health-related problems and support the healthy growth and development of children and youth.

Creating supportive environments and strengthening community action for health are two key health promotion strategies which need to be strengthened and to occur in all school communities. The Government of Ontario has committed to “Making Ontario Schools Healthier Places to Learn.” It has taken action in the areas of physical activity promotion, school nutrition, safer schools, tobacco use prevention, mental health services for children and youth, and parent involvement in education. In Ontario, it has become clear that the education sector is currently bearing much of the responsibility for the learning and healthy growth and development of children and youth. The need for inter-ministerial, multi-sectoral support has become essential.

In May 2005, the government named a School Health Coordinator as part of its commitment to joining the Pan-Canadian Joint Consortium on School Health. This is an important first step towards the development of an infrastructure of policies, legislation and guidelines that the World Health Organization has identified as essential for ensuring that resources are allocated and coordinated at the local, national and international levels. Both the broader community and school community need to work together to support health and education (World Health Organization, 1995).

A strong investment in building “healthy schools” is needed in order to promote the health of children, youth, families and staff in school communities. The Healthy Schools model is consistent with the internationally accepted Comprehensive School Health (CSH) approach that provides students with many opportunities to observe and learn positive health attitudes and behaviours. A systematic review on the effectiveness of this approach indicates that health promotion interventions are most effective when they involve a multifaceted approach and that classroom education should be implemented in combination with changes to the school environment and/or family/community participation (Stewart, 2001).

The Mandatory Health Programs and Services Guidelines direct public health to work with all schools and school boards to implement health promotion programming, but do not yet stipulate that a Comprehensive School Health approach should be used. This clarification is needed to ensure that public health units allocate the resources necessary to enable the building of capacity within school communities so that they can take their own action on health issues.

### ***Physical Environments***

The physical environment – the houses, buildings, parks, playgrounds, streets, and pathways, as well as the air, water, soil, food and consumer products that surround these infrastructures – has both direct and indirect influences on health, quality of life and well being. Professional and public awareness and concern about the potential impact of prenatal and/or childhood exposure to hazardous substances through the physical environment is on the rise.

Overall, children are more susceptible to negative impacts from exposure to hazardous substances than adults because 1) they are more likely to be exposed, 2) they are physiologically more vulnerable, 3) they have a longer life ahead of them during which an illness could manifest itself and 4) as their bodies develop (from conception through to adulthood) they go through periods of time during which different organs and systems in their bodies are uniquely sensitive to specific substances, known as “windows of vulnerability” (Selevan, Kimmel, and Mendola, 2000, United States Environmental Protection Agency, 2003). This vulnerability is affected not only by their social environment but also their physical environment which implies some children are more at risk than others. For example poverty is a significant risk factor, placing children in Aboriginal communities, newcomers to Canada and visible minorities at higher risk than other children (Chaudhuri, 1998).

There are indications that environmental exposures throughout developmental periods (prenatal, postnatal, and early childhood) when coupled with the notion of developmental windows of vulnerability, have the potential to negatively affect health, during childhood and later in life. Disease patterns among children are also changing over time. For example, asthma now affects more than 12% (c.a. 1 million) of Canada’s children, a figure that has quadrupled since the early 1980s and both indoor and outdoor air pollution are implicated (Health Canada, 1998). Over 23,000 chemicals are registered for commercial use in Canada, of which only 69 have been fully evaluated for effects on human health (Health Canada, 2004).

This reality of knowing very little about the health implications of exposure to large numbers of substances is unlikely to change in the near future. Waiting for conclusive causal relationships between specific substances and specific health effects will therefore result in a lack of action to protect children from potential harm due to environmental exposures. Applying the precautionary principle offers an alternative approach. This decision-making and policy tool is increasingly being put forward as a way to address the reality of ongoing incomplete scientific information. It has been incorporated into law in numerous European countries, is currently being explored by the Canadian government and is slowly making its way into legislative thinking in this country (Rogers, 2003, Environment Canada, 2001). It states that a lack of scientific certainty is no excuse for inaction in situations where there is a potential threat to human health or the environment. In plain language it states that we need to be “better safe than sorry”.

