MAKE CHILDREN FIRST

Learning Initiative Guidelines

KEY MESSAGES

Introduction

The environment and experiences of young children effect their health and well being for a lifetime. While communities have many services and supports, there is work to be done in linking them with each other and with the knowledge that research has provided. Knowing this, and the importance of the whole community being invested in the well being of young children, the Ministry of Children and Family Development has funded three communities to support the process of learning what it will take to bring the parts together to develop an effective system of supports for all children from preconception to school entry.

- The Ministry of Children and Family Development is committed to **strengthening and supporting healthy early childhood development.**

- **Early is critical in two ways.** What happens in a child's first 6 years has a lifelong effect on health, mental ability and social skills. We also know that when children and families need professional support, the earlier they get it, the more valuable it is.

- **All children** deserve our best efforts to put into practice what we know works best to nurture healthy growth and development. There are some supports that all children need, and others that will only be needed by those children who have with a specific need.

- Research is strengthening what parents have known all along, that giving children the best start takes **learning opportunities, safety and nurturing relationships, support to parents, effective health care, and strong community networks.**

- Everyone in the community shares the responsibility for the early life of a child. Children's health and well-being cannot be the best without the commitment of governments, communities, professionals, family serving groups and most of all – families.

- Families are key to their children's health and well-being and are an integral part of the community.

- Children can benefit most if strategies are a result of broad community involvement. This allows for recognition of community strengths and needs, local solutions and an ability to draw on a variety of resources.

- Local solutions build a sense of community. Three British Columbia communities have been selected to demonstrate how the knowledge we have about childhood development can be used in a community plan to support of all their children from 0-6 years.

Young Children's needs (What parents have always known)
Children thrive when they have:

- **Protection** from injury, harm, neglect, and illness and disability.

- **Relationships –** how well children develop is influenced by the care and attention they receive from their parents and other caring adults.

- **Opportunity and hope** – children all need opportunities to play, explore, love, and learn. They need to build a strong belief in their own abilities.

- **Community**: Most children grow up in families. Families need support networks around them. A community, which works together, is needed for optimal child development.

Who can make a difference?

- There are many people and groups who understand and believe in the importance of early childhood, and contribute in wonderful ways. Some of these groups include social programs, healthcare, parent/family programs, literacy groups, recreation, childcare centres, pre-schools, community and neighbourhood organizations, and of course - families.

- Only a connected, community-based approach can address the full range of young children's needs.

- This initiative is about bringing it all together. What does it take? How can it happen? What are the needed parts?

- These selected communities will experience, evaluate and monitor the process of bringing groups and people together to create a complete system for healthy development of children from pre-conception to school entry.

- The plan is to apply the learning in communities who can benefit from this initiative and to apply the learning to future funding decisions.

How will this happen?

- The selected communities have been building on past work and strengths since December 2000, bringing people together through advisory groups, community forums and focus groups.

- The communities have been refining their understanding of the characteristics of their communities as they relate to what children need.

- Experienced researchers and evaluators are involved in the process

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1.0   Introduction

At a meeting held in September 2000, the Federal/Provincial/Territorial First Ministers (excepting Quebec) released a communiqué called the "Early Childhood Development Accord", whereby governments have agreed to use their increased funding to:
- promote healthy pregnancy, birth and infancy;
- improve parenting and family supports;
- strengthen early childhood development, learning and care; and
- strengthen community supports.

Each provincial or territorial government will be able to tailor its ECD services to better meet the needs of Canadian children. For Canadian families, these new investments will ultimately mean better access to services such as pre-natal classes and screening, pre-school programs and child care, and parent information and family support. Further investments in ECD could mean better services for pregnant women and their infants, improved access to special needs supports, or a network of parent resource centres.

The Ministry of Children and Family Development (MCFD) is committed to supporting children, youth and their families and has identified early childhood development as one of its' priorities.

MCFD Vision

The Ministry of Children and Family Development envisions a province of healthy children and responsible families living in safe, caring and inclusive communities.

MCFD Mission

To promote and develop the capacity of families and communities to:
- care for and protect vulnerable children and youth; and
- support adults with developmental disabilities

Principles

The following principles guide the ministry in its work:
- We believe in the right and primary responsibility of families to protect and support the growth and development of children and youth.
- We believe that government must acknowledge and reinforce the capacity of communities to support and enhance the resilience of children and families.

- We believe that this ministry should provide the minimal intervention necessary to ensure the safety and well being of our most vulnerable community members.

Role and Mandate
The Ministry is to:
- Advance the safety and well being of vulnerable children, youth and adults.
- Advance early childhood development through strategic investments.
- Advance and support a community-based system of family services that promotes innovation, equity and accountability.

Goal
The Ministry goal that is specifically related to the Learning Initiatives is:**Goal 3**: To improve family capacity and improve readiness to learn for children under six, including children with special needs.

Objective: To promote early childhood development as a key strategic investment.

Strategies:
- Build community capacity to develop and deliver co-ordinated early childhood development supports and services that are based on community composition and needs.
- Support Aboriginal communities to work in partnership to develop and implement early intervention strategies that meet their needs.
- Enhance parental education initiatives to assist parents in having opportunities that enhance their responsibility to make the most of their children's development. Develop partnerships with the private sector to broaden community involvement and capacity for early childhood development initiative

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Accountability Statement of the Minister of Children and Family Development

'The 2002/03 – 2004/05 Ministry of Children and Family Development Service Plan was prepared under my direction in accordance with the Budget Transparency and Accountability Act. I am accountable for the basis on which the plan has been prepared. The plan was developed in the context of the government's New Era commitments which are to be addressed by
May 17,2005. All material fiscal assumptions and policy decisions as of January 28, 2002 have been considered in preparing the plan and I am accountable for
achieving the specific objectives in the plan.'

Accountability Statement of the Minister of State for Early Childhood Development

"I am the Minister of State for Early Childhood Development and under the Balanced Budget and Ministerial Accountability Act, I am accountable for achieving the following results for 2002/03:
- Establish a measure for the proportion of kindergarten aged children who are 'ready to learn'
- Establish one early childhood development learning site per region to foster the integrated planning and delivery of early childhood development"

Purpose of the Guidelines

These guidelines are intended to communicate the principles and key issues to be addressed in the *Make Children First* Learning Initiatives. They are supplemented by other key documents that provide an umbrella framework for this initiative, including:

- The Ministry of Children and Family Development Service Plan
- The Early Childhood Development Action Plan for BC
- The Ministry of Children and Family Development Strategic Plan for Aboriginal Services.

In addition, the following provide consistent key messages and principles, which form the basis of the Learning Initiatives:

- Building a National Strategy for Healthy Child Development, A Report of the Federal/Provincial/Territorial Advisory Committee on Population Health, March 1998.
- Early Years Study: Final Report, Dr Fraser Mustard and Mary McCain
- Investing in Early Child Development: The Health Sector Contribution (Prepared by the Federal/Provincial/Territorial Advisory Committee on Population Health).
- Our Promise to Children, Canadian Institute of Child Health, 1997.

A key element of the initiative is **linking and building relationships**. It is recognized that there are multiple initiatives in the province that are intended to promote healthy early childhood development. Some examples funded by MCFD are the Urban Aboriginal Early Childhood Initiative, Building Blocks, Family Home Visitor training. Programs funded by the Health Authorities include Pregnancy Outreach Programs and the Nobody's Perfect Parenting Program. In addition to these initiatives, there are many from other ministries and the federal government. In each community, there are many more that have been developed locally in response to identified community needs and priorities. The intent of this project is to learn about bringing these many resources together in a community and to explicitly recognize their role. Processes are sought to integrate, not duplicate, building the capacity of communities to support the healthy growth and development of children and their families.

Make Children First is a demonstration of the government's commitment to developing an integrated system of effective services and supports for our youngest children. It is intended to augment and strengthen existing supports for healthy development of young children from preconception to school entry.

1.0 Introduction
1.1 The Early Years

The early childhood years from preconception to school entry are the most important foundation years for brain development and subsequent learning, behaviour and health. Identifying young children before the age of school entry who are at-risk of poor social, emotional, cognitive and physical development, and working together with their families to improve outcomes for the children will strengthen the families capacity to support their healthy growth and developmental needs. .

An infant's brain has 100 billion neurons at birth, and these neurons will grow and connect with other neurons in response to repeated experiences. The baby's relationship with parents, and the sights, sounds, smells and feelings experienced, all influence the physical development of the infant's brain and how it functions for the rest of the child's life. There are critical periods during which the neural pathways develop, i.e., binocular vision, emotional control, response to stress, language and literacy, symbols and relative quantity. There is evidence that children, who do not experience adequate stimulation early in life, will be more likely to encounter learning, behavioural or emotional problems later in life.

The Ministry of Children and Family Development (MCFD) is committed to strengthening and supporting healthy early childhood development. The *Make Children First* Learning Initiative is a project to determine the components, viability and benefits of a comprehensive early investment strategy for all children pre-conception – 6 and their families in BC. Through this initiative, the ministry intends to learn:
- the key community characteristics needed to support young children and their families;
- the processes for communities and service providers to determine their strengths and their needs;
- the processes that facilitate relationship building amongst all sectors of the community;
- a strength-based approach to service delivery; and
- emerging best practices to bring the strengths and needs of communities together to improve the well-being and health of young children.

1.2 Rationale

The aim of the *Make Children First* Learning Initiative is to:
- recognize and link the multiple services and supports that a community has to offer,
- facilitate bringing community-based service providers together to ensure there is a comprehensive, integrated system of services for children and their families,
- connect families and their children to the services, at the appropriate time, and to
- connect research and community experience through the support of a multi-discipline research group.

