

Guidelines for Ontario's Enhanced/Expanded Infant Development Programs

**Early Years and Healthy Child Development Branch
Ministry of Community and Social Services**

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Preface

In 1974, the Ministry of Community and Social Services established Infant Development Programs to serve children ages 0 to 3 who have a developmental disability or are at risk of delays in development. These family-centred programs work directly with parents¹/cargivers² and children, and provide assistance with motor development, communications skills and social interaction.

The 45 Infant Development Programs in place across the province are part of a continuum of prevention and early intervention services for children, and are linked with a broad range of early years and other social services.

In May 2001, as part of Ontario's Early Years Plan, John Baird, the Minister Responsible for Children, announced an increase in funding for Infant Development Programs and asked the programs to expand to serve children up to the age of 5 and to take steps to improve access to their services.

To provide direction for the expanded, enhanced Infant Development Programs, the Early Years and Healthy Child Development Branch and the Ontario Association for Infant Development created a small, ad-hoc, committee to develop program guidelines.

These guidelines, which are based on the 1987 Infant Development Program guidelines, reflect current recommended "best" practices in infant development as well as the changes required to operate an enhanced/expanded program. They are designed to be flexible enough to accommodate regional differences, new knowledge and the evolution of Infant Development Programs.

Ontario's Early Years Plan.

Ontario Early Years Plan is designed to give Ontario children the best possible start in life, and ensure they are "physically and emotionally healthy, safe and secure, ready to learn, and socially engaged and responsible."

Its goal is to improve lifelong health, well-being, and learning for all children by expanding, enhancing and strengthening the province's universal and targeted early years initiatives, and building on existing partnerships, programs and services.

The Plan, which is based on extensive research into healthy child development and the early years, is part of a larger national initiative. In September 2000, the First Ministers made a commitment to invest in the early years, and the federal government agreed to provide funding to support programs and services that would:

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

¹ The term "parents" describes the adults who retain legal guardianship for the infant or child.

² The term "caregivers" describes the adults who may be involved with the infant or child, but do not have guardianship rights.

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I. Purpose and Guiding Principles

Purpose

Infant Development Programs are part of a continuum of early years prevention and early intervention programs in Ontario. Their role is to:

- enhance the growth and development of infants and young children with developmental disabilities or at risk for developmental delay
- promote the quality of life of the child and family.

Staff in Infant Development Programs recognize that the family is the major decision-maker in a child's life. To ensure satisfactory and meaningful outcomes, the family must be actively involved in all services and interventions. When serving children and their families, Infant Development Programs will:

- provide an integrated approach to infant development and family-centred intervention that is parent/caregiver-led and responsive to parent/caregiver strengths, competencies and priorities
- take an interdisciplinary and collaborative approach, working with other service providers to provide the greatest opportunity for optimal development of the child and family unit
- provide support within the child's natural environment where the infant development specialist serves many functions.

Infant Development Services include but are not limited to:

- informal and formal child and family needs assessments
- direct early intervention in all developmental domains (gross and fine motor, social and emotional, adaptive functioning, language and cognitive)
- interventions to promote secure infant attachment
- assistance in accessing specialised funding and information about additional community resources, supports, and other professional or alternative services
- assistance in obtaining information about the child's condition or diagnosis
- supportive counselling for families who receive a diagnosis of developmental delay or medical condition
- advocacy for and with families in their relationship with health, social and community services
- sharing information about typical and atypical child development
- play-based therapeutic intervention plans
- community-wide planning with other service providers
- proactive public education to help decrease the effects of preventable delays
- support to enhance parenting skills and parental competence
- intervention to promote positive parent-infant interactions and support the relationship

Principles Guiding Infant Development Programs

The guidelines for Ontario's enhanced/expanded Infant Development Programs are based on the following principles:

1. **Early identification and intervention:** Infants and young children at risk for developmental delays will be identified as early as possible and receive appropriate interventions.
2. **Accessibility:** Families will have access to infant development services, regardless of geographic location.
3. **Diversity:** Infant development services will respect each family's individual needs and circumstances, and be sensitive to social, linguistic and cultural diversity. Programs will be responsive to the unique needs of the Aboriginal community and of francophone families in areas designated to provide French language services.
4. **Family-centredness:** The family is the central decision maker for the child. Infant development services will strengthen parent's abilities to nurture and enhance child well being and development
5. **Teamwork/Co-ordination:** Parents and other providers/disciplines/services will play an active role in planning and providing a range of infant development services. Service providers and families will work together, using a holistic, family-centred approach, to co-ordinate services and minimise fragmentation and overlap of services.
6. **Community involvement:** Infant Development Programs will strive to support and develop individual, family, and community capacities.
7. **Confidentiality/Consent:** Infant Development Programs will keep all client information confidential, and comply with all legal and regulatory requirements. Participation in infant development services is voluntary, and Infant Development Programs will ensure they have parents' consent before providing services to a child.
8. **Accountability:** Infant Development Programs are accountable to families and communities, their sponsoring agencies and to the Ministry of Community and Social Services through the regional offices.

NOTE: Individuals working with children and families have a legal responsibility to report suspected child abuse or neglect under the Child and Family Services Act (CFSA). In cases of suspected abuse or neglect, the duty to report over-rides other responsibilities to the family.

Confidentiality and consent provisions are articulated in legislation, regulation, policy and legal agreements specific to particular programs and agencies. Compliance with the appropriate legislation and regulation is a requirement under the law.

II. Target Population

Infant Development Programs serve children from 0 to 5 years of age who have a developmental disability or are at risk of developmental delay.

Risks

The developmental risks that children face have been divided into three categories (adapted from Tjossem³). An infant's or child's development may be in jeopardy from one or more of these categories of risk:

1. **Established Risk** – These are risks related to diagnosed medical disorders, such as:
 - genetic and chromosomal syndromes (e.g., Down syndrome)
 - neurological disorders (e.g., seizures, cerebral palsy)
 - congenital malformations of the nervous system (e.g., microcephaly, hydrocephalus)
 - sequelae of infections of the nervous system (e.g., meningitis, encephalitis, HIV, CMV, herpes)
 - metabolic disorders (e.g., untreated hypothyroidism, PKU).