### ***Personal Health Practices and Coping***

Coping skills, which allow an individual to deal with the challenges and stresses in their everyday lives, begin to develop early in life. How people deal with challenges can influence their vulnerability to cancer, cardiovascular disease, mental disorders, unintentional injuries, suicide, and other health problems (Health Canada, 1999).

People’s health practices, including their level of physical activity, eating habits, oral health practices prenatal practices, sexual practices, and use of alcohol and other drugs have a profound effect on their health and well being. Many disabilities and chronic health problems that arise in adulthood can be traced to negative health behaviours entrenched during childhood and adolescence. Research indicates that low birth weight and premature birth have negative



outcomes for children's health (McCain and Mustard, 1999); that babies who are regularly exposed to second-hand smoke have a greater chance of dying from Sudden Infant Death Syndrome (Program Training and Consultation Center of the Government of Ontario, 2003); that breast milk provides benefits beyond the immediate nutritional needs of the child, including a potential reduction in infant and childhood morbidity and mortality (Davis, 2001); that the longer the duration of breastfeeding the greater benefits to cognitive development (Angelsen, Jacobsen, and Bakkeiteig, 2001); and that bottled fed children, on average, have more cavities and are more likely to need orthodontics than children who were breastfed exclusively for at least 6 months (Perinatal and Child Health Survey Consortium, 2003).

Public health prenatal interventions found to be effective include smoking cessation programs during pregnancy which increase quit rates and decrease intrauterine growth restriction and preterm births (Moner, 1994; Lumley, Oliver, Chamberlain, and Oakley, 2004). Prenatal education and postpartum support improve both initiation and duration of breastfeeding. (Sikorsk, Renfrew, Pindoria, and Wade, 2002, Palda, Guise, and Wathen, 2004).

### ***Family Practices***

As children grow, their family's and their own health practices start to affect their physical and mental health. Research suggests that poor diet and inactivity during childhood increases the risk of overweight and obese children (Taylor, Evers, and McKenna, 2005). The likelihood of being overweight or obese tended to rise with time spent watching TV, playing video games or using the computer in children aged 6 to 17 (Tjepkema and Shields, 2005, Basrur, 2004) and unhealthy eating habits during childhood may interfere with optimal growth and development (Taylor, Evers, and McKenna, 2005).

### ***Sexual Practices***

Sexual health practices resulting in sexually transmitted infections (STIs) continue to be a major health threat in Canada. Epidemiological studies indicate Chlamydia, gonorrhea, and infectious syphilis steadily increased by 60% between 1997 and 2002 affecting primarily adolescents (Public Health Agency of Canada, 2002).

### ***Substance Use***

Adolescent drug use can have immediate consequences, but also can have long-term impact on adult life. Ontario students, grade 7 through Ontario Academic Certificate (OAC) report the use of alcohol and other drugs: alcohol 65.6%; cigarettes 23.6%; and cannabis 29.8% and that the drug use for all three of these drugs peaked when students were in grade 9 (Sieswerda and Adalf, 2002).

### ***Dental Health Practices***

Oral health is more than the absence of pain and disease. Dental health plays an important role in the overall health and well-being of a child. Poor dental health can lead to painful infections, premature loss of primary teeth, poor eating habits, speech problems, and expensive dental treatment. Dental pain, bleeding and infection can interfere with learning in school and lead to tooth loss and impair the growth and development of children (Ayhan, Suskan and Yildirim, 1996; Ac, Shulman, Ng, and Chussid., 1999). A US study has reported that 52 million hours of school are missed each year due to tooth decay and other dental problems (Gift, Reisine and Larach., 1992).

