Healthy Babies Healthy Children Guidance Document

This document is in support of the Healthy Babies Healthy Children Protocol.

The Healthy Babies Healthy Children Protocol is a component of the *Family Health Standard (Reproductive and Child Health Guidelines)* of the *Ontario Public Health Standards*

Child and Youth Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
2012
Healthy Babies Healthy Children - Vision

Women and their families in the prenatal period and families with children from birth until their transition to school, identified with risk will be provided with opportunities to achieve their potential.

Every child and parent identified with risk in Ontario will have access to evidence-informed programs and services that support healthy child development and effective parenting.

© Queen’s Printer for Ontario, 2012
Published for the Ministry of Children and Youth Services
Healthy Babies Healthy Children - Program Description

Within general policy and practice requirements, Healthy Babies Healthy Children (HBHC) provides service to women and their families in the prenatal period and to families with children from birth until their transition to school. Directed by the HBHC Protocol, the Program includes:

- Screening of pregnant women and families with children,
- Home visiting services to vulnerable families who have been identified with risk on the Healthy Babies Healthy Children (HBHC) Screen and have had risk confirmed through an In-depth Assessment (IDA) using the Family Assessment Instrument (FAI) tool,
- Service coordination, and
- Support for referral/recommendation to community programs and resources that will address key issues in the early years.

Foundational to support improved community wide services for the early years, the HBHC Program is part of an integrated service system based on research and evaluation.
Table of Contents

Healthy Babies Healthy Children - Vision ................................................................. i

Healthy Babies Healthy Children - Program Description ........................................ ii

Acknowledgements ......................................................................................................... v

PART I: HBHC PROGRAM DELIVERY ........................................................................... 1

Section 1: Introduction and Overview ........................................................................... 1

a) Development of the MCYS HBHC Guidance Document ........................................ 1

b) Document Overview ................................................................................................ 2

c) Program Background and Rationale ...................................................................... 3

d) Program Principles, Scope and Logic Model ......................................................... 5

e) Program Components and Activities ..................................................................... 9

f) Program Roles and Responsibilities ..................................................................... 11

Section 2: Background .................................................................................................... 17

a) Introduction .............................................................................................................. 17

b) Theoretical Framework ........................................................................................... 18

c) The Function of the Public Health Nurse (PHN) in Home Visiting ...................... 19

d) The Function of the Lay/Family Visitor in Home Visiting ........................................ 21

e) Roles of Other Professionals to Support Home Visiting ........................................ 22

f) A Review of the Literature on Home Visiting Best Practices ................................. 22

g) The Importance of Building Relationships ............................................................ 24

Section 3: OPHS HBHC Protocol Requirements ............................................................ 26

1) General Policy / Practice Requirements ................................................................. 26

2) Screening ................................................................................................................. 34

3) Assessment ............................................................................................................. 48

4) Support Services .................................................................................................... 64

5) Blended Home Visiting Services ......................................................................... 67

6) Service Coordination ........................................................................................... 74

7) Referrals / Recommendations to Community Services ....................................... 77

8) Service and System Integration ........................................................................... 81

9 and 10) Research and Evaluation ........................................................................... 83
Glossary..............................................................................................................................................87

PART II: HBHC Screening and Assessment Tools............................................................................91

1) Overview ...........................................................................................................................................91
2) HBHC Screening Tool.....................................................................................................................92
3) Family Assessment Instrument.......................................................................................................94
4) HBHC Family Service Plan Guide, 2012........................................................................................102
5) HBHC Family Friendly Service Plan............................................................................................126

APPENDICES.......................................................................................................................................135

Appendix 1: Review of the Literature on Home Visiting Best Practices – Additional Results ..........135
Appendix 2: Sample Assessment Questions and Anchor Descriptions.............................................141
Appendix 3: Knowledge to Action Framework................................................................................180
Appendix 4: How Can I Use the Family Service Plan Datamart?......................................................181
Appendix 5: Expected HBHC Outcomes and Indicators.................................................................182

References............................................................................................................................................184

List of Figures
Figure 1: HBHC Program Logic Model .......................................................................................... 7
Figure 2: Screening, Assessment and Referral to Blended Home Visiting Flowchart .................... 35
Figure 3: Child Development Trajectory....................................................................................... 49

List of Tables
Table 1: Service Provider Roles ..................................................................................................... 14
Table 2: CFSA Clause 72 ............................................................................................................... 29
Table 3: Adjustment for Age ......................................................................................................... 46
Table 4: Characteristics of the 18-Month Visit ............................................................................ 79
Acknowledgements

Members of the Healthy Babies Healthy Children Protocol and Guidance Document Consultation Working Group:

**Andrea Reist**
Regional Municipality of Waterloo Health Department
Director of Healthy Babies Healthy Children

**Anne Biscaro**
Region of Niagara Public Health Department
Director, Family Health and Chief Nursing Officer

**Bonnie King**
City of Hamilton Public Health Services
Program Manager, Family Health Division

**Diane Bewick**
Middlesex-London Health Unit
Director of Family Health Services

**Kim Gardiman**
Northwestern Health Unit
Manager of Family Health

**Lorraine Repo**
Thunder Bay and District Health Unit
Manager

**Mary Lou Walker**
Toronto Public Health
Associate Director, Healthy Families

**Mary Jean Watson**
Simcoe Muskoka District Health Unit
Manager

**Patti Gauley**
Eastern Ontario Health Unit
Director, Chief Nursing Officer
The Healthy Babies Healthy Children Protocol and Guidance Document Consultation Working Group would like to thank the following individuals for their contribution to the development of this Guidance Document:

**Dr. Heather Manson**
Chief
Health Promotion, Chronic Disease and Injury Prevention
Public Health Ontario

Staff from the Ministry of Health and Long Term Care including:

**Jacky Sweetman**
Public Health Practice Advisor
Public Health Division
Executive Director’s Office, Office of the Chief Medical Officer of Health

**Janette Bowie**
Programs and Standards Advisor
Public Health Promotion Division
Standards, Program and Community Development

**Nancy Sullivan**
Public Health Practice Advisor
Public Health Division
Public Health Standards, Practice and Accountabilities Branch

Many other people actively contributed to our work including:

**Diane Finkle-Perazzo** who edited and copy reviewed the final work.

Thank you to all who have contributed.
PART I: HBHC PROGRAM DELIVERY

Section 1: Introduction and Overview

The Ontario Public Health Standards (OPHS) (1) specify the mandatory health programs and services provided by boards of health. They are published by the Ontario Minister of Health and Long-Term Care (MOHLTC) under the authority of the Health Protection and Promotion Act (HPPA). (2) Boards of health in Ontario are responsible for implementing these program standards, including any protocols that are incorporated within.

The OPHS are based on the principles of need, impact, capacity and partnership/collaboration. They rest on a foundation provided by four key functions: population health assessment, surveillance, research/knowledge exchange and program evaluation.

Each standard includes protocols which are program and topic specific documents that provide direction on how boards of health must operationalize specific requirements within the OPHS. They are an important mechanism by which greater standardization is achieved in the province-wide implementation of public health programs.

Protocols identify the minimum expectations for public health programs and services. Boards of health have the authority to develop programs and services in excess of minimum requirements where required to address local needs. Boards of health are accountable for implementing the standards including those protocols that are incorporated into the standards.

The Ministry of Health Promotion (MHP) was assigned responsibility by an Order in Council (OIC) for the Family Health Standard (3) which includes the Reproductive and Child Health Guidelines. The Ministry of Children and Youth Services (MCYS, or the “ministry”) was assigned responsibility by an OIC for the administration of the Healthy Babies Healthy Children components of the Reproductive Health (3) and Child Health Standards. (4) The Healthy Babies Healthy Children Protocol (5) provides direction to boards of health in delivering the Healthy Babies, Healthy Children (HBHC) Program.

a) Development of the MCYS HBHC Guidance Document

The Ministry of Children and Youth Services worked in collaboration with public health units to draft the HBHC Guidance Document. This process included consultation with staff of the MOHLTC including the Health Promotion Division
(formerly the Ontario Ministry of Health Promotion and Sport) responsible for the delivery of the Reproductive Health Standard and the Child Health Standard of the Ontario Public Health Standards 2008, as well as representatives from Public Health Ontario.

The HBHC Guidance Document supports the HBHC Protocol and will provide boards of health with information they need to support the delivery of HBHC Program services. While the OPHS and associated protocols published by the Minister of Health and Long-Term Care, under Section 7 of the HPPA are legally binding, guidance documents that are not incorporated by reference to the OPHS are not enforceable by statute. This guidance document is intended to be used as a resource to assist professional staff employed by local boards of health as they plan and execute their responsibilities to the HBHC Protocol under the HPPA and the OPHS to deliver the HBHC Program.

The HBHC Guidance Document provides specific advice about the OPHS requirements related to the HBHC components of the Family Health Reproductive and Child Health Standards. It will provide boards of health with information to ensure that the HBHC Program is delivered consistently across the province and meets provincial expectations. These guidelines should be used to assist in local planning, to guide program delivery and to orient and train new staff.

The HBHC Guidance Document updates and replaces the October 2003 HBHC Consolidated Guidelines and the HBHC Complete Guide to Screening and Assessment. Although this guidance document will be used primarily by HBHC service providers who are responsible for all components of HBHC, it will also be useful for other health and social service partners involved in the delivery and support of the HBHC Program.

b) Document Overview

There are two parts to the HBHC Guidance Document. Part I provides general information about overall HBHC Program delivery and Part II provides screening and assessment tools used in the delivery of the HBHC Program to support the screening and assessment components of the HBHC Protocol.

Part I is divided into three sections: Section 1 provides an introduction and overview; Section 2 covers background information, information about home visiting best practices (which includes the importance of home visiting as a service delivery strategy) and a jurisdictional review of home visiting models; and Section 3: includes a statement of each program requirement as outlined in the HBHC Protocol and evidence-based practices and priorities to support those requirements.
c) Program Background and Rationale

Introduced by the Ontario Government in 1998, Healthy Babies Healthy Children is a foundational program of the Ministry of Children and Youth Services. Its purpose is to help children get a healthy start in life. The Program does this by focusing on families from the prenatal period until the child’s transition to school through:

- Screening and assessments to identify and confirm risks that could affect a child’s healthy development and referrals to community programs and services;
- Supports for new parents;
- Provision of home visiting program services to promote: parental and family health, adaptations to parenting and parenting capacity, child growth and development, healthy parent child relationships, and promote positive social support; and
- Support for access and referral/recommendation to community programs and resources that will address key issues in the early years.

It is well known that early childhood experiences make a critical difference in children’s development and in their health and well-being both during childhood and when they are adults. (6) Research into child development has repeatedly shown that early interactions and experiences not only affect the way the human brain is wired, they also have a decisive impact on children’s emotional and intellectual development. (7)

Each year in Ontario, babies are born into families where a number of factors, including those related to economic, psychosocial, behavioural and lifestyle influences make it challenging for them to achieve their full physical, mental and emotional potential. Identifying these barriers and intervening as early as possible (with a program such as Healthy Babies Healthy Children in conjunction with other programs services in a community inclusive of other health unit program such as reproductive and child health, dental or communicable disease) can improve the life chances for these vulnerable children and their families and may prevent serious problems later in life. (6) Research also indicates that there are proven and effective tools that can be used to identify families and children at risk. (8) Certain interventions, such as home visiting, service coordination, and referrals to appropriate services, can build family strengths and support healthy child development. (9-12)
# A History of the HBHC Program

The following is a brief overview of the major milestones marking the history and development of the HBHC Program.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>January-May 1997</td>
<td>The Ontario Government introduced Phase 1 of the HBHC Program to serve families with children from prenatal to the age of two at high-risk. Boards of health were responsible for managing and delivering the program.</td>
</tr>
<tr>
<td>May 1998</td>
<td>The Ontario Government announced an enhancement of the HBHC Program budget including increases of $10 million in 1998/99, $20 million in 1999/00, $10 million in 2000/01, for a total commitment of $50 million by 2000/01. This enhancement allowed for the expansion into First Nations communities.</td>
</tr>
<tr>
<td>July 1998</td>
<td>The HBHC Early Identification Process - Background Paper was issued.</td>
</tr>
<tr>
<td>March 1999</td>
<td>The Ontario Government announced an additional $17 million for HBHC postpartum enhancement and an expanded program to serve all families with children prenatal to age six.</td>
</tr>
<tr>
<td>March 1999</td>
<td>The Family Screening, Review and Assessment Manual was issued.</td>
</tr>
<tr>
<td>May 1999</td>
<td>The HBHC Implementation Guidelines - Phase 2 were issued.</td>
</tr>
<tr>
<td>June 1999</td>
<td>Regional training took place on the use of the Family Assessment Instrument.</td>
</tr>
<tr>
<td>June 1999</td>
<td>A provincial stakeholder workshop was held to develop an effective early identification initiative for children not identified during the postpartum period.</td>
</tr>
<tr>
<td>May 1999</td>
<td>The first stage of the Integrated Services for Children Information System (ISCIS) was launched.</td>
</tr>
<tr>
<td>July 1999</td>
<td>Boards of health implemented ISCIS Stage 1A.</td>
</tr>
<tr>
<td>October 1999</td>
<td>Boards of health implemented postpartum services.</td>
</tr>
<tr>
<td>March 2000</td>
<td>A short-term evaluation of the HBHC Program was implemented.</td>
</tr>
<tr>
<td>April 2000</td>
<td>Aboriginal Healing and Wellness took responsibility for managing the First Nations component of HBHC for both on reserve and off reserve communities.</td>
</tr>
<tr>
<td>July 2000</td>
<td>Early childhood (early identification) screening was added to provide a way to identify children after the postpartum period and up to age six who may benefit from HBHC services.</td>
</tr>
<tr>
<td>October 2000</td>
<td>Prenatal guidelines were issued.</td>
</tr>
<tr>
<td>October 2001</td>
<td>An updated policy statement on home visiting was issued.</td>
</tr>
<tr>
<td>January 2002</td>
<td>A policy statement on HBHC universal screening and assessment of children postnatal to age six was issued.</td>
</tr>
<tr>
<td>April 2002</td>
<td>The short-term evaluation of the HBHC Program was completed.</td>
</tr>
<tr>
<td>March 2003</td>
<td>The Consolidated Guidelines for Healthy Babies Healthy Children were released.</td>
</tr>
<tr>
<td>July 2008 – November 2009</td>
<td>The HBHC Home Visiting Research Project was conducted.</td>
</tr>
<tr>
<td>April 2009</td>
<td>Activities were commenced to support the development of a new program screening tool.</td>
</tr>
<tr>
<td>October 2008</td>
<td>The HBHC Protocol 2008 as part of the Ontario Public Health Standard was released.</td>
</tr>
</tbody>
</table>
November 2009 | MCYS Minister approval was received to begin the process of strengthening the HBHC Program.
February 2011 | Focused education and training to strengthen home visiting was initiated.
March 2011 | HBHC proposed program changes were announced.
February 2011 to Fall 2012 | The HBHC Screen Evaluation (Phase 1 and Phase 2) took place.
Fall 2012 | The HBHC Protocol 2012 and revised HBHC Guidance Document were released.

Aboriginal HBHC

Although the Healthy Babies Healthy Children Program is intended to serve all families with young children in Ontario, these guidelines apply only to HBHC services delivered through boards of health. The Ontario Ministry of Community and Social Services’ Aboriginal Healing and Wellness Strategy is responsible for managing the Aboriginal component of the HBHC Program for both on reserve and off reserve Aboriginal communities. For information on the Aboriginal component of Healthy Babies Healthy Children, contact:

Manager, Aboriginal Healing and Wellness Strategy
880 Bay Street – 2nd Floor
Toronto, ON M7A 2B6  416-326-6907.

The HBHC Program is based on equity and inclusion. It is expected that public health units will move toward a model of information sharing of HBHC screening results between health units and AHBHC providers, both on- and off-reserve and continued exploration of common education and training opportunities to build strength and capacity.

d) Program Principles, Scope and Logic Model

HBHC Program Principles

- Families and communities share the responsibility for children’s healthy development. In the course of parenting and raising a child, families can move from relative health and strength to need and back again. When families are in need, the community must be available to support them as they rebuild their strength.

- HBHC is a family-centred voluntary program that strives for involvement by being inclusive and building relationships with both families and service providers.

- Guided by strengths-based practice, the HBHC Program is focused on improving outcomes for the child and the family and giving
• families the support and information they need to make healthy choices for themselves and their children.

• The HBHC Program also works from an equity and social justice perspective so that all families, inclusive of all markers of diversity, have an opportunity to receive the support they need in order to optimize the healthy growth and development of their children.

• The HBHC Program is not intended to be a stand-alone program. It is designed to link and integrate with all other related initiatives, build on the success of other programs and services and foster new partnerships within the volunteer, charitable and business communities. The results of this integrated and collaborative delivery system should improve outcomes for individuals and families.

The delivery of the HBHC Program will:
• Be sensitive to and respect the different characteristics of families and communities, that may include but are not limited to: social, linguistic, cultural, racial, and gender diversity.

• Respond to the needs of francophone families (see the following for more information http://www.ofa.gov.on.ca/en/index.html ).

• Include members of hard-to-reach communities in helping to shape the services that will build family and community strengths.

• Contribute to the prevention of child neglect and abuse.

HBHC Program Scope
The HBHC Program is one of the mandatory programs and services delivered by boards of health under the authority of the Health Protection and Promotion Act (HPPA) as defined in the Ontario Public Health Standards (OPHS). Although the program must be offered and available in every community in Ontario, the program is voluntary and therefore, family participation in the HBHC Program is not mandatory. Families must consent to be involved in the HBHC Program.

The HBHC Program is provincially managed and delivered locally by boards of health through the province’s public health units in partnership with hospitals, nurses, physicians, midwives and other health and social service providers.

The HBHC Program Logic Model provided in Figure 1 below lays out the Program vision, goals, components, tools, objectives and short/long-term outcomes.
Figure 1: HBHC Program Logic Model

Vision
Women and their families in the prenatal period and families with children from birth until their transition to school, identified with risk will be provided with opportunities to achieve their potential.

Every child and parent identified with risk in Ontario will have access to evidence-informed programs and services that support healthy child development and effective parenting.

Goals
To promote optimal physical, cognitive, communicative and psychosocial development in children through a system of effective prevention and early intervention services for families.

To act as a catalyst for coordinated, effective, integrated system of services and supports for healthy child development and family well-being through partnerships and collaboration with a network of service providers and through participation in community planning activities.

Components
- General Policy
- Screening
- Assessment
- Support Services
- Blended Home Visiting
- Service Coordination
- Referrals
- Service and System Integration
- Evaluation and Research

Tools and Resources
- HBHC Screen
- Family Assessment Instrument
- Parent Information
- HBHC Staff
  - Public Health Nurses
  - Family Home Visitor
  - Social Worker (Optimal)
  - Managers and support staff
- Family Service Plan
  - Key to Success (IBS)
- NCs: Promoting Maternal Mental Health During Pregnancy, Keys to Caregiving, Parent-Child Interaction Scales
- Partnerships, Developmental Screen (IBS)

Objectives
1. Identify families with risk for compromised parenting and child development in an efficient and timely manner.

2. Improve pre-natal and birth outcomes.

3. Improve parenting capacity.

4. Improve the parent-child relationship.

5. Improve child development outcomes.

6. Improve the social capital of parents (e.g., parental health, education attainment, housing, stability).

7. Promote access to and use of needs-based services and supports (formal and informal) for children whose families have been identified with risk.

8. Contribute to client-level service integration by supporting access and service coordination models as services are provided in a seamless manner to children and their families.

9. Contribute to system-level service integration by supporting initiatives focused on the early years, and by taking a leadership role in the co-ordination of needs-based service provision at the community level.

10. Utilize a continuous quality improvement approach to mobilize data and evidence for service improvement.

Short-term Outcomes
- 100% of HBHC screens will be accurately completed.
- Families that screen positive are confirmed with risk.
- Increased service focus to support parents and child interactions, child development and parenting capacity.
- Frequency, duration and length of home visiting sessions reflect the needs of vulnerable families.

Long-term Outcomes
- Increased percentage of community referrals to HBHC services.
- Improved child outcomes.
- Improved parent-child relationship.
- Improved parenting capacity.
- Improved child development outcomes.
- Increased use of community services to meet identified family needs.
- Improved responsiveness to the needs of vulnerable populations through utilization of HBHC referral data to strengthen alliances at early years community planning boards.
HBHC Program Vision

- Women and their families in the prenatal period and families with children from birth until their transition to school, identified with risk will be provided with opportunities to achieve their potential.

- Every child and parent identified with risk in Ontario will have access to evidence-informed programs and services that support healthy child development and effective parenting.

HBHC Program Goals

- To promote optimal physical, cognitive, communicative and psychosocial development in children through a system of effective prevention and early intervention services for families.

- To act as a catalyst for a coordinated, effective, integrated system of services and supports for healthy child development and family well-being through partnership and collaboration with a network of service providers and through participation in community planning activities.

HBHC Program Objectives

1. Identify families with risk for compromised parenting and child development in an efficient and timely manner.
2. Improve prenatal and birth outcomes.
3. Improve parenting capacity.
4. Improve the parent-child relationship.
5. Improve child development outcomes.
6. Improve the social capital of parents (e.g., parental health, education attainment, housing stability).
7. Promote access to and use of needs-based services and supports (formal and informal) for children whose families have been identified with risk.
8. Contribute to client-level service integration by supporting access and service coordination models so services are provided in a seamless manner to children and their families.
9. Contribute to system-level service integration by supporting initiatives focused on early years and by taking a leadership role in the coordination of needs-based service provision at the community level.
10. Utilize a continuous quality improvement approach to mobilize data and evidence for service improvement.
e) Program Components and Activities

The HBHC Program consists of the following service delivery components. These components can occur at three entry or referral points to the HBHC Program: prenatal, postpartum and early childhood.

- **Screening** is offered (in collaboration with health service providers and through referrals received from other agencies and individuals) to pregnant women and their families and to families with children from birth to their transition to school for any risks to healthy child development. Screening can occur prenataally, postpartum and/or during early childhood (i.e., at anytime up to a child’s transition to school).

- **Assessment** of women and their families in the prenatal period and families with children from birth until transition to school who are identified with risk for compromised healthy child development and parenting ability. Assessment can occur prenataally, postpartum and/or during early childhood (i.e., anytime up to a child’s transition to school).

- **Support services** in the prenatal, postpartum and early childhood period that provide information about the importance of the early years, promote positive parent-child relationships and healthy child development as well as referring families confirmed with risk to HBHC Program blended home visiting services and other community services.

- **A blended model of home visiting** service for women and their families in the prenatal period and families with children from birth to transition to school who are confirmed with risk to compromised parental and family health including adaptations to parenting and parenting capacity, child growth and development, healthy parent child relationships and promotes positive social support. This is a collaborative approach between public health nurses, lay/family home visitors and other professionals as approved by the ministry.

- **Service planning and coordination** for families with children (from prenatal to transition to school) who are confirmed with risk to compromised parental and family health includes adaptations to parenting and parenting capacity, child growth and development, healthy parent child relationships, and promote positive social support.
• **Referrals and/or recommendations** to other services for families with children (from prenatal to transition to school) who are confirmed with risk to compromised parental and family health, include adaptations to parenting and parenting capacity, child growth and development, healthy parent child relationships, and promote positive social support.

• Participation in **service and system integration** activities which may include:
  - Integration of local/community services for families and children;
  - Implementation of services for families and children along a continuum; and
  - The development of a local vision, policies and procedures for children’s/early years services.

• **Evaluation and research** to support ministry established efforts to measure and analyze the activities of the HBHC Program.

In support of fidelity to the HBHC Program model, the following program components must be supported:

• Screening – must be completed using the HBHC Screen with no adaptations to the content of the 36 questions. In addition, for data integrity, the sequence of the questions in paper copy should not be rearranged.

• Assessment – must be completed using the In-Depth Assessment process (as described in Section 3, sub-section 3). All questions of the Family Assessment Instrument, including supplemental questions, should be addressed to complete the assessment process.

• Support Services – follow up contacts must be completed based on the results of the HBHC Screen (as described in Section 3, sub-section 4) with priority given to families identified with risk.

• Blended Home Visiting – must use a collaborative home visiting model, taking into consideration levels of service, and include standard interventions (e.g. NCAST and PIPE) with completion of the Family Service Plan, as described in Section 3, sub-section 5.

• Service planning and coordination – all families receiving home visiting services must be offered service coordination and a service coordinator must be identified as described in Section 3, sub-section 6.

• Referral and recommendation – health units must establish collaborative partnerships with other community programs to support the identification of vulnerable families and provide services for families confirmed with risk, as described in Section 3, sub-section 7.
• Service and system integration – health units must be involved with community planning tables addressing the early years, as described in Section 3, sub-section 8.

f) Program Roles and Responsibilities

The Healthy Babies Healthy Children Program is funded by the Ontario Ministry of Children and Youth Services, managed provincially by the Strategic Policy and Planning Division, Child and Youth Development Branch, Child Development Unit and is delivered locally by boards of health, in partnership with hospitals, midwives, nurses, physicians and other health and social service providers across the province.

Ministry of Children and Youth Services (MCYS)

The MCYS is the provincial manager of the HBHC Program. The ministry is responsible for policy, program design/development, operations and evaluation. Its key responsibilities are to:

• Provide leadership, expertise and coordination to support the policy development, planning, implementation, evaluation and assessment of the HBHC Program.

• Develop (in consultation with service providers) and provide the Protocol and Guidance Document for the HBHC Program which includes identification of the program vision, goals, and objectives, as well as program outcomes and related indicators.

• Intergovernmental and cross agency collaboration (e.g., MOHLTC, MEDU, Better Outcomes Registry and Network (BORN) and Public Health Ontario).

• Allocate the funding for the HBHC Program, approve the annual funding for each site and support terms and conditions as outlined in service agreements.

• Select the appropriate program tools and support related education and training which support fidelity to program delivery and implementation.

• Develop and provide the information management system (ISCIS) to help boards of health maintain HBHC Program records and assist in monitoring the HBHC Program.

• Identify, lead and/or support research and evaluation initiatives to strengthen program quality.

• Define HBHC Program and program-related outcomes and indicators.
• Analyze and aggregate ISCIS data for strategic planning and resource allocation.

MCYS Regional Offices
The Regional Offices represent the MCYS in local communities. Their key responsibilities are to:

• Help ensure that pregnant women and their families and families with young children from birth to transition to school have access to a range of early years services.
• Help ensure all early years services, including those provided by the HBHC Program are linked and integrated.
• Participate in and support (with boards of health) a network of health and social service providers.

Ministry of Health and Long-Term Care (MOHLTC)
The MOHLTC works in partnership with the MCYS. Its key responsibilities are to:

• Help manage the relationship between the HBHC Program and providers responsible for services in the prenatal, postpartum and early childhood periods.
• Through liaison role, help facilitate a relationship between the local health integration networks (LHINs) and MCYS.

Hospitals/Midwives
Hospitals with birthing units and midwives have the first postpartum contact with families. Their key responsibilities are to:

• Develop a protocol with their local board of health to administer a prenatal screen (if the hospital/midwife provides prenatal services).
• Administer a postpartum screen with all consenting mothers of newborns.
• Work in collaboration with their local board of health to help ensure the results of all postpartum screens reach the local public health unit.
• Develop a protocol with their local board of health to coordinate postpartum services and avoid duplication if the hospital/midwife operates a postpartum clinic or provides postpartum home visits.
• Advise their local board of health about the number of births within the catchment area of the public health unit and outside the catchment area of the public health unit (within two weeks of the end of each quarter).

• Advise their local board of health about the number of mothers with newborns who do not consent to having information sent to the HBHC Program.

Primary Care Providers
Primary care providers provide health care for babies and children. Their key responsibilities are to:

• Monitor and assess children’s development using appropriate tools (e.g., prenatal, early childhood screening tools, including but not limited to the Rourke Baby Record-Ontario).

• Refer families who would benefit from the HBHC Program, when identified with risk for compromised parenting and child development. This could also include identification at routine well-child care or at additional screening opportunities.

Boards of Health
The board of health is the local manager and coordinator of the HBHC Program. Its key responsibilities are to:

• Help ensure all the components of the HBHC Program are implemented based on the OPHS HBHC Protocol and within their allocated resources.

• Comply with the financial, administrative, and program requirements of the service contract with the provincial government.

• Manage the funds provided by the provincial government.

• Hire, train and supervise public health nurses, other professionals and lay home visitors who deliver components of the HBHC Program.

• Co-coordinate with other professionals, agencies, and organizations to ensure HBHC services are provided (e.g., screening services, service coordination, etc.).

• Develop effective working relationships/referral protocols with other professionals, agencies, and organizations (in particular hospitals), children’s protection services, and other partners.
• Provide the data and information required for regional or provincial monitoring and evaluations. (Data for provincial monitoring will be submitted in keeping with the reporting schedule provided by the ministry.).

• Monitor and analyze HBHC services and identify and resolve any issues.

• Participate in and support a network of early years health and social service providers.

• Promote the integration of early years programs and services within the community.
Table 1: Service Provider Roles

<table>
<thead>
<tr>
<th>Public Health Nurse (PHN)</th>
<th>Family Home Visitor</th>
<th>Other Professional as part of the Blended Home Visiting Team</th>
<th>Community Partners (Primary Care, Prenatal Clinics, Hospitals, Midwives, Social Services etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening</strong></td>
<td>• Provide skilled screening using the HBHC Program screen in the prenatal, postpartum and early childhood periods.</td>
<td>• Support and facilitate parent-report based screening (e.g., the Nipissing District Developmental Screen).</td>
<td>• Provide skilled screening using the HBHC screen (prenatal, postpartum and early childhood) supported through their local public health unit.</td>
</tr>
<tr>
<td></td>
<td>• Provide support to community professionals using the screen as a liaison resource.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>• Provide skilled assessment to confirm risk through the In-Depth Assessment (IDA).</td>
<td>• Social workers conduct assessments, related to the four FSP goals of housing, education and employment, financial stability, and settlement/cultural adaptation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide skilled assessment of family interactions using tools as described by the ministry based on the theoretical framework of HBHC and other frameworks as described by the PHU.</td>
<td>• Support coordination through observation of the family’s ability to meet goals and follow through on referrals.</td>
<td>• Through their own existing professional and organizational standards, provide assessment and related referral of vulnerable families who would benefit from HBHC Program services.</td>
</tr>
<tr>
<td></td>
<td>• Provide skilled assessment of child and family needs and related goals to complete the FSP.</td>
<td>• Communicate all observations to blended home visiting team.</td>
<td>• Communicate findings, with consent, to the blended home visiting team to assist in completion of the FSP.</td>
</tr>
<tr>
<td><strong>Support Services</strong></td>
<td>• Work with community partners to provide access to program and related information.</td>
<td></td>
<td>• Work with local PHUs to provide access to program and related information.</td>
</tr>
<tr>
<td><strong>Blended Home Visiting</strong></td>
<td>Work in the collaborative setting of the team to:</td>
<td>• In the collaborative setting of the team social workers provide education, consultation and counselling related to the four FSP goals of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide health teaching, health promotion, education, consultation and counselling to address family goals.</td>
<td>• Housing</td>
<td>• Housing</td>
</tr>
<tr>
<td></td>
<td>• Utilize HBHC Program support materials as necessary (e.g., NCAST materials).</td>
<td>• Education and employment</td>
<td>• Education and employment</td>
</tr>
<tr>
<td></td>
<td>• Track services provided in ISCIS and other methods as prescribed by the PHU.</td>
<td>• Financial stability, and</td>
<td>• Financial stability, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Settlement/cultural adaptation.</td>
<td>• Settlement/cultural adaptation.</td>
</tr>
<tr>
<td></td>
<td>Work in the collaborative setting of the team to:</td>
<td>• Support and reinforce health teaching and health promotion using peer model.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support and reinforce health teaching and health promotion using peer model.</td>
<td>• Use role modelling to support skill and knowledge development.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use active listening and empathy to support families.</td>
<td>• Use active listening and empathy to support families.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review and reinforce family goals.</td>
<td>• Review and reinforce family goals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support the delivery of parent-report based screening.</td>
<td>• Support the delivery of parent-report based screening.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Track services provided in ISCIS and other methods as prescribed by the PHU.</td>
<td>• Track services provided in ISCIS and other methods as prescribed by the PHU.</td>
<td></td>
</tr>
</tbody>
</table>
### Service Coordination

<table>
<thead>
<tr>
<th>Public Health Nurse (PHN)</th>
<th>Family Home Visitor</th>
<th>Other Professional as part of the Blended Home Visiting Team</th>
<th>Community Partners (Primary Care, Prenatal Clinics, Hospitals, Midwives, Social services etc.)</th>
</tr>
</thead>
</table>
| • Work collaboratively with the blended home visiting team and community partners to identify and negotiate family goals and update the FSP.  
  • Utilize skills in communication, conflict resolution, and leadership to work with blended team members and community partners for service provision.  
  • May have lead role of Service Coordinator. | • Work collaboratively with the blended home visiting team and community partners to set and meet family goals as agreed in the FSP.  
  • Maintain communications with other team members regarding service provision. | • Work collaboratively with the blended home visiting team and community partners to set and meet family goals as agreed in the FSP.  
  • Maintain communications with other team members regarding service provision. | • Work collaboratively with the blended home visiting team and community partners to set and meet family goals as agreed in the FSP.  
  • May take on the role of Service Coordinator. |

### Referral/Recommendation

| • Identify the need for additional resources and supports, facilitate linkages to meet these needs over time.  
  • Complete paperwork and reports to facilitate access to community services.  
  • Communicate referrals to the team. | • Identify the need for additional resources and supports, facilitate linkages to meet these needs over time.  
  • Assist families with access services.  
  • Communicate referrals to the team. | • Identify the need for additional resources and supports, facilitate linkages to meet these needs over time.  
  • Complete paperwork and reports to facilitate access to community services.  
  • Communicate referrals to the team. | • Identify vulnerable families who would benefit from HBHC Program services and complete referral to local PHU. |

### Service and System Integration

| • Participate on committees relevant to health unit or community early years planning.  
  • Advocate for families to receive needed services/supports.  
  • Advocate and support integrated, collaborative partnerships for a strong early years system. | • Advocate for families to receive needed services/supports.  
  • Participate on committees relevant to the four social work domains.  
  • Advocate for families to receive needed services/supports. | • Participate on committees relevant to the four social work domains.  
  • Advocate for families to receive needed services/supports. | • Participate on committees relevant to health unit or community early years planning. |

### Research and Evaluation

| • Participate in PHU and ministry research and evaluation activities. | • Participate in PHU and ministry research and evaluation activities. | • Participate in PHU and ministry research and evaluation activities. | |

**Note:** The Family Service Plan (FSP) is an HBHC Program outcome measurement tool that further describes strategy categories for service delivery, provides key definitions and outlines the roles and responsibilities of team members involved in delivery of the HBHC Program. This tool also provides a description of the types and levels of goals achieved by families with different risk factors in the HBHC Program. (See Part II (4)).
PART I: HBHC PROGRAM DELIVERY

Section 2: Background

a) Introduction

It is widely known that the period between conception and transition to school is the most critical period of a child’s growth and development. Experiences during these early years can have health and social effects that last a lifetime. (13 – 15) Home visiting programs provide families with support during this important period when it is most necessary to ensure their children’s healthy growth and development.

It is well-understood that home visits provide many positive benefits to families: They have been shown to enhance maternal parenting practices, improve the quality of the child’s home environment and further children’s development. Home visiting programs are strongly rooted in the theory that services delivered in the home can have a positive impact on families and that altering parenting practices can result in measurable and long-term benefits for children’s development.

Home visiting programs often reach out to families and caregivers who would not otherwise seek support, families or caregivers who face challenges as well as children who are vulnerable due to health or developmental issues. These programs make clients feel more at ease and encourage them to share issues in a comfortable environment that allows support and guidance to be tailored in a way that suits each unique circumstance.

Home visiting programs can vary dramatically in their underlying theoretical models and in many other ways such as: the types of families they reach, the number and intensity of visits prescribed, program length, curriculum and approach. Programs can also differ in terms of who provides services (e.g., nurses vs. paraprofessionals), implementation practices (e.g., screening) and the range of outcomes observed.

Home visiting has proven to be a beneficial and cost-effective way to provide important and necessary support services to families and children. (16) However, if home-visiting programs are to achieve maximum impact, it is essential that they adhere to carefully crafted and mandated practice guidelines. Among other things, these guidelines ensure that the credentials of professional staff are consistent with program goals and that program practices adhere to established theoretical models.
b) Theoretical Framework

One of the most prominent observations in the literature about PHN home visiting is that the application of theories and models is not consistent. According to McNaughton (17) “The use of explicitly stated theoretical frameworks to guide identification of client problems, selection of nursing intervention and dosage and the expected changes as a result of the intervention is not evident.”