2. **Biological Risk** – These are risks related to a history of prenatal, perinatal, neonatal and/or early developmental events which may affect the central nervous system and increase the probability of developmental problems, such as:
 - pre- or perinatal complications (e.g., small for gestational age, anoxia, stroke in utero or during/after birth)
 - prematurity and associated complications (e.g., respiratory distress syndrome, cerebral haemorrhage, jaundice)
 - sensory impairments such as blindness and deafness
 - child of parent(s) with a developmental disability or sibling having developmental disability of unknown origin
 - early global developmental delays
 - parents with chronic, established mental illness
 - prenatal substance abuse.

3. **Psychosocial Risk** – These are risks related to the child's environment. Infants and young children in this category appear to be biologically sound but are at risk of delayed development because of individual susceptibilities or vulnerabilities magnified by environments which cannot respond adequately to their physical, developmental, and/or social-emotional needs. Psychological risk may be associated with:
 - child characteristics, such as a "difficult" temperament or other behavioural characteristics (not including an infant mental health disorder or Autism)
 - caregiver characteristics, such as inexperience or mental health problems
 - attachment difficulties

³ Tjossem, T.D. (1976). Early intervention: Issues and approaches. In T.D. Tjossem (Ed.), Intervention strategies for high-risk infants and young children. Baltimore, MD: University Park Press.

- non-organic failure to thrive
- child neglect or abuse.

Service providers will use these categories of risk to assess the child's and family's service needs, and identify the most appropriate services. The categories also help a community identify its service priorities.

Priorities

Infant Development Programs will give priority to infants and children with established or biological risk, as they are the only early years program specifically targeted to serve these children and their families.

Depending on the community's needs, Infant Development Programs may also serve children with psychosocial risk. However, in many communities, Infant Development Programs are only one of a range of services available to children at psychosocial risk. Children and families will also have access to other community resources, such as family support services, child and family intervention services, children's mental health services, or child welfare services. Infant Development Programs and other community services such as, Children's Treatment Centres, Healthy Babies Healthy Children, Preschool Speech and Language services, Resource Teacher programs and Ontario Early Years Centres, should continue to work co-operatively to plan services for children, and determine how best to serve families with young children at psychosocial risk of developmental delay.

III. Eligibility for Service

Referral to the Infant Development Program

Infant Development Programs will accept self-referrals from parents and from other sources with parental consent.

To encourage the earliest possible identification and referral of infants and young children, the Infant Development Program should:

- identify the most likely sources of referrals within and outside the community
- approach all sources individually in a systematic way to ensure they understand the services the Infant Development Program provides and are referring children and families at risk in a timely way
- sponsor ongoing community awareness and liaison activities that encourage consistent and informed referrals.

Referral Information Required

Infant Development Programs are expected to function within guidelines provided as part of initiatives such as Making Services Work for People. At a minimum, the Infant Development Programs will collect the following referral information:

- name of child and name of parent(s) or guardians(s)
- address and relevant telephone numbers
- child's date of birth
- child's gender
- date of referral
- referral source and contact person
- other agencies involved, contact person and purpose of involvement
- name of family physician and/or paediatrician, if involved
- reason for referral (including relevant information that may be available from the referral source regarding diagnosis, present developmental level, behaviour of concern, psychosocial concerns)
- the child's medical information including:
 - a) medical history
 - b) current medical status
 - c) physical and sensory functioning
 - d) any restrictions or precautions for program participation
- family information, including the family composition, how the family understands the child's developmental risk or problem, and what the family expects from the program
- environmental factors that may affect the child's risk.

Criteria for Acceptance into the Program

Program Criteria

Infant Development Programs will accept children and families referred to their program when:

- parents have given informed consent for the referral to the program
- the child resides within the geographic area served by the program
- the child is younger than 5 years of age at the time of referral and before child's six birthday
- the reason for referral falls within the local program's mandate.

Infant and Child Variables

Programs will also take into account the child's degree of risk, the priority of the risk(s) identified, and the level and quality of development the child exhibits. An infant or young child with a significant degree of delay in one or more areas of development will be an obvious candidate for service and intervention. In some cases, the quality of a child's functioning may warrant attention, regardless of his or her level of functioning.

To determine whether a child falls into the program's mandate, the program may require that a suspected hearing impairment or physical disability be investigated. Any Infant Development Programs that do not have the staff to do comprehensive clinical assessments will refer families to the appropriate clinicians for these investigations as required.

Family Variables/Informed Consent

When deciding whether to accept an infant or child, Infant Development Program staff will also take into account the family's strengths and needs, the dynamics of the relationship between the parents and child, and the physical and social resources in the home.

As the primary decision makers for their children, parents are essential participants in the service decision. Infant Development Program staff will ensure that parents fully understand the nature of the program and the role of program staff. The family and program staff will jointly identify needs, issues and resources. Program staff will then identify the needs that fall within the mandate of the Infant Development Program as well as needs that can be met more appropriately by other services, and determine which needs should be given priority. They will also inform parents about any alternative services available to them.

Infant Development Programs will obtain the parents' informed consent before accepting the child into the program, or sharing any information (verbal or written) about the child or family.

Environmental Variables

Environmental factors combined with established or biological risk can significantly increase a child's vulnerability. Environmental variables which may influence priority in service provision include, for example:

- isolation
- age or experience of parent/caregiver
- poverty, homelessness
- violence in the home
- substance abuse
- health and safety issues.

If the family has instrumental or other needs (e.g., medical issues) that should be met before the child can participate in the program, family members and service providers should consider postponing the service until those needs are met.

When parenting practices are the major reason for referral, Infant Development Programs will give priority to parents who demonstrate a commitment to increase their level of knowledge and ability to foster their child's development. To ensure the family receives appropriate services, Program staff will also co-ordinate with parenting services, such as Healthy Babies, Healthy Children.

When a Child Does Not Meet the Criteria

If a child does not meet the criteria or requirements for entry into the Infant Development Program, the program will refer the family to another, more appropriate service or support.

Referrals to Other Services

Some children referred to Infant Development Programs may have needs which will either be met more appropriately by another service or should be managed jointly with other services. In these cases, the Infant Development Program will make a referral to other agencies only after discussion with parents or caregivers.

At the community levels, agencies will develop protocols to:

- ensure that children and families receive appropriate services
- facilitate referrals among a wide range of early intervention supports and services, including but not limited to Healthy Babies, Healthy Children and Preschool Speech and Language services.

