

Acknowledgments

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Purpose

This policy brief seeks to provide guidance to decision makers, systems planners, and policy makers about ways to support infants, young children, and their families in light of the mental health needs emerging from or being worsened by the coronavirus (COVID-19) pandemic. It does so through an examination of the following research questions:

1. What are the mental health impacts of COVID-19 on new and expectant parents, infants, young children, and their families in Canada? In what ways do these impacts change across different population groups?
2. What are the risk and protective factors associated with resilience and positive mental health for new and expectant parents, infants, young children, and their families in the context of COVID-19?
3. What measures are being adopted in Canada to respond to the mental health needs of new and expectant parents, infants, young children, and their families? What measures ought to be amplified or changed?

Using a population mental health approach, the brief provides recommendations from a promotion and prevention lens that includes a strong focus on health equity and the social determinants of health.^{1,2} Since the full range of child-protection policies is beyond the current scope, issues of child maltreatment are mainly considered from a prevention perspective. In recognition of the increasing diversity of families in Canada, a *parent* will be taken to mean “anyone who is a primary caregiver for children, whether in a biological or other kind of relationship” (p. 5).³

Method

We conducted a rapid scan of the academic and grey literature between July and November 2020, drawing on findings from a previous Mental Health Commission of Canada (MHCC) COVID-19 response scan (April 2020)⁴ and scoping work conducted by the MHCC’s Early Childhood Mental Health team.^{5,*}

A first draft of our findings was circulated for comment to members of the MHCC’s expert advisory group on early childhood mental health, the Canadian Centre on Substance Use and Addiction, the Canadian Paediatric Society’s task forces on early years and on child and youth mental health, the Canadian Academy of Child and Adolescent Psychiatry’s executive and advocacy committees, and the Public Health Agency of Canada. The MHCC considered all such input in developing this policy brief.

Key messages

- **Successfully bolstering early childhood mental health and resilience is fundamentally about adequately funding and resourcing *people*, with attention to human resources and retention.** Areas of strategic investment include expanding universally available, high-quality, and culturally safe mental health and substance use services, as well as early childhood education (ECE) for diverse parent groups, infants, young children, and extended families.

* See Appendix A for details about our search strategy.

- **While there are many risk factors at play, there are reasons to be optimistic: increased social, emotional, and financial supports can strengthen resilience.** Providing communities, families, parents, and children with needed supports at the appropriate level of intensity can help to alleviate the mental health impacts of the pandemic. Such supports may also empower families and help to prevent understandable grief and suffering from becoming pathologized.
- **Parenting stress can be reduced through rapid, strategic investments that can help prevent adverse outcomes for child development, mental health, and families.** Areas of investment include flexible employment benefits, universal child care, peer-support programs, mental health first aid (MHFA), and digital early literacy interventions. An added emphasis is warranted on adaptation to rural and remote communities and on expansion of home visiting, perinatal interventions, and family-systems interventions.
- **Health equity, sex- and gender-based analysis (SGBA+), and intersectionality should guide areas of strategic investments and improvements in infrastructure.** Parents with young children have been particularly stressed by school closures during the pandemic, with a disproportionate impact on women. The pandemic is also compounding stressors for children, parents, families, and communities that experienced a greater social disadvantage prior to the pandemic, including racialized, Indigenous, single parent, low-income populations and those living with mental illness or developmental needs.*

Introduction

While the COVID-19 pandemic is having impacts on the mental health and well-being of the whole population, those on parents and families of infants and young children are unique and significant. This group has had to juggle multiple roles and responsibilities, often in the face of lost or reduced financial security, social support, and suspension or disruption in family routines, such as child care, schooling, and outdoor activities.⁶⁻⁸ Because too many stressors have combined with inadequate protective factors, opportunities for resilience and optimal child development have been impeded.^{9,10}

Amid COVID-19, 40 per cent of parents in Ontario are reporting behavioural-emotional challenges in their children.¹¹ Across the country, 61 per cent of parents are “very” or “extremely” concerned with managing their child’s behaviours, anxiety, emotions, and stress levels.¹² In the U.S., 33 per cent of parents are reporting an increase in their children’s “fussiness” or disruptive behaviours.¹³ A U.S.-based survey found that, for 53 per cent of women and 37 per cent of men, coronavirus-related stress was negatively affecting their mental health.¹⁴ In Canada, between May and September 2020, 10 per cent of respondents reported experiencing suicidal ideation since the onset of the pandemic (up from three per cent in 2016), with thoughts of suicide more common among parents and parents of young children (13 per cent).¹⁵ These rates may be even worse for children with pre-existing mental health conditions, which in British Columbia, could increase 10-fold from pre-COVID-19 levels.¹⁶

The pandemic is having an impact on parental mental health, particularly for women and in households with younger children. One example is an increase in the rates of maternal mental illness.¹⁷⁻¹⁹ Compared with the pre-COVID-19 period, maternal depression has increased from 10 per cent to 32 per cent for

* See Appendix B for an overview of recommended areas for strategic investments.

mothers of children 0-18 months; from 9 per cent to 42 per cent for mothers of children 18 months to 4 years old; and from nine per cent to 43 per cent for mothers of children 5 to 8 years old.²⁰ A poll conducted by the MHCC and the Canadian Centre on Substance Use and Addiction found that parents with children under 12 were more likely to report moderate to severe symptoms of anxiety than the general population (34 versus 26 per cent). Further, this increase in anxiety is paired with an increase in alcohol use. Parents who use alcohol in households with children under 12 were also more likely to report increased use than the general population (37 versus 30 per cent) and report problematic use (29 versus 22 per cent).²¹

These pandemic trends are concerning for each of the four reasons discussed below:

1. Positive child development, which promotes health, mental health, and social outcomes later in life, is critically reliant on quality relationships with parents.^{22,23} Attachment and social-emotional development are the building blocks needed to ensure that quality relationships are established and maintained. Yet, when parents have fewer resources available to help them cope — psychologically, financially, or socially — it can cause a breakdown in family relationships, something that occurs across diverse family populations and ethnic groups.²⁴⁻²⁷

Left unabated, too much parental stress* of the sort being experienced during the pandemic can become “toxic,” translating into behaviours that reduce parental responsiveness and enhance toxic stress.† Factors contributing to or resulting from toxic stress are known as adverse childhood experiences (ACEs),‡ which include parental alcohol and drug consumption, spousal conflict, intimate partner violence, parental separation, verbal and physical abuse, and neglect.²⁸⁻³⁴

Parenting stress at infancy also enhances the risk for mental illness in preschoolers.³⁵ For parents of children with developmental needs (e.g., autism spectrum disorder), such stress is associated with an elevated presence of pediatric sleep problems — a precursor to both child and parental mental illness.³⁶

2. Whether or not daycares and schools have reopened, discrepancies in access remain.³⁷ Though some population groups prefer child care through extended kin networks,^{38,39} early childhood education (ECE) improves parent-child relationships and resilience. For children of lower socio-economic status, ECE can reduce disparities in cognitive and linguistic development, promote school readiness, and increase academic and vocational achievement (as well as social outcomes later in life).⁴⁰⁻⁴⁵ Other gains associated with access to schools and ECE include increased social support, adherence to healthy routines and structures, and food security for low-income children.⁴⁶

* *Parental* and *parenting* stress are used interchangeably in this brief. Both refer to the distinct stress experienced by parents when their perception of the demands of parenting exceed their available resources. (See, e.g., “Parenting Stress,” by K. Deater-Deckard, N. Chen, and S. El Mallah, 2017, *Oxford Bibliographies Online*, para. 1. <https://doi.org/10.1093/OBO/9780199828340-0142>).