The earlier a child's needs for additional support or services can be identified and addressed, the more likely the child and family will experience meaningful results from the support provided. It is critical that all children and families have the benefit of

those who understand healthy child development, and who can recognize when further attention is needed. Families vary in the information they have, and their ability to access service providers, through the learning initiative, communities are looking at how to eliminate these barriers to accessing information and services. When community partners collaborate to determine a coordinated, integrated system of service delivery, everyone benefits – children, families, service providers and the community.

2.0 Principles of Practice

The principles of practice are many, but the following principles embrace and apply to the *Make Children First* initiative. They can be identified thus:

- Accountability
- Transparency
- Evidence-based
- Family-centred
- Community-based
- Community Development Approach
- Integrated
- Sustainability
- Building Capacity
- Inclusive
- Responsive
- Universal Access

2.1 Goals of the Learning Initiatives

The following goals support the overall intent of the Learning Initiatives – to develop a comprehensive, integrated service delivery system that supports children and their families:
- To develop integrated, community-based models for services to young children and their families that address resiliency and capacity-building,
- To build relationships amongst the full range of service providers in the public, private, voluntary and corporate sectors, who support young children and their families.
- To learn from the experiences in rural, urban and remote communities of the province.
- To utilize current research and existing and emerging best practices to define the essential components of an early childhood development model for British Columbia.
- To involve communities, service providers, researchers and MCFD and regional Health Authority staff in the development of the model.
- To strengthen family capacity to optimize the healthy growth and development of their children, preconception to age 6.

- To mobilize communities and strengthen their capacity to both understand the importance of early childhood development and to support the healthy growth and development of children and their families.

3.0   Community Development: A Process

3.1   Community Involvement

A coordinated, community-based approach is important to promote, encourage and support healthy development of children from preconception to school entry.

Children need supportive environments and the choices that a community can provide. Community is the sustaining context in which families live. Communities cross generations where children grow up, live, thrive and eventually and become full participating, contributing members. A vibrant community is made of families, workplaces, schools, parks, police, libraries, media, spiritual groups, cultural centres and more. All these parts have a role in shaping a child's future.

Each community has its own characteristics and its own resources that must be understood to develop an effective plan. This understanding is the community context that must be linked with the known needs for healthy early childhood development. Identification, collection and bringing multiple information sources together for a "big" picture is key. Through this process, different community sectors, individuals and agencies come together with the common objective of contributing to healthy early childhood development. Involved parties will develop new understandings of their own role, and the roles of others. The process that is often referred to as community mapping, facilitates community action from inside the community. It allows the exposure of potential links, resources, opportunities as well as gaps and inequities. The process will also point to needs for new data and information.

Communities provide children and their families with opportunities for:
- Recreation
- Access to reading and books
- Social connections to other parents
- Parks and green space to play
- Information
- Safety
- Learning
- Contributing to the whole community

In Port Alberni, all the service providers completed a 'Map of Learning Opportunities' to identify the supports and services their organization provides in the following spheres:
- Language
- Artistic Development
- Healthy Environment
- Spiritual/ Cultural
- Parenting
- Personal/ Social
- Physical Growth and Development

This shift from organizing by services to organizing by learning opportunities has allowed committee members to see there were many taken for granted opportunities/ assets in the community that contribute to the growth and development of children. This highlighted outcomes for the child rather than needs or deficits that required intervention in the way of services. Completion of the Learning Opportunity Maps has resulted in programs expanding the range of activities. For example, the Healthy Beginnings Program has added a literacy component as they realized they didn't have anything in the sphere of Literacy

Each community has its own characteristics and its own resources that must be understood to develop an effective plan. This understanding is the community context that must be linked with the known needs for healthy early childhood development. Identification, collection and bringing multiple information sources together for a "big" picture is key. The process of gathering the data, brings together different community sectors, individuals and agencies with a common philosophy of contributing to early childhood development. Community partners will develop new understandings of their own role, the role of others and how they relate to each other and all contribute to the capacity of the community to support young children and their families.

The process that is often referred to as community mapping, facilitates community action from inside the community. It facilitates the development of potential links, resources, opportunities as well as gaps and inequities. The process will also point to needs for new data and information.

Consequently, to move forward, public and private sector understanding, commitment and investment are needed. The importance of healthy child development must be understood as it contributes to:
 ➢ the well being of individual children and their families;
 ➢ the health status of communities, and
 ➢ actual investment.
Key messages already stated can be combined with local issues and realities to gain support for a focus on early childhood development and supporting families, e.g., National Children's' Agenda, Canadian Institute of Child Health, Health Canada, The First Years Last Forever, The Early Years Study, and others.

3.2   Principles

Community development is not a static process. The principles listed are all important and processes need to be continually checked to ensure the principles are continuing to be the basis of discussions, activities and continually contribute to relationship building.

- Trust.
- Collaborative decision-making for involvement, information, and evaluation of priorities.
- Building a common vision.
- Equality of partnership.
- Inclusive.
- Respect.
- Valuing different ways of doing things.
- Reflecting evidence-based best practice.
- Asset-based approach.
- Mutual accountability and joint ownership of plan, resources, and responsibility.

3.3   Community Advisory Structures

The planning of the initiative needs to encompass collaborative partnerships and build on the resources of the community, maximizing the learning opportunity in a short period of time.

3.3.1   Learning Initiative Advisory / Consultation Structures

Communities may already have established committees that plan and coordinate services for families with infants and young children. An existing committee or key representatives from existing committees may provide the steering support needed to move the initiative forward. It is important to review the composition of the existing structures to ensure that they represent the full range of the service providers in the community.
If the initiative uses an existing community committee, strategies need to be in place to expand it to ensure all interested sectors are represented.
The membership of the committee needs to be intersectoral and representative of key stakeholders in the community. The committee may wish to utilize sub-committees and linkages with other standing committees to ensure the size of the steering committee remains manageable.
The advantage of sub-committees is it broadens the opportunities for community participation and ownership as well as dedicating resources to specifc projects within the plan.

> Each Learning Initiative has a different Advisory structure, reflecting the existing community structures and an approach that works in their community
>
> Eastern Fraser Valley: There is an Implementation Team, made up of the Implementation Manager and contracted staff; Implementation Committee (IC); reporting to the IC are 5 Task Groups and 2 Committees.
>
> Port Alberni and the West Coast: There is an Implementation Team, made up of managers from MCFD and the Central Vancouver Island Health Region; and a Community Advisory Committee (CAC). The core membership of the CAC is the 0-6 sub-committee of the Port Alberni Child and Youth

The community structures may include both advisory and decision making committees. It is important that participants clearly understand their roles.

Membership should include:

- MCFD Regional Executive Director or designate.
- Public Health Nursing Leader or designate.
- Designated Implementation Manager
- School District Representative
- Key representatives from the Aboriginal community

Other community members to involve include representatives from: —
- a parent association (if possible).
- ECD service providers.
- municipal government.

> In Prince George, the existing Building Blocks committee applied to take on responsibility for the Learning initiative. The Steering Committee is made up of representatives from MCFD, the Northern Interior Regional Health Board, School District 57, representatives of each sub-committee and two representatives who bring the Aboriginal perspective. There are several working groups that report to the Building blocks committee.

- the child care sector.
- the voluntary sector,
- the business sector, and
- other key community partners in the area of early childhood development.

The overall Advisory Committee will be responsible for:

- developing a plan for the implementation of the initiative, including community involvement activities;
- finalizing the community mapping process;
- participating in the development of the evaluation blueprint and identifying local evaluation needs;
- facilitating collaborative, innovative problem solving approaches;
- determining how to make the best use of financial and human resources;
- developing a budget plan for the initiative.
- determining training needs; and
- keeping the project true to the community vision.

3.3.2 Implementation Manager

Communities chosen as Learning Initiatives will need to identify an Implementation Manager to lead the project at the community level and facilitate full community involvement. This support is critical to ensure that the initiative proceeds in a timely and efficient manner. Dedicated implementation support also minimizes the impact of the initiative on ongoing management activities in the region.

It is desirable to have an existing manager from either the regional MCFD office or the Regional Health Authority fill this position. This role could be a secondment arrangement, with funding from the project used to backfill their existing position, to ensure that the Implementation Manager is able to focus on the project. The Implementation Manager should have a working knowledge of, and expertise in, prevention and early support programs, and community development as well as the contracting process.

Responsibilities of the Implementation Manager include:

- Chairing and/or providing staff support to the Community Steering Committee and other advisory structures.
- Leading the process with the Community Steering Committee to develop:
  - implementation plan and budget for the project
  - evaluation framework
  - training plan
  - screening and assessment plans
  - marketing plan
  - community awareness plan and tools
- Facilitating full community involvement,

- Developing and managing contracts for the component pieces of the project.
- Attending provincial meetings and teleconferences as the project liaison,
- Being the primary spokesperson for the project,
- Working with community agencies, providing component services to ensure that service delivery is seamless, integrated, and user-friendly,
- Ensuring that the project meets timelines and deliverables,
- Providing information on evidence-based research and best practices to the project, and
- Being accountable to the MCFD Regional Executive Director and the Public Health Nursing Leader, for the ongoing management of the project.

3.3.3 Funding

The funding provided to the learning initiatives is intended to provide resources to lead the initiative, integrate community supports, involve the community, increase the understanding of the resources and assets of the community, and to develop the plan for a comprehensive system of linked services and supports. It is also meant to provide resources to do thorough evaluation of the process and keep documentation needed to share the experience and identify issues as they arise.

This innovative approach recognizes the complexity and challenge of bringing communities together. The processes and their results will not happen on their own, and therefore, need continuous support and knowledge of committed groups of people.

