Annual Report on Children 2001-2002

Prepared by the Premier's Council on Healthy Child Development

Prince Edward Island CANADA

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Our Vision

Children in Prince Edward Island will thrive in an atmosphere of love, care and understanding. They will be valued as individuals in childhood and will be given a sense of hope and pride in themselves and our Island, as well as opportunities to reach their full potential as adults.

Respected and protected, Island children will respect and protect the rights of others. Valued, nurtured and loved, they will grow up able to contribute to a society that appreciates literacy, diversity, supports the less able, and shares its resources.

Given the opportunity to develop their physical, creative, intellectual, emotional, social and spiritual capacity to the fullest, children in Prince Edward Island will become tomorrow’s successful and enthusiastic parents, caregivers, workers and citizens.

....For Our Children: A Strategy for Healthy Child Development
November 2000
Introduction

The Premier’s Council on Healthy Child Development was established by Premier Pat Binns in March 2001 as a demonstration of the provincial government’s commitment to the Healthy Child Development Strategy, a Prince Edward Island initiative focussing on children from the prenatal period to early school years.

Premier Binns first introduced council members to the community at the Healthy Child Development Planning Conference in Charlottetown. The council members are Islanders who collectively bring a wealth of experience and knowledge about children.

The council’s role is to advise the Premier on issues affecting young children in PEI. The council monitors the implementation of the Healthy Child Development Strategy by reviewing the indicators of child well-being and determining whether the strategy is reaching its goals for healthy child development. This Annual Report on Children 2001-2002 assists in fulfilling the council’s mandate.

This report consists of four main sections. First, a brief background of the Healthy Child Development Strategy and its implementation is provided. Second, highlights of child-related events and samples of child and family focussed initiatives that help achieve the goals of the Healthy Child Development Strategy are described. Following that, a section outlining indicators of child well-being will allow members of the council to monitor improvements in healthy child development over time. The report ends with detailed information on our investments through the federal/provincial/territorial Early Childhood Development Initiative.
Healthy Child Development Strategy

The goals of the Healthy Child Development Strategy are that all children in Prince Edward Island will:

- be safe and secure
- enjoy good health
- be successful at learning
- benefit from social belonging and responsibility

The Healthy Child Development Strategy belongs to all Islanders, since all Islanders have a role to play in helping children reach these goals. Government provides leadership, but the involvement of communities, businesses and families is needed to ensure its success.

The strategic model that guides this initiative outlines a vision for children and sets out statements of values, both of which were developed in consultation with Islanders. The strategy’s guiding principles and enabling conditions set the stage for all partners to use the strategic directions in addressing the key areas of action.

The strategy uses a continuous planning approach, based on evidence of how children develop and based on examples of good practice. Ongoing measuring and evaluation are key activities in understanding when and how a difference is being made in the lives of children.

Provincial government departments recognize their role in enhancing the ability of parents and communities to care for their children. The departments acknowledge that healthy child development is based on interrelationships between social and economic environments, which together allow healthy growth for our children. Departments work together to promote healthy development for Island children through the Children’s Secretariat.

The Children’s Secretariat includes five provincial government departments (Health and Social Services, Education, Office of the Attorney General, Community and Cultural Affairs, and Development and Technology) at the staff and deputy minister levels. The core staff of the secretariat is housed in the Department of Health and Social Services. The secretariat provides support to the Premier’s Council on Healthy Child Development and focuses on policy development and coordination for children from prenatal to eight years old.

The Children’s Working Group is a broad, intersectoral group that includes community representatives who focus on key areas of action, members of the Children’s Secretariat, and representatives of key sectors who are involved with children. The Children’s Working Group is a “network of networks” that links with individuals, organizations and coalitions who are working on behalf of young children and their families. The Children’s Working Group shares information and explores opportunities to share resources across networks. Members provide links to communities and bring varying perspectives to broad initiatives such as public education, research and building a continuum of programs and services for children. The Children’s Working Group also develops an annual action plan to identify priorities for activities designed to work toward the strategy’s goals.
The Premier’s Council is impressed with the range and scope of activities undertaken in 2001-2002 to promote healthy child development. It is the collective ownership of the strategy – involving community, business and volunteer sectors, parents and families — that ensures its success. During 2001-2002, Islanders came together in many venues to focus their thoughts and ideas on children. The following highlights some of these events and describes some of the recognition given to these collaborative efforts.

More than 100 representatives from community organizations and government attended the first Annual Children’s Think Tank held on November 19, 2001, in Charlottetown. Participants were asked to consider the Healthy Child Development Strategy, to identify priority directions for action and to build links and working relationships across networks.

Participants at the first Annual Think Tank recommended principles to guide the implementation of the Healthy Child Development Strategy:

- A Universal and Inclusive Approach
- Sustainability of Programming and Services
- Shared Leadership
- Prevention and Promotion

The Honourable Jeffrey E. Lantz, Minister of Education and Attorney General, launched the Healthy Child Development Web site during the Think Tank. It can be accessed at www.gov.pe.ca/hcd.

In the fall 2001 the Children’s Secretariat and the University of Prince Edward Island worked together to host Web-Based Early Childhood Development Discussions. This was done in collaboration with the University of Toronto and several leading early childhood development researchers who were invited to discuss their work and the future directions of their fields. Using Internet-based technology, these discussions were broadcast to various locations across Canada and provided viewers with an opportunity to respond through online communication.

The National Roundtable on Active School Communities, hosted by the Department of Community and Cultural Affairs, was held October 18-20, 2001, in Charlottetown. The event provided a unique opportunity for representatives from governments, communities and schools to come together to share successes, develop strategies and commit to action. Delegates represented three sectors (health, education, and recreation and sport) and came from every province and territory.

Roundtable participants agreed that:

- An active school community is one in which all citizens, including teachers, students, parents, administrators and community leaders, work together to create physical and social environments that support active, healthy lifestyles.
- An active school community will support a number of initiatives that encourage physical activity. These may take place in the home, the school or the community-at-large.
The Early Childhood Development Association released the research findings of the *Understanding the Early Years* project in November 2001. *Understanding the Early Years* (UEY) is a national research initiative funded by Human Resources Development Canada. The *Early Childhood Development in Prince Edward Island Report* describes children’s outcomes and explains them in terms of family and community factors. The research evidence will be used by communities to identify needs for local activities and services supporting families with young children. Governments will use this research to gain an understanding of the key influences and state of children’s well-being and to develop policies that best promote children’s well-being.

As part of the Quality and Pride in the Public Service conferences held annually in PEI, the Institute for Public Administration Canada presented the Cooperative Efforts – Public Service Excellence Award to the Healthy Child Development Advisory Committee in June 2001. The advisory committee developed the Healthy Child Development Strategy. The Cooperative Efforts award is presented to a group demonstrating cooperation, creativity and team spirit in the workplace.

The theme for 2001 Crime Prevention Week was *Think Community Safety! It Takes a Whole Community to Keep Us Safe!* Peaceful communities are essential for healthy child development and healthy child development is essential for peaceful communities. Children who get a good start are less likely to be involved in crime. Crime Prevention Week is intended to encourage people from all walks of life to get involved in activities that continue to promote crime prevention and community safety. Each year, the Premier’s Crime Prevention Awards Program recognizes individuals, organizations and businesses who are making significant contributions in this area. Continuing to protect Island children from crime will allow them the opportunity to live happy, healthy, productive lives.

Throughout the fall of 2001, a series of public consultations on family violence affirmed the work of the Premier’s Action Committee on Family Violence Prevention. The consultations revealed a shift in the public’s response to family violence and resulted in a greater understanding and awareness of family violence. Islanders expressed a desire to know more about what they could do to make our communities and our families safer. Most importantly, a commitment was made to work together to decrease the incidence of family violence.

The consultations highlighted that children must be a priority in order to break the cycle of violence, and that children who experience or witness family violence need support. The consultations repeatedly revealed that it is critical to provide timely support for children suffering from abuse. Exposure to family violence inhibits a child’s ability to trust, learn, develop and reach his or her full potential.

The PEI Literacy Alliance organized a carousel of family literacy activities at the Charlottetown Mall to celebrate Family Literacy Day with partners Frontier College Students for Literacy, UPEI and the Confederation Centre Children’s Library.

The carousel encouraged parents and children to watch or participate in activities that promote literacy and offered advice on activities that help children develop the ability to learn and a love reading. Family literacy kits containing tips for skill development, fun activities that promote literacy and low-cost ways to develop learning skills were distributed. Children took home bookmarks, posters, buttons, books and puppets. Approximately 150 parents and children attended.
The Early Childhood Development Association of PEI released *For Our Educators, A Study of the Early Childhood Education Sector*. This study addressed key challenges such as lack of fiscal resources, staff retention and recruitment, low wages and benefits and the limited access to education and continuing education opportunities. The report also provides strategic direction to guide the work of the association.

A review of age of school entry into the public school system was undertaken by the Department of Education. In recent years, there has been much debate about the optimal age of school entry for children, their families and the school system. Mounting evidence suggests that younger children may not be as developmentally ready as their older peers to learn in a classroom environment. Children are more likely to experience success if they are older upon entering school. Public consultations gave Islanders an opportunity to provide input.

A new *Child Protection Act* was introduced in the Legislature in December 2001 as a cornerstone of the Department of Health and Social Services' commitment to the health and well-being of children. One of the key elements of this act is to ensure child protection processes take into consideration the developmental timelines of children. Regulations to accompany the act have been developed in consultation with the health regions.

The *Dr. J.H. O'Hanley Award of Excellence* is presented annually to an individual or organization who has made exceptional contributions and has demonstrated outstanding dedication and loyal service to the care of children in PEI. The 2001 recipient of the award, Ms. Edna Peters, has worked for 36 years in PEI's hospital system.
The development of healthy children is the responsibility of everyone and is not limited to formal programs in which children are involved. Children benefit from informal interactions with their families, caregivers, coaches and teachers during everyday activities at rinks, libraries, parks and grocery stores.

The Premier’s Council would like to recognize the following initiatives, as a small sampling of the many government and community-based programs and services that impact PEI children and families, within our goals as identified in the Healthy Child Development Strategy.