IV. Service Needs Assessment

Screening and assessment are important facets of infant and child development services. Information obtained can be used for a variety of purposes. Screening is used to determine eligibility and the need for further evaluation. Screening tools may be used as part of an assessment, but are not sufficient for diagnosis and may not be sufficient for measuring change. Screening tools can be differentiated from surveillance tools (e.g. *Nipissing Developmental Screen, Parent Evaluation of Developmental Status*) as the latter are used primarily to identify children who require further screening or assessment. Assessment is used for diagnosis, identifying goals and interventions, and measuring change. It is critical that the screening/assessment process be individualized according to the unique needs of the child and family. This includes consideration of cultural, ethnic and linguistic backgrounds and the potential bias of screening/assessment tools.

Assessment is an ongoing collaborative process to gather information from multiple sources in order to make decisions. Within the context of infant and child development services, this includes direct observation of the child's play and the interaction between child and parent/caregiver, as well as assessment of the child's skills in different developmental domains.

Infant Development Program staff will use the comprehensive tools available to support the assessment process in early intervention programs. The administration of screening and assessment tools requires program staff to have the necessary theoretical grounding and qualifications. In the absence of that background and training, staff will record their objective observations.

The service needs assessment involves systematically collecting information that will:

- contribute to the service decision to accept the child into the program.
- establish a baseline description of the family and child that will be used to evaluate the changes made and program effectiveness.
- identify intervention goals in order to develop an individualized family service plan for the child and family.
- give parents/caregivers the opportunity to contribute to the plan and gain information about their child.

Professionals and families will collaborate in planning and implementing the assessment process. Each assessment will be individualized and appropriate for the child and family. Professional judgement and discretion are required to ensure that programs make individual decisions and obtain only the required information.

Staff of Infant Development Programs will make every effort to involve parents/caregivers in the assessment process from the outset. This will give staff the opportunity to inform parents/caregivers about the purpose of the assessment, engage them in the process, and include them in decisions made on the basis of assessment results. Parents/caregivers who appreciate the uses and limitations of assessment procedures and who understand the identified strengths and needs of their child are better equipped to make informed decisions. Communicating with parents/caregivers is an integral part of the assessment process.

To complete a service needs assessment, program staff will collect:

- family and environmental information.
- developmental information including parent-child interaction and social-emotional development.

1. Family and Environmental Information

Early intervention programs focus on the needs of the child and the parent-child relationship. Information about the family and family environment can help the Infant Development Program understand the influences on parent-child interactions and appreciate the impact the intervention may have on the whole family in order to develop a more individualized approach and a more effective intervention.

Infant Development Programs will begin collecting family information with the first direct contact with the parents or caregivers. The initial contact, whether by telephone or in person, provides an opportunity to explore parents'/caregivers' awareness of or attitude toward the referral, their immediate expectations or concerns, and their receptivity to participating in the program.

As a general guide, the following family information will be necessary to make the initial service decision, develop an individualized family service plan, or evaluate program interventions:

- identifying data and family characteristics.
- Parent's/caregiver's description of the child's birth and medical history, current health status and daily routine.
- the impact of having a child with high risk factors:
 - ⌚ the history of the problem and the family's experiences related to it.
 - ⌚ parent's/caregiver's knowledge and understanding of the problem.
 - ⌚ social, emotional, and instrumental supports available from other immediate and extended family members.
 - ⌚ attitude toward participating in the program.
 - ⌚ environmental and situational stressors.
 - ⌚ resources and social support.

Infant Development Programs will collect information about the feelings, attitudes and values that affect the parent's/caregiver's relationship with the child.

Family Capacity/Receptivity to Participate

A range of factors may affect a parent's/caregiver's capacity or receptivity to participate in intervention. For example:

- The birth of a child with an established or biological risk can affect the family's physical and emotional availability. Medical or health care routines may take an inordinate amount of time and limit the time available for program activities.
- Adapting to the birth of a child at risk is a gradual and ongoing process. Parents/caregivers may experience an acute sense of loss and grief for the "wished for" child, shock, disbelief, anger, guilt or depression. Each parent/caregiver moves through a process of adjusting intellectually and emotionally at a different rate. Their expectations for their child and their willingness to participate in an intervention program reflect their current stage of adaptation. The Infant Development Program should attempt to balance the need for intervention with the family's needs (e.g., to grieve).

- Families may experience varying levels of receptiveness depending on the referral circumstances, the parent's/caregiver's' view of the child, and the reason for referral. Their receptivity may be influenced by the degree to which they feel in control of the decision to participate and their perceptions of their own and their child's need for the services offered. This may be particularly true for families who are experiencing psychosocial risk.
- The parent's/caregiver's level of commitment or degree of ambivalence will affect their willingness to engage in a working alliance with program staff.
- Environmental and situational stresses as well as resources and social supports will affect parent's/caregiver's physical and emotional adaptability. The birth of an infant with established or biological risk may create stress on existing resources and social support systems. Parents/caregivers may require more formal assistance to obtain resources and support.

By reviewing family relationships, program staff can identify patterns of caretaking responsibility among partners, siblings and extended family members. They can also assess the financial and physical demands on the family, and the family's need for information and contact with others in similar circumstances. This assessment will assist with identifying family needs and facilitate the ongoing process of adapting to having a child at risk.

Some parents/caregivers may be under significant environmental and situational stress, or have few resources and supports in coping with the stress. In these cases, in addition to providing child development services, program staff will help the family develop support systems. In some cases, the development of family support systems may be a prerequisite to families participating in a meaningful way in a program.

Where family or individual functioning appears to indicate the need for further assessment or support, front-line personnel will refer the family to a professional with appropriate training in clinical social work, clinical psychology, psychiatry, or family counselling.

Throughout the information gathering process, it is important for program staff to clarify the family's intentions with respect to participating in program services and/or continuing the assessment process.

2. Parent-Child Interaction / Social-Emotional Development Information

The early parent-child relationship is vital to the child's later development. Both child and parent/caregiver influence the pattern of interactions and the nature of the attachment relationship that develops. Positive and mutually satisfying interactions facilitate social-emotional development, enable the child to take full advantage of learning opportunities, and foster the parent's/caregiver's sense of competence.

When assessing the parent-child interaction, program staff will:

- consider the characteristics of the child.
- assess the knowledge and attitudes of the parents or caregivers.
- observe interactions between parent/caregiver and child.