† According to the Harvard Center on the Developing Child’s [Toxic Stress](#) page, a toxic stress response “can occur when a child experiences strong, frequent, and/or prolonged adversity . . . without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years (para. 6).”

‡ For the purposes of this brief, ACEs are early life events that are stressful or traumatic, which mould or shape the health of children and families, with impacts that often transcend generations (see [Di Lemma et al.](#), 2019).

Yet ECE accessibility was already limited prior to COVID-19, through limitations in reach, affordability, and cultural appropriateness.⁴⁷⁻⁴⁹ Licensed centres, which are benchmarked to best practices and professional standards, provide better social-emotional development gains for children, they are unavailable for 75 to 80 per cent of people in Canada.⁵⁰⁻⁵² Moreover, significant gaps remain in early childhood workforce needs, including elevating salaries to meet or exceed two-thirds of salary levels for teachers.^{53,54} Prior to the pandemic, ECE access proved to be challenging for First Nations parents and for single, racialized mothers, especially in rural and remote areas.^{55,56}

When child care is culturally tailored to First Nations, through programs such as Aboriginal Head Start, it can further enhance development and promote linguistic mastery and knowledge of First Nations languages. Traditional teachings offered in child care can promote greater satisfaction with child-care and ECE services among First Nations parents. Limited reports suggest that single, First Nations mothers find public ECE and child care preferable to alternative arrangements.⁵⁷

During the first wave of the pandemic, disproportionate risks to child development across socio-economic, gendered, and racialized lines were amplified by inadequacies and disruptions in ECE and child care.⁵⁸⁻⁶⁰ For example, during school disruptions, parents with at least a bachelor's degree were more likely to engage in academic activities with their children three or more times a week, compared with parents with only a high school diploma (88 and 67 per cent, respectively).⁶¹

Disruptions and inequities in access to ECE may also be perpetuating traditional gender roles in families, especially when they are combined with the long-standing gaps in both paid parental leave and father-friendly mental health services. Although all parents are experiencing stress during the pandemic, the traditional gendered division of labour has left many women who have remained in the workforce balancing work and caring for children from home — a situation that has exacerbated stress and created mental health impacts for all parents.⁶²⁻⁶⁹

This confluence of forces may have also undermined women's workforce participation rates, which as of April 2020, fell to their lowest point (55 per cent) since May 1986.^{70,71} The current situation may compromise child development through deprivation of the resources needed for child safety and security, while at the same time limiting women's ability to experience upward social mobility to the benefit of their children, family, and society.⁷²⁻⁷⁴

3. There are many pre-existing issues in the availability, relevance, and quality of mental health services for early years populations and their parents.⁷⁵ Canada's child mental health services and supports are characterized and challenged by long wait-times and weak accountability mechanisms for public funding.⁷⁶⁻⁷⁸ Certain priority populations and parent groups continue to experience limited access to pre- and post-natal mental health services, telemedicine, telepsychology, and family therapy.⁷⁹⁻⁸²

These access issues exist in conjunction with rising emotional-behavioural issues — the single largest reason for referral to children's mental health services over the past three decades⁸³ — which indicate significant developmental vulnerabilities (precursors to child mental illness). As of 2014, on average 27.6 per cent of 5-year-olds had one (or more) emotional-behavioural issue (using slightly different time periods for each province and territory).⁸⁴ In addition, some reports indicate inadequacies in infant and early childhood health training among mental health practitioners.^{85,86} A

survey released during COVID-19 shows that 57.3 per cent of perinatal mental health practitioners do not receive specialized training in perinatal mood and anxiety disorders.⁸⁷ The confluence of community and family stressors now being experienced may further jeopardize parent and infant mental health and worsen the adequacy of services and supports.

4. Global health emergencies can considerably impact children's development, health, and mental health outcomes across the lifespan, even for well-resourced, well-educated families.⁸⁸ Quarantines imposed during previous infectious disease outbreaks, such as the 2003 SARS epidemic, provide one example. As a result of SARS quarantine measures, 28.9 per cent of adults (from a community sample) met the cut-off scores for post-traumatic stress disorder (PTSD).^{89,90} These impacts were also felt by quarantined children, whose risk of having PTSD symptoms was four times greater than that of non-quarantined children.^{91,92} The reach, duration, and impact of COVID-19, however, is much greater than any previous infectious disease outbreak or emergency.⁹³⁻⁹⁵

With these issues in mind, the brief identifies and explores key targets for intervention. It also makes recommendations about ways to offset negative mental health impacts, while fostering child, parent, and community resilience in the face of stress and uncertainty.

Considerations

In the first years of life, the brain grows a million new connections a second. It also triples in size from 0-6 years of age.⁹⁶ This period is also the single most plastic and yet vulnerable period of brain development in the life course.^{97,98} Children's emerging brain architecture is highly reliant on the nature and quality of relationships with their primary parents.⁹⁹⁻¹⁰¹ Quality relationships realized through [serve-and-return exchanges](#) provide children with the building blocks needed for secure attachment, emotional regulation, health, and well-being across the lifespan.^{102,103}

While the COVID-19 pandemic is an unprecedented global event, we know from previous economic downturns, recessions, natural disasters, and smaller-scale infectious disease outbreaks that such events can disrupt early brain development. These events often disrupt or alter parent-child and parent-infant relationships and interactions as well as parents' sensitivity to their infant's or child's needs.^{104,105} Chronic stress can also trigger the activation of genetic markers implicated in mental illness.^{106,107} These impacts are most pronounced if the stressful experiences are left unabated and/or happen during pregnancy and periods of rapid brain development. For instance, pregnant mothers exposed to the Quebec ice storms had elevated rates of the stress hormone cortisol, which translated into increased levels in their toddlers that was later associated with externalizing disorders in adolescence.^{108,109}

Why focus on parental stress?

While some impacts are brought about by a mother's biology, parenting stress also manifests itself psychologically and behaviourally. When a parent's stress is tolerable, parental coping strategies can model appropriate responses for children. Yet, when the situation becomes overwhelming, stress can negatively influence parents' cognitions, worsen coping strategies, and trigger mental health symptoms (e.g., depressive episodes).^{110,111} This confluence of factors can prevent secure attachment and decrease parents' sensitivity to their infant's or children's needs.^{112,113}

Understandably, parental stress is associated with perceived parenting stress and self-reported mental health problems and is specifically linked to generalized anxiety disorder and depression. These associations are most robust when parents spend more than 20 hours a week on child care or homeschooling.^{114,115} Beyond this threshold, parental stress can undermine children’s and parents’ mental health and resilience and diminish parents’ ability to care for themselves or be attentive to their children.¹¹⁶

Too much stress can translate into harsh and punitive parenting and child maltreatment, which stifles children’s development through hypervigilance to threat and by compromising a child’s sense of safety and capacity to self-regulate.^{117,118} Over the long term, child maltreatment increases the risk of emotional problems and mental illness across the lifespan.¹¹⁹ In the context of disasters, crises, and economic downturns (or some combination thereof), parenting stress may be triggered by financial pressure, alterations in family structures and routines, unequal or unsustainable parenting roles, mental health impacts, and the loss of social supports. Through these channels, stress originating from outside the family can disrupt child development within the family.^{120,121}