**Goal:** All children in Prince Edward Island will be safe and secure.

*Children's basic needs for food, shelter, clothing and a safe physical environment will be met. Children will be protected from abuse, neglect, discrimination, exploitation and danger.*

Many Island schools are using the Bully Prevention Program which advocates for the prevention of bullying and anger management. Teachers attended workshops and *Un pas de plus* was translated for francophone and immersion teachers.

All schools in PEI participated in the initial training titled Positive Behaviour Intervention and Support. This is a process which focuses on fostering a safe and caring school environment to enhance student academic and social success. Several schools are now working on the development of a school code of conduct with a focus on positive support.

Thirty-four individuals are trained to carry out Child Car Seat Check-ups across PEI. These people represent many walks of life including Family Resource Centre staff, Public Health, Highway Safety/Access PEI, nurses, community volunteers, RCMP, City Police, the Co-Operators Insurance Company, and others from various health regions.

During 2001-2002, 400 child car seats were checked for proper installation during car seat clinics and roadside checks across PEI. In addition to car seat checks, the trained individuals responded to many phone calls over the year to help answer questions or concerns of Islanders.
Recognizing that the Sir Louis Henry Davies Law Courts Building in Charlottetown can be stressful for children, efforts have been made to ensure that the child victim/witness waiting areas in the Court House are more welcoming and supportive for children and their families. Toys and activities are provided for children to play with while waiting for court.

Family Law Services, a division of the Office of the Attorney General, follows a child-centred approach when dealing with families faced with legal issues. This initiative was established on the belief that the future of society depends on the well-being of its children. This new section brings together services and programs that have a direct effect on families’ and children’s well-being.

The Healthy Child Allowance was increased to $38 per month in 2001. This allowance enables children to enroll in community sporting, musical, arts and cultural activities. This supports recommendations in the Healthy Child Development Strategy around the importance of active children and the need to make these activities accessible to low-income families.

The PEI Tobacco Reduction Alliance (PETRA) is delivering a number of tobacco reduction programs. The Smoke-Free Vehicle decals, an important tool in reducing the number of children exposed to the harmful effects of second-hand tobacco smoke, continue to be distributed by Access PEI across the province. Smoke-Free Homes research in partnership between PETRA and UPEI continues to explore the process households use to make their homes smoke-free.

The Public Health Nursing program within the health regions continues to support women who are pregnant and/or new mothers who wish to quit smoking by providing access to a number of self-help programs provided by PETRA including Stopping When You Are Ready; Start Quit, Stay Quit; and How Not To Smoke.

The RCMP Hug-A-Tree and Survive Program is a search and rescue program targeted at children from kindergarten to the early school years. The program teaches children how not to become lost in the woods, what to do if they become lost, how not to come to harm and how they can help searchers find them.
Goal: All children in Prince Edward Island will enjoy good health.

Children will be as physically, emotionally and spiritually healthy as possible, with strong self-esteem, coping skills and enthusiasm.

A Diabetes Pediatric Follow-up Clinic (multi-disciplinary) was established in coordination with pediatricians at the Queen Elizabeth Hospital. This program provides quarterly follow-up for children and their families.

The Public Awareness Campaign Committee regarding Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) has been working hard to create awareness and promote prevention of FAS/FAE. Posters and brochures are available at Public Health Nursing Offices and Liquor Control Commission outlets throughout PEI.

The Breastfeeding Coalition is a broad-based provincial working group dedicated to the promotion of breastfeeding in Prince Edward Island. The coalition includes representatives from all regional health authorities across the province, community partners and the Department of Health and Social Services. The coalition provided training to public health nurses across the Island in order to increase their knowledge and skills in breastfeeding supports.

Lactation consultant services are available to patients, staff nurses and physicians for referral or consultations to support breastfeeding. The consultant offers prenatal and postnatal support and assistance in hospitals and communities across the Island.

Best Start completed its three-year pilot project in the Queen’s Health Region funded by the National Crime Prevention Centre. Best Start is an extensive screening, assessment and community-based home-visiting program for children from birth to three years and their parents. The program goals are to prevent child abuse and neglect, and to improve behavioural, learning and health outcomes for children. Partners included Queens Region Public Health Nursing and the CHANCES Family Resource Centre.

Oncology Services for Children has moved from the Cancer Treatment Centre to the Pediatric Unit of the Queen Elizabeth Hospital. The Pediatric Unit provides a supportive environment for children and families.

The PEI Association of Acadian and Francophone Women, in partnership with several other francophone community organizations, developed a self-esteem kit for Acadian and francophone children. The kit is available for sale to those who wish to purchase it for use in the classroom or at home.
The Patrick A. Gill Asthma Education Centre has a mandate to improve services to children and adults with asthma using a coordinated and consistent approach to asthma management. Through assessment, education and ongoing follow-up, clients are better able to manage their asthma. The Asthma Education Centre leads the Maritimes in positive outcomes for children with asthma such as decreased emergency room visits, decline in hospital admissions and fewer days missed from school.

The comprehensive approach to children’s mental health led by the Children’s Mental Health Coalition is now supported by two child psychiatrists in the province, as well as by the outreach child psychologist at the Isaac Walton Killam (IWK) Hospital through the use of video-conferencing.

In partnership with the Canadian Mental Health Association and Human Resources Development Canada, a pilot project is providing funding for eight in-home support workers working under the direction of the community health therapists.

Prevention and early intervention programs are also being implemented to improve mental health among all Island children.

Through increased participation in Assessment Courses, many teachers and school counselors have upgraded their knowledge and skill level in administering and interpreting various assessment tools that are used in the public education system. The bachelor level courses focus on academic assessment tools and graduate level assessment courses emphasize psycho-educational tools.

The Prenatal Psycho-social Assessment provides a province-wide integrated system for assessing women’s psycho-social health in the prenatal period. All pregnant women in PEI are to be assessed for psycho-social risk factors (e.g., smoking, stress, parenting, lack of finances, social support, family violence, and alcohol and drug use). The assessment tool, Ask Me! Identifying Stressors for Pregnant Women is available for use by care providers. Referral networks in each region are identified for use with this comprehensive assessment, to better respond to risk situations in a timely and integrated manner. The Prenatal Resource Directory was revised in January 2002 and new physicians in the province are provided with information about the assessment.

Movin’ to Salt Lake City was an exciting new active living initiative developed by the Heart and Stroke Foundation of Prince Edward Island, Go For Green and the Active Living Alliance of Prince Edward Island with honourary chairman, Dave “Eli” MacEachern, Olympic Gold Medalist. The initiative was an incentive program designed to promote and encourage physical activity among Island school children and is the beginning of the Active Healthy Schools Initiative. Children traveled one kilometre “closer to Salt Lake City” for every minute they were physically active. The program was available to all elementary and consolidated schools in PEI – approximately 12,000 children. The goal was to have all Island school children take part in 30 minutes of physical activity per day outside of regular physical education classes.
Recent research has indicated an increase in the prevalence of childhood obesity that is linked to a lack of physical activity. Habits established in childhood carry over to adulthood; therefore, encouraging physical activity in youth enhances future health by increasing the likelihood that they will remain active as adults.

The workshop **Achieving Healthy Weights in PEI Children: The Role of Physical Activity and Nutrition** provided Islanders an opportunity to meet with other people in the fields of health, education, recreation and sport and nutrition with similar interests and goals. The sessions focused on the factors that contribute to childhood obesity and provided information on children’s health behaviours and changing food patterns. Participants worked to develop a blueprint for a collaborative strategy to promote healthy weights in children in PEI.

The many partners involved, who are working together to improve the lifestyles of Island children, showed tremendous support for this initiative. The partners include PEI Active Living Alliance, Heart and Stroke Foundation of Prince Edward Island, University of Prince Edward Island, Queens Health Region, Department of Community and Cultural Affairs, Department of Health and Social Services, Department of Education and Dietitians of Canada.

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**Goal:** All children in Prince Edward Island will be successful at learning.

*Children will have opportunities to reach their potential for good physical and social development, artistic development, language, literacy, numeracy and general knowledge. Throughout their lives, they will have opportunities to learn so they can develop the skills and knowledge they need for a successful transition to adulthood.*

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**The Measuring and Improving Kid’s Environments (MIKE) program** is a two-year pilot project that commenced in August 2001. Coordinators have been hired to provide information, resources, training and support to 200 staff in 29 licensed child care centres. This information and support will increase the staff’s capacity to deliver inclusive, quality child care services to Island children. The MIKE pilot project is jointly managed by the Early Childhood Development Association of PEI and the Department of Health and Social Services. Project partners have implemented the MIKE pilot program to promote and support best practices of early childhood educators.

**Au service de la francisation** is a project developed by the Department of Education in collaboration with the *Fédération des parents de l’Î.-P.-É.* Sessions were offered to parents of preschoolers in each region, East Prince, West Prince and Queens, in introduction to computers and for the study of software. A software exhibition was also offered in each region to allow families to purchase French software. Kindergarten educators received a half-day of in-service.
Recommendations and lessons learned will soon be available from the three-year community/government pilot project Little Expressions Mean a Lot. This pilot focused on rural service delivery of speech language services to the 18-month to six-year-old population in Kings County. The project’s objectives were to establish a multi-disciplinary team approach to speech and language services, and to increase public awareness and community capacity around speech language intervention. This is a partnership of the Early Childhood Development Association of PEI, Southern and Eastern Kings Health regions, Carousel Family Resource Centre, Lend a Hand Family Resource Centre, health professionals, the Laubach Literary Society and parents.

Through the Education for Pregnant and Parenting Youth (EPPY) program, East Prince Public Health Nursing partnered with the Department of Education and others to establish a workshop on Family Literacy for pregnant and parenting youth.

In order to promote literacy in early school years, grades one to three teachers received training on early literacy assessment practices and all schools with grades one to three were provided with early literacy assessment tools. Supplementary reading materials aimed at supporting struggling readers were added to these classrooms as well.

The PEI Literacy Alliance sponsored the Summer Tutoring Program for Kids. As a result, 22 tutors were hired through the Summer Career Placement of HRDC to provide 10 weeks of one-on-one tutoring for 600 elementary-school-age children who were identified as having reading difficulties. Other partners included the Department of Education, the Community Development Bureau, school boards and libraries.

Two one-day workshops were developed and presented by the Literacy Initiatives Secretariat to pregnant and parenting youth in both Charlottetown and Summerside. The workshop, entitled Celebrating Our Children, featured an asset-based model of showing the young women how to increase literacy in their everyday activities.