The impact of oral health problems on general health and quality of life has been described in a growing amount of literature. These include the links between periodontal disease and systemic diseases (Genco, Glurich, Harazthy, Zambon and Denardin, 1998), periodontal disease and having preterm low-birth-weight children (Lopez, Smith, and Gutierrez, 2002), and oral diseases and diabetes mellitus and cerebrovascular incidents (Grossi and Genco, 1998; Loesche et al., 1998). In addition, problems with oral health affect a person's ability to function and quality of life as well as affecting the lives of their families (Locker, Jokovic and Stephens, 2002; Filstrup et al., 2003). Healthy teeth and mouths are necessary for an individual to thrive in today's society.

Inequalities in oral health exist due to differences in financial status and the ability to access dental care. Poor dental health is more common in the most deprived sections of society - poor children are suffering from a "silent epidemic" of dental diseases. Findings from studies indicate that low-income children have higher disease rates, a higher percentage of unmet dental need, and lower utilization rates for dental care services. Dental care in early childhood is necessary to give every child a good start to life. Although improved treatment services are required, they can never alone reduce the underlying causes. Efforts should focus on oral health promotion to reduce the burden of dental illness for future generations.

### ***Health Services***

Health Services are designed to promote and maintain optimum well-being. These services are provided by a variety of health professionals who address the basic needs of children and youth with regard to their physical and mental health. However, limited accessibility across the province and geographical variation in accessibility must be taken into account. Health services are provided by numerous Ministries including Ministry of Children and Youth Services, Recreation, Housing, Education as well as Health. Public Health is linked with these Ministries through the provision of related programs and services. However, communication systems between sectors are limited as is joint planning and policy development. To move towards a more integrated, cohesive system these mechanisms must be addressed.

#### ***Primary Health Care Services***

At its core, primary health care is defined as a set of universally accessible first-level services that, amongst other services, promote health, prevent disease and provide supportive services. Its aim is to have the right provider, in the right place, at the right time providing appropriate access to health services. Public health practitioners provide primary health care services to families in each community of the province through such venues as home visits to families with a new infant, child development assessment at a well baby clinic, breastfeeding counselling through telephone access, dental screening in school communities, smoking cessation support with adolescence, family planning services at clinics, and infectious disease outbreak follow up in daycares. These services may be funded by Ministries and through several government levels however, the family receiving services will benefit from an experience which is integrated and complimentary. This short list of examples underscores the importance of working with multidisciplinary partners from several sectors/ministries in order to ensure a more cohesive system of health services for families.

The fit of public health and the new provincial models for primary health care - Family Health Teams (FHTs) – has not yet been clearly articulated. FHTs bring together family physicians, nurse practitioners, registered nurses, registered dietitians, social workers and other health professionals in interdisciplinary teams. FHTs will provide system navigation for patients and a more focused emphasis on health promotion, illness prevention and early detection/diagnosis. This role makes for an ideal opportunity to link with many initiatives and programs delivered by public health units.

### ***Gender and Culture***

Gender clearly produces differences in the health status of children and youth in Canada. Young men have higher rates of injury, death and disability and a higher incidence of learning and conduct disorders. Young women are more likely to have reduced education, have a lower income, be single parents, and to have lower levels of self esteem (Health Canada, 1999).

Culture is a shared identity based on such factors as common language, shared values and attitudes, and similarities in ideology. As noted by Health Canada (1999), some people face additional health risks due to marginalization, stigmatization and lack of access to culturally appropriate services. Culture specific practices can also have an impact on the overall health of a population.

Gender and culture are inherent in all other determinants of health, creating important impacts on healthy child and youth development. Public health measures need to take gender and cultural roles into account when providing programs and services for children and youth.

### **Conclusion**

In order to make a real and lasting impact on the health of Ontario's children and youth, the Ontario government must simultaneously support the use of a comprehensive health promotion approach and the provision of direct services for children, youth and families. Integration and coordination of health promotion approaches and services for children and families at the system level requires collaboration among various provincial ministries.