As part of the comprehensive system of supports, the funded communities will conduct a review and plan of universal and targeted screening processes required to increase the access of children and their families to early identification of needs and supports. The appendix of this guide provides further information on specific screening tools across the developmental continuum.

The initiatives will also conduct a community mapping process and administer the Early Development instrument to determine the baseline of children's readiness to learn in the community.

> In Port Alberni, there was a concern regarding the waitlist for speech and hearing services. As a result of a review by the Language and Physical Growth and Development Sub-committee, the health unit realigned their services in order to provide additional services to more children and families. Now all children get an initial assessment quickly and are assessed as mild, moderate or severe. Children with severe speech difficulties continue to get individual therapy; parents of children with moderate difficulties are referred to a newly developed group program; and parents of children with mile difficulties get educational material and a tool kit of resources to support their child. This shift in service delivery has eliminated the waitlists. The change will be evaluated to determine the effectiveness of this approach for children with mild and moderate needs.

Bearing in mind the importance of the whole community being invested in health and early childhood development and the complexity of doing this, funding has been provided to allow dedicated people to focus on the process. This framework will assist the Ministry of Children and Family Development and

British Columbia communities to make decisions about strategies and funding targeted at improving the health and well-being of children from preconception to school entry.

Throughout the process, by bringing the community together, there is the opportunity to reorient existing services and address gaps to meet community needs.

3.3.4   Accountability

The accountability for the *Make Children First* initiative in each of the funded communities rests with the Regional Executive Director in partnership with the Regional Health Authority director responsible for public health.

3.3.5   Communication

In order to involve and inform all parts of the community a communication plan will be helpful. Brochures, local media, presentations and other strategies will be helpful in helping the community feel ownership in the initiative, and encourage them to be involved. The Communications Branch of MCFD is working with the learning initiatives to develop a 'look' that incorporates both provincial guidelines and successful community approaches. CD Roms will be provided that include compoments to be used for consistent visual identity. All communications must acknowledge the project is a consortium of MCFD, the Regional Health Authority and community partners.

3.4   Community Mapping Strategy

A key component of the initiative is the building of service networks in an integrated fashion. Learning initiatives will need to complete a community mapping process to ensure that integration is maximized and services are not duplicated.

Community mapping is described as a collaborative process that essentially visualizes a community and its resources and assets. The information can help when decisions have to be made regarding resource allocation, service delivery design and access points. Sometimes called "community asset mapping", it focuses on identifying the resources within a community, how these resources link with each other, and where the gaps exist. Ideally, it is used in conjunction with a map overlay that describes the target population and where they live.

There are many different community maps that can be developed ranging from simple coded dots on a community map to a detailed map of services, transportation systems and predictive population data encoded on a Geographic Information System (GIS). For the purpose of the initiative, it is not necessary to embark on a detailed, technologically advanced process. Rather, sites are encouraged to develop an inventory of the services and how the services and programs interact and link with each other to provide an integrated system of early childhood services.

Within communities, there are various resources that can assist with the technical aspect of community mapping. In Prince George, the initiative accessed the expertise of a medical geographer at the University of Northern British Columbia; in Port Alberni, the initiative is working collaboratively with the resources in the municipality; and in the Eastern Fraser Valley, they have accessed community expertise. The Human Early Learning Partnership, a multi-disciplinary academic research consortium based out of UBC, is supporting this component of the Learning Initiatives. The Learning Initiatives have facilitated the administration of the Early Development Instrument (EDI) to provide a baseline measure of children's readiness to learn. (See Appendix 3 for a detailed description of the EDI.)

The community mapping process or strategy serves a number of purposes; namely:

- It provides additional input and information on the community.
- It provides participants with a hands-on process that, in turn, leads to a greater sense of ownership, commitment and enthusiasm of the initiative.
- It results in a valuable visual representation of the community demographics and community services that provides a platform for planning.
- It contributes to the whole community's understanding of the importance and impact of an integrated, coordinated approach to early childhood development.
- When combined with the results of the EDI it provides opportunities to relate community opportunities with child performance.

4.0   Appendix I: Key Concepts
4.1   Population Health Model

Population health focuses on factors that enhance the health and well being of the overall population. This approach focuses on the entire range of individual and collective factors that determine health and well being, and the interactions among them. Strategies are designed to affect an entire population, or particular subgroups within the population. In the case of the "*Make Children First*" initiative, the subpopulation is children preconception to school entry. Working in a population health model means building strategies that address the whole population of children preconception to school entry, while they continue to serve the needs of individual children and families with specific needs for intervention or support.

4.2   Health Promotion

Health promotion is the process of enabling people to increase control over and to improve their individual and family health and well being. In health promotion, community is a central concept. In order to enable people to control and improve their health, it is critical to involve the community in describing it's strengths and barriers to provide it's members with optimal health and well being, and making decisions about policies and programs. Communities will be the context in which the system for early childhood support will exist.

4.3   Community as a Central Concept

As recognized by the definition of health promotion, community is a central concept. Each community is unique and will have their own set of strengths, resources and capabilities. What this initiative strives for is application of available knowledge and experience about what contributes to healthy child development, in the context of a unique community. The degree to which a community understands the importance of early childhood development to their future prosperity will be part of the strengths of the community. Part of the success of this initiative will be the understanding and commitment of a community as a whole to healthy early childhood. Systems that grow through community initiatives and supports will be more sensitive to the needs of their families and the characteristics of the community. Building community capacity includes expanding the participant base and developing both formal and informal networks that support early childhood development. This can lead to increased access to and sharing of resources, reciprocal links and supportive interactions, and most importantly, building collegial cross-sector relationships.

5.0   Appendix II: What Children Need

5.1   Protection

From the time a child is conceived, they need to be protected and provided with the physical things that we know contribute to their health. We know their mothers need to be well nourished, and free from excess stress. We know that babies need to be free of alcohol, tobacco and other drugs during their development. We know that if mothers receive prenatal care, then a baby will be born healthier. We also know that mothers and fathers will be better able to provide this protection if they learn about healthy planned pregnancies long before they are pregnant.

Once a baby is born, the complexity of their need for physical health and safety increases. Breastfeeding, immunizations, car seats, and protection from sudden infant death syndrome are some examples of effective supports. The support and information a family needs is great at this time of transition to parenthood. The resource, *Baby's Best Chance: A Parent Handbook of pregnancy and Baby Care* provides the provincial standard in providing information to parents.

> The Best Chance Series: *Baby's Best Chance Parent Handbook of Pregnancy and Baby Care; Toddlers First Steps*; and *Preschoolers Ready to Learn* will provide standard information for all new parents and support care providers challenging them to meet the needs of children in the early years in the best way possible.

When a child and his family have an individual need, beyond what all children need, early intervention and/or support will make a tremendous difference to their healthy development. Identification of needs specific to individual children and families must be done early to prevent impairment of a child in reaching their full potential. For example, we need to know if a child is hearing impaired, if they have a disease or disorder, or if their environment presents risks to their safety and development. Research has shown specific screening tools used by trained professionals can increase the identification of children with individual needs and increase the likelihood that they will receive support or treatment effective in maximizing their opportunity for healthy development and achievement of their potential. While the health sector is the primary contact for all expectant and new parents, systems of support and intervention cross all sectors.

Examples of supports that all children and families need
- Prenatal care
- Nutrition
- Freedom from exposure to drugs and alcohol
- Breastfeeding support
- Supportive workplaces
- Information about pregnancy
- Information about how to keep young children safe (car seats, SIDS prevention, SBS prevention,
- Immunizations
- Freedom from exposure to smoke

- Access to health care
- Surveillance for health and developmental issues (new-born hearing screening, new-born examination, universal screening to identify need for additional support)

Examples of support that *some* children and families need – in addition
- Pregnancy outreach
- Alcohol and drug treatment
- Safe houses
- Mental health supports
- Financial support
- Extensive home visiting
- Employment and training services
- Family support services

5.2   Relationships

A great deal of brain development occurs before a baby is born, and the prenatal health of a mother and child is not to be understated. However, when a baby is born the brain is far from developed. A newborn's neurons are not yet connected into the intricate patterns that characterize the mature human brain. A crucial period for the development of functions such as arousal, behaviour and emotion occurs during the first years of life. If a baby is cared for by an adult who is intensely involved with, and responsive to them, a attachment relationship will develop. This important relationship provides emotional safety and security that a young child needs to develop and establishes connections in the brain, which can reduce anxiety and allow the brain to better take in and incorporate the world around them. When a child does not experience a nurturing relationship, such as in an environment of neglect, lack of responsiveness or abuse there is an assault on a child's development, which negatively effects their biological reaction to stress and change.

Examples of what all children need Reading, books in the home
- Positive parenting
- Healthy parents
- Work/family arrangements

5.3   Opportunity and Hope

Infants and children need responsible, consistent, safe care within stimulating and supportive environments. A family and community which promotes physical health and social and emotional well being and inspires learning and self esteem will have these characteristics. Parents, caregivers and the wider community need knowledge, skills and supportive conditions to be able to effectively provide this environment for children.

Examples of needs for all children and their families
- Quality childcare

- Safe environment (clean air, water, parks and sanitation)
- Housing
- Social and community cohesion
- Stable family
- Family and caregivers who are knowledgeable about healthy early childhood development
- A community which recognizes, and understands the value of healthy childhood
- Parent information
- Parent & child programs for recreation and socialization

Examples of services that some children need in addition
- Enhanced childcare
- Family supports
- Specialized family education programs (i.e., Nobody's Perfect; Family Home Visiting))

6.0   Appendix III: Early Identification

Universal screening has been demonstrated to be an effective method of early identification. The goal of screening is to search for potential health problems among the entire population, and to then do a more comprehensive assessment. In universal screening, no one is singled out and there is no labelling or stigmatization of any members of a population. If children needing supports are identified, assessed and connected with the supports needed, the incidence of subsequent problems in development, learning and behaviour is reduced. Screening processes indicate when further assessment is needed, and may not in themselves point to a need for services. Screening activities should include parents and be carried out within the context of other supports and services, and can only be effective if it is part of a comprehensive and continuous system of early childhood supports.