Parents in the Evangeline region participated in a series of Workshops for French Families on various topics such as reading aloud, shared reading, playing with letters and words, language is the basis, writing, using reading and writing in everyday life and helping with homework.

The Community Development Bureau, housed within the Department of Development and Technology, works closely with PEI communities to help them bring their projects to realization. One such project is the Fort Augustus Community Heritage Park Project. A coalition of 13 service groups (including 4-H and Allied Youth) in the Fort Augustus area created a management committee to survey the students in the schools and kindergarten about activities they would like to see happen in their community.

Families and Schools Together (FAST) is an innovative two-year prevention and parent involvement program offered by the Catholic Family Services Bureau. The program helps children between five and nine years of age who have academic or behaviour problems. FAST gives parents and their children an opportunity to spend quality time together, enjoy one another and participate more fully and comfortably in their local community. The intention is to help children to succeed.
Project L.O.V.E. (Let Older Volunteers Educate) finds older or retired volunteers to help students in school with reading and other school skills. Volunteers work with elementary school students in over half of the schools in PEI. They typically volunteer one half-day per week and work with one student at a time, or with a small group of students.

All English elementary schools in the province are now involved in the beginning implementation of Reading Recovery, an effective early intervention program designed to reduce the number of children with literacy difficulties in schools through a series of individual lessons taught everyday in addition to classroom instruction.

**Goal:** All children in Prince Edward Island will benefit from social belonging and responsibility.

Young children will be helped to form stable attachments to nurturing adults, including strong supportive relationships within and outside their families. All children will be encouraged to develop an understanding of the rights and responsibilities of belonging to a wider community and to understand the personal and social consequences of their choices.

There is an increased emphasis on aboriginal education in early school curriculum. The Grade one social studies curriculum has been re-written and now includes learning and understanding about Aboriginal people and culture in Atlantic Canada. A list of available speakers has also been developed and distributed to support Island schools in understanding Aboriginal culture and spirituality.

The Department of Education has adopted a Special Education Policy. The policy supports a continuum of services to assist children with special educational needs in their learning and is based on a philosophy of inclusion.

Through the Department of Education’s ongoing kindergarten curriculum development and support, early childhood educators working in kindergarten received training on language arts and math curricula. The kindergarten consultants provided on-site support as well as group meetings for educators and owner-operators, both in English and French programs.

The Fédération des parents de l’Île-du-Prince-Édouard developed a guide entitled Guide de la mise sur pied de service de garde for establishing a francophone network of early childhood and daycare centres throughout the Island. These services were not available in any francophone region of PEI except Charlottetown.
The *Roots of Empathy* program has been introduced through trained facilitators who teach infant development and nurture the growth of empathy in students. Over a nine-month period, children have the opportunity to observe the baby’s development and to witness the parent-child relationship. The facilitator visits a classroom three times per month and a baby and family accompany the facilitator during one of these visits per month. The program brings messages of tolerance and diversity. It teaches emotional literacy, fosters a culture of caring and team building in the classroom and teaches children how to read and interpret a baby’s cues, to understand temperament and to take another’s perspective.

The *PEI Disability Support Program* is designed to improve access to disability supports, provide assistance with disability costs, and promote equitable access outside of income support programming. One of the three main components of the program focuses on child disability supports and early intervention. Enhanced assistance for children focuses on early intervention to help in overcoming barriers and to ensure that children with disabilities participate fully in PEI society. Available in all regions across the province, the program provides personal care support, early intervention therapy and support for preschool children with Autism Spectrum Disorders.

The departments of Health and Social Services and Education have developed an *Integrated Autism Strategy* to ensure human and financial resources are directed to support individuals with Autism Spectrum Disorder (ASD) and their families in a planned and organized manner. The provincial autism therapists work with parents, the PEI Autism Society, the medical community and other partners to provide early interventions for clients with ASD.

The treatment for ASD requires integration of a number of services including medical, family, preschool programs, training of in-home workers, parents and therapists such as speech and occupational therapy. Individual treatment plans are developed based on developmental curriculum. Teaching methods adhere to the applied behavioural analysis treatment model. Treatment plans are supported by staff and parental training, an autism intervention specialist and pediatric, psychological and therapeutic support services.

More than 20 training sessions were given to school staff, administration, Canadian Union of Public Sector Employees, and parents to support their work with children with ASD. Information packets, curriculum and assessment materials are now available for borrowing by schools and families interested in learning more about ASD and effective teaching strategies.
The Positive Parenting From Two Homes program is designed for parents who are separating or parenting from two homes and are concerned about their children getting caught in the middle of parental conflict. Some of the topics discussed at the sessions include: positive parenting, other people in children’s lives, children’s grief, what children need, and developmental ages and stages.

Each school year the RCMP connect with all schools in their own jurisdiction through the RCMP School Liaison Program. From elementary to high schools, each school is assigned a police officer who, during the year, attends classes, makes presentations and participates in school activities.

The events and initiatives described in the Highlights 2001-2002 and the Reaching Our Goals sections of this annual report are just a few examples of the many valuable activities, both formal and informal, taking place everyday for PEI children. All these activities help to improve outcomes for children.
“The early years of life are critical in the development and future well-being of the child, establishing the foundation for competence and coping skills that will affect learning, behaviour and health.”¹ But what constitutes a child’s well-being?

One of the commonly used approaches to define well-being incorporates a framework comprised of five “domains” of child well-being:

- **physical health and motor development** refers to the child’s general state of health and gross motor skills;
- **emotional health** refers to the child’s self-esteem, coping skills and overall emotional well-being;
- **social knowledge and competence** refers to the way children behave and are able to communicate feelings and wants;
- **cognitive learning** refers to the ways in which children perceive, organize and analyse information provided by their social and physical environment; and
- **language and communication** refer to the child’s ability to communicate.

As discussed in the previous sections, PEI’s Healthy Child Development Strategy focuses on four specific goal areas for children – safety and security, good health, success at learning, and social engagement and responsibility. In order to determine if the strategy is reaching those goals, we must understand which components, or “domains,” of child development indicate success in each of the goal areas. Once those “indicators” are identified, we must then begin to measure how children in PEI are doing on each of the indicator measures. The beginning measures will establish a baseline of information to allow monitoring of these indicators over the next number of years. The monitoring will determine whether progress is being made.

**What Influences Child Well-being?**

Children are shaped by the world around them, and many environments affect their development. It is generally accepted that “healthy children emerge most often from healthy families, and healthy families are in turn promoted by healthy communities.”² Understanding the key factors that influence child development can help society make choices that build more supportive environments for children and enhance their development.

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¹ First Ministers’ Communiqué on Early Childhood Development, September 2000
We believe that families are one of the most important influences on children’s well-being. Parents are the primary support for children and have a critical role in shaping how a child develops, both mentally and physically.

Each child is born with a particular set of characteristics inherited from their parents that can influence their well-being in all five domains. Genetic inheritance can provide protective as well as risk factors, whose impact can often be mediated by other environmental influences.

Families are shaped by the physical and community environments in which they live. Communities provide the basic infrastructure for family life including housing, education and employment. Physical surroundings can greatly affect children’s health and well-being, and research is beginning to provide evidence that growing up in a community that is perceived to have higher levels of cohesion, stability and social supports will lead to healthier child development.

How Can Child Well-being Be Measured?

While all aspects of child well-being and the factors that influence well-being cannot yet be measured, great progress has been made over the past years in expanding data collection in this area. One of the most important sources for information is the research data collected by the National Longitudinal Survey of Children and Youth (NLSCY), which is designed to enhance knowledge about children in Canada, and in particular young children. (See Appendix 2 for further information on the NLSCY.)

In addition to the NLSCY, there are other national sources of information on young children. In particular, the Vital Statistics registry is a valuable source of information on the physical health of young children. The Census is another source of information on young children and their families. Two postcensal surveys, the Participation and Activity Limitation Survey and the children’s component of the Aboriginal Peoples Survey are likely to be sources for information in the future.

The PEI Reproductive Care Program collects information and reports on both mothers and infants before (prenatal) and after (postnatal) birth. Additional indicator data, such as the number of children who are being breast-fed at the time they leave the hospital, are available through this program.

Also particular to PEI is the provincial data provided by the Understanding the Early Years research program. This program, coordinated by the Early Childhood Development Association of PEI, assesses child development in all five domains of child well-being. Kindergarten teachers use the Early Development Instrument (EDI) during the middle of the kindergarten year to measure children’s readiness to learn.

How Is PEI Reporting on Young Children’s Development?

For a number of years, provincial, territorial and federal governments across Canada have been working together, and with communities, to improve child well-being. Governments have recognized the importance of regularly monitoring and reporting on the status of young children’s well-being as a means of helping inform policy and building public awareness and understanding. In their September 2000 Communiqué on Early Childhood Development, First Ministers committed to “make regular public reports on outcome indicators of child well-being using an agreed-upon set of common indicators … related to the objectives established for early childhood development.”

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3 The first release of the Participation and Activity Limitation Survey is scheduled for December 2002.

4 Initial release of The Aboriginal People’s Survey is planned for September 2003. Phase I of the data collection was completed October to December 2001. Phase II is currently underway.
In determining which indicators to report on, governments tried to address all five of the domains of well-being in order to paint as complete a picture of child well-being as possible. Governments looked at which indicators were recognized both nationally and internationally as key indicators of child well-being, while remaining aware of what data was available at the national and provincial/territorial levels in Canada.

Considerations also included ensuring that the indicators were meaningful to the public, and would enhance knowledge of child well-being without duplicating reports that are currently being done by others (e.g. non-governmental organizations and researchers). Experts were consulted to ensure that the indicators selected were both meaningful and methodologically sound. We will also supplement this information with PEI-specific indicators, drawn from our own provincial data sources as described above.