The OPHA Child and Youth Health Work Group envisions an Ontario with an integrated system to ensure child and youth health services are provided in a manner that maximizes the potential of all the complimentary programs and services offered by all the partners involved and is willing to provide the leadership to achieve this end.

## References

- Acs, G., Shulman, R., Ng, M.W., & Chussid, S. (1999). The effect of dental rehabilitation on the body weight of children with early childhood caries. *Pediatr Dent*, 21,109-113.
- Angelsen, N.K., Jacobsen, G., & Bakketeig, L.S. (2001). Breast feeding and cognitive development at 1 and 5 years. *Arch. Dis. Child*, 85, 183-188.
- Ayhan, H., Suskan, E., & Yildirim, S. (1996). The effect of nursing or rampant caries on height, body weight, and head circumference. *J Clin Pediatr Dent*, 20, 209-212.
- Basrur, S. (2004). Healthy weights, healthy lives. Retrieved July 22, 2005 from [http://www.health.gov.on.ca/english/public/pub/ministry\\_reports/cmoh04\\_report/healthy\\_weights\\_112404.pdf](http://www.health.gov.on.ca/english/public/pub/ministry_reports/cmoh04_report/healthy_weights_112404.pdf)
- Beck, C.T. (1995). The effects of postpartum depression on maternal-infant interaction: A meta-analysis. *Nursing Research*, 44(5), 298-304.
- Blackman, J.A. (2002). Early intervention: A global perspective. *Infants and Young Children*, 15(2), 11-19.
- Bowlby, J. (1969). *Attachment*. New York: Basic Books.
- Canadian Institute for Health Information. (2004). Improving the Health of Canadians. Retrieved July 7, 2005 from [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=cphi\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_e)
- Cantu, C. (2002). Early intervention services: A family-professional partnership. *The Exceptional Parent*, 32(12), p.47.
- Chaudhuri, N. (1998). Child health, poverty and the environment: The Canadian context. *Canadian Journal of Public Health*, 89(1), 26-30.
- Couchman, B. (2002). From precious resources to societal accessory: Canada's six to twelve years of age. National Children's Alliance Symposium.
- Davis, M.K. (2001). Breastfeeding and chronic disease in childhood and adolescence. *Pediatr Clin North Am*, 48(1), 125-41.
- Deater-Deckard, K., Dodge, K., Bates, J.E., & Pettit, G. (1996). Physical discipline among African American and European American mothers: Links to children's externalizing behaviours. *Developmental Psychology*, 32 (6), 1065-72.
- Environment Canada, (2001). *A Canadian perspective on the precautionary approach/principle discussion document*. Retrieved July, 2005 from [http://www.ec.gc.ca/econom/discussion\\_e.htm](http://www.ec.gc.ca/econom/discussion_e.htm)
- Filstrup, S.L., Briskie, D., da Fonseca, M., Lawrence, L., Wandera, A., & Inglehart, M.R. (2003). Early childhood caries and quality of life: child and parent perspectives. *Pediatr Dent*, 25, 431-440.
- Genco, R., Glurich, I., Harazthy, V., Zambon, J., & DeNardin, E. (1998). Overview of risk factors for periodontal disease and implications for diabetes and cardiovascular disease. *Compendium*, 19, 40-45.