> In the Eastern Fraser Valley, a committee lead by Public Health, is examining strength based approaches to screening. To focus on the strengths of individuals and families to address identified areas of need.

The Make Children First: Learning Initiatives will build in a system of universal, population-based screening that is designed to ensure that all infants and children at risk for poor health and developmental outcomes are identified and referred to appropriate services.

6.1   Preconception Health

Utilizing health promotion and prevention activities before pregnancy occurs comprises the foundation of preconception health care. Incorporating such efforts is vitally important as many women can be pregnant for several weeks without their knowledge and yet this early period is the time of greatest developmental risk to the fetus.

> Prince George has taken the leadership in research that could lead to a focus on Preconception health and screening.

Preconception care does not only focus on the physical health of the woman but also on social, psychological, environmental, and emotional issues facing both parents. According to the National Guidelines for Family-centred Maternity and Newborn Care (Health Canada, 2000), preconception care incorporates many components that are based on the principles of family-centred maternity and newborn care. Some of these are listed below:

- Encourage women and men to prepare actively for pregnancy.
- Focus on the many environments influencing the family, including the social, psychological, spiritual, and physical.
- Respect the diversity of people's lives and experiences.
- Incorporate informed choice, thereby helping a woman and her partner to understand health, social, and environmental issues that may affect conception and pregnancy.

- Attempt to identify parents with increased genetic risks and provide them with sufficient knowledge to make informed decisions about their reproductive options.

As this document was being prepared, a well-researched and standardized self-administered screening tool for use during the preconception period was not identified. However, the National Guidelines for Family-centred Maternity and Newborn Care provide a Canadian perspective on the specific issues and context that need to be considered.

Using creativity and local knowledge, a preconception care initiative could be provided using a variety of mediums and in various community locales. Preconception care and education should be incorporated into the following:

1. School Curricula
   - Activities that promote a realistic and age-appropriate view of raising a family and the accompanying responsibilities should be incorporated.

2. The Workplace
   - Many employers already offer some form of an employee wellness program such as back care sessions, heart health, and influenza vaccination programs. These provide opportunities to incorporate health promotion information to working women about preconception planning and parenting.

3. Media
   - Local media could be accessed to deliver appropriate messages about preconception health.

4. Primary Care
   - It is recommended that preconception counselling be incorporated into general preventive care. For example, an information campaign could be tied to the provision of pap smear and birth control services by general practitioners and youth clinic staff.

5. Community Settings
   - Learning initiatives should consider the wide variety of community settings where residents already gather. Examples include community libraries, shopping malls, childcare facilities, and fitness centres. Such settings provide excellent opportunities to provide either written or verbal information on preconception health.

6.2   Prenatal Psychosocial Risk Assessment

As reported by the National Guidelines for Family-centred Maternity and Newborn Care (Health Canada, 2000), routine prenatal care should incorporate screening and assessment for psychosocial health risk factors. Without a systematic enquiry for all pregnant women, many problems will go undetected.

> Note: it is anticipated that one of the 2002 sites will take on responsibility for determining the effectiveness of the ALPHA form in BC.

A woman-completed version of the ALPHA (Antenatal Psychosocial Health Assessment) Form has been developed based on input from both providers and women. The new form was recently piloted with family physicians and public health nurses throughout PEI with favorable results and is the version recommended to be used by Learning initiatives. The form is used after 20 weeks gestation and is given to women to complete while they wait to be seen by their physician. The caregiver reviews the woman's responses and discusses options for support as deemed necessary.

This tool was developed in Ontario by a team of experts through a rigorous research process and is designed for use by family physicians, obstetricians, midwives, and nurses. It incorporates key antenatal psychosocial factors found in the literature as being strongly associated with poor postpartum outcomes (Wilson et al., 1996). It is also recommended by the National Guidelines for Family-centred Maternity and Newborn Care (Health Canada, 2000).

Psychosocial factors included in the ALPHA Form include:
- Social support.
- Nature of the couple's relationship.
- Recent stressful life events.
- Feelings towards the pregnancy after 20 weeks.
- Relationship with parents in childhood.
- Prenatal education.
- Self-esteem.
- History of psychiatric/emotional problems.
- Substance abuse risk.
- Family violence (both historical and current).
- Child-rearing attitudes.

Pilot studies in Ontario on the use of the tool report that women are comfortable with this form of enquiry and providers note an increased rapport with women (Reid et al., 1998).

Integrating the form into the prenatal care services provided by physicians will require a well-developed consultation process. The PEI experience could provide some factors and steps to consider. As the physician consultation process unfolds, the Learning Initiatives may wish to pilot the tool in the community prenatal outreach program(s). This intermediary step could provide information on the applicability of the tool in BC,

and the ways appropriate support and follow-up can be provided to identified women and their families.

6.3   Postnatal Screening and Assessment

Universal postpartum screening and assessment are key components in the early identification of infants and their families at-risk for poor health and developmental outcomes. As stated earlier in the guidelines, the use of screening and assessment tools is intended to augment, not replace professional judgement. The Learning Initiatives will need to examine the current use of postpartum screening tools, the extent to which the population of postpartum families are accessed and screened, the nature of postpartum follow-up in the community, and the possible need for extra training for staff.

> The Eastern Fraser Valley has established a volunteer postpartum telephone support network, especially for families in rural communities.

6.3.1   Nursing Priority Screening Tool

The Nursing Priority Screening Tool or Parkyn Tool is strongly recommended for consideration by the Learning Initiatives. Helen Parkyn, a former Public Health Nursing Administrator in Kamloops, developed this tool. It uses a number of factors contributing to risk, and assigns a weight to each of them, dependent on how much they contribute. Factors identified by the tool include the existence of congenital or acquired health challenges, developmental factors, and family interaction patterns. The tool is currently being used extensively in New Brunswick, Newfoundland, and Ontario as well as in British Columbia. Ontario has made some alterations to the form such as minor wording changes to some indicators (e.g., changing the word "disability" to "challenge") and removing the measurement of bilirubin as a risk factor.

> A joint MCFD and Regional Health Authority Study in Dawson Creek clearly identified the positive relationship between families with a high score on the Parkyn Tool and the likelihood of their children coming into the care of MCFD.

For the Learning initiatives, two minor revisions were made. A signature line was added to the bottom, and space is provided to indicate where a referral is made for further assessment. Neither of these changes will alter the validity or reliability of the tool.

6.3.2   Family Assessment Tools

There are numerous family assessment tools in the literature that examine a variety of factors including family stress, coping skills, parenting capacity and family functioning. Assessment tools are essential in providing a clear picture of family strengths and needs, and provide a standard decision-making process. Learning Initiatives will be expected to examine the assessment tools currently used by service providers, particularly public health nurses who have a key role in the provision of early postpartum support. Questions to consider include:

- What assessment tools are currently used by public health nurses for families identified through the Nursing Priority Screening tool as "high priority"?
- How are the tools used to shape the decision for follow-up?
- What are the challenges in using the tool?

It is anticipated that the Learning initiatives will identify at least one family assessment tool to use for families screened by the Nursing Priority Screening Tool.

6.3.3   High Priority Parenting Program

The High Priority Parenting Program was initially developed in the early 1980s to provide guidance to provincial health units in the delivery of public health nursing services to families with identified parenting concerns. In 1996, the guidelines were reviewed and updated to reflect the current research and the changing nature of nursing services and community resources. A copy is included in the support materials.

Many health units have used the document as a resource from which to build their own initiatives to meet local needs. As Learning Initiatives review their current structure and service networks, they are encouraged to use the High Priority Parenting Program as a basis on which to plan and prioritize services. In particular, the document provides guidance on incorporating a family's strengths into the assessment and planning.

Many health regions have extensive experience using the Nursing Priority Screening Tool and the High Priority Parenting Program. It is anticipated that the Learning Initiatives will incorporate the use of the tool and the program guidelines into their postpartum model of care in a way that enhances screening efforts and the integration of service delivery.

6.3.4   Screening for Postpartum Depression

It is estimated that between 10%-20% of women experience some degree of postpartum depression during the first year after birth, and many remain untreated. Untreated postpartum depression can have a devastating effect on the well being of the mother, the mother's relationship with her infant, and her relationship with her partner and other family members.

Screening for postpartum depression is vitally important as many women attempt to conceal their struggles with depression from those around them, embarrassed that their feelings are not "motherly". Often, a woman feels a degree of self-blame when she finds that instead of feeling happy and content being a mother of an infant, she feels withdrawn and despondent. Fortunately, the outcome for women who receive appropriate treatment for depression is good; approximately 65% recover within a year.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals to detect mothers suffering from postnatal depression within the first 6-8 weeks after delivery (Cox et al.,1987). It consists of 10 short statements, each followed by four possible responses. The mother is asked to underline the statement which best reflects how she has felt during the past week. Most mothers complete the scale without difficulty in less than five minutes.

The EPDS is recommended by the National Guidelines for Family-centred Maternity and Newborn Care (2000) and has been recently adopted for wide use in Newfoundland. The tool has been selected for use by the Learning Initiatives to identify women at-risk for postpartum depression.

6.4   Universal Newborn Hearing Screening

The Learning Initiatives provide an opportunity to explore ways to improve on the current method of identifying infants who are at-risk for hearing loss. Currently, most regional health boards utilize what is known as the High Priority Hearing Registry (HPHR). This is a questionnaire containing five or seven case history or physiological criteria known to be associated with increased risk of congenital or delayed onset hearing loss. Newborns who are identified by the registry as being "at-risk" are referred for behavioural hearing assessments at 6 months adjusted age, with follow-up for those infants with risk criteria associated with delayed onset or acquired hearing loss.