The common indicators for reporting agreed to by provinces and territories are listed below:

1. Physical Health:
   - Pre-term Birth Rate
   - Healthy Birthweight
   - Immunization as Per Health Sector
   - Infant Mortality Rate
   - Breastfeeding

2. Safety and Security:
   - Injury Mortality Rate
   - Injury Hospitalization Rate

3. Early Development (includes social and emotional development):
   - Physical Health and Motor Development
   - Emotional Health
     - Emotional Problem/Anxiety
     - Hyperactivity
   - Social Knowledge and Competence
     - Physical Aggression, Conduct Behaviour
     - Pro-social Behaviour
     - Language Skills

4. Family-related Indicators:
   - Parental Education
   - Level of Income
   - Parental Health
     - Parental Depression
     - Tobacco Use During Pregnancy
   - Family Functioning
   - Positive Parenting
   - Reading by Adult

5. Community:
   - Neighbourhood Satisfaction, Safety and Cohesion
The PEI Healthy Child Development Strategy focuses on children from the prenatal period to early school years. At this time, reliable data (collected on a regular, consistent basis) is not readily available for children in these age groups. Data is typically reported for children from birth to five years of age and for six to 12 years of age. This report provides indicators of child well-being for the birth to five-year population (unless otherwise noted).

**Indicators – Premier’s Council Summary**

It is very encouraging to see that PEI children are faring quite well, for the most part, on par with Canadian rates. Specifically, note the following indicators presented in this report:

- The physical health of children in PEI is comparable to the health of children across Canada.
- PEI has a low incidence of low birth weight, but has a high incidence of high birth weight.
- Breastfeeding rates are lower than the national rates. However, the council does note that the prevalence of breastfeeding has been gradually improving over the last number of years, and notes the leadership provided by the PEI Breastfeeding Coalition, by the Prince County Hospital, and by family resource centres through their prenatal nutrition programs.
- PEI also demonstrates a low incidence of childhood diseases that are preventable through immunization. Council members have noted that a large percentage of children in PEI receive their immunizations, and applaud the efforts of parents and public health nurses in this area.
- PEI rates for hospitalization due to injury are similar to the national rates.
- The level of education of mothers is consistent with the national levels, but the rate for fathers without a high school diploma is higher than the national average.
- Families are functioning well and Island parents have good interactions with their children.
- A high proportion of Island children are read to daily by an adult.
- Parental depression levels are relatively low.
Physical Health

Healthy Birth Weight

The single greatest health concern during the prenatal stage of life is the prevention of low birth weight.

(National Council of Welfare, 1997)

We understand that low birth weight is associated with approximately 75 per cent of infant deaths, and is a leading underlying cause of illness in infancy and childhood.

Low birth weight can cause long-term disabilities, creating multiple needs for physiotherapy, speech therapy, specialized equipment, teaching specialists and other costly services. The Canadian Council on Children and Youth reports that the cost of caring for each low weight baby to the age of two years can reach $200,000.

It is clear that a healthy pregnancy contributes to the birth of a full-term infant, without complications, with desirable birth weights and with healthy brain development. Healthy women are more likely to deliver healthy babies. Some influences on the mother’s health are environmental, such as income level, nutrition, social supports, and safety at home and in the workplace.

A low rate of low birth weight babies is a good overall sign of newborn health. Among developed countries, a low birth weight rate of less than 5.0 per cent is considered good.

(OECD Health Data 2001 CD-ROM)

Other influences, however, are determined by lifestyle choices and include such behavioural variables as smoking, alcohol consumption, and use of prescription and non-prescription drugs. Good prenatal care is also a determinant in the birth of healthy babies, and includes components such as early and continuing assessment of the mother and fetus, health education and promotion, provision of medical, economic and psycho-social support when needed, and consistent followup.

High birth weight, however, can present a different set of risks for the newborn baby. With high birth weight babies, there is a greater potential for complications for both mother and baby during delivery. For the mother, longer labour and higher risk of trauma to the birth canal are potential consequences. Increased incidence of Cesarean sections, which have a set of risk factors, has also been associated with high birth weight.

For the baby, a high birth weight means that there is a greater risk of asphyxia, depressed skull fractures, hematomas and bleeding of the head. Injuries resulting from difficult shoulder deliveries include clavicular (collar bone) fractures and paralysis of the shoulder and face. Babies born of diabetic mothers are at greater risk for the future development of hypoglycemia. High birth weight babies may have poor motor skills and have more difficulty in regulating behavioural states. They may also tend to be more difficult to arouse, have feeding difficulties and may have problems maintaining a quiet alert state.
The reasons for high birth weight babies vary. Research has established that the best known condition is maternal diabetes; however, only a very small percentage of high birth weight babies are born to diabetic mothers. Other reasons associated with high birth weight are that larger mothers tend to have larger babies and women who have already had more than one pregnancy are more prone to having a baby over nine pounds, or 4,000 grams.

For both 1998 and 1999, PEI has a low birth weight rate similar to the Canadian average. However, the high birth weight rates for PEI are above the Canadian average.

Low birth weight is reported as the percentage of live births with a weight less than 2,500 grams (5 lbs, 8 oz).

The high birth weight rate is the percentage of live births with a weight greater than 4,000 grams (just under 9 lbs).

The data provided here is for 1998 and 1999 which presents the same time frame as the 1998/1999 NLSCY Cycle 3 data for many of the other child well-being indicators.

Low birth weight and high birth weight are two of the 11 common indicators and fulfil the Early Child Development communiqué reporting commitment.
In PEI, Public Health Nurses are responsible for childhood immunizations. Children receive their immunizations at two, four, six, 12, and 15 months of age.

Childhood immunization is measured here by the incidence (rate of new cases per year) of three childhood diseases that are preventable through adequate immunization programs: invasive meningococcal disease, measles and haemophilus influenza b (Hib).

i) Incidence of Meningococcal Disease
A new generation of very effective vaccines is now available against this disease that can be given to infants as young as two months of age. The National Advisory Committee on Immunization (NACI) recommends three doses of this vaccine at two, four and six months of age for routine immunization. Most cases of this disease occur in the 0 to 19-year age group, and immunization programs generally focus on this group. There is strong potential for significant reduction in incidence over time.

PEI, like most other Canadian jurisdictions, currently does not routinely provide this immunization per the NACI recommendations. PEI does provide it for individuals at increased risk of infection due to a splenectomy or equivalent immune deficiency.

ii) Incidence of Measles
The Pan-American Health Organization has adopted the goal of measles elimination as have all provinces and territories. Two doses of measles vaccine are required for complete protection; the first dose is given at 12 months and the second dose prior to school entry, at either 18 months or four to six years of age. PEI instituted an immunization program including the second dose for measles in 1997.

iii) Haemophilus Influenzae-b (invasive) (Hib) Disease
Invasive haemophilus influenzae b was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in children prior to the introduction of Hib vaccines. Vaccine preventable cases are now rare. Four doses of the vaccine are given in combination with diphtheria, pertussis, tetanus, and polio before the age of two years. PEI started the four-dose schedule for this vaccine in 1992.

Compared to the Canadian average, PEI has a very low incidence rate of these three childhood vaccine-preventable diseases. PEI had no cases of measles, invasive meningococcal disease or Hib disease in 1998 or 1999. In fact, PEI has had no cases of measles reported for children aged five and under in the 10-year period from 1990 to 1999 and only four reported cases of invasive haemophilus influenzae b in the same time period.

<table>
<thead>
<tr>
<th>Incidence rates of measles, invasive meningococcal disease and invasive Hib disease, 1998 &amp; 1999, per 100,000 children five years and under.</th>
<th>1998</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>PEI</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Invasive meningococcal disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>PEI</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Invasive Hib disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>PEI</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Source:** Division of Immunization and Respiratory Diseases, Health Canada
The incidence of invasive meningococcal disease is reported as the rate of new cases by year per 100,000 children five years and under.

The incidence of measles is reported as the rate of new cases reported by year per 100,000 children five years and under.

The incidence of Hib disease is reported as the rate of new cases reported by year per 100,000 children five years and under.

Immunization is one of the 11 common indicators and fulfills the Early Childhood Development communiqué reporting requirement.

Infant Mortality

The infant mortality rate is a long-established measure of child health as well as the well-being of a society. It reflects the effectiveness of medical care, preventive care and the attention paid to maternal and child health, as well as broader social factors such as maternal education, smoking and deprivation. Low birth weight in Canada is the principal cause of infant mortality. Among developed countries, an infant mortality rate of less than four per 1,000 is considered exceptionally good. Only Japan and Iceland had achieved such low rates by 1996.

Infant mortality is reported as the number of infants who die in the first year of life per 1,000 live births.

In 1998 and 1999, PEI had infant mortality rates that were somewhat higher than the Canadian average. This does not indicate a “problem,” nor is it reflective of a long-term trend. PEI’s small sample size means that an increase or decrease of a few cases can appear as large fluctuations from year to year above or below the national average and thus should be interpreted with caution.

PEI’s six-year average rate (1994 to 1999) of 5.7 per 1,000 was the same as the Canadian six-year average. Also, over the two previous decades to 1999, both the PEI and the national rates decreased considerably.

![Chart showing infant mortality rates for 1998 and 1999 in Canada and PEI.]

Source: Canadian Vital Statistics - Birth Database (Statistics Canada).
Exclusions: Births with unknown gestational age and gestational age less than 20 weeks; births to non-Canadian residents.

The data provided here is for 1998 and 1999 and presents the same time frame as the 1998/1999 NLSCY Cycle 3 data for many of the other child well-being indicators.

Infant mortality is one of the 11 common indicators and fulfills the Early Childhood Development communiqué reporting commitment.
Pre-term Birth Rate

Pre-term or premature births result when a baby is born before it is full-term. Pre-term births can result in respiratory problems for the infant, various infections and neurodevelopmental handicaps for the baby. Between 75 and 85 per cent of all prenatal mortality in Canada is a result of pre-term births.

The pre-term birth rate for PEI is similar to the Canadian average.

The pre-term birth rate is the percentage of live births with a gestational age at birth of less than 37 completed weeks (less than 259 days).

Source: Canadian Vital Statistics - Mortality, Summary List of Causes (Statistics Canada).

Exclusions: Births to non-Canadian residents.
Breastfeeding

Breastfeeding is an ideal source of nutrition for babies. Breast milk contains immunoglobulins and antibodies that fight infection and as a result, breastfed babies have less childhood illnesses such as respiratory infections, asthma, eczema, and food allergies. Breast milk protects babies from gastrointestinal and respiratory infections and middle ear infections (otitis media).

For mothers, breastfeeding is associated with reduced risk of postpartum bleeding, improved postpartum bone remineralization and a reduced risk of ovarian cancer. The act of breastfeeding itself encourages maternal-infant attachment and bonding which is important to the future relationship between mother and child.