- Gift, H.C., Reisine, S.T., & Larach, D.C. (1992). The social impact of dental problems and visits. *Am J Public Health*, 82, 1663-1668.
- Grossi, S.G., & Genco, R.J. (1998). Periodontal disease and diabetes mellitus: a two-way relationship. *Annals of Periodontol.* 3, 51-61.
- Health Canada. (2004). Categorization of substances on the domestic substance list. Existing Substances Division. Retrieved July, 2005 from [http://www.hc-sc.gc.ca/hecs-sesc/exsd/categorization\\_dsl.htm](http://www.hc-sc.gc.ca/hecs-sesc/exsd/categorization_dsl.htm)
- Health Canada. (1999). *Healthy development of children and youth: The role of the determinants of health*. Health Canada Publications.
- Health Canada. (1998/99). *National population health survey*. Retrieved July, 2005 from [http://www.phac-aspc.gc.ca/ccdpc-cpcmc/crd-mrc/asthma\\_e.html](http://www.phac-aspc.gc.ca/ccdpc-cpcmc/crd-mrc/asthma_e.html)
- Locker, D., et al. (2002). Family impact of child oral and oro-facial conditions. *Community Dent Oral Epidemiol.* 30, 438-448.
- Loesche, W.J., Schork, A., Terpenning, M.S., Chen, Y.M., Kerr, C., & Dominguez, BL.(1998). The relationship between dental disease and cerebral vascular accident in elderly United States veterans. *Ann Periodontol.* 3, 161-174.
- Lopez, N.J., Smith, P.C., & Gutierrez, J. (2002). Higher risk of preterm birth and low birth weight in women with periodontal disease. *J Dent Res.* 81, 58-63.
- Lumley, J., Oliver, S.S., Chamberlain, C., & Oakley, L. (2004). Interventions for promoting smoking cessation in pregnancy. *The Cochrane Database of Systematic Reviews*, Issue 3. Retrieved July 25, 2005 from [www.mrw.interscience.wiley.com/chochance/chochance\\_elsysrev\\_subjects\\_fs.html](http://www.mrw.interscience.wiley.com/chochance/chochance_elsysrev_subjects_fs.html)
- McCain, M.N. & Mustard, J.F. (1999). Reversing the real brain drain: Early years study final report. Retrieved July 7, 2005 from [http://www.innocents.ca/pdf/early\\_years\\_study.pdf](http://www.innocents.ca/pdf/early_years_study.pdf)
- Moner, S.E. (1994). Smoking and Pregnancy. Canadian Guide to Clinical Preventative Health Care. Ottawa: Health Canada 26-36. Retrieved July 25, 2005 from [www.hc-sc.gc.ca/hppb/healthcare/pubs/clinical\\_preventative/index.html](http://www.hc-sc.gc.ca/hppb/healthcare/pubs/clinical_preventative/index.html)
- Mustard, F. & Picherack, F. (2002). *Early childhood development in British Columbia: Enabling communities*. Founders Network.
- Offord, D.R. & Lipman, E.L. (1996). Emotional and behavioural problems. *In Growing up in Canada: National Longitudinal Survey of Children and Youth* (pp.119-26). Ottawa, ON: Human Resources Development Canada and Statistics Canada.
- Olweus, D. (1980). Familial and temperamental determinants of aggressive behaviour in adolescent boys: A causal analysis. *Developmental Psychology*, 16, 644-60.
- Ontario Public Health Association. (2004). *Public health responds to the challenge to reduce poverty and enhance resiliency in children and youth*. Retrieved July 8, 2005 from [http://www.opha.on.ca/ppres/2004-05\\_pp.pdf](http://www.opha.on.ca/ppres/2004-05_pp.pdf)