Consequently, parenting stress is a strategic priority for prevention and intervention, modified through supported and supportive parenting. It is crucial to restoring the human, social, and financial resources parents need to parent effectively and help families cope and bounce back from the shocks and adversities of COVID-19. Reducing parental stress starts by ensuring that families’ basic needs are met.¹²² Doing so is critical for preventing ACEs and for maintaining or reestablishing healthy spousal and parent-child relationships, parent and child mental health, and child development.^{123,124}

Interventions are especially important when children are in critical developmental periods, since compared with older children they are more strongly affected by too much parental stress and adversity. Such stress and adversity may combine with mental health histories, coping capacities, and parental skills and education.¹²⁵ For instance, compared with 7- to 11-year-old children, preschoolers that experience parental separation are at much greater risk for externalizing disorders in adolescence.¹²⁶

Despite current efforts to mitigate these risks, recent surveys indicate that more actions, from progressive social policy to mental health services and supports, are needed to offset or reduce current levels of parent and family stress. In the United States, 68 per cent of parents reported increased stress since the pandemic began.¹²⁷ During the summer of 2020, one-third of Canadian families reported very high or extreme anxiety about the family stress related to COVID-19 confinement. When extreme family stress was present, it was associated with a reduced likelihood to report better mental health.¹²⁸

Recommendation 1: Focus on parenting stress as a strategic priority for intervention.

Adopting sex, gender, and health-equity lenses

As with many social issues, the sources and severity of parental stress are not evenly distributed.¹²⁹ Parental stress exacerbates the social determinants of health and inequalities that existed prior to

COVID-19. For example, those living with multiple disadvantages across race, class, education, disability, and immigration status have been disproportionately affected by unemployment during the pandemic.¹³⁰⁻¹³² As of August 2020, the highest rates of unemployment in Canada were experienced by people of Arabic (17.9 per cent); African, Caribbean, and Black (ACB) (17.6 per cent); and Southeast Asian (16.6 per cent) ethnicity.¹³³ Unemployment rates of 10 per cent for First Nations, Inuit, and Métis (FNIM) prior to the pandemic rose to 16.6 per cent between March and May 2020.¹³⁴ In addition, 41 per cent of FNIM families reported “very high” or “extreme” concern about the impacts of quarantining on family stress, compared with 28 per cent for non-Indigenous families. Further, 47 per cent of FNIM women reported this concern, compared with the 33 per cent of men.¹³⁵

Similarly, among populations that use drugs, COVID-19 infection-control measures have worsened the opioid crisis, which hospitalized 16 people a day and killed 4,000 in 2018. British Columbia reported 183 opioid-related deaths in June 2020, compared with 76 in June 2019.¹³⁶ Although this crisis has been heightened by the increasing contamination and toxicity of the illegal drug supply (e.g., carfentanil),¹³⁷ COVID-19 infection control has caused disruptions in and losses of substance use services, such as harm reduction (e.g., safe consumption sites), opioid agonist therapies, and continued medication access (buprenorphine, methadone). Along with worsened drug toxicity (e.g., higher fentanyl concentrations), this situation has spurred drug overdose and relapse rates among pregnant and parenting mothers who use drugs.¹³⁸

As in previous infectious disease outbreaks, ethnically diverse communities are at a heightened risk of death, dying, and forced exposure to the coronavirus. Structural factors such as economic inequality, racism, discrimination, congregate housing, disruptions and inadequacies in health and social services, alongside a lack of access to green spaces, safe communities, and nutritious foods, increase these risks.¹³⁹⁻¹⁴¹ Such inequities are linked to greater risk factors, fewer protective factors, and potentially reduced resilience in the face of COVID-19.^{142,143} For parents, children, and families in these communities, COVID-19 threatens to augment and compound complex trauma, grief, loss, and suffering.¹⁴⁴

In other studies, women reported higher levels of fear of about contracting the virus and more difficulties with sleep, anxiety, nervousness, and sadness than men.^{145,146} Pregnant women are at a disproportionate risk for infection and complications from COVID-19. When combining these social and demographic factors, the psychological risks of COVID-19 increase in a cumulative and compounding fashion. For example, research shows that pregnant and/or parenting women, those closest to family stress, and/or those who have recently experienced a death in the family are most likely to experience severe mental distress. These demographic and psychosocial risk factors may combine with disruptions or impediments to health, mental health, and social-service access to worsen psychological risks.¹⁴⁷

For these reasons, efforts to reduce parental stress associated with the COVID-19 pandemic must employ a sex and gender as well as a health-equity lens. Doing so is imperative for examining and adopting policies and making strategic investments that can respond to the mental health needs of diverse parent and family populations affected by the pandemic.^{148,149}

Recommendation 2: Embed a sex- and gender-based analysis (SGBA+) and a health-equity lens in all policy, programs, and research pertaining to the mental health needs of the population age 0-6 and their parents.

What we know about parental stress and child mental health

Based on the available evidence, the following section discusses each major source of parental stress and the populations and parent groups that may be impacted the most.

Financial stress

Financial stress and economic insecurity not only affect mental health, they also alter parent-child relationships and parenting behaviours.¹⁵⁰⁻¹⁵³ The prevalence, severity, and distribution of early childhood mental illness also exists along a socio-economic gradient.^{154,155} A one-standard-deviation rise in financial insecurity is associated with an increased score of 0.41 on the General Health Questionnaire (a measure of anxiety),¹⁵⁶ and during previous economic downturns, unemployment has contributed to suicide risk.¹⁵⁷

Financial stress has been identified as one of the most frequent mental health stressors associated with COVID-19.¹⁵⁸⁻¹⁶⁰ During the pandemic, 38.2 per cent of mothers across North America have reported financial strain.¹⁶¹ As of October 2020, the number of individuals in Canada receiving employment insurance had tripled from its February pre-pandemic levels,¹⁶² and as of May, 14.6 per cent reported being food insecure, up from 10.5 per cent in 2017-18.¹⁶³ For those affected by food insecurity, 64 per cent said this disruption is affecting their connection with loved ones.¹⁶⁴ In the U.S., a recent study found that half of those lacking financial resources reported experiencing more parental stress,¹⁶⁵ while 22 per cent of parents reported issues related to purchases for basic needs.¹⁶⁶

While COVID-19 has touched the lives of everyone in Canada, low-income, FNIM, and immigrant and racialized families have been disproportionately affected.¹⁶⁷⁻¹⁶⁹ According to Statistics Canada data six months after the pandemic began, 35 per cent of racialized respondents said that COVID-19 was significantly affecting their ability to meet their financial obligations, compared with 22 per cent of White respondents.¹⁷⁰ Among FNIM respondents, 28 per cent said they had borrowed (or expected to borrow) money to cover basic needs, compared with 19 per cent of the general population.¹⁷¹ These diverse populations are overrepresented in industries hardest hit by the pandemic, as are women.

As of August 2020, the level of women's workforce participation was the lowest (55 per cent) since 1986.¹⁷² Paralleling past trends, financial stress has been especially acute for mothers across diverse family types.^{173,174} With inequities in pay and parental leave, mothers who are part of a couple are usually the first (and often the only) parent to take time off.^{175,176} While single mothers were three times more likely to live in poverty prior to the pandemic,¹⁷⁷ the economic recovery from COVID-19 to date has been worst for single mothers and mothers of children under 6.¹⁷⁸

It is striking that 37.5 per cent of single mothers with children under 12 lost their jobs or are working from home, compared with 25.5 per cent of mothers of two-parent families.¹⁷⁹ In April and May 2020, employment rates of single mothers hovered near 50 per cent, compared with a range of 67 to 69 per cent for mothers who were part of a couple.¹⁸⁰ Compared with other family types, single mothers of

children under 6 have experienced the worst recovery in terms of hours of work lost. For this group, rates were near 55 per cent in May, compared with 31 per cent for single mothers of children over 6. As of August 2020, economic recovery rates were down 37 per cent for single mothers with children under 6, compared with 15 per cent for single mothers of children over 6.¹⁸¹

Consequently, there is a significant need to provide ongoing financial support, especially for those now experiencing the worst economic insecurity and job loss. In particular, accessible child care is critical for supporting and maintaining workforce participation.^{182,183} These strategies are vital to alleviating sources of family distress and restoring effective parenting, child coping habits, and resilience.¹⁸⁴

Recommendation 3: Ensure the continuation of income support measures for all parents, with an emphasis on parent populations facing disproportionate economic impacts from the pandemic.