Program staff will include a summary of parent-child interaction in the client record.

Child Characteristics

Children with physical disabilities, visual or auditory impairments, those born prematurely and those with other disabling conditions may have characteristics that make it more difficult for them to interact or attach with parents and caregivers. The child's special needs may affect his/her responsiveness which, in turn, can influence the parent's/caregiver's actions, attitudes and self-esteem.

Infants and children also vary in temperament, in activity level, and in their ability to signal needs and respond in a way that is rewarding to parents/caregivers. Infants and young children with no established or biological risk may have individual or temperamental characteristics or behaviours that disrupt their interactions with parents. For example, they may have irregular sleep/wake cycles and eating patterns, or they may be slow to adapt, become easily upset, and react with intensity to new situations. Others may display low intensity of emotional expression and cope with communicative mismatches in their interactions by withdrawing or avoiding further contact. Program staff will observe and record information on the child's social, emotional, cognitive, language, and motor development. Program staff will collect the following information on the child:

- history of development.
- physical characteristics.
- temperament (e.g., irritability, consolability, adaptability, threshold level, mood, intensity, activity, rhythmicity, distractibility, persistence, approach/withdrawal).
- development of emotional expression.
- social responsiveness (e.g., smiling, eye contact, responsiveness to holding, imitation and reciprocal play ability, repetitive behaviour patterns, ability to discriminate mother from strangers, demands for caregiving).
- effectiveness of prelinguistic communication (e.g., differential crying, patterns, variety and frequency of vocalization, gestures and other non-verbal communication).

This information will help staff assess the child's progress in the program. For example, children who do not show progress on traditional measures will often show marked changes in responsivity.

Parent Knowledge and Attitudes

Parents and caregivers provide repeated opportunities for the child to interact. They can initiate and maintain interaction by joining the child's ongoing activities and adapting their cues and responses to the child's capabilities. In these interactions, parents/caregivers differ in their responsiveness and sensitivity to their child's emotional signals. Most parents/caregivers learn to compensate or adjust their interactions to optimize their child's development and responsiveness. However, some parents/caregivers may find an irritable or unresponsive child demanding and unrewarding. They may react by reducing their contact and engaging in less positive interactions, which can limit the child's experiences and increase the risk of developmental delays.

In some cases, the stress of inadequate physical, social and personal resources may interfere with parent's/caregiver's capacity to nurture their child and reduce their sense of parenting satisfaction and fulfilment. Some parents/caregivers may also have attitudes toward child rearing that distort their perceptions and responses to their children.

Program staff will gather information to assess the parent's/caregiver's knowledge, attitudes and ability to interact with their child. They may look specifically at factors such as:

- the parent's/caregiver's knowledge of normal child development and individual differences.
- the parent's/caregiver's understanding of the handicapping condition.
- the accuracy of the parent's/caregiver's views of the child's abilities.
- the parent's/caregiver's instrumental parenting skills (e.g., parenting style, ability to provide a safe environment, behaviour management techniques, ability to provide play materials and experiences appropriate to the child's age and ability).

Parent-Child Interactions

By observing parent-child interactions, program staff may be able to identify interventions that could make those interactions more rewarding. Program staff will observe the behaviours and characteristics of both the parent and the child, and the impact they have on each other.

When observing parents and children, program staff will assess the quality of a range of interactions, such as:

- the parent's/caregiver's response to child cues (e.g., sensitivity and responsiveness to signal).
- the parent's/caregiver's attention or accessibility to the child.
- the parent's/caregiver's responsiveness to distress and crying, responsiveness to vocalization, co-operation-interference, and flexibility.
- the amount of physical contact between parent/caregiver and child, and the nature of the contact (e.g., affectionate, interfering, intrusive, routine, avoidant).
- visual contact and face-to-face interaction between parent and child (e.g., eye contact, pacing of interactions, tendency to maintain contact at a distance).
- expression of positive affect (e.g., amount of emotional expression, nature of emotional expression, acceptance-rejection).

Program staff working with families with diverse cultural backgrounds will be aware of parenting norms in those cultures. To ensure their services are culturally sensitive, Infant Development Programs may also consider using volunteer or student visitors and/or interpreters with the same cultural background as a client. In multicultural areas staffing should reflect the population served.

3. Developmental Information

The Infant Development Program will gather information about the child's individual developmental status, including measures of the child's cognitive, motor, adaptive, sensory, social-emotional, and language functioning.

Infant Development Program staff will conduct a child-centred assessment of the child's developmental skills, including for example:

- motor (gross and fine) skills.
- language (expressive and receptive) skills.
- social-emotional skills (including play, child-to-child interaction and child-to-parent interaction).
- adaptive skills (self-care).

- cognitive skills (including pre-academic skills and problem-solving).
- sensory skills (visual, tactile, auditory and vestibular).

Assessment will be ongoing and act as feedback to parents and Infant Development Program staff.

4. Developmental Screening and Assessment Tools

There is considerable research regarding the effectiveness of particular assessment tools that can be helpful to the professional who is considering what tools to use when conducting an assessment. When deciding upon specific screening or assessment tools it is important to consider current reliability and validity information for each test. Such information is helpful in determining whether the tool is the most appropriate given the age of the child, the weaknesses exhibited and the purpose for the evaluation.

No single screening or assessment tool can provide all the developmental information needed for the service needs assessment. Certain tools may be more appropriate in some cases than others. Program staff will be familiar with a variety of screening and assessment tools, and be able to choose those that will:

- serve the purposes of assessment.
- reflect the individual assessment needs of the child and family.
- accommodate their expertise and professional training.

Principles For Selection And Use Of Screening And Assessment Tools

Infant Development Programs use a variety of assessment techniques and tools, including observations, interviews, motor, and neuromotor assessments, as well as standardized and criterion-referenced tests. When selecting assessment tools, Infant Development Programs will ensure that:

- staff have the appropriate qualifications and training to administer the tools and interpret the developmental information (i.e., program staff require practical knowledge and skills to perform assessments, as well as specific training to interpret the information).
- their assessment policies and practices adhere to accepted standards for the use of these techniques and tools.
- the tools contain sufficient incremental steps in development, in the age range of the child, to allow program staff to measure the child's progress.
- a measure of child functioning using a screen or more in depth norm referenced instrument is obtained for all children upon program entry (within 90 days of the first visit), and at discharge, or transition to other programs.*
- parents/caregivers are encouraged to have the child's hearing and vision assessed prior to assessment by the Infant Development Program.
- at least one person per program can administer a "B" level test.
- "A", "B", and "C" level tools are used as appropriate.**

A Menu of Recommended Screening and Assessment Tools was developed through expert consultation (see Appendix 1). The goal of this menu is to recommend valid and reliable tools to programs while recognizing that children experience a wide range of developmental disabilities and therefore require a range of tools.