- Ontario Public Health Association. (2004). Resolution on physical punishment of children. Retrieved July 7, 2005 from [http://www.opha.on.ca/ppres/2004-05\\_pp.pdf](http://www.opha.on.ca/ppres/2004-05_pp.pdf)
- Ontario Public Health Association. (1997). Violence: A public health issue. Retrieved July 20, 2005 from [http://www.opha.on.ca/ppres/1997-01\\_res.pdf](http://www.opha.on.ca/ppres/1997-01_res.pdf)
- Palda, V.A., Guise, J.M., & Wathen, C.N. (2004). The Canadian Task force on preventative health care interventions to promote breastfeeding: Applying the evidence in clinical practice. *CMAJ*. 170(6), 976-78.
- Perinatal and Child Health Survey Consortium. (2003). *Breastfeeding practices in northern Ontario*. Retrieved July 8, 2005 from <http://www.tbdhu.com/reports/Nopchs/BREASTFEEDING%20FINAL.pdf>
- Program Training and Consultation Center of the Government of Ontario. (2003). Smoke-free homes: Steps to make your home smoke-free.
- Public Health Agency of Canada. (2002). *2002 Canadian sexually transmitted infections (STI) surveillance report: Pre-release*. Retrieved July 7, 2005 from [http://www.phac-aspc.gc.ca/stds/stdmsts/stddata\\_pre06\\_04/index.html](http://www.phac-aspc.gc.ca/stds/stdmsts/stddata_pre06_04/index.html)
- Public Health Agency of Canada. (2005). *Make every mother and child count: Report on maternal and child health in Canada*. Retrieved July, 2005 from [http://www.phac-aspc.gc.ca/rhs-ssg/whd05\\_e.html](http://www.phac-aspc.gc.ca/rhs-ssg/whd05_e.html)
- Public Health Goals Secretariat. (2005). *Public health goals for Canada: A federal, provincial and territorial commitment to Canadians*. Retrieved July 8, 2005 from <http://www.healthycanadians.ca/wrkbook-e.html>
- Raine, K.D. (2005). Determinants of healthy eating in Canada. *Canadian Journal of Public Health*, 96 Supplement 3, pp. S8-S14. Retrieved, July 2005 [www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/cjph\\_e.html](http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/cjph_e.html)
- Rogers, M.D. (2003). Risk analysis under uncertainty, the precautionary principle and the new EU chemicals strategy. *Reg. Toxicol. and Pharm.* 37, 370 – 381.
- Selevan, S.G., Kimmel, C.A., & Mendola, P. (2000). Identifying critical windows of exposure for children's health. *Environ Health Perspect.* 108(3), 451-455.
- Sieswerda, L.E. & Adalf, E.M. (2002). Student drug use in Northwestern Ontario: Results of the Northwestern Ontario student drug use survey. Thunder Bay District Health Unit: Thunder Bay, Ontario.
- Silkorsk, J., Renfrew, M.J., Pindoria, S. & Wade A. (2002). Support for breastfeeding mothers. *The Cochrane Database of Systematic Reviews*. Issue 1. Retrieved July 25, 2005 from [www.mrw.interscience.wiley.com/cochrane/cochrance\\_clsysrev\\_subjects\\_fs.html](http://www.mrw.interscience.wiley.com/cochrane/cochrance_clsysrev_subjects_fs.html)
- Stewart, M. (2001). The effectiveness of the health promoting schools approach and school-based health promotion interventions. *Public Health Research, Education and Development Program*. Effective Public Health Practice Project. Hamilton, Ontario. Retrieved July, 2005 from <http://www.city.hamilton.on.ca/phcs/EPHPP/EPHPPResearch.asp>

- Taylor, J.P., Evers, S. & McKenna, M. (2005). Determinants of healthy eating in children and youth. *Canadian Journal of Public Health*, 96 Supplement 3, pp.20-26. Retrieved, July 2005 from [www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/cjph\\_e.html](http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/cjph_e.html)
- Thomas, H., Boyle, M., Micucci, S., & Cocking, C. (2002). Community-based Interventions to improve child mental health: Review of reviews. *Public Health Research Education and Development Program*. Effective Public Health Practice Project, Hamilton, ON.
- Tjepkema, M. & Shields, M. (2005). *Canadian Community Health Survey: Overweight Canadian Children and Youth*. Statistics Canada: Ottawa.
- United States Environmental Protection Agency (USEPA), Office of Children's Health Protection. (2003). *Critical Periods in Development* - 48 pp. Paper Series on Children's Health and the Environment.
- United States Environmental Protection Agency (USEPA), Office of Children's Health Protection. (2003). *Overview of the Special Vulnerability and Health Problems of Children* - 39 pp. Paper Series on Children's Health and the Environment.
- Watt, S., Sword, W., Krueger, P., & Sheehan, D. (2002) A cross-sectional study of early identification of postpartum depression: Implications for primary care providers from the Ontario mother & infant survey. *BMC Family Practice*. 3(5), 1-7.
- Willms, J. D. (2002). *Vulnerable children*. The University of Alberni Press.
- World Health Organization. (1998). *Health promotion glossary*. Retrieved July 9, 2005 from [http://whqlibdoc.who.int/hq/1998/WHO\\_HPR\\_HEP\\_98.1.pdf](http://whqlibdoc.who.int/hq/1998/WHO_HPR_HEP_98.1.pdf)
- World Health Organization. (1995). *Global school health initiative*. Retrieved on July 26, 2005 from [http://www.who.int/school\\_youth\\_health/gshi/en/index.html](http://www.who.int/school_youth_health/gshi/en/index.html)