Housing stress and domestic violence

As extreme financial stress is related to precarious housing, homelessness, and increased susceptibility to COVID-19, affordable housing is needed to shelter and protect infants, children, and parents. Current reports indicate that women, girls, and gender-diverse people are at an increased risk of losing their households.^{185,186} International studies found that those experiencing homelessness during the first wave of the pandemic reported worsened physical and mental health.¹⁸⁷ For those with mental illness, a lack of housing is one of the chief barriers to accessing mental health services and continuity of care. In the Greater Toronto Area, referrals to victim services increased threefold during the first wave of the pandemic, indicating that a rapid expansion of shelters is critical to protect those fleeing domestic violence.^{188,189} Under Canada's National Housing Strategy, \$236.7 million is allocated to homelessness and the emergency response to COVID-19, while \$40 million is being provided to support shelters for women fleeing domestic violence.^{190,191} This funding appears to be a step in the right direction. Nevertheless, recurrent shortages in shelter beds and access to mental health and substance use services for these populations remain ongoing challenges.

Recommendation 4: Further expand and monitor access to housing and shelter for parents at risk of precarious housing, homelessness, and/or domestic violence.

Working and parenting at home

Following the first wave of the pandemic, the closure of schools and early learning centres compromised work-life balance; parents were now facing competing time demands between caregiving and work responsibilities.¹⁹² Just two per cent of children continued attending child care, and only nine per cent of study participants reported using child-care services during the first wave of shutdowns (as of July 29, 2020). Just prior to the fall, 49 per cent of parents felt reluctant to send their children back to school or child care due to the health of their child or a family member.¹⁹³ Yet, in June 2020, 74 per cent of

parents in Canada reported “very high” or “extreme” concern for their ability to balance child care, schooling, and work responsibilities. These concerns are especially high for parents of preschool and young school-aged children, at 70 and 80 per cent, respectively.¹⁹⁴

During this time, many families also reported reduced physical activity, lower sleep quality, and increased screen time — all of which pose risks for child development.^{195,196} Conversely, outdoor recreation and play are among the largest protective factors for population mental health and are especially beneficial for promoting the social-emotional and cognitive development of young children.^{197,198} Yet, only 4.8 per cent of children in Canada between 5 and 17 met physical activity guidelines during the first wave of COVID-19 lockdowns.¹⁹⁹

Recommendation 5: Provide guidance regarding screen time and physical activity for young children to parents who are working from home, and increase access to spaces for outdoor play.

Parental leave and remuneration policies

As with financial strain, higher parental stress is unevenly distributed by gender or socio-economic status. COVID-19 measures may have also interacted with social policies and norms to reinforce traditional caregiving roles — with mothers, young parents, parents of young children, and single parents absorbing the greatest burdens.²⁰⁰⁻²⁰³ Some reports indicate that households with the lowest income are experiencing the most parental stress or are juggling multiple roles and responsibilities.²⁰⁴

Recommendation 6: Strengthen income support and paid parental leave policies to promote more balanced gender roles and reduce parental stress.

Reduced social support

The pandemic is also impacting the nature and quality of spousal relationships and social supports. Community surveys have found that feelings of isolation and loneliness are on the rise in Canada. As of July 2020,

- 43 per cent of parents were reporting “very high” or “extremely high” concern about staying connected with friends and family²⁰⁵
- 37 per cent of parents were “very concerned” or “extremely concerned” with their ability to get along and support one another²⁰⁶
- 40 per cent of new mothers were reporting loneliness.^{207,*}

While various pockets of society are feeling more lonely, these experiences are especially acute for single parents and parents of young children.^{208,209} Previous research syntheses found that social support was also weaker for divorced and separated families, compared with two-parent families.²¹⁰

* Based on a survey of 31 pregnant and postpartum women.

One study found that older, higher-income mothers actually experienced significantly less social support than younger or lower-income mothers.²¹¹

Physical isolation is associated with increased family stress and adverse psychological outcomes, including a fourfold increase in post-traumatic stress symptoms in parents and children.^{212,213} Following patterns seen during previous disasters and emergencies, the loss or reduction of social supports may increase the impacts of community and societal traumas (such as living through a pandemic and widespread bereavement).

Degraded social supports can increase the risk for child maltreatment and domestic violence.^{214,215} Risks for these and other ACEs are worsened by the parental consumption of alcohol and other substances — which is on the rise during the pandemic.²¹⁶⁻²²⁰ Conversely, the increased involvement of extended family members during quarantine can reduce the risk of harsh approaches to parenting.^{221,222}

Previous disaster research found some cases of improved emotion sharing and bonding within families.²²³ Preliminary COVID-19 research in the summer of 2020 found that six in 10 parents were spending more time connecting with their children, and parents of young children were nearly twice as likely to spend time on artistic pursuits, compared with couples who had no children or were parents of youth.²²⁴

Nevertheless, these trends warrant close examination and monitoring. Recent scoping reviews on social isolation among parents of children under 5 found that little is known about these experiences for new and expectant fathers. A more thorough evaluation of public health actions to reduce the social isolation of parents of children ages 0-5 is needed.²²⁵

Recommendation 7: Rapidly expand social and community services and supports that foster social connection, with direct outreach to parents who are reporting high levels of social isolation or substance use.

Family breakdown and custody issues

An Ontario-based survey of 7,500 cohabiting and married parents in May 2020, found that 49 per cent were reporting high spousal conflict.²²⁶ Understandably, such high levels are a precursor to separation and divorce.²²⁷ During COVID-19, the presence of cumulative stressors may interact with divorce risks to impact family functioning.²²⁸ Marital issues and divorce contribute to risks for the emotional and social development of children, including child maltreatment, exposure to subsequent adversities, internalizing (e.g., depression, anxiety) and externalizing disorders (e.g., conduct disorders, substance use), and psychosocial problems.²²⁹⁻²³¹ Even before COVID-19, 1.19 million children in Canada under 18 had parents who were separated.²³² Given that the size and needs of this population are expected to grow during the pandemic, it is important to address the relative paucity of specific mental health services and supports available to them.²³³⁻²³⁵

For parents that do separate, meta-analyses and international consensus statements recommend equal, shared parenting to optimize children's chances of success and quality of life across a range of social, emotional, and behavioural outcomes.²³⁶⁻²³⁹ One study with African populations in Canada and younger

European mothers in Montreal also identified absent fathers as a significant life stressor.²⁴⁰ Yet, with the current configuration of family-law policies, sole-custody awards occur 82 per cent of the time, with shared custody most likely in jurisdictions that have undergone legislative reform.²⁴¹ In the absence of shared custody, 60 per cent of non-custodial parents see their children zero to three months a year.²⁴²