It has long been established that this method misses half of the infants who actually have a hearing loss, since in many cases the hearing loss is of unknown aetiology. Furthermore, the average age of identification of congenital hearing loss in BC, using the HPHR, is 18 months of age, well past critical periods for speech and language development. Without a screening program such as the HPHR, the average age of confirmation of congenital hearing loss increases to 44 months of age.

In March 1999, the Public Health Audiology Council of BC (PHAC) prepared a best practices document on identification of hearing loss in infancy. It was recommended that a Universal Newborn Hearing Screening (UNHS) program be implemented in the province with the goal being to identify more infants and at an earlier age than is currently done.

Recently, the provinces of Alberta and Ontario both announced the development of UNHS in their jurisdictions. Within BC, the Capital Health Region has implemented UNHS beginning in early 2001. In the United States, federal legislation is supporting state-wide UNHS programs; and other countries, such as Australia, are also moving in that direction.

The screening technology involved in UNHS involves the use of one or a combination of two physiologic measures – OtoAcoustic Emissions (OAE) and

Automated Auditory Brainstem Response (ABR) – during the first month of life. Newborns identified by the OAE/ABR screening test as being "at-risk" are then followed up by either an additional community based screening or referred for a diagnostic ABR. This diagnostic assessment provides the clinician with a frequency-specific measurement providing direction for early support. Both audiologic and medical evaluation to confirm the presence of hearing loss and to determine type, nature, options for treatment and (whenever possible) aetiology of the hearing loss, should occur before 3 months of age.

The rationale for this recommendation is as follows:

- The incidence of hearing loss in newborns is higher than any other health condition for which newborn screening is currently performed.
- Early identification of hearing loss and appropriate intervention and treatment before six months of age has a significant impact on speech and language development. This is apparent for those with mild through profound hearing loss.
- Speech and language development is critical for a child's learning but also for his or her emotional well-being and future potential.
- Children with a hearing loss who are not identified early and who are not provided appropriate intervention require long-term special education services at a significant cost to the public.
- Experience with UNHS in other jurisdictions reveals that the test correctly identifies children with hearing loss and has an acceptable false positive rate.

6.4.1   Intermediary Models

It is recognized that implementing a UNHS program in the first phase of the Learning Initiatives would be ambitious. However, there are a variety of models Learning Initiatives may wish to consider. At the minimum, Learning Initiatives will be expected to utilize the High Priority Hearing Registry if it is not already in use. As more information is gathered about the feasibility of implementing a UNHS, communities may wish to embark on an intermediary model that combines the use of the registry and the OAE/ABR physiologic screening on a targeted group of the population. All infants identified as being at-risk for hearing loss through the OAE/ABR route would receive community-based screening or diagnostic ABR assessment within four weeks of the referral. Confirmation of the hearing loss and determination of type and degree would be achieved by three months of age.

Intermediary models, which would confirm the presence of congenital hearing loss by age three months in the targeted populations are:

1. All infants identified through the HPHR as being at-risk could be screened using OAE/ABR measures.
2. All infants admitted to the NICU for more than 48 hours, plus all other infants with a family history of hearing loss.

3. All infants admitted to the NICU for more than 48 hours, plus all infants identified through the HPHR as being at-risk.

Each of these models would need to be combined with a protocol for identifying infants with delayed onset or acquired hearing loss.

Either approach has the following benefits:
- More infants could potentially be identified at a younger age as having a hearing impairment, with appropriate intervention in place by six months of age.
- Families with infants identified at birth as being at-risk for congenital hearing loss would not have to wait until the child is six months of age, thus reducing anxiety for the parents.

6.5   Developmental Screening and Surveillance

A literature review of developmental screening tools used in public health nursing practice was prepared for the Ministry of Children and Families by Butler and Geber in 1998. This document provides an overview of the current literature on the wide variety of tools available and different approaches to developmental screening and monitoring. A complete copy of the review available and listed in the Resources section.

An important point made in the literature review was that developmental monitoring of children should not be confined to the periodic use of screening tools at fixed ages. Instead, the use of a surveillance model is recommended. Butler and Geber (1998) state that a sound developmental surveillance model include the following characteristics:

- It provides a flexible continuous process involving input from health professionals, parents, childcare workers, parents and others.
- The child is viewed as a whole and, wherever possible, in the context of their normal environment.
- Observations of developmental progress are performed during all child health encounters.
- Developmental milestones are reviewed with the parents.
- Clinical judgement and observation skills are relied on.
- Developmental surveillance does not preclude the use of screening or prescreening tools. Indeed, screening tests should be incorporated into the larger process.

In order to achieve this dynamic and integrated approach, it is essential that learning initiatives look at innovative ways to enhance the skill level of all service providers who have access to preschool children. One example would be to provide training on early childhood development to a cross-section of service providers such as PHNs, early childhood educators, social workers, community centre staff, and library staff, to name a few. Providing training to mixed professional groups can

generate cross-disciplinary discussions, a better appreciation for each other's roles, and promote partnerships on local initiatives.

6.5.1   Parent-involvement Screening and Monitoring Activities

There has been an evolution in the nature of infant screening and assessment to move from a focus on professional assessment of only the infant/child to a more inclusive partnership with the parents (Long, 1992). Squires, Nickel, and Bricker (1990) list five reasons to utilize parent input in screening:

1. Parents possess more complete information not readily available to professionals such as developmental history, personality characteristics, social-emotional adjustment, and functioning in the home environment.
2. By involving parents as partners, the groundwork is set for collaborative relationships which can also lead to increased parent participation in early support initiatives should their child need them.
3. It is cost effective. Utilizing parent-completed tools allows for greater numbers to be screened. Professionals can then focus their attention on families needing assistance due to low literacy and/or language barriers and follow-up with infants and young children needing early support services.
4. Parents increase their own knowledge of early childhood development and ways to enhance their children's progress.
5. Parent-completed tools can invite/elicit questions and concerns from parents in a more active manner.

For these reasons, the developmental screening process will involve the active participation of parents in the completion of the tool. When literacy or language barriers exist, professional assistance should be available.

Parents should be provided with information on healthy infant/child development at every opportunity such as in immunization clinics, physician waiting rooms, child care settings, family resource programs, recreation programs, schools, women's shelters, and hospital settings. Learning initiatives will need to examine what kinds of information to provide that is appropriate for their community, and to ensure parents have an access point to call for assistance as questions arise about their child's development.

6.5.2   Ages and Stages Developmental Screening Tool

Ages and Stages Questionnaire (ASQ): A Parent-Completed, Child-Monitoring System, Second Edition (1999) has been selected as the developmental screening tool for the Learning initiatives. Selection of this tool took into consideration the "Screening Tools Criteria" developed by Butler and Geber (1998). Studies on the most recent 1999 edition of the ASQ show that it is a reliable and valid screening instrument. The tool is used by the National Longitudinal Survey of Children and Youth and the BC Infant Development Program. A recent survey of public health units in BC also revealed that the ASQ is the most commonly used screening tool. Eight health regions have started

using the tool during the last two years and seven more are considering using it in place of the Denver Developmental Screening Test.

The tool has been expanded to include eight additional age intervals for a total of 19 questionnaires designed to be completed by parents or other primary caregivers. Questionnaire intervals include 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age. Each questionnaire contains 30 developmental items written at a reading level from the fourth- to the sixth-grade level. Illustrations are also added to provide more clarity. Translations are also available in Spanish. Items can be divided into five areas of development: communication, gross motor, problem solving, and personal-social. A new companion tool including social-emotional components will be available for field testing in the near future.

6.5.3   Children Under 18 Months of Age

Since only 1%-2% of the general population of children between 0 and 24 months of age are found to have developmental delays (Wolraich, 1996), it is imperative that accessing children during the first 18 months is done in a cost-effective and efficient manner. Because all infants will be screened using the Nursing Priority Screening Tool, moderate and high risk infants and their families can receive follow-up and early support services which will include developmental monitoring by professionals and trained paraprofessionals. Infants and their families who are not identified at-risk will benefit from the system of promotion and prevention services available in the community that will include health promotion materials on childhood development.

6.5.4   Children At 18 Months of Age

Universal developmental screening at 18 months of age is a key component in the Learning initiatives for the following reasons:
- Children reach significant developmental milestones at this age.
- It coincides with the 18-month immunization schedule.
- It provides an opportune time for families to receive anticipatory guidance in dealing with the toddler years.

The screening can be conducted in a variety of ways:
- In communities where most of the immunizations are done by Public Health, the ASQ questionnaire could be provided to parents to complete during the 15-minute post-immunization observation time. Extra staffing time may be needed to review the results with parents and address questions/concerns raised.
- In communities where the majority of immunizations are provided by family physicians, the Learning initiatives will need to explore how physicians could be involved. The Learning initiatives may wish to explore the feasibility of mailing out questionnaires to families who do not access public health immunization clinics and also pilot the tool with interested physicians.

6.5.5 Children At 3 Years of Age

Three years of age is an opportune time to screen children again for developmental challenges in addition to dental, vision, and nutritional concerns. This touch point will rely on a collaborative approach involving the various sectors of professionals, agencies and services who have contact with preschool children. Utilizing the various age-intervals provided in the ASQ will provide flexibility, as not all children will be screened at exactly three years of age. Learning initiatives will need to consider the following in their planning:

> The Eastern Fraser Valley has a pilot project where 3 year olds are screened by childcare providers in a childcare setting. This is an excellent example of collaboration between Public Health and the Child Development Centre facilitated by the Learning Initiative.