To further support program capacity, specific tools have been highlighted as critical to effective program delivery, and make up the *Basic Tool Kit* (see Appendix 2). Infant Development Programs will ensure they have the tools listed on the *Basic Tool Kit*.

The Ministry of Children and Youth Services will coordinate a Standing Task Group to review and revise the *Menu of Recommended Screening and Assessment Tools* and *Basic Tool Kit* biannually.

*Exceptions may be made based on individual child, family or system service variables and must be documented.

E.g. Family refusal, follow-up agency completes assessment.

** Requirements to administer instruments:

A-level: Do not require an individual to have advanced training in assessment and interpretation.

B-level: Require more expertise on the part of the examiner than A-level tests. The administration procedures and interpretation of test results are generally more complex than A-level products.

Practitioners who do not have a master's degree but who have completed specialized training or have developed expertise in a specific area may administer B-level tools (e.g. infant development).

C-level: Require verification of a doctorate in psychology, education, or a related field, or licensure. B-level practitioners can administer under the supervision of a psychologist.

Companies that supply B and C-level tools will require verification of credentials when ordering.

When an Infant Development Program requests an external consultation or assessment, it will provide the external consultant or assessor with:

- recent history and assessment information about the infant/child or family.
- the specific reasons for concern, including behaviour in the area or domain of functioning.
- a list of questions to be answered by the assessment and how assessment results will be used.

Documenting Assessment Information

Infant Development Programs will keep records of a child's developmental assessment, including:

- identifying data.
- reason for referral.
- relevant medical information.
- list of tools and techniques used, date of administration, and name of person involved in administration.
- observations of behaviour during assessment which could affect performance.
- summary of performance from all assessment techniques used for each of the relevant developmental domains or areas of competence or disability, including range of performance and the identification of strengths and needs in each area.

Records will clearly refer to ages reported as chronological or corrected age.

Program staff will prepare assessment reports on each child/family. The assessment report:

- documents the child's/family's involvement with the program.
- establishes the child's baseline status before intervention.
- provides a summary of what the Infant Development Program knows about the child, the family, and their interactions.
- identifies any information still required.
- describes the child's and family's strengths and weaknesses.

- identifies the child's immediate needs in each area assessed.
- documents assessment results clearly.
- includes recommendations for intervention.

Infant Development Program staff, with the family, will use the assessment report to prioritize needs and prepare an Individualized Family Service Plan. There is no set format for the assessment report; programs can adapt the format to their needs.

All contacts with the family will be recorded, either on the referral form or on a separate document. Programs will include a brief family information summary in the client record. When recording family information, program staff will record direct observation or parental report. Assessment information will be recorded/summarized in the client record. All information will be kept confidential, and program staff will comply with the confidentiality and informed consent provisions articulated in legislation, regulation, policy and legal agreements. When information is shared, it will be done in ways that are respectful of families.

* See Writing SOAP Notes¹

Sharing Assessment Information

The assessment information Infant Development Programs gather may be useful and relevant for parents, other agencies and professionals involved with the child. When sharing assessment information, program staff will determine the amount of information and detail required (i.e., each group has different information needs) as well as the most effective way to communicate the information. Reports will be reviewed with parents and may be provided to other agencies and professionals after adhering to current legislation regarding sharing of information and only with the signed informed consent of parents or guardians.

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⁴ Ginge Kettenbach, (1995). Writing SOAP Notes. 2nd Ed. F.A. Dans Co. Philadelphia.

V. Individualized Family Service Plans

Staff of Infant Development Programs will develop an individualized family service plan for each family accepted into service.

Developing an individualized family service plan – or a plan tailored specifically to the needs of the family -- is a process of identifying priorities and setting goals for the child/family based on the strengths and needs identified during the assessment process, and identifying the strategies and methods to achieve those goals.

Individualized family service planning involves the following steps:

- assigning a service co-ordinator
- involving parents
- developing the plan
- reviewing/revising the plan.

1. Assigning a Service Co-ordinator

Service co-ordination is a family-centred process of planning, locating, co-ordinating and monitoring the services and supports to meet the child's and family's needs.

Infant Development Programs will have a family-centred policy of assigning a child and family to a specific program staff person (i.e., service co-ordinator) at an early stage of service delivery, who will be responsible for:

- initiating and co-ordinating the individual family service planning process for that child and family (unless the Program and the parents have agreed that multiple program staff will be involved in developing the plan)
- co-ordinating the timing and delivery of program services
- taking into account the role of other service providers currently providing services
- planning to introduce any new services that may be required by the infants and young children and family
- communicating with other agencies/service providers involved with the child/family.

(For a description of the service co-ordinator's role, see box on next page.)

About Service Co-ordination

Many terms -- such as case co-ordination, service facilitation, resource co-ordination and case management -- are used interchangeably to describe the service co-ordination function. Since 1998, the term preferred by the Ministry of Community and Social Services is service co-ordination. This term recognizes that professionals are now working with parents and families as equal partners in assessment, decision-making and intervention.

Service co-ordination is particularly important when several agencies are involved in serving a family and their roles appear to overlap. It is not uncommon for families with children at risk to have contact with a variety of specialists and agencies providing a range of treatment, counselling, financial, housing and substitute care services. Even within a single program or agency, a family may have contact with a number of different program personnel. Effective service co-ordination, which establishes one person as the primary service provider for the family, can help ensure the service system does not lose sight of the child as an individual or of the cumulative demands that the services make on parents.

The Infant Development Program will include other agencies providing service to the child and family in the family service planning process, but only with the informed consent of parents or caregivers. Part of the planning process will involve clarifying the roles and responsibilities of each agency working with the child/family and designating a service co-ordinator. When reviewing the child's/family's service needs, the agencies or service providers involved with the family will share information regarding their role.

2. Involving Parents

Parents will be active participants and decision makers in the family service planning process, and will have the opportunity to contribute their depth of knowledge about their child.