An exception to this rule can be found in the work of Olds, et al (9,10,12,13) who based their outcome domains on a few theories, including the social ecology theory. In this framework, a child’s human environment provides the main influence on development. The child is surrounded by a nested series of settings (immediate and extended family, school, community and culture) that affect the child directly and through their interaction.

Home-visiting interventions based on this model are designed to improve parents’ resources and their ability to create a health-promoting environment that in turn leads to improved child health and development. (18)

Drummond, Weir and Kysela’s review (19) found that several studies supported a parent-infant interaction model where the enhancement of maternal-infant interaction leads to improved parenting and child development. The use of a conceptual model could increase the likelihood of a cohesive program implementation and valid evaluation. (19)

The HBHC Program theoretical framework incorporates ecological systems theory (20,21,22,23) which explains human development based on the influence of several systems, including family as a proximal system and society as a distal system. The HBHC Program theoretical framework also incorporates the Transactional Model of Development, which acknowledges the importance and value of the child’s dynamic experiences with his/her environment including the family and the social context of the family. (24) Furthermore, the HBHC Program framework also uses the approaches of the Family Centred Model developed by Dunst, Trivette, and Deal (25) which focuses on the strengths found within families to support parenting.

These models combine to frame the HBHC Program. Families identified and confirmed with risk in the areas of child health and development, parent health and development, parent-child relationships (as a dynamic source of developmental supports and/or barriers), and the family, community and societal systems that surround them are supported with health teaching, counselling and referral based on their own strengths and identified needs.
In addition, the role of professionals and para-professionals working with families is primarily to support change, both at the individual family level as well as the at the community level. This change, in relation to the HBHC Program, may occur as a result of actions to implement program components such as professional screening and assessment, or may occur as result of the various strategies as outlined in the Family Service Plan (FSP).

In all cases, family and community level change is influenced following the Transtheoretical Model of Behaviour Change. (26,27) This model identifies five stages of change, identified as:

- Precontemplation,
- Contemplation,
- Preparation,
- Action, and
- Maintenance.

All stages can be used to support HBHC Program delivery and to determine the appropriate strategies for service delivery to individual families and/or communities.

c) The Function of the Public Health Nurse (PHN) in Home Visiting

The Canadian Community Health Nursing Standards of Practice (28) identifies activities PHNs carry out when they provide home visiting services. These include, but are not limited to the following:

- Promote, protect and preserve the health of individuals and families, groups, communities and populations in the settings where they live, work, learn, worship and play in an ongoing or episodic process.
- Consider and address the impact of the determinants of health within the political, cultural, and environmental context on health.
- Support capacity building approaches focused on client strength and client participation.
- Protect and enhance human dignity respecting social, cultural and personal beliefs and circumstances of their clients.
- Engage in evidence-informed decision making.
- Practice with an emphasis on teamwork, collaboration, consultation and professional relationships. (28)
Although home visiting for vulnerable families is primarily focused at the individual and family level, PHNs also integrate their personal and clinical understanding and knowledge of the health and illness experiences of individuals and families into their population health promotion practice.

Santos (29) found that community health nurses are the most appropriate subgroup of nurses to provide home visiting services to vulnerable families. Several standards of practice have been identified relative to working with vulnerable families. (For more information on these standards of practice see: www.chnc.ca.)

Best practices for working with vulnerable families can include:

- Establishing partnerships through collaborative teamwork and community development, e.g.:
  - Establish partnerships in the community to identify community needs and issues in order to strengthen community action, and
  - Foster a collaborative environment by bringing together varied disciplines, skills, talents, perspectives, knowledge and experience of many team members, colleagues, community services and agencies.

- Family support services may be provided through informal, episodic contact or through intensive PHN involvement. PHNs can promote and support health in families by:
  - Providing anticipatory guidance,
  - Advocating on behalf of a family, and
  - Using an interdisciplinary approach to ensure services are coordinated and comprehensive.

- Assist families in recognizing their strengths and utilizing these to address concerns and goals identified by the family.

- Provide clinical expertise and guidance regarding:
  - Pre/postnatal follow-up,
  - Infant / toddler nutrition and feeding,
  - Growth and development,
  - Nutrition,
  - Parent / child relationships (e.g., bonding, attachment),
  - Parenting support,
  - Community resources,
  - Family planning,
  - Child safety, and
  - Communicable diseases and their prevention.
d) The Function of the Lay/Family Visitor in Home Visiting

Research has not clearly shown whether it is more effective for professionals or paraprofessionals to provide home visits. (30)

A randomized trial completed by Korfmacher, O’Brien, Hiatt and Olds (31) compared the differences in home visits by nurses and paraprofessionals during pregnancy and infancy. Both nurses and paraprofessionals completed one month of intensive training with regular in-service training. Because nurses were expected to exercise more independent judgment in helping mothers deal with physical health concerns, the nurses were given more in-depth training on the physical health and development of the mother and child. It was found that each group provided services in very different ways. For example, nurses may have focused on maternal health behaviours while paraprofessionals may have focused more on safety/environment issues. The attrition rate of mothers was higher and there were fewer visits in the paraprofessional group. Anecdotal evidence showed that paraprofessional visitors had difficulty engaging many of the families. These results support the critical aspect of PHNs in developing a therapeutic relationship with the family (see Part I, Section 2g).

Olds et al (11) conducted a randomized control trial which took this comparison of nurses and paraprofessionals study one step further. In this analysis, paraprofessionals improved mother-child interaction and the rates of subsequent pregnancy. The nurses, on the other hand, produced significant and important effects on women’s prenatal use of tobacco, timing and likelihood of subsequent pregnancy, subsequent births and participation in the workforce, mother-child responsive interaction, emotional, language and mental development of children. For most outcomes in which the nurses produced beneficial effects, the paraprofessional effects were half as good. The researchers speculated that nurses are likely to have engagement and persuasive power (nurses are rated by the public as having the highest honest and ethics standards of all professions). The authors concluded that it is likely that professionals other than nurses can serve as effective home visitors if they are given the right program resources. It is worth noting that in the above studies, the same curriculum/protocols were used for both groups (cross training).

Additional studies have demonstrated promising results when paraprofessionals are supported with certain criteria. For example, when paraprofessionals are given clear parameters and curriculum to deliver, as well as regular supervision, families have better outcomes. (32-35)

Some researchers have also suggested there may be greater benefit to families when the paraprofessional role is focused on teaching certain parenting skills (36) however, studies that looked specifically at paraprofessionals who focused on family violence
showed that benefits took place only with intensive services over a 2 year period. (37-39)

Research has shown that the success of paraprofessionals in home visiting is promising when there is clear content or curriculum for delivery, regular supervision and intensive long-term visiting. Although there are no statistical regressions linking supervision with outcomes, all the studies that reported successful outcomes, involved supervision. As well, where there was poor fidelity to the program model, there were poor program outcomes, particularly in terms of the number of completed home visits. (35,40,41)

e) Roles of Other Professionals to Support Home Visiting

Collaboration is a key skill in supporting home visiting as it allows professionals and paraprofessionals associated with a family’s care to identify and work towards shared goals. Reviews of collaboration and interprofessional education determined that no rigorous evidence exists to support interprofessional collaboration, but that there is benefit to interventions that support collaboration. Good collaboration requires:

- a shared goal,
- consensus over tasks and issues,
- timely communication,
- constructive management of conflict, and
- continual monitoring. (42)

Knowledge translation interventions and interprofessional collaboration interventions all aim to improve health care processes and outcomes which facilitate evidence-based practice. (43)

f) A Review of the Literature on Home Visiting Best Practices

A review was conducted to survey existing literature on nursing home visiting best practices for vulnerable/overburdened families including screening and assessment tools, practice guidelines and curricula/interventions. This review (which is summarized below) demonstrated that home visiting programs should focus services on the most vulnerable families with risk to compromised child development and parenting. (13) Further details about this review are provided in Appendix 1: Review of the Literature on Home Visiting Best Practices – Additional Results.

Effective programs have multiple components, offer long-term sustained services that are delivered by professionals or highly trained paraprofessionals, and include early enrolment, counselling, referral clinics as well as quality relationships with staff. (37,44-50) Though the current evidence is mixed related to child health outcomes and maternal health outcomes, parenting after home visiting has been shown to have consistent positive movement. (30) This can be partially attributed to methodological issues related to measuring some outcomes such as child abuse but it may also be
related to programs offering a narrow range of outcomes instead of a comprehensive approach that addresses a wider range of needs. Similarly, additional research has confirmed that programs that offer home visiting to families with multiple social risks and include early initiation during pregnancy, long-term sustained services, and utilize an ecological model in addressing specific parenting behaviours have the most beneficial outcomes. (18, 51)

Other home visiting research has determined that home visiting only has a moderate effect on outcomes, particularly child health outcomes. This is partly attributed to inconsistent support and fidelity to a theoretical and practical model. As well, it is acknowledged that home visiting is most effective when it is part of a broad set of services for families which includes centre-based child development programs and integrated community services. (52, 53)

According to a literature reviewed conducted by The Zero to Three Policy Centre, a national, non-profit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers, delivery of programs/services should include:

- The use of a theoretical framework/model to guide all aspects of the service with clearly defined goals and objectives.
- Careful recruitment, education and training of home visitors (professional and paraprofessional) such that they have an understanding of the framework and an evidenced-based curriculum focusing on how to meet the goals and objectives of the program.
- A program model that supports intensive follow-up with vulnerable families, recognizing that a minimum of four visits or 3-5 months of services is required before change will occur.
- The pursuit of a comprehensive approach, using collaboration with other community organizations, in which multiple needs of families are addressed. This includes a broad set of services for families and young children (not just visiting) such as center-based group care.
- Stable and adequate funding.
- Evaluation and continuous quality improvement to ensure fidelity to the program model in order to meet the program goals and objectives.

The Attrition of Vulnerable Families from Home Visiting Programs

Issues of enrolment, engagement and retention are repeatedly highlighted in the literature. Kitzman, Olds, Cole and Yoos (54) have identified the following issues:

- *Gaining and maintaining access to families.* Clients often miss appointments due to multiple demands. Sometimes this is intentional and may reflect a lack of motivation. Nurses are sometimes reluctant to confront a problem because they fear they may alienate the family. They describe a “dance of confronting and backing off”.
• *Environmental limits.* The cognitive-growth-fostering activities recommended by program protocols are often frustrating and difficult to achieve due to conditions such as crowded households, difficulties in maintaining toys, and lack of privacy.

• *Identifying and engaging all relevant players.* Incorporating all family members into the program can be challenging with conflicting family member schedules or family members who do not want to engage.

• *Delivering the protocol/curriculum elements.* The needs and strengths of families vary. Although many home visiting program protocols are designed to be flexible, nurses often juggle immediate survival needs with the health-promotion goals of the program. Some mothers are not literate and there can be differences in how families accept program activities. Nurses can address these issues by educating parents about child development and involving them in developing activities that fit their lifestyles.

• *Balancing nurse responsibility and client responsibility.* Many nurses walk a fine line between doing too much and not doing enough. In some instances nurses may decide to carry out a task as an expression of caring and as an affirmation of the mothers’ worth. At other times, they may decide to complete tasks themselves because they feel there is a risk of failure.

• *Balancing maternal life-course goals with child/family needs.* Nurses struggle to choose a goal to focus on and some mothers are not able to juggle caregiving and other personal goals.

• *Maintaining a balance between the future and the present.* Sometimes clients do not share the nurses’ optimism about the future because their survival demands are so great that little attention can be paid to anything else.

• *Managing in the face of cultural complexities.* It can be difficult for a nurse to fully understand the unique culture and lifestyle of a family. Nurses are constrained by what families feel is acceptable and it may be difficult to determine when a family’s behaviour is based on cultural beliefs and when it is a maladaptive response.

• *Waiting for mothers to change.* When children’s needs are unmet they are vulnerable to conditions with long-lasting effects. It can be challenging and stressful for nurses to balance mothers’ unique goals and concerns and the needs of their children.

**g) The Importance of Building Relationships**

Effective PHN home visiting depends on the characteristics and skill level of the nurse including ability to build trust, therapeutic use of self, good communication and ability to develop a therapeutic relationship. (11,17-19,51,54, 55-60)
It has been hypothesized that positive maternal-child outcomes are related to the development of a trusting relationship between the home visitor and the mother. (56) Building this trusting relationship will allow the nurse to understand the meaning of a family’s health concern and to respond appropriately. (61) PHNs will not be successful in screening, assessment and intervention if this basic tenant is unmet.

Building relationships is one of the five Canadian Community Health Nursing Standards of Practice and an integral part of practice. “Building relationships within community health nursing is based upon the principles of connecting and caring. Connecting is the establishment and nurturing of a caring relationship and supportive environment that promotes maximum participation of the individual/community and their self-determination. Caring involves the development of empowering relationships, which preserve, protect and enhance human dignity. Community health nurses build caring relationships based on mutual respect and on an understanding of the power inherent in their position and its potential impact on relationships and practice”. (28)

Although it is increasingly recognized that quality relationships with families are the vehicle through which early childhood home-visitation programs achieve their success, there are no universally accepted methods of promoting effective provider/client relationships. (48) Nevertheless, the literature does provide some insight into the key components of a therapeutic relationship.

**Relationship Building Strategies**

PHNs can better understand their client’s unique situation if they take time to get to know them. It has been shown that multiple contacts between a nurse and client provide the right environment to develop trust. A review by McNaughton (17) revealed a number of important characteristics that build relationships between PHNs and mothers. McNaughton also concluded that goals such as health promotion, enhanced client self-worth, self-efficacy and independent decision-making affect the PHN/client relationship.

Jack et al (56) have offered a Canadian theory of maternal engagement regarding PHNs and family visitors who work with vulnerable families. Their study of 20 mothers was based on intensive blended (PHN and home visitor) home visits and highlighted the need for PHNs to identify client fears and perceptions and to explain their role to all family members. The theoretical model of maternal engagement with PHNs and family visitors contains the following key items:

- Overcoming fear,
- Building trust, and
- Seeking mutuality.
PART I: HBHC PROGRAM DELIVERY

Section 3: OPHS HBHC Protocol Requirements

1) General Policy / Practice Requirements

a) Legislation, Standards of Care and Professional Practice

i) All individuals, agencies and organizations that deliver the HBHC Program shall comply with all relevant legislation, regulations, policy and legal agreements and with accepted standards of care and professional practice.

Most legal and professional requirements will already be addressed under existing legislation, standards and guidelines (e.g., the Health Protection and Promotion Act (2), Ontario Public Health Standards (1), the Regulated Health Professions Act - the Nursing Act) (62), professional governing bodies (e.g., College of Nurses, College of Social Workers), health unit policies and practices. However, HBHC Program sites are also required to have in place appropriate policies and procedures for:

Financial Reporting: Boards of health must comply with the Healthy Babies Healthy Children financial reporting requirements.

These requirements are set out in Healthy Babies Healthy Children Terms and Conditions and Service Planning.

b) Informed Consent for Service

i) The board of health shall help to ensure that all families who participate in the HBHC Program, including HBHC screening (prenatal, postpartum and early childhood), are given appropriate information to support informed consent for receipt of HBHC Program services.

HBHC is a voluntary program for all expectant mothers and families with children from birth until their transition to school. The principle of informed consent is entrenched in common law and nursing standards.

The service components provided through the HBHC Program as described in this document are considered a type of treatment as defined by both legislation and practice standards. The Health Care Consent Act (HCCA) (63) sets out explicit rules regarding when consent is required for treatment or admission to a care facility, and who can give the consent when the client is not capable of doing so. The Act also sets out rules for when a practitioner identifies the need to obtain consent from a substitute
decision-maker for personal assistance services (e.g., activities of daily living). In
addition, the College of Nurses of Ontario has recommended practice guidelines for
obtaining consent. (64)

To that end, public health units will provide policies and procedures to support HBHC
staff in determining and obtaining consent for service, both implied and explicit, as
necessary.

c) Confidentiality and Disclosure of Information

i) Confidentiality and disclosure provisions are articulated in a variety of
legislation, regulations, policies and legal agreements specific to particular
programs and agencies. It is a requirement under law that HBHC Programs
comply with all relevant legislation and regulations.

Issues of confidentiality and disclosure may arise when information about a client
and/or family is transferred from one agency or professional to another (e.g., from
hospitals to public health programs, from public health programs to other early years
service providers, etc.). HBHC Programs must have a policy in place which is consistent
with existing legislation.

Because HBHC is a program that collects, uses and discloses personal health
information, the provisions of the Personal Health Information Protection Act, 2004 (65)
(PHIPA) will apply to health information custodians (boards of health, health
professionals, etc.) who administer or assist in administering the HBHC Program.
PHIPA requires health information custodian to post a notice of information practices
so that patients are aware of the purposes of the collection, use and disclosure of the
personal information.

ii) The board of health shall develop an appropriate policy regarding consent,
confidentiality and disclosure of client information. This policy shall be approved
in writing by the Information Privacy Coordinator.

Public Health Units

The provisions of the Personal Health Information Protection Act (PHIPA) (65) apply to
the collection, use and disclosure of personal information by boards of health. The
confidentiality provisions of the Health Protection and Promotion Act (2) relating to
communicable diseases also apply to boards of health. The approval of the privacy
policies will be monitored through the board of health’s Healthy Babies Healthy Children
Service Agreement Terms and Conditions for program accountability.
Hospitals

The provisions of PHIPA apply to the collection, use and disclosure of personal health information by both private and public hospitals. It is the expectation of the Ministry of Children and Youth Services that, in the course of collecting, using and disclosing patient information for HBHC Programs, public health units will work with local hospitals to develop procedures that help ensure compliance with the related legislation.

When Parents do not Consent to Disclose Screening Results

The success of the HBHC Program depends upon the active involvement of parents. As a best practice, when administering HBHC screening tools, health and social service providers (e.g., prenatal clinics, hospital nurses, primary care providers, midwives and social service providers) should have the informed consent of mothers and/or families before sharing screening results with the public health unit.

Sometimes a parent who does not consent to screening or to have screen results forwarded, may still request contact with the health unit. This may occur, for example, as a result of lack of privacy during the screening process, or when family members are present during screening. In situations such as this, the screener may ask for the parent’s consent to provide the parent’s contact information to the public health unit. When contact information is received, the PHN at the health unit will make contact with the family and offer the HBHC Program services initiated by the screening process. This is to be considered an external referral. See ISCIS User Guide (71) for further details.

d) Inclusiveness

i) The board of health shall provide client centered services in a culturally relevant and inclusive manner. Diversity considerations may include but are not limited to: language, socioeconomic status, race, religious affiliation, sexual identity, immigration status and mental or physical ability.

HBHC Programs can foster and support diversity in communities by creating environments that accept, appreciate, accommodate and make use of the diverse talents, skills, abilities, perspectives and leadership styles of all clients. When potential clients cannot access or fully participate in a service because of a diversity consideration this should be considered a barrier.
In order for the HBHC Program to be accessible, inclusive and responsive, diversity barriers should be identified and addressed using the public health unit’s existing policies and procedures (e.g., diversity, access and equity). In addition, consideration should be made for all of the dimensions of diversity as described below.

**Dimensions of Diversity**

- Aboriginal peoples / communities (inclusive of First Nations, Métis and Inuit peoples)
- Gender
- Age
- Language
- Care-giving responsibilities (e.g., balancing of personal life responsibilities such as senior care)
- Marital/family status
- Citizenship status
- Race
- Disability
- Regional location
- Education level
- Religion
- Employment status
- Sexual orientation
- Ethnicity
- Socioeconomic status
- French language

**e) Duty to Report**

i) The *Child and Family Services Act (CFSA)* (67) requires that any person who has reasonable grounds to suspect a child is (or may be) in need of protection must report that suspicion (and the information on which it is based) to child protection services forthwith. The Act specifies that persons who perform professional duties with respect to children could be liable to a penalty for not reporting.

ii) In addition to the legal requirement to report, the board of health shall require all employees who work with children and families to consult with child protection services about any family situation in which child protection advice would be helpful.

Boards of health are required to help ensure that all staff who deliver the HBHC Program are aware of the health unit’s established policy and procedures for handling potential abuse cases.
Table 2: CFSA Clause 72

CFSA s. 72 (1) Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect that a child may be in need of protection, the person must promptly report the suspicion and the information upon which it is based to a society. (See the CFSA subsection (1) for the entire and up-to-date list.)

CFSA s. 72 (2) The duty to report is an ongoing obligation. If a person has made a previous report about a child and has additional reasonable grounds to suspect that a child is or may be in need of protection, that person must make a further report to a children’s aid society.

CFSA s. 72 (3) The person who has the reasonable grounds to suspect that a child is or may be in need of protection must make the report directly to the children’s aid society. The person must not rely on anyone else to report on his or her behalf.

CFSA s. 72 (4) Professional persons and officials have the same duty as any member of the public to report a suspicion that a child is in need of protection. The Act recognizes, however, that persons working closely with children have a special awareness of the signs of child abuse and neglect and a particular responsibility to report their suspicions and so makes it an offence to fail to report. Any professional who fails to report a suspicion, where the information on which that suspicion was obtained in the course of his or her professional or official duties, is liable on conviction to a fine of up to $1,000.

iii) The board of health shall provide that all employees who deliver the HBHC Program services receive education and training in the board of health’s established policy and procedures for handling potential cases of children in need of protection.

Individuals and agencies delivering the HBHC Program are in a unique position to identify families at high risk of violence, abuse or neglect and who may require professional intervention.

In addition to the legal requirement to report, HBHC Program providers are further encouraged to consult with the appropriate child protection services about any family situation where child protection advice would be helpful. The purpose of this consultation is to seek advice about whether or not (in the opinion of the child protection agency) there is a duty to report or an ongoing duty to report.

When consulting with the appropriate child protection services on situations where there is no duty to report, HBHC Program staff are expected to adhere to their public health unit’s confidentiality policies.

f) Personal Safety

i) The board of health shall provide education and training to all HBHC Program employees so they are able to implement personal safety policy and procedures and deal with personal safety issues as they deliver HBHC Program services.
Personal safety is the responsibility of both employees and employers. Boards of health will develop appropriate policies and procedures to support the personal safety of all HBHC Program staff. This includes, but is not limited to:

- Measures that reduce risk to personal safety including compassion fatigue.
- Training of staff in personal safety measures.
- Maintaining a mechanism for reporting and recording incidents.
- Evaluation of personal safety policies and procedures on a regular basis.

In addition, boards of health are required to have in place policies and procedures for reporting serious occurrences that include notification of the Ministry of Children and Youth Services.

g) Education, Information and Training

i) The board of health shall provide ongoing education, training, and support to integrate learning for all employees responsible for the delivery of the HBHC Program.

ii) The board of health shall provide education and training, as required by the Ministry of Children and Youth Services (“the ministry”), to support home visiting best practices and guidelines.

Fidelity to a program model and knowledge of model activities is a key component to successful home visiting. (68, 69) Fidelity is related to the extent to which an intervention is implemented as intended and the quality of the intervention. (70) Fidelity to the HBHC Program model is supported primarily through education, training and reflective practice. Best practices have determined that frequent reflective practice supports the quality delivery of infant-family intervention programs such as home visiting programs (71).

Education, training and support for staff who deliver the HBHC Program should be evidence-informed and address all program components including screening, assessment, blended home visiting, service coordination, referrals to community as well as service and system integration. Province-wide initiatives for specific activities within the HBHC Program will be initially coordinated by the ministry and sustained through boards of health individually and in partnership with each other.

In all education, training and support efforts, best practices and program standardization will be the leading goals and boards of health will ensure delivery of curriculum as prescribed by the ministry.
h) Service Agreements

i) The board of health shall meet the HBHC Program financial reporting requirements as described in annual service agreements.

The approval will be monitored through the board of health’s Healthy Babies Healthy Children Service Agreement Terms and Conditions for program accountability.

ii) The board of health shall provide HBHC Program services that support standardized program delivery. Refer to the Health Babies Health Children Guidance Document, 2012 (or as current) for further information.

The HBHC Program Guidance Document is to be used to assist professional staff employed by local boards of health as they plan and execute their responsibilities to the HBHC Protocol under the HPPA and the OPHS to deliver the HBHC Program.

The HBHC Guidance Document provides specific advice about the OPHS requirements related to the HBHC components of the Family Health Reproductive and Child Health Standards. It will provide boards of health with information to ensure that the HBHC Program is delivered consistently across the province and meets provincial expectations. The HBHC Program Guidance Document should be used to:

- Assist in local planning,
- Guide program delivery, and
- Orient and train new staff.

iii) The board of health shall maintain current agreements with services and organizations that deliver the HBHC Program to provide screening, assessment, home visiting or service coordination or other services for the HBHC Program.

The HBHC Program is delivered by boards of health in partnership with hospitals, nurses, physicians and other health and social service providers. All organizations involved should negotiate the necessary agreements, protocols, procedures or guidelines to guide their working relationships.

Agreements, protocols, procedures or guidelines should cover:

- The services provided by each organization including service coordination.
- The referral process.
- The management of client information/records including discharge notification.
- Any reporting requirements (both at a service level and at the individual client level).
• The data the organizations must provide to the HBHC Program and the timelines for providing that data.
• Issue and conflict resolution mechanisms.

The goals of such agreements are to identify families who would benefit from the HBHC Program services, to develop an appropriate and smooth flow of cases between agencies and organizations delivering services, to promote service integration and to avoid service duplication.

Agreements of Service with Child Protection Services
The board of health’s agreements with the child protection services should specify how the two agencies will make decisions about continued assessment and service for families whose situation has been reported and investigated. Once the child protection concerns are being addressed, the child protection worker and the HBHC Program blended home visiting team, led by the PHN, may determine that the family would benefit from HBHC Program services, such as home visiting or other support services.

It is important that the HBHC Program and local child protection services work together to develop and identify services to meet the needs of families at the highest risk of domestic violence, child abuse or neglect and to develop services to meet their needs while continuing to support their voluntary involvement with the HBHC Program.

i) Data Collection

i) The board of health shall enter and maintain the screening and assessment information they gather about families, the services provided to families, and referrals to other services and programs in the Integrated Services for Children Information System (ISCIS).

Boards of health use ISCIS to record the following data:
• Basic client demographics, family profile and contact information.
• Screening/assessment results/scores (including any notes and comments).
• The service coordinator assigned during each period of service delivery.
• The family’s In-Depth Assessment contacts (e.g., phone call, home visit).
• Results of the In-Depth Assessment.
• Family Service Plan content.
• Results from other assessments completed during the course of service (e.g., NCAST Parent-Child Interaction Scales), including notes and comments.
• Referrals from and into the HBHC Program.
• Home visits (e.g., date, length of time spent, name of visitor, etc.).
Health unit staff can use ISCIS to generate reports on the HBHC Program services (e.g., number of live births, number of families eligible for services, number served, and number referred to other services, etc.) and to monitor factors, such as the length of time families remain in the Program, the cost of the Program and wait times for services. ISCIS can also be used to generate a profile report for a given family and a number of other pre-defined reports.

The board of health will help ensure data is recorded accurately and entered within established timelines that support the ministry’s monitoring requirements.

All data recorded by HBHC Programs remains in the custody and control of the health unit and is only used at an anonymized and aggregate level by the ministry to support program management, resource allocation and program improvements.

Public health unit staff will comply with the documentation and records management policies and standards of their individual health units. Note: Detailed information on ISCIS and how to use the system is provided in the HBHC ISCIS User Guide. (71)

2) Screening

Background

Screening is the first step in identifying families and children who may be at risk to compromised healthy child development or parenting, and who would benefit from a more in-depth assessment.

The screening process is intended to provide greater focus on risk identification for families who can benefit from HBHC Program home visiting services and will enable those vulnerable families to access support in an efficient manner.

The HBHC Program offers universal screening at three stages:

1. Prenatal screening occurs before a baby is born.
2. Postpartum screening occurs shortly after birth (e.g., before mother and child have left the hospital).
3. Early childhood screening can occur any time after the postpartum period up to the transition to school (e.g., from six weeks of age up until school entry).

Rationale

In order to ensure that any issues that compromise healthy child development are identified and supported as early as possible, families need access to universal screening at different points throughout their children’s early years. Establishing a risk factor surveillance system that uses consistent screening tools at different points in time supports population health initiatives for the early years. For example:
• Prenatal screening helps identify problems that can occur during pregnancy and helps to ensure that babies have a better start in life.
• Postpartum screening helps identify families with newborns who may need assistance.
• Screening services at different stages up to the transition to school helps ensure that any child who is missed in the early (prenatal or postpartum) screens or whose situation changes will still be identified and receive appropriate services.

Figure 2 below provides a flowchart which details the key steps that take place during HBHC screening, assessment and referral.
Figure 2: HBHC Screening, Assessment and Referral to Blended Home Visiting Flowchart

HBHC Vision
Women and their families in the prenatal period and families with children from birth until their transition to school, identified with risk, will be provided with opportunities to achieve their potential.
Every child and parent identified with risk in Ontario will have access to evidence-based programs and services that support healthy child development and effective parenting.

HBHC Program Population

Prenatal

Postpartum (birth to 6 weeks)

Early Childhood (6 weeks until transition to school)

Self-Identified Families who may benefit from HBHC Program

Families who may benefit from the HBHC Program are identified and referred to the Prenatal Program.

HBHC Program Referral

HBHC Screen completed prenatal, postpartum, early childhood by Primary Care or ECE as part of their continuum of care.

Risk Identified?

NO

YS

Early Years Information provided

Families referred to appropriate services, information provided and discharged.

HBHC Program Assessment

HBHC Referral

HBHC Screen completed prenatal, postpartum or early childhood by PHU.

Must take place 60 days of discharge for postpartum women only.

HBHC Program Referral

HBHC Screen completed prenatal, postpartum or early childhood by PHU.

In Depth Assessment

HBHC PHU completes Family Assessment Instrument and Brief Supplemental Questions, as needed. Assessments are based on the age/stage of child and family (e.g. prenatal assessment, postpartum assessment or early childhood assessment).

The EIA may also be part of the process towards achieving goal identification of the family service plan.

HBHC Program Referral

HBHC Program Blended Home Visiting

July 2012
a) General Considerations

i) The board of health shall promote and use the HBHC Screen (consisting of prenatal, postpartum and early childhood screening components) to complete all elements of screening as described below.

The HBHC Program screening process was developed as a more focused and enhanced tool to screen families. It was based on a 2009 MCYS survey of public health units which indicated there were inconsistent approaches to screening across the province. Based on this survey, as well as an interjurisdictional review and expert input, a revised HBHC Screen was developed to improve screening consistency and to better identify families and children with risk. One of the key features of the revised HBHC Screen was that it provided screening at all three stages: prenatal, postpartum and early childhood. Through two phases of validation evaluation (73), the HBHC Screen has been determined to be an adequate first stage Screen, capable of identifying risk families using a cut-score of two. The Screen shows a moderate sensitivity and specificity as defined by the American Academy of Pediatrics (74).

ii) The board of health shall administer the HBHC Screen using the model defined by the “ministry”.

A strong relationship between the public health unit and key partners, including hospitals, midwives and primary care clinicians, is pivotal in providing a continuum of care to families and enhances the screening process. As demonstrated through the second phase of screen validation (73), the liaison role is pivotal for all three stages of HBHC screening (prenatal, postpartum and early childhood).

The Screening Liaison Model is an effective model in developing relationships with partners and in helping to ensure that a quality screening process is followed. The key functions required as part of the Screening Liaison Model include the following:

- **Program triage role**: The PHN is expected to help ensure contact and prioritize program services for those families “identified with risk”.
- **Support for hospital nurses and/or other community partners in developing strategies to ask sensitive screening questions**: The PHN is responsible for troubleshooting where there may be gaps in understanding of HBHC Screen questions and providing appropriate support/tools for hospital nurses in effective completion of screens.
- **Quality control in screen completion**: All screens, received from hospital, midwives, primary care and other community partners, would be reviewed by the screening liaison PHN to help ensure that they are completed in a comprehensive manner. For those screens not meeting program standards for completion, the screening liaison PHN would provide immediate follow-up, liaising with the appropriate staff to make sure that questions are properly
understood and to determine why screens are incomplete as well as providing the necessary education to improve screen completion.

- Providing information and education about HBHC and screening to hospital staff (including midwives) and other community partners: There is an ongoing expectation that PHNs are responsible for disseminating information and education about the HBHC Screen and the HBHC Program.

**iii) The board of health shall integrate information obtained from other organizations into the HBHC Screen information, with family consent.**

With consent, PHUs will collect all HBHC Screens for entry to the ISCIS system. This data will support development of a screening history for families. Every effort will be made not to duplicate screening and assessment of families. When identified, families with multiple existing service providers will obtain appropriate consents, where necessary, to share information and will use existing information to support completion of the HBHC Screen. For example, prenatal screens can be partially completed using the Antenatal I and II obtained, with consent as necessary, from obstetricians, midwives or prenatal clinics. The questions completed using this information do not need to be completed during screening discussions with the family, instead the conversations can focus on obtaining the missing information in order to accurately complete the HBHC Screen.

**iv) The board of health will help to ensure that all families, including families that decline HBHC services, receive appropriate information about community resources for parents including materials as required by the ministry.**

HBHC parent information will include child development information, a description of programs available to support children and their families and important contact numbers for further assistance.

The objectives of providing parent information are to:

- Support the HBHC Program by helping to ensure that families with identified risk get the extra support they need prenatally, after the birth of their child and in the early years of parenting and child development.
- Improve access to the HBHC Program for all families in the prenatal period, following the birth of a child and up to their transition to school.
- Provide information about the HBHC Program.
- Make it easier for parents to connect with other local programs and services and to access trusted information about the development of their children, which may include, but is not limited to:
  - Breastfeeding resources (e.g., clinics),
  - Infant and child parenting groups,
Early years community settings.

Bearing in mind the voluntary nature of the HBHC Program and its confidentiality requirements, some families may choose not to accept HBHC screening services. If a family declines screening, the PHN will use local protocols, procedures or guidelines to help to ensure that the family receives information and support for local community programs and services.

**Screening Delivery Sites and Providers**

The HBHC Screen is delivered in sites where families with young children seek other services, such as: prenatal programs, physician’s offices, community health centres, community clinics, hospitals, schools and other early years community settings.

Screening, in general (i.e., beyond the HBHC Screen) can be carried out by a range of health and social service professionals, including prenatal educators, primary care physicians, nurse practitioners, midwives, other PHNs, teachers and hospital nurses. In the case of older children (from six weeks up to transition to school), some screening can also be done by parents. Other screenings may lead to HBHC screening (e.g., NDDS, NutriStep).

**Screening Strategies**

The HBHC Program screening process is based on three key strategies:

1. Utilizing the appropriate component(s) of the HBHC Screen (prenatal, postpartum or early childhood).
2. Supported by the screening liaison role, encouraging the ongoing support and involvement of primary health care providers, social service providers and educators by providing appropriate screening tools, education in healthy child development and information on screening/surveillance.
3. Encouraging the support and involvement of parents and families by providing appropriate screening tools (e.g., NDDS) and referrals to sites that provide parent services and education.

**b) Prenatal Screening**

Prenatal screening aims to reach all pregnant women in Ontario in order to identify families with risk and ensure they are referred to services before the baby is born. The screen is preferably administered as early as possible during pregnancy.

**Rationale**

The period between conception and birth provides the foundation of a child’s well-being. It is a time when the child’s basic neural structures are established and will have a
direct impact on development. It is also a time when the attachment between mother and child (also a crucial part of healthy child development) begins. (72-75) The prenatal period is a critical time for mothers with risk and the optimal starting point for the HBHC Program services. The relationship that develops after the baby’s birth is often enhanced if the home visitor (professional and/or paraprofessional) gets to know the mother in the prenatal period.

All families require access to information, programs and services during the prenatal period that will provide the support they need to help ensure they have the healthiest baby possible. Families who experience negative psychosocial and/or health factors (such as low income, poor living conditions, isolation, violence in the home, poor nutrition, poor working conditions, lack of access to services, smoking and alcohol and substance abuse) need comprehensive support and interventions that will help them cope with and/or overcome these barriers. The HBHC Program seeks ways to help ensure that needed services begin prenatally. Intervention at this stage is often highly effective because pregnant women are ready to learn and willing to modify behaviour to protect their child.