Throughout the pandemic, the Supreme Court of Canada has emphasized the need to maintain custody schedules, while respecting physical distancing measures.²⁴³ Family courts rapidly pivoted to video conferencing, requiring an “urgent” designation for matters to be heard, such as in cases where parents were demonstrably violating COVID-19 public health measures during custody hours.^{244,245} Despite these measures, there are reports of denied supervised and unsupervised visitations for non-custodial parents, increases in the removal of children from homes, and delays in family court hearings.²⁴⁶⁻²⁴⁸ Some reports indicate that rural and remote persons with little-to-no access to the internet were disadvantaged in the transition to virtual technology.²⁴⁹

Regarding child welfare, parent-child visits were temporarily suspended during the early part of the pandemic. As with child custody cases, virtual visitations were used in lieu of in-person visitations. While this shift to virtual technology aligned with COVID-19 public health measures, potential trade-offs and the consequences of these communication methods have not yet been evaluated. Most obviously, virtual communication prevents physical touch, which is key to parent-child bonding. Especially among young children and infants, the temporary suspension of in-person visits may have hampered opportunities for social and emotional development. Disruption of these services, if only temporarily, may have prevented necessary parenting-skills training and hindered the ability of some parents (i.e., who are involved in the child welfare system) to address their children’s developmental needs.²⁵⁰

As with other issues covered in this brief, disruptions in child custody and access to child welfare services may have disproportionately impacted families experiencing heightened social precarity. Prior to COVID-19, FNIM and racialized families were overrepresented in the child welfare system.^{251,252} Transitions to virtual services for child custody and child welfare may have disproportionately affected similar populations, including those who lack smartphones or internet access.^{253,254}

While issues of child maltreatment and abuse justify termination of the parent-child bond in some cases, disrupting these services may have a detrimental impact on promoting secure attachment and social-emotional development when it occurs during the sensitive period of rapid brain development. Further, father absenteeism may disproportionately impact boys, who model and learn their resilience skills and experience additional social, developmental, and academic gains from their fathers.²⁵⁵ Disruptions in access to parents may also have negative social-emotional impacts on infants and children in families overexposed to child welfare systems (e.g., family court, child protection). Greater attention to families affected by disrupted access to family court services and in-person child welfare visits is needed to promote optimal parent-child bonding and family reunification processes.

Recommendation 8: Rapidly expand services and supports for divorced or separated families, and review family-law provisions regarding shared custody.

Recommendation 9: Address SGBA+ and health-equity impacts on disrupted access to child custody, supervised visitations, and child-parent reunification processes.

Parental mental illness and children with developmental disabilities

Evidence suggests that higher rates of parental depression and anxiety are associated with increased caregiver burden and reduced parent-child closeness.²⁵⁶ Further, parental mental illness is one type of ACE than can disrupt child development.²⁵⁷ In part, this mechanism is thought to work through reduced caregiver sensitivity and fewer opportunities for serve-and-return exchanges.²⁵⁸ A recent systematic review found a robust association between maternal depression and insecure, disorganized attachment among preschoolers, which confers subsequent risks for mental health and social outcomes later on.²⁵⁹ Many drivers of parental mental illness are related to the sources of parental stress previously mentioned, including lower household income, financial strain, and low social support.^{260,261} Gender differences have also been detected, with parental mental illness associated with increased parent-child conflict for male parents, and reduced child-parent closeness for female parents.²⁶²

Parents of children with developmental needs may also be vulnerable to stresses stemming from the pandemic.²⁶³ During the first wave of COVID-19, the RAPID-EC research project in the U.S. compared rates of mental illness and stress between households with children under 5, with and without developmental disabilities. Across several domains, researchers found the following:²⁶⁴

- parental anxiety: household rates were 70.3 per cent in children under 5 with developmental difficulties versus 40.2 per cent without such difficulties
- parental depression: 64.4 per cent versus 27.3 per cent
- parental stress: 55.4 per cent versus 44.2 per cent
- child behavioural problems: 35.9 per cent versus 26.8 per cent
- child anxiety: 33.5 per cent versus 10.3 per cent

As of October 2020, a survey of parents of children living with developmental disabilities in Canada found that 60 per cent were concerned about their children's mental health, compared with 43 per cent of parents without that designation. Among these parents, 76 per cent were concerned about managing their children's anxiety and emotional state, compared with 57 per cent of parents of children without developmental disabilities. Their child's academic progress was also a concern for 58 per cent, compared with 36 per cent among those of children with no such disabilities.²⁶⁵

While these statistics signal mental health disparities,²⁶⁶ research prior to the pandemic found that mental health coverage for children with disabilities is highly fragmented. Long wait-times are common, as are issues with cultural safety.²⁶⁷ Researchers and policy makers are highlighting the fact that neuro-divergent children and their parents appear to be disproportionately affected by the closure, halting, and suspension of daycares, ECE centres, schools, and other services that support complex needs.^{268,269} Given these findings, further interventions are needed to reverse and rectify the entrenchment of inequities in the health and mental health of children with disabilities and their families.²⁷⁰

Recommendation 10: Provide targeted mental health services and supports to parents of young children, and foster increased collaboration and integration of mental health and developmental service providers.

Recommendation 11: Provide tailored outreach and parenting, social, and mental health supports for parents of children living with developmental needs.

Options for Promotion and Prevention

While the risks appear great, we can respond to and diminish parental stress by attending to the social determinants of health. By overlaying social determinants with the prevalent factors linked to child maltreatment, family violence, and other ACEs, we can shape and refine adequate policy responses. Improving the resources families have at their disposal can reverse the course of epigenetic changes, protect child development, and foster resilience. We must also conduct research and support all parents, as well as co-parent and child-parent relationships, across diverse families in Canada. By examining these parts of a “family system,” with an eye to SGBA+ and health equity, we can identify, monitor, and create opportunities for improvement in the programs, policies, and services offered.

We can best achieve these goals by means of a population health framework: through mental health promotion and mental illness prevention. According to the World Health Organization, “prevention is concerned with avoiding disease while promotion is about improving health and well being” (p. 9).²⁷¹ In this brief, options for mental health promotion and primary (or universal) mental illness prevention are focused on strengthening protective factors and reducing risk factors for all parents and families with children 0-6. Options for secondary (selected) prevention and early intervention are focused on targeted interventions to reduce risk factors for those at high risk of developing a mental health problem or illness and to provide timely access to services and supports when problems first emerge.

Mental health promotion and mental illness prevention for all

Social support and general wellness

Social support is one kind of “human capital” that helps individuals and communities bounce back from stress and adversity. Studies have found that such support in families and the community can offset the risks of low birth weight and early adversity to improve children’s social-emotional and cognitive development.²⁷²⁻²⁷⁵ Sibling relationships can also protect against parenting stress and spousal conflict.²⁷⁶

For mothers of children 0-18 months, quality spousal relationships may protect children and child-parent relationships against maternal depression.²⁷⁷ Social supports such as family and community relationships can mitigate the effects of parenting stress, substance use, depression, and post-traumatic stress, while also improving parenting behaviours.²⁷⁸⁻²⁸¹ In February and March 2020, during the COVID-19 stay-at-home orders in the U.S., the size and availability of social-support networks were associated with reduced symptoms of depression and generalized anxiety disorder in adults.²⁸²

Consequently, creating opportunities to build closeness, such as through shared family activities that respect physical distancing measures, remains a critical protective function.²⁸³ Finding innovative ways to stay connected is vital during this challenging time, as is the maintenance of serve-and-return exchanges between parents and their children.²⁸⁴ Cross-sectional surveys have found that cultivating partner emotional support and using virtual communication are integral to fostering resilience for pregnant and parenting women.²⁸⁵ Other forms of resilience-building activities for this population include encouraging physical activity, eating healthy foods, spending time outdoors, fostering gratitude, and adhering to routines and schedules.^{286,287}

Improving access to green spaces, parks, and recreational activities in the community is especially critical to limiting the impacts of increased screen time and disrupted ECE access for socially disadvantaged communities. To this end, working with public health officials to promote green-space access and reallocate roadways to accommodate outdoor activity and safe physical distancing is vital.²⁸⁸

Among diverse communities, some ACB women and mothers have more extensive psychosocial networks that protect their mental health against economic and racialized marginalization, and they report lower rates of mental health service use. However, these differences may be partially attributed to a cultural stigma and systemic barriers toward seeking help.²⁸⁹⁻²⁹¹ Race-based data on social connectedness and mental health during COVID-19 remains absent.²⁹² Further examination and monitoring of changes in social connectedness for parents of children under 6, across racialized and ethnic groups, are needed.