## **Resolution #1**

**WHEREAS** The Mandatory Health Programs and Services Guidelines for public health set as a goal “to increase the percentage of children and youth who meet physical, cognitive, communicative and psychosocial development milestones”; and

**WHEREAS** studies indicate many physical, social and environmental factors influence the health of children; and

**WHEREAS** studies have shown that by investing in sustainable, integrated and comprehensive child and youth health promotion programs and addressing determinants of health we can strengthen the health of children, youth and their families; and

**WHEREAS** the provincial accountability of services provided to children and youth are now distributed across three ministries, the Ministry of Health and Long-Term Care, Ministry of Children and Youth Services, and the new Ministry of Health Promotion; and

**WHEREAS** an integrated and comprehensive system of children and youth services including, health promotion, disease prevention and treatment services is necessary for the optimal benefit to individuals, families, groups and communities and Ontario’s future society;

**THEREFORE BE IT RESOLVED** that the OPHA take a strong advocacy position and write a letter to the relevant ministers within the government of Ontario and, in particular, the Chief Medical Officer of Health in order to establish an improved method of delivering the services related to the Family Health program standard of the Mandatory Health Programs and Services Guidelines for public health in Ontario.

**BE IT FURTHER RESOLVED** that the OPHA advocate for strengthening the role of public health in Family Health programs and services by the release of augmented Mandatory Health Programs and Services Guidelines.

### **Resolution #1 Implementation Plan:**

OPHA Child and Youth Health Workgroup in collaboration with other workgroups will plan meetings with the Chief Medical Officer of Health, Minister of Health and Long-Term Care, Minister of Children and Youth Services, Minister of Health Promotion and other ministries to discuss an integration plan.

OPHA Child and Youth Health Workgroup, in collaboration with others will prepare a letter to the Chief Medical Officer of Health presenting OPHA’s position on priority being given to updating the Family Health Program standard in the Mandatory Health Program and Services Guidelines.

OPHA Child and Youth Health Workgroup will distribute the *Child and Youth Health: Strengthening Inter-Ministerial Integration* position paper to the Ministry of Children and Youth Services, including regional offices, the Ministry of Health and Long-Term Care, Public Health



Division, all Ontario Public Health Units, the new Ontario Public Health Agency, Provincial Capacity Review Committee and others.

## **Resolution # 2**

**WHEREAS** the Mandatory Health Programs and Services Guidelines includes the *Healthy Babies, Healthy Children Program* in the Family Health Standard, but the Ministry of Children and Youth Services *Best Start Strategy* is absent; and

**WHEREAS** the Ministry of Children and Youth Services *Best Start Strategy* includes the *Healthy Babies, Healthy Children Program* as one component, but the Family Health programs and services in the Mandatory Health Programs and Services Guidelines is absent; and

**WHEREAS** The Mandatory Health Programs and Services Guidelines for public health set as a goal “to increase the percentage of children and youth who meet physical, cognitive, communicative and psychosocial development milestones”; and