Parents can become involved in the family service planning process in two ways:

- as active members of the planning team
- as the central figure in intervention plans and goals.

Parents will also contribute to identifying/setting goals for themselves.

Skills/Role of the Service Co-ordinator

A service co-ordinator:

- has the primary responsibility for identifying service priorities
- has an integrated view of the child within the family context
- facilitates decision-making about the services required
- is accountable for ensuring that all reasonable efforts are made to provide appropriate, comprehensive services (i.e., services that are consistent with the strengths and goals of the child and family and in the best interests of the child), and for documenting and reviewing those efforts
- advocates on behalf of clients (children and families)
- knows the local service system and how to obtain and co-ordinate the required services in a way that respects the family
- is aware of his/her responsibilities under Section 72 of the CFSA (i.e., "Duty to Report" provision) and can communicate those responsibilities clearly to the family and other agencies
- identifies and co-ordinates services that other individuals and or agencies may provide.
- monitors the goals and well-being of the child and family – and helps the family achieve and maintain a quality of life consistent with its values, priorities, strengths and preferences.

Infant Development Programs will ensure that parents are involved in a way that acknowledges and supports them in their role as primary and able decision-maker for their infant or child.

Program staff will communicate this attitude toward parents by:

- clarifying and interpreting information from in-program assessments as well as those from other professionals
- providing a frame of reference that will help parents understand age-appropriate behaviour and stages in relevant areas of development
- consulting parents about their own and their child's needs, their priorities, and plans for intervention
- providing the information and opportunities for parents to play an active role in service decisions (e.g., involvement of other agencies), and in case management activities (e.g., case conferences)
- engaging them in devising short-term objectives and implementation plans

- providing opportunities for all family members to participate by being flexible in how services are delivered.

When planning goals with parents, program staff should:

- encourage parents to articulate their expectations and desires for their child, the importance they attach to their child's behaviour and development, and their expectations of their own involvement in the program
- help parents identify and articulate their own specific parenting needs
- recognize the strengths and needs of parents when considering the extent to which the parent will be involved in the intervention process.

Program staff are advised to avoid covert goals (i.e., goals of which the parents are unaware).

3. Developing the Plan

For each family, the Infant Development Program will develop a family service plan designed to meet the family's individual needs. The plan will establish (based on the family strengths and needs identified during the assessment) the services that will lead to the infant's/child's optimal developmental functioning.

A written family service plan will specify:

- the current date
- the name and age of the infant(s and/or) young child(ren)
- the names of the caregivers
- the strengths and needs that apply to each domain under consideration, based on the assessments available, including the family, parent-infants and young children interaction, environmental and developmental assessments
- the overall goals and their priority
- a general statement of how each goal is to be met
- the individual responsible for each goal and the individuals participating in the planning process
- the dates for the accomplishment of each goal and for the review of the family service plan
- the designated service co-ordinator
- comments or revisions made at review time.

The family service plan will be developed by a team that consists of – at a minimum -- the child's parents and the program staff. The team will identify all the child/family goals, and then establish priorities based on the relative impact different goals will have on the child's quality of life, the family priorities, and the available time and resources. The team will then identify the strategies (e.g., supports, services and programs) to accomplish the priority or immediate goals, and assign responsibilities and timelines for achieving those goals. Immediate goals should be achieved before the next time the plan is reviewed. Goals not given priority are set aside to be reviewed at a later date. Because of the rapid changes that can occur in an infant's development, the plan and its goals should be reviewed every six months at a minimum.

Based on the family's goals, the service co-ordinator will prepare a detailed implementation plan for each goal and document progress in attaining each goal. For the program staff involved, the implementation plan is usually the plan for sessions and/or home visits with the child and family. In some cases, session or

home visit plans might include actions to be taken outside of sessions (e.g., making a referral for further assessment, or contacting a physician).

Implementation plans will always specify:

- well-defined objectives that would lead to accomplishing an overall goal
- the methods to achieve each objective
- the method for monitoring progress and evaluating each objective
- the time frame for achieving each objective.

The goal planning and implementation process lends itself to a variety of techniques and styles of intervention, monitoring and evaluation. Programs will adapt their procedures when necessary for each case.

Program staff will discuss the purpose and objectives of each session or visit with the parents/caregivers involved, and provide appropriate opportunities for parents/caregivers to participate in the planning and intervention, including teaching, skill building and other activities. Parents should receive a written copy of the family service plan and the methods for achieving program goals. Parents/caregivers should also be involved in recording progress or other observations.

From the overall goals of the individualized family service plan, program staff develop the objectives of the implementation plan. Objectives are precise statements of expected outcomes. They are generally shorter in term and more restricted in scope than are the goals. For example, a goal might be: a parent will teach the child management technique of setting and enforcing age-appropriate limits. An objective arising from this goal might be: the parent will physically remove and/or redirect the child from a target object on every occasion observed during a visit.

When developing the family service plan, the team may identify a range of needs that can be met in a variety of ways. For example, if a family's need for financial assistance because of a child's handicapping condition or the program needs more diagnostic information, the service co-ordinator may refer the child/family to other agencies or medical facilities. If a family needs more information on normal child development or an infant needs to develop a particular motor skill, the service co-ordinator will look at a different kind of intervention.