The Canadian Pediatric Society, Dieticians of Canada and Health Canada recommend exclusive breastfeeding for at least the first four months of life and continuing breastfeeding and complementary foods for up to two years of age and beyond.5

A. Prevalence of Breastfeeding

In 1998-1999, the prevalence of breastfeeding reported for PEI was below the Canadian average.

The prevalence of breastfeeding is measured as the proportion of children from birth to age three who have ever been breastfed.

B. Duration of Breastfeeding
The World Health Organization and the Breastfeeding Committee of Canada recommends that breastfeeding six months or more is optimal. The rates of duration of breastfeeding reported for PEI are similar to the national rates. However, approximately only one-third breastfeed more than six months.

Duration of breastfeeding indicates the length of time that children from birth to age three were breastfed.

C. Breastfeeding at Discharge
Despite the lower rates of prevalence in breastfeeding in PEI, there has been a steady improvement in the rate. The time trend graph shows that since 1990, there has been a steady increase in the number of new mothers who breastfeed.

![Breastfeeding at discharge graph](image)
Safety and Security

Each year, injuries kill more children and youth over the age of one year than all other causes combined. For every injury-related death, there are 45 hospital admissions and an estimated 1,300 visits to emergency rooms across the country. Yet, it is estimated that more than 90 per cent of these injuries are predictable and preventable.

Health Canada reports that injuries from childhood falls cost Canadians $630 million every year. These are falls that can be prevented by redesigning the structure of playgrounds, targeting hazards in the home and by simply teaching children how to fall. If these types of prevention strategies reduce the incidence of falls by 20 per cent for children from birth to nine years of age, there would be 1,500 fewer hospitalizations, 13,000 less non-hospitalized injuries, and 54 fewer injuries leading to permanent disability. The net savings could total more than $126 million every year.

Injury rates, for children from birth to five years, that result in death or hospitalization are reported here as indicators of child safety and security. There are six types of injury: motor vehicle traffic crash (MVTC), falls, other unintentional injury, self-inflicted injury, assault and other injury not included in these categories.

In the area of safety and security, we are reporting on injury mortality rates and injury hospitalization rates.

A. Injury Mortality Rate

The injury mortality rates for PEI tend to be similar to the national rates. The exceptions are in 1998 when the motor vehicle traffic crashes (MVTC) and other unintentional injuries were well above the national rate.

When interpreting these results, it is important to note that because PEI has a very small population, the sample size for this indicator is very small. As a result, even small numbers of cases can cause the relatively large fluctuations/variations in the rates of reported data from year to year. For example, the 1998 MVTC rate of 9.8 per 100,000 is the result of one death and the 19.7 rate for other unintentional is a result of two deaths.

**Injury mortality rate is the proportion of children aged 0-5 years who die as a result of an injury.**

**Injury mortality is one of the 11 common indicators and fulfills the Early Child Development communiqué reporting commitment.**

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### Injury Mortality Rate for Children Age 0-5

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate per 100,000 age 0-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>MVTC</td>
<td>9.8</td>
</tr>
<tr>
<td>Falls</td>
<td>0.3</td>
</tr>
<tr>
<td>Other-Unnt</td>
<td>5.1</td>
</tr>
<tr>
<td>Self-Inflicted</td>
<td>19.7</td>
</tr>
<tr>
<td>Assault</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Source: Canadian Vital Statistics - Mortality Database (Statistics Canada).
Exclusions: Non-Canadian residents.
B. Injury Hospitalization Rate

The injury hospitalization rates tend to be similar to the national rates and there is not much variation from 1998 to 1999. It appears that falls and other unintentional injuries are the most common causes of hospitalization due to injuries for children from birth to five years of age in Canada and in PEI.

Injury hospitalization rate is the proportion of children from birth to five years of age who are hospitalized for treatment of injuries.

Source: This data is managed by Canadian Institute for Health Information (CIHI) - hospital records. However, it remains the property of the respective hospital.
### Early Development

The six indicators that follow provide some information on a variety of factors that reveal how developed a child is physically, emotionally, behaviourally and cognitively. Data from the NLSCY, Cycle 3 (1998-1999) is reported. The NLSCY data was collected in two ways: by direct assessment of the child and by surveying the Person Most Knowledgeable (PMK) which was usually the child’s parent or guardian.

Following this report on NLSCY data is a report on the findings from the research conducted in PEI using the Early Development Instrument (EDI) which reports on “readiness to learn” measures of five year olds a few months after entering a kindergarten program. The data is reported to provide additional early development information and is not meant to be compared with the NLSCY measures.

### A. Physical Health and Motor Development

#### i) Motor and Social Development

In the NLSCY, the Motor and Social Development scale consists of a set of 15 questions that measure dimensions of the motor, social and cognitive development of young children from birth through three years old; the questions vary by age of the child. The questions focused on motor skills, such as the ability of an infant to follow the movement of an object with his/her eyes or to sit up by him/herself. On the social development side, a question for an infant was, “Has he/she ever smiled at someone when that person talked to or smiled at him/her?” For a child closer to three years old, a question was, “Has he/she ever dressed him/herself without any help except for tying shoes?”

Motor and social development from the NLSCY is reported as the percentage of children from birth to three years of age who have delayed, average or advanced levels of development in these areas.

**Summary:** The vast majority of Island children from birth to three years of age had an average level of motor and social development. 12.4 per cent had delayed development. These results were similar to the Canadian average.
B. Emotional Health

Behaviour scales examined in the NLSCY are emotional problems/anxiety, hyperactivity-inattention, and physical aggression/conduct disorder. The purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child’s behaviour.

Emotional health indicators provide information on the rates of children aged two to five who exhibit these behaviours. Data was collected through the NLSCY survey, Cycle 3 (1998-1999) by surveying the person most knowledgeable (PMK) who was usually the child’s parent or guardian.

i) Emotional Problems/Anxiety
To measure emotional problems and/or anxiety, the PMK was asked how often the child seemed to be unhappy or depressed, worried, too fearful, nervous, or had trouble enjoying him/herself.

Emotional problems and/or anxiety measures from the NLSCY are reported as a percentage of children aged two to five who have “not high” or “high” levels of emotional problems and/or anxiety.

**Summary:** 14.1 per cent of Island children aged two to five years exhibited high levels of emotional problems and/or anxiety, similar to the Canadian average of 13.8 per cent.

*Emotional problems/anxiety is one of the 11 common indicators and fulfills the Early Child Development communiqué reporting commitment.*

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**Source:** NLSCY, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire.

**Exclusions:** Children living in the Territories; children living on reserve; children living in institutions.
ii) Hyperactivity – Inattention
To measure hyperactivity-inattention, the PMK was asked how often the child was restless, distractible, impulsive, could not concentrate, sit still or stick to any activity.

Hyperactivity-inattention measures from the NLSCY are reported as a percentage of children aged two to five who have “not high” or “high” levels of hyperactivity and/or inattention.

Summary: 14.2 per cent of Island children aged two to five years exhibited high levels of hyperactivity and/or inattention, similar to the Canadian average of 12.2 per cent.
iii) Physical Aggression/Conduct Disorder
To measure physical aggression and conduct disorder, the PMK was asked how often the child is defiant, has difficulty awaiting a turn in games or groups, has angry moods, kicks, bites or hits other children, and if punishment doesn’t change his/her behaviour.

Physical aggression/conduct disorder measures from the NLSCY are reported as a percentage of children aged two to five years who exhibited “not high” or “high” levels of physical aggression, opposition and/or conduct disorder.

Summary: 15.1 per cent of Island children aged two to five years exhibited high levels of physical aggression, opposition and/or conduct disorder, similar to the Canadian average of 13.5 per cent.
C. Social Knowledge and Competence

Social knowledge and competence indicators provide information on the rates of children aged two to five who exhibit prosocial behaviour. Data was collected through the NLSCY survey, Cycle 3 (1998-1999) by surveying the person most knowledgeable (PMK) who was usually the child’s parent or guardian and do not represent professionally diagnosed problem behaviours.

i) Prosocial Behaviour
To measure prosocial behaviour, the PMK was asked how often the child will help another child who is hurt, sick, having difficulty with a task, or comfort a child who is crying/upset.

Prosocial behaviour measures from the NLSCY are reported as a percentage of children aged two to five years who have “not low” or “low” levels of prosocial behaviours.

Summary: Seven per cent of Island children aged two to five years exhibited low levels of prosocial behaviour, below the Canadian average of 10.1 per cent.

Prosocial behaviour is one of the 11 common indicators and fulfills the Early Child Development communiqué reporting commitment.
D. Language Skills

Cognitive learning and communication indicators provide information on receptive and hearing vocabulary skills for children aged four and five years. Data was collected through the NLSCY, Cycle 3 (1998-1999) by directly assessing children using the Peabody Picture and Vocabulary Test – Revised (PPVT-R). The purpose of this test was to measure school readiness of the child.

The Peabody Picture Vocabulary Test – Revised (PPVT-R) measures an individual’s receptive vocabulary ability. It measures one facet of general intelligence: vocabulary. During this test, the examiner states a word and the child is shown a page with four line drawings. The examiner asks the child to point to the picture that matches the word.

Language skills measures from the NLSCY are reported as a percentage of children aged four and five years who had delayed, average and advanced receptive or hearing vocabulary skills per their score on the (PPVT-R).

Summary: The vast majority of Island children aged four and five years had average receptive or hearing vocabulary skills. 7.4 per cent were delayed, which is below the Canadian average of 15.9 per cent.

Exclusions: Children age 4-5 for whom the PMK did not provide consent for the PPVT-R to be administered, children living in the Territories; children living on reserve; children living in institutions.

Language skills is one of the 11 common indicators and fulfills the Early Child Development communiqué reporting commitment.
Readiness to learn – PEI results from the Early Development Instrument survey

In addition to the NLSCY developmental information provided in this Early Development section, findings from the Early Development Instrument (EDI) survey provide information on how “ready” five-year-old children were to learn at school, i.e., their ability to meet the task demands of school, such as being cooperative, sitting quietly and listening to the teacher, and to benefit from the educational activities that are provided at school. The best time to measure this is when the children are in kindergarten, the beginning of their school experience. The five EDI scales are: physical health and well-being; social competence; emotional health and maturity; language and cognitive development; and communication skills and general knowledge.