- How can the parent community be involved in helping to plan effective outreach strategies?
- How can parents be accessed through the sites where they naturally congregate such as malls, schools, family resource centres, child care centres, food banks and recreation centres?
- How can the child-care sector be involved?
- How can the local school boards be involved? Is there a way to link early school registration with early identification of developmental challenges?
- How can screening and data collection efforts be coordinated to ensure appropriate follow-up?
- What strategies could be used to collect information on the number of children screened and identified through the collaborative approach?
- What supplemental strategies could be employed to reach the "hardest-to-reach" families?

6.6   Nutrition Screening

Learning initiatives may wish to consider utilizing a simple parent-completed nutrition checklist included in the appendix. This tool was developed by Helen Yeung of the Vancouver/Richmond Health Board. The main purpose of the tool is to identify a child at nutritional risk for iron deficiency anaemia, failure to thrive, growth problems, and other nutrient deficiencies. Learning initiatives will need to consider how the results of the tool would be used and the availability of follow-up services and supports for families identified. This questionnaire has not been tested, hence it is being described as a checklist versus a screening tool. Learning Initiatives are welcome to make changes to the tool, adopt another tool, or continue with current strategies used to assess families for nutritional concerns.

6.7   Vision Screening: Vision First Check

A child's eyes develop rapidly at an early age. While they might appear to be growing normally, developmental problems are often apparent only to trained professionals. Many parents do not realize that the 2nd and 3rd year in their child's is the ideal time to screen vision.

A partnership between the former Ministry for Children and Families, now the Ministry of Health Services and the B.C. Association of Optometrists is making sure that this window of opportunity for eye health in a child's life is not missed. Vision First Check is a screening program for three year-olds designed to prevent, identify and treat vision problems before permanent eye damage occurs.

> This collaborative initiative is currently in effect in 10 areas of B.C.: Capital Health Region, Cariboo, Central Vancouver Island, Coast Garibaldi, East Kootenay, Kootenay-Boundary, Northern Interior, North Shore, Northwest, and Upper Vancouver Island. It is hoped the program will expand to other areas during the next year thus increasing access to promotional material throughout the province.

6.8   Dental Screening: Smile Savers

Early childhood caries (ECC), or nursing bottle tooth decay, is rampant caries in the primary teeth of infants and toddler. ECC is caused by frequent and prolonged exposure of the teeth to sugar and the bacteria streptococcus mutans. The relationship between a mother's oral health and that of her infant is important. Dental caries is an infectious disease, and reducing a mother's cavity-causing bacteria will limit the amount of bacteria that is passed on to her baby. Most cases of ECC are preventable, but early detection is necessary to prevent or stop the progression of this disease.

Each year more than 5000 British Columbian children undergo a general anaesthetic to treat ECC. Dental procedures are the most common surgical procedure that children receive in hospitals. A hospital setting is often required for children's dental procedures, due to their young age and the length of time required for treatment. he cost to treat ECC in a hospital setting can range from $1,500 - $2,500 per case. he cost to the BC's health care system is $7,500,000 to $12,500,000 per year.

Approximately 40% of children entering Kindergarten have existing or restored caries. Untreated dental decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school and reduced self-esteem. Children are often unable to verbalize their dental pain. The present state of children's oral health has been referred to as a "silent epidemic of dental and oral diseases."

How Can ECC be Prevented?

Oral health care is a critical component of health care and must be included in the design of community programs. Learning Sites have the opportunity to build collaborative programming with agencies and allied health professionals who provide services to over burdened families – where the rates of ECC are greatest. They can provide education to parents and care givers on oral hygiene practices

and appropriate feeding habits for their children. Parents can be taught "Lift the Lip" technique to be alerted to the early signs of decay. Caught early, the decay process can be halted by the use of fluoride varnish. This is a simple preventative technique that results in a 25% - 75% reduction of ECC. It is one of the most useful new tools for caries prevention in a public health setting.

There is a potential to virtually eliminate dental caries in all our children. Using the most effective prevention techniques (fluoride varnish), providing the skills and techniques to families and care givers to detect early signs of ECC (as well as medical providers) and support to families to implement ECC-preventive feeding practices will have a dramatic impact on reducing ECC in our communities.

8.0 Appendix IV: Planning for Universal Newborn Hearing Screening

While there are many strong arguments for a move towards implementing a full Universal Newborn Hearing Screening program in a community, there are also issues that need to be addressed before a model is designed and implemented. These include resource implications, training needs, access issues, and the need to respond to a higher number of young infants with a range of hearing loss. For this reason, Learning Initiatives are encouraged to embark on a carefully considered process in developing their model. The first step is to create a local task force to lead the exploration of options and make recommendations to the Learning Initiatives Steering Committee.

Questions to consider:

What are the characteristics of the population to be screened?
- How many infants are born per year in the Learning initiatives community?
- Are these infants born in primarily one birthing hospital or is there more than one hospital to consider?
- Do many families have to travel far to the birthing hospital?
- Are there many infants born at home in the community?
- Does the hospital(s) have a newborn ICU?

What are the discharge patterns for newborns and mothers:
- How soon are newborns and their mothers discharged from hospital after delivery (consider both vaginal and c/s births)?
- What is the model of newborn follow-up in the community? Are all newborns seen by public health within a few days of discharge? Do mothers routinely have follow-up appointments with a physician?

To what extent is the High Priority Hearing Registry utilized in the community?
What is the capacity of the local audiology clinic?
- What services exist for infant diagnostic assessment and follow-up within the first three months of age?
- Does the clinic have access to diagnostic ABR and diagnostic OAE?
- Does the clinic deliver the BC Hearing Aid Program?
- Does the clinic have an inventory of loaner hearing aids that can be accessed by newborns within one month of diagnosis?
- Does the clinic have a waitlist for infant and child audiology assessments?
- How would the clinic manage the increased referrals of infants for diagnostic assessments and hearing aid evaluations?
- What are the challenges for families to access the services at the audiology clinic?
- Does the clinic have a parental referral system for child assessments?
- How would the clinic manage the identification of delayed onset or acquired hearing loss?

What is the availability of the UNHS technology?

- What access is there in the community for the necessary equipment to conduct OAE and Automated ABR screening on newborns?
- If the screening were to happen in a birthing centre, are there sufficient birth numbers to warrant a screener coming in daily (7 days/week)? If not, how could this task be incorporated into current staffing to ensure infants are not missed?
- What could be the challenges for families in the area to access the technology?
- What resources would be needed to ensure the equipment is maintained?

What are the potential implications of identification of young infants with hearing loss?
- What early supports are in the community for families of young infants who have been referred for diagnostic assessment because of being at-risk for hearing loss?
- What early supports are in the community for families of young infants diagnosed with a hearing loss?
- Families will need to have access to general information on child development and specific information on hearing loss and language development. What supports are in the community to assist families in accessing this information?
- Where is the expertise in the community in supporting parents who are dealing with the recent diagnosis of a health problem in a newborn?
- Where is the medical expertise in the community for assessing medical intervention?
- What capacity does your community have to meet the amplification needs of newborns, given the financial implications for parents?
- What follow-up system will need to be implemented?

What are the potential training needs for staff?
- How many staff would need to be trained in screening and diagnostic procedures?
- How will the training be accessed?
- Are there implications for union agreements in relation to tasks performed and work schedules (i.e., births occur 7 days a week, and screenings in hospital prior to maternal discharge must accommodate this schedule)?
- Will a turnover of staff affect training plans?

How can the initiative be evaluated?
- What can be learned from the planning process?
- What tracking mechanisms are in place or could be employed?

> Eastern Fraser Valley Experience: Learning Initiative funding was used to purchase additional audiologist time to research the viability universal newborn hearing screening and make recommendations.

─ It is recognized that implementing a UNHS program in the first phase of the Learning initiatives would be ambitious. However, there are a variety of models Learning initiatives may wish to consider. At the minimum, Learning initiatives will be expected to utilize the High Priority Hearing Registry if it is not already in use. As more information is gathered about the feasibility of implementing a UNHS, communities may wish to embark on an intermediary model that combines the use of the registry and the OAE/ABR physiologic screening on a targeted group of the

population. All infants identified as being at-risk for hearing loss through the OAE/ABR route would receive community-based screening or diagnostic ABR assessment within four weeks of the referral. Confirmation of the hearing loss and determination of type and degree would be achieved by three months of age.

Intermediary models, which would confirm the presence of congenital hearing loss by age three months in the targeted populations are:

4. All infants identified through the HPHR as being at-risk could be screened using OAE/ABR measures.
5. All infants admitted to the NICU for more than 48 hours, plus all other infants with a family history of hearing loss.
6. All infants admitted to the NICU for more than 48 hours, plus all infants identified through the HPHR as being at-risk.

Each of these models would need to be combined with a protocol for identifying infants with delayed onset or acquired hearing loss.

Either approach has the following benefits:
- More infants could potentially be identified at a younger age as having a hearing impairment, with appropriate intervention in place by six months of age.
- Families with infants identified at birth as being at-risk for congenital hearing loss would not have to wait until the child is six months of age, thus reducing anxiety for the parents.

Intermediary Models for UNHS
It is recognized that implementing a UNHS program in the first phase of the Learning initiatives would be ambitious. However, there are a variety of models Learning initiatives may wish to consider. At the minimum, Learning initiatives will be expected to utilize the High Priority Hearing Registry if it is not already in use. As more information is gathered about the feasibility of implementing a UNHS, communities may wish to embark on an intermediary model that combines the use of the registry and the OAE/ABR physiologic screening on a targeted group of the population. All infants identified as being at-risk for hearing loss through the OAE/ABR route would receive community-based screening or diagnostic ABR assessment within four weeks of the referral. Confirmation of the hearing loss and determination of type and degree would be achieved by three months of age.