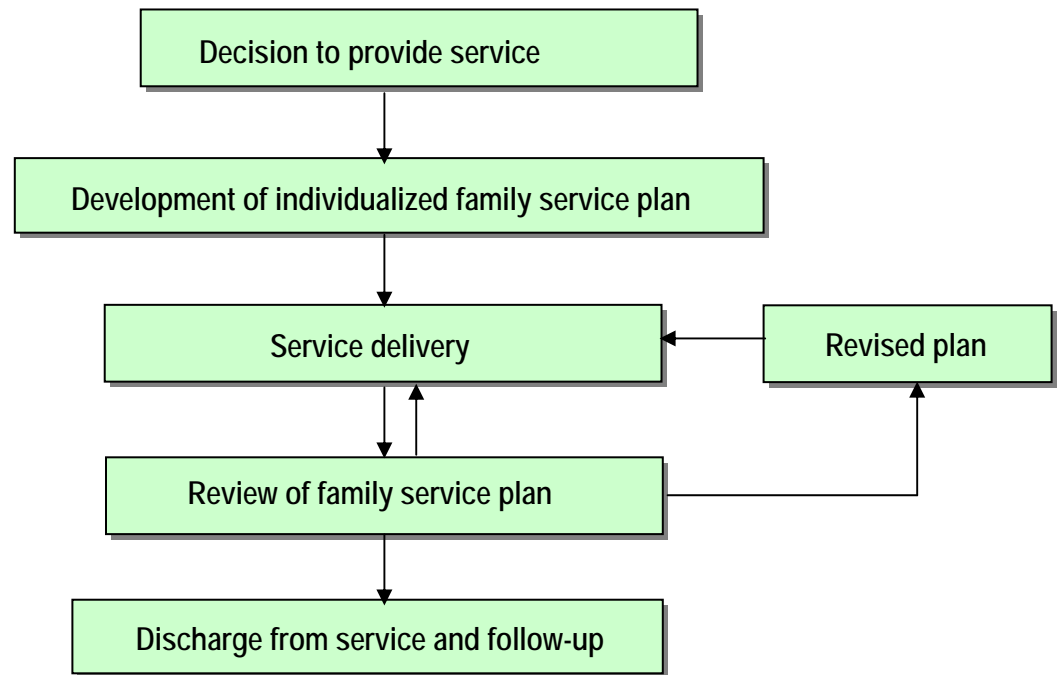
Procedures for monitoring and evaluating objectives will vary based on the objective and methodology the program uses. Both parents and program staff may be involved in monitoring and recording outcomes.

4. Reviewing/Revising the Plan

Each family service plan should be reviewed at least every six months and more frequently if required. The purpose of the review is to:

- evaluate the success or appropriateness of the initial family service plan
- identify any new or changing needs due to changes in the family situation, the child's development and/or parent-child interactions.

The process of accepting a family into the program, developing a plan and then reviewing the plan can be illustrated graphically as follows:



When reviewing a family service plan, program staff will consider:

- the goals and objectives accomplished
- the satisfaction of parent, program staff and others with service delivery activities and progress made
- any new information relevant to the child (i.e., individual, developmental, interactional or family changes)
- identification and prioritization of any new goals/objectives
- changes to the plan
- plans to terminate service (see Section VI).

During a structured review of the family service plan, the parents and program staff exchange information about:

- the extent to which their expectations have been met
- their satisfaction with the progress to date
- any desired changes in service delivery.

They may also discuss reasons for continuing or terminating service. For children/family who are ready to leave service, the review visit also provides a natural opportunity to discuss future plans and make appropriate referral arrangements, if necessary.

During the review, program staff will update family information. They may also administer norm-referenced and/or criterion-referenced instruments, or take other steps to reassess the infant/child. During the re-assessment, program staff may choose – with the parents' consent -- to ask other program staff or external consultants for a specialized consultation, a second opinion, or a more objective assessment.

During the review, program staff will also update information on other agencies involved with the child/family – particularly if the family requires assistance with service co-ordination – and inform other

service providers about any changes or revisions in the plan. When more than one agency is involved with the family, the service co-ordinator may organize – with the parents' approval – a case conference to review the family service plan.

VI. Discharge and Transition Planning

Infant Development Programs will develop policies and procedures for discharging children from service, which should include:

- a final assessment of the child's development
- documentation of goals and objectives accomplished
- documentation, in consultation with parents, of continuing service needs of the child and family
- involvement of parents in decisions regarding future services
- referral to appropriate agencies and services as required
- notification of other agencies and services as required
- documentation of the discharge/transition process and follow-up contacts
- written summaries to parents or caregivers.

When preparing to discharge a child from service, the Infant Development Program will prepare a discharge plan that may include:

- the reason for discharge
- date of discharge
- dates of referral to and involvement with other agencies
- dates agencies previously involved with family are notified about the child being discharged from service.

The decision to discharge a child from service should be based on specific criteria, such as: the child/family have achieved the service plan goals, the child's/family's needs can be met more appropriately by another agency, the child has reached the age limit for the program, or the family chooses to end the service.

Transition Planning

For some children and families, discharge may mark the end of a relatively long-standing and significant relationship with program staff. Families who are best able to move on are those who have control over the process and have been given enough time to plan/prepare for closure. To help them make the transition out of service, the Infant Development Program will develop a transition plan well in advance of discharge.

The plan will include any necessary services or supports such as:

- steps the program will take to facilitate the transition to another service
- an ongoing commitment to continue to respond to parents' requests for information on resources available to them
- plans to reassess the child's service needs at a set time if the child still meets the program's age and service requirements (i.e., 5 years of age or younger, with a developmental delay)

Infant Development Programs should also consider developing specific guidelines or protocols with other agencies, such as child care programs, nursery schools, kindergarten, resource teachers, and boards of education to help the child make the transition from the Infant Development Program to these other services. In some cases, these protocols may include provisions for Infant Development Program staff to provide consultation services for an agreed upon period of time to child care or school staff to help the child integrate into a community or pre-school setting. The nature and scope of the consultation services should be planned before the child makes the shift to the new service.

VII. Organizational/Operational Issues

Ministry, Sponsor and Service Provider Relationships

Organizational Structure

The 45 Infant Development Programs in place across the province are currently sponsored by a number of different organizations, such as child welfare agencies, child development agencies, children's mental health treatment agencies, hospitals and public health units. Some Infant Development Programs are organized as a unit within a comprehensive service, some are component of a multidisciplinary service, and others are "stand alone" programs. Regardless of how they are structured, Infant Development Programs are part of a continuum of early intervention services and will link with a broad range of early years and other social services in the community.

Accountability

The primary accountability relationship for Infant Development Programs is between the Ministry of Community and Social Services Regional Office and the executive and board of the program's sponsoring agency. A secondary relationship is between the Ministry of Community and Social Service Regional Office and the Infant Development Program. When the program is part of an agency that provides other related services funded by the ministry, communication is more likely to occur between the ministry's program supervisor and a manager of the broader range of services. When the program is a unique service within an organization that has limited involvement with the ministry, it is more common for the ministry's program supervisor to have direct contact with the agency's Infant Development Program director or co-ordinator.

Human Resources

Professional Staff

All Infant Development Programs and their sponsoring agencies will have clearly defined human resource policies and procedures (e.g., staff safety, staff recruitment, job responsibilities, caseloads and assignments, staff development and performance evaluations).