Prenatal screening is an effective way to identify a larger proportion of families with risk as early as possible during the pregnancy. Research has demonstrated that the HBHC Screen questions can identify families that may be at risk and who require a more in-depth assessment during the prenatal period to confirm risk. (76)

The HBHC Program (See Part I, Section 1) seeks to promote optimal growth and development in children through a system of early identification and early intervention services. If families have the right support and information, they are better able to give their children a good start. Even families that are not considered at risk can benefit from access to appropriate prenatal information and prevention resources. The HBHC Program will also refer parents to other sources of prenatal and parenting information, such as the board of health’s prenatal programs, the Ontario Early Years Centres, family practice networks/family health teams and community health centres and midwife groups as well as birthing centres.

**REQUIREMENTS**

1) The board of health shall work with primary care providers and community partners involved in prenatal care to offer screening to all pregnant women.

A substantially high proportion of pregnant women in Ontario see a physician or other primary care provider during pregnancy and it follows that an effective way to deliver prenatal screening is through these health care providers. It is essential that HBHC Program staff work collaboratively with public health and other program and service providers.
providers. These include but are not limited to: prenatal clinics, other prenatal services (e.g., CAPC/CPNP), sexual health and family planning clinics, primary care physicians, community health centres, nurses, midwives, nurse practitioners, pre-birth clinics in hospitals and emergency rooms. Involvement with other service providers involved in prenatal care helps to ensure that all pregnant women are offered screening.

ii) The board of health shall use and promote the HBHC Screen (prenatal) as required by the ministry.

The HBHC Screen (prenatal) includes questions that identify factors associated with parenting difficulties and problems with child development. All questions should be administered to determine if the parent is at risk. In the event that a concern is identified using question 36 only, families will still require a complete assessment to confirm risk. Thus, screening where all questions have a response is recommended to decrease the incidence of false positive identification. The HBHC Screen should be completed by a health professional (as described above) and not by the client.

It is acknowledged that other prenatal assessment tools, such as the Antenatal 1 and 2 Record (77) and the Antenatal Psychosocial Health Assessment (ALPHA form) (78) are currently being used. The Public Health Branch of the Ministry of Health and Long-Term Care and the Child and Youth Development Branch of the Ministry of Children and Youth Services support the use of these tools. However, it should be noted that these tools should be used in conjunction with the HBHC Screen to identify families who would most benefit from the HBHC services.

iii) The board of health shall establish a procedure for obtaining the results of the HBHC Screen (prenatal).

iv) The board of health shall be responsible for entering the results of the HBHC Screen (prenatal) in ISCIS or any other system specified by the ministry.

Results of all HBHC Program prenatal screens will be provided to the board of health responsible for entering the data in ISCIS. As a best practice, health care providers should have the mother’s consent to share this information with the board of health. All completed screens will be provided to the PHU to establish case management if the risk status of a family changes.

When results from screens or tools other than the HBHC Screen are received by the board of health, a HBHC PHN will incorporate the relevant data and then contact the parent(s) and accurately complete the HBHC Screen.

If the family is already receiving an existing HBHC service (e.g., blended home visiting)
and a new HBHC Screen is received and scored without risk, the services cannot be automatically discharged based on the new screen. It is the role of the lead PHN providing service to reassess the family for continued services in light of the new screen. Consult the HBHC-ISCIS User Guide (71) for detailed data entry instructions.

c) Postpartum Screening

HBHC postpartum screening aims to reach all consenting women who give birth in Ontario, identify those who may be at risk and link them to HBHC Program services. The HBHC Screen (postpartum) includes a series of questions that identify families with risk for challenges to healthy child development who may benefit from HBHC Program services.

Postpartum screening is administered after the birth of the baby and either before discharge from hospital or anytime prior to discharge from midwifery care, depending on and in response to the needs of the mother and family.

Rationale

Postpartum screening is an efficient and effective way to reach almost all families with new babies in Ontario and to identify those who may be at risk very early in their children’s development. The HBHC Screen (postpartum) is a universal tool administered in hospitals and by midwives, with consent of the family member who is being screened and the newborn child for whom they are the parent/guardian.

REQUIREMENTS

i) The board of health shall work with hospitals, birthing centres, midwives and other partners to offer the HBHC Screen (postpartum) to all women who give birth in Ontario.

Service protocols with local hospitals and midwives should help ensure the responsibility for postpartum screening is appropriately assigned and that screening is done as part of routine postpartum care for all families as described in the section entitled Screening Service Delivery Sites.

ii) The board of health shall use and promote the HBHC Screen (postpartum), as required by the ministry.

The HBHC Screen (postpartum) is most effective when all questions are completed and the intent of the questions is fully understood (as outlined in the HBHC Screen tip sheet). If all items are not completed, with risk families may not be identified. In the event that a concern is identified using question 36 only, families will still require a complete assessment to confirm risk. Thus, screening where all questions have a
response is recommended to decrease the incidence of false positive identification.

The education and training of health care staff should emphasize the use of the HBHC Screen tip sheet which outlines instructions, definitions and additional information for health care providers. The HBHC Screen (postpartum) is intended to provide greater focus on risk identification for families who can benefit from HBHC home visiting services and will enable these vulnerable families to access support more quickly.

iii) The board of health shall work with hospitals, birthing centres, midwives and other partners to establish a procedure for notifying the boards of health of all births and for obtaining the results of all postpartum screens.

The public health unit is responsible for providing the appropriate mechanisms for obtaining informed consent that supports their compliance with current relevant legislation.

iv) The board of health shall be responsible for entering the results of the HBHC Screen (postpartum) in ISCIS or any other system specified by the ministry.

Vulnerable families have greater involvement with home visiting services and a more positive experience when they build a trusting relationship with the provider. (17, 56, 68, 69) This process is supported by timely referrals that enhance provider responsiveness. It is important that boards of health receive the HBHC Screen (postpartum) in a timely manner. This will help ensure that families with risk receive HBHC services quickly after discharge from postpartum care. As a best practice, health care providers should have the mother's informed consent before sharing this information with the health unit.

When boards of health receive a birth notification (e.g., HBHC Screen) for families who live outside their jurisdiction, they are responsible for passing that information along to the board of health where the family resides in a timely manner and arranging for receipt of the HBHC Screen or other notification as necessary. The appropriate board of health is responsible for entering the results of the HBHC Screens into ISCIS.

d) Early Childhood Screening and Promotion (6 weeks up to transition to school)

Early childhood screening and promotion aims to reach all families in Ontario with children in the early years, from six weeks to the transition to school. It consists of screening and monitoring tools for parents and professionals and other service providers working with children that can be used to determine whether children are achieving developmental milestones. The HBHC Screen (early childhood) has been developed to identify families with risk for challenges to healthy child development who may benefit from additional services of the HBHC Program, such as home visiting.
Rationale

Early childhood screening and promotion supports the HBHC goal of universal screening for healthy child development that extends from the prenatal period up to a child’s transition to school. While the prenatal and postpartum screens are effective ways to identify risk as early as possible, opportunities for screening are also essential ways to identify children with risk later in childhood, as they become toddlers and preschoolers.

Families’ situations can change over time or, in some cases, vulnerable children may have been missed during early screens. Social predictors can have a strong impact on child development and families need easy access to screening, assessment and intervention for healthy child development throughout their children’s early years and as an alternate way to benefit from the HBHC Program if required. They also need to be empowered to play an active role in the ongoing monitoring and assessment of their children’s development.

A comprehensive system of universal screening, assessment and promotion for healthy child development, prenatal up to transition to school requires the ongoing support and involvement of primary health care providers, educators, social service providers and parents during the early years.

Strengthening and Supporting the Involvement of Parents and Families

Parents and families can play a vital role in monitoring their children’s development. The HBHC Program provides screening tools that can be administered by parents and also links/refers parents to local parent-serving sites such as community health centres, family practice networks and Ontario Early Years Centres.

Primary health care providers who have regular contact with families have opportunities to observe children during routine office or clinical appointments and should play a significant role in monitoring healthy child development. Establishing a network of key care providers who are willing to take an active part in the child health screening and monitoring process can help establish a community environment that supports healthy child development and persuade their colleagues to participate.

The HBHC Program will provide parents with information about accessing or access to the Nipissing District Developmental Screen® (NDDS®) for use in monitoring their child’s achievement of developmental milestones. The NDDS is a parent-completed, developmental checklist designed to assist parents, health care providers and child care professionals with a convenient and easy-to-use method of recording the development and progress of infant and children within certain age groupings.

REQUIREMENTS
i) The board of health shall use and promote the HBHC Screen (early childhood), as prescribed by the ministry.

ii) The board of health shall work with primary care providers, educators and others working within the field of early learning and child development to provide all families access to early childhood screening and promotion.

Boards of health will administer the HBHC Screen (early childhood) to all families who are interested in the HBHC Program to determine if families are at risk and could benefit from additional services offered by HBHC Program. They will also work with other public health unit staff, primary care providers, educators and others working within the field of early learning and healthy child development to provide all families access to screening throughout the early years. In the event that a concern is identified using question 36 only, families will still require a complete assessment to confirm risk. Thus, screening where all questions have a response is recommended to decrease the incidence of false positive identification.

The HBHC Program aims to increase the involvement of primary care providers, as well as educators and others working within the field of early learning and child development in local planning and monitoring of ongoing healthy child development, including professional screening and assessment. The goal is to maximize interdisciplinary collaboration among health, social service, education and other providers within the field of early learning and encourage effective referrals. (See Section 7: Service and System Integration for more details related to collaborative relationships.)

iii) The board of health shall be responsible for entering the results (with family consent) of the early childhood screen in ISCIS or any other system specified by the ministry.

The board of health is responsible for entering the results of the HBHC Screen (early childhood) and the NDDS into ISCIS both for the purposes of case management and surveillance.

iv) The board of health shall provide parents with the Nipissing District Developmental Screen® (NDDS®) for use in monitoring their child’s achievement of developmental milestones.

v) The board of health shall provide local public health unit contact information for parents to discuss results of the NDDS and arrange follow-up.

Parents play an important role in nurturing their children and preparing them for school. (79) The environments that they create and the choices they make about early
learning activities have the greatest influence on their children’s development.

According to research, parents’ participation in monitoring their children’s development empowers the family, strengthens its sense of responsibility and promotes primary prevention. Having parents participate in monitoring their children is an effective way to educate them about healthy child development and the strategies they can use to promote achieve this goal. To this end, public health units should help ensure there is consistent practice in the access, distribution and completion of the NDDS for children born at full-term gestations.

When providing information to families of children born at less than 37 weeks who wish to use the NDDS, public health units should apply the key messages below (see Table 3) to provide information about use of the tool with this population. If a child has been identified with developmental delay or concerns and is receiving follow-up service use of the NDDS may not be necessary. If a parent requests access to NDDS, this can be accommodated with a discussion about the role and purpose of the tool.

The Nipissing District Development Screen® (NDDS®)

The NDDS is a parent-completed checklist which provides parents, health care providers and child care professionals with a convenient and easy-to-use way to record the development and progress of infants and children within certain age groups. The NDDS can be used with all children and not just children with potential issues, needs or risks. NDDS provides a quick way to identify areas that may require extra help. It is not a diagnostic tool and it is not meant to be a formal assessment. The HBHC Program has secured province-wide rights to make the NDDS-2011 widely and broadly available throughout communities in Ontario.

Areas of development covered by the NDDS include vision, hearing and communication, gross and fine motor, cognitive, social/emotional and self-help. Age appropriate activities accompany the screens and are designed to promote overall development. The screens coincide with immunization schedules as well as key developmental stages up to age six and examines thirteen developmental stages: one and two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, thirty months, three years, four years, five years and six years.

The NDDS is available in the following formats: pictorial, low literacy tool, e-NDDS and as an interactive online tool. The tool is also available in French, Spanish, Chinese and Vietnamese. Translations for other common languages will be made available for use as they are developed.
Table 3: Adjustment for Age

Understanding the need for adjustment for age when conducting developmental screens for children born < 37 weeks gestation

- Evidence-informed practice advises the close monitoring of premature infants at high risk for developmental delays.
- Age adjustment was introduced into developmental assessment because of a concern that young children born prematurely were being over-diagnosed as developmentally delayed when assessed based on their chronological age.
- Some developmental processes may have an intrinsic timeline that is not significantly altered by a child’s birth and as a result, the use of adjusted age rather than chronological age may be more appropriate for these children.
- There is frequent assertion that premature babies will catch up at some time, such as twenty-four months. Although there is face validity to the idea that any effect of prematurity may become insignificant as a child ages, it is also possible that as time passes, additional developmental and environmental factors such as parenting, nutrition, opportunities to develop skills, may overshadow any effects of prematurity or render them undetectable.
- Reaching 24 months of age or optimal opportunities provided for growth and development do not necessarily equate to a true disappearance of the prematurity effect.

vi) The board of health shall work with primary care providers and community partners to develop procedures for referring vulnerable families to the HBHC Program and sharing results of early childhood screens.

The HBHC Program aims to increase the involvement of primary care providers (as well as educators and others working within the field of early learning and healthy child development) in local planning and monitoring of ongoing healthy child development, including professional screening and assessment. Its goal is to maximize interdisciplinary collaboration among health and social service, education and other providers within the field of early learning and encourage effective referrals. Sharing results in aggregate and population-based reporting will support ongoing work to identify other areas for development in the field of early identification of vulnerable families.

vii) The board of health shall designate HBHC Program staff to provide support and program delivery, as required by the ministry, for additional screening opportunities in the early years.

These additional screening visits are opportunities for:
- Monitoring growth and development,
- Early identification of risk, and
- Referral to early intervention and treatment.
Of equal importance is the opportunity to support parents, through anticipatory guidance, to enhance parenting skills that have been shown to impact and optimize child outcomes. (80) Furthermore, supporting parents to identify risk factors, both biological and social, will support chronic disease prevention as there is a growing body of literature that demonstrates early exposures and risks have a significant impact to later adulthood illness and disease. (81-85)

In addition, the screening liaison role as described previously will support these additional screening opportunities by:

- Providing liaison and outreach to HBHC Program community partners in order to support and prove quality assurance for appropriate identification of vulnerable families who would benefit from HBHC Program services and/or completion of the HBHC Screens as appropriate. This may include the following functions:
  - Education and training related to population health, screening, health impacts of the early years and risk factors to child development.
  - Development of tools or job aids to support identification or quality completion of HBHC Screens.
  - Creating partnerships and collaboration to improve identification or HBHC Screen completion.
- Collaboration and partnership with primary care in the implementation and delivery of the enhanced 18 month well-baby visit.
- Providing support for additional screening opportunities as described by the ministry (e.g., the 36 month/transition to school screening opportunity).

3) Assessment

Assessment is the second step in identifying families and children who may be with risks that compromise healthy child development and parenting. Families who are confirmed with risk can benefit from targeted interventions that include support services and blended home visiting. The objective of HBHC Program assessment is to confirm risk in vulnerable families who would most benefit from targeted interventions during the time between pregnancy and a child’s transition to school.

In-depth assessment is completed using the HBHC Family Assessment Instrument (FAI) which confirms risk at all three stages of entry to the HBHC Program:

- Prenatal assessment,
- Postpartum assessment, and
- Early childhood assessment.
a) General Considerations

Rationale

Children’s developmental trajectories and parents’ capacity to parent are influenced by many different genetic and experiential factors. Although individual children develop at their own pace, normally they progress through an identifiable sequence of physical, cognitive and social/emotional growth and change. The number of risk factors a child is exposed to can be an important predictor of potential developmental challenges, future health, including coping, adaptation and chronic disease prevention. (83, 85-87) Unless they are extreme, one or two risk factors are unlikely to negatively impact development. However, as the number of risk factors increases, the negative effect will multiply.

There are also important protective factors which can contribute to early resiliency. Proximal factors, such as the quality of parent-child interactions, maternal mental health or child health are critical to child development. Distal factors, such as housing, educational attainment or social supports have an indirect influence on child development usually through the parent-child interaction.

Figure 3: Child Development Trajectory (88, 89)

Categories of influence identified as particular risk and protective factors that affect the trajectory of child development include:

- Prenatal health,
• Infant/child health (physical and mental/emotional),
• Parent’s health (physical and mental/emotional),
• Parenting knowledge, and
• Availability of positive social supports.

By identifying the cumulative risk and protective factors through in-depth assessment supports it is possible to:
• Mobilize a family’s strengths to address potential and identified risks.
• Identify appropriate interventions to support healthy child development.
• Build positive social supports to further add to protective factors.

REQUIREMENTS

i) The board of health shall contact all families identified with risk by the HBHC Screen (prenatal, postpartum, early childhood) upon receipt of the tool.

Through timely intervention, the ability to assess is an essential aspect of PHN home visiting interventions. The initial contact with a family who has screened positive provides a unique opportunity to begin the home visiting process by establishing entry to the home and a trusting relationship. (17, 56) During this initial contact, in-depth assessment, a Family Service Plan and corresponding referrals can be initiated. Though these elements occur sequentially (see Algorithm, page 35) in this document, they can be implemented concurrently in practice so as to facilitate a timely and effective response.

In addition, the screening liaison role will help to support the initiation of HBHC Program services for vulnerable families through their triage responsibilities as described previously. Recent evaluation has determined, that where the screening liaison nurses are able to provide follow-up contact and begin assessment (e.g. IDA Contact), vulnerable families are more likely to accept the next steps in service delivery of the HBHC Program (90).

ii) The board of health shall conduct in-depth assessments using the in-depth assessment tool required by the ministry. The tool shall be completed by the public health nurse.

In-depth assessment for the HBHC Program is carried out using the HBHC Program Family Assessment Instrument (FAI). The HBHC FAI includes 23 items and three supplemental questions that reflect the five categories of influence during the trajectory of child development. This tool has been determined to be a valid method of confirming risk for families (91). In support of quality nursing care, and as this assessment supports further referral and intervention, all efforts will be made to
complete all of the questions, including the three supplemental questions.

The HBHC FAI has been linked to two other assessment tools that are also used to assess family risk:

- The *Antenatal Psychosocial Health Assessment* (ALPHA) consists of 35 questions that assess a pregnant woman’s psychosocial health and was developed for use by physicians, nurse practitioners and PHNs. ALPHA questions focus on family factors (e.g., social support, stressful events and the couple’s relationship), maternal factors (e.g., attendance at prenatal care, feelings about pregnancy, relationship with parents, self-esteem and mental health), substance use and family violence that could put the infant and family at risk.

- The *Child Protection Standards in Ontario* (2007) (89) which contain a set of tools used by child protection workers to complete investigations, risk assessments and related plans.

In order to assess the consistency of the FAI, during the 2001 HBHC Program Evaluation, the FAI was administered twice to a set of families. The extent of agreement on overall risk level assessment between the two administrations of the FAI was approximately 92%, indicating consistency. Three supplemental questions were added in 2009 to support the role of a social worker as part of the blended home visiting team. These questions are considered as part of the IDA process as a supplement to the FAI and should be used to support IDA completion for all families.

**Service Delivery Sites**

The ideal site to initiate the FAI is in the home where the primary caregiver and the child are living. This allows for objective evaluation of the living conditions and housing stability and may also allow for observation of family interactions, food security concerns, and evidence of family violence. When situations allow, the FAI can be *initiated* by telephone during the first contact after receipt of the HBHC screen. In these cases, the FAI must be completed in the home where the primary caregiver and other caregivers can be observed with the child.

If the family is not comfortable with allowing HBHC staff to enter the home or if HBHC staff is not comfortable with the home visit setting due to a personal safety issues, an alternative community site can be arranged. Note: non-entry to the home in itself provides valuable information related to the assessment process and should be noted.

In all cases, the infant/child must be present during assessment to allow for professional observation of the infant/child interactions with the primary caregiver.

**Assessment Strategies**

The FAI should be administered, at minimum, during one home visit and/or as soon as
possible after the HBHC Screen or external referral for assessment takes place. There must be an opportunity to observe the infant/child interactions with the primary caregiver, and other caregivers when available, in order to complete the family assessment.

Families should receive only one family assessment for each service period (i.e., during the period from intake or opening a file to discharge from the HBHC Program). The family assessment must be repeated when a discharged family re-enters the program and begins another service period. A second FAI can be completed in the same service period, but is not a requirement, in the same service period if there is new information that enhances the confirmation of risk process. The two FAIs should be linked on ISCIS to provide a complete picture of the family. Consult the *HBHC ISCIS User Guide* (71) for further details on linking assessments.

The FAI should be completed by a PHN. Every effort should be made to appropriately train and orient PHNs to the administration of the tool, particularly in relation to how it confirms risk and identifies families who would benefit from social support and blended home visiting interventions. Because the establishment of a therapeutic and trusting relationship is key to successful home visiting interventions, the professional doing the family assessment should, whenever possible, be the same one who will provide blended home visiting if risk is confirmed. (17)

**The Seven Step Process for Administering the FAI**

**Step 1. Acquiring informed consent from family members to complete the in-depth assessment**

- Participation in the in-depth assessment is voluntary. The PHN must have the family’s informed consent to conduct the visit and complete the family assessment.
- If the family does refuse to participate in the in-depth assessment, the PHN can provide information about services available in the community. The PHN must advise the family that blended home visiting services, including support services and service coordination, cannot be provided unless an in-depth assessment is completed.
- Health units must help to ensure service delivery that is culturally competent. This includes offering participation in Aboriginal HBHC and/or French HBHC, as appropriate.

**Step 2. Gaining the trust of the primary caregiver/family members**

- The visit to initiate the in-depth assessment will likely be the first time the primary caregiver and/or family members have met the PHN face-to-face. Establishing a trusting relationship between the PHN and the family is key to gaining access to the family and completing the assessment. When safety
concerns are presented during the assessment process, exceptions to including the family members in the assessment could be considered as part of professional nursing judgement. Including primary caregiver and family members in this assessment process supports the family to optimally meet their potential as reflected in the HBHC Program vision.

- A trusting relationship can be established by:
  - Developing a partnership with the family so that they consider the PHN as part of an active process in identifying their strengths in order to address their risk concerns.
  - Supporting the families to identify their health values and how these could be addressed through the blended home visiting program.
  - Building and nurturing the relationship as part of the assessment process. (Consult the literature review provided in Section 2 for more details).

**Step 3. Setting the tone for the in-depth assessment**

- The FAI is designed to be used as part of a supportive conversation with the caregiver rather than a formal interview. The topics are arranged as the kind of exchange a professional might have with an expectant mother or parent of a new baby.
- Not all in-depth assessments will follow this pattern, so the PHN must be flexible.
- In keeping with the HBHC Program focus on building family strengths, the PHN will acknowledge and reinforce the areas in which the family is doing well.

**Step 4. Making skillful observations**

- The FAI supports professional judgement. The PHN should note objective and subjective observations of the family in order to help identify family needs.
- The PHN should observe the infant/child interaction with the primary caregiver and with the secondary caregiver where possible.

**Step 5. Gathering relevant information**

- Open-ended questions that probe for details will support the gathering of relevant information to complete the FAI. Sample questions and anchor descriptions are provided in Appendix 2: *Sample Assessment Questions and Anchor Descriptions*.

**Step 6. Completing the form and rating the items**

- For each of the items in the FAI, PHNs must provide a rating from 0 (not an issue) to 4 (an area of major concern).
• Any item that scores 2 or higher is an area of concern. When there is not enough information to give a rating, the item is scored as 9.
• To help PHNs assign ratings, the FAI provides an anchor description for each degree of severity for each item. The anchor descriptions define specific levels of status or functioning of a child, caregiver or family and the rating they would receive in the FAI. For a complete list of anchor descriptions, see Appendix 2: Sample Assessment Questions and Anchor Descriptions.
• When choosing an anchor description:
  – Choose the anchor description that most closely reflects the assessment of severity for that particular item. (It does not have to match exactly.)
  – For anchor descriptions that have more than one part, not all parts need apply to select that particular anchor.
  – Not all anchor descriptions are mutually exclusive. Parts from more than one anchor description may reflect a particular case. Always choose the risk level that seems to fit most closely.
  – When multiple children and/or parents have different levels of risk for the same item, select the highest appropriate rating and then identify the particular child or parent in the summary description.
  – Always rate the actual risk – do not take into account any services or supports that the family is receiving. Select the anchor description that would apply if services were withdrawn or did not exist. PHNs will have an opportunity in the final scoring/analysis to take into consideration the supports and services the family is receiving now, as well as those that can be provided.
• **Note:** There are two sets of boxes for ratings for all child-related items except those that apply to the pregnancy. The first box is used for information/ratings that apply to the newborn. The second box can be used for an older child in the home who is present during the in-depth assessment (or a younger child, when the older child is referred for services through early childhood). There are also two sets of boxes for the questions that apply to caregivers, so the form can be used to score two caregivers, if both are present during the in-depth assessment.

**Step 7. Determining whether the infant/child is at risk of abuse or neglect and whether there is a “duty to report”**
• HBHC Program PHNs will identify children in need of protection and refer them to appropriate child protection services. Conversely, child protection workers may refer back to the health unit families where the child protection issues have been or are being addressed and the family still has risk for poor child development and would benefit from further support and assistance, such as blended home visiting.
• **Duty to report**
- Under the Child and Family Services Act (CFSA), individuals who work with families and children have a duty to report suspected child abuse or neglect. If, during the process of conducting the in-depth assessment, the PHN believes there is a “duty to report” as described in the CFSA, the PHN will follow the public health unit’s established policy and procedures for handling potential abuse cases. (See requirements described under “Duty to Report” Part I, Section 3, Item 1e)
- Once the situation has been reported, the child protection worker will make a decision about initiating a protections investigation if required. The child protection services and the public health unit will make a joint decision about continued assessment and service.
- To aid in the decision-making, the FAI has identified when a PHN completing the report must exercise the duty to report and consult the appropriate child protection services (See Appendix 2 of the FAI for details).

Responsibility to consult
- In some cases, a PHN may determine that there is no “duty to report” as specified under the CFSA. However, based on the family’s rating on one or more of the items in the FAI, it is recommended that the PHN or the public health unit consult with child protection services.
- The purpose of the consultation with the children’s aid society is to:
  - Seek advice about whether or not, in the opinion of the children’s aid society, there is a duty to report. If so, the referral/report must be made immediately.
  - Obtain general advice and information about the children’s aid society and its mandate
  - Build an effective working relationship between the two service systems.
- When consulting with child protection services on situations where there is no duty to report, PHNs should adhere to the health units’ confidentiality policies.

Scoring and Analyzing the Assessment Results
To “score” the HBHC FAI, the PHN must analyze the information, findings and observations, consider the inter-relatedness of different items and their ratings and take into account the family’s strengths. For example, items rated 2 or lower may help reduce the risk posed by items that rate higher than 2. The family’s strengths and resources can be protective factors that significantly reduce the impact of some of the risks identified during the in-depth assessment.

Note: Although they impact the family’s experience of stressors, the three supplemental questions have not been validated and should not be considered as part
of the overall scoring process. These supplemental questions can be used to support the scoring of other items in the FAI. For example, scores and anchor descriptions of supplemental question #I: Family Settlement Support may help to determine scoring for question #14: Availability of Social Supports of the FAI.

Analysis of the FAI is important because it provides a picture of the family’s risk and protective factors as well as other important issues or needs that should be addressed. It also forms the basis for developing the Family Service Plan. (See Protocol Requirement Item #5 for more details on developing the Family Service Plan)

Pages 8 and 9 of the HBHC FAI provide worksheets to support the scoring and analysis process and are divided into five parts:

- **Part A: Summary of the ratings assigned to the assessment factors.**
- **Part B: Summary of the family's strengths and how the strengths interact with each other.**
- **Part C: Summary of the family's risks and how the risks interact with each other.**
- **Part D: Analysis of how the strengths and risk interact to increase and/or decrease risk.**
- **Part E: Overall rating for risk of poor child development.**

The worksheet must be completed as part of the in-depth assessment needed to develop an understanding of how protective and risk factors interact for the family and areas of concern that could be addressed through blended home visiting services.

**Part A: List ratings**

- Insert the rating for each item in the appropriate box.
- List any other factors that should be considered as part of the assessment (e.g., the PHN’s observation of the family, information received from other sources, information not covered by the 23 items).
- Confirm that there is enough information to complete the assessment. If the summary of the ratings includes a large number of “9”s (indicating insufficient information), it may be necessary to ask other questions or obtain more information before the in-depth assessment can be completed.

**Part B: Describe family strengths**

- Summarize the family’s strengths. Include the items where the family scored 0 or 1.
- Include the other physical, emotional or social/environmental strengths observed during the assessment that could play a significant role in reducing a child’s risk (e.g., the caregiver’s motivation/determination, physical health and/or experience dealing with problems/stresses; caring friends and family or appropriate social network; access to services such as substance abuse
• Describe how the strengths interact and their potential impact on the child. This will help with completion of the Family Service Plan. (See Protocol Requirement Item #5)

Part C: Describe family risks

• Summarize the family’s risks and areas of concern. Include the items where the family scored 2 or more.
• Include any other risks observed during the in-depth assessment.
• Describe how the risks interact with one another. Group or cluster risks that may lead to a different assessment of the family’s needs than if the risks were considered individually. For instance, a score of 3 on question #5 related to the child having difficult behaviour/temperament and a score of 3 on question #10 demonstrating unrealistic parenting expectations would multiply to create a higher level of risk for abuse/neglect.

Part D: Analyze strengths and risks

• Describe how the strengths identified in Part B and the risks identified in Part C interact to increase and/or decrease risk.
• Incorporate the family’s perceptions of strengths and risks.
• Note: When completing this section, consider how a lower rating on one item (strength) may offset a higher rating (risk) on another one and vice versa.

Developing an Overall Rating

The FAI does not provide a place to include a final number score or rating for a family and child. This is because the family’s overall rating rests primarily on professional judgement, rather than a numerical calculation. Although the individual item ratings are indicators for the final assessment and are recorded as part of the assessment, the PHN can override them and provide his/her own overall rating for the infant, another child in the family (if appropriate) and for the family as a whole.

Instead of providing a number score, the PHN rates the infant, child and family by confirming the presence of significant risk based on the following guidelines:

No risk confirmed (low/moderate risk) describes a situation where any threat to healthy child development is low or insignificant.

• Most items were rated 0 or 1.
• Any items that rated higher than 1 were offset by lower ratings on other items or by individual or family strengths.
• The child is experiencing healthy physical and emotional growth with no obvious delays.
• The family shows respect and support for the child’s individual temperament.
• The caregiver is providing an environment that is physically and psychologically safe for the child to explore.
• The caregiver responds to the child sensitively and consistently.
• Interactions within the family are supportive and positive.
• The caregiver praises and encourages developmental accomplishments and demonstrates awareness of age appropriate behaviours.
• There is no evidence of psychosocial risk factors such as isolation, substance abuse, family violence, unstable living conditions or insecure access to food.
• Where there are risks such as unrealistic expectations, unsupportive or non-nurturing relationships or poor coping strategies, these are offset considerably by other protective factors such as high motivation and no impediments to accessing services, multiple sources of reliable and useful support, and/or high cooperation with services.
• The caregiver is receptive to any suggestions made by the PHN.

Confirmed with risk (moderate/high-risk) describes a situation where there are several significant risk factors that work together to negatively impact healthy child development and the family demonstrates a need to be linked to health and/or social services in the community. This means that, based on the HBHC Family Assessment Instrument:
• Several items were rated 2 or more.
• Any items that rated 3 or 4 are not likely to be offset by lower ratings on other items or by family or individual strengths.
• The child is experiencing moderate to serious illness or disability that may adversely affect his/her ability to achieve developmental milestones.
• The caregiver has difficulty supporting and respecting the child's individual temperament or the caregiver expects emotional support from the child and can only provide limited nurturing for the child.
• The caregiver is not providing an environment that is consistently physically and psychologically safe for the child to explore, has serious mental/emotional disturbance that severely affect the ability to protect and or care for the child or is neglecting the child. (Even unintentional neglect may have a significant impact on child development).
• The caregivers' unrealistic expectations about the child's developmental progress are resulting in inconsistent and/or harsh discipline, inappropriate verbal interactions or intentional neglect.
• The interactions within the family are indifferent, if not controlling unsupportive and non-nurturing, possibly moving to rejection of the child or hostility towards the child.
• There is some evidence that the family has poor or no coping strategies for dealing with stress, support from family is unreliable, living conditions are unsafe and unstable, all resulting in a negative effect on the child's growth and
• There is some evidence that the caregiver is unwilling or unable to follow through on suggestions to modify problematic conditions and/or behaviours.
• Some of the families will be involved with children’s protective services or other programs such as Infant Development, CAPC, substance abuse or mental health services or have significant medical involvement with physicians or the hospital.

Meeting Urgent Needs
During the course of completing the in-depth assessment and administering the FAI, the PHN may identify a child or family member in need of medical care (e.g., an emergency that requires immediate attention) or an urgent problem that needs prompt action. In these cases, the PHN will help the family call an ambulance or obtain an emergency appointment with a physician.

If a communicable disease threatens the child’s health or there is concern about the family’s ability to care for the child, assessors are required to follow appropriate reporting procedures as prescribed by the health unit.

While conducting assessments, family members may disclose a variety of psychosocial issues that require professional treatment or intervention. It is important that assessors develop strong partnerships with staff working in family violence, mental health, substance abuse and link families to these services as appropriate. Based on protocols established by health units, PHNs will refer to these services when required.
Linking Families to Appropriate Resources

All families confirmed with risk by the FAI will be referred to the HBHC Blended Home Visiting Program. As part of HBHC Program services, a service coordinator will be identified, links will be made with a family home visitor as appropriate, and a Family Service Plan (FSP) will be initiated. These services require family consent for service and a willingness to address mutually agreed upon FSP goals.

All referrals made as a result of completing the in-depth assessment through completion of the FAI will be documented on the final page of the FAI.

iii) The board of health shall integrate information obtained from other organizations into the in-depth assessment tool, and related tools that support assessment, with family consent.

Every effort should be made to avoid duplicating family assessments. When identified, families with multiple existing service providers will obtain appropriate consents, where necessary, to share information and will use existing assessments to support completion of the in-depth assessment.

iv) The board of health shall enter all assessment results in ISCIS or any other system specified by the ministry.

Data Entry and Documentation

Detailed explanations of how to complete data entry and documentation of the FAI and IDA using HBHC-ISCIS are available through the *HBHC-ISCIS User Guide*. (71)

b, c, d) Prenatal, Postpartum and Early Childhood Assessment

Rationale

Assessment is an important intervention in and of itself, because it provides an opportunity for a knowledgeable trained professional to open a dialogue with parents that will allow for health teaching and education, reinforcing of family skills and strengths, and sharing of resources. These assessments should be guided by current guidelines (e.g., Health Canada-Infant Feeding [http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/index-eng.php]; RNAO Best Practice Guidelines) and grounded in the literature and resources which support evidence informed practice.

Prenatal conditions significantly impact child health outcomes and overall child development. This is a time when the child’s basic neural structures are established and there are significant impacts that can affect certain genetic pre-dispositions. Reduction of prenatal risks has been found to have a significant impact on overall resilience in
development. (90) Thus, establishing the existence of prenatal risk and protective factors supports the identification of families who are confirmed with risk and would benefit from home visiting supports.

Postpartum assessment allows the professional to establish a baseline (in cases where prenatal assessment was not already completed) for the family’s risk and protective factors.

An alternative opportunity for early childhood screening and assessment provides responsive support for optimal child development trajectories and long-term health and well-being. Early childhood assessment opportunities allow exploration of risk and protective factors at the individual, family and community level. Establishing the existence of early childhood risk and protective factors supports the identification of families who are confirmed with risk and would benefit from home visiting supports.

**REQUIREMENTS**

**b) Prenatal Assessment**

i) The board of health shall conduct an in-depth assessment on all consenting pregnant women who have been identified with risk by the HBHC Screen.

The in-depth prenatal assessment is completed using the FAI described above. This assessment should be carried out with families who have been identified with risk using the HBHC Screen conducted during the prenatal period. The purpose of this assessment is to confirm risk for the family in the prenatal period. The in-depth assessment must be initiated for all families, who consent to continued services and are identified with risk based on the HBHC Screen, regardless of the number and type of risk factors.

Informed broadly by the themes present in *NCAST-Promoting Maternal Mental Health During Pregnancy (PMMHDP)* (91) assessors will consider the following in their assessment (see PMMHDP TAP Cards).