In 2000, the EDI was conducted as part of the Understanding the Early Years (UEY) study. The purpose was to collect developmental information, or “readiness to learn” measures on five year olds a few months after entering a kindergarten program. PEI was one of five UEY sites that conducted the EDI and is the only UEY site that has done this research on a province-wide scale. In PEI, the EDI was completed for 1,287 children. Across the five UEY sites, approximately 6,900 junior and senior kindergarten children were included in the EDI. The EDI survey was completed by kindergarten teachers who assessed each child’s readiness to learn.

While some of the measures appear to be similar to the NLSCY indicators, note that the survey methods, age groups and year of data collection are different; therefore, the results from the NLSCY and from the EDI should not be compared.

The EDI data is being reported here because it provides further information on the early development status of Island children by means of a province-wide survey that will be conducted in subsequent years for ongoing comparison.
A. Physical Health and Well-being

In PEI, the Early Development Instrument (EDI) survey was completed by kindergarten teachers to measure the physical health and well-being of their students. This was done as part of the Understanding the Early Years (UEY) study carried out in five sites across Canada. The characteristics measured were the child's motor skills, energy levels, fatigue, and clumsiness. For example, questions on the EDI included, “Is this child well coordinated?” or “How often is the child too tired to do school work?”

Summary: Almost 60 per cent of Island children in the EDI survey rated as very good or excellent with respect to their health and well-being.

The average health and well-being score for PEI (scores for children with special needs were not included in this average) was 8.9 out of a possible 10, which was the same average score for the five UEY sites across Canada.
B. Social Competence

In PEI, the Early Development Instrument (EDI) survey was completed by kindergarten teachers to measure the social competence of their students. This was done as part of the Understanding the Early Years (UEY) study carried out in five sites across Canada. Social competence measures self-confidence and tolerance, and identifies the child’s ability to get along with other children, accept responsibility for his/her own actions, and work independently. For example, a question on the EDI was, “Would you say that this child follows instructions?”

Summary: The distribution of Island children across the social competence ratings was quite even. Approximately 75 per cent of Island kindergarten children surveyed had OK to excellent social competence, while 25 per cent rated poorly or were identified as vulnerable.

The average social competence score for PEI (scores for children with special needs were not included in this average) was 8.4 out of a possible 10, which was the same average score for the five UEY sites across Canada.

<table>
<thead>
<tr>
<th>Social competence</th>
<th>Percentage of survey group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>26.7</td>
</tr>
<tr>
<td>Very Good</td>
<td>23.5</td>
</tr>
<tr>
<td>OK</td>
<td>15.3</td>
</tr>
<tr>
<td>Poor</td>
<td>10.1</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>10.1</td>
</tr>
</tbody>
</table>

These rates exclude the scores for children with documented special needs.
These rates include the scores for Francophone kindergarten children.
C. Emotional Health and Maturity

In PEI, the Early Development Instrument (EDI) survey was completed by kindergarten teachers to measure the emotional health and maturity of their students. This was done as part of the Understanding the Early Years (UEY) study carried out in five sites across Canada. Emotional health and maturity measures a child’s general emotional health and maturity, and identifies minor problems with aggression, restlessness, distractibility or inattentiveness, or excessive sadness on a regular basis. For example, a question on the EDI was, “Would you say that this child is upset when left by a caregiver?”

Summary: Three-quarters of Island children in the EDI survey rated OK or above with respect to their emotional health and maturity. Close to 25 per cent are doing poorly or are vulnerable.

The average emotional health and maturity score for PEI (scores for children with special needs were not included in this average) was eight out of a possible 10, which was similar to the average score of 7.9 for the five UEY sites across Canada.

These rates exclude the scores for children with documented special needs.
These rates include the scores of Francophone kindergarten children.
**D. Language and Cognitive Development**

In PEI, the Early Development Instrument (EDI) survey was completed by kindergarten teachers to measure the language and cognitive development of their students. This was done as part of the Understanding the Early Years (UEY) study carried out in five sites across Canada. Language and cognitive development measures mastery of the basics of reading and writing, interest in books, and numerical skills (e.g., recognizing numbers, counting). For example, teachers were asked to comment on the child’s use of language to communicate, his/her interest in books and his/her abilities related to reading and writing.

**Summary:** Three-quarters of Island children in the EDI survey rated OK or above with respect to their language and cognitive development. Almost 25 per cent are doing poorly or are vulnerable.

The average language and cognitive development score for PEI (scores for children with special needs were not included in this average) was 8.2 out of a possible 10, which was similar to the average score of 7.9 of the five UEY sites across Canada.
E. Communication and General Knowledge

In PEI, the Early Development Instrument (EDI) survey was completed by kindergarten teachers to measure the communication skills and general knowledge of their students. This was done as part of the Understanding the Early Years (UEY) study carried out in five sites across Canada. Communication skills and general knowledge measures the child’s general knowledge and his/her ability to articulate clearly, and to understand and communicate. For example, teachers were asked, “how would you rate this child’s ability to communicate his/her own needs in a way understandable to adults and peers, or how would you rate this child’s ability to understand on first try what is being said to him/her?”

Summary: The distribution of Island children in the survey across the communication skills and general knowledge ratings showed that approximately 70 per cent had good to excellent social competence. Almost 30 per cent rated poorly or were identified as vulnerable.

The average social competence score for PEI (scores for children with special needs were not included in this average) was 8.4 out of a possible 10, which was similar to the average score of 7.8 for the five UEY sites across Canada.
Family-related Indicators

Family-related indicators refer to those measures that reflect various aspects of parental health and behaviour. The health and behaviour of parents or guardians can exert a tremendous influence on the child’s own health and well-being. There are seven family-related indicators reported here: parental education, reading by adult, level of income, parental depression, tobacco use during pregnancy, family functioning and positive parenting. All of the data for the measures reported, except level of income, was gathered through the NLSCY survey.

It is important to note that the information collected through the NLSCY is self reported. In other words, the information is subjective based on the parents’ and guardians’ responses. For example, the information collected on parental depression does not reflect a clinical diagnosis of depression, but only the responses reported from the individuals interviewed themselves.

A. Parental Education

Parental education levels can impact children’s outcomes. Research indicates that a maternal education level is a factor influencing breastfeeding decisions – the higher the level of education, the greater likelihood of breastfeeding. Education levels can also impact employment opportunities available to the parents, which in turn influences income levels. Higher-educated parents may also place a higher importance on education for their children.

The level of education rates for PEI mothers of children five years of age and younger was similar to that of the Canadian average in 1998-1999, with almost half having graduated from a college or university program. The education level for Island fathers was lower than the Canadian average with respect to more Island fathers not completing high school and less Island fathers graduating from college or university.

Exclusions: Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster father; children living in the Territories; children living on reserve; children living in institutions.
i) Mother’s highest level of education is defined as the highest level of education attained by the mother of children from birth to five years of age.

ii) Father’s highest level of education is defined as the highest level of education attained by the father of children from birth to five years of age.

B. Level of Income

Income levels have a strong influence on the decisions parents are able to make for their children. Parents may struggle to provide nutritious meals or warm clothing for their children. Low income levels may impact the ability of parents to care for their children if they are struggling to cope with their economic situation.

Low income has been linked to an increased risk for low birth weights, an increased risk for boys to injury, an increased likelihood of parental depression and a decreased likelihood of breastfeeding. Children in low-income families are also less likely to be involved in organized recreational activities.

For both 1998 and 1999, more than one-quarter of Island children five years of age and under were living below the low income measure. These rates are similar to the Canadian average.

This indicator reflects the proportion of children five years of age and under living below the post-tax low-income measure (LIM). Post-tax LIM is a relative measure based on the median income in Canada. The LIM is equal to half or less of the median after-tax income (the total income after tax deductions at which half of families fall above and half of families fall below) adjusted for family size (number of adults and children). The LIM does not reflect geographic differences in living costs across Canada.
C. Parental Health – Depression

Parental depression has been identified as a risk factor for children’s outcomes as depression impacts the parents’ ability to provide for the well-being of their children. A parent’s ability to interact with or participate in learning activities with his or her child can be limited by depression. Children living with a depressed parent are more likely to have social, emotional or behavioural difficulties.

It appears that a low number of Island children five years of age and under live with a parent that exhibits high symptoms of depression. The rate for PEI was almost half that of the Canadian average.

Parental depression data is gathered from the NLSCY. The depression scale in the NLSCY represents a condensed version of the Depression Rating Scale (CES-D). This scale measures the occurrence and severity of symptoms associated with depression in the public at large and does not represent the occurrence of clinically diagnosed depression.

This indicator reflects the proportion of children aged 0-5 years whose Person Most Knowledgeable (PMK) exhibits high symptoms of depression.
D. Parental Health – Tobacco Use During Pregnancy

Maternal smoking during pregnancy is a major risk factor for low birth weight babies, both in terms of having a small baby delivered at full term and of having a premature birth.

In 1998-1999, more than one in five Island children under one year of age were born to mothers who smoked during pregnancy. This rate is similar to the Canadian average.

**Smoking during pregnancy reflects the proportion of children aged 0 to 1 years whose mother smoked during her pregnancy with the child.**

*Data was collected through the NLSCY survey from the person most knowledgeable (PMK) about the child if he/she was 0 to 1 years old.*


**E. Family Functioning**

Family functioning refers to the quality of relationships between family members. To collect data on family functioning, a parent (or the person most knowledgeable about the child) was asked questions such as, “Are you able to talk about your feelings with another family member?”

Data collected through the NLSCY indicates that children living in families with high levels of dysfunction have a 40 per cent greater chance of having behavioural difficulties than children living in homes with average functioning. Children from poorly functioning families may also have poor relationships with their peers.

This indicator reflects the proportion of children five years of age and under living in families with high levels of dysfunction. Almost eight per cent of Island families have been reported as having a high level of dysfunction. This rate is below the Canadian average.

Family functioning data was gathered from the NLSCY survey using the family functioning scale, which provided a global assessment of family functioning around things such as problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control. Overall, it indicates the quality of relationships between family members. The scale does not reflect clinical diagnoses.
F. Positive Parenting

The NLSCY measures positive parenting by looking at positive interactions between parent and child. Positive interactions influence the child’s success in future life. Parents were asked questions such as “How often do you praise your child?”, “How often do you talk and play with your child?” and “How often do you laugh together?”