Infant development services will be provided by professionally trained staff – preferably from a variety of disciplines (e.g., physical therapy, occupational therapy, and speech/language therapy, psychology, health care, special education, family systems and child development). Volunteers and parents may be used to help deliver services in appropriate circumstances.

Infant Development Programs are responsible for determining the educational qualifications and skills that staff require, and for determining their ongoing professional development and training needs. Ongoing training is critical to providing quality services. At a minimum, that training should include but not be limited to: child development family systems, cultural sensitivity, interpersonal communication, and general health and well being. Staff should participate in cross disciplinary training based on best practice.

Infant Development Programs will use participatory management, peer review and team problem solving to promote effective service delivery and individual staff competency.

Parents, Volunteers and Students

The use of parents, volunteers and students can benefit the program, its clients and the volunteers. Infant Development Programs will develop policies and procedures for using volunteers, including parents, and students in their programs when appropriate. These policies should:

- describe clearly the roles and responsibilities of volunteers (taking into account any collective agreements)
- require volunteers, students and their educational institutions to sign written agreements developed by the program's sponsoring agency.

Infant Development Program staff will obtain informed consent from the family before involving a volunteer or student directly in delivering service.

Staff will also provide the training and ongoing supervision that volunteers and students need to be able to contribute to and learn from the program.

Service Delivery Models

Infant Development Programs currently use a variety of service delivery models, which can differ in:

- location (e.g., home, centre, clinic, hospital)
- focus of the intervention (e.g., child, parent-child, family as a whole, group)
- frequency of contact
- delivery approach (e.g., consultation, mediator teaching, one-to-one intervention)
- team approach (e.g., multi-disciplinary, inter-disciplinary, trans-disciplinary).

Home-based intervention is usually the primary location for delivering infant development services because it gives staff the opportunity to establish rapport with the child and caregivers as a unit, and develop the atmosphere of trust and understanding that is an integral part of any family-oriented program. A home-based intervention, which occurs in the family's own environment, also reinforces the home as the main locus of behaviour change and the parent(s) as the primary decision-maker for the child.

In addition to working directly with children and families, Infant Development Programs will provide other services to meet the needs of their communities, such as:

- consultation to other professionals in the community on children at risk
- community education
- student practicum placements
- participation in community planning for services for people with developmental disabilities and for children with special needs, and for the continuum of services for children and families.

Documentation

Service Documentation

Infant Development Program will develop a systematic method of documenting client information at each stage of the service process. This documentation provides a complete record of each child's involvement with a program and creates a client information system. Programs may find it useful to develop a number of well-designed forms to document the services elements provided to each client, such as:

<u>Service Element</u>	<u>Documentation</u>
Intake	Referral documentation
User identification	Release of information documentation
Eligibility determination/Admission	Medical information and health history
Assessment	Family information
Family service planning	Parent-child interaction information
	Developmental assessment (formal or informal) initial report
Service delivery	Individual family service plan
	Individual implementation plans, client contact and home/office visit records
Review of service needs	Status/progress report
Discharge/transition planning	Discharge plan
	Transition plan

Infant Development Programs will establish and follow a written procedure for creating, maintaining and disclosing records, consistent with relevant legislation.

Infant Development Programs will periodically audit client files for completeness.

Administrative Documentation

Infant Development Programs, like all human service programs, are required to keep administrative documentation. Each program will have:

- a policy and procedures manual to provide a common reference for program personnel and a valuable resource in training new personnel
- a system for monitoring and documenting its use of financial, human, and physical resources.

The Ministry of Community and Social Services and the program's sponsoring agency will determine the programs' regular service reporting requirements, including reports and statistical summaries (e.g., annual reports or monthly summaries of service statistics). In their reports, Infant Development Programs may be asked to address issues such as program effectiveness and external accountability for the service provided.

Program Review/Evaluation

Infant Development Programs will regularly review and evaluate their services, policies, practices, processes and outcomes. Program evaluation is early intervention examines the ability of the Infant Development Program to work with families to achieve planned outcomes for children at risk and their families.

When evaluating their operations, programs should assess their ability to respond to individual and family needs and improve quality of life, as well as their ability to meet established professional and agency standards. Any comprehensive evaluation of early intervention services, such as infant development services, should include the following components:

- family-centred practice
- professional standards and accountability
- cultural sensitivity
- fiscal and human resource management
- occupational health and safety
- planning
- child, family and community outcomes
- family-centred practice.

When evaluating their services, programs should consider using a mix of statistical and qualitative information.

See Ontario Association for Infant Development Best Practices.

Participation in Research

Infant Development Programs may occasionally be asked to participate in research and development projects. Any consideration of using Ministry of Community and Social Services funding for research requires the Minister's approval. Before asking clients to participate in any research, Infant Development Programs will carefully consider any ethical and legal issues, such as confidentiality and the comfort, well-being and safety of participants.

Before agreeing to participate in any research project, Infant Development Programs will ask the ethics committee or office of human research of their sponsoring agency or institution to review the research proposal. The Program will also ask the service co-ordinator and the program sponsor to assess the impact of any proposed research on clients, program personnel, and the agency (e.g., cost/benefit analysis, risk analysis).

VIII. Community Relations

Community Education

Successful Infant Development Programs actively promote their services, and use pamphlets, media coverage (i.e., newspapers, television and radio) and speaking engagements to explain their services and increase community awareness.

While community education is important, it is secondary to providing individualized family service.

To ensure that all potential referral sources in the community are aware of the infant development services available, program personnel should meet periodically with other early years services and professionals (e.g., staff from Healthy Babies Healthy Children, school resource programs, Preschool Speech and Language programs) to exchange information about service mandates, target populations, the nature of services offered, and referral procedures.

When appropriate, Infant Development Programs should establish protocols with agencies that share service responsibilities, and review these agreements regularly.

Orientation for new staff will include information on community agencies and their personnel.

Community Building

Infant Development Programs will support the development of individual, family and community capacities or community building. They will:

- help families and their children become contributing members of their communities, and develop supporting relationships beyond the nuclear family
- encourage communities to be more competent and inclusive.

Many different activities can be part of community building, including:

- teaching families advocacy skills
- giving families information about the community
- working with other service providers to enhance service delivery
- seeking out and strengthening natural supports and linkages
- providing culturally sensitive services
- educating the community
- supporting the development of community groups
- supporting community efforts to reduce crime, provide affordable housing and increase employment.