When using the FAI during the prenatal period, assess the prenatal influences through questions #1, #2 and #3. For families where this is the first pregnancy or there are no other children in the home, questions related to the child’s influences (#4, #5 and #6) should be scored with values of 9 (Insufficient information to make a rating). **Note:** These questions should not be marked as 0 because this would indicate no-risk which would be incorrect because during the prenatal period, child influence cannot be assessed. If the family continues services after the child is born, these questions could be reassessed to support service planning. The initial prenatal FAI cannot be amended by information from subsequent assessments. This information can be documented in
nursing notes and used as significant factors in the Family Service Plan completion (See Protocol Requirement Item #5). Alternatively, though not a requirement and based on professional judgement, a subsequent FAI could be completed postpartum and linked to the prenatal assessment. Consult the *HBHC ISCIS User Guide* (71) for further details.

The person interviewed for the in-depth assessment during the prenatal assessment should be the expectant mother. Other significant caregivers should be included if possible as they have an important impact on the prenatal outcomes.

c) Postpartum Assessment

i) The board of health shall conduct an in-depth assessment on all consenting postpartum families who have been identified with risk by the HBHC Screen.

The in-depth postnatal assessment should be completed using the FAI described above. This assessment should be carried out with families who have been identified with risk using the HBHC Screen conducted during the postpartum period. The purpose of this assessment is to confirm risk for the family during the postpartum period. The in-depth assessment should be initiated for all families who consent to continued services and are identified with risk based on the HBHC Screen, regardless of the number and type of risk factors.

Informed broadly by the themes present in *NCAST-Keys to Caregiving* (92) (e.g., infant state, infant behaviour, infant cues, state modulation, feeding interaction) this assessment includes, but is not limited to, assessment of:

- Infant hydration and hydration.
- The presence of jaundice and other abnormalities.
- The mother’s physiological recovery from childbirth
- The mother’s confidence in basic baby care.
- The mother-infant interaction.
- The mother’s emotional health and adjustment.
- The safety of the home environment.
- Parenting knowledge and capacity.
- Level of parenting support available.
- Family relationships and family adjustment to the new baby.
- The health and development of other young children in the home.

As described earlier, the FAI form includes two sets of checklists regarding the child and the caregivers. If an older sibling lives in the home, an additional checklist in the child-related questions should be used. The name of the older child and date of birth should also be recorded on the first page of the assessment. When there are several older children, the newborn child should be recorded as child (1) and the subsequent children recorded as child (2), (3), etc. If there is a second caregiver in the home when the IDA is
conducted, the second checklist in the caregiver sections should be used. The name of the second caregiver is recorded on the first page of the FAI.

As described above, if there is an existing prenatal FAI, a subsequent postpartum FAI can be completed to include the newborn child’s influences as part of the balance of risk and protective factors. The subsequent FAI must be linked to the first in order to provide accurate data in ISCIS. Consult the HBHC ISCIS User Guide (71) and IRSS Guide (93) for further details.

**d) Early Childhood Assessment**

i) **The board of health shall conduct an in-depth assessment of all consenting families with children, from six weeks of age up to their transition to school who have been identified with risk by the HBHC Screen.**

The in-depth assessment is also completed using the FAI described above. The in-depth assessment should be initiated for all families who consent to continued services and are identified with risk based on the HBHC Screen, regardless of the number and type of risk factors.

The early childhood assessment as described in the FAI will include, but is not limited to, assessment of:

- Child feeding and nutrition.
- The presence of health or development concerns.
- The parent/caregiver’s physical ability to care.
- The parent/caregiver’s confidence in basic care.
- The parent-child interaction.
- The parent/caregiver’s emotional health and role adjustment.
- The safety of the home environment.
- Parenting knowledge and capacity.
- Level of parenting support available.
- Family relationships and family adjustment to the new baby.
- The health and development of other young children in the home.

In addition, the results from completed NCAST Parent-Child Interaction: Feeding/Teaching Scales (94) can be incorporated into the FAI for the early childhood period.

The FAI form includes two checklists about the child and caregivers. If there are other siblings in the home during the assessment, the second checklist in the child-related questions should be used. The name of the additional child(ren) and their date(s) of birth is also recorded on the first page of the assessment. In the event that there are
several other children, the child who is referred for assessment should be recorded as child (1) and the subsequent children recorded as child (2), (3), etc. If there is a second caregiver, the second check-list in the caregiver sections should be used. The name of the second caregiver is recorded on the first page of the FAI.

### 4) Support Services

**Rationale**

Evidence has shown that effective knowledge translation is central to inform parent, caregiver, family and public decision-making that affects the lives of young children. (95) Thus, supporting all families to understand the importance of the prenatal period, early parenting and the early years requires a coordinated effort that involves mobilizing the latest child development research and making this information accessible in a variety of ways.

Please note, current evidence does not demonstrate effective identification of vulnerable families through the contact interventions that are described below (91). Identification of vulnerable families is best accomplished through complete and accurate screening (e.g. completion of all 36 questions of the HBHC Screen). Please refer to Section 3, sub-section 2, for more details on how to achieve accurate and complete screening.

**REQUIREMENTS**

**Access to Information and Resources**

a) i) The board of health shall, in collaboration with program and community partners, provide vulnerable pregnant women with access to information and resources about the prenatal period that will help them and their families promote positive parent-child relationships and child development.

b) i) The board of health shall provide that all families who have given their consent are contacted by a public health nurse within 48 hours of being discharged from a birth admission.

c) i) The board of health shall, in collaboration with program and community partners, provide vulnerable families with children, from six weeks of age up to their transition to school with information and resources that will help families promote positive parent-child relationships and child development.

Public health units will, in collaboration with program and community partners, provide all families, regardless of their stage of screening (Prenatal, Postpartum or Early
Childhood) with public health unit contact information (e.g., phone number, email / website address) for the HBHC Program as well as information on parenting and child development resources available in the local community. This will include, but is not limited to:

- Breastfeeding resources (e.g., clinics).
- Infant and child parenting groups.
- Early years community settings.

This can be achieved by distribution of the brochures: “Tips for New Parents” (2012) and the “HBHC – You and Your baby” (2012), or other brochures as advised by the ministry, with the addition of other public health unit handouts as appropriate.

Additionally, when HBHC Screens completed in the postpartum period are received the following two options exist for contact:

**HBHC Screen: Families “not identified with risk”:**
For families where HBHC Screen score is less than 2 risk factors, the family is considered “not identified with risk”. These families will be eligible to receive an attempted postpartum contact within 48-hours of discharge. This contact will be for the purposes of information sharing. This contact can take place by any of the following means: face-to-face, telephone, voice message, letter (date sent is a confirmed contact), text message or email.

The information shared must include:

- **a) Clear messaging for the following:**
  - Parent-Child Relationship (e.g., “Comfort your baby when he cries.”)
  - Infant Nutrition (e.g., “Breast milk provides all the nutrition your baby needs for the first six months.”)
  - Child Development (e.g., “The way you talk to, play with, teach and love your child will help him grow and learn.”)
  - Infant Safety (e.g., “Help your child explore safely.”)
  - Importance of Play (e.g., “Babies learn naturally through play.”)
  - Parent Self Care (e.g., “Taking care of yourself is important too!”)
- **b) Community and online resources; and,**
- **c) Local contact information for further support as necessary.**

If, during the process of information sharing, the family self-identifies the need for further HBHC Program services, the PHN completing the contact will complete a new HBHC Screen and process the family as a self-referral to the HBHC Program. Details of this interaction will be entered into HBHC-ISCIS.
Public health units will make efforts to support weekend and statutory holiday coverage within their current resources and collective agreements.

**HBHC Screen: Families “identified with risk”:**

For families where the HBHC Screen score is greater than or equal to 2, the family is considered “identified with Risk” and must receive the IDA Contact within 48-hours of discharge. The IDA Contact provides the opportunity for home visiting in order to complete the assessment process. A successful IDA Contact is one in which a PHN has spoken to a responsible family member (two-way communication) and is able to confirm the family’s willingness to continue with HBHC Program services (either by acceptance of the home visit and/or by initiation of the IDA). One-way communications (e.g. text, written, voicemail) can be used to set-up the IDA Contact or the home visit for the purposes of completing the IDA, but do not serve as the IDA Contact. Families will continue to receive HBHC Services as described in the HBHC Screening, Assessment and Referral to Blended Home visiting Flowchart. In the event that an IDA Contact, initiation of the In-Depth Assessment and initiation of the Family Serve Plan, or any combination of these, takes place before the family leaves the hospital, further 48-hour response for the purpose of IDA Contact is unnecessary.

This timing is based on the standard for acceptable community follow-up for new mothers who have spent the standard amount of time in hospital after delivery. Recent evidence has determined that families who receive and IDA Contact within 48 hours have a significantly higher rate of IDA success compared to those who received IDA Contact after the 48 hour time period (91). Thus, every attempt should be made to minimize declined services by prioritizing the IDA Contact within 48-hours from discharge of birth admission taking into consideration current resources and collective agreements. Additionally, the Board of Health will work with the hospitals to help ensure appropriate protocols are in place for mothers who leave hospital early.

Bearing in mind the voluntary nature of the HBHC Program and its confidentiality requirements, if a family with an “identified with risk” score does not accept continuation with HBHC Program services, the PHN will use local protocols, procedures and guidelines, as available, to provide recommendations for information and support through alternate community programs.

**Referring to Blended Home Visiting**

a) ii) The board of health shall refer pregnant women confirmed with risk by the in-depth assessment to the HBHC Program blended home visiting services and other community services.

b and c) ii) The board of health shall refer families confirmed with risk by the in-
Public health units will refer all consenting families confirmed with risk (identified as high or moderate risk through completion of the In-Depth Assessment – see Section 3, sub-section 3) to the blended home visiting services as well as other community services. After the initiation of an in-depth assessment, a Family Service Plan and corresponding referrals may be initiated as part of this early interaction with the family.

5) Blended Home Visiting Services

Background

The HBHC Program Blended Home Visiting Service is an early intervention for families who are confirmed through screening and assessment as being with risk of compromised child development.

The goals of blended home visiting services, as identified in the HBHC Program Family Service Plan Guide include:

- Continued education/employment training,
- Effective breastfeeding maintenance,
- Effective management of addiction/dependency,
- Effective settlement and cultural adaptation,
- Financial stability,
- Healthy attachment,
- Healthy nutrition and food security,
- Healthy relationships,
- Housing stability,
- Independent life skills,
- Optimal growth and development,
- Optimal parental health,
- Optimal prenatal health,
- Parental self care,
- Positive parenting,
- Positive support network and trusting relationships with professionals, and
- Safe environment.

These goals are achieved through the collaborative efforts of blended home visiting team members who use tools such as the Family Friendly Service Plan (FFSP) and other assessments and interventions such as NCAST Parent-Child Interaction: Feeding and Teaching Scales (94) and Partners in Parenting Education (PIPE)®. (96)
As described in Section 1, the blended home visiting model involves team home visiting with PHNs and family home visitors (FHV) also known as lay home visitors. The team may also include a social worker.

Rationale

Home visiting is an early intervention for families with risk of compromised healthy child development. It has been shown to build family strengths that address and minimize these risk factors where possible. Effective home visiting services should include the following elements:

- Trusting relationships between service providers and the family.
- Coordinated efforts focused on clearly defined family goals.
- A comprehensive evidence-informed approach in which multiple family needs/goals are addressed.
- An intensive service based on the family’s identified needs/goals.
- Evaluation of the process and feedback for improvement. (28,68,97,98)

Blended home visiting teams provide support to families confirmed with risk through expressive aid (provision of sympathy, empathy, understanding, affection, acceptance and being a confidante); instrumental aid (providing information, advice and material aid) and by helping families to mobilize and strengthen their own social support. (17)

REQUIREMENTS

a) The board of health shall establish policies and procedures to manage home visiting services.

The development of policies and procedures to guide all aspects of blended home visiting services will include:

- Recruiting, training, monitoring and supervising PHNs, family home visitors and social workers (where applicable).
- Use of the Family Service Plan and other related tools and education activities to assess and provide information and interventions to families confirmed with risk in the following (but not limited) domains:
  - Parental and family health,
  - Adaptations to parenting and parenting capacity,
  - Child growth and development,
  - Healthy parent child relationships, and
  - Social support.
- Information management and documentation of home visiting in accordance with the policies and procedures of the local public health unit and professional practice standards.
b) The board of health shall provide home visiting services to pregnant women and families with children from birth up to their transition to school who have been identified with risk using the HBHC Screen and have had risk confirmed through an in-depth assessment.

The HBHC Program offers a coordinated and planned approach to providing home visiting services. All families confirmed with risk shall be offered blended home visiting services.

If families are not willing to accept the blended team, all efforts will be made to retain the family in service and introduce the team intervention over time as a trusting relationship is developed.

When families are hesitant or unwilling to accept service, PHNs and managers should consider including the following questions in determining whether to continue to offer home visiting services:

• Is the family already receiving parenting support from another agency?
• Is the family currently able to focus on parenting issues and benefit from home visiting?
• Is home visiting the most appropriate way to meet the family's needs?
• Is the family willing to accept blending home visiting services and willing to participate in the program?
• Is the home environment safe for the PHN and FHV?

If home visiting is not appropriate, HBHC Program staff will link the family to other appropriate services.

c) The board of health shall use a blended model of home visiting by public health nurses, family home visitors and other professionals as approved by the ministry.

Blended Model of Home Visiting: Service Provision

The HBHC Program supports the use of a blended home visiting model which is based on established best practices for the provision of intensive home visiting services. (68, 69) Levels of service are determined using the in-depth assessment which confirms risk and supports the initial Family Service Plan. Thus, where a family is confirmed with risk using the FAI and it is determined that they have higher and more urgent needs, visits with increased frequency and length (e.g., twice a week) may be necessary. In contrast, vulnerable families who are receiving home visiting and have successfully addressed their crisis and some of the family goals may receive home visiting every two weeks in order to build capacity in the family for eventual independent access to community resources.
Families with high needs and fewer strengths will require a level (or “dosage”) of service which is appropriate to their circumstances. (97) The frequency of visits (e.g., weekly, bi-weekly, twice-a-month) from each member of the team will depend on the goals, strategies and specific responsibilities needed to meet family needs and the strategies and goals identified. (99-102) The frequency of PHN visits to conduct assessments, provide interventions and to update the Family Service Plan will also depend on identified needs, goals, strategies and specific responsibilities.

Collaboration in blended home visiting is essential to providing support. (98, 103) Goals and strategies are identified in the Family Service Plan Guide along with descriptions of team member responsibilities. Consult Part II – HBHC Screening and Assessment Tools for the complete Family Service Plan.

When families are in special or crisis situations, PHNs will use professional judgment to determine the appropriate level of service required to support an effective and trusting relationship between the family, PHN and family home visitor. This could happen before or after identifying the goals and strategies for the Family Service Plan.

**Collaborative Team Practice and Effective Communication**

The HBHC Program blended model of home visiting combines the enabling, modeling and teaching skills of family home visitors with those of a PHN who also has skills in adult education, health teaching, communication, problem solving, conflict resolution; strength-based planning, child and family health and other areas.

The social worker, as part of the blended home visiting team, participates as a team member in the delivery of HBHC Program services by providing counselling and making referrals on issues related to the four Family Service Plan goals related to:

- Socio-economic conditions especially those related to housing and financial resources and planning,
- Immigration and settlement,
- Employment, and
Educational attainment.

Effective communication between the family home visitor and PHN (as well as other members of the team) is essential. It is particularly important for the members of the blended home visiting team to communicate with one another whenever:

- The family misses two home visits in a row.
- There is an incident that involves a "Duty to Report" (consult Section 1e for more details).
- There are concerns about personal or client safety.
- The complexity of the family requires regular debriefing.
- The family does not appear to be engaged or is not working on its goals.
- The family meets goals earlier than the next scheduled review date.
- A significant change/crisis occurs in the family or in the services the family is receiving.

The goal of the blended home visiting team is to work effectively together, provide consistent messages to the family and deal with issues in a timely manner. Through communication and collaboration, the blended home visiting team will negotiate their relevant roles based on what is needed to address the family's needs.

The board of health shall plan home visiting services in collaboration with the family. Home visiting services are delivered in the home, but may be delivered in an early years community setting that families and children attend or in an alternative and mutually agreed-upon setting.

Home visiting ideally takes place in the home, however in exceptional circumstances visits may have to take place in alternative locations to support the establishment of a trusting relationship and the safety of both the family and provider. Research demonstrates that home visiting is most effective when it is frequent, long-term, comprehensive, integrated with other community services and flexible in responding to the unique needs and strengths of each family. (68, 98) Frequent, comprehensive and long-term services allow lay home visitors to establish a solid rapport and trust with families and be more receptive to new information. Thus, the exceptional circumstances of visiting occurring outside of the home, though not ideal, are used to support long-term relationship building.

Establishing a safe place to meet (usually the family home or other community setting) is essential. Members of the blended home visiting team will make all efforts to help ensure that client safety and privacy is maintained in any location. Assessment of living conditions, safe environment and housing stability are important for service provision and attempts should be made to visit in the family's home whenever possible. In addition, some visits may take place outside of the home to support the transition of
the family to local community services (e.g., food banks, early years community programs).

e) The board of health shall support the development, implementation and evaluation of the Family Service Plan using tools as approved by the ministry

Families are more likely to be active participants and to benefit from the HBHC Program when they are actively involved in planning for home visits. The Family Service Plan will provide the home visiting team with an easy-to-use automated system for monitoring the selection, progress and achievements of a family’s goals. Consult Part II – HBHC Screening and Assessment Tools for the complete Family Service Plan.

Effective communication with families is essential to success. Communication should be empowering and respectful. Other tools can be used to support this process. Consult Part II – HBHC Screening and Assessment Tools for the complete Family Friendly Service Plan

A Family Service Plan can be initiated during the initial (IDA) contact with the family and updated as necessary after the in-depth assessment is complete. From that point on, the Plan should be regularly reviewed and revised to ensure that the family continues to address their goals. The Family Service Plan must be reviewed prior to discharge from HBHC Program services. Details of the Family Service Plan shall be recorded into ISCIS. Consult the HBHC-ISCIS User Guide (71) for details.

The Family Service Plan is developed in collaboration with the family. It sets out:

- The family’s strengths and needs.
- The family’s goals.
- The steps that will be taken to help the family achieve the goals.
- The services that will be provided.
- The responsibilities of all those involved with the family.

The plan must also be continually monitored and revised to reflect any changes in the family’s situation and/or their goals or progress.

f) The board of health shall support public health nurses, family home visitors and other professionals with evidence-informed home visiting guidelines as required by the ministry. Refer to the Healthy Babies Healthy Children Guidance Document, 2012 (or as current) for more information.

High quality, effective home visiting should be intensive, multi-faceted and based on need. In keeping with best practices, HBHC Programs are expected to:

- Offer home visits combined with service coordination as early as possible,
preferably starting in the prenatal period for high-risk populations such as young, first-time, low-income mothers or new immigrant families.

- Offer frequent, intensive home visiting over the long-term to benefit the family.
- Vary the frequency and duration of the home visits based on the families’ needs (e.g., families may need more frequent services just after an infant is born and less frequent services later as parents become more confident and receptive; families may need more services as new parenting issues arise, such as when an infant becomes a toddler or if there is a change in the family’s marital, employment or housing status).
- Link families to appropriate ongoing support as they transition out of HBHC services.

Training and orientation of HBHC staff will incorporate education directives provided by the ministry (e.g., NCAST Promoting Maternal Mental Health during Pregnancy, Keys to Caregiving and Parent-Child Interaction (PCI); Feeding and Teaching Scales, Partners in Parenting Education etc.). (91, 92, 94) These materials and tools will be a foundational support to the HBHC Program.

These resources, as appropriate to the context of the family receiving service (e.g. prenatal, postpartum and early childhood), should be provided or used:

- Prenatally, where applicable.
- Within the first two visits after the in-depth assessment is completed.
- In-line with developmental milestones.
- Prior to an update of the Family Service Plan, as appropriate.
- In conjunction with complementary specialized programming delivered to HBHC Program families (e.g., interactional guidance).
- When preparing a family for transition or discharge from HBHC services.

In addition, reflective practices can be used to support the appropriate use, frequency and intensity of these resources, as well as other resources as used by the public health unit. Reflective practices can include, but are not limited to:

- Facilitated case review.
- A formal process to support reflection on the appropriate and effective use of the tools.
- Linked professional development opportunity.

The results of these tools and resources should support goal development and strategies and apply appropriate interventions which may include, but are not limited to:

- Anticipatory guidance related to all aspects of child development.
- Mobilizing social support.
- Parenting assessment and related health teaching or referral.
• Breastfeeding promotion and support.
• Problem solving.
• Developing trusting relationships.
• Improving utilization of social support.
• Enhancing parental self-esteem and confidence.
• Providing health teaching and health information for the purposes of promoting health. (17)

9) The board of health shall enter all blended home visiting services in ISCIS or any other system specified by the ministry.

Detailed explanations of how to complete data entry and documentation using HBHC-ISCIS are available through the HBHC-ISCIS User Guide. (71)

Results and updates to the Family Service Plan will be entered into HBHC-ISCIS.

All supplementary tools that are available in HBHC-ISCIS (e.g., NDDS, NCAST Parent-Child Interaction Scales) will be entered into the system for data management purposes. A complete list of available tools related to Healthy Babies Healthy Children is available in Part II of this Guidance Document.

6) Service Coordination

Background

HBHC Program service coordination* is a family-centred process that helps ensure that families identified with risk can access services and informal supports that reflect their values, priorities, strengths and preferences. Service coordination provides a process that guides families through a complex system and helps them access the programs and services they need. In addition, service coordination supports the process of linking and working with other community providers in order to maximize service resources and minimize duplication in services.

*Also referred to as care coordination, service facilitation, resource coordination and case management. The term "service coordination" is used to acknowledge that parents and families are partners in assessment, decision-making and intervention.
The objectives of service coordination are to:
- Designate a service coordinator for each family confirmed with risk (based on the results of the Family Assessment Instrument (FAI) as part of an in-depth assessment).
- Involve families in identifying their strengths and weaknesses, setting goals and identifying the services they need.
- Help families access the services they need.
- Remove barriers to accessing services for families identified with risk.

Rationale
Families often feel frustrated or overwhelmed by the array of services and many are unable to access the services they need. Service coordination provides an effective early intervention for families experiencing problems with effective parenting and healthy child development. If families receive appropriate, integrated, needs-based, coordinated services that build on their strengths, they are more likely to benefit.

REQUIREMENTS

a) The board of health shall offer service coordination and identify a service coordinator for all pregnant women and their families and families with children from birth up to their transition to school who are eligible for home visiting services.

All families identified with risk on the HBHC Program screen and confirmed with risk by the Family Assessment Instrument (FAI) are eligible to receive service coordination. Families who accept service coordination will be assigned a service coordinator, who will be clearly identified on the family’s file.

Service coordinators may be assigned:
- When the family is confirmed with risk; or
- When a Family Service Plan is developed.

b) The board of health shall develop procedures to support service coordination in conjunction with community partners.

The HBHC Program will work with community networks and committees to streamline and strengthen service coordination by developing policies, procedures and protocols that clearly establish:
- Common principles.
- Common interagency intake, referral and family conference procedures.
- Common release-of-information / consent forms to facilitate the sharing of client reports and records.
• Coordinated screening and assessment services, where applicable, that eliminate duplication of evaluation.
• Reciprocal sharing of pertinent information.
• An interagency transition service plan.
• Common interagency child and system tracking. (This mechanism holds agencies accountable for identifying why services are not being provided and what strategies will be used to resolve the problem. It is also an effective strategy for communicating service delivery needs for complex cases and eliminates inconsistent messages to families.)
• Common service/conflict resolution procedures, policies and reporting.

a) Service Coordinator Role
When communities have established models for assigning service coordinators, the HBHC Program should consider these practices.

The service coordinator does not necessarily need to be the PHN who is providing HBHC Program services to the family. When the PHN is not identified as the service coordinator (e.g., Child Protection Services are identified as the service coordinator), attendance at service coordination meetings will have representation from the PHN and from members of the HBHC blended home visiting team (e.g., family home visitor or social worker). Other community service providers may also be represented in service coordination meetings.

Professionals from other agencies may also be assigned as service coordinators. In general, the choice of service coordinator should be based on the family’s needs. For example, when child protection concerns are primary, a child protection service provider may be the designated service coordinator or when children have multiple health issues and special needs, community care access centre staff may be the designated service coordinator.

Building on existing conflict resolution skills, family centred and strength-based delivery of services, technical and professional education and training, skills and support for the service coordination role should include, but are not limited to:
• The ability to advocate on behalf of children and families.
• Knowledge of the local service system and how to obtain and coordinate the required services.
• Awareness of Section 72 of the CFSA (67) "Duty to Report" provision and demonstrated ability to clarify and communicate duty to report issues when working with other agencies.
• The ability to work collaboratively with other partners using effective listening and communication skills and conflict mediation skills.
• The ability to provide family access to the most appropriate services available to
address the best interests of the child in a way that respects the family's wishes.

- The ability to ensure the methods used to achieve the family’s goals are understood by those involved with the child.
- The ability to monitor the implementation of the Family Service Plan.

The service coordinator will help to ensure that HBHC Program documentation appropriately reflects the family’s issues, strengths and progress as well as all specific efforts to enhance and protect the well-being of children and their families who have been confirmed with risk.

Service coordinators are also responsible for discharge planning of vulnerable families. This planning should be done in consultation with the blended home visiting team and other service providers. The Family Service Plan should be used as a guide to:

- Support and inform a systematic and inclusive decision-making process.
- Ensure that the parent is an equal participant in determining and evaluating services and supports (using the Family Friendly Service Plan as needed).
- Determine when a family is ready for discharge from the HBHC Program.

c) The board of health shall enter all service coordination activities in ISCIS or any other system specified by the ministry.

7) Referrals / Recommendations to Community Services

Background

Families identified with risk through the HBHC Screen and confirmed using the Family Assessment Instrument as part of an in-depth assessment should be referred or recommended to appropriate programs and services available in the community. Families who may be identified using the HBHC Screen but are not confirmed with risk on the FAI as part of an in-depth assessment may also benefit from other programs and services available in the community and can be referred or recommended to appropriate programs and services.

Family physicians, community paediatricians, nurse practitioners, nurses and other primary health care providers, as well as other providers in the early years are in a unique position to improve the odds for positive childhood development outcomes by virtue of their continuing contact with their patients and families over time. Parents are more likely to seek professional help if they understand the timelines for their child’s developmental milestones. Parents who are knowledgeable about what to expect from their child at certain stages are more likely to discuss their concerns with their primary health care provider. Collaboration with these partners will improve risk identification as well as appropriate referral for the HBHC Program.
Rationale
HBHC blended home visiting and service coordination is available only to consenting families with risk confirmed by the FAI as part of an in-depth assessment. The HBHC Program will also identify families with risk on the HBHC Screen but who are not confirmed with risk on the FAI as part of the in-depth assessment. All of these families can benefit from additional support services beyond the general content that is provided at three points in time (prenatal, postpartum and early childhood) described in Section 4: Support Services.

Families who are not confirmed with risk can be supported by other early years services in the community whereas families who are confirmed with risk will likely need more support through specific referrals and possibly accommodations to access services. In addition, community early years programs and services can also support the identification of vulnerable families who could benefit from HBHC Program services with referrals into the Program. Families whose risk status changes can re-enter the program at any time, when and if necessary. This would be deemed an external or self-referral.

REQUIREMENTS

a) The board of health shall participate and collaborate in partnership with a network of health and social service providers to support pregnant women and their families and families with children from birth up to their transition to school in attaining and sustaining their health and developmental potential.

b) The board of health shall refer pregnant women and their families and families with children from birth up to their transition to school, identified with risk on the prenatal, postpartum and/or early childhood screen and who require additional support, to programs or services available in the community.

The HBHC Program is not intended to be a stand-alone program. It is part of a comprehensive system of programs and services available to families with children (prenatal up to their transition to school) that is designed to provide all children in Ontario with the opportunity for the best possible start in life. The HBHC Program must be integrated with other services in the community and is expected to work with other organizations to support young children and their families. (Consult Service Integration/System, Section 3-8).

Families who have been identified with risk using the HBHC Screen but not confirmed with risk, will benefit from a recommendation to these community services. Families who have been identified with risk using the HBHC Screen and are confirmed with risk will require referral (written or verbal) to a specific source of service or information.
c) The board of health shall respond to HBHC Program referrals for all families identified with risk from other available screening opportunities during the early years.

There are a variety of additional early childhood screening opportunities (e.g., the Enhanced 18-Month Well-Baby Visit). In support of the HBHC Program goal of early identification and intervention, these additional screening opportunities can help to provide opportunity for a collaborative discussion with parents about child development. Also, when needed, these opportunities can support the identification of children with needs, concerns or risks that can affect healthy child development.

Sometimes a child and family’s situation changes over time. It is also possible that children and families are missed during early screens. When this occurs, families may require additional screening and monitoring for healthy child development. Families also need to be empowered to play an active role in the ongoing monitoring and assessment of their children’s development.

Table 4: Characteristics of the 18-Month Visit

<table>
<thead>
<tr>
<th>The 18-month visit (<a href="http://www.18monthvisit.ca">www.18monthvisit.ca</a>) is one of the last regularly scheduled visits coupled to immunization and potentially the last time children are seen before school entry. Key developmental milestones occur by this age and parents seek help and advice for a variety of issues related to their child’s behaviour and development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 18-months, the development of major motor and communication milestones should have been reached and other developmental concerns may be detected (e.g., autism spectrum disorder).</td>
</tr>
<tr>
<td>Characteristics of the Enhanced 18-Month Well-Baby Visit include:</td>
</tr>
<tr>
<td>1. A consistent, focused, developmental review and evaluation at 18 months of age, completed by a primary health care provider in collaboration with parents.</td>
</tr>
<tr>
<td>2. The use of standardized tools such as the Nipissing District Developmental Screen(104), the parent–completed developmental checklist for use at the visit and the Rourke Baby Record (105) – Ontario version, evidence-based guide for health professionals in the delivery of the enhanced visit.</td>
</tr>
<tr>
<td>3. A process to support discussions with parents on healthy child development; provide information on parenting and community programs that promote healthy child development and early learning and when needed, provide referrals to specialized community services for those children with potential issues, needs and risks.</td>
</tr>
<tr>
<td>4. A measurement and evaluation component that tracks how 18-month old children are doing.</td>
</tr>
</tbody>
</table>

A comprehensive system of surveillance, screening and assessment for healthy child development requires the ongoing support and involvement of primary health care providers, educators, social service providers and parents during the early years.
The HBHC Program supports strategies that provide early identification and intervention for children, support discussions with parents on healthy child development, provide information on parenting and community programs that promote healthy child development and early learning and when needed, provide referrals to specialized community services for those children identified with potential issues, needs and risks. Some of these strategies include:

1. **The Enhanced 18-Month Well-Baby Visit**
   
The HBHC Program supports an *Enhanced 18-Month Well-Baby Visit*, either through providing information for primary care providers or through working collaboratively with them to help ensure that all families have access to information about child development, a developmental evaluation at 18-months and appropriate referrals to community services including the HBHC Program where appropriate.

2. **Additional Screening Opportunities**
   
Many communities have developed additional screening opportunities that can be used during the early years such as clinics in conjunction with community programs and/or school/kindergarten registration. These screening opportunities can be supported by HBHC Program staff to ensure that all families have access to information about child development, an age appropriate developmental screen (e.g., NDDS) and appropriate referrals to community services including the HBHC Program where appropriate.

3. **Involvement of Parents and Families**
   
Parents and families can play a vital role in monitoring their children’s development. To strengthen and support parents in that role, the HBHC Program will provide appropriate screening tools that can be administered by parents (e.g., NDDS) and link or refer parents to local programs and sites such as community health centres, family practice networks and the Ontario Early Years Centres. As well, the HBHC Program will help ensure that all families who self-refer to the Program will receive the appropriate components of the HBHC Program.

---

*d)* The board of health shall enter all referrals to community programs and/or services in ISCIS or any other system specified by the ministry.
8) Service and System Integration

Background
The HBHC Program does not stand on its own. It is part of a comprehensive province-wide system of programs and services provided to families (from the prenatal period up to their child’s transition to school) which is designed to support the children who need it most with an opportunity for the best possible start in life. The HBHC Program must be integrated with other services in the community and is expected to work with other organizations in moving forward with a local vision for early years services.

A focus on system rather than services positions child development within a broader view and recognizes that child development must be seen as inseparable from the child’s social context. (20-22) The goal of system integration is to involve all services and relevant stakeholders that have a role in children’s services in developing and adopting a shared vision, goals and accountability for the system. (106)

A focus on system integration also recognizes that it is important for families to obtain the services they need in a timely and seamless manner. An integrated service system allows for better support of children and their families in Ontario by overcoming the fragmentation that makes it challenging for parents and service providers to navigate the system.

The integration process brings together two or more service providers and/or organizations who can respond more effectively together to the diverse needs of the people they serve. Early years system integration involves bringing together service providers and organizations that support children’s healthy development into a comprehensive and seamless system.

When services are integrated, families with young children experience significantly reduced barriers to access. In addition, families benefit from reduced service gaps and/or duplication and a more cohesive system of services and supports.

Rationale
Healthy child development provides the foundation for a vital and productive society and a prosperous and sustainable future. Healthy development is a causal chain. Understanding the relationships between each link in this chain provides a science-based framework for understanding systems, programs and practices that will support the healthy development of all young people and their families. Positive experiences throughout childhood and adolescence provide a foundation for sturdy brain architecture and a broad range of skills and learning capacities.

A system of streamlined access for children and their families must be built on evolving evidence about the best ways to support and promote lifelong healthy development.
This system should identify needs early and provide a gateway to a continuum of services such as professional observation (developmental surveillance), screening, assessment and intervention to support healthy development.

The HBHC Program spans the pre-natal stage up to a child’s transition to school and is designed to provide services to families that are at risk for healthy child development. The services offered by the HBHC Program may complement services already in place and link with all other early years initiatives but should never duplicate or replace any existing services. Strong relationships with key partners in the community are essential to successfully delivering services to clients.

REQUIREMENTS

a) The board of health shall engage and work with the community in planning and delivering the HBHC Program through representation and participation in community networks.

The Ministry of Children and Youth Services has supported the creation of Best Start Networks, a consortium of programs/agencies and relevant stakeholders that work together to support healthy child development. Best Start Networks have been encouraged to work towards an integrated network that incorporates community needs and resources in a collaborative environment.

The ministry has also supported the development of community Early Child Development and Parenting Resource System Pathway templates which illustrate how the local early child development and parenting resources system functions in a community, region or district. The development of these community referral pathways helps to meet the goals of system integration and is key to revealing how resources are organized within a community so that young children are offered an opportunity for healthy development and the best start in life.

Across the Province, there are numerous community planning initiatives that have an interest in addressing the needs of children and their families. Given the foundational nature of the HBHC Program and its focus on the pre-natal stage, universal screening at the postpartum stage and programming for early childhood, it is incumbent on boards of health to participate in these community planning initiatives and to raise awareness about the programs that are delivered by the HBHC Program and the type of services that support clients outside of the HBHC Program.

b) The board of health shall promote the HBHC Program to community partners.

Many other public health unit programs, agencies and individuals in a community may identify children and families who could benefit from HBHC Program interventions and services. The HBHC Program is responsible for contacting those agencies and individuals to make them aware of the Program and encourage them to refer vulnerable families who could benefit from HBHC Program services. Such families may experience negative psychosocial and/or health factors (such as low income, poor living conditions, isolation, violence in the home, poor nutrition, poor working conditions,
lack of access to services, smoking and alcohol and substance abuse) and need comprehensive support and interventions that will help them cope with and/or overcome these barriers.

c) The board of health shall develop procedures with community partners for:
   i) Accepting referrals from other agencies and individuals; and
   ii) Referring pregnant women and their families and families with children (from birth up to their transition to school) to other agencies.

Many community agencies and individuals may identify children and families who could benefit from HBHC Program services. HBHC Program staff are responsible for contacting those agencies and individuals to make them aware of the Program and encourage them to refer families who will then be screened (using the HBHC Screen) and possibly supported by home visiting services or appropriately referred to other health unit or community programs and services.

9 and 10) Research and Evaluation

REQUIREMENTS

9 a) The board of health shall participate in provincial HBHC Program research activities as prescribed by the ministry.

10 a) The board of health shall participate in provincial HBHC Program evaluation activities as prescribed by the ministry.

The HBHC Program is evidence-based. Its screening tools, interventions and activities have been selected based on the best available evidence and are continually refined to reflect new and evolving research and knowledge.

The ministry is responsible for the ongoing evaluation of the HBHC Program.