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- All infants admitted to the NICU for more than 48 hours, plus all other infants with a family history of hearing loss.
- All infants admitted to the NICU for more than 48 hours, plus all infants identified through the HPHR as being at-risk.

Each of these models would need to be combined with a protocol for identifying infants with delayed onset or acquired hearing loss.

Either approach has the following benefits:
- More infants could potentially be identified at a younger age as having a hearing impairment, with appropriate intervention in place by six months of age.
- Families with infants identified at birth as being at-risk for congenital hearing loss would not have to wait until the child is six months of age, thus reducing anxiety for the parents.

8.0   Appendix IV: Monitoring and Evaluation

8.3   Goals, Objectives and Outcomes

A formative evaluation framework has been developed for the learning initiatives. This will provide guidance to the regions as they develop their own evaluation frameworks that are unique to their community. The following has been used for Year 1.

8.2 Capturing the Experience

The experiences and "stories" of the learning initiatives will also be essential to demonstrate and illustrate the challenges and success of the communities as they progress towards the project's goals. Documentation of this aspect of the process is essential if other communities are to learn and get guidance from the experience of the learning initiatives. This information will be provided centrally through status-reporting frameworks to be developed collaboratively between the learning initiatives and the Ministry of Children and Family Development's Early Childhood Development Team.

8.3   Process Evaluation: Year 1

Purpose

This paper presents a set of goals, objectives and outcome statements to be used by PP&ES Learning initiatives in evaluating the effectiveness of planning and implementing the **Make Children First Project**.

The benefits of early childhood care and development already have a strong evidentiary base. What is not so clearly known is how positive outcomes are affected from the perspective of planning for specific community-based services. Outcome-oriented evidence of effective community-based service delivery planning from geographically and demographically diverse Learning initiatives communities will become the basis for developing a provincial model of community-oriented, strengths/assets-based service delivery to families of children preconception to school entry.

The following framework associates goals, objectives and outcomes with each stage of planning community-based services. Implementation Managers should refer to the ***Draft Guidelines for the Make Children First Learning initiatives*** for guidance regarding the specific planning and implementation expectations for each stage and the initiative overall.

NOTE RE EVALUATION

Following is the goal, objective and outcome of the **learning process** associated with the Make Children First Initiative:

Goal – The knowledge- and evidence-base and capacity to judge the effectiveness of the **learning process** associated with the Make Children First Initiative.

Objective – To develop and implement an evaluation framework following the Community-Based Evaluation model.

Outcome – The community has identified/developed the partnerships, data sources, tools and expertise necessary to provide evidence of the effectiveness of the **learning process** associated with the Make Children First Initiative.

PRIORITIZING PROJECT STAGES / EVALUATION DEADLINES

The project stages have been prioritized in relation to how the project should generally progress. Obviously, activities associated with each stage of the project will occasionally overlap, run concurrently, or change order to accommodate effective achievement of the project objectives. The evaluation frameworks developed by the Learning initiatives should be mindful of the priorities assigned to the stages, since it is assumed that the success of later stages of the project will depend to a great deal on whether, and to what effect, the objectives of the earlier stages have been achieved.

NOTE: TIMELINES ARE UNDER REVISION AND BEING DETERMINED BY EACH SITE   There are **three deadlines** associated with the evaluation. Evaluation of **Stages 1 to 3** must be completed and reported on by **March 31, 2001** (i.e., end of the Ministry's fiscal period). Evaluation of **Stages 4 to 6** must *begin within the next two (2) months*, with a **preliminary report** on the evaluation of these stages included in the **March 31** report. It is recognized that Stages 4 to 6 will require considerable time to evaluate, especially since they may require research designs that rely on data collected over time. **Final evaluation results for Stages 4 to 6** are due **June 30, 2001**. The evaluation deadline for **Stages 7 and 8** is also **June 30, 2001**. The **June 30** report should also contain the *assessment of the Learning Site's achievement of the overall objectives for the project*.

Make Children First Learning initiatives – Overall Program (Evaluation Deadline June 30, 2001)

Goal 1 – To implement a vision & comprehensive plan for ensuring a community resource base which is oriented toward promoting the wellness of families & children preconception to school entry.

Objective 1 – To develop a vision & implementation plan for Integrated Service Delivery (**ISD**) in the community.

Outcome 1 – Infrastructure exists which values, nurtures, & enhances the development of families & children preconception to school entry.

Goal 2 – To implement a vision & plan for promoting community attitudes which value early childhood development (**ECD**).

Objective 2 – To develop a vision & implementation plan for reinforcing existing community values in support of early childhood development (**ECD**), and promoting change in community attitudes toward greater valuing of the ECD and its benefits for families and children preconception to school entry.

Outcome 2 – Community acknowledges the value of early childhood development (**ECD**) and endorses a plan to promote & enhance the early development of children preconception to school entry.

Stage 1. Implementation Mgr/Team (Evaluation Deadline March 31, 2001)

Goal – Community-focused leadership in the daily operation of the Learning Site.

Objective – To designate a community implementation manager / team.

Outcome 1 – Operational leadership will have the capacity to co-operate in service delivery co-ordination / resource management with primary community & Ministry stakeholders.

Outcome 2 – A program which demonstrably avoids or minimizes any negative resource impacts on established programs attributable to the introduction of new programming.

Stage 2. Community Steering Committee (Evaluation Deadline March 31, 2001)

Goal – The capacity to make community service decisions with the benefit of advice, guidance & validation from the community.

Objective – To establish a reasonably representative Community Steering Committee.

Outcome – The Community Steering Committee is broadly & fairly representative of community interests & shares a common vision.

Stage 3. Community Mapping – A) Resources (Evaluation Deadline March 31, 2001)

Goal – A comprehensive awareness of the community's assets / resources for families & children preconception to school entry.

Objective – To develop, maintain & promote the use of a community map of the community's assets / resources for families & children preconception to school entry.

Outcome – The community – planners, service providers & families – will improve their awareness & use of the community's assets / resources for families & children preconception to school entry.

Stage 3. Community Mapping – B) Demographics (Evaluation Deadline March 31, 2001)

Goal – The capacity to predict & plan for the program resource needs of families & children preconception to school entry.

Objective – To develop a plan for addressing the resource needs of families & children preconception to school entry based on demographic & geographic profiles of the community consumer base.

Outcome – The community will improve its understanding of the community's utilization of, & need for, resources for families & children preconception to school entry.

Stage 4. A Child- & Family-Friendly Community Facilitated Through Strength-Based Service Delivery (Evaluation Deadlines: Preliminary, March 31, 2001; Final, June 30, 2001)

Goal – The capacity to plan, model & measure improvements in the "child & family friendliness" of the community, as facilitated through a strength-based service delivery system, for families & children preconception to school entry.

Objective – To develop & apply a framework, modeled on strength-based service delivery, which articulates the goals & objectives of the community for planning, modeling & measuring improvements in the "child & family friendliness" of the community.

Outcome – The community will improve its ability to implement, monitor & report on improvements in the "child & family friendliness" of the community within the context of a strength-based service delivery system.

Stage 5. Screening & Assessment (Evaluation Deadlines: Preliminary, March 31, 2001; Final, June 30, 2001)

Goal – A comprehensive awareness of the availability & utilization of screening & assessment tools / resources in the community.

Objective 1 - To develop & maintain a community Screening Array for families & children preconception to school entry.

Objective 2 – To develop a priority list of screening & assessment tools / resources which the community lacks.

Objective 3 – To develop a strategic plan for optimal utilization of existing community screening resources and / or the development of appropriate screening resources which the community lacks.

Outcome – The community will improve its understanding of what actions are required to address the lack of screening & assessment tools / resources, & / or to optimize the utilization of existing tools / resources.

Stage 6. Community Awareness (Evaluation Deadlines: Preliminary, March 31, 2001; Final, June 30, 2001)

Goal 1 – The community as a whole is aware of the developmental issues & challenges of all families of children preconception to school entry.

Objective 1 – To deliver a public awareness campaign focusing on the developmental issues & challenges of all families of children preconception to school entry.

Outcome 1 – Community is noticeably more aware of the developmental issues & challenges of all families of children preconception to school entry.

Goal 2 – The community as a whole is aware & supportive of the **Make Children First Project**, its service principles, goals, & benefits to the community.

Objective 2 – To deliver a public awareness campaign focusing on the benefits of the **Make Children First Project** to the well-being of all families & children preconception to school entry.

Outcome 2 – Community is noticeably more aware & is supportive of the **Make Children First Project** & its benefits.

Stage 7. Program Standards

Goal – To understand the particular service needs & community resources necessary to ensure relevance & equity in the community service delivery system for families & children preconception to school entry.

Objective 1 – To identify the resources necessary to address community service gaps.

Outcome 1 – Community has an improved understanding of the "fit" between community assets / resources & consumer needs for families & children preconception to school entry.

Objective 2 – To investigate & document strategies for determining the appropriateness of the resources with which service gaps are filled.

Outcome 2 – Community has an evidence-based, outcomes-oriented implementation plan for optimizing the relevance & equity of its service delivery system for families & children preconception to school entry.

Stage 8. Service Enrichment / Building on Opportunities

Goal – The capacity to "enrich" the community service base for families & children preconception to school entry as resources become available.

Objective – To gain the insight of community interests regarding the appropriate mix of tools & resources to achieve an "enriched" service delivery system.

Outcome – Community has a workable, consultation-oriented plan for "enriching" the service delivery mix.