Spirituality and religion

Although many factors impact the therapeutic potential of spirituality on mental health, spiritual practices may buffer psychosocial stress and promote post-traumatic growth and resilience among diverse communities.²⁹³⁻²⁹⁸ Spiritual practices, such as prayers, rituals, and expressive arts, promote empowerment and autonomy in an otherwise uncertain and unknowable circumstance. Spirituality can prevent psychiatric sequelae from translating into clinically significant symptoms and promote self-care of persons with pre-existing conditions. For example, randomized control trials on Eastern philosophical practices, such as Buddhism's Eightfold Path, have shown decreased stress, improved immune response, and reduced anxiety among older adults.^{299,300} U.K.-based research comparing psychiatric service users found greater levels of anxiety and psychotropic medication use among participants not engaged in spiritual practices.³⁰¹

Spiritual practices have also been associated with improved life satisfaction and reduced hospital stays.³⁰²⁻³⁰⁴ In this sense, spirituality has a role to play in reducing the need and demand on more formal mental health services.³⁰⁵ Previous research has found that churches and religious practices can reduce the impacts of father absenteeism and lacklustre income support.³⁰⁶

Consequently, spiritual and religious practices and centres may serve an important function in mitigating the mental health impacts of COVID-19 on families and communities. While spirituality and spiritual practices are well-poised to attend to grief, suffering, and loss in harmonious, adaptive ways, developmentally and culturally appropriate forms of grief are also needed to foster post-traumatic growth and resilience for diverse children and parents.^{307,308}

Mental health first aid and peer support

Within the current environment, there is an opportunity to increase and improve access to mental health first aid (MHFA) and peer support.³⁰⁹ Previous meta-analyses have found that MHFA programs reduce participants' negative attitudes and improve mental health literacy, knowledge, and supportive behaviours toward those with lived and living experience of mental health problems and illnesses.^{310,311} Once adapted to a digital format, the MHCC's MHFA Caring for Others program was delivered to 3,142 participants between April and October 2020.³¹²

While the exact use and benefit of virtual peer support during COVID-19 is yet to be determined, Mental Health America said these services were especially critical for helping children, youth, and parents cope with traumatic stress reactions, as well as supporting them in screening for burnout and providing a conduit to more formal services and supports.³¹³ Meta-analyses have found that internet-based peer-support interventions provide a sense of community and emotional support for mothers while promoting fathers' transition to parenthood.³¹⁴ Further, during the COVID-19 crisis in China, peer-support interventions reduced harms associated with perinatal depression among women and served as a cost-saving measure during the temporary suspension of mental health services.³¹⁵

Recommendation 12: Expand access to mental health first aid and peer-support interventions for diverse parent populations and their 0-6-year-olds.

High-quality early childhood education

As early literacy promotes school readiness; confers long-term social, academic, and mental health benefits; and bridges the multimillion word and vocalization gaps of low-income, socially disadvantaged children, there is an ethical imperative to reimagine early learning solutions.³¹⁶⁻³¹⁸

Building on previous federal, provincial, and territorial agreements already codified through the Multilateral Early Learning and Child Care Framework, the federal government provided an unprecedented increase totalling \$1.2 billion in child-care supports for 2020-21 — 67 per cent more than the largest previous annual investment, made in 2005-06.³¹⁹ This investment preceded the September 2020 speech from the throne, and garnered bipartisan, business, and community support for sustained, long-term investments in Canada's child-care and early learning infrastructure — investments that could generate an estimated \$45 to \$90 billion per year through women's increased workforce participation and the post-COVID-19 recovery.³²⁰

Using part of these funds to make strategic investments in innovative public-health approaches to early learning curriculums and education, such as through digital modalities, is critical. Tailored solutions will be especially vital for rural, remote, northern, and FNIM communities, which have been particularly sensitive to the disruptions or losses of ECE supports during the pandemic,³²¹ although they will need to ensure opportunities to transmit cultural knowledge. This tailoring is a current area of intense focus and investment for the Canadian Children's Literacy Foundation.* In cases where extended kinship networks

* A. Siller, personal communication, Sept. 25, 2020.

are preferred, adequate financial, social, and economic resources will also need to be made available to family members who are providing care.³²²⁻³²⁴

Recommendation 13: Earmark funding from the 2020-21 Multilateral Early Learning and Child Care Framework to fund the expansion of evidence-based, innovative digital early learning solutions, especially for rural, remote, northern, and FNIM communities.

Gender equity in parenting and employment

COVID-19 has accelerated the need to adopt evidence-based public policies that support optimal child development. Many of these measures were endorsed by major international and Canadian declarations prior to the pandemic, including the UN *Convention on the Rights of the Child*,³²⁵ and the World Association for Infant Mental Health’s position paper on the rights of the infant.³²⁶ Measures were also endorsed under the UN’s Sustainable Development Goals,^{327,*} UNICEF’s Canadian Index of Child Well-Being,³²⁸ and the work of the Atkinson Centre.³²⁹ As we have learned of the low COVID-19 complication and mortality risk for infants and young children,³³⁰ the stressors currently affecting families and children have further legitimized calls for continued access to ECE, schooling, and child care.³³¹ It has also spurred the need for quality early learning and education at a national level, universal basic income, flexible work accommodations, and paid sick leave.

Without these measures, women’s workforce participation rates, especially for single mothers and mothers of young children, may continue to be negatively impacted by disproportionate financial and family stress that compromises early childhood mental health. Many of these stresses also threaten to degrade advances in gender equity at home and in the workplace.

While the Canada Emergency Response Benefit (CERB) has been helpful for society, various parent groups have reported delays in payments.³³² Pre-existing provincial initiatives (such as Manitoba’s prenatal benefit, which provides \$10 to \$81.41 per month to facilitate better prenatal care and nutritious food access) should also be studied for continuity and delays during the pandemic.³³³

As government officials now look to provide longer-lasting economic supports, caution is warranted in how social welfare instruments are executed. A review of 100 large-scale social protection policies found that benefits were structured in a way that perpetuated traditional parental roles.³³⁴ While millennial fathers are more involved in caregiving than previous generations, caregiver burdens amid COVID-19 continue to fall disproportionately on women.³³⁵⁻³³⁷

* Specifically, Action 3, to “ensure healthy lives and promote well-being for all at all ages in areas,” including child and maternal health.

Recommendation 14: Review income-support policies to support women’s participation in the workforce, and provide targeted mental health supports for single mothers and mothers with young children.