HBHC Program sites may be asked to participate in research and evaluation in a number of ways, including but not limited to:

- Supporting activities to enable and mobilize the Knowledge to Action Framework. (107,108) (Consult Appendix 3 – Knowledge to Action Framework)
- Providing information/documentation on the operation and organization of their program and services.
- Being interviewed or completing surveys.
- Identifying families to be interviewed or to participate in validation studies of HBHC Program instruments and securing their consent to be interviewed and to use their service information.
- Coordinating local research tasks, collecting local data and encouraging full
health unit participation in local and province-wide research and evaluation opportunities.

- Disseminating research results and participating in ongoing discussions to provide advice and guidance to inform program policy.

The purpose of research and evaluation includes but is not limited to:

- Providing information to local service providers and their partners for program planning and improvements.
- Providing information to the ministry for program planning and improvements.
- Supporting the ministry in monitoring the extent to which the HBHC Program is meeting its desired outcomes.

In addition, HBHC Program delivery will take advantage of existing and new forms of data collection as needed, to support the individual and community work for strengthening the identification of needs and developing appropriate targeted responses. (109) For example, public health units have access to datamarts through the Internal Reporting Sub-System (IRSS) of ISCIS. These datamarts are to be used to support HBHC Program delivery identification of gaps in order to support the process of improvement. Datamarts can also be used to aid in the evaluation of such improvement. The Plan-Action-Study-Do model can be applied to assist in this process. (See Appendix 4 – How Can I Use the Family Service Plan Datamart?)

a) HBHC Outcomes and Indicators

Guided by the MCYS Strategic Plan, the HBHC Program has identified outcomes that are directly linked to program components. The outcomes are divided into short-term program outcomes and long-term population or system outcomes. Each outcome described below is grounded in evidence and measurable through existing data collection methods. Although data collection and reporting is expected from the point of implementation of the HBHC Protocol, the outcomes will be an ongoing time-based measurement. (See Appendix 5: HBHC Program Outcomes and Indicators.)

The expected HBHC Program outcomes are:

- 100% of HBHC Screens will be accurately completed.
- Families that screen positive using the HBHC Screen are confirmed with risk during the assessment.
- Increased service focus to support parent-child interactions, child development and parenting capacity.
- The frequency, duration and length of home visiting services should reflect the needs of vulnerable families.
  - Measuring these aspects of home visiting services is important because it
demonstrates the fidelity of the program model, supports program management and improvement and can help to identify attrition from the program. (97)

- Increased referral to and access of community services.
- All public health units will participate in early years community planning bodies.

The HBHC Program expected population or system outcomes are:

- An increased percentage of families will be screened and accurately identified with risk.
- An increased percentage of community referrals to the HBHC Program will be received prenatally, postpartum and during the early childhood period.
- Improved prenatal outcomes:
  - Families who receive HBHC Program services prenatally will be supported to access appropriate health services, nutrition resources and social support services, in addition to promotion of healthy behaviours among pregnant women and their families, which help to provide support for optimal birth outcomes including, but not limited to, birth weight and gestation. (98)
- Improved parent-child relationships:
  - Families who receive HBHC Program services prenatally will also be supported in developing prenatal attachment.
  - Families who receive HBHC Program services during the postpartum or early childhood period will be supported in helping to develop positive parent-child relationships and positive attachment behaviours.
- Improved parenting capacity:
  - Families who receive HBHC Program blended home visiting services will be supported in developing sensitivity to cues, nurturing responses and awareness of their role to support child development as well as healthy parent-child relationships.
- Improved child development outcomes:
  - Families who receive HBHC Program blended home visiting services will be supported in their development of skills and access to information to support their role in monitoring their child’s development as well as their role in promoting healthy parent-child relationships. Both activities support improved child development outcomes. (80)
- Increased use of community services to meet identified family needs.
- Improved responsiveness to the equity needs of marginalized and emerging populations through utilization of ISCIS referral data to strengthen alliances at early years community planning boards.
Healthy Babies Healthy Children Guidance Document

Identified HBHC Program indicators which will support measurement for these outcomes are:

1. The total number of screens completed at three points in time: (a) prenatal, (b) postpartum, (c) early childhood and number of screens received as incomplete (no responses), partially completed (less than 36 responses) or only question #36 completed.

2. 10-25% of total HBHC Screens received are confirmed with risk during assessment.
   - Literature has identified that 15-30% of families will be identified as vulnerable and benefit from some level of service. (74, 110-113)

3. A) The various Family Service Plan goals as reflected in the Family Assessment Instrument results.
   B) Increased number of families in the prenatal and early childhood period identified with active Family Service Plan goals.
   c) Family Service Plan goals achieved at time of discharge.

4. Number of HBHC Screens completed in the prenatal and early childhood period received from community resources.
   - Literature identifies that home visiting services that are started early and maintained for a prolonged period of time have greatest effect on child outcomes. (68, 98)

5. As a population health indicator, increased number of prenatal HBHC clients with children born at >2500gm and >37 weeks gestation.
   - Within a system of support, prenatal clients have the opportunity to link with appropriate health services and prenatal resources which are documented to positively affect birth weight and gestation outcomes.

6. Improvement between pre-service and post-service scores of NCAST Parent-Child Interaction Feeding and Teaching scales.

7. Consistent NDDS completion demonstrating children receiving HBHC Program blended home visiting services are meeting milestones.

8. A) Average frequency, duration and length of home visits as well as completion rate of scheduled home visits.
   B) Number of families that receive long-term services equal to or less than 18 months, compared to number of families that discharge at equal to or less than 6 months.

9. Increased "referred to and accessed" response rate to community referrals.

10. HBHC Program involvement in an increasing number of community planning boards and tables related to children and/or the early years.

To ensure that HBHC Programs benefit from evaluation and research, the ministry will continue to distribute evaluation updates and share research information with all sites.
Glossary

Assessment: The process of determining the nature, cause, progression and prognosis of a problem and the personalities and situations involved therein; the function of acquiring an understanding of a problem, what causes it and what can be changed to minimize or resolve it. Specifically to the HBHC Program, assessments reflect the identification of family strengths and capacities. Assessment information identifies factors that influence a parent and child's ability to develop their full potential. Factors can include a client’s physiological, psychological, mental, economic, behavioural, lifestyle, emotional, sociological and spiritual status.

In the HBHC Program, professional assessments are conducted by a professional, guided by competencies and a skill set under the direction of standards and guidelines that are sponsored by a regulatory college and meet legislative requirements and standards of the profession.

Blended home visiting: HBHC Program blended home visiting services serve vulnerable families who have been identified with risk on the HBHC Screen (prenatal, postpartum, early childhood) and have had risk confirmed through an in-depth assessment. These services are provided by an integrated team consisting of PHNs, family home visitors and other professionals, as approved by the ministry.

Child development: Inclusive of developmental delay, parenting and social context.

Community partners: Community partners include a broad range of service providers, organizations and leaders who have a vested interest in the well-being of children (from prenatal up to their transition to school) and their families (regardless of organization type or funding source).

Employees: Staff employed by and/or on contract with the board of health.

Family/lay home visitor/family visitor: A trained individual from the community who works one-on-one with families modeling effective parenting, by providing HBHC Program home visiting services using specific strategies. Family/lay home visitors/family visitors receive training to become skilled peer mentors and are supported by PHNs and/or other professionals.

Family Service Plan (FSP): A standardized format for monitoring the selection, progress and achievements of goals for HBHC Program families receiving services.
**Guidance document**: Topic specific document(s) that provide guidance relevant to operationalizing and implementing the *Ontario Public Health Standard* (OPHS) and incorporated protocols.

**In-depth Assessment (IDA)**: Completed with families using the *Family Assessment Tool*, a series of questions/observations designed to assess the child's prenatal care, the child (in cases where the child has already been born), the primary caregiver(s), the family situation and the services/supports the family is receiving.

**Informed Consent**: As defined by the College of Nurses of Ontario, based on the Health Care Consent Act, consent is *informed* if, before giving it the person received the information about the treatment that a reasonable person in the same circumstances would require to make a decision; and the person received responses to his/her requests for additional information about the treatment. The information must specify the:

- nature of the treatment;
- expected benefits of the treatment;
- material risks and side effects of the treatment;
- alternative courses of action; and
- likely consequences of not having the treatment.

**Integrated Services for Children Information System (ISCIS)**: A provincial data system used for collecting information about the HBHC Program.

**Nipissing District Developmental Screen® (NDDS®)**: A parent-completed developmental checklist designed to assist parents, health care and child care professionals with a convenient and easy-to-use method of recording the development and progress of infants and children within certain age groupings. It is not a diagnostic tool and is not meant to be a formal assessment of the child's skills but rather a quick survey to determine areas that may require some extra help. The screens coincide with immunization schedules as well as key developmental stages up to age six.

**Primary care**: The first level of medical care provided by general practitioners and family physicians, nurse practitioners, nurses and other allied health professionals. The goal of primary care is to assess, treat and monitor the healthcare needs of patients.

**Provide information**: The act of informing, telling or sharing relevant and up-to-date knowledge on a specific subject of interest and/or family need. Information can be provided in person, by phone, in writing, email and through various media (e.g., flyers/brochures, website links, DVDs), consistent with agency policies and procedures.
Provide support and/or resources: The act of providing access to the HBHC Program service provider's own professional organizational services for family and as appropriate, facilitates service coordination with the family and multiple service providers.

Public health nurse (PHN): A skilled professional who is concerned with the health needs of the community as a whole. PHNs with the HBHC Program have special education and are knowledgeable about local children's and family services, committed to evidence-informed practice and up-to-date with the early years literature. They have skills in adult education, health teaching, communication, problem solving, conflict resolution, strength-based planning and child and family health and/or other areas.

Recommend other supports and services: The act of advising as a course of action, for example, "I recommend that you go to the neighbourhood Ontario Early Years Centre."

Refer to other supports and services: The act of directing (in writing or verbally) to a source for help or information.

Reflective practice: A technique that supports HBHC Program staff to reflect on events, experiences and outcomes relating to their clinical practice and incorporate the knowledge gained into future HBHC activities. (114)

Screening: The act of identifying a group of people (e.g., mother, father, guardian, caregiver, child) experiencing needs, issues or risks that may compromise healthy child development and/or parenting ability and who may benefit from a more thorough evaluation and receipt of HBHC Program services or other services.

Serious occurrence: A serious occurrence is an extraordinary event that is unexpected, overwhelming or distressing and possibly dangerous. It is usually tragic or traumatic and may include, but is not limited to: serious injury, death or serious threat. The incident occurs during the process of service delivery and results in client or staff, injury (mental or physical) or death, or in an adverse outcome for the client or community partner, including injury (mental or physical) or complication.

Service coordination: A family-centred process that supports families, with identified and confirmed risk, to access services (i.e. linking with other community resources) and both formal and informal supports which reflect the families values, priorities, strengths and preferences. Also referred to as care coordination, service facilitation, resource coordination and/or case management. The term "service coordination" is used to acknowledge that parents and families are partners in assessment, decision-making and intervention.
**Service coordinator:** A person who is assigned, as part of the service coordination process, to guide families through the complex system of services and help them access appropriate programs and services based on a family's identified FSP goals.

**Service integration:** Service integration is a component of system integration that has a specific focus on services and programs.

**Social Capital:** The working trusting relationships that a person has with other people and/or agencies in their community which are useful for the development of the individual and/or children in their care. (115)

**System integration:** System integration is an ongoing process whereby local service providers and relevant stakeholders engage in a progressively greater degree of joint service activity along an integrated continuum to provide families with better access to services. The language of system integration highlights the importance of focusing not only on services but on the role of the broader community.

**Transition to school:** With junior kindergarten by school boards not mandated, the population for “transition to school” is all children from birth until October of the year the child is eligible for entry into senior kindergarten, to a maximum age of 70 months. (116)

**Vulnerable:** When the well-being of families and children may be threatened by individual, parental or family circumstances or when something about the child, parent or family is creating a risk.

**With-risk:** A family is determined to be with risk, if the HBHC Screen (confirmed by an in-depth assessment and nursing judgment) identifies that there is a serious likelihood that a child may not reach his or her potential and the family may benefit from more intensive HBHC Program services (e.g., blended home visiting services, service coordination, etc.).
PART II: HBHC Screening and Assessment Tools

1) Overview

The information and tools in this section will help HBHC staff and their community partners identify families with infants and children who are vulnerable and need support. This section consolidates all the information on screening and assessment tools for Healthy Babies Healthy Children. Although the information in this section will be used primarily by public health nurses who are responsible for screening and assessment, it will also be useful for other health and social service partners involved in screening and assessment.
2) HBHC Screening Tool

<table>
<thead>
<tr>
<th>Healthy Babies Healthy Children Screening Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Name:</td>
</tr>
<tr>
<td>Mother’s DOB:</td>
</tr>
<tr>
<td>City/Town:</td>
</tr>
<tr>
<td>Telephone (Home):</td>
</tr>
<tr>
<td>HBHC Screening Stage:</td>
</tr>
<tr>
<td>Prenatal</td>
</tr>
<tr>
<td>Reason for no response:</td>
</tr>
<tr>
<td>A requires further assessment, B client declined to answer, C unable to assess</td>
</tr>
</tbody>
</table>

### Section A: Pregnancy & Birth

| 1) Multiple birth? | [Yes/No] |
| 2) Prematurity (born at least 37 weeks) | [Yes/No] |
| 3) Was the birth weight less than 1500g? | [Yes/No] |
| 4) Was the birth weight more than 4000g? | [Yes/No] |
| 5) Apgar score of less than 5 at 5 minutes? | [Yes/No] |
| 6) Health conditions/medical complications during pregnancy that impact infant? |
| e.g. diabetes | Please List |
| 7) Complications during labour and delivery? |
| e.g. scheduled c-section, emergency c-section, infant trauma or distress, maternal death, premature birth, maternal medical complications | Please List |
| 8) Maternal smoking of cigarettes during pregnancy? | [Yes/No] |
| 9) Maternal smoking of more than 100 cigarettes (5 packs) in her lifetime prior to pregnancy? | [Yes/No] |
| 10) Maternal alcohol use during pregnancy? | [Yes/No] |
| 11) Maternal drug use during pregnancy? |
| Include information on all drugs, medications, vitamins, or herbal supplemenst that influence behaviour and develop into anomalies | Please List |
| 12) No prenatal care before sixth month? | [Yes/No] |

### Section B: Family

<table>
<thead>
<tr>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>13) Is less than 15 years old?</td>
</tr>
<tr>
<td>14) Was less than 16 years old when first child was born?</td>
</tr>
<tr>
<td>15) Experienced a previous loss? (pregnancy or baby)</td>
</tr>
<tr>
<td>16) Is a single parent?</td>
</tr>
<tr>
<td>17) Mother and child do NOT have a designated primary care provider?</td>
</tr>
<tr>
<td>18) Does NOT have an HCP number?</td>
</tr>
<tr>
<td>19) Did NOT complete high school?</td>
</tr>
</tbody>
</table>

### Section C: Parenting

| Client cannot identify support person to assist with parenting of the baby/child? | [Yes/No] |
| Client cannot identify support person to assist with care of the baby/child? | [Yes/No] |
| Client or family in need of new support? | [Yes/No] |
| Client has concerns about money to pay for housing, health and family food, clothing, utilities or other basic necessities? | [Yes/No] |
| Client or parenting partner has a history of depression, anxiety, or other mental illness? | [Yes/No] |
| Client or parenting partner has a disability that may impact parenting? | [Yes/No] |
| Client expresses concern about their ability to parent baby/child? | [Yes/No] |
| Client expresses concern about their ability to parent baby/child? | [Yes/No] |
| Client or parenting partner has been involved with Child Protection Services as a parent? | [Yes/No] |
| Client expresses that their child is difficult to manage? | [Yes/No] |
| Client’s response patterns are inconsistent or inappropriate to the baby’s/child’s cues? | [Yes/No] |

### Section D: Infant/Child Development

| Parent(s) identified a risk factor? |
| e.g. hearing, speech and language, cognitive/developmental, motor skills, vision, physical development, self-help skills | Please List |

### Section E: Health Care Professional Observations

| Health care professional has concerns about the well-being of client and/or baby? | [Yes/No] |

**Additional Comments:**

Client consents to release of information for purposes of validation exercise?

Signature of health care professional completing screen with client:

Data:

- [HN (Health Unit)]
- [RN (Hospital)]
- [Primary Care Provider (Community)]
Healthy Babies Healthy Children Screening Tool

Instructions, Definitions, Additional Information for Care Providers

Regular Screening of Families

Health care providers are in a unique position to have an impact on positive childhood development outcomes by virtue of their ongoing contact with parents and families over time. Completed screens need to be sent to your local public health department's Healthy Babies Healthy Children Program so that families can receive the support and services needed. This screen is intended to identify at-risk families who may benefit from the Healthy Babies Healthy Children home-visiting program during the prenatal, postnatal, or early childhood periods.

Instructions for Completion

Please provide ONE response for each question; if a yes/no response cannot be provided, please indicate the reason for no response in the right-hand column.

Reasons for no response: A individual completing the screen may have concerns or suspect a risk but needs more information in order to confidently identify the item as a risk. B indicates that the client declined to answer the question. C unable to assess or unable to ask the client (for example, client was in distress, there was no opportunity for a private discussion about the risk, etc.).

Please have INCUS Family ID Number blank. This number will be completed by Health Units. All identifying information will be eliminated from the screen before it is sent to MOCC for analysis.

For all questions, a "Yes" indicates a risk. Some items have been reversed, questions 17, 19, 20, 22, so that a "yes" indicates a risk. For example, "Mother does NOT have an OB/MR number." The more "yes" responses, the more likely a family is at risk.

This HBMIC Screen should be used for prenatal, postnatal and early childhood clients:

Screening of prenatal clients:
- Conception to birth of infant.
- Answer all questions except for questions 2, 3, 4, 5, 7, 21, 33, 34, 35.
- These questions DO NOT apply when screening prenatal clients and should be left BLANK.

Screening of postnatal clients:
- Birth of infant up to 6 weeks of age.
- In the case of multiple births, one screening is completed for each infant.
- Answer all questions.

Screening of early childhood clients:
- From 6 weeks of age.
- One screen is completed for each infant/toddler
- Answer all questions.

Suggested Introduction to Screening for Health Care Professionals

"As part of the Healthy Babies Healthy Children program, all families in Ontario are offered the chance to speak to someone about how they are doing [insert: during their pregnancy, after the birth of a baby, or when their children are in early childhood]. I would like to spend some time talking to you about your family, the supports you have, and any challenges that you may face. We gather the same kind of information from all families at this stage (pregnancy, after birth, early childhood of children) and use the information to support families in getting services that they may find helpful.

If you find there are some things you don't feel comfortable talking to me about, just let me know and I will move to another topic. If you have any questions or concerns throughout our discussion today, please let me know. If you and your family might need some extra support, a Public Health Nurse will contact you to talk about services that may be available to you."

Additional Information for Selected Questions

All questions are grounded in evidence and are reflective of the identification of potential risk. A reference list for the literature that supports the evidence for the Healthy Babies Healthy Children Program can be obtained by contacting the Ministry of Children and Youth Services, Healthy Babies Healthy Children program staff.

The following provides additional tips for completing specific questions:

Section A: Pregnancy and Birth (Questions 1-22)

6) Health conditions During pregnancy that impact infant
- Include: diabetes, edema, congenital heart disease, HIV, Health B: antenatal postnatal

7) Complications during labour and delivery
- Include: labour that required medical intervention, delivery of a newborn with serious congenital heart disease, infant resuscitation or delivery including respiratory distress syndromes and complications

9) Ask about mother's alcohol use throughout her pregnancy. Discussing alcohol use and fetal development with all women normalizes discussion of this issue and introduces a harm reduction approach to prevention.

11) Maternal drug use during pregnancy
- Include: illegal drug use during pregnancy and prescription drugs that impact on activities of daily living or are habitual use
- Include: non-prescription prescription drugs and small amounts of over-the-counter drugs

Section B: Family (Questions 13-22)

16) Include, if necessary, supplemental or acquired health challenges with genetic, physical or environmental conditions (e.g. Down's Syndrome, birth defects, etc.). If a suspected health challenge exists they are "A" should be checked off.

21) Include sources of support from usually available (e.g. family, friends, etc.).

Section C: Parenting (Questions 23-34)

23 & 24) Parenting refers to meeting the child's emotional and social needs (e.g., providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the child's basic physical needs (e.g., feeding, diapering, and bathing).

25) A mother who is new to Canada, less than 5 years living in Canada, who lacks social support, may be experiencing social isolation (someone is defined as someone new to Canada).

27) Include present or past depression, anxiety or emotional problems. Include if either mother or father/partnering parent indicates a history of mental illness.

28) Include mental or physical challenges for mother or father/partnering parent.

31) Include distress or conflict between parenting partners (e.g., separation arguments, presence of physical, verbal, emotional or sexual abuse in the home). This should be broadly defined as either by direct observation or expressed by the client.

Note nursing questions related to partner violence should not be asked with partner present with client.

32) Include family’s past or present involvement with Child Protection Services and/or involvement of client or parenting partner with Child Protection Services when they were a child.

33) Client may express difficulty managing children’s behavior (e.g., temper tantrums, excessive crying, etc.).

34) Include inappropriateness or lack of response when inappropriateness is in need of comfort, rank of eyes contended or physical contact. This could be broadly defined as either by direct observation or expressed by the client.

Section D: Infant/Child Development (Question 35)

This question should be answered in direct response to a developmental concern specifically raised by the parent and should not include parent concerns or questions about the normal care of a newborn or child. Areas of development include vision, hearing, and communication, gross and fine motor, cognitive, social/emotional, and self-care. Parental concerns may be identified through the Nipissing Developmental Dis delays Screening Tool (NDCDS) tool that assists parents and caregivers to monitor child development. More information on the NDCDS can be found at www.nipc.ca.

Section E: Health Care Professional Observations (Question 36)

Health care professional's concerns include professional observations of the client and family.

Signatures:

The screen should be signed by the individual who obtains consent from the mother. If additional information is completed by another practitioner, this individual should provide their initials beside the signature line.
3) Family Assessment Instrument

**Healthy Babies Healthy Children: Family Assessment**

**Please indicate the persons present during the assessment.**

<table>
<thead>
<tr>
<th>Caregivers</th>
<th>CHILD(1)</th>
<th>CHILD(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth (yyyy/mm/dd)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Data Collection**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Category</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical Development</td>
<td>Child (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Prenatal Health Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Depression during Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Baby/Child’s Behavioural Temperament</td>
<td>Baby/Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Child's Response to Caregiver</td>
<td>Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary Descriptions**

1. **Parental Education**
   - Attended most prenatal classes during pregnancy.
   - Attended most prenatal classes during previous pregnancy.
   - Did not attend prenatal classes but actively sought out other prenatal education and support.
   - Attended less than 3 prenatal classes and has not sought out other prenatal education and support.
   - Did not attend any prenatal classes and has not sought out other prenatal education and support.
   - Insufficient information to make a rating.

2. **Prenatal Health Care**
   - Sought prenatal care (doctor/nurse/health professional) in first trimester.
   - Sought prenatal care in second trimester.
   - Sought prenatal care in third trimester.
   - Did not seek any prenatal care until last month.
   - Did not seek any prenatal care.
   - Insufficient information to make a rating.

3. **Depression during Pregnancy**
   - Not depressed during pregnancy.
   - Sought prenatal care (doctor/nurse/health professional) in first trimester.
   - Sought prenatal care in second trimester.
   - Sought prenatal care in third trimester.
   - Did not seek any prenatal care until last month.
   - Did not seek any prenatal care.
   - Insufficient information to make a rating.

4. **Baby and Child’s Physical Health and Development**
   - Healthy and no obvious physical illness or disability, developmental delay, or lack of physical development.
   - Mild physical illness or disability, potential developmental delay, or lack of physical development; does not restrict baby/child’s activities.
   - Moderate physical illness or disability, potential developmental delay, or lack of physical development; restricts baby/child’s activities somewhat but permits with special care.
   - Serious physical illness or disability, potential developmental delay, or lack of physical development; restricts baby/child’s activities without special care.
   - Severe physical illness, disability, developmental delay, or lack of physical development; requires medical care.
   - Insufficient information to make a rating.

5. **Baby/Child’s Behavioural Temperament**
   - No significant behaviour/temperament problems; easy to soothe.
   - Marginally difficult behaviour/temperament; marginally tense, irritable, and difficult to soothe.
   - Moderately difficult behaviour/temperament; moderately tense, irritable, and difficult to soothe.
   - Very difficult behaviour/temperament; extremely tense, irritable, and difficult to soothe.
   - Insufficient information to make a rating.

6. **Child’s Response to Caregiver**
   - Child reacts and responds to caregiver in age-appropriate way.
   - Marginal anxiety with warm, familiar, familiar.
   - Moderately anxious with familiar, warmer, tendencies.
   - Very anxious with unfamiliar, disinterested, and possible violent interaction.
   - Extreme anxiety with uninterested, frowning, withdrawn, or passive.
   - Insufficient information to make a rating.
| 7. Physical Capacity to Care for Child Caregiver |
|---|---|---|---|---|
| 0. Healthy with no identifiable risk to child care capacity. |
| 1. Very limited physical impairment or illness with virtually no impact on child care capacity. |
| 2. Moderate physical impairment or illness resulting in only limited impact on child care capacity. |
| 3. Physical impairment or illness which seriously impacts child care capacity. |
| 4. Incapacitated due to chronic illness or disability resulting in inability to care for child. |
| 5. Insufficient information to make a rating. |

| 8. Mental, Emotional and Intellectual Capacity to Care for Child Caregiver |
|---|---|---|---|---|
| 0. No identifiable mental/behavioral disturbance or developmental disability. |
| 1. Symptoms of mental/behavioral disturbance or developmental disability with no impact on child care capacity. |
| 2. Moderate mental/behavioral disturbance or developmental disability with limited impact on child care capacity. |
| 3. Serious mental/behavioral disturbance or developmental disability which seriously impacts child care capacity. |
| 4. Incapacitated due to mental/behavioral disturbance or developmental disability resulting in inability to care for child. |
| 5. Insufficient information to make a rating. |

| 9. Feelings Towards Pregnancy and Baby Caregiver |
|---|---|---|---|---|
| 0. After 20th week of pregnancy, pregnancy was consistently accepted, and the baby is now consistently wanted. |
| 1. After 20th week of pregnancy, pregnancy was accepted most of the time, and the baby is now consistently wanted most of the time. |
| 2. After 20th week of pregnancy, pregnancy was accepted only about half the time, and the baby is now consistently wanted only about half of the time. |
| 3. After 20th week of pregnancy, pregnancy was not accepted most of the time, and the baby is now consistently wanted only about half of the time. |
| 4. After 20th week of pregnancy, pregnancy was not accepted, and the baby is now consistently unwanted. |
| 5. Insufficient information to make a rating. |

| 10. Expectations of Child Caregiver |
|---|---|---|---|---|
| 0. Realistic expectations with strong support. |
| 1. Realistic expectations with minimal support. |
| 2. Inconsistent expectations leading to confusion. |
| 3. Unrealistic expectations with angry/irate/irritable. |
| 4. Unrealistic expectations with violent punishment. |
| 5. Insufficient information to make a rating. |

| 11. Acceptance of Child Caregiver |
|---|---|---|---|---|
| 0. Very accepting of child and engaged with child. |
| 1. Limited acceptance of child or limited engagement with child. |
| 2. Inefficient and cold to child. |
| 3. Inconsistent and unemotional. |
| 4. Rejection and hostile to child. |
| 5. Insufficient information to make a rating. |

<p>| 12. Motivation/Responsibility Caregiver |
|---|---|---|---|---|
| 0. Motivated to meet child's needs, and caregiver has no impediments to solving problems. |
| 1. Motivated to meet child's needs, but caregiver has some impediments to solving problems. |
| 2. Motivated to meet child's needs, but caregiver has multiple impediments to solving problems. |
| 3. Very little motivation to meet child's needs and refuses supports. |
| 4. Insufficient information to make a rating. |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Summary Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td><strong>Ability to Cope with Illness</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. No stress or trauma.</td>
</tr>
<tr>
<td></td>
<td>2. Resilient without external support.</td>
</tr>
<tr>
<td></td>
<td>3. Insufficient information to make a rating.</td>
</tr>
<tr>
<td>14.</td>
<td><strong>Availability of Social Supports</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. Multiple sources of reliable and useful support.</td>
</tr>
<tr>
<td></td>
<td>2. None reliable or useful.</td>
</tr>
<tr>
<td></td>
<td>3. Insufficient information to make a rating.</td>
</tr>
<tr>
<td>15.</td>
<td><strong>Family Identify and Interactions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. Family interactions usually positive.</td>
</tr>
<tr>
<td></td>
<td>2. Insufficient information to make a rating.</td>
</tr>
<tr>
<td>16.</td>
<td><strong>Living Conditions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. Safe no hazardous conditions.</td>
</tr>
<tr>
<td></td>
<td>2. Unsafe, one hazardous condition that is dangerous to children.</td>
</tr>
<tr>
<td></td>
<td>3. Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Page</th>
<th>Summary Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td><strong>Housing Stability</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. Stable housing - no reason to leave current housing in the foreseeable future.</td>
</tr>
<tr>
<td></td>
<td>2. Insufficient information to make a rating.</td>
</tr>
<tr>
<td>18.</td>
<td><strong>Food Security and Nutrition</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. Adequate nutrition.</td>
</tr>
<tr>
<td></td>
<td>2. Insufficient information to make a rating.</td>
</tr>
<tr>
<td>19.</td>
<td><strong>Alcohol or Drug Use</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver</strong></td>
</tr>
<tr>
<td></td>
<td>1. Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
## Assessment Worksheet

**A.** Insert the rating for each assessment factor in the box. List any other factors that should be considered in this family's assessment.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prenatal Education</td>
<td></td>
</tr>
<tr>
<td>2. Prenatal Health Care</td>
<td></td>
</tr>
<tr>
<td>3. Depression during pregnancy</td>
<td></td>
</tr>
<tr>
<td>4. Baby/Child's Health and Development</td>
<td></td>
</tr>
<tr>
<td>5. Baby/Child's Behavior/Temperament</td>
<td></td>
</tr>
<tr>
<td>6. Child's Response to Caregiver</td>
<td></td>
</tr>
<tr>
<td>7. Physical Capacity to Care for Child</td>
<td></td>
</tr>
<tr>
<td>8. Mental, Emotional, and Intellectual Capacity to Care for Child</td>
<td></td>
</tr>
<tr>
<td>9. Feelings towards Pregnancy and Baby</td>
<td></td>
</tr>
<tr>
<td>10. Expectations of Child</td>
<td></td>
</tr>
<tr>
<td>11. Acceptance of Child</td>
<td></td>
</tr>
<tr>
<td>12. Motivation/Responsibility</td>
<td></td>
</tr>
<tr>
<td>13. Ability to Cope with Stress</td>
<td></td>
</tr>
<tr>
<td>14. Availability of Social Supports</td>
<td></td>
</tr>
<tr>
<td>15. Family Identity and Interactions</td>
<td></td>
</tr>
<tr>
<td>16. Living Conditions</td>
<td></td>
</tr>
<tr>
<td>17. Housing Stability</td>
<td></td>
</tr>
<tr>
<td>18. Food Security and Nutrition</td>
<td></td>
</tr>
<tr>
<td>19. Alcohol or Drug Use</td>
<td></td>
</tr>
<tr>
<td>20. Family Violence</td>
<td></td>
</tr>
<tr>
<td>21. Abuse/Neglect of Caregivers as a Child</td>
<td></td>
</tr>
<tr>
<td>22. History of Abuse/Neglect Committed by Present Caregivers</td>
<td></td>
</tr>
<tr>
<td>23. Cooperation with Services/Supports</td>
<td></td>
</tr>
</tbody>
</table>

Plants of dealing with insufficient information (ratings of ‘Y’)
- Subsequent visits
- Contact with other agencies
- Other

**B.** Summarize the family's strengths including, but not limited to, factors rated 0-3 or A, and how the strengths interact with each other.
### Assessment Worksheet

**C.** Summarize the family's risks and how the risks interact with each other.

**D.** Describe how the strengths identified in B and the risks identified in C influence or decrease risk. Incorporate the family's perception of strengths and risks.

### Overall Rating for Risk of Poor Child Development

<table>
<thead>
<tr>
<th>Child (1)</th>
<th>Child (2)</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Moderate Risk</td>
<td>Moderate Risk</td>
</tr>
<tr>
<td>High Risk</td>
<td>High Risk</td>
<td>High Risk</td>
</tr>
</tbody>
</table>

Signature of Assessor

Date completed (yyyy/mm/dd)

### Resources Recommended

**Healthy Babies Home Visitor Program**
- Lay Home Visitor
- Public Health Home Visitor

**Child Development and Therapy Program**
- Infant Development Program: Child 1, Child 2
- Speech Services: Child 1
- Other (e.g., Children's Treatment Centre, Behaviour Management) Child 1, Child 2

**Medical Services**
- Additional Prescribed Appointments
- Additional Postpartum Appointments
- Additional Well-Baby Visits: Child 1, Child 2

**Children's Aid Society**

**Parenting Programs**
- Nobody's Perfect
- Parenting Classes/Parent Support Group
- Community Resource/Center/Mother's Group

**CCAC (nursing service, other)**

**Breastfeeding Services**
- Doula
- Lactation
- Other

**Social Assistance**

**Other Community Programs**
- Public Health Home Visits
- Premature Education Services
- Smoking Cessation Resources
- Nutrition
- Social Worker
- Addiction Treatment Programs
- Assault Women's Resource/Shelter/Counselling
- Legal Aid
- Mental Health: Psychologist/Psychiatric/Psychotherapist
- Marriage/Family Therapist
- Supportive Counseling by Provider
- Better Beginnings, Better Futures
- CAPC
- Pregnancy Prevention
- Child Care
- Immigration Services
- Program for Abused Spouses
- Other

Signature of Assessor

Date completed (yyyy/mm/dd)

Name of Service Coordinator
In-Depth Assessment Supplement

In-Depth Assessment (IDA) Supplement

Instructions for Use:
1) Please complete the IDA Supplement as part of the current In-Depth Assessment. Note that there is no cumulative risk rating for the three new questions listed below. They are to be considered stand-alone questions to be used in conjunction with the current IDA.
2) Follow the suggested sequencing of the three new questions listed below with the current In-Depth Assessment.
3) Please note that Question I on Family Settlement Support will not apply to all families and if not relevant, please rate 10 as the most appropriate answer. Questions II and III are mandatory and should be completed on all families.
4) Anchor descriptions in Appendix A are provided for each question for your reference starting on page 3 of this document. Also, a set of sample assessment questions to guide your discussion with the family are provided in Appendix B on page 5.
5) Please begin to input your ratings for the IDA supplement on ISOBIS under “Project IDA Assessment Supplement” starting May 11, 2009.