High scores indicate a high degree of positive interaction. The chart to the right reflects the proportion of children five years and under whose parents scored low in the positive interaction measure.

Of Island children aged five years and under, 8.5 per cent experience a low level of interaction with their parent. The rate for PEI was below the national rate.

Positive parenting is the proportion of children whose parents or person most knowledgeable scored low on the positive parenting measurement.
G. Reading by Adult

A child’s experience in the preschool years sets the foundation for supporting future literacy development. Attitudes toward books and reading can be established at a very young age. Young children need many opportunities to interact in positive ways with parents and other role models.

Reading by adult refers to the exposure of the child to reading activities with a parent or another adult (and therefore should not be interpreted to refer specifically to parent-child interactions).

Almost 70 per cent of Island children aged two to five are read to or are able to read to an adult on a daily basis. This rate is above the Canadian average. Approximately only one in 10 children are read to multiple times in a day for both PEI and across Canada. One in five Island children are read to only a few times per week and this rate is below the national rate.

Reading by adult measures how often the child aged two to five is read to by an adult or how often an adult listens to the child read.
Community-related Indicators

This section focuses on the neighbourhood as not only a geographical unit, but as a dynamic environment that exerts many influences upon its residents, particularly children. There are many factors within a neighbourhood that can impact on a child’s health and well-being. Neighbourhood influences can be socio-economic as in the rate of lone-parent families or levels of financial support, physical as in cleanliness or the conditions of buildings, or psychological as in the cohesiveness of those living in the community or the sense of safety a child feels in the community.

A. Neighbourhood Satisfaction, Safety and Cohesion

Information from the NLSCY on neighbourhood cohesion is presented below as well as two indicators specific to PEI on socio-economic risks and physical conditions in PEI neighbourhoods.

i) Neighbourhood cohesion
Neighbourhood cohesion data was gathered from the NLSCY survey using the neighbourhood scale to assess the extent of the presence/absence of certain neighbourhood characteristics. An example would be the feelings expressed by a parent about the social unity/cohesion of the child’s neighbourhood.

This indicator reflects the proportion of children aged five and under whose neighbourhoods exhibit lower levels of cohesion.

Summary: The sense of low neighbourhood cohesion expressed by Island parents on the NLSCY survey is almost half the rate of that expressed in the Canadian average.
As part of the Understanding the Early Years research project that was conducted in PEI in 2000, a Community Mapping Study was carried out. This study gathered information about the physical and socio-economic characteristics of neighbourhoods where children aged six and under lived.

Neighbourhoods were defined based on the boundaries of Enumeration Areas (EAs). There are 267 EAs in PEI.

ii) Socio-economic risks of PEI neighbourhoods

A social index was created using the data from nine variables: unemployment rate, individual poverty rate, population aged 15 and over without high school diploma, proportion of lone-parent families, proportion of population speaking neither official language, rate of recent immigrants, annual mobility (transience), home ownership, and proportion of the total income in the neighbourhood received through government transfer payments.

This indicator reflects the number of risks associated in each neighbourhood. For 71 of the 267 neighbourhoods, inadequate data made it impossible to calculate a level of risk.

Summary: 56.2 per cent of neighbourhoods had four risks or less associated with it. Approximately 75 per cent of Island children aged six and under lived in these neighbourhoods. However, approximately one-quarter of children lived in the higher-risk neighbourhoods. These neighbourhoods tended to be in the urban areas of Charlottetown and Summerside with some scattered across the rural areas of the Island. Those neighbourhoods with seven or more risks were all located in Charlottetown or Summerside. No areas of PEI scored eight or nine risks.
iii) Physical rating of PEI neighbourhoods
A neighbourhood observation instrument was developed for researchers to collect data on several physical/environmental variables: traffic patterns, type of neighbourhood (rural, small town, urban), condition of buildings and roads, lighting, noise, overall safety, litter and the presence and condition of parks and playgrounds.

This data was put together to give an overall rating out of a possible 26 of the physical condition of each neighbourhood. The lower the score, the better the condition of the neighbourhood.

Summary: The vast majority of neighbourhoods scored relatively well on the quality of their physical conditions. It should be noted that no area of the Island scored higher than 20. There were areas throughout the rural and urban sections of the Island that scored very well.

Approximately 75 per cent of Island neighbourhoods received a score of 11 or less on a scale with possible scores ranging from six to 26. However, just over 10 per cent of the neighbourhoods were rated as having the least favourable conditions. Many of these areas contained a high proportion of children and had high numbers of potential socio-economic risk factors.
Conclusion

Prince Edward Islanders have a strong commitment to healthy child development, as is evidenced by the vast number of child-related activities that took place in 2001-2002. Most encouraging are the many partnerships that exist between organizations with similar goals and interests. We commend this work and encourage further collaboration and joint initiatives.

We were pleased to see that the PEI results are, for the most part, on par with the Canadian results. This is the first year of reporting on child well-being data and we look forward to having comparative data in future reports. This will help us to identify trends and progress in terms of improving child outcomes in PEI.

We are making progress in our efforts for the development of healthy children and families in PEI. It is the collective ownership of this strategy – involving community, business and volunteer sectors, as well as parents and families – that will ensure its continued success.
Appendix 1

Children’s Working Group

A number of community and government organizations have had representatives participate in Children’s Working Group events and activities. These organizations include:

- Association for Community Living
- Atlantic Network for Injury Prevention
- PEI Boys and Girls Club
- Cap enfants Family Resource Centre
- Carousel Family Resource Centre
- CHANCES Family Resource Centre
- Charlottetown City Police
- Community Mental Health
- Community Legal Information Association
- Early Childhood Care and Education – Holland College
- Early Childhood Development Association of PEI
- East Prince Health Region
- Eastern Kings Health Region
- Eastern School Board
- Evangeline Community Health Centre
- Four Neighbourhoods Community Health Centre
- French School Board
- Health Canada
- Heart and Stroke Foundation
- HRDC
- IODE
- Kids West Family Resource Centre
- Kids ’R First Family Resource Centre
- Kiwanis Club
- Société Saint-Thomas-d’Aquin
- Fédération des parents de l’Île-du-Prince-Édouard
- Laubach Literary Council
- Learning and Reading Partners
- Lend A Hand Family Resource Centre
- Mi’kmaq Family Resource Centre
- PEI Active Living Alliance
- PEI Association of Police Chiefs
- PEI Bike Helmet Coalition
- PEI Breastfeeding Coalition
- PEI Cancer Society
- PEI Council of the Disabled
- PEI Home and School Federation
- PEI Literacy Alliance
- PEI Literacy Secretariat
- PEI Lung Association
- PEI Multicultural Council
- PEI Native Council
- PEI Newcomers’ Association
- PEI Recreation and Facilities Association
- PEI Red Cross Society
- PEI Teacher’s Federation
- PEI Tobacco Reduction Alliance
- PEI Transition House Association
- Premier’s Action Committee on Family Violence Prevention
- Queens Health Region
- RCMP
- Richmond Centre
- Scouts Canada
- Southern Kings Community Health Centre
- Southern Kings Health Region
- Sport PEI
- St. John Ambulance
- University of Prince Edward Island
- West Prince Health Region
- Western School Board
National Longitudinal Study on Children and Youth

The National Longitudinal Study on Children and Youth (NLSCY) began to collect information about children and families in Canada during late 1994 and early 1995. At that time, researchers interviewed parents of about 23,000 children up to the age of 11. Parents (or the person most knowledgeable about the child) shared information not only about their children, but also about themselves and the children's families, schools and neighbourhoods.

The NLSCY revisits those children every two years. Data was collected in 1996-1997 and again in 1998-1999. Data that was collected in 2000-2001 is still being analysed; as we are nearing late 2002 and early 2003, researchers are preparing to interview parents (or person most knowledgeable about the child) again, for the fifth cycle of data on children and families. More than 800 Prince Edward Island children have been part of the NLSCY.

In keeping with a need for a greater understanding of learning and development in the early years, in addition to the ongoing interviews with parents of the original sample, more children aged five and under are being added to the sample.
Early Childhood Development Initiative

In September 2000, Prince Edward Island joined with other provinces and territories and the federal government in a commitment to support families and communities in their efforts to ensure that young children can fulfil their potential to be healthy, safe and secure, ready to learn and socially engaged and responsible. Through this Early Childhood Development Initiative (ECDI), the federal government has committed to an annual transfer of funding to provincial and territorial governments over a five-year period.

Funding received through the ECDI is intended to introduce, improve, and/or expand early childhood development programs and services. In Prince Edward Island, a range of programs already exists which supports early childhood development. The ECD Initiative provides an opportunity to strengthen existing programs and invest in new ones.

The First Ministers' Agreement on Early Childhood Development includes four key areas:

- healthy pregnancy, birth, and infancy
- early childhood development, learning, and care
- parenting and family supports
- community supports

In fiscal year 2001-2002, Prince Edward Island received $1.3 million for investments in early childhood development which were integrated with the provincial Healthy Child Development Strategy. Specifically, PEI made the following investments in 2001-2002:

**Early Childhood Development, Learning, and Care**
- Measuring and Improving Kids’ Environments (MIKE)
- Grants to early childhood centres to support children with special needs
- Publicly funded/community-based kindergarten

**Parenting and Family Supports**
- Disability supports for children from birth to age six
- Professional program support for home-based early intervention

**Community Supports**
- Healthy Child Development Strategy – nurturing a community development approach
Area of Investment:
Early Childhood Development, Learning, and Care

Measuring and Improving Kids’ Environments (MIKE)

The Measuring and Improving Kids’ Environments (MIKE) project provides program support, training, and development to early childhood centres across the province. A two year pilot initiative, MIKE commenced in August 2001 and will conclude its pilot phase in June 2003.

The first phase of the project (2001-2002) focused on licensed full-day early childhood centres providing inclusive programs for children with special needs. The second phase (2002-2003) will expand the project to include all licensed early childhood centres. As well, follow-up assessments will be carried out during the second phase, in order to measure the impact of the efforts to improve quality.

The project has provided an opportunity to begin to objectively measure quality in licensed centres, to target the supports needed to improve environments, and to be able to measure the impact of those supports.