**WHEREAS** studies indicate many physical, social and environmental factors influence the health of children; and

**WHEREAS** studies have shown that by investing in sustainable, integrated and comprehensive child and youth health promotion programs and addressing determinants of health we can strengthen the health of children, youth and their families; and

**WHEREAS** a significant number of Canadian children demonstrate behavioural problems, including emotional disorders and psychological disturbances which have a potential for lifelong consequences and approximately 19.1 percent Canadian children among aged 4-11 have one or more behavioural problems; and

**WHEREAS** one of the key factors that influence the development of behavioural problems is the parents’ style of parenting; and

**WHEREAS** coping skills, which allow an individual to deal with the challenges and stresses in their everyday lives, begin to develop early in life. As well how people deal with challenges can influence their vulnerability to cancer, cardiovascular disease, mental disorders, unintentional injuries, suicide, and other health problems; and

**WHEREAS** studies indicate the many benefits of breastfeeding including the prevention of chronic diseases, and cognitive development; and

**WHEREAS** studies on early identification and intervention of young children indicate more positive child health outcomes; and

**WHEREAS** Public Health provides nurse practitioner services in affiliation with public health practitioners in the provision of episodic care as well as prevention and promotion care to families with children and youth in many communities; and

**WHEREAS** Public Health is responsible to provide early identification services through the universal early intervention program, *Healthy Babies, Health Children* and is responsible to provide Family Health programs and the Early Childhood Development projects to promote the health of children, youth and their families; and

**WHEREAS** the Ministry of Children and Youth Services has provided direction for local communities to establish a *Best Start Strategy* and provides the policy for the *Healthy Babies, Health Children* program;

**THEREFORE BE IT RESOLVED** that the OPHA advocate for the Family Health Program Standard in the Public Health Mandatory Health Programs and Services Guidelines be a required component of the *Best Start Strategy*; and

**BE IT FURTHER RESOLVED** that the OPHA advocate for the inclusion of *Best Start Strategy* in the augmented Family Health standards Mandatory Health Program and Services Guidelines; and

**BE IT FURTHER RESOLVED** that the OPHA advocate for the inclusion of the goals for early childhood development projects in the augmented Family Health standards Mandatory Health Program and Services Guidelines; and

**BE IT FURTHER RESOLVED** that the OPHA advocate for strengthening the Mandatory Health Program and Services Guidelines in parenting, breastfeeding, attachment and environmental health that promote healthy child developmental successes; and

**BE IT FURTHER RESOLVED** that the OPHA advocate for Public Health to establish a formal link with the Family Health Teams and other primary care reform partnerships to strengthen the link in the early identification of children with developmental problems.

### **Resolution # 2 Implementation Strategy**

OPHA Child and Youth Health Workgroup in collaboration with others will plan meetings with Chief Medical Officer of Health and the Ministry of Children and Youth Services to support the inclusion of the Family Health Program Standard in the Best Start Strategy and for the inclusion of the Best Start Strategy in the Family Health Program Standard.

OPHA Child and Youth Health Workgroup in collaboration with others will plan meetings with the Chief Medical Officer of Health to request the inclusion of health promotion activities related to Early Childhood Development in the Family Health Standard in the Mandatory Health Program and Services Guidelines.

OPHA Child and Youth Health Workgroup in collaboration with others will plan meetings with the Minister of Health and long-Term Care, Chief Medical Officer of Health, the Primary Care Lead, and the Ministry of Children and Youth Services to support a formal arrangement between Public Health and Family Health Team Planners.

**Regarding Resolutions, Position Papers, and Motions:**

**Status:** Policy statements (resolutions, position papers, and motions) are categorized as:

**Active**, if:

1. The activities outlined in the policy statement's implementation plan have not yet been completed,
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

**Archived**, if:

1. The activities outlined in the policy statement's implementation plan have been completed, or
2. The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supercedes the latter.

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