<table>
<thead>
<tr>
<th>I. Family Settlement Support (to follow Q14 in current IDA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Multiple sources of reliable and useful settlement supports, interpretation and culturally appropriate services</td>
</tr>
<tr>
<td>1. Some reliable and useful settlement supports, interpretation and culturally appropriate services</td>
</tr>
<tr>
<td>2. Limited settlement supports, interpretation and culturally appropriate services</td>
</tr>
<tr>
<td>3. Limited settlement supports, interpretation and culturally appropriate services but unreliable</td>
</tr>
<tr>
<td>4. No settlement supports, interpretation and culturally appropriate services</td>
</tr>
<tr>
<td>5. Insufficient information to make a rating</td>
</tr>
<tr>
<td>6. Not relevant/not applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Financial Stability (to follow Q17 in current IDA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Financially stable</td>
</tr>
<tr>
<td>1. Fairly financially stable</td>
</tr>
<tr>
<td>2. Financially unstable</td>
</tr>
<tr>
<td>3. Financially very unstable</td>
</tr>
<tr>
<td>4. Financially extremely unstable</td>
</tr>
<tr>
<td>5. Insufficient information to make a rating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver 1</th>
<th>Caregiver 2</th>
<th>III. Education/Training and Employment (to follow Q17 in current IDA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Completed education level that supports independence and secure employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Some reliable educational support services and/or employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Some reliable educational support services and/or employment but limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Some reliable educational support services and/or employment but unreliable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. No educational support services, or unemployed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Insufficient information to make a rating</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Appendix A: Anchor Descriptions for the IDA Supplement

<table>
<thead>
<tr>
<th>Questions</th>
<th>Anchor Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Family Settlement Support</strong></td>
<td>Strong network of integrated settlement supports, interpretation and culturally</td>
</tr>
<tr>
<td></td>
<td>appropriate services available in the community relevant to family's needs</td>
</tr>
<tr>
<td>0. Multiple sources of reliable and useful settlement supports,</td>
<td>Some settlement supports, interpretation and culturally appropriate supports are</td>
</tr>
<tr>
<td>interpretation and culturally appropriate services</td>
<td>available in the community relevant to family's needs</td>
</tr>
<tr>
<td></td>
<td>Limited settlement supports and interpretation and culturally appropriate services</td>
</tr>
<tr>
<td>1. Some reliable and useful settlement supports, interpretation and</td>
<td>available in the community that are relevant to family's needs</td>
</tr>
<tr>
<td>culturally appropriate services</td>
<td>Limited settlement supports and interpretation and culturally appropriate services</td>
</tr>
<tr>
<td></td>
<td>available in the community that only occasionally meet family's needs</td>
</tr>
<tr>
<td></td>
<td>No settlement supports, interpretation and culturally appropriate services available</td>
</tr>
<tr>
<td>2. Limited settlement supports, interpretation and culturally</td>
<td>in the community to meet family's needs</td>
</tr>
<tr>
<td>appropriate services but unreliable</td>
<td>Insufficient information to make a rating</td>
</tr>
<tr>
<td></td>
<td>Not relevant/not applicable</td>
</tr>
<tr>
<td>4. No settlement supports, interpretation and culturally appropriate</td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
</tr>
<tr>
<td>9. Insufficient information to make a rating</td>
<td></td>
</tr>
<tr>
<td>10. Not relevant/not applicable</td>
<td></td>
</tr>
<tr>
<td><strong>II. Financial Stability</strong></td>
<td></td>
</tr>
<tr>
<td>0. Financially stable</td>
<td>No anticipated reasons for reduction in family income and adequate financial</td>
</tr>
<tr>
<td></td>
<td>resources in the foreseeable future</td>
</tr>
<tr>
<td>1. Fairly financially stable</td>
<td>Financially secure and adequate financial resources for at least six months to a</td>
</tr>
<tr>
<td></td>
<td>year into the future</td>
</tr>
<tr>
<td>2. Financially unstable</td>
<td>Impending loss of income but with some savings and/or inadequate financial resources</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Financially very unstable</td>
<td>to meet basic needs but community resources and supports help maintain family</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Financially extremely unstable</td>
<td>Impending loss of income and no savings and community resources and supports only</td>
</tr>
<tr>
<td></td>
<td>available for the short-term to maintain family</td>
</tr>
<tr>
<td>5. Insufficient information to make a rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>III. Education/Training and Employment</strong></td>
<td>No family income and no savings and/or inadequate financial resources to meet</td>
</tr>
<tr>
<td></td>
<td>current basic needs and no community resources available to maintain family</td>
</tr>
<tr>
<td>0. Completed education level that supports independence and secure</td>
<td>Caregiver has permanent (full time or part time) education/employment</td>
</tr>
<tr>
<td>employment</td>
<td>Caregiver is making good progress and regularly attending and actively participating</td>
</tr>
<tr>
<td></td>
<td>in education programs/supports and/or is employed on a regular basis although not</td>
</tr>
<tr>
<td></td>
<td>permanent (full time or part-time)</td>
</tr>
<tr>
<td>1. Some reliable educational support services and/or employment</td>
<td>Caregiver attends educational programs/supports with some absences and/or is</td>
</tr>
<tr>
<td></td>
<td>employed occasionally (casual or seasonal employment)</td>
</tr>
<tr>
<td>2. Some reliable educational support services and/or employment but</td>
<td>Caregiver has poor attendance and participation in educational program/supports and/or</td>
</tr>
<tr>
<td>limited</td>
<td>employment</td>
</tr>
<tr>
<td>3. Some reliable educational support services and/or employment but</td>
<td>Caregiver does not attend any educational program, or is unemployed</td>
</tr>
<tr>
<td>limited but unreliable</td>
<td></td>
</tr>
<tr>
<td>4. No educational support services, or unemployed</td>
<td></td>
</tr>
<tr>
<td>9. Insufficient information to make a rating</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Sample Assessment Questions for the IDA Supplement

I. Family Settlement Support

- Who is helping you with settling into your new community?
- Do you find their support and services useful?
- What barriers are you encountering as you settle into your new community?

II. Financial Stability

- Do you ever experience difficulty in meeting your family’s financial needs?
- Do you have any concerns about your ongoing ability to meet your family’s financial needs?
- What resources are available to you should you need financial help?

III. Income and Social Status

Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.

Why are higher income and social status associated with better health? It is not just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But life effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their depression to act are the key influences. Higher income and status generally results in more control and discretion. And the biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping strategies for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.

III. Education/Training and Employment

- Are you currently working or studying? If so, for how long have you been working or studying?
- Do you work/study full-time or part-time?
- Do you consider your position stable? Do you have any concerns about attendance?
- What are your employment or education goals?

IV. Education and Literacy

Health status improves with level of education. Education is closely tied to socioeconomic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.

V. Employment/Working Conditions

Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

Table of Contents:

Purpose of the Family Service Plan
Key Features of the Family Service Plan
Process for Completing the Family Service Plan
Goal Titles and Accompanying Goal Definitions
General Strategy Category Titles and Definitions
Goal Status Definitions
Indicator for Levels of Achievement of a Completed Goal and Definitions
Reasons for Not Completing a Goal and Definitions
Tools to Ascertain Level of Achievement of a Completed Goal
Strategy Status Definitions
Reasons for Not Completing a Strategy and Definitions
Appendix A: Examples for Levels of Goal Achievement for Goal Titles

Purpose of the Family Service Plan:
• The new service plan provides an improved standardized format for collecting data on the goals achieved by HBHC families.
• The new Family Service Plan will illustrate the differences in types of and levels of goals achieved by families with different risk factors in HBHC.
• The information provided in the Service Plan can be used to better understand the needs of families at the level of the public health unit.

Key Features of the Family Service Plan:
• The purpose of the Family Service Plan is to provide the home visiting team with an easy to use automated system for monitoring the selection, progress and achievements of goals of a family.
• A drop-down menu of 16 “goal titles” (and accompanying definitions as reference point) to choose from for a family.
• An “Other Goal” title to capture unique goals (as necessary).
• A drop-down menu to select more details on strategies used to implement a goal using the “general strategies categories”.
• Opportunity to continually update plan and monitor family’s progress through the “goal status” and “strategy status” feature of the plan.
• Minimal data entry required – required data is organized as categories that are selected by mouse “clicks”.
• Additional text boxes available for goal details and strategy details box for those health units wanting to capture more information for own use.
• Measurement component linked to goals through the “levels of achievement” drop-down menu.
• Ability to indicate reasons for not completing a goal to better understand family and service barriers.
• Printout of plan available for monitoring family’s progress and to get a snapshot on family’s current status on the service plan.

**Process for Completing Family Service Plan:**

- Review the specific details of the Family Service Plan by referring to the HBHC Family Service Plan Guide.
- PHN completes the Family Service Plan on the Integrated Services for Children Information System (ISCIS) in collaboration with members of the home visiting team.
- Complete a maximum of 5 goals per family.
- Provide clear rationale for goal selection based on family’s strengths and desires and risks identified through the In-Depth Assessment.
- Use “Other Goal” Title only in extenuating circumstances when you have a unique goal that is not similar to any of the goal titles already provided.
- Review plan with family and members of home visiting team on a regular basis – i.e. conduct an independent visit or a joint visit (as determined by your health unit).
- Based on review of plan with family update the Family Service Plan on a regular basis using the goal status and strategy status features.
- Update the plan before discharging family from home visiting.

**Optional Areas to Complete:**

- Notes section on first page of the plan (area where PHN can list high level summary details on the service plan).
- Specific details of the home visit (where health units can record detailed information about interactions with family members).
- Goal details and strategy details (where health units can record specific family and community service related details or record the rationale for selecting a goal for example the related nursing diagnosis).
## Goal Titles and Definitions

<table>
<thead>
<tr>
<th>Goal Titles</th>
<th>Definitions of the Goal Titles</th>
</tr>
</thead>
</table>
| Continued Education/Employment Training         | **Definition:** Access to and participation in adult education and literacy enhancement programs (including ESL/language skills training) or further education and training to support life course development (e.g., gaining or keeping employment).  
**Family Members Involved:** Caregiver(s)        |
| Effective Breastfeeding Maintenance             | **Definition:** Child receives breast milk from the breast or expressed breast milk. Child is thriving and gaining weight according to milestones. Mother maintains breastfeeding by seeking supports to resolve breastfeeding issues and concerns.  
**Family Members Involved:** Infant, Child, Caregiver(s) |
| Effective Management of Addiction/Dependency    | **Definition:** Parent is actively managing dependency using a harm reduction approach so that there is minimal impact on the family and on ability to parent.  
**Family Members Involved:** Caregiver(s)        |
| Effective Settlement and Cultural Adaptation     | **Definition:** Client is empowered to access ethno-cultural and linguistic supports and resources to help in the process of adapting, actively participating and contributing to various aspects of life in a new country/community of residence.  
**Family Members Involved:** Child, Caregiver(s)  |
| Financial Stability                              | **Definition:** Availability of adequate funds to meet basic needs. Income from employment and other financial support is predictable, sustainable and provides financial protection for the family.  
**Family Members Involved:** Caregiver(s)        |
| Healthy Attachment | **Definition:** Parent is responsive to child’s cues, sensitive to child’s behaviour and responds appropriately to the child’s stage of development. Parent meets the child’s emotional and physical needs in an affectionate and comforting manner. Parent and child have a close and secure interpersonal relationship that fosters child experience and learning.  
**Family Members Involved:** Child, Caregiver(s) |
|-------------------|--------------------------------------------------------------------------------------------------|
| Healthy Nutrition and Food Security | **Definition:** Family members, at all times, have access to sufficient, safe, healthy, nutritious and affordable food to maintain a healthy and active life.  
**Family Members Involved:** Infant, Child, Caregiver(s) |
| Healthy Relationships | **Definition:** Mutual respect, trust, valued communication and freedom from coercion and physical, mental, sexual and emotional abuse.  
**Family Members Involved:** Infant, Child, Caregiver(s) |
| Housing Stability | **Definition:** Housing is stable, suitable, safe and meets family’s needs. No change in current housing is anticipated in the foreseeable future.  
**Family Members Involved:** Caregiver(s) |
| Independent Life Skills | **Definition:** Demonstrates ability to complete activities of daily living (preparing meals, banking, shopping, paying bills, laundry, etc.) independently.  
**Family Members Involved:** Caregiver(s) |
| Optimal Growth and Development | **Definition:** Age-appropriate milestones in biological, physical, social/emotional, and language/cognitive development are being met.  
**Family Members Involved:** Infant, Child |
| Optimal Parental Health | **Definition:** Balanced state of complete physical, mental, social, sexual and spiritual well-being and not merely the absence of disease.  
**Family Members Involved:** Caregiver(s) |
| Optimal Prenatal Health | **Definition:** Optimizing maternal, fetal and neonatal health through use of positive maternal health practices and access to relevant prenatal health care.  
**Family Members Involved:** Pregnant Mother and Partner |
|-------------------------|--------------------------------------------------------------------------------|
| Parental Self Care      | **Definition:** Parent focuses on personal health, well-being and self-renewal and utilizes positive self-care practices in order to meet the demands of work and family life.  
**Family Members Involved:** Caregiver(s) |
| Positive Parenting      | **Definition:** Parent is knowledgeable, skilled and consistent regarding positive parenting practices. Parent is able to review past practices and be open to change. Parent responds to child’s activities in a manner that promotes independence, growth and development.  
**Family Members Involved:** Caregiver(s) |
| Positive Support Network and Trusting Relationships with Professionals | **Definition:** Reliable social support network made up of family, friends and peers, professionals, paraprofessionals and community resources. Parent accepts involvement of supports and actively participates in activities.  
**Family Members Involved:** Caregiver(s) |
| Safe Environment        | **Definition:** Parent is knowledgeable regarding hazardous conditions that may harm child. Parent understands and anticipates the need to make modifications and makes the necessary changes and ensures appropriate supervision as child progresses through developmental stages.  
**Family Members Involved:** Child, Caregiver(s) |
### General Strategy Categories and Definitions

<table>
<thead>
<tr>
<th>General Strategy Categories</th>
<th>Definitions for Strategy Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>• Definition</strong></td>
</tr>
<tr>
<td></td>
<td><strong>• Team members involved</strong></td>
</tr>
</tbody>
</table>

**Conduct screening**

To identify a group of people (e.g., mother, father, guardian, caregiver, child) experiencing needs, issues or risks that may compromise healthy child development and/or parenting ability and who may benefit from a more thorough evaluation and receive HBHC program services or other services.

The new HBHC screen can be used at three stages:

- Prenatal screening
- Postpartum screening; and
- Early childhood screening.

The Nipissing District Development Screen® can also be used to support screening.

**Team members involved:**
PHN, other professionals with the permission of the ministry (HBHC Protocol 2012 or as current), FHV – specific screening tools (e.g., NDDS) as determined by the ministry.

**Conduct assessment**

The process of determining the nature, cause, progression and prognosis of a problem and the personalities and situations involved therein; the function of acquiring an understanding of a problem, what causes it, and what can be changed to minimize or resolve it. Specifically to HBHC, assessments reflect the identification of family strengths and capacities. Assessment information identifies factors that influence a parent and child's ability to develop their full potential. Factors include a client's physiological, psychological, mental, economic, behavioural, lifestyle, emotional, sociological, and spiritual status.

**Professional assessments:** conducted by a professional, guided by a competencies and skill set
<table>
<thead>
<tr>
<th>General Strategy Categories</th>
<th>Definitions for Strategy Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Definition</td>
</tr>
<tr>
<td></td>
<td>• Team members involved</td>
</tr>
</tbody>
</table>

under the direction of standards and guidelines that are sponsored by a regulatory college and meet legislative requirements and standards of the profession.

HBHC assessments are delivered by the PHN at various points:

- Determination of “confirmed with risk” situations based on nursing judgement and the results of an in-depth assessment using the Family Assessment Instrument.
- Determination of the Parent-Child relationship strengths and areas for concern as determined by NCAST® Parent-Child Interaction Feeding and Teaching Scales.
- Determination of a new mother’s postpartum mood status using the Edinburgh Postpartum Depression Scale (optional)

**Family/Lay Home Visitor/Family Visitor assessments:** conducted by an individual with specialized knowledge and technical training who works closely with and is supervised by a professional. This may incorporate PHU initiated tools such as “Tool for Determining Frequency of FHV Visits”

**Team members involved:**
**Professional assessments:** PHN, or, other professionals with the permission of the ministry (HBHC Protocol 2012)

**Family/Lay Home Visitor/Family Visitor assessments:** FHV
**Provide information**

The act of informing, telling or sharing relevant and up-to-date knowledge on a specific subject of interest and/or need for family.

Information can be provided by:
- verbally sharing (e.g., in-person, by phone, in writing, email);
- providing experience and instruction;
- through various media (e.g., flyers/brochures, website links, DVD).

**Team members involved:**
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012)

---

**Conduct health teaching**

**Note:** The term “health” teaching should be interpreted in broad terms to enact all the social determinants of health and to view health as physical, mental, social, sexual and spiritual well-being and not merely the absence of disease.

Based on areas of interest or need, conducting health teaching involves identifying learning needs and knowledge or skills deficits, developing a plan, using an established plan to educate client on health related topics and actively involving family members in the learning process e.g., role modeling, demonstration, coaching, repetition, practice over time.

Resources used to support health teaching may include:
- NCAST Keys to Caregiving
- Promoting Maternal Mental Health During Pregnancy
- Partners in Parenting Education materials
- Nipissing District Developmental Screen®

**Team members involved:**
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012)
| **Counsel** | Counselling involves engaging family in an active therapeutic process by providing knowledge-based and anticipatory guidance that focuses on using family strengths and competencies and includes strategies such as narrative solution focused approaches, motivational interviewing and debriefing.  

**Team members involved:**  
PHN, other professionals with the permission of the ministry (HBHC Protocol 2012) |
| **Coach/ Problem solve/Role Model** | **Coaching:**  
Coaching, a method of directing, instructing and training a person with the aim to achieve some goal or develop special skill. Coaching can be done through observation, giving feedback, teaching, and/or helping to develop a plan of action.  

**Problem solving:**  
Problem solving includes working with the family to gather information, identify the issue or problem, consider alternatives and follow an agreed upon course of action.  

**Role Model:**  
Show through examples and personal practices that can be emulated by others.  

Materials from Partners in Parenting Education can be used to support all of these strategies.  

**Team members involved:**  
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012) |
| | Provide support and/or resources | Provide access to the HBHC service provider's own professional and organizational services for family and, as appropriate, facilitates service coordination with the family and multiple service providers.

**Team members involved:**
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012) |
|---|---|
| | Recommend other supports and services | Advise as a course of action, for example, I recommend that you go to the neighbourhood Ontario Early Years Centre.

**Team members involved:**
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012). |
| | Refer to other supports and services | To direct (in writing or verbally) to a source for help or information.

**Team members involved:**
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012). |
| | Advocate for other supports and services. | To support or speak in favour of; the act of directly representing or defending others. Championing the rights of individuals through direct intervention or through empowerment. Advocate for needs based services within the community.

**Team members involved:**
PHN, FHV, other professionals with the permission of the ministry (HBHC Protocol 2012). |
### Goal Status and Indicators of Level of Achievement for a Completed Goal

<table>
<thead>
<tr>
<th>Goal Status</th>
<th>Indicators of Level of Achievement for a Completed Goal</th>
<th>Definitions for Level of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planned</strong></td>
<td>Achieved</td>
<td>Completed goal positively impacted family. Review Appendix A of the HBHC Family Service Plan Guide to review examples that demonstrate levels of achievement for each goal title.</td>
</tr>
<tr>
<td><strong>In Progress</strong></td>
<td>Partially Achieved</td>
<td>Completed goal minimally impacted family. Review Appendix A of the HBHC Family Service Plan Guide to review examples that demonstrate levels of achievement for each goal title.</td>
</tr>
<tr>
<td><strong>Withdrawn</strong></td>
<td>Not Achieved</td>
<td>Completed goal did not impact family. Review Appendix A of the HBHC Family Service Plan Guide to review examples that demonstrate levels of achievement for each goal title.</td>
</tr>
<tr>
<td><strong>Completed</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reasons for Not Completing a Goal

<table>
<thead>
<tr>
<th>Reasons for Not Completing a Goal</th>
<th>Definition for Reasons for Not Completing a Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait list for accessing services</td>
<td>Wait list prevents client from accessing service</td>
</tr>
<tr>
<td>Service not available</td>
<td>Service not available</td>
</tr>
<tr>
<td>Transportation barrier</td>
<td>Transportation barrier</td>
</tr>
<tr>
<td>Language barrier</td>
<td>Language barrier</td>
</tr>
<tr>
<td>Financial barrier</td>
<td>Financial barrier</td>
</tr>
<tr>
<td>Cultural barrier</td>
<td>Cultural barrier</td>
</tr>
<tr>
<td>Physical barrier</td>
<td>Physical barrier (e.g., no wheelchair or stroller accessibility)</td>
</tr>
<tr>
<td>Child Care barrier</td>
<td>Unable to participate in a program, service etc. due to lack of availability of child care</td>
</tr>
<tr>
<td>Family Crises</td>
<td>Family Crises (e.g., illness resulting in hospitalization for parent or child, mental health issues are very acute)</td>
</tr>
<tr>
<td>Unable to work on goal</td>
<td>Client unable to work on goal i.e. too much going on with client, other personal issues took precedence etc.</td>
</tr>
<tr>
<td>No follow through on goal</td>
<td>No follow through by client on goal</td>
</tr>
<tr>
<td>Family discharged</td>
<td>Family Discharged</td>
</tr>
</tbody>
</table>

If applicable, list tools used to ascertain/determine level of achievement for a completed goal.
### Strategy Status Definitions and Reasons for Not Completing a Strategy

<table>
<thead>
<tr>
<th>Strategy Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>Strategy has been identified but NOT working on the strategy with family at this time</td>
</tr>
<tr>
<td>In Progress</td>
<td>Working on the strategy with family</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>Changing course of action i.e. stopping a strategy with the family since it is no longer a priority for them OR parent not ready to work on strategy OR parent not receptive to working on strategy</td>
</tr>
<tr>
<td>Completed</td>
<td>Implemented the strategy</td>
</tr>
<tr>
<td>Not Completed</td>
<td>Did not implement the strategy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Not Completing a Strategy</th>
<th>Definition for Reasons for Not Completing a Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait list for accessing services</td>
<td>Wait list prevents client from accessing service</td>
</tr>
<tr>
<td>Service not available</td>
<td>Service not available</td>
</tr>
<tr>
<td>Transportation barrier</td>
<td>Transportation barrier</td>
</tr>
<tr>
<td>Language barrier</td>
<td>Language barrier</td>
</tr>
<tr>
<td>Financial barrier</td>
<td>Financial barrier</td>
</tr>
<tr>
<td>Cultural barrier</td>
<td>Cultural barrier</td>
</tr>
<tr>
<td>Physical barrier</td>
<td>Physical barrier (e.g. no wheelchair or stroller accessibility)</td>
</tr>
<tr>
<td>Child Care barrier</td>
<td>Unable to participate in a program, service etc. due to lack of availability of child care</td>
</tr>
<tr>
<td>Family Crises</td>
<td>Family Crises (e.g. illness resulting in hospitalization for parent or child, mental health issues are very acute)</td>
</tr>
<tr>
<td>Unable to work on strategy</td>
<td>Client unable to work on strategy i.e. too much going on with client, other personal issues took precedence etc.</td>
</tr>
<tr>
<td>No follow through on strategy</td>
<td>No follow through by client on strategy</td>
</tr>
<tr>
<td>Family discharged</td>
<td>Family Discharged</td>
</tr>
</tbody>
</table>
# Appendix A: Examples of Goal Achievement for Each Goal Title

<table>
<thead>
<tr>
<th>Goal Titles</th>
<th>Definitions of the Goal Titles</th>
<th>Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued Education/ Employment Training</td>
<td>Definition: Access to and participation in adult education and literacy enhancement programs (including ESL/language skills training) or further education and training to support life course development (e.g., gaining or keeping employment).</td>
<td>Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td></td>
<td>Family Members Involved: Caregiver(s)</td>
<td>Achieved: Parent actively engaged in educational/employment training program. Demonstrates initiative, confidence and priority setting abilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partially Achieved: Parent demonstrates limited participation in education/employment training activities. Attendance is inconsistent due to other demands.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Achieved: Parent not participating in education/employment training. Parent does not recognize value of ongoing education to meet needs and own ability to succeed.</td>
</tr>
<tr>
<td>Effective Breastfeeding Maintenance</td>
<td>Definition: Child receives breast milk from the breast or expressed breast milk. Child is thriving and gaining weight according to milestones. Mother maintains breastfeeding by seeking supports to resolve breastfeeding issues and concerns.</td>
<td>Achieved: Child receives breast milk exclusively until 6 months of age. Child continues to breastfeed during the introduction of solids and sustained breastfeeding is established/encouraged for up to two years and beyond. Child is thriving and gaining weight according to milestones. Mother is maintaining breastfeeding by effectively seeking supports to resolve issues and concerns.</td>
</tr>
<tr>
<td></td>
<td>Family Members Involved: Infant, Child, Caregiver(s)</td>
<td>Partially Achieved: Child receives some breast milk until 6 months of age, with non-</td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples:</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>• Definition</td>
<td>• Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
</tbody>
</table>
|             | • Family Members Involved     | breast milk supplement.  
|             | • Example (where applicable)  | Child continues to receive some breast milk during the introduction of solids up to the age of two.  
|             |                               | Child has some nutritional delays however; parent is aware and seeking support.  
|             |                               | Mother is maintaining breastfeeding by seeking supports to resolve issues and concerns, at times but not consistently. |
|             |                               | **Not Achieved:**  
|             |                               | Child is not receiving breast milk until 6 months of age.  
|             |                               | Child does not continue to breastfeed during the introduction of solids.  
|             |                               | Child is not thriving and gaining weight according to milestones.  
|             |                               | Mother does not seek supports to resolve issues and concerns. |
| Effective Management of Addiction/Dependency | **Definition:** Parent is actively managing dependency using a harm reduction approach so that there is minimal impact on the family and on ability to parent.  
|                                                   | **Family Members Involved:** Caregiver(s) | **Achieved:** Parent has completed or is actively engaged in relevant counselling/support/treatment. Parent does not smoke or use substance in the child’s environment (e.g., home, car). If the parent chooses to use substances, the parent ensures the child is adequately cared for in a safe alternative environment.  
<p>|                                                   |                                             | <strong>Partially Achieved:</strong> Parent engages in relevant counselling/support/treatment most of the time. Parent sometimes smokes or uses substance in the child’s |</p>
<table>
<thead>
<tr>
<th>Goal Titles</th>
<th>Definitions of the Goal Titles</th>
<th>Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Definition&lt;br&gt;• Family Members Involved&lt;br&gt;• Example (where applicable)</td>
<td>• Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td>Effective Settlement and Cultural Adaptation</td>
<td>Definition: Client is empowered to access ethno-cultural and linguistic supports and resources to help in the process of adapting, actively participating and contributing to various aspects of life in a new country/community of residence.&lt;br&gt;Family Members Involved: Child, Caregiver(s)</td>
<td>Achieved:&lt;br&gt;Parent accesses the ethno-cultural supports and resources and demonstrates cultural adaptation by actively participating in various aspects of life in their new country/community of residence.&lt;br&gt;Partially Achieved:&lt;br&gt;Parent is accessing limited ethno-cultural supports and resources and participating in some aspects of life in their new country/community of residence.&lt;br&gt;Not Achieved:&lt;br&gt;Parent is not accessing ethno-cultural supports and resources and is not participating in community activities.</td>
</tr>
<tr>
<td>Financial Stability</td>
<td>Definition: Availability of adequate funds to meet basic needs. Income from employment and other financial support is predictable, sustainable and provides financial protection for the family.&lt;br&gt;Family Members Involved: Caregiver(s)</td>
<td>Achieved:&lt;br&gt;Parent has adequate funds available to meet basic family needs. Income from employment or other financial support is predictable and sustainable and provides financial protection for the family.&lt;br&gt;Partially Achieved:</td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples:</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>- Definition</td>
<td>- Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td></td>
<td>- Family Members Involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Example (where applicable)</td>
<td></td>
</tr>
</tbody>
</table>

**Healthy Attachment**

**Definition:** Parent is responsive to child’s cues, sensitive to child’s behaviour and responds appropriately to the child’s stage of development. Parent meets the child’s emotional and physical needs in an affectionate and comforting manner. Parent and child have a close and secure interpersonal relationship that fosters child experience and learning.

**Family Members Involved:** Child, Caregiver(s)

**Achieved:**
Parent demonstrates a good understanding of many of the following: the need to respond readily to child’s cues, sensitivity to child’s behaviour, responding appropriately to the child’s stage of development, the importance of meeting the child’s emotional and physical needs in an affectionate and comforting manner, fostering a close and secure interpersonal relationship that fosters child experience and learning.

**Partially Achieved:**
Parent demonstrates some understanding of the following: the need to respond readily to child’s cues, sensitivity to child’s behaviour, responding appropriately to the child’s stage of development, the importance of meeting the child’s emotional and physical needs in an affectionate and comforting manner, fostering a close and secure interpersonal relationship that fosters child experience and learning.

**Not Achieved:**
Parent has inadequate funds available to meet basic family needs. Income from employment or other financial support is neither predictable nor sustainable and does not provide financial protection for the family.
<table>
<thead>
<tr>
<th>Goal Titles</th>
<th>Definitions of the Goal Titles</th>
<th>Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Members Involved</td>
<td>Example (where applicable)</td>
<td>Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
</tbody>
</table>

**Healthy Nutrition and Food Security**

**Definition:** Family members, at all times, have access to sufficient, safe, healthy, nutritious and affordable food to maintain a healthy and active life

**Family Members Involved:** Infant, Child, Caregiver(s)

**Achieved:**
Parent demonstrates ability to buy and transport food for child and self all of the time. The parent demonstrates knowledge and skill to plan, prepare and feed nutritious, safe, age appropriate foods.

**Partially Achieved:**
Parent demonstrates the ability to buy and transport food for child and self most of the time. The parent has the knowledge and capacity to obtain emergency food supplies in the event that they occasionally run out of food. The parent demonstrates knowledge and skills for planning, preparing and feeding nutritious, safe, age appropriate foods.

**Not Achieved:**
Parent not demonstrating the ability to buy and transport food for child and family. The parent has run out of food. The parent does not demonstrate the knowledge and skill for planning, preparing...
<table>
<thead>
<tr>
<th>Goal Titles</th>
<th>Definitions of the Goal Titles</th>
<th>Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Definition</td>
<td>• Examples of goal achievement based on the following three levels:</td>
</tr>
<tr>
<td></td>
<td>• Family Members Involved</td>
<td>achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td></td>
<td>• Example (where applicable)</td>
<td>and feeding nutritious, safe, age appropriate foods.</td>
</tr>
<tr>
<td>Healthy Relationships</td>
<td>Definition: Mutual respect, trust, valued communication and freedom from coercion and physical,</td>
<td>Achieved: Family members demonstrate mutual respect, trust, valued</td>
</tr>
<tr>
<td></td>
<td>physical, mental, sexual and emotional abuse.</td>
<td>communication and freedom from coercion, physical, mental, sexual, and</td>
</tr>
<tr>
<td></td>
<td>Family Members Involved: Infant, Child, Caregiver(s)</td>
<td>emotional abuse.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partially Achieved: Family members experiencing some difficulty in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>demonstrating mutual respect, trust, valued communication and freedom</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from coercion, physical, mental, sexual, and emotional abuse. However,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>are engaged in relevant support services to resolve interpersonal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>difficulties.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Achieved: Family members not demonstrating mutual respect, trust,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>valued communication and freedom from coercion, physical, mental,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sexual, and emotional abuse.</td>
</tr>
<tr>
<td>Housing Stability</td>
<td>Definition: Housing is stable, suitable, safe and meets family’s needs. No change in current</td>
<td>Achieved: Parent maintains a stable, safe, suitable housing environment</td>
</tr>
<tr>
<td></td>
<td>housing is anticipated in the foreseeable future.</td>
<td>that meets family needs. No change in housing is anticipated in the</td>
</tr>
<tr>
<td></td>
<td>Family Members Involved: Parent</td>
<td>foreseeable future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partially Achieved: Parent verbalizes difficulty maintaining a stable,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>safe, suitable housing environment that meets family needs. Family has</td>
</tr>
<tr>
<td></td>
<td></td>
<td>taken action to change housing conditions.</td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples:</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Definition</td>
<td>• Examples of goal achievement based on the following three levels: <strong>achieved</strong>; <strong>partially achieved</strong>; <strong>not achieved</strong></td>
</tr>
<tr>
<td></td>
<td>• Family Members Involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Example (where applicable)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Achieved:</td>
<td>Parent has been unable to achieve a stable, safe, suitable housing environment that meets family needs.</td>
</tr>
<tr>
<td>Independent Life Skills</td>
<td>Definition: Demonstrates ability to complete activities of daily living (preparing meals, banking, shopping, paying bills, laundry, etc.) independently.</td>
<td>Achieved: Child demonstrates initiative and confidence in ability to independently complete activities of daily living including shopping, preparing meals, house keeping, laundry, banking, paying bills etc.</td>
</tr>
<tr>
<td></td>
<td>Family Members Involved: Parent</td>
<td>Partially Achieved: Parent sometimes demonstrates ability to independently complete activities of daily living including shopping, preparing meals, house keeping, laundry, banking, paying bills etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Achieved: Parent lacks ability to independently complete activities of daily living including shopping, preparing meals, house keeping, laundry, banking, paying bills etc. Parent demonstrates neither desire nor initiative to improve abilities and activities.</td>
</tr>
<tr>
<td>Optimal Growth and Development</td>
<td>Definition: Age-appropriate milestones for biological, physical, social/emotional, and language/cognitive development are being met.</td>
<td>Achieved: Evidence of child meeting all developmental milestones, no delays identified. Physically or mentally challenged child is consistently stimulated and integrated to optimal level of functioning. Parents are actively engaged in child’s developmental process, and in intervention and/or treatment as required.</td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Definition</td>
<td>• Examples of goal achievement based on the following three levels:</td>
</tr>
<tr>
<td></td>
<td>• Family Members Involved</td>
<td>achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td></td>
<td>• Example (where applicable)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partially Achieved:</td>
<td>Evidence of child meeting most developmental milestones, some delays identified.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physically or mentally challenged child somewhat stimulated and integrated to optimal level of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>functioning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents are aware of delays and open to seeking intervention and/or treatment for child.</td>
<td></td>
</tr>
<tr>
<td>Not Achieved:</td>
<td>Evidence of significant delays impacting on child's overall development.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents are experiencing difficulty in recognizing their child's growth and development needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents not engaged in promoting child's development; parent is not seeking intervention and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment for child.</td>
<td></td>
</tr>
<tr>
<td>Optimal Parental</td>
<td>Definition: Balanced state of complete physical, mental, social, sexual and spiritual well-</td>
<td>Achieved: Evidence of parental well-being in all aspects of health.</td>
</tr>
<tr>
<td>Health</td>
<td>being and not merely the absence of disease.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Members Involved: Parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partially Achieved:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concerns identified regarding one or more aspects of health and parent has sought out</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment/assistance/support to address the concern(s).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Achieved:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The parent does not recognize issues related to one or more aspect of health or does not</td>
<td></td>
</tr>
<tr>
<td></td>
<td>engage in intervention/treatment for child.</td>
<td></td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples:</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Optimal Prenatal Health | **Definition:** Optimizing maternal, fetal and neonatal health through use of positive maternal health practices and access to relevant prenatal health care.  
**Family Members Involved:** Pregnant Mother and Partner | **Examples of goal achievement based on the following three levels:** *achieved; partially achieved; not achieved*  
address the concern. |

**Achieved:**  
Parent demonstrates a good understanding of the following: prenatal care, nutrition, self-care, mental health and social support during pregnancy.  
Parent has implemented preventative measures related to the following risks: smoking, environmental tobacco smoke, alcohol and other substances, woman abuse and hidden exposures during pregnancy.

**Partially Achieved:**  
Parent demonstrates some understanding of the following: prenatal care, nutrition, self-care, mental health and social support during pregnancy.  
Parent implements some preventative measures related to the following risks: smoking, environmental tobacco smoke, alcohol and other substances, woman abuse and hidden exposures during pregnancy.