Nevertheless, paid paternity leave is on the rise globally — from 21 per cent in 1995 to 52 per cent in 2015. A 2019 report from 13 countries, including the U.S. and Canada, found that 85 per cent of fathers surveyed would “do anything” to be more involved in caring for a newborn or adopted child in the early weeks and months.³³⁸ In Canada, this has translated into 46 per cent of fathers using their paid parental-leave benefits between 2012-17, compared with just 34 per cent of fathers between 2001-06. This pales in comparison, however, to the 88 per cent of mothers who used maternity leave benefits between 2012-17.³³⁹ Similarly, over 80 per cent of mothers returned to work between 27 and 52 weeks after the birth or adoption of their child, compared with 36 per cent of fathers outside Quebec, and 17 per cent of fathers in Quebec. Further, just 48 per cent of fathers took paid parental leave for five weeks or less, the maximum allowed for paid paternity leave (under the maximum reimbursement rate).^{340,341}

Various factors can be attributed to these discrepancies, including negative portrayals of fathers as incompetent (i.e., the father-deficit model), stigma against men as parents, and the fact that just 30 per cent of companies provide paid paternity-leave benefits.^{342,343} Given that paid paternity leave reduces gender inequities and promotes child and maternal health, there is a need to investigate and support paid parental leave for fathers.^{344,345} While mothers and fathers in Canada (outside Quebec) can divide up to 35 weeks of paid parental leave, women have access to 15 weeks of specific maternity leave and, as of 2019, men have access to five weeks of specific paternity benefits. These differences may contribute to Canada’s current ranking (24th among OECD countries) in parental leave policies overall and being in last place for paid paternity-leave policies.³⁴⁶

There is also a need to create and fund more services and supports that build fathers’ confidence, skills, and competencies in caring for their infants and children. Paternal postpartum depression, which affects four to 25 per cent of new fathers, is associated with child maltreatment, behavioural challenges for preschoolers, and childhood mental illness.³⁴⁷⁻³⁴⁹ The needs of new fathers remain largely overlooked in policy frameworks, parental training programs, and mental health services and supports in Canada (and globally).³⁵⁰⁻³⁵⁶

There is also a need to support adoptive and foster parents, who are currently restricted in the use and availability of benefits that support parental leave. This is an issue meticulously explored by Cichocki et al., who argue that adoptive parents should have 15 weeks of employment insurance benefits (i.e., the equivalent time offered to mothers outside Quebec) — a measure agreed to by 94 per cent of adoptive parents surveyed across Canada.³⁵⁷ Preliminary evidence collected during COVID-19 has found parenting stress levels especially high among foster parents since the start of the pandemic, with effects greatest for those who are unmarried and have lower income and poorer mental health status.³⁵⁸ Given the intersection between higher parenting stress and compromised attachment for these populations, further research (with access to service and policy support) is critical to reducing cumulative and compounding risks.³⁵⁹

Recommendation 15: Study how to incentivize and support increased paternal involvement in child rearing, including targeted mental health supports for fathers and other non-gestational parents.

Recommendation 16: Fully expand parental leave benefits for adoptive and foster parents.

Targeted mental illness prevention and early intervention

Access to e-mental health services

For populations experiencing symptoms of mental health problems and illnesses or high levels of distress, there is a need to examine and respond to inequities in access to telehealth and telepsychology services.³⁶⁰⁻³⁶² Part of this response will require shifting to platforms most suitable to diverse populations and demographic groups.³⁶³ Many studies, including the MHCC's initial COVID-19 environmental scan, have found that teleservices offered during the first wave of the pandemic were more easily accessible to well-off families, and less available to those that are ethnically diverse, rural, remote, and socially/economically disadvantaged.^{364,365}

These inequities are themselves embedded in community surveys undertaken during current and previous disasters, which disproportionately focused on the needs of women with a higher socio-economic status.^{366,367} Among such respondents, the biggest barriers to accessing mental health services during the first COVID-19 wave were (1) not having sufficient energy or time (34.53 per cent), (2) the cost of services (17.95 per cent), and (3) not believing they needed them (15.25 per cent).³⁶⁸ Given that socially disadvantaged communities face disproportionate sources of parenting stress, there is a need to identify the mental health needs of more diverse parent populations.^{369,370}

Recommendation 17: Conduct more research surveying the health, mental health, and social service needs of diverse, lower socio-economic-status parent populations, and segment virtual service access in ways that are culturally, geographically, and socially/economically appropriate.

Gaps in perinatal mental health services and supports

The COVID-19 pandemic has caused significant disruptions in health and mental health services for pregnant women and new mothers.³⁷¹ Shortages in health-services coverage during the first wave of the pandemic included gaps in maternal mental health services, and the suspension of opportunities for bonding, breastfeeding, and skin-to-skin contact in intensive care.^{372,373} Yet, research to date has found low rates of mother-to-infant transmission (of the coronavirus), with no evidence supporting intrauterine or transplacental transmission from infected pregnant mothers to their fetuses.³⁷⁴ Amid COVID-19, 69 per cent of perinatal mental health practitioners surveyed reported reduced in-person visits and reduced overall service access.³⁷⁵ The suspension of in-person services may be especially

harmful for those parents fleeing domestic violence and for infants of new mothers living with a substance use disorder or going through opiate or opioid withdrawal.³⁷⁶

At a population level, perinatal and postpartum depression rates in Canada prior to COVID-19 were as high as 23 per cent for new mothers and appeared to be even more common during the first wave of the pandemic.³⁷⁷⁻³⁸⁰ During the pandemic, 95.8 per cent of 438 perinatal health practitioners believe that perinatal mental health services are insufficient, and 87 per cent of those practitioners are not mandated to screen for perinatal mental illness. Currently, Alberta is the only Canadian jurisdiction to do so.³⁸¹ Consequently, there is an increased need to more consistently screen, identify, and manage perinatal mental illnesses (e.g., postpartum depression), with enhanced access to and provision of both in-person and virtual mental health services and supports.³⁸²⁻³⁸⁴ For new mothers living with a substance use disorder and those at risk of domestic violence, there may be additional needs for modified perinatal care (i.e., a gold standard for opioid use disorder during pregnancy), including routine and early psychosocial assessments, access to substance use and harm reduction services, as well as adequate housing, employment supports, and access to peer-recovery networks.^{385,386} To adequately restore person-centred care, organizational policies should seek to balance the safety concerns of staff with the benefits of in-person services.³⁸⁷

Amid intensified calls for a national perinatal mental health strategy, advocates, service users, researchers, and systems planners should look to areas of disrupted or lapsed perinatal mental health services and supports during the COVID-19 pandemic, as a focus for standardization and system- and quality-improvement initiatives.^{388,389}

Recommendation 18: Conduct an SGBA+ of gaps in perinatal mental health, health, and social services, ensuring long-term follow up, virtual service, and in-person service coverage that works and is culturally appropriate.

Recommendation 19: Utilize gaps in perinatal mental health coverage as a basis for action and for systems and quality improvement on the impending national perinatal mental health strategy.