Program Objectives
The goal of the MIKE program is to increase the levels of quality in licensed early childhood programs across PEI. In order to accomplish this goal, MIKE focuses on increasing the capacity of staff in early childhood centres to provide higher quality services for all children within their programs. This program promotes and supports best practices of early childhood educators in the delivery of inclusive and quality child care services to Island children.

Target Population
The first year of the program targeted half of the licensed full-day centres (in all regions); by the second year, all licensed full-day centres will be involved.

Department(s) Responsible
The Department of Health and Social Services provides funding for the project activities, supervision of consultants and liaisons with government and national initiatives.

The Early Childhood Development Association of PEI maintains communication with association members, administers the project and liaises with other early childhood initiatives in the community.

Program Indicators

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>Fiscal Year 2001-2002 – $50,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>The first phase of the project (2001-2002) focused on licensed full day early childhood centres providing inclusive programs for children with special needs. A total of 29 centres participated in the program.</td>
</tr>
<tr>
<td>Quality</td>
<td>Centre directors and staff were introduced to the ECERS-R assessment tool and invited to participate in the program. Staff of the MIKE program completed assessments and shared the results with directors and staff. Together, plans were developed to address areas that needed improvement and MIKE staff provided valuable advice and support as centres worked to improve the early childhood environment. During the second year of the program, improvements to quality will be measured as a result of the planned follow-up assessments with licensed centres.</td>
</tr>
</tbody>
</table>
Grants to Early Childhood Centres to Support Children With Special Needs

Special Needs Grants provide additional funding to licensed early child development centres in order to support inclusive programs for children with special needs. Typically, this funding is used to employ additional staff in order to lower the child-staff ratio at the centre, thus allowing all staff to be able to provide for extra/individualized programming for the child with special needs.

Program Goal and Objectives
The goal of the Special Needs Funding Program is to support the inclusion of children with special needs in licensed early child development settings. In order to reach this goal, the following objectives have been outlined:

- to support licensed centres with appropriate resources to provide individualized programs with quality early childhood education environments;
- to encourage communication among parents, centre staff, and other professionals involved in working with the child;
- to eliminate the need for parents of children with special needs to be income tested for eligibility for such additional services; and
- to provide for accountability on the part of licensed child development facilities for funded programs.

Target Population
Funding is provided on behalf of children with special needs who are attending licensed early childhood development centres. For the purpose of this grant, a child with special needs is defined as one who, in order to attain the usual development goals, requires additional and/or specific types of stimulation/care.

Children who would normally fall into this population include those with issues relating to: mobility, cognition, development delay, vision or hearing loss, speech, behavioural issues and children who have multiple disabilities.

Department Responsible
The Department of Health and Social Services is responsible for the administration of the Special Needs Grant program.

Program Indicators

Expenditures
In 2001-2002, a total of $867,000 was spent on this program. Of this total, $300,000 was invested using funds from the Early Childhood Development Initiative.

Availability
Funding was provided to 56 early childhood programs on behalf of 164 children and their families.

Accessibility
Funding to our target population has increased by 33 per cent.

Affordability
This grant is available to centres for children who meet the criteria. Parents are not income/needs tested for eligibility for these support services.
Publicly Funded, Community-Based Kindergarten

PEI’s community-based, publicly funded kindergarten was introduced in September 2000. As part of the early childhood system, kindergarten on PEI is privately owned and operated. Throughout the three-year implementation phase the provincial government, under the leadership of the Department of Education, will continue to develop curriculum and policy that reflects and supports their unique approach to kindergarten.

In 2001-2002, the second year of implementation of this program, additional investments were made as part of the Early Childhood Development Initiative.

Program Objectives
The goal is to fund a core community-based program, thus enabling more children to attend kindergarten and providing consistent curriculum for Island children.

Target Population
In 2001-2002, children who were five years of age as of January 31 of the current school year were eligible for kindergarten.

Department(s) Responsible
The Department of Education is responsible for the development and funding of a core kindergarten program. Kindergarten programs are licensed as early childhood centres according to PEI’s Child Care Facilities Act. The Minister of Health and Social Services is responsible for this act. The Department of Health and Social Services continues to be responsible for supports for children with special needs and certification of early childhood educators, while both departments share responsibility for licensing and program inspections.

Program Indicators

**Expenditures**
In 2001-2002, expenditures for the kindergarten program totaled $3.2 million. Of this amount, $500,000 was invested from the Early Childhood Development Initiative. Total expenditures during 2000-2001 were $2.5 million.

**Availability**
There were 91 community-based kindergarten sites during the 2001-2002 school year. A total of 1,697 children attended these programs.

**Accessibility**
Based on PEI’s birth rate, 97 per cent of children eligible for kindergarten are attending. Attendance increased 12 per cent the first year kindergarten was publicly funded and has remained constant.

**Affordability**
The Department of Education fully funds a core kindergarten program for all community kindergartens on PEI. During the second year, funding was increased to all kindergarten programs.
Area of Investment: Parenting and Family Supports

Disability Supports for Children From Birth to Age Six

The PEI Disability Support Program (DSP) is a social program with a financial component. Introduced in October 2001, the program is designed to assist Islanders (children and adults) who have a qualifying disability (physical, intellectual, neurological) to overcome barriers, to attain a satisfactory quality of life, and to strive to achieve financial independence. The program assists families with extraordinary child rearing needs directly related to the child’s disability and offers supports and referrals to other agencies where complimentary services may be obtained.

Within the overall structure of the DSP, supports are being offered for children from birth to six years of age and their families. The DSP may assist children with disabilities by offering support to them and their parent(s)/guardian(s).

Target Population
The DSP is available to all Islanders with a qualifying disability (described as a physical, neurological or intellectual disability) and who require disability-specific supports.

In 2001-2002, a total of 91 children from birth to six years of age and their families received supports from this program. In previous years, children and their families received varying levels of support from the Family Support Program. The DSP has broadened the scope of possible supports and the level of financial support.

Department(s) Responsible and Delivery Agents
The Department of Health and Social Services has full responsibility for this program and Disability Support Units are now in place in each health region. Disability Support Workers are specifically trained to work with children and adults with disabilities and their families. They work as partners with individuals and families to develop a support plan to meet disability-specific needs.

Program Indicators

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>$300,000 (for children from birth to age six years).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>91 children were assisted with this program.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>The Disability Support Program is designed to meet the unique needs of each individual or family. There is a broader range of disability supports available to preschool children, in particular for children with diagnosis of Tourette’s syndrome which was not supported in the previous program. There are also enhanced supports to pre-school children with the diagnosis of autism such as 20 hours of intensive behavioural intervention per week and intensive behavioural intervention program supplies.</td>
</tr>
</tbody>
</table>
Professional Training, Consultation, and Program Support for Home-based Early Intervention

During 2001-2002, the Department of Health and Social Services contracted the Bancroft Neurohealth Institute to provide training and support in the area of autism. Bancroft is a private, not-for-profit organization, serving people with disabilities since 1883. Bancroft is internationally recognized as a leader in special education, rehabilitation, evaluation and research. The CARES (Center for Autism Research and Education Services) program at Bancroft is a key resource in the continuum of services for people with autism.

Bancroft staff provided on-site training for parents, caregivers, and therapists in behaviour-based interventions. As well, Bancroft staff provided regular consultation to the Preschool Autism Consultant in the development of learning objectives for children diagnosed with Autism Spectrum Disorder.

Program Objectives
The goal of this time-limited project was to increase the capacity of Island professionals and parents in the development, supervision, and delivery of behaviour-based interventions for children diagnosed with autism spectrum disorder through hands-on training to the Autism Consultant, other therapists, in home staff, and family members.

Target Population
Departmental and regional staff, in home staff, and family members of children with autism ages birth to preschool.

Department Responsible
The Department of Health and Social Services contracted Bancroft Neuro Health Institute and coordinated training and consultation.

Program Indicators

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>$30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>This program increased the knowledge base and skill level of all participants.</td>
</tr>
</tbody>
</table>
Area of Investment: Community Supports

Healthy Child Development Strategy Community Development

The Healthy Child Development Strategy is a multi-departmental initiative focused on improving outcomes for children in Prince Edward Island. The strategy builds on the successes of programs, services, and community supports, and encourages partnerships between community, business, and government.

During provincial consultations prior to the launch of the strategy, Islanders emphasized the need for community involvement in the development of policy, programs and services for children and families. They stressed that the success of the strategy depends on community ownership. However, Islanders also reported that they wanted Government to provide leadership in this endeavour.

In order to ensure a role for community, the implementation of the Healthy Child Development Strategy is monitored by the Premier’s Council on Healthy Child Development. Council members are individuals from across PEI who represent a variety of experiences and backgrounds.

As well, the Children’s Working Group (CWG) is integral to the implementation of the goals and objectives of the Strategy’s Key Areas of Action. Members of the CWG include representatives chosen by the community, and government representatives from each of five provincial departments involved in the Healthy Child Development Strategy. These government representatives work together on the Children’s Secretariat.

The Early Childhood Development Association (ECDA) of PEI coordinates the Understanding the Early Years project for the province. The Children’s Secretariat has partnered with the ECDA on a joint workplan in order to promote community action in meeting the goals and objectives of the Healthy Child Development Strategy.

Program Objectives

Objectives for the community development work of the strategy include:

- strengthening and building on current partnerships;
- providing opportunities for discussion and networking for organizations, community groups and government departments;
- sharing information with communities across PEI; and
- encouraging community action for healthy child development.

Target Population

Efforts in community development have been directed to the following populations:

- community-based organizations working on behalf of young children and their families;
- parents;
- business;
- community and municipal leaders; and
- special populations, including francophone and aboriginal populations.
Department(s) Responsible
There are five provincial government departments involved with the Healthy Child Development Strategy. These include:

- Department of Health and Social Services (lead);
- Department of Education;
- Department of Community and Cultural Affairs;
- Department of Development and Technology; and
- Office of the Attorney General.

Program Indicators

**Expenditures**  $110,000

**Availability**  These efforts have supported events such as the Premier’s Council’s Think Tank, meetings of the Children’s Working Group, network meetings, provincial network conference, community meetings and presentations, etc.

**Quality**  In partnership with UEY, the community development efforts are being evaluated by Social Research Development Corporation.