**Not Achieved:**  
Parent demonstrates some understanding of the following: prenatal care, nutrition, self-care, mental health and social support during pregnancy.  
Parent implements some preventative measures related to the following risks: smoking, environmental tobacco smoke, alcohol and other substances, woman abuse and hidden exposures during pregnancy.
<table>
<thead>
<tr>
<th>Goal Titles</th>
<th>Definitions of the Goal Titles</th>
<th>Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Definition</td>
<td>• Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td></td>
<td>• Family Members Involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Example (where applicable)</td>
<td></td>
</tr>
<tr>
<td>Parental Self Care</td>
<td><strong>Definition:</strong> Parent focuses on personal health, well-being and self-renewal and utilizes positive self-care practices in order to meet the demands of work and family life. <strong>Family Members Involved:</strong> Parent</td>
<td><strong>Achieved:</strong> Parent demonstrates understanding of the following: identifying areas of need, scheduling time for self, having spiritual, social and community support, and participating in health care, personal care, recreation and relaxation. <strong>Partially Achieved:</strong> Parent demonstrates understanding of some of the following: identifying areas of need, scheduling time for self, having spiritual, social and community support, and participating in health care, personal care, recreation and relaxation. <strong>Not Achieved:</strong> Parent not demonstrating understanding of the following: identifying areas of need, scheduling time for self, having spiritual, social and community support, and participating in health care, personal care, recreation and relaxation.</td>
</tr>
<tr>
<td>Positive Parenting</td>
<td><strong>Definition:</strong> Parent is knowledgeable, skilled and consistent regarding positive parenting practices. Parent is able to review past practices and be open to change. Parent responds to child’s activities in a manner that promotes independence, growth and development. <strong>Family Members Involved:</strong> Parent</td>
<td><strong>Achieved:</strong> Parent demonstrates knowledge, skills and consistency for the following: Realistic expectations, establishing routines, interactive play, appropriate limits, and positive discipline. <strong>Partially Achieved:</strong> Parent demonstrates knowledge, skills and consistency for some of the following: realistic expectations, establishing routines,</td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples:</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>• Definition</td>
<td>• Examples of goal achievement based on the following three levels: <em>achieved; partially achieved; not achieved</em></td>
</tr>
<tr>
<td></td>
<td>• Family Members Involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Example (where applicable)</td>
<td></td>
</tr>
<tr>
<td>Positive Support Network and Trusting Relationships with Professionals</td>
<td><strong>Definition:</strong> Reliable social support network made up of family, friends and peers, professionals, paraprofessionals and community resources. Parent accepts involvement of supports and actively participates in activities. <strong>Family Members Involved:</strong> Parent</td>
<td><strong>Achieved:</strong> Parent perceives and has a consistently reliable social support network. Parent accepts involvement of supports and actively participates in activities. <strong>Partially Achieved:</strong> Parent perceives and has a social support network, however unreliable. Parent accepts involvement of supports and participates in activities some of the time. <strong>Not Achieved:</strong> Parent does not have a consistent, reliable social support network. Parent neither accepts involvement of supports nor participates in activities.</td>
</tr>
<tr>
<td>Safe Environment</td>
<td><strong>Definition:</strong> Parent is knowledgeable regarding hazardous conditions that may harm child. Parent understands and anticipates the need to make modifications and makes the necessary changes and ensures appropriate supervision as child progresses through developmental stages.</td>
<td><strong>Achieved:</strong> Parent demonstrates a good understanding of environments hazardous to children and anticipates the need to make modifications and ensures appropriate supervision as child progresses through developmental stages.</td>
</tr>
<tr>
<td>Goal Titles</td>
<td>Definitions of the Goal Titles</td>
<td>Examples:</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>• Definition • Family Members Involved • Example (where applicable)</td>
<td>• Examples of goal achievement based on the following three levels: achieved; partially achieved; not achieved</td>
</tr>
<tr>
<td>Family Members Involved: Child, Parent</td>
<td></td>
<td>Partly Achieved: Parent demonstrates some understanding of environments hazardous to children and anticipates the need to make modifications and ensures appropriate supervision as child progresses through developmental stages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Achieved: Parent not demonstrating understanding of environments hazardous to children and does not anticipate the need to make modifications and does not ensure appropriate supervision as child progresses through developmental stages.</td>
</tr>
</tbody>
</table>
5) HBHC Family Friendly Service Plan
Working Together to Meet My Family’s Goals

I. Child and Family Information
   Family Name:
   Name(s) of Child(ren):
   Date:

II. Main Contacts for Healthy Babies Healthy Children
   Public Health Nurse:
   Public Health Nurse Phone Number:
   Family Home Visitor:
   Family Home Visitor Phone Number:

III. Working Together
   Pregnant women and families often have questions and need information and support. We are meeting with you to learn about your family and how we all can work together to make a plan to meet your goals. As part of our conversations, we will talk about what your family does well, areas where you need some supports, areas where you have questions, and what you want to learn more about.

IV. What My Family Does Well:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

V. Where My Family Needs Support:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

VI. What Would My Family Like to Learn More About:
   __________________________________________________________
My Family's Goals:
Listed below are some topics that may be of interest to you and your family. Check (√) each topic with “Interested”, “Not Interested”, or “Does not apply”. Under each topic you can check (√) the questions that you would like to discuss and learn more about. You may also add any questions or comments. Once you have finished, place a star (*) besides your top 3 to 5 goals.

**Pregnancy:** ☐ Interested ☐ Not Interested ☐ Interested but not right now ☐ Does not apply to me
Optimal Prenatal Health
☐ How do I stay healthy during pregnancy e.g., eat healthy, get enough rest and sleep, get some physical activity?
☐ How will my body and my feelings change?
☐ How is my baby growing?
☐ How do I protect my unborn baby from harm?
☐ How do we prepare for birth?
☐ How do I know if I am going into labour too soon?
☐ What do I take to the hospital?
☐ What do I need to prepare for the baby?
☐ How do I prepare myself and my family for the baby?
☐ How will I feed my baby?
☐ What will my day with my baby look like?
☐ How will I learn and respond to my baby’s special language?
☐ What do I do with a crying baby?
☐ Where can I get support in the community?
☐ Comments or Other Questions:

Update: 


**Connecting with your Baby/Child:** ☐ Interested ☐ Not Interested ☐ Interested but not right now
Healthy Attachment
☐ How will I learn and respond to what my baby is telling me?
☐ How do I know what my baby/child wants?
☐ How do I comfort my baby/child?
☐ How do I talk or play with my baby/child?
☐ How do I get to know my baby/child’s personality?
☐ Comments or Other Questions:

Update: 


Healthy Babies Healthy Children Guidance Document
**Breastfeeding:**  □ interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me

(Effective Breastfeeding Maintenance)

- □ What do I need to know about feeding my baby?
- □ How do I know if my baby is gaining weight?
- □ How do I know if my baby is getting enough?
- □ What do I need to keep up my milk supply?
- □ How do I get support to keep on breastfeeding?

Comments or Other Questions:

---

Update: ________________________________

---

**Food and Healthy Eating:**  □ interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me

(Healthy Nutrition and Food Security)

- □ How do I feed my baby/child?
- □ What do I feed my baby/child?
- □ How do I make my own baby food?
- □ How do I deal with picky eaters (e.g., food refusal, food allergies or sensitivities)?
- □ How do I feed my family healthy foods on a budget?
- □ Where can I go to get food for my family?

Comments or Other Questions:

---

Update: ________________________________

---

**How Children Grow and Develop:**  □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me

(Optimal Growth and Development)

- □ How do I know if my baby/child is growing and developing properly?
- □ How can I help my baby/child grow and develop?
- □ How can I help my baby/child learn to talk?
- □ What play activities can I do with my baby/child?
- □ How can I help my baby/child deal with different emotions?
- □ How can I help my baby/child interact and play with other children?
- □ How do I take care of my baby/child’s teeth and gums?
- □ How do I go about getting my baby/child immunized?
- □ How do I help others know what my baby/child needs to grow and develop?
Comments or Other Questions:

______________________________________________________________

Update: _______________________________________________________________________

______________________________________________________________

______________________________________________________________

Being a Parent: □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me
(Positive Parenting)
□ How do I know if my baby/child is sick?
□ What do I do if my baby/child is sick (e.g., use of thermometer, cold/warm bath, humidifier)?
□ What medications can I give to my baby/child when they are sick?
□ How do I handle my baby/child’s behaviour?
□ How do I deal with sibling rivalry?
□ What do I do when I get frustrated with my baby/child?
□ How do I toilet train my child?
□ What are normal sleeping patterns?
□ How can I handle my baby/child’s sleeping problems?
□ Where can I go for help with parenting?
□ Comments or Other Questions:

______________________________________________________________

Update: _______________________________________________________________________

______________________________________________________________

______________________________________________________________

Safety: □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me
(Safe Environment)
□ How do I make my home safe for my baby/child?
□ How do I make my baby/child’s sleep area (crib/bed) safe?
□ How do I make sure my baby/child is safe outdoors (yard, playground, sidewalk or street)?
□ How do I keep my baby/child safe when they are riding in a car?
□ How do I make sure to leave my baby/child with a good caregiver when I am not around?
□ How do I make sure that my caregiver’s environment is safe for my baby/child?
□ How do I make sure that my baby/child is safe with pets?
□ Comments or Other Questions:

______________________________________________________________

Update: _______________________________________________________________________

______________________________________________________________

______________________________________________________________
**Daily Activities:**
- [ ] Interested
- [ ] Not Interested
- [ ] Interested but NOT right now
- [ ] Does not apply to me

(Independent Life Skills)
- [ ] What does a typical day look like for me?
- [ ] What would my day look like with my new baby?
- [ ] How do I better organize myself and my time?
- [ ] How do I plan family routines?
- [ ] How do I make the most of my day with my family?
- [ ] Comments or Other Questions:

Update:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Your (Parent’s) Health:**
- [ ] Interested
- [ ] Not Interested
- [ ] Interested but not right now
- [ ] Does not apply to me

(Optimal Parental Health)
- [ ] How do I make healthy lifestyle choices? Eat healthy? Get enough rest and sleep? Get some physical activity?
- [ ] How do I plan for future pregnancies?
- [ ] What are my birth control options?
- [ ] Where do I go if I need emergency care (e.g., 911, poison control, urgent care, telehealth)?
- [ ] How do I find a doctor/nurse practitioner/midwife?
- [ ] Where can I go for help if I am feeling down, depressed or anxious or need to talk about stressful things from my past?
- [ ] Comments or Other Questions:

Update:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Taking Care of Yourself:**
- [ ] Interested
- [ ] Not Interested
- [ ] Interested but not right now
- [ ] Does not apply to me

(Parental Self-Care)
- [ ] How do I know when I am stressed?
- [ ] How can I handle my stress in a healthy way?
- [ ] Where can I go for support?
- [ ] How do I make time for myself?
- [ ] Comments or Other Questions:

________________________________________________________________________
Tobacco/Drugs/Alcohol:  □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me  
(Effective Management of Addiction/Dependency)
  □ How do I know if I have an addiction?
  □ How do I quit/reduce smoking?
  □ How do I quit using alcohol?
  □ How do I quit my other additions (e.g., gambling, internet, sexual)?
  □ How do my addictions impact my family?
  □ How are my partner’s or other family member’s addictions affecting my family?
  □ Where do I go for help?
□ Comments or Other Questions:

Your Supports:  □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me  
(Positive Support Network and Trusting Relationships with Professionals)
  □ What services or programs are available for me, my baby/child and my family (e.g., Ontario Early Years Centres (OEYCs), recreation centres, moms groups)?
  □ How do I make sure that I keep my or my family’s regularly scheduled appointments?
  □ How do I get legal, settlement and income support?
□ Comments or Other Questions:

Update:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Family and Friends:  □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me
(Healthy Relationships)
☐ What supports do I have in my life?
☐ What is a “healthy relationship”?
☐ How do I form and keep a healthy relationship?
☐ Where do I go for help if I feel unsafe in my relationship?
☐ How can I communicate better with family and friends?
☐ How can our family support each other during difficult times?
☐ Who can I depend on during times of need?
☐ Comments or Other Questions:

__________________________________________________________
__________________________________________________________

Update: __________________________________________________

__________________________________________________________

Money and Income:  □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me
(Financial Stability)
☐ Where do I go for help so I can pay for food, housing, clothing, or transportation?
☐ How do I learn to manage my money?
☐ Where can I get help if I am worried about my gambling or my partner’s gambling?
☐ How do I go about paying for childcare/daycare/baby sitter?
☐ Comments or Other Questions:

__________________________________________________________
__________________________________________________________

Update: __________________________________________________

__________________________________________________________

School and Work:  □ Interested  □ Not Interested  □ Interested but not right now  □ Does not apply to me
(Continued Education/Employment Training)
☐ How do I return to school?
☐ Where can I get reading help?
☐ How can I complete my Grade 12 education?
(OSSD (Ontario Secondary School Diploma)) or GED (General Educational Development) for the Ontario High School Equivalency Certificate)
☐ How can I attend training to get or keep a job?
☐ Comments or Other Questions:

__________________________________________________________
__________________________________________________________

Update: __________________________________________________

__________________________________________________________
Housing: [ ] Interested  [ ] Not Interested  [ ] Interested but not right now  [ ] Does not apply to me
(Housing Stability)
[ ] How do I find safe and affordable housing?
[ ] Where can I go for help if I am having housing problems?
[ ] Comments or Other Questions:

Update: ___________________________________________ ________________________________

Language and Culture: [ ] Interested  [ ] Not Interested  [ ] Interested but not right now  [ ] Does not apply to me
(Effective Settlement and Cultural Adaptation)
[ ] How do I learn about life in Canada?
[ ] Where do I find cultural supports in my community?
[ ] How do I improve English or French as a Second Language (ESL or FSP) skills?
[ ] Comments or Other Questions:

Update: ___________________________________________ ________________________________

VIII. Other Questions That I Have:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

IX. Other Things You Can Help Me With:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
Home Visiting Appointment Reminder
Today’s Visit

Date

Public Health Nurse

Family Home Visitor

Before The Next Visit

My Family and I will...

My Nurse will...

My Family Home Visitor will...

My Next Scheduled Visit

Date
Start Time

Adapted from: Family Home Visiting Unit, Community and Family Health Division, Maternal and Child Health Section, Minnesota Department of Health. Family Home Visiting Program Minnesota Department of Health Report to the Minnesota Legislature 2012. Minneapolis, Minnesota Department of Health; 2012.
APPENDICES

Appendix 1: Review of the Literature on Home Visiting Best Practices – Additional Results

Search methodologies used for the literature review included:

- CINAHL (Cumulative Index of Nursing & Allied Health Literature) search utilizing words such as ‘public health nursing’, ‘community health nursing’ combined with ‘home visiting’, ‘high-risk’, ‘screening tools’, ‘assessment tools’, ‘interventions’, ‘evaluation’, ‘outcomes’ and/or ‘documentation’.
- Utilizing current reference lists that were relevant and easily accessible e.g., PhD reference list from a key informant, reference list from Minnesota Department of Health, BC Healthy Child Forum 2004 literature review.

Nurse Home Visiting Outcomes

In order to identify best practices for home visiting it is important to first identify programs with the best outcomes and then dig deeper to understand the tools and approaches these programs use.

Although Ciliska et al (117) note that there are no negative affects of home visiting documented in the literature, according to Santos (29) the highest-risk participants in the randomized effectiveness trails of Early Head Start and Hawaii Healthy Start did not show positive effects. Santos concludes that Canada needs more evidence on whether ECD programs delivered in the real world actually do more good than harm.

A cursory review of the ECD/home visiting evidence was compiled for the 2004 BC Healthy Child Forum. This review showed that:

- Identifying higher risk communities or populations is essential.
- Programs are most effective if they are focused on the most disadvantaged and vulnerable parents and children. These programs should be provided by professionals (or well-trained paraprofessionals) and must be multi-component, intensive and sustained. Programs also need to be tailored to local social and cultural conditions.
- In order to prevent low-birth weight, it is critical that home visits and clinical services are provided to adolescent mothers in an intensive manner that includes early enrollment, counselling, referral clinics and quality relationships with staff.
• PHN visits to disadvantaged first-time mothers from pregnancy through the first two years results in increased parental caregiving, increased safety at home, decreased hospital use, less substance use and some benefits on immunization. These visits can also reduce maltreatment, physical abuse and neglect. (37,44-47,49,50)

Bull et al (30) provide a more in-depth analysis including a review of nine key systematic literature reviews of prenatal and postnatal home visiting programs where nurses were the primary visitors. (37,45,117-123) It is interesting to note that Canadian researchers completed almost half of these systemic reviews. Bull’s key findings are as follows:

**Can home visiting improve child health outcomes?**
- There is insufficient evidence regarding a beneficial impact on low birth weight or other pregnancy outcomes.
- The evidence regarding a relationship between home visiting and child abuse is incomplete and complex. Positive effects tend to be associated with measures of parenting rather than in direct measures of abuse.
- There are significant methodological problems with measuring child abuse in trials of home visiting. These include the limited ability to collect good data on abuse incidence. Note: This finding is echoed by Chaffin (124) in his commentary – *Is it Time to Rethink Healthy Start/Healthy Families?*
- There is good evidence that home visiting programs have an impact on reducing rates of childhood injury.
- There is some evidence to suggest a beneficial impact on intellectual development in children. This impact is more apparent among children with identified problems associated with low birth weight or failure to thrive.
- There is insufficient evidence to determine the effect of home visiting interventions on immunization or hospital admission rates.
- Home visiting programs have the potential to encourage and support breastfeeding.
- There is weak evidence to suggest a positive effect on children’s diets.

**Can home visiting improve the quality parenting?**
- There is good evidence to suggest that home visiting has a positive effect on various dimensions of parenting or mother-child interaction.

**Can home visiting improve outcomes for mothers?**
- There is some evidence that points to a positive effect on the detection and management of postpartum depression.
• There is insufficient evidence to prove any long-term benefit on access to social support.
• There is insufficient evidence to prove any long-term benefit on maternal life course development.

What is the best way to deliver home visiting programs?
• The evidence suggests that interventions that are focused on a narrow range of outcomes are less effective than those with a more comprehensive approach that addresses multiple needs.
• There is some evidence to suggest that more intensive programs have a greater impact, but the ideal intensity and duration is not clear.
• It is not clear that home visits from professionals are more effective than paraprofessionals.

Bull et al also highlight many methodological issues within the literature such as:
• High rates of attrition or low rates of participation;
• Inadequate randomization;
• Limited follow-up periods in evaluations to test whether positive effects dissipate over time;
• Insufficiently detailed descriptions of the timing, content and methods of the interventions;
• Difficulties in separating the effect of each of the aspects of interventions;
• Small sample sizes;
• Lack of a specified theoretical foundation;
• Diverse and difficult to measure outcomes;
• The use of different instruments to measure the same outcomes which weakens the potential for pooling the effect sizes across studies; and
• A significant threat of report bias related to child abuse, e.g., mothers may be less likely to report such outcomes.

Bull’s results are supported by a number of other reviews:
• Drummond (19) concluded that exhaustive descriptions of actual practices are scarce and that there is a need to better: describe practices, consider client variables in all phases of programming and ensure adequate measurement.
• Santos (29) stated that, “In light of extensive efficacy evidence on home visiting, there is growing consensus that the field must now move from asking whether early childhood intervention works to asking how it works” (pg 2). As a result, it is challenging to identify the curricula and interventions that define public health nursing best practice.
• Kearney (18) identified that nurse home visiting has a more consistent effect on maternal well-being, interaction and parenting than on child health or health care use and that projects designed to alter specific parenting behaviours in families with pre-existing problems such as drug use were less effective.
• Deal (51) added that the most beneficial outcomes are home visits initiated early in pregnancy, interventions are longer in duration, an ecological model is basis for interventions and visits are targeted at families with multiple social risk factors.
• Santos (29) points out that there is a human resource challenge in meeting these outcomes. “Community health nurses – perhaps the most appropriate subgroup of nurses to provide home visiting represent 68 per 100,000. Given the magnitude of need, there simply will never be enough nurses to meet this demand” (Santos, 2005).

The Future of Children Program (http://www.futureofchildren.org) is a collaboration of the Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institution whose mission is to translate the best social science research about children and youth into information that is useful to policymakers, practitioners, grant-makers, advocates, the media, and students of public policy. This program has contributed a number of studies, evaluations and reviews to the home visiting literature.

In a review of six well-evaluated American programs (125) The Future of Children Program found that home visiting program benefits were modest and usually evident in only a subset of the families originally enrolled in the programs. This review concluded that:
• There are inherent limitations in home visiting programs and that more modest expectations for their success are needed.
• Home visiting programs should be funded as part of a broad set of services for families and young children.
• Once families are enrolled in home visiting programs, they receive on average about half the intended number of visits.
• No studies have been conducted to demonstrate the minimum number of home visits needed to result in change. Researchers have speculated that four visits or three to six months of services may be required for change.
• There are deviations in the original modules/curriculum that are designed for home visiting programs.
• New sites should remain as close to the original model as possible if they expect to reproduce similar results.
• Home visiting programs often focus on the behaviour of parents versus children. This is probably why outcomes for children are not as marked.
• Children’s’ development should be promoted through more child-focused interventions, e.g., the Watch, Wait, and Wonder technique.
• Home visits in combination with center-based group care leads to benefits for child development.
• The success of home visiting programs is dependent upon other community services provided.

The Zero to Three Policy Centre, a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers. (http://www.zerotothree.org) has recommended the following evidence-based best practices for home visiting programs:

• Invest in programs that have a track record of effective home visiting or that are modeled on such programs. While home visiting can be a valuable means of service delivery, funding efforts should focus on those programs that have demonstrated success or are based on such effective models.

• Support new initiatives that incorporate known elements of effectiveness. A review of 20 years of successful programs for young children and consultation with leading experts identified six key elements of effective home visiting:
  • Clearly defined goals and objectives;
  • Home visitors who know how to reach these goals and objectives;
  • Careful recruitment and training of home visitors;
  • Collaboration with other community organizations;
  • Stable and adequate funding; and
  • Evaluation and continuous quality improvement.

• Ensure that investments support rigorous, ongoing evaluation and continuous improvement efforts. Program evaluation allows home visitors, supervisors, funders, and participating families to know whether a program is being implemented as designed and the extent to which it is meeting the objectives. This information can be used to continually refine and improve service delivery. When designing a home visiting program, it is therefore essential to include the time and funding required for thorough planning and evaluation.

• Integrate home visiting with other programs and supports. Connecting home visiting efforts with other child and family services, particularly those focused on children's well-being and healthy development will help to ensure that young children and their families have the support that they need.

According to the Zero to Three Policy Center, home visiting programs should:
• Use a theoretical framework/model to guide all aspects of the service.
• Pursue a comprehensive approach that addresses the multiple needs of families and includes a broad set of services for families and young children (not just visiting) and collaboration with other community organizations.
• Seek stable and adequate funding.
• Provide intensive follow-up. A minimum of four visits or 3-5 months of services may be required before change occurs.
• Use a consistent, evidenced-based curriculum that meets the goals/objectives of the ECD program with trained staff who know how to reach these goals.
• Ensure home visiting programs are comprehensive. Deviations from original models of care (e.g., Olds work) will not achieve similar outcomes.
• Include child-focused interventions, not just parent focused interventions e.g., the *Watch, Wait, and Wonder* technique, interactional guidance videotaping.
• Provide ongoing evaluation and continuous quality improvement.
Appendix 2: Sample Assessment Questions and Anchor Descriptions

**NOTE: Child Protection Services consultation is required by Duty to Report under the Child and Family Services Act where there is a dotted line (- - - - -) in the ratings and anchor description.

PRENATAL INFLUENCE

1. Prenatal Education

Sample questions:
- Tell me about the prenatal education you had during this pregnancy.
- How did you get information about taking care of yourself during the pregnancy and how to handle childbirth?

Note: Assessment should determine mitigating circumstances that may have affected a woman’s decisions to attend prenatal classes such as language, transportation or monetary barriers. These circumstances include the mother’s feelings towards the pregnancy.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Attended most prenatal classes this pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Mother has attended prenatal education or participated in an online or mobile prenatal module, during this pregnancy where information on benefits of early prenatal medical care, sound nutrition practices, physical and emotions changes during pregnancy and effects of smoking and substance abuse was provided.</td>
</tr>
<tr>
<td>1</td>
<td>Attended most prenatal classes during previous pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Mother has attended prenatal education or participated in an online or mobile prenatal module during previous pregnancy.</td>
</tr>
</tbody>
</table>
2. **Prenatal Health Care**

Sample questions:
- *Tell me about the kind of prenatal health care you had during the pregnancy.*
- *Were there any challenges to getting to or receiving this care?*

A late start to prenatal care, after the third trimester, is a risk factor to healthy outcomes. It is important to assess why there was a late start to prenatal care and identify if there was a relation to abuse by a partner. (This is important because there is a relation between abuse and failure to seek prenatal health.)

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Sought out prenatal care (doctor/other health professional) in first trimester. Mother attended appointment with doctor or nurse/nurse practitioner or midwife in first trimester.</td>
</tr>
<tr>
<td>1</td>
<td>Sought out prenatal care in second trimester. Mother attended appointments with doctor or nurse/nurse practitioner or midwife in second trimester.</td>
</tr>
</tbody>
</table>
2 Sought our prenatal care at beginning of third trimester. Mother attended appointments with doctor or nurse/nurse practitioner or midwife at the beginning of the third trimester.

3 Did not seek any prenatal care until last month of pregnancy. Mother did not attend prenatal care from doctor or nurse/nurse practitioner or midwife until last month of pregnancy.

4 Did not have any prenatal care. Mother did not attend any prenatal care.

9 Insufficient information to make a rating.

3. Depression During Pregnancy

Sample questions:

- *How are you feeling about this pregnancy? Do you have any concerns about yourself, your baby or even the two of you together? (NCAST - PMMHDP)(91)*
- *Have you ever been involved in counselling? What kind? With whom? How was it for you? (NCAST - PMMHDP)(91)*
- *Do you have a history of depression during or after pregnancy? If yes, tell me about what worked or what didn’t to help you through this time.*

Assessors should look at factors that increase a women’s risk of mood disorders including: recent serious life stress, lack of social support, couple relationship problems, a family history of depression, previous emotional and/or psychiatric problems, a previous episode of pregnancy related or postpartum depression and an infant who is difficult to care for.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not depressed during pregnancy. Mother has not experienced any symptoms commonly associated with depression such as: sadness or frequent crying, despondency, anxiety, feelings of isolation, being overwhelmed, confusion or inability to cope with the new situation.</td>
</tr>
</tbody>
</table>
1. Some symptoms of depression occasionally experienced during pregnancy.
   Mother has occasionally experienced some symptoms that are associated with depression as listed above.

   Mother has experienced a moderate level of symptoms that are associated with depression such as being unable to sleep, not eating well, difficulty making decisions.

3. Repeated depressive episodes during pregnancy or history of depression.
   Mother has experienced depressive episodes that persist or has a history of postpartum depression.

4. Incapacitated at least once due to depression during pregnancy or history of severe depression.
   Mother has been incapacitated at least once due to depression during pregnancy or history of severe postpartum depression demonstrated by an inability to care for her baby or thoughts of harming herself or her baby.

9. Insufficient information to make a rating.

**INFANT/CHILD INFLUENCE**

4. **Baby's/Child's Physical Health and Development**

Sample questions:
- *Tell me about the baby’s health so far.*
- *Have there been any health problems or concerns?*

In addition to assessing any health problems the child may have, it is important for assessors to determine how well parents are coping with caring for and feeding their baby or child.
<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Healthy and no obvious physical illness or disability, developmental delay or lack of physical development. The baby/child is healthy and has no illness. Baby/child’s weight and/or height are at or above the 10th percentile.</td>
</tr>
<tr>
<td>1</td>
<td>Mild physical illness or disability, potential developmental delay or lack of physical development; does not restrict the baby/child’s activities. Mild illness or disability. The baby/child’s height and weight is between 5th or 10th percentile; reason is known.</td>
</tr>
<tr>
<td>2</td>
<td>Moderate physical illness or disability, potential developmental delay or lack of physical development; restricts the baby/child’s activities somewhat but overcome with special care. Moderate illness or disability. The baby/child’s activities are achieved with special care and treatment. The baby/child’s weight and height are below 5th percentile for age for known medical reasons.</td>
</tr>
<tr>
<td>3</td>
<td>Serious physical illness or disability, potential developmental delay or lack of physical development; restricts the baby/child’s activities without special care. Illness, developmental delay or disability seriously restricts activities and requires special care which caregiver views as burdensome. Parent is cooperative and willing to learn.</td>
</tr>
<tr>
<td>4</td>
<td>Severe physical illness, disability, developmental delay or lack of physical development; the baby/child requires medical care. Severe/chronic illness or disability, strong potential for developmental delay, substance use having serious effect on the baby/child’s health and development, drug withdrawal or positive toxicology, disability or handicap or severe pain/discomfort from conditions which severely restricts the baby/child’s activities. Special efforts unable to restore such activities. The baby/child’s weight and height are below 5th percentile for age; reason may be attributed to quality of care. Parent is unable or uncooperative in providing the quality of care required.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
5. Baby/Child’s Behaviour and Temperament

Sample questions:
- Describe your baby/child’s routine and behaviours for me.
- How do you soothe your baby/child when he/she is upset?
- Observe the infant state and related behaviours as related to: alertness, visual response, auditory response, habituation and consolability. (NCAST – Keys to Caregiving)(92)

A baby or child’s temperament and the caregiver’s response to it can be important factors in the child’s emotional development. When assessing a baby/child’s temperament or behaviour, assessors should talk to the caregiver about the baby/child’s activity level, regular routine, mood, reactions, adaptability and distractibility. They should also talk to the caregivers about strategies they use to encourage healthy baby/child functioning.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No significant behaviour/temperament problems; easy to soothe. Temperamentally easy baby; responds well to mother; soothes easily; positively approaches most new situations, adapts quickly, has a predominantly positive mood; behaviour seems age appropriate with acceptable school behaviour.</td>
</tr>
<tr>
<td>1</td>
<td>Marginally difficult behaviour/temperament - marginally tense or irritable, but usually easy to soothe. The baby/child generally demonstrates regular biological rhythms, occasional difficulty with adaptability to new situations and people and distractibility.</td>
</tr>
<tr>
<td>2</td>
<td>Moderately difficult behaviour/temperament – moderately tense, irritable and difficult to soothe. Tense, irritable baby; cries frequently; difficult to calm or soothe; irregularities in sleep and hunger patterns; the child adapts slowly to changes in routine and typically rejects new toys, food and/or people; difficult with task persistence and significant pattern of aggression or withdrawal at school with friends or siblings; uses behaviour to gain attentions.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3</td>
<td><strong>Very difficult behaviour/temperament – tense, irritable and difficult to soothe.</strong> Baby is highly irregular and unpredictable in sleep, feeding and elimination patterns; the child withdraws from and/or rejects new people, situations and things; displays intense reactions and is unable to persevere with task or focus attention in school; occasionally violent and dangerous to others; withdrawn from social interactions, displays lack of trust, particularly with significant others; destructive with objects or possessions; some self-abuse behaviours.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Extremely difficult behaviour/temperament – extremely tense, irritable and difficult to soothe.</strong> Baby can be extremely rigid or non-responsive. Has only two moods: crying and sleeping. Provides parents with no positive reinforcement for caregiving. Child is violent and dangerous to others and self; displays behavioural extremes; shows exaggerated fear of closeness or physical contact; is inappropriately wary of adults.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Insufficient information to make a rating.</strong></td>
</tr>
</tbody>
</table>

6. **Child’s Response to Caregivers**

Sample questions:

- *How does your child respond to you during daily routines, feeding or in play situations? (NCAST – PCI)*
- *How does your child indicate when she/he needs you?*
- *Observe: cuddliness, smile, motor behaviour, irritability and readability (NCAST – Keys to Caregiving)*
A strong attachment relationship between baby and parent may be the most critical factor in the first year of growth and development. Assessors should be aware that the child’s response to caregivers can reflect how the child has been cared for in the past. NCAST materials from Keys to Caregiving and the Parent-Child Interactions scales can support assessment of this factor.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Child trusts and responds to caregiver in age-appropriate way.</td>
</tr>
<tr>
<td></td>
<td>Child trusts and responds to caregiver in age-appropriate, positive way. Minor conflicts with caregiver are resolved and are seldom long-term. Child is calm, relaxed and self-assured. Child engages positively with caregiver and elicits affections and responds with facial expression, posture and behaviour.</td>
</tr>
<tr>
<td>1</td>
<td>Marginally anxious with some hesitancy toward caregiver.</td>
</tr>
<tr>
<td></td>
<td>Child is sometimes cautious around caregiver; sometimes hesitant to approach caregiver for reassurance; the child may withdraw from caregiver when reassurance is offered by caregiver.</td>
</tr>
<tr>
<td>2</td>
<td>Moderately anxious with apprehension and suspicion toward caregiver.</td>
</tr>
<tr>
<td></td>
<td>Child is apprehensive and suspicious toward caregiver; appears inappropriately fearful of caregiver. Minimal eye contact between caregiver and the child. Child does not respond to caregiver’s affection.</td>
</tr>
<tr>
<td>3</td>
<td>Very anxious with negative, disruptive and possibly violent interaction.</td>
</tr>
<tr>
<td></td>
<td>Child/caregiver interaction is very negative. Interaction is disruptive, unpredictable or possibly violent. Child does not respond, over-responds or withdraws if caregiver displays affection or anger.</td>
</tr>
</tbody>
</table>
4. Extremely anxious with uncontrolled fear, withdrawal or passivity.

No interaction between the child and caregiver. Child is extremely fearful, shakes or cowers hysterically or cries uncontrollably from fear. Child is extremely passive, withdrawn or aloof toward caregiver.

9. Insufficient information to make a rating.

**CAREGIVER INFLUENCE**

7. **Physical Capacity to Care for Child**

Sample questions:
- *How has your own health been since the birth of your baby?*
- *What, if any, are the physical limitations for you in being able to care for your child?*

The health of the primary caregiver may affect the family’s ability to care for the child and the resulting healthy child development. Some parents may have recent acute health problems, perhaps associated with pregnancy and childbirth, which can affect their physical capacity to care for the child and may need short-term help. Note: Consider presence of substance use/abuse withdrawal symptoms, such as insomnia, chronic fatigue, irritability, severe headaches, seizures, nausea and vomiting. Responses and scoring from question #19 may support scoring for this item.

However, health problems are not always a sign that parents are physically unable to care for their children. Some parents have chronic health problems, but have made arrangements for adequate support. In these cases, it’s important for assessors to help determine whether the family will need additional supports as the child grows (e.g., to reflect increased demands of a child who is now mobile).

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Healthy with no identifiable risk to child care capacity.</td>
</tr>
<tr>
<td></td>
<td>Caregiver in generally good health with no identifiable illnesses, disabilities or inadequate health habits that would impact child care.</td>
</tr>
<tr>
<td>Rating</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
<td>Very limited physical impairment or illness with virtually no impact on child care capacity.</td>
</tr>
<tr>
<td>2</td>
<td>Moderate physical impairment or illnesses resulting in only limited impact on child care capacity.</td>
</tr>
<tr>
<td>3</td>
<td>Physical impairment or illness which seriously impairs child care capacity.</td>
</tr>
<tr>
<td>4</td>
<td>Incapacitated due to chronic illness or disability resulting in inability to care for the child.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>

**Consult with Child Protection Services**

8. **Mental/Emotional/Intellectual Capacity to Care for the Child**

Sample questions:

- *Have you experienced any recent changes in your appetite, either eating more or a lot less than usual? How about sleeping, about how much do you sleep each night? Is this normal for you? Has your energy level changed at all? (NCAST -PMMHDP) (91)*

- *Have you ever been involved in counselling? What kind? With whom? How was it for you? (NCAST -PMMHDP)(91)*
• Have you ever been hospitalized for any reason related to mental health, such as depression?
• Are you on any medications like anti-depressants? Have you ever been?
• Have you ever had any feelings like you wanted to hurt yourself or kill yourself? Tell me about those times. Are you having any of those feelings today? (NCAST - PMMHDP) (91)

It is important for assessors to determine whether a parent has ever experienced a mental health problem. The affect should also be observed, including the caregiver’s orientation and mood. The assessor should also determine where a caregiver’s intellectual limitations or poor reasoning abilities may affect his or her ability to care for a child.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No identifiable mental/emotional disturbance. Caregiver has no symptoms of mental illness, physiological disturbance or intellectual limitations. Appears to be emotionally stable.</td>
</tr>
<tr>
<td>1</td>
<td>Symptoms of mental/emotional disturbance or developmental disability with limited impairment of child care capacity. Caregiver experiences transient symptoms of psychological stress, emotional problems or from mental illnesses with little or no impairment of baby care capacity. Parent may have some intellectual limitations which do not affect his/her ability to care for the child.</td>
</tr>
</tbody>
</table>

Consult with Child Protection Services

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Moderate mental/emotional disturbance or developmental disability with limited impairment of child care capacity. Feelings such as powerlessness, low self-esteem, anxiety attacks or mood swings have a mild impact on the baby care capacity. Caregiver has some intellectual limitations or developmental disability which somewhat restricts ability to protect/care for the child.</td>
</tr>
<tr>
<td></td>
<td>Serious mental/emotional disturbance or developmental disability which seriously impairs child care capacity.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3</td>
<td>Incapacitated due to mental/emotional disturbances or developmental disability resulting in inability to care for the child.</td>
</tr>
<tr>
<td>4</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>

**Parenting Knowledge Influence**

9. **Feelings Toward Pregnancy and Baby**

Sample questions:

- *How did you feel when you found out you were pregnant?*
- *When did you first sense your child? What was that like for you? Does your child seem real to you yet? (NCAST -PMMHDP) (91)*
- *How do you think you will be different as the mother of the child than you were as a woman before you had a child? (NCAST -PMMHDP) (91)*
- *Who else will be involved in your child’s life? How do/did they feel about the pregnancy? How do they feel now? (NCAST -PMMHDP) (91)*
Attitudes towards pregnancy can affect the ability to bond with the child. Mothers who considered terminating the pregnancy or who planned to place the baby for adoption, but changed their minds at the last minute, may not be prepared for the responsibilities of parenting. They may find it difficult to bond with the child or have problems balancing their own and their child’s needs and the child may be at risk.