Early childhood mental health capacity

Opportunities are needed to address the symptoms of multiple mental health problems and illnesses through electronic cognitive behaviour therapy interventions. Many of these interventions could focus on emotional dysregulation and be offered in tandem with parental-skills training.³⁹⁰⁻³⁹² Combining services may help mitigate or reduce the COVID-19-related stressors on families that contribute to child behavioural and adjustment issues, child maltreatment, and intimate partner violence. These services and supports should be offered together to optimize child development and best support families.³⁹³⁻³⁹⁵

Combinations of clinical intervention and parental-skills training are also integral to evidence-based home visiting programs, such as Manitoba's Families First, and the British Columbia and Ontario pilots of the Nurse-Family Partnership program. However, determining the disrupted services and adaptations needed during the COVID-19 outbreak is also warranted. Pregnant and parenting mothers who face domestic violence, use drugs, or are reluctant to seek services may especially benefit from home visiting

and doula support.^{396,397} Some evidence from Australia indicates that doulas may be well positioned to screen for mental health problems and psychosocial adversity.³⁹⁸ Prior to COVID-19, Families First demonstrated improved parenting skills, social support, neighbourhood cohesion, and environmental mastery,* while the Nurse-Family Partnership reduced child maltreatment and mortality risk and spurred improvements in children’s cognitive development.^{399,400}

Longer-term follow-up and monitoring are also needed for new and expectant mothers with mental health histories, given that worse treatment outcomes are more typically found there.^{401,402} As with home visiting programs, mental health service providers should remain vigilant for families where child maltreatment and domestic violence are present.⁴⁰³⁻⁴⁰⁵ In efforts to make telepsychology services culturally safe, increasing consideration of the religious and cultural beliefs of parents is also needed to foster optimal child development and resilience.^{406,407}

Finally, there is also a need to build increased trauma-based training and workforce development opportunities across the settings where children live, learn, and play.⁴⁰⁸ These efforts could build upon pre-existing calls to foster competencies for infant and early childhood mental health across all child-facing service sectors, including among professionals in health, mental health, perinatal care, primary care, and education.⁴⁰⁹⁻⁴¹³ As children return to daycares and schools, more efforts will be needed to further incentivize and protect the professional development needs of early educators and child-care providers.^{414,415}

Recommendation 20: Audit workforce competency needs for diverse professional groups working with infants, young children, and their parents. Identify opportunities to embed infant and early childhood mental health competencies across relevant settings and institutions.

Strategic Investments, Accountability, and Progress

If current community estimates and past disaster research are any indication, the mental health impacts of COVID-19 on infants, children, families, and parents are likely to be felt for some time. While preventive measures are needed to mitigate and reverse these trends, there is little-to-no way of tracking developments in this area due to limitations in population-level, standardized performance measurement, and race-based data.^{416,417} These issues are compounded by a shortage of evaluation, research or empirical evidence on the mental health services and supports that are currently offered to families. Further uptake of population-based measures in infant and early childhood mental health is needed to ensure accountability and to track and measure progress in this area.⁴¹⁸

* According to the [Families First Program Evaluation](#) report, environmental mastery occurs when mothers or parents “report feeling in charge of their situations and managing the responsibilities and demands of their daily lives” (p. 12).

While youth mental health has justifiably seen a significant influx in research, service, and policy support, now is the time to make similar strategic investments in mental health services and supports for expectant and new parents, infants, children, and families. As outlined in Appendix B, investments in services should complement social policy investments that promote individual, infant, child, and family resilience — including universal child care, paid parental leave (for mothers, fathers, and adoptive parents), affordable housing, and robust income supports. To address current disparities and protect against the long-term mental health impacts of COVID-19, all public policy decisions should be strongly rooted in SGBA+ and health equity.

As we plan for the future, these investments are needed to strengthen Canada’s long-term social, economic, and productivity goals. Decades of research on early child development (along with emerging brain science and economic studies) have shown that these actions are critically needed to reduce the burden of chronic and non-communicable disease, as well as the onset, maintenance, and worsening of negative mental health impacts, by stopping this adverse trajectory at its earliest point. The COVID-19 pandemic demonstrates that addressing family and parenting stress now is critical. Actions here will be key to realizing Canada’s signatory obligations to the UN *Convention on the Rights of the Child* and emerging supports for the rights of the infant, which seek to ensure that children live in safe, secure environments, free from violence, strife, maltreatment, and abuse.^{419,420} Actions here will also promote secure attachment across the increasing diversity of parent and family structures in Canada.

Conclusion

While several factors associated with ACEs and suboptimal child development are on the rise, there are reasons to be optimistic. Many challenges in parental mental illness, parenting stress, and spousal conflict may be resolved by reprioritizing and increasing resourcing for the human, financial, and social supports that are critical to fostering resilience. While the data on CERB benefits is inconclusive, it may have been the single most effective driver in reducing some of the mental health impacts of COVID-19 on young children, infants, and families. The opening of strategic policy windows on affordable housing, universal basic income, and child care is also a step in the right direction.

An examination of the current gaps in resourcing and accountability in the early childhood mental health sector may ensure that investment and infrastructure decisions are allocated to equitable, low-cost, and high-return activities.⁴²¹ As several studies have shown, there is simply no better return to be made in society.⁴²²⁻⁴²⁴ Investments in infants, children, and their parents provide benefits that will be felt and seen for years to come. Now is the time for policy makers to follow through on these actions to spur Canada’s post-COVID-19 recovery through resources promoting infant, child, and family resilience and transformative social change.

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Appendix A

Search strategy

Search Terms	Databases
<ul style="list-style-type: none">• Early years OR Early childhood mental health OR Infant AND mental health AND COVID-19• Early years OR Early childhood mental health OR Infant AND mental health AND COVID-19 AND policy	Google Search, Google Scholar
* Research was also pulled from previous MHCC engagements/projects on infant and early childhood mental health.	

Appendix B

Areas of strategic investments, stratified by type of parenting stress and priority population(s)

Family Stress Type	Priority Populations	Evidence-Based Responses
General — Adverse childhood experiences	<ul style="list-style-type: none"> • policy makers • parents • neighbours 	<ul style="list-style-type: none"> • parental education on ACEs, serve-and-return exchanges (Circle of Safety, Brain Builders Lab, etc.)
Financial stress	<ul style="list-style-type: none"> • mothers • single parents • low-income households • FNIM communities 	<ul style="list-style-type: none"> • CERB benefits • universal basic income • food security initiatives • affordable housing
Social support loss/spousal conflict	<ul style="list-style-type: none"> • single parents 	<ul style="list-style-type: none"> • mental health first aid • peer-support interventions • equal/shared parenting • affordable housing
Parental stress issues	<ul style="list-style-type: none"> • mothers • single parents • parents of young children • parents of children with developmental needs • low-income households 	<ul style="list-style-type: none"> • continuation of early learning/daycare/education access • paid parental-leave policies, including improvements in paid paternity-leave benefits; further compensating unpaid or underpaid caregiving roles — i.e., mothers, single mothers, ECE workers • further incentivizing father involvement in non-paid child rearing roles, including tackling the father-as-parent stigma, the lack of parenting programs that include fathers, and the prevalence of parenting programs operating from a “father deficit” model • CERB benefits • universal basic income
Parental mental illness and substance use	<ul style="list-style-type: none"> • parents with pre-existing histories • pregnant and parenting mothers 	<ul style="list-style-type: none"> • mental health first aid • peer-support interventions • cognitive behavioural therapy

	<ul style="list-style-type: none"> • new and expectant fathers 	<ul style="list-style-type: none"> • family systems therapies • perinatal health and mental health supports offered in tandem with parenting-skills training • substance use and harm reduction services and continued medication access (e.g., buprenorphine, methadone)
Child mood, behavioural issues	<ul style="list-style-type: none"> • children with developmental needs • low-income children 	<ul style="list-style-type: none"> • evidence-based early learning initiatives • increased integration of developmental and child mental health service providers • access to outdoor play, while respecting social distancing measures • access to friends, family that respect social distancing measures • food security initiatives • affordable housing • equal/shared parenting • infant and early years, trauma-based workforce competency training



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