8.4 What Have we Learned to Date?

The Make Children First Learning Initiative is not a stand-alone program or service. It is designed to learn about the links and integration of all types of community supports that have been demonstrated to support healthy, early childhood development. The initiative is an opportunity to experience formal supports and infrastructure, which can bring multiple resources together for a common goal, i.e., healthy children.

Key Learning from Prince George

– An established and functioning collaborative community structure needs to be in place
– Dedicated and ongoing leadership and funding/resources
– Program flexibility is critical to ensure that community based solutions are sought for community identified needs. very complex issues.
– There are many good resources available in community but are often uncoordinated and are not maximized..
– Building an aboriginal component to the project has taken careful and methodical work that is respectful
– Building community capacity underlies much of the community and organizational action planned.

Key Learning Eastern Fraser Valley

– By working collaboratively, we will enhance the lives of children in our area.
– We can be most effective when we link services and supports, so that families experience a seamless continuum of supports.
– Building on strengths is far more effective than focussing on deficits.
– It takes more than services to support families and children. It takes the whole community.
– We need to listen to families, ensure that they are participants in the process, and respect their needs and wishes.

- Improved understanding of what families need want and benefit from.

Key Learning from Port Alberni and the West Coast

- Early childhood experiences make a critical and long-term difference in children's early development, and in their health and well being during childhood and as adults.
- Providing support to children and their families within an integrated, comprehensive and responsive system of services facilitates optimal early childhood experiences.
- In order for this system to be effective it must employ an ongoing, inclusive process of planning, implementation and evaluation.
- Ongoing support is vital in ensuring that this system of services has the capacity to provide this essential support to children and families.

A framework and/or practice which focuses on promoting appropriate learning opportunities for children and their families that build capacity rather than remediate deficits has been well-received by the community.

Examples of how this framework and practices are implemented are as follows:

- Interdisciplinary subcommittee explored new technology and best practice principles: Port Alberni Speech Services have reoriented its practice and service delivery model, which has eliminated the waitlist for this service.
- Families with limited resources felt frustrated with their perceived "lack of access" to learning opportunities for their children. These families also demonstrated a "limited awareness" of available Learning 0pportunities. Together the community and families are addressing these concerns.
- A multi-disciplinary Literacy subgroup of the Make Children First Advisory are gathering and reviewing early literacy resources.

9.0   Appendix V: Resources
9.1 WEB Resources
9.1 developmental screening tools used in public health nursing practice was prepared for the Ministry of Children and Families by Butler and Gebe

10.0 Appendix VI: Expectations
10.1 It is an expectation that the learning initiatives:
- establish a representative community steering committee,
- establish an implementation manager position
- complete a community mapping process;
- administer the EDI,
- develop innovative strategies to engage all members of the community thus increasing access to screening and subsequent supports and services,
- take the lead on the examination least one aspect of universal screening.

11.0 Forms

Parkyn Tool The personal information collected relates to and is necessary for program operations and will be kept confidential in compliance with the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection and use of this information, contact your Health Unit Nutrition staff.

NURSING PRIORITY SCREENING

August 2000

Revised for Learning Sites

A.	CHILDREN WITH KNOWN DISABILITY

1) Congenital anomaly
   a) Major (probability of permanent disability) e.g. Down's Syndrome, Cerebral palsy, F.A.S. 9
   b) Moderate (correction may be possible) e.g. Cleft palate 6

B.	DEVELOPMENTAL RISK FACTOR

2) Low birth weight
   a) 0 – 1499 gm...9
   b) 1500 1999 gm..8
   c) 2000 – 2499 gm..6
3) Bilirubin level over 500 umo/L 8
4) Complications of pregnancy
   a) Infections that can be transmitted in utero and may damage the fetus (e.g. rubella) 9
   b) Drugs – e.g.: alcohol use diagnosed in mother 9
5) Complications of labour and delivery
   a) Labour requiring mid forceps including breech delivery with forceps 4
   b) Infant trauma or illness (e.g.: convulsions, respiratory syndrome..6
   c) Apgar at 5 minutes only if less than 7. Deduct apgar score at 5 minutes from 10 points ....__
6) Family history of a disability not detectable at birth that could affect development
   e.g.: deafness, mental disability...4

C.	FAMILY INTERACTION RISK FACTORS

7) Age of mother   a) 15 and under...9
        b) 16 or 17 8
        c) 18 or 19 5
8) Social Situation
   a) Father of infant not resident but other support available..2
   b) Father not resident and no support 7
   c) Father resident and supportive but no other social support, or severe isolation or geography 4
9) On social assistance or financial difficulties 4
10) No prenatal care before sixth month 3
11) Mental illness or disability in mother and/or father
   a) Schizophrenia or manic depression...7
   b) Postpartum depression with this baby 9
   c) Mental disability of parent 6
12) Prolonged postpartum maternal separation (5 days or more)
   a) With frequent infant contacts (visits or phone as feasible) 2
   b) Little or no contact 6
13) Assessed lack of bonding e.g. eye contact, touching, etc. minimal..6
14) Other lack of bonding e.g. family distress/violence, low education status, failure to thrive, difficulty parenting
   an older child, parental history of being abused/neglected, current substance abuse by either parent, etc(score 1-9)
   _____

15) Any other factors/comments not included above
   _____
   _____
   _____

Priority Score: 9 and over = high priority;   6 to 8 = moderate priority;
                 3 to 5 = low priority   0 to 2 = minimal priority

Total Score:_____

If referred for further assessment, indicate where_____

Guidelines for the Nursing Priority Screening

This screening form is intended for completion by public health nurses after their postnatal contacts with mother/babe/families.

Valuable information to assist the public health nurse complete the form may be obtained from:

> Hospital nurses
> Early Maternity Discharge nurses
> Physicians
> Records and referral forms

in addition to direct contacts with the client and family.

Public Health Nurses are reminded that this tool is for screening in the postpartum period and is not intended as a full assessment. If a child is identified as at risk by the screening, additional assessment will be needed before plans are developed. The level at which further assessment and planning takes place is a regional policy decision. However, as a minimum it would be expected that those screened at 9+ would get further assessment.

Most of the categories are self explanatory but a few benefit from additional explanation:

No. 3   Bilirubin Level
> Although 500 umd/L is an accepted level for health full term infants (BCRCP and American Academy of Pediatrics), a lower level e.g. 400/umd/L. may be considered for premature sickly babies.

No. 9 Social assistance is obvious. Financial difficulties are defined as insufficient money to cover basic e.g. mortgage/rent, food, clothes, baby needs, etc.

No. 11
  b)   Postpartum depression here refers to a mother diagnosed with this baby. A history of previous depression may be noted under 15 as a flag for extra attention/support during this postpartum but does not necessarily lead to a concern for the baby at this time.

No. 14

Scoring is left open as most of these concerns fall on a continuum. E.g. difficulty raising an older child could be minor i.e. lack of knowledge on managing a sibling's behaviour to major such as apprehension of the older child. Hence the score might be 2 or 3 in the first situation or 9 in the latter.

Nursing judgement is to be used to decide the degree of concern and thereby the appropriate score.

No. 15

This is left open for additional comments that may have short or long term significance. Examples:

> As noted previously a history of postpartum depression with significance this time as yet unknown.

It could be concern about smoking behaviour especially if the smoking is in the immediate vicinity of the child.

The physical environment of the house or the apartment.

NUTRITION CHECK ✓ for your Kindergarten child

☺ Food Allergies?
    ☺ Cookie Monster?
        ☺ Picky Eater?
            ☺ Weight Concerns?

Eating well is one of life's great pleasures. It helps your child be healthy, strong and happy. NUTRITION CHECK gives you an idea of how well your child is eating.

Your Community Nutritionist is available at the immunization clinic (or later by phone) to discuss any concerns you have about your child's nutrition. We invite you to come to a discussion oriented class "Nutrition for KinderKids". Please sign up today!

Check (✓) all that apply MOST OF THE TIME:

A. **ABOUT FOOD:**
YES

☐ 1. My child drinks at least 2 childsize glasses of milk per day.

☐ 2. My child is offered vegetables at least 2 times a day (for e.g. potatoes, carrots, tomatoes, broccoli, peas, squash, salad, etc.)

☐ 3. My child eats fruit every day (for e.g. bananas, oranges, raisins, peaches, apricots, apples, etc.)

☐ 4. My child drinks less than 2 childsize glasses of juice or sweet drinks (e.g. pop, fruit beverages, lemonade, koolaid) per day.

☐ 5. My child eats meats or alternatives 2-3 times a day. (Alternatives could be fish, poultry, peanut butter, tofu, kidney beans, other cooked dried beans, lentils, split peas or nuts).

☐ 6. My child eats 2-3 snacks a day.

☐ 7. We limit "junk" food choices to no more than once a day (e.g. nacho or potato chips, candy, pop, etc.)

B. **ABOUT EATING:**
YES

☐ 1. We often have battles over food or eating.

☐ 2. I often tell my child to eat more.

☐ 3. I have some concerns about my child's current body shape or weight (under?/over?).

☐ 4. I have some concerns about how my child's weight will turn out.

☐ 5. Our family sits and has a meal together at least once a day.

C. **ACTIVITY LEVEL:**
YES

☐ My child gets lots of active play.

D. **DOES YOUR CHILD FOLLOW A SPECIAL DIET?**
(e.g. diabetes, food allergies, vegetarian, etc.)
☐ NO
☐ YES, Diet type:_____
_____
_____
_____

E. **OTHER THINGS YOU WOULD LIKE TO DISCUSS WITH A COMMUNITY NUTRITIONIST:**
_____
_____
_____
_____
_____

Child's First name:
_____

Boy ☐
Girl ☐

Age: _____

The personal information collected relates to and is necessary for program operations and will be kept confidential in compliance with the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection and use of this information, contact your Health Unit Nutrition staff.