Assessors should be aware that it is normal for a woman and/or her partner to experience some feelings of ambivalence in the early stages of pregnancy. However, if either partner continues to not want to accept the pregnancy after the 20th week, this indicates a higher risk of neglect or child abuse and may also indicate distress in the parent relationship or women abuse.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>After the 20th week of pregnancy, pregnancy was consistently accepted and the baby is now consistently wanted. Mother is excited about being pregnant and is looking forward to the birth of the baby.</td>
</tr>
<tr>
<td>1</td>
<td>After the 20th week of pregnancy, pregnancy was accepted most of the time and the baby is now wanted most of the time. Mother expresses occasional doubts about the pregnancy but most of the time is looking forward to the birth of the baby.</td>
</tr>
<tr>
<td>2</td>
<td>After the 20th week of pregnancy, pregnancy was accepted only about half of the time and the baby is now wanted only about half of the time. Mother expresses frequent doubts about the pregnancy and is only partially looking forward to the birth of the baby.</td>
</tr>
<tr>
<td>3</td>
<td>After the 20th week of pregnancy, the pregnancy was not accepted most of the time and the baby is now unwanted most of the time. Mother has expressed overriding doubt and misgivings about the pregnancy and the birth of the baby.</td>
</tr>
<tr>
<td>4</td>
<td>After the 20th week of pregnancy, the pregnancy was not accepted and the baby is now unwanted. Mother has expressed a rejection of the pregnancy and the birth of the baby.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>

*Consult with Child Protection Services*
10. Expectations of Child

Sample questions:
- When your baby cries, what is she/he telling you?
- How do you respond when your baby cries?
- What are other behaviours your child uses to communicate his/her needs and wants? (NCAST – Keys to Caregiving) (92) How do you respond?
- How do you cope with disagreements between you and the other people who help to care for your child about how to handle the cues and how to raise your child?

Parents and other adults who have unrealistic expectations of their infant (e.g., expecting a baby to sleep through the night) may misinterpret a baby’s cries and not recognize their infant or child as a social human being who communicates needs and wants through non-verbal forms of communication. If the parent’s expectations regarding developmental milestones are too rigid or unrealistic or other adults in the family’s social network are encouraging inappropriate parenting behaviour, the child may be at risk for compromised child development.

Assessors must consider the individual caregivers and their immediate family unit as well the culture impact as these are all significant factors that affect parenting styles. It is important to ask parents about their own beliefs about child rearing as well as the beliefs of the other adults who will be supporting parenting.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Realistic expectations with strong support.</td>
</tr>
</tbody>
</table>
1 | Realistic expectations with minimal support. | Good knowledge of age-appropriate behaviours with realistic standards most of the time. May not encourage the baby or reach out to the baby when necessary to meet standards. May not encourage or assist the child with task when necessary to meet standards. Verbal messages are generally controlled and appropriate to the baby’s age and misconduct. Partner, grandmother and other caregivers disagree with the mother’s good knowledge. |

2 | Inconsistent expectations leading to confusion. | Has knowledge of age-appropriate behaviour, but is inconsistent in expectations. Baby/child is left frustrated and confused by inconsistency. Verbal interactions and discipline are inconsistently administered and often not appropriate to the child’s age and misconduct. Caregivers are inconsistent in responding to the baby’s cries. |

**Consult with Child Protection Services**

3 | Unrealistic expectations with angry conflicts. | Unrealistic expectations lead to regular conflicts and anger toward the baby over crying or toward the child over behaviour. Caregiver frequently administers excessive physical discipline or intentional neglect. Verbal discipline is frequently inappropriate and excessive in response to a newborn or in response to the child’s age and misconduct. |
4 Unrealistic expectations with violent punishment.

Unrealistic, not age-appropriate expectations may result in violent behaviour or punishment for the baby’s failure to meet expectations. Physical discipline or intentional neglect is the caregiver’s only response to the baby’s crying/child’s misconduct and pattern of physical discipline or intentional neglect is escalating in severity.

9 Insufficient information to make a rating.

11. Acceptance of the Child

Sample questions:
- Tell me about your child. How would you describe your child to me?
- When your child behaves in ways that bother you, what do you do?

Infants and children who are not accepted by their parents/primary caregivers are at risk of neglect, abuse and/or compromised growth and development.

Assessors should be aware that some parents are unable to accept their new baby. Sometimes one parent accepts the new baby, but the other does not. The parents’ ability to accept the child may be affected by the impact they feel the child has had on their lives. Assessors should also be sensitive to any lack of acceptance of a sibling of the newborn, which can manifest after the birth.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Very accepting of the child and engaged with the child. Frequently and spontaneously speaks about accomplishments of the child with approval. Accepts the child even when the child cries frequently.</td>
</tr>
<tr>
<td>1</td>
<td>Limited acceptance of the child or limited engagement with the child. Describes the child positively most of the time, but only when asked. Only occasionally does so spontaneously.</td>
</tr>
</tbody>
</table>
Consult with Child Protection Services

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Indifferent and aloof to the child.</td>
<td>Caregiver or partner is neither accepting nor rejecting. Relates to the child in matter-of-fact functional terms by has little emotional involvement and rarely demonstrates acceptance.</td>
</tr>
<tr>
<td>3</td>
<td>Disapproves of and resents the child.</td>
<td>The child is seen as disruptive and the cause of many problems. Caregiver or partner disapproves of or criticizes the child constantly and is resentful of the child.</td>
</tr>
<tr>
<td>4</td>
<td>Rejects and is hostile to the child.</td>
<td>The child is viewed as evil or bad. The child is consistently criticized and put down. The child is resented and even hated. The caregiver or partner is hostile to the child.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
<td></td>
</tr>
</tbody>
</table>

12. Motivation and Responsibility

Sample questions:
- **What if any, are the regular care giving tasks and parenting issues that you think you might find difficult? How do you think you’ll handle these?**
- **What are the possible barriers that might keep you from meeting your child’s needs in the way that you’d like and how do you think you’ll handle these? (e.g., lack of money, isolation, lack of support)**

Motivation refers to the caregiver’s ability to follow through with activities required to care for the child and to any barriers that may prevent the caregiver from fulfilling these responsibilities (e.g., language barriers, lack of transportation, lack of cognitive capacity). Caregivers who are not motivated or who encounter barriers are at risk of parenting problems.

When assessing the caregiver’s motivation/responsibility, the assessor should also take into account the caregiver’s acceptance and expectations of the baby. As well, the caregivers’ knowledge of available services must be considered.
<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Caregiver is motivated to meet the child’s needs and has no impediments to solving problems.</td>
</tr>
<tr>
<td>1</td>
<td>Caregiver is motivated to meet the child’s needs, but has some impediments to solving problems.</td>
</tr>
<tr>
<td>2</td>
<td>Caregiver is motivated to meet the child’s needs, but has multiple impediments to solving problems.</td>
</tr>
<tr>
<td>3</td>
<td>Consult with Child Protection Services</td>
</tr>
<tr>
<td>Very little motivation to meet the child’s needs.</td>
<td>Does not reject caretaking role but is indifferent or apathetic to the child’s needs; not concerned enough to resist competing demands on money, time and attention; takes no responsibility for the child’s unmet needs.</td>
</tr>
<tr>
<td>4</td>
<td>No motivation to meet the child’s needs.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
13. Ability to Cope with Stress

Sample questions:
- Having a baby is a big event. Have there been other big events in your life this past year?
- Are there other events happening in your life that you consider a source of stress? What are these and how are you coping?

High levels of stress, combined with a lack of coping skills, can create a high-risk environment for a child. Some families experience high levels of chronic stress, such as living in poverty, living in substandard housing or having personal physical health problems. Other families experience short-term acute stress, such as unexpected job loss or death of a family member. People react differently to stress. Some are very resilient under high levels of stress, while others are unable to cope.

When assessing the family’s ability to cope with stress, the assessor should also look at the decisions the caregiver makes to determine whether they contribute to keeping the family in constant crisis.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Free from stress influence. Family is currently (and has been) free from any major stressors during the last year.</td>
</tr>
<tr>
<td>1</td>
<td>Resolution without adverse effect. One or more stressors have occurred, but the family has resolved any associated crisis with no adverse effect on child care capacity.</td>
</tr>
<tr>
<td>2</td>
<td>Stabilized after period of anxiety and/or crisis(es). One or more stressors have occurred, but the family has stabilized after crisis. Child care capacity adversely affected during periods of crisis.</td>
</tr>
</tbody>
</table>

**Consult with Child Protection Services**

| 3 | Prolonged anxiety and/or crisis(es) strains coping skills. One or more stressors have occurred which resulted in a prolonged or current crisis. Caregiver’s coping strategies are strained and adversely affect child care capacity. |
4. Chronic anxiety and/or crisis(es) with limited coping.  

One or more stressors have caused caregiver to act severely depressed or immobilized. Crisis is adversely affecting child care on a chronic basis; caregiver exhibits inappropriate, very limited or no coping skills.

9. Insufficient information to make a rating.

**SUPPORT/SERVICE INFLUENCE**

14. Availability of Social Supports

Sample questions:

- *Who are the people you consider as parenting supports?*
- *How is this support helpful or not helpful to you as a parent?*

Social support reflects an individual’s sense of belonging and safety with a caring partner, family or community. Families that lack social support will often be isolated, have little or no help with daily tasks, stressful events or crises and receive little or no social, emotional or concrete help from a spouse, close friend or family member. Assessors must determine whether the mother or caregiver perceives the available support to be useful. Some may have people to provide support, but the support may not be useful or it may not be available when they need it.

Lack of social support or isolation may be a particular issue for families from marginalized populations such as new immigrants, Gay, Lesbian or Transgender families or Aboriginal families who face barriers of access and equity related to social services. Responses and scoring from question I of the supplement can support the scoring of this item.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Multiple sources of reliable and useful support.</td>
</tr>
<tr>
<td></td>
<td>Strong relationships with partner, family, friends and neighbours; available for necessary support. Caregivers are involved with activities outside the home.</td>
</tr>
</tbody>
</table>
1. **Some reliable and useful support.**  
Satisfactory relationships with partner, family and friends. May participate in one or more community, religious or other social groups. Community services are available and accessible.

2. **Some reliable support, but limited usefulness.**  
Partner and family are supportive, but not close by. Some support from friends. Community services are available but difficult to access.

3. **Some support, but unreliable.**  
Support from partner, family/friends is inconsistent/unreliable. Limited community services are available and accessible. Transportation or mobility is difficult.

4. **Effectively isolated.**  
Geographically and/or socially isolated from community supports. Alienated from or ongoing conflict with partner, extended family, friends or neighbours.

9. **Insufficient information to make a rating.**

<table>
<thead>
<tr>
<th>15. Family Identity and Interactions</th>
</tr>
</thead>
</table>

Sample questions:
- *Parenting can be a difficult time for some families. How does your family divide the work and deal with the demands of parenting?*
- *Describe the kind of support you get from your family, friends or partner.*

Families can be a source of support and a source of dysfunction and/or additional stress. The quality of family interactions can make it easier or more difficult to adjust to a newborn and can be an indicator of the potential for domestic abuse. For example, if the partner and other family members are supportive and get along well, there is less risk of abuse. If there are ongoing family tensions, the risk of child neglect or domestic abuse increases.
<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Family interactions typically supportive. Child and caregiver roles are appropriate. Adult caregivers provide appropriate amounts of emotional nurturance and support to the child. Caregiver has stable marriage or relationship with their partner; family members appear close, supportive and caring.</td>
</tr>
<tr>
<td>1</td>
<td>Family interactions are usually positive. Child and caregiver roles are normally distributed and fulfilled with only occasional minor exceptions. Family roles are sometimes confused and ineffective. Interaction between family members is usually positive with only occasional relationship problems within family; or family is adapting to recent alteration or breakdown in family structure.</td>
</tr>
<tr>
<td>2</td>
<td>Inconsistent family interactions. Adult caregivers expect a disproportionate amount of emotional support and comfort from children. Caregivers provide inconsistent emotional support for children. Interactions between members is unsupportive or indifferent. Family is adapting poorly to change in family composition.</td>
</tr>
</tbody>
</table>
Consult with Child Protection Services

3  Family interactions are generally indifferent.  Caregivers rely on children to provide emotional support in daily living; provide only limited emotional nurturance to children. Roles and responsibilities are confused and misunderstood. Limited positive family interactions. Some members are isolated from family functioning, including scapegoating the baby or another child. Change in family composition is disrupting the functioning of one or more family members.

4  Negative family interactions.  Caregivers fail to provide children with emotional nurturance. Abdicating of parental roles; interaction between family members primarily negative. Serious disruption of family functioning resulting from significant change in family composition.

9  Insufficient information to make a rating.

16. Living Conditions

Sample questions:

- Are there any infant/child safety issues that you’ve identified in the house? What would you like to do about any safety issues?
- Where does the infant/child sleep, play and eat?

Living conditions, particularly shelter, are important factors in child development. Unsafe living conditions are a threat to a child’s health and well-being. They can also affect the caregiver’s ability to provide for the child. For example, newborns, who are especially sensitive to heat, cold, injury and other threats need to be protected from undue exposure, unsafe cribs, rodents and insects. Young children who are vulnerable to injury need to be protected from unsafe toys and from jealous or uncontrolled pets.

Young children are also more sensitive to toxins and absorb chemicals at a faster rate than adults, thus the environment and toys should be considered in terms of toxins such as lead, BPA and second hand smoke.
Assessors should observe all aspects of the child’s living environment which include but are not limited to:

- Lack of heat in winter or excessive heat in summer, as well as ability to manage during extreme weather alerts;
- Leaking gas from stove or heating unit;
- Signs of a recent fire and/or history of fires;
- Dangerous objects or substances (e.g., medications, used syringes, cleaning products, plants) stored in unlocked cabinets, on lower shelves, under sinks or in the open;
- Lack of water or utilities;
- Peeling lead-based paint;
- Hot water/steam leaks from radiator;
- Inadequate heating/plumbing/electricity;
- Evidence of vermin;
- Garbage not disposed of properly;
- Perishable food not properly stored;
- Evidence of human or animal waste;
- Unsafe baby equipment (e.g., cribs, playpens, toys);
- Improper use of car seat;
- Dangerous or jealous animals;
- Lack of working fire detector; and/or
- second hand smoke.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Safe; no hazardous conditions apparent. Caregiver is able and willing to modify a potential risk as soon as it is pointed out. No hazardous conditions apparent.</td>
</tr>
<tr>
<td>1</td>
<td>Fairly safe; one possibly hazardous condition that may harm children. Caregiver is able and willing to modify condition as soon as it is pointed out. One possibly hazardous condition that may harm children. Caregiver is able and willing to modify condition as soon as it is pointed out.</td>
</tr>
</tbody>
</table>
Consult with Child Protection Services

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Unsafe; one hazardous condition that is dangerous to children. Caregiver is unable or unwilling to modify condition.</td>
<td>One hazardous condition that is dangerous to children and is unable or unwilling to modify condition.</td>
</tr>
<tr>
<td>3</td>
<td>Very unsafe; multiple hazardous conditions that are dangerous to children.</td>
<td>Multiple hazardous living conditions that are dangerous to children.</td>
</tr>
<tr>
<td>4</td>
<td>Extremely unsafe; multiple hazardous conditions that are dangerous to children and have caused physical injury or illness.</td>
<td>Multiple hazardous conditions that are dangerous to children and have caused physical injury or illness. There is severe overcrowding.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
<td></td>
</tr>
</tbody>
</table>

17. Housing Stability

Sample questions:
- How long have you been living here?
- Are there any concerns about your ability to live here over the next year?

Unstable housing creates stress for all family members and makes it extremely difficult for caregivers to meet children’s needs. In some families, children can be the source of unstable housing. For example, landlords or extended families who provide shelter for the primary caregiver and partner, may not want a baby in the house and may make conditions inhospitable. In other cases, a new baby may cause financial problems that lead to eviction.

Assessors should identify the root causes of any housing instability (e.g., lack of money, lack of housing in the community, lack of management skills) and determine whether there are resources available to help the family obtain or maintain stable housing after the baby’s arrival.
### Ratings

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Stable housing – no reasons to leave current housing in the foreseeable future.</td>
</tr>
<tr>
<td>1</td>
<td>Fairly stable housing – housing will be stable for at least six months in the future.</td>
</tr>
<tr>
<td>2</td>
<td>Unstable housing – fixed address, but family/landlord threatening eviction; other possible reasons to leave current housing.</td>
</tr>
<tr>
<td>3</td>
<td>Very unstable housing – no fixed address; rotates among municipal or charitable shelters or friends.</td>
</tr>
<tr>
<td>4</td>
<td>Extremely unstable housing – no fixed address, no regular shelter.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>

**Consult with Child Protection Services**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>No fixed address; rotates among municipal or charitable shelters or friends.</td>
</tr>
<tr>
<td>4</td>
<td>No fixed address; no regular shelter.</td>
</tr>
</tbody>
</table>

### Food Security and Nutrition

Sample Questions:

- *In the past month, were there any days when you ran out of food to prepare meals? If so, what do you do then? (Probe for what options and strategies has are being used.)*
- *Are you breastfeeding? How is it working? How long do you plan to breastfeed?*
- *If the child is taking solids: How often does your child drink milk? Eat vegetables/fruit? bread/rice/pasta/cereal? meat/eggs/beans?*

People have food security when they continually have enough food that they like to eat, that is safe, and, helps them to be healthy, as well as when they can get this food in ways that make them feel good about themselves and their family. For many families, food often comes after other more urgent expenses, such as rent, telephone, transportation, clothing and diapers. Lack of food security or inadequate nutrition can result in a baby’s failure to thrive, poor growth or iron deficiency anemia.
Running out of money for food is a source of anxiety and stress. Assessors should be aware that it is common for a parent who doesn’t have enough money for food to feed the children first, even if it means going hungry. If the mother is breast-feeding, this can affect her health and in some cases may affect the infant’s health.

New mothers who are not breastfeeding may not have anticipated the high cost of baby formula. The cost may cause them to dilute the formula, re-use formula from previously fed bottles or give the baby diluted juice, sugar water, rice water, pop, tea, baby cereal dissolved in water, cow’s milk or diluted evaporated milk.

Assessors should also be aware that many people are reluctant or unable to use food banks. Responses and scoring from supplemental questions I and II may support the scoring for this item.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Secure access to food – no problems with access to food for self or the child in the past or foreseeable future. Adequate nutrition. Baby is provided with regular appropriate feedings on demand. Child is provided with regular, balanced meals.</td>
</tr>
<tr>
<td>1</td>
<td>Fairly secure access to food – has occasionally run out of food in past, but has secure source of food for self and child now and for the foreseeable future. Fairly adequate nutrition. Baby is provided with regular feedings. Child is generally provided with regular meals but occasionally meals are skipped or daily diet is unbalanced. Good food storage.</td>
</tr>
<tr>
<td>2</td>
<td>Insecure access to food. Sometimes runs out of food at the end of the month; is unable to feed self or the child at least once in the last six months. Inadequate nutrition. Worries about running out of money for food; uses a number of strategies such as delaying rent or using food banks to prevent running out of food. Baby is occasionally missing feedings or is occasionally being given diluted formula or inappropriate foods (e.g., soft drinks, excessive juice). The child frequently misses meals and daily diet is unbalanced. Food safety (e.g., potential for choking, perishable foods not refrigerated) is an issue.</td>
</tr>
</tbody>
</table>

Consult with Child Protection Services
3 Very insecure access to food – relies on multiple sources, but is frequently unable to feed self or the child. Very inadequate nutrition. Baby is regularly missing feedings or is regularly being given diluted formula. The child regularly misses meals and meals are unbalanced. The child may supplement diet out of home (e.g., Hot breakfast program). Food safety (e.g., potential for choking, perishable foods not refrigerated) is an issue.

4 Extremely insecure access to food – relies totally on foodbanks, friends, panhandling. Extremely inadequate nutrition. Almost no food is available in the home and the child may have been seen scrounging for food. Food safety (e.g., potential for choking, perishable foods not refrigerated) is an issue.

9 Insufficient information to make a rating.

19. Alcohol or Drug Use

Sample questions:
To help identify an alcohol or substance abuse concern, assessors can start by asking about the mother’s drug or alcohol use during pregnancy (which some women find less threatening) or ask the standard CAGE assessment questions used in the addiction system to help identify a drinking problem:

- C Have you felt you ought to cut down on your drinking?
- A Have people annoyed you by criticizing your drinking?
- G Have you felt bad or guilty about your drinking?
- E Have you ever needed an eye-opener in the morning to get going?

- Do you or your partner use recreational drugs? If yes, what drugs do you use? How often do you use them?
- How do you deal with child care when alcohol or drugs are being used?

Substance use prenatally – by either the primary caregiver or partner – increases the child’s risk of medical and psychosocial problems (e.g., fetal alcohol spectrum disorder). Substance use by caregivers after the child’s birth is a risk factor for neglect, abuse and poor child development. Assessors should try to determine whether the caregivers’ substance use is affecting their ability to parent.
<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No misuse of alcohol or drugs. No history of substance abuse. May drink but in moderation. No use of illegal drugs or drug-related activity. No observable effects on everyday functioning.</td>
</tr>
<tr>
<td>1</td>
<td>Occasional substance use or history of substance abuse. Occasionally smokes marijuana or drinks alcohol to point of headaches, dizziness or fatigue. Mild effects on child care ability or everyday functioning.</td>
</tr>
<tr>
<td>2</td>
<td>Occasional substance use with negative effects on behaviour. Uses drugs other than marijuana or alcohol occasionally or binges on alcohol or marijuana. Negative effects on social behaviour (e.g., job absenteeism, constant arguments at home, dangerous driving) and on child care. Short-term stupor impairs performance.</td>
</tr>
<tr>
<td>3</td>
<td>Substance use with serious social/behavioural consequences. Regular and heavy abuse of one or more substances: alcohol or drugs. High-risk of not meeting social responsibilities (e.g., danger of losing job, financial problems, spouse threatens to leave, child care suffers).</td>
</tr>
<tr>
<td>4</td>
<td>Substance use with severe social/behavioural consequences. Compulsion to use substance, loss of control over use and continued use despite adverse consequences. Suspected sale and/or manufacture of drugs; dropout from social responsibilities (e.g., unemployment, spouse has left, child is abandoned); or severe behavioural problems (e.g., extreme aggression or passivity, no concern for future, confusion much of time).</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>

*Consult with Child Protection Services*
20. Family Violence

Sample questions:

- In general, how would you describe your relationship with your partner? How do you and your partner solve arguments?
- Do you ever feel frightened by what your partner says or does? Have you ever been hit/pushed/shoved/slapped/threatened by your partner? Has your partner ever humiliated you or psychologically abused you in other ways?

Violence in the home is associated with poor child health and development. A partner or adult who is violent with the primary caregiver may also be violent with the child (i.e., current or past woman abuse is associated with child abuse). A caregiver who has been a victim of violence may be more likely to hit, slap or threaten a child and may assume that this is a reasonable response/reaction. A caregiver who feels physically threatened may not have the resources to care for or protect a child. The increased demands and stress of parenting may also lead to verbal or physical abuse.

Assessors should be aware that violence during pregnancy is a particularly strong indicator of risk. Women who are abused during pregnancy are more likely to be abused during the postpartum period and to experience postpartum depression. Every effort should be made to identify any signs of past or current abuse or violence in the family. Assessors must also be aware that women who are abused are often reluctant to talk about it and may hide it. They are also unlikely to confide information about abuse if the abusing adult is present during the assessment.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Mutual respect.</td>
</tr>
<tr>
<td></td>
<td>There is mutual communication. Conflicts between family members are handled positively with mutual respect.</td>
</tr>
<tr>
<td>1</td>
<td>Verbal aggression.</td>
</tr>
<tr>
<td></td>
<td>Family members exhibit verbal aggression. Member may exhibit some anxiety or apprehension in the presence of other members.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Consult with Child Protection Services</strong></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Isolation and intimidation, threats of harm.</td>
</tr>
<tr>
<td>3</td>
<td>Incidents of physical violence in family; imbalance of power and control.</td>
</tr>
<tr>
<td>4</td>
<td>Repeated or serious physical violence or substantial risk of serious physical violence in family.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
21. Abuse/Neglect of Caregiver as a Child

Sample questions:
- *What was it like for you when you were growing up? How were you disciplined and how often? How would you say you got along with your parent(s) and sibling(s)?* (NCAST – PMMHD)
- *How do you feel about parenting compared to how you were parented?*

People who were abused as children or who witnessed abuse often find it difficult to parent and are at higher risk of abusing their partner and their own children. They may need more support than parents who do not have a history of abuse. When assessing for a history of abuse or neglect, assessors should be aware that violent childhood experiences include physical, emotional, and/or sexual abuse.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No perceived abuse/neglect as a child. Recounts being loved and well cared for with no incidents of abuse or neglect.</td>
</tr>
<tr>
<td>1</td>
<td>Perceived abuse/neglect as a child with no specific incidents. Does not recount being abused or neglected. Expresses dissatisfaction with the care or treatment s/he received when young.</td>
</tr>
<tr>
<td>2</td>
<td>Episodes of abuse/neglect as a child. Recounts being abused or neglected as a child, but not severely or recurrently; with no apparent impairment.</td>
</tr>
<tr>
<td>3</td>
<td>Recurrent but not severe abuse/neglect as a child. Recurrent abuse/neglect as a child; may have resulted in emotional or physical impairment.</td>
</tr>
<tr>
<td>4</td>
<td>Severe abuse/neglect as a child. Severe abuse/neglect as a child resulted in serious emotional disturbance and/or physical scars/disability.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
22. History of Abuse/Neglect Committed by Present Caregivers

Sample questions:
- Do you have any children who are not living with you? If so, tell me about them.
- Do you have any children in foster care? Why are your children in foster care?

The risk of child neglect or abuse increases when the primary caregiver, partner or any other adult who has access to the child has a history of committing any form of abuse or neglect. The risk is also higher when a parent has had another child placed in foster care. Caregivers who have abused one child are more likely to abuse another and may need support to develop appropriate parenting skills.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No history of abuse/neglect. There is no information available that previous abuse/neglect has occurred. Skip to 23.</td>
</tr>
</tbody>
</table>

**Consult with Child Protection Services**

<table>
<thead>
<tr>
<th>1</th>
<th>Abuse/neglect concerns. Children or other sources provide information that raises concerns about possible past abuse/neglect, but there is no real clarity about the nature of such abuse/neglect.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Previous abuse/neglect. There are disclosures of previous abuse/neglect of a specific nature.</td>
</tr>
<tr>
<td>3</td>
<td>Serious recent incident or a pattern of abuse/neglect. There has been recent serious abuse/neglect or there exists a non-escalating pattern of abuse/neglect.</td>
</tr>
<tr>
<td>4</td>
<td>Severe or escalating pattern of past abuse/neglect. Severe past abuse/neglect or an escalating pattern of seriousness.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
23. Co-operation with Services/Supports

Sample questions:

- Are you receiving supports or services now from an agency or a neighbourhood or faith group?
- If yes: Are these services or supports useful to you? What part of those services or supports are not useful to you? Why?

Caregivers who are already receiving services and supports and who are actively co-operating with or participating in those services are more likely to make effective use of other services, such as HBHC Program services.

In addition to asking the suggested questions, the assessor can listen carefully to the story of the primary caregiver’s life. Are services considered useful or is there indication that they are all a waste of time? All of this will help determine how receptive the family will be to services. Assessors should be aware that this item is extremely important in calculating the family’s overall risk. Families who are co-operating with services can significantly reduce their risk in other areas (e.g., appropriate use of services can compensate for any risks posed by a parent’s physical health problems). Responses and scores to questions I and III of the supplemental questions can be used to support scoring for this item.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Cooperates with supports/services. Accepts involvement of recommended supports/services. Actively participates in services, if needed.</td>
</tr>
<tr>
<td>1</td>
<td>Cooperates, with generally appropriate response to supports/services. Accepts involvement and utilizes supports/services, but full service benefits are not always realized due to various factors such as ambivalence, disorganization, etc. May require additional supports and active encouragement to fully utilize services.</td>
</tr>
<tr>
<td>2</td>
<td>Cooperates, but poor response to supports/services. Accepts involvement and utilizes supports/services, but utilization is poor. Accepts referrals but may delay action, may postpone or not keep appointments: may drop services too soon.</td>
</tr>
</tbody>
</table>
3 Cooperates minimally, but resists supports/services. May verbally accept supports and services involvement. May resist utilization of services. Requires constant prodding/assistance to use services or participates in service in a minimally acceptable manner.

4 Refuses to cooperate. Refuses involvement in supports/services. Actively resists and sabotages support/service efforts, e.g., by making it impossible to contact family.

9 Insufficient information to make a rating.

SUPPLEMENTAL QUESTIONS

I. Family Settlement Support

Sample questions:
- Who is helping you with settling into your new community?
- Do you find their support and services useful?
- What barriers are you encountering as you settle into your new community?

Culture
Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services. (126)

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Multiple sources of reliable and useful settlement supports, interpretation and culturally appropriate services. Strong network of integrated settlement supports, interpretation and culturally appropriate services available in the community relevant to family’s needs.</td>
</tr>
</tbody>
</table>
1  Some reliable and useful settlement supports, interpretation and culturally appropriate services.

Some settlement supports, interpretation and culturally appropriate supports are available in the community relevant to family’s needs.

2  Limited settlement supports, interpretation and culturally appropriate services.

Limited settlement supports, interpretation and culturally appropriate services are available in the community that are relevant to family’s needs.

3  Limited settlement supports, interpretation and culturally appropriate services but unreliable.

Few settlement supports, interpretation and culturally appropriate services are available in the community that only occasionally meet family’s needs.

4  No settlement supports, interpretation and culturally appropriate services.

No settlement supports, interpretation and culturally appropriate services are available in the community to meet family’s needs.

9  Insufficient information to make a rating.

II. Financial Stability

Sample questions:

- Do you ever experience difficulty in meeting your family’s financial needs?
- Do you have any concerns about your ongoing ability to meet your family’s financial needs?
- What resources are available to you should you need financial help?

Income and Social Status

Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.
Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations and their discretion to act are the key influences to health status. Higher income and status generally results in more control and discretion. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems. (126)

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Financially stable.</td>
</tr>
<tr>
<td>1</td>
<td>Fairly financially stable.</td>
</tr>
<tr>
<td>2</td>
<td>Financially unstable.</td>
</tr>
<tr>
<td>3</td>
<td>Financially very unstable.</td>
</tr>
<tr>
<td>4</td>
<td>Financially extremely unstable.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
III. Education/Training and Employment

Sample questions:

- Are you currently working or studying? If so, for how long have you been working at your job or studying?
- Do you work/study full-time or part-time?
- Do you consider your position stable? Do you have any concerns about attendance?
- What are your employment or education goals?

Education and Literacy

Health status improves with level of education. Education is closely tied to socioeconomic status and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security and job satisfaction. And it improves people’s ability to access and understand information to help keep them healthy. (http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#education)

Employment / Working Conditions

Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities. (126)

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Anchor Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Completed an education level that supports independence and secure employment. Caregiver has permanent (full time or part time) education/employment.</td>
</tr>
<tr>
<td>1</td>
<td>Some reliable educational support services and/or employment. Caregiver is making good progress and regularly attending and actively participating in education program/supports and/or is employed on a regular basis although not permanent (full time or part-time).</td>
</tr>
<tr>
<td></td>
<td>Some reliable educational support services and/or employment but limited.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3</td>
<td>Some reliable educational support services and/or employment but is unreliable.</td>
</tr>
<tr>
<td>4</td>
<td>No educational support services or unemployed.</td>
</tr>
<tr>
<td>9</td>
<td>Insufficient information to make a rating.</td>
</tr>
</tbody>
</table>
Appendix 3: Knowledge to Action Framework

Appendix 4: How Can I Use the Family Service Plan Datamart?

How Can I Use the Family Service Plan Datamart?


I Want to Run a Report in Report Packages

A. Pre-defined Report
1. Select the report package, e.g., Family Service Plan.
2. Select the report you want to run, e.g., Family Service Plan Status for All Families.
3. Enter the report parameters, typically a date range.
4. Click Finish to run the report.
5. To save the report using Adobe Acrobat Reader:
   1. On the Adobe toolbar, click the Save button.
   2. In the Save a Copy dialog box, browse for the folder where you want to save the file.
   3. In File name, type the name of your report.

B. Management Report
1. On the Report button, click the Display a Sample Report button.
2. Select Monitoring Report (for submission to MCSU).
4. Epidemiology Report (showing non-identifiable child and reproductive health indicators).

C. Monitoring Report
3. Specify a date range or select the date.
4. Select the branch offices for which you want to run the report.
5. Select which part of the monitoring report you want to run.
6. Run the report.
7. Click on the hypervised numbers to view the drill-down reports.

The Plan-Do-Study-Act (PDSA) Cycle

The PDSA Cycle provides a model for improvement that focuses on a trial-and-learning approach.

1. Plan
   - Objectives
   - Questions and predictions
   - Plan to carry out the cycle (who, what, when, where, why).

2. Do
   - Carry out the plan
   - Document problems and unexpected observations
   - Begin analysis of the data

3. Study
   - Complete analysis of the data
   - Compare data predictions
   - Summarize what was learned

4. Act
   - What changes are to be made?
   - Next cycle

For additional help, please contact the OCS IT Service Desk at www.ics.gc.ca or 1-888-857-4873 or 416-246-7171.

©Ministry of Children and Youth Services, 2011.
## Appendix 5: Expected HBHC Outcomes and Indicators

<table>
<thead>
<tr>
<th>Program</th>
<th>Outcomes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of HBHC Screens will be accurately completed.</td>
<td>Total number of HBHC Screens completed at three points in time: (a) prenatal, (b) postpartum, (c) early childhood and number of screens received as incomplete (no responses), partially completed (less than 36 responses) or only question #36 completed.</td>
<td></td>
</tr>
<tr>
<td>Families that screen positive using the HBHC Screen are confirmed with risk during the assessment</td>
<td>10-25% of total HBHC Screens received are confirmed with risk during assessment</td>
<td></td>
</tr>
</tbody>
</table>
| Increased service focus to support parent-child interactions, child development and parenting capacity | A) The Family Service Plan goals as reflected in the Family Assessment Instrument results.  
B) Increased number of families in prenatal and early childhood period identified with active Family Service Plan goals. | |
| The frequency, duration and length of home visiting services should reflect the needs of vulnerable families | A) Average frequency, duration and length of home visits as well as completion rate of scheduled home visits.  
B) Number of families that receive long term services equal to or less than 18 months, compared to number of families that discharge at equal to or less than 6 months. | |
| Increased referral and access of community services | Increased "referred to and accessed" response rate to community referrals. | |
| All public health units will participate in early years community planning bodies | Public health units involved in an increasing number of community planning boards and tables. | |
### Outcomes Indicators

<table>
<thead>
<tr>
<th>Population</th>
<th>Outcomes</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An increased percentage of families will be screened and accurately identified with risk.</td>
<td>10-25% of total HBHC Screens received are confirmed with risk during assessment.</td>
</tr>
<tr>
<td></td>
<td>An increased percentage of community referrals to HBHC will be received prenatally, postpartum and during the early childhood period.</td>
<td>Number of HBHC Screens completed in the prenatal and early childhood period from community resources.</td>
</tr>
<tr>
<td></td>
<td>Improved prenatal outcomes.</td>
<td>As a population health indicator, increased number of prenatal HBHC clients with children born at &gt;2500gm and &gt;37 weeks gestation.</td>
</tr>
<tr>
<td></td>
<td>Improved parent-child relationships.</td>
<td>Improvement in pre-service and post-service scores of NCAST Parent-Child Interaction Feeding and Teaching scales.</td>
</tr>
<tr>
<td></td>
<td>Improved parenting capacity.</td>
<td>Improvement in pre-service and post-service scores of NCAST Parent-Child Interaction Feeding and Teaching scales.</td>
</tr>
<tr>
<td></td>
<td>Improved child development outcomes.</td>
<td>Consistent NDDS completion demonstrating children receiving Home Visiting services are meeting milestones.</td>
</tr>
<tr>
<td></td>
<td>Increased use of community services to meet identified family needs.</td>
<td>Increased &quot;referred to and accessed&quot; response rate to community referrals.</td>
</tr>
<tr>
<td></td>
<td>Improved responsiveness to the equity needs of marginalized and emerging populations through utilization of ISCIS referral data to strengthen alliances at Early Years community planning boards.</td>
<td>Public health units involved in an increasing number of community planning boards and tables.</td>
</tr>
</tbody>
</table>


The following Acts were also consulted in the development of the *Healthy Babies Healthy Children Guidance Document*:
