The Community Plan for Protecting Infants in High Risk Environments in London and Middlesex County: A Process and Outcome Evaluation

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- Susan Dill – Women's Community House
- Rhonda Hallberg – Children's Aid Society of London and Middlesex (Executive Committee Chair)
- Mary Huffman – Middlesex-London Health Unit (Liaison Committee chair)
- Melissa McCann – Middlesex-London Health Unit (Program Evaluator)
- Julia Pigache – Child and Parent Resource Institute
- Shelley Stewart – Rotholme Women's and Family Shelter
- Maureen Reid – Children's Aid Society of London and Middlesex
- Virginia Rutledge – Merrymount Children's Centre
- Debbie Vickers – Children's Aid Society of London and Middlesex (Coordinator of the Community Plan)

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- Julia Pigache – Child and Parent Resource Institute
- Shelly Stewart – Rotholme Women's and Family Shelter
- Debbie Vickers – Children's Aid Society of London and Middlesex (Coordinator of the Community Plan)
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- Nancy Summers, Contract Program Evaluator
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- Deborah Radcliffe, Contract Program Evaluator
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EXECUTIVE SUMMARY

This report describes the results of a process and outcome evaluation of the "Community Plan for Protecting Infants in High Risk Environments in London and Middlesex County" (herein referred to as the Community Plan). The main goal of the Community Plan is to establish a community-based communication process for identifying and providing interventions to support infants under the age of 24 months who are living in high risk environments in the City of London and Middlesex County.

Background

The development of the Community Plan resulted from recommendations that were outlined in the 2000 Heikamp Inquest Jury as a result of an infant death. Five week old, Jordan Heikamp, died in 1997 of chronic starvation in a Toronto shelter. The inquest resulted in numerous recommendations to improve inter-agency collaboration and planning around the needs of infants. Community partners within Middlesex-London came together in a community forum in June 2001 to discuss the recommendations from the inquest. The results of the forum led to the development of the Community Plan that was launched in June 2003.

The Community Plan is one of three initiatives that is part of the Family Abuse Prevention Project at Middlesex-London Health Unit and funded by the Ministry of Children and Youth Services as an Early Child Development (ECD) project. The City of London Children Services Fund and in-kind contributions from participating community agencies have provided additional funding to support the Community Plan.

Evaluation

This report documents the findings from the process and outcome evaluation of the Community Plan. The evaluation design was developed by members of the Executive Committee and a Program Evaluator from Research, Education, Evaluation and Development (REED) Services at Middlesex-London Health Unit.

Evaluation Purposes

The purposes of this combined process and outcome evaluation were to:

- Obtain feedback from service providers about the Community Plan process and use of the Community Plan tools.
- Identify factors that support service providers to participate in the Community Plan process.
- Identify areas for improvement in the Community Plan process, including areas for improving inter-agency communication, collaboration, and mobilization of services.
- Identify the gaps in service that currently exist in London and Middlesex County in relation to protecting infants living in high-risk environments.
- Assess the outcomes of the Community Plan on the provision of services to infants living in high risk environments.

Methodology

The evaluation involved both quantitative and qualitative methods including analysis of Community Plan Questionnaires, Community Plan Audit Forms and service provider focus groups.

Findings

Over the course of the four year initiative, there were 1920 Community Plan Questionnaires completed and returned with approximately three-quarters (74.8%; 1437/1920) submitted by staff members at Children's Aid Society (CAS). Consistent with the mandate of the initiative, infants were between birth and 24 months of age, and had an average of 13 months old at the time that Community Plan Questionnaires were administered. Some mothers completed Community Plan Questionnaires when they were pregnant.

In almost all Community Plan Questionnaires completed, the primary caregiver was the parent of the infant. Parents/caregivers were 26 years of age on average, and ranged in age from 15 to 62 years old. The most common risk factors identified related to the infants' environment, including a history of violence in the caregiver's current or past relationships, the caregiver having no residence or living in substandard housing, and the caregiver having a history of homelessness or moving frequently. Risk factors related to the emotional health of the caregiver and impaired family support

system were also among the most frequently reported. Based on the identification of one or more risk factors, over a quarter of infants (26.4%; 506/1920) who are screened using the Community Plan Questionnaire were referred for follow-up to community agencies either to initiate a Community Plan or to connect the primary caregiver and/or infant with other services within the community (e.g. public health nurses, physicians, physiotherapist, family home visitors, etc.). In these cases, there was enough evidence that sufficient harm to the infant could occur and follow-up was needed.

Of the 812 Community Plan Audit Forms that were completed and submitted, 441 new Community Plans were initiated over the four-year period. Almost all Community Plans were coordinated by CAS staff. Most Community Plans are reviewed one to two times, and as many as 17 reviews have been completed on some Community Plans. In these particular cases, the child may be four or five years old, but the community process continues and becomes known as a case conference. Continuing with the process in many cases is seen as beneficial by the family involved because it continues to promote the health and well-being of the child, and in some cases addresses the needs of other children in the family who may be living in a high risk environment. Analysis of Community Plan Audit Forms indicated that only a few community plans (i.e. 26) have been officially terminated. This finding reflects the ongoing continuity of the Community Plan process, even though the child is beyond the age of 24 months.

The focus groups provided a way for service providers to share their experiences of implementing the Community Plan and to discuss the impact that the initiative has had over the last several years. Participants described several factors that support their participation and communication between agencies, including: Liaison Committee representatives, Liaison Committee Meetings, the Community Plan Coordinator, education/training opportunities, Community Plan conferences, and program evaluation activities.

Several challenges involved in the Community Plan process were also noted by focus group participants and are evident from the Community Plan data collection tools. Ensuring that staff members are adequately trained to implement the community plan process was noted as a challenge especially among agencies where turnover rates are high. There are differing perceptions of risk with regards to completion of the Community Plan Questionnaire. Furthermore, it is difficult for service providers to track agencies that parents/caregivers currently have connections with. Several concerns were expressed about Community Plan Conferences in terms of scheduling, recording, chairing, distribution of minutes, frequency of updates, and participation of community agencies.

Participants identified evidence to suggest that the Community Plan has improved the identification and referral of infants living in high risk environments and has increased the coordination of services to support parents/caregivers. The Community Plan provided a new mechanism to identify and address infant risk factors through the use of the Community Plan Questionnaire assessment process and Community Plan conferences that did not exist previously.

There is a heightened awareness level among service providers of the risks and conditions that impact infant safety and well-being. The plan provides a helpful reminder of the importance of placing infants' health in the forefront.

The ongoing participation of agencies in the Community Plan Process demonstrates their commitment level to continue to work towards the common goal of protecting infants. Over the course of the initiative, there has been an increase in the number of agencies participating in the Community Plan conferences and an expansion in the variety of sectors represented, including social services, education, health care, daycare, and probation. Focus group participants identified that the Community Plan helped to improve inter-agency communication by focusing on the needs and well-being of the infant; establishing a process to discuss inter-agency challenges, providing opportunities for networking; and by improving awareness of service provider roles and capacities.

Focus group participants noted that barriers between service providers and parents/caregivers have been reduced by providing opportunities for both parties to ask questions of one another that may not have been asked previously. The generation of ideas that results from Community Plan meetings may not have occurred prior to the development of the initiative as a result of the joint participation of various service providers, parents/caregivers and informal supports. Furthermore, the cooperation and joint responsibility among all parties involved reduced duplication in services, in order to more effectively protect the health and well-being of infants.

Recommendations

While there is evidence from this evaluation to suggest that the Community Plan has positively impacted interagency communication and service delivery coordination, there are several areas of the Community Plan process that require further attention and provide opportunities for enhanced training and communication among service providers. The Executive Committee plans to work together with the Liaison Committee and other community agencies as required in order to address the areas for improvement that were noted in this evaluation, and to ensure sustainability of the Community Plan in Middlesex-London. The following recommendations are provided:

1. Consider modifications to Community Plan tools and process as identified in the process and outcome evaluation.

2. Develop a plan to address challenges in ongoing implementation and sustainability of the Community Plan process.

3. Obtain ongoing resources for the sustainability of the Community Plan process and training, including the continuity of the Community Plan Coordinator role.

4. Continue to support ongoing education and training opportunities in the Community Plan.

5. Pursue options for continuing the evaluation component of the Community Plan as the evaluation of the Community Plan ends at the end of December 2006 with the completion of the Early Childhood Development fund.

6. Work with community agencies to identify the gaps in service and knowledge that exist within the community with regards to the protection of infants living in high risk environments.

7. Work with community agencies to advocate and pursue strategies to address gaps in service that exist in the area of protecting infants living in high risk environments with a particular focus on addressing social and economic determinants of health.

8. Continue to expand the use of the Community Plan within the community by reaching out to recruit new agencies not currently involved.

INTRODUCTION

This report describes the results of a process and outcome evaluation of the "Community Plan for Protecting Infants in High Risk Environments in London and Middlesex County" (herein referred to as the Community Plan). The main goal of the Community Plan is to establish a community-based communication process for identifying and providing interventions to support infants under the age of 24 months who are living in high risk environments in the City of London and Middlesex County. A pilot phase began in June 2003 and ended in December 2003. A formative evaluation reported in May 2004 provided feedback on the pilot phase. Since the pilot phase, data collection has been ongoing to continue to monitor and assess the implementation of the Community Plan.

The purpose of this evaluation is to assess the process and outcomes of the Community Plan. Data has been gathered from Community Plan tools and focus groups with service providers to understand the successes, challenges and areas for improvement in the Community Plan, as well as to investigate the impact that the Community Plan has had on the provision of services to infants living in high risk environments. The findings and recommendations discussed in this report are intended for the members of the Executive Committee, Liaison Committee, and other interested community partners in order to continue to improve implementation, highlight the value of the Community Plan initiative, and ensure sustainability.

The report is arranged in the following way. The document begins with a "Background" section on the events leading up to the development of the Community Plan in London and Middlesex County. An overview of the purpose of the Community Plan and its guiding principles are reviewed. The "Evaluation Purpose" section outlines the six evaluation questions that were articulated for the evaluation, followed by the "Methodology and Data Analysis" section that outlines the data collection tools and evaluation methods. The "Findings" section presents the results of the evaluation in relation to the six evaluation questions. The last three sections (i.e. "Limitations", "Summary" and "Recommendations") discuss limitations of the evaluation findings, provide an summary of the findings, and offer recommendations for next steps in the Community Plan initiative.

BACKGROUND

The development of the Community Plan resulted from recommendations that were outlined in the 2000 Heikamp Inquest Jury as a result of an infant death. Five week old, Jordan Heikamp, died in 1997 of chronic starvation in a Toronto shelter. The inquest resulted in numerous recommendations to improve inter-agency collaboration and planning around the needs of infants. These recommendations were intended for governments, and medical and community service agencies, including Children's Aid Societies, public health units, hospitals, and shelters.

In response to the Heikamp case and the Jury's recommendations, community partners within Middlesex-London gathered in June of 2001 at a community forum. The results of this community forum led to the development of the Community Plan for the Middlesex-London area. The Community Plan outlines a coordinated and collaborative communication process to identify infants under the age of 24 months who are living in high risk environments and to establish supports for the infants and their caregivers. "An infant is considered to be living in an high risk environment when conditions exist that could result in significant harm or mortality to the infant" (Community Plan Manual, 2004). This Community Plan was shared with service providers within the community in January 2003. A six-month pilot phase was launched in June 2003, which resulted in the development of a formative evaluation report (Radcliffe, 2004). Recommendations from the formative evaluation were implemented in order to improve the Community Plan process. Ongoing monitoring and evaluation efforts over the course of the four-year initiative have taken place.

The Community Plan is one of three components of the Family Abuse Prevention Project led by Middlesex-London Health Unit. The Family Abuse Prevention Project also includes the following initiatives based on the Heikamp Inquest:

- The expansion of the Public Health Nursing Program to provide outreach on a regular basis to residents of youth shelters, and women's and family shelters, including such services as health education, routine health assessment, effective linkage and referral to community resources and counselling.
- The development of community education initiatives aimed at increasing knowledge among service providers and the general public on issues of child and/or women abuse, infants living in high risk environments and services available (Family Abuse Prevention: Evaluation Plan, 2003).

The Family Abuse Prevention Project is a four-year initiative that began in January 2002 and ends in December 2006. In 2001, the Ministry of Health and Long Term Care (MOHLTC) announced funding for the Early Childhood Development (ECD) projects that provided support to expand existing early child development initiatives beyond Public Health Mandatory Health Programs and Services Guidelines requirements for children birth to six years of age. In 2004, the Ministry of Children and Youth Services assumed responsibility for the ECD projects. The Family Abuse Prevention Project, including the evaluation of the Community Plan is funded by the Ministry of Children and Youth Services. Additional funding to support the Community Plan has been provided by the City of London Children Services Fund and in-kind contributions from participating community agencies.

Overview of the Community Plan

The goal of the Community Plan is to establish a community-based process for identifying and providing interventions to support infants under the age of 24 months who are living in high risk environments in London and Middlesex County. The Community Plan Manual provides a comprehensive overview of the guidelines and procedures for implementing the Community Plan process. (Refer to this document for more specific information about the process). The guiding principles of the Community Plan are listed below, followed by a description of the Community Plan process that was included in the Formative Evaluation report (Radcliffe, 2004).

Guiding Principles of the Community Plan

- The paramount guiding principle for the Community Plan is the recognition that the safety and well-being of the infant takes precedence over any other client consideration in the delivery of service.
- Service delivery partnerships are essential for ensuring the safety and well-being of infants in high risk environments.
- Ongoing communication of each community partner's interventions is essential to ensuring the safety and well-being of the infant.

- Recognize the importance of strengthening and supporting the caregiver's ability to nurture the infant in a manner that promotes optimal growth and development.
- Ensure that the interventions of the service provider support and encourage effective communication as a key concept in the delivery of their services.
- Build on the caregiver's strengths and provide community supports in a coordinated manner.
- Ensure that interventions are respectful of the caregiver's culture, religion, background and traditions.
- Ensure the interventions are respectful of the caregiver's physical, mental and developmental status.
- Ensure that services are coordinated with duplication of services kept to a minimum.
- Ensure that access for children and caregivers to appropriate services and supports is a paramount consideration for service providers.
- Support an information management system that is based on partnership and is respectful of confidentiality.

Community Plan Process adapted from the Formative Evaluation (Radcliffe, 2004, pg. 11-12)

The Community Plan establishes an inter-agency process that calls on professionals to work collaboratively in the mobilization of community supports and resources for infants and their caregivers.

For those agencies that are typically not infant/child centered, the Plan requires a significant shift in service orientation. The manual states that a "paramount...principle" guiding the process is for agencies to place the infant at the focus of service delivery, ensuring that his/her well-being and safety "takes precedence over any other client consideration" (Community Plan Manual, 2004). The development of service delivery partnerships and on-going communication between partner agencies are identified as two other guiding principles intended to promote infant safety and well-being in high risk settings.

Identification and Referral to the Community Plan

When mothers or other primary caregivers with infants (up to 24 months) have contact with the social service system, the Community Plan requires agencies to give priority to the needs of the infant in the provision of agency services. To assist in the identification of risk to the infant, service providers participating in the Community Plan, who do not have access to a risk assessment tool for children are expected to complete the Community Plan Questionnaire (formally called the Community Plan Screening Tool, see Appendix A for the current Community Plan Questionnaire tool). The Questionnaire contains risk factors in areas pertaining to: the child; the caregivers(s); the environment in which the child and caregiver reside; and the level of support the caregiver is receiving. An infant is considered to be living in a high risk environment when conditions exist that could result in either significant physical, developmental or emotional harm, or in mortality.

The Questionnaire is not a formal risk assessment instrument designed to quantify the level of risk in a particular situation. Instead, it is intended only as a guide so that service providers can consider those factors that have been shown to indicate risk. Providers are asked to consider the nature of any relevant single factor, or combination of factors, when determining the degree of risk and decisions to initiate the process. Decision-making around Community Plan initiation, therefore, requires service providers to exercise professional judgement.

Initiating the Community Plan Process

If there is sufficient risk to initiate the Community Plan process, the service provider must also consider whether the case should be reported to the CAS for further investigation. The Community Plan manual identifies the referral of high risk cases to the CAS as a critical step in the process, and underscores that the Community Plan process is in no way intended to replace a professional's duty to report child protection issues or neglect.

In cases where an environment is deemed high risk, the identifying service provider assumes the role of Interim Community Plan Coordinator and responsibility for: identifying other service providers working with the family; determining the infants'/family's needs and supports; mobilizing services required immediately; and coordinating the first Community Plan conference. The first conference provides a venue for professionals to listen to caregivers and for the parties to exchange information and to develop consensus around goals and a plan of action. This information becomes part of a summary document: the Community Plan. At the initial conference, an ongoing Community Plan Coordinator is appointed and individuals responsible for implementing various elements of the Plan are identified.

Community Plan Development and Termination

On-going review of plan goals and progress and the continued mobilization of community supports are the responsibility of the Community Plan Coordinator. While the Manual suggests timelines for conducting reviews, the frequency of Community Plan consultations and conferences are shaped by the nature of the infant's and caregiver's needs. Conferences are required more frequently, for example, when significant changes are required in a care plan (e.g. due to significant life stresses).

The Community Plan Manual also sets out procedures for conflict resolution in different scenarios, the responsibilities of the Service Provider Liaison, and guidelines for the termination of Community Plans.

EVALUATION PURPOSE

This report documents the findings from the process and outcome evaluation of the Community Plan. The evaluation design was developed by members of the Executive Committee and the MLHU Program Evaluator.

Purposes of the Evaluation

The purposes of this combined process and outcome evaluation were to:

- Obtain feedback from service providers about the Community Plan process and use of the Community Plan tools.
- Identify factors that support service providers to participate in the Community Plan process.
- Identify areas for improvement in the Community Plan process, including areas for improving inter-agency communication, collaboration, and mobilization of services.
- Identify the gaps in service that currently exist in London and Middlesex County in relation to protecting infants living in high-risk environments.
- Assess the outcomes of the Community Plan on the provision of services to infants living in high risk environments.

Evaluation Questions

It is important to ensure that the Community Plan process continues to be implemented as intended and to assess Community Plan tools to ensure that they are assisting with the identification of infants living in high risk environments. Furthermore, it is important to assess the outcomes that have resulted from the initiation of the Community Plan over the last four years. The following six evaluation questions are listed below:

1. Are the Community Plan Questionnaire and Community Plan Audit Form effective tools to assist in the identification of infants living in high risk environments and to monitor the Community Plan process?
2. What parts of the Community Plan process have been helpful for supporting the agencies participating in the Community Plan process and enhancing communication?
3. What challenges, if any, currently exist in the Community Plan?
4. What areas are there for improvement in how agencies work together to implement the Community Plan?

5. What gaps in service currently exist in London and Middlesex County in relation to protecting infants living in high-risk environments?

6. What has been the impact of the Community Plan on the provision of services to infants living in high risk environments? Does the Community Plan promote the health of high-risk infants? If so, how?

METHODOLOGY & DATA ANALYSIS

An integrated process and outcome evaluation was designed to assess the implementation and outcomes of the Community Plan. The process evaluation was designed to investigate the successes, challenges and areas for improvement in the Community Plan process. The outcome evaluation was designed to assess the outcomes of the Community Plan and discuss the impact of the Community Plan. The evaluation involved both quantitative and qualitative methods including analysis of Community Plan Questionnaires, Community Plan Audit Forms and service provider focus groups. These three methods are described below.

Community Plan Questionnaire

The Community Plan Questionnaire, formally called the Screening Tool, was created to provide a mechanism for service providers to identify factors that may increase the risk of social, emotional, physical, developmental harm or death. The Questionnaire is arranged into 4 separate sections that identify risk factors relating to: (1) the infant, (2) the caregiver; (3) the environment in which the child and caregiver lives; and (4) the caregivers' social support system. The seriousness of any one factor, or the combination of many factors, provides an indication of the extent to which the infant is living in an environment where conditions exist that could result in significant harm to the infant. This tool helps to guide the decision-making process in order to determine whether or not there is sufficient risk to initiate follow-up to health and social services and/or a Community Plan. This is a subjective decision and is not based on a certain number of risk factors or predetermined level of risk, but rather service providers' professional observation and assessment. The Community Plan Questionnaire is not intended as a series of questions to ask during a meeting with the parent/caregiver. The content of the questionnaire guides the discussion with the parent/caregiver. The Community Plan Questionnaire has gone through several revisions since the pilot phase in order to improve the collection of data. The current Community Plan Questionnaire is included in Appendix A.

From June 1, 2003 through June 30, 2006, a total of 1920 Community Plan Questionnaires were completed. Data from the Community Plan Questionnaires were coded, entered into Excel spreadsheets, and analyzed using SPSS.

Community Plan Audit Form

The Community Plan Audit Form is a tool used to monitor the Community Plan process. Audit Forms are completed by Community Plan Service Provider Liaisons. Service Provider Liaisons are members that provide support within their agency to implement the Community Plan. Agencies within the community who have signed the Memorandum of Understanding assign a Service Provider Liaison who will ensure that their agency adheres to the Memorandum, assists with conflict resolution, brings forth issues arising from the Community Plan Process, and attends Community Plan Liaison Committee meetings every two months. The Community Plan Audit Forms that Service Provider Liaisons complete include information that summarizes the content recorded in a Community Plan Conference Summary Sheet (see Appendix B). Summary Sheets are completed at the end of each Community Plan Conference by the Community Plan Coordinator. The Community Plan Audit Forms list the agencies and informal supports who were involved in the Community Plan conference, identify the Community Plan Coordinator, indicate the number of reviews and/or initial meeting, and note termination of the Community Plan. Several revisions to the Community Plan Audit Form have been made over the course of the initiative. The current audit form is included in Appendix C.

From June 1, 2003 through June 30, 2006, a total of 812 Community Plan Audit Forms were completed. Data from the Community Plan Audit Forms were coded, entered into Excel spreadsheets, and analyzed using SPSS.

Service Provider Focus Groups

Three focus groups were held at the Liaison Committee meeting on May 30th, 2006. At the beginning of the Liaison Committee meeting, an introduction was provided to describe the purpose of the focus groups and to describe the process of conducting the sessions. Written informed consent was obtained from focus group participants (see Appendix D for the Information Letter and Informed

Consent Sheet). Liaison Committee members were divided into three groups of 7 to 10 participants. The Program Evaluator from Middlesex-London Health Unit, and two members of the Community Plan Executive Committee facilitated one of three sessions. Two members of the Community Plan Executive Committee, and one staff member from Children's Aid Society recorded the focus groups, and probed for clarification of participants' comments as needed. In each focus group session, there was a facilitator and a recorder. The discussion was recorded on flip chart paper.

The focus groups were structured around seven main questions and were designed to gather information about the successes, challenges and areas for improvement in the Community Plan process. The focus group questions also aimed to gather information about impact of the Community Plan on the provision of services for high-risk infants (See Appendix E for the focus group questions).

The focus group evaluation questions were developed by the MLHU Program Evaluator in collaboration with members of the Community Plan Executive Committee. Liaison Committee members were invited to provide their feedback on their involvement in the Community Plan initiative. Three weeks prior to the focus groups, liaison committee members were sent a reminder about the focus groups planned for their next committee meeting on May 30, 2006. As requested, they were sent a list of the focus group questions for them to review in advance of the sessions (see Appendix E). Liaison Committee members were encouraged to consult with their co-workers and other front-line staff members to gather feedback about the questions. If Liaison Committee members were unable to attend the meeting on May 30th, they were encouraged to provide their written comments by email or by mail.

Feedback was gathered from 35 participants in total. Of the 35 participants, there were 24 participants who attended the focus groups held on May 30th, 2006. There were 7 to 10 participants in each focus group session. Additional written feedback was gathered from 11 participants who were not able to attend the focus groups. Written feedback was gathered from Liaison Committee members and other front-line service providers from their respective agencies.

A thematic analysis was undertaken by the MLHU Program Evaluator to analyze the focus group data. Responses were reviewed by each question and common themes were identified. Comments that participants made at the end of the focus groups were incorporated into the questions that pertained to the specific comment.

FINDINGS

Results from Community Plan Questionnaires and Communitiy Plan Audit Forms

Evaluation Question 1: Are the Community Plan Questionnaire and Community Plan Audit Form effective tools to assist in the identification of infants living in high risk environments and to monitor the Community Plan process?

Feedback concerning the effectiveness of the Community Plan Questionnaire and Community Plan Audit Forms was available from three sources: (A) the Community Plan Audit Form, (B) the Community Plan Questionnaire, and (C) focus groups.

A. Analysis of Community Plan Questionnaires

A total of 1,920 Community Plan Questionnaires were completed between June 1, 2003 and June 30, 2006. Almost three-quarters (74.8%, n=1437) of Community Plan questionnaires were completed by Children's Aid Society (CAS). The remaining forms were completed by other agencies including: Rotholme Women's and Family Shelter (8.5%; n=163); Women's Community House (3.5%, n=67); heartspace (2.8%, n=54); Youth Action Centre (2.4%, n=47), St. Joseph's Health Centre (2.2%, n=42), Women's Rural Resource Centre (1.7%, n=33); Salvation Army Bethesda Centre (1.3%, n=24), Glen Cairn Community Resource Centre (0.7%, n=13); Child / Parent Resource Institute (0.4%, n=7); Zhaawanong Shelter (0.2%, n=3); and Merrymount Children's Centre (0.1%; n=2). There were 28 screening tools (1.5%) where the agency name was not recorded.

To obtain a profile of the clients involved in the Community Plan process, additional demographic characteristics were added to the Community Plan Questionnaire in February 2006, including age of the infant and caregiver gender. The results of these demographic characteristics are described in the following section. Other types of information about the caregiver and agency have been collected from early phases of the initiative including caregiver age,

the status of the caregiver, the length of time that the caregiver has been known by the agency, and sources of information that are used to complete the Community Plan Questionnaires. The results of this information are included below. Due to data being collected at different times throughout the initiative, the denominator varies across the data reported as indicated in the brackets following the reported percentages.

Age of the Infant: The mandate of the initiative is to support infants under the age of 24 months who are living in high risk environments. As a result, infants range in age from birth to 24 months. The average age of the infant at the time that the Community Plan Questionnaires were completed was 13 months and the median age was 12 months (based on 69 cases collected in 2006). There was at least one mother involved when she was pregnant.

Caregiver Gender: Almost all caregivers involved in the completion of Community Plan Questionnaires were female (97.1%, n=67/69). However, this data is only based on data collected between January and June of 2006. There were two (2.9%) cases where there was no response for caregiver gender.

Caregiver Age: The average age of the caregiver at the time that Community Plan Questionnaires were completed remained steady at approximately 26 years of age since data began to be collected in January 2004. Between January and June of 2006, the median age was slightly lower at 25 years and the mode (i.e. the most frequently reported age) was 24 years. Over the period between January 1, 2004 and June 30, 2006, caregivers ranged in age from 15 to 62 years of age at the time that the Community Plan Questionnaires were completed.

Caregiver Status: In approximately 9 in 10 Community Plan Questionnaires (89.8%, n=1188/1323) that were completed, the primary caregiver was the parent of the infant (based on data from January 1, 2004 to June 30, 2006). Grandparents were the primary caregiver in 1% (13/1323) of cases, and other family members were the primary caregiver of the infant in less than 1% of cases (0.2%, n=3/1323). However, there is a large percentage of Community Plan Questionnaires were this information was not reported (9%, n=119/1323).

Length of Time Caregiver is Known to Agency: Approximately, 4 in 10 caregivers (43.6%, 425/975) were known to the agency for 2 days (48 hours) or less at the time that the Community Plan Questionnaires are completed. Approximately 3 in 10 caregivers (28.4%, n=277/975) were known to the agency for 3 days (72 hours), and 2 in 10 caregivers (21.8%, n=213/975) were known for 7 days or more. This data is based on data collected between January 1, 2005 and June 30, 2006 (18 month time period). There were several Community Plan Questionnaires where data was not recorded for this particular question (6.2%, 60/975).

Sources of Information: Service providers used three main sources of information to complete Community Plan Questionnaires, including files, the caregiver and agency staff. Data collected between January 1, 2005 and June 30, 2006 (18 months) indicated that 7 out of every 10 Community Plan questionnaires completed (70.1%, 683/975) involved the caregiver as a source of information to complete the Community Plan questionnaire. Files were also used in approximately 3 in 10 cases (28.7%, n=280/975), and staff members were involved in 1 in 4 cases (25.0%, n=244/975). There was also a large percentage of forms (18.6%, n=181/975) were this information was not recorded during the 18 month time period (January 1, 2005 and June 30, 2006).

Risks Identified from Community Plan Questionnaires

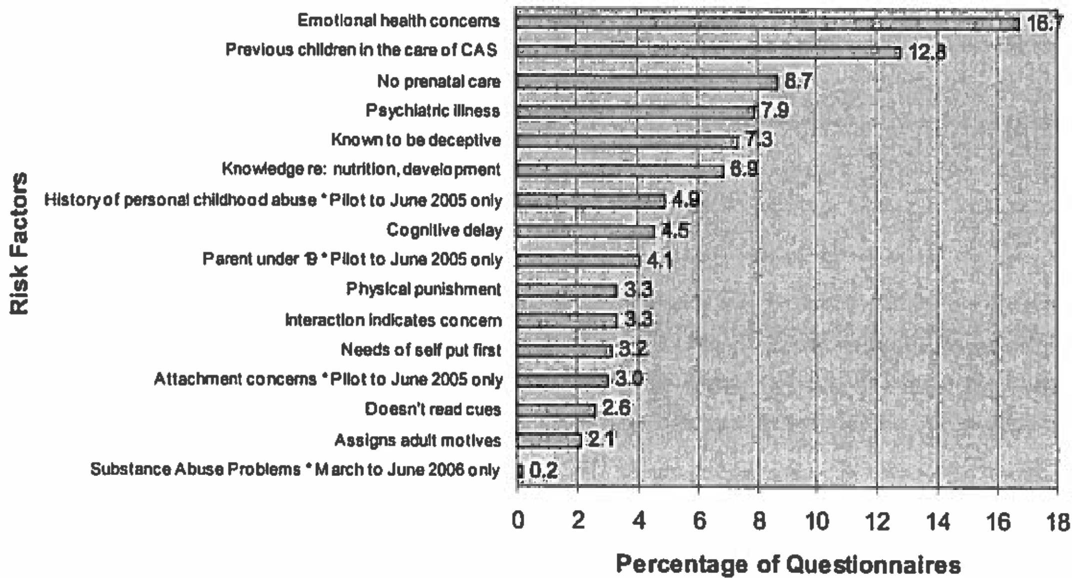
The Community Plan Questionnaires were analyzed according to the risk factors that were identified. The questionnaire (see Appendix A) is organized into four main categories of risk factors including: (1) risk factors related to the primary caregiver, (2) risk factors related to the environment, (3) risk factors related to the social support system, and (4) risk factors related to the infant.

(1) Risk Factors Associated with the Primary Caregiver

Of the 13 risk factors related to the caregiver that are currently listed on the Community Plan Questionnaire (see Appendix A), the four most common risk factors included (see Figure 1):

- Primary Caregiver demonstrates signs of emotional health concerns such as frequent loss of control and depressive symptoms (16.7%, n=321/1920)
- Previous children in the care of CAS; or in the care of others (12.8%, n=245/1920)
- Mother did not have adequate prenatal care (i.e. little or no medical care, inadequate nutrition) (8.7%, n=167/1920)
- Primary Caregiver has diagnosed psychiatric illness and may or may not be receiving or complying with treatment (7.9%, n=152, 1920)

Figure 1: Risk Factors Related to the Caregiver as reported on Community Plan Questionnaires (n=1920)

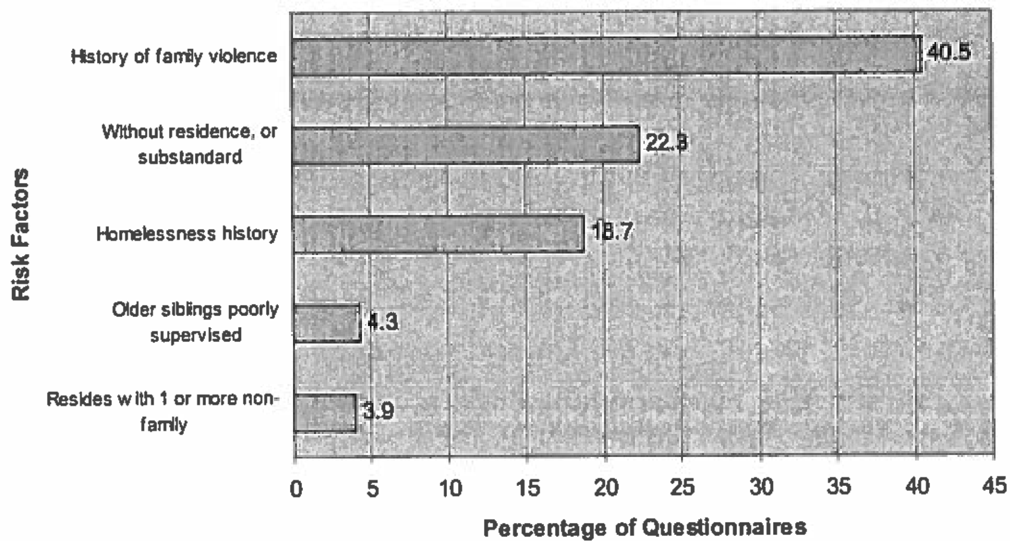


(2) Risk Factors Associated with the Environment

Of the five risk factors related to the environment, the three factors most frequently identified included (see Figure 2):

- History/evidence of family violence within the Primary Caregiver's current or past relationships (40.5%, n=778/1920)
- Primary Caregiver is without residence, or housing is substandard and/or potentially hazardous to the infant (i.e. lack of heat or plumbing, inadequate provisions for the child, etc.) (22.3%, n=429/1920)
- Primary Caregiver has a history of homelessness, or has moved residences frequently (more than twice a year) (18.7%, n=359/1920)

Figure 2: Risk Factors Related to the Environment as reported on Community Plan Questionnaires (n=1920)

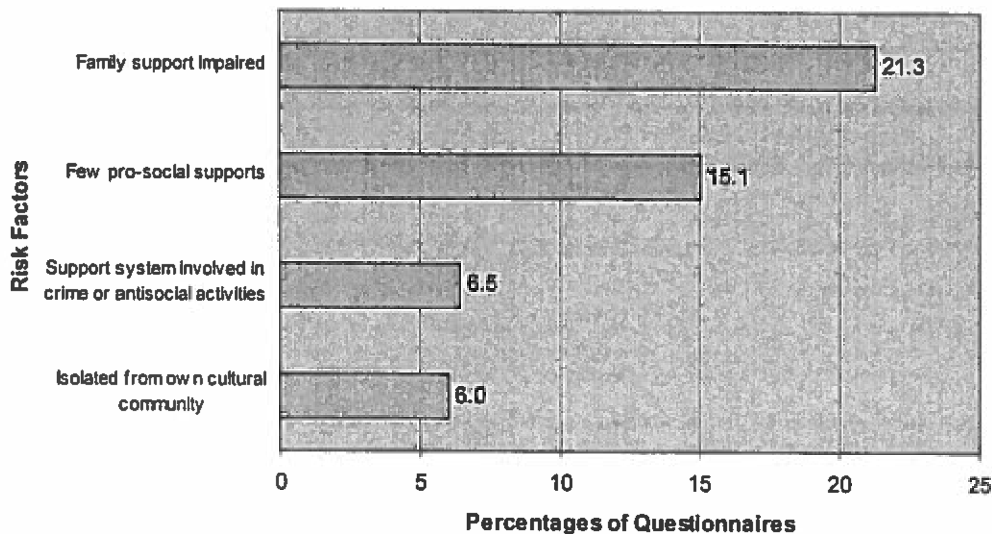


(3) Risk Factors Associated with the Social Support System

Of the four risk factors related to the caregiver's social support system, the three most common factors reported included (see Figure 3):

- Primary Caregiver's ability to get support from their family is impaired (21.3%, n=408/1920)
- Primary Caregiver is isolated and identifies few, if any, pro-social supports (15.1%, n=289/1920)
- Primary Caregiver's perceived support system is involved in criminal or antisocial activities, which impacts efforts to care for the child (6.5%, n=124/1920)

Figure 3: Risk Factors Related to the Support System as reported on Community Plan Questionnaires (n=1920)

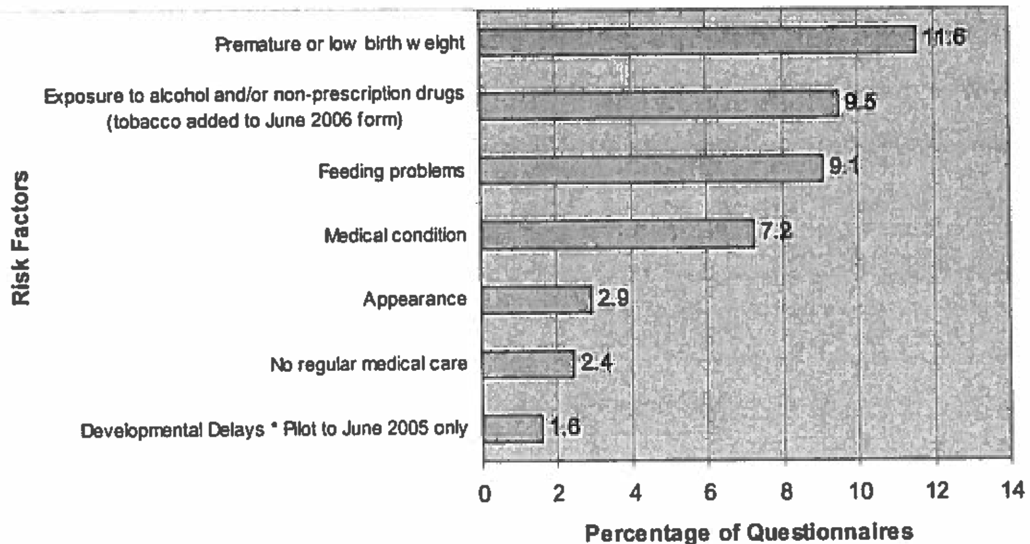


(4) Risk Factors Associated with the Infant

Of the six risk factors related to the infant that are currently included on the Community Plan Questionnaire, the three most common risk factors included (see Figure 4):

- The infant was premature or low birth weight when born (11.6%, n=22/1920)
- Exposure to alcohol and/or non-prescription drugs during pregnancy (tobacco added to 2006 Questionnaire – only 69 cases represented) (9.5%, n=182/1920)
- Problems with feeding (breast or bottle, or with baby foods) (9.1%, n=174/1920)

Figure 4: Risk Factors Related to the Infant as reported on Community Plan Questionnaires (n=1920)



Across all Community Plan Questionnaires, the five most common risk factors identified included the following:

1. History/evidence of family violence within the Primary Caregiver's current or past relationships (40.5%, n=778/1920)

2. Primary Caregiver is without residence, or housing is substandard and/or potentially hazardous to the infant (i.e. lack of heat or plumbing, inadequate provisions for the child, etc.) (22.3%, n=429/1920)

3. Primary Caregiver's ability to get support from their family is impaired (21.3%, n=408/1920)

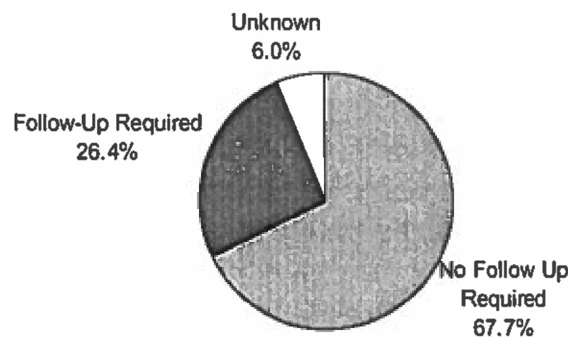
4. Primary Caregiver has a history of homelessness, or has moved residences frequently (more than twice a year) (18.7%, n=359/1920)

5. Primary Caregiver demonstrates signs of emotional health concerns such as frequent loss of control and depressive symptoms (16.7%, n=321/1920)

Follow-Up Required

Figure 5 illustrates that over a quarter (26.4%, n=506/1920) of infants who were screened using the Community Plan Questionnaire were referred for follow-up to community agencies either to initiate a Community Plan or to connect the primary caregiver and/or infant with other service providers within the community [e.g. public health nurse (PHN), physicians, physiotherapist, family home visitors, staff at Women's Community House, staff at London Intercommunity Health Centre]. In these cases, there was enough evidence that sufficient harm to the infant could occur and follow-up was needed. The remaining cases did not warrant further follow-up (67.7%, n=1299/1920), and 6.0% (115/1920) of cases had missing data.

Figure 5: Follow-Up Required as Reported in Community Plan Questionnaires (n=1920)



Of the 506 cases where follow-up was required, the exact number of cases that involved the initiation of a Community Plan, and those that required follow-up to other service providers is unknown due to the various ways in which the data was recorded. A rough estimate of 217 cases (42.9%, 217/506) involved the initiation of a Community Plan as indicated by the recording of a date for the Community Plan conference or the indication that a date for the conference was to be scheduled. Data from the Community Plan Audit Forms indicated that 441 Community Plans were initiated between the pilot phase and June 30, 3006. As a result, the data from Community Plan Questionnaires is likely an underestimation of the number of actual plans initiated because of a number of factors. Inconsistencies in how the data was recorded on Community Plan Questionnaires may account for a large percentage of the difference. If follow-up was checked off, but there was no indication that a date for the conference was set or planned to be set, the follow-up is counted in the general follow-up category, but not as the initiation of a Community Plan. Some service providers who may have initially indicated that follow-up was not required may have reconsidered the case and initiated the Community Plan process. Similarly, in some cases follow-up was indicated, but it was noted that the initiation of a Community Plan will be determined later by the ongoing case worker once the mother establishes community supports, or once a PHN is assigned.

Modifications to the Community Plan Questionnaire were made in March of 2006 in order to improve the accuracy and consistency of recording follow-ups that are required. Service providers are asked to specify which type of follow-up is required including: referral to CAS, initiation of a Community Plan, and further assessment by other health and social services professionals.

A detailed breakdown of Community Plan Questionnaire data over the four-year initiative is included in Appendix F. Data is broken down into specific time periods over the four-year initiative to illustrate trends over time.

B. Analysis of Community Plan Audit Forms

Over the course of the four-year initiative from June 1, 2003 to June 30, 2006, Community Plan Service Agency Liaisons reviewed the Community Plan conference summary sheets (see Appendix B) and completed 812 Community Plan Audit Forms. Results from the Community Plan audit forms indicate that there were 441 Community Plans initiated over the four-year period. Of these Community Plans at least one of them was a prenatal Community Plan. Tracking of prenatal Community Plans started in 2006 and as a result, data is unavailable from previous years.

Community Plan Coordinator: Almost all (95.2%, n=773/812) Community Plans are coordinated by CAS staff. Other agencies who have coordinated Community Plans include Middlesex-London Health Unit (1.8%, n=15/812), Women's Community House (0.1%, n=1/812), Merrymount Children's Centre (0.1%, n=1/812) and the Youth Action Centre (0.1%, n=1/812). There were also several Community Plans where the coordinator was not identified (2.2%, n=18/812), and where "other" agencies coordinated Community Plans (0.4%, n=3/812).

Agency Involvement: Over the course of the four-year initiative, there have been many partnerships and collaborative efforts to carry out the Community Plan process. This is evident from the agencies and individual professionals who attended Community Plan conferences. The number and variety of agencies and professionals involved in Community Plan conferences increased since the pilot phase. In the initial phase, there were approximately 40 agencies. Between January and June 2006, there were 66 agencies and individual professionals involved in Community Plan meetings. Over the course of the four-year initiative, approximately 75 health and social service agencies within Middlesex-London have been involved in conferences, as well as 36 physicians, 13 daycares, and 7 educational institutions (see Appendix G for a list of agencies involved). In addition to the formal agencies and professionals that participated, there were also several informal caregiver supports that attended conferences, including grandparents, aunts, uncles, friends, church members, etc.

Reviews of Community Plans: An essential component of the Community Plan process is the review that takes place during Community Plan conferences. The follow-up meetings provide opportunities to determine how the Community Plan goals are being addressed. The majority of Community Plans are reviewed approximately one to two times. Other Community Plans have been reviewed as many as 17 times. It is assumed that these Community Plans that have been reviewed numerous times are with clients who have been involved with the Community Plan process early in the initiative. In cases where Community Plans have been reviewed 15-17 times, the child is beyond 24 months of age. Anecdotal evidence from Executive Committee members and Liaison Committee members suggests that in these particular cases, the perceived risk to the child's health and well-being is still sufficient to warrant continuation of the

Community Plan process, and the 'Community Plan' becomes known an a 'case conference'. In many cases, the child may be four or five years old, although the audit form and community plan conference summary sheet do not gather information on the age of the infant.

Termination of Community Plans: Between June 1, 2003 and June 30, 2006, a total of 26 Community Plans were terminated. Examples of reasons for termination included: child turned two years old; client/mother completed service plan goals; risks have been reduced; family re-located outside of jurisdictions; and service providers have completed their involvement. An additional reason for termination included the caregiver unwilling to work with community partners. In these particular cases, it was noted that other interventions were pursued including continued involvement from CAS. Anecdotal evidence from Executive Committee and Liaison Committee members provided an explanation for the low number of Community Plans that have been terminated. In many cases, there is no official termination of the Community Plan even thought the child is beyond the age of 24 months. As aforementioned, the 'Community Plan' becomes known as a 'case conference'.

A detailed analysis of Community Plan Audit Forms is included in Appendix G. Data is broken down into specific time periods over the course of the four-year initiative to demonstrate trends over time.

C. Focus Group Feedback on the Community Plan Questionnaire

During the focus groups, service providers shared their experiences in using the Community Plan Questionnaires. Some participants noted challenges with the Community Plan questionnaire as a tool for the risk identification and referral. Concerns were expressed about the need for more dialogue on differing perceptions of risk. While the Community Plan questionnaire is intended as a guide for identifying high risk environments and is not intended as a quantitative checklist to determine risk, there appears to be more clarification needed among service providers about the interpretation of the questionnaire.

They also identified the following specific areas of the questionnaire that can be modified:

- The question about current client involvement in a Community Plan should be at the beginning of the questionnaire, rather than at the end of the questionnaire.
- There is no place on the Community Plan questionnaire to indicate agencies in which clients are currently connected. A checklist of agency names would be helpful in prioritizing the agency representatives who should be involved with Community Plan meetings.

Success Factors in the Community Plan Process

Evaluation Question 2: What parts of the Community Plan process have been helpful for supporting the agencies participating in the Community Plan process and enhancing communication?

Participants described several aspects of the Community Plan process that have been helpful in supporting agency participation and communication. These supporting factors have been grouped into the following categories: (1) Liaison Committee Representatives, Liaison Committee Meetings, and Community Plan Coordinator Role, (2) education/training opportunities, (3) Community Plan conferences, (4) Community Plan purpose, and (5) program evaluation activities.

(1) Liaison Committee Representatives, Liaison Committee Meetings and Community Plan Coordinator Role

Participants described contact from the Coordinator of the Community Plan Initiative as helpful, and also noted the support that is available from the Liaison Committee representative at their agency. One participant explained:

"Its helpful to know a process is set-up and liaison available to address questions/concerns"

Several participants also noted the following factors that are successful with the Liaison Committee meetings:

- The supportive role of the chair of the committee as a resource.
- The discussion and interaction to resolve issues.

- The networking opportunities provided.
- The "agency highlight" that describes the mandates and activities of agencies.

(2) Education/Training Opportunities

Many participants indicated that the education and training opportunities that have been provided have been helpful to provide understanding about the Community Plan process and implementation. The initial training and orientation to the Community Plan process was viewed as key to effective implementation. The role of the coordinator in keeping staff training updated is essential. Regular training helped to ensure consistent awareness level and implementation of the Community Plan process.

(3) Community Plan Conferences

Several participants described aspects about the Community Plan conferences that have been helpful.

- The scheduling of routine Community Plan conferences provided a "safety net" for the families and service providers.
- Over time, Community Plan conferences ran more smoothly when there was an increased understanding of the process.
- Providing a summary of the main points discussed at the Community Plan was helpful.
- Holding Community Plan conferences in the child's home has been beneficial.
- The Community Plan conferences provided opportunities for service providers (e.g. public health nurses, CAS workers, etc.) to meet together to have a dialogue around how to implement the Community Plan effectively.

(4) Community Plan Purpose

One participant identified that it has been helpful to be reminded that the infant is the primary client through the Community Plan process. The existence of the Community Plan also provided opportunities to reflect on the values underlying the Community Plan and service provider agencies.

(5) Program Evaluation Activities

Participants noted that program evaluation activities (e.g. focus group discussions and questionnaires) that have been implemented throughout the Community Plan process have been helpful.

Challenges in the Community Plan

Evaluation Question 3: What challenges, if any, currently exist in the Community Plan?

There were several challenges that were noted by participants at all stages of implementing the Community Plan. The challenges and difficulties identified by participants are organized by common themes, including (1) education and training, (2) Community Plan conference coordination, (3) interagency communication, (4) parent/caregiver involvement in Community Plan conferences, and (5) differing treatment philosophies of agencies.

(1) Education and Training

Some participants noted the challenge associated with ensuring that staff members are adequately trained in implementing the Community Plan process. In agencies where there are high turnover rates, keeping staff members trained is difficult.

(2) Community Plan Conference Coordination

Several concerns were expressed about Community Plan Conferences in terms of scheduling, recording, chairing, distribution of Community Plan minutes, frequency of updates, and participation of community agencies.

- Scheduling Community Plan conferences with all parties present within a short time frame was difficult at times. For example, one participant explained the difficulties with arranging Community Plan meetings when parents/caregivers are in the hospital.
- There is a need for a recorder at each meeting. Furthermore, there is a need for clarifying expectations with Community Plan agencies that the Community Plan chair does not necessarily need to record the minutes.

- Sometimes there were challenges with the distribution of minutes from Community Plan conference meetings. For example, minutes were not always forwarded in a timely fashion as outlined in the Community Plan Manual.

- There has been an increase in paperwork as a result of the Community Plan process.

- If the coordinator of the Community Plan changes, the entire tone of the Community Plan conference meeting changed as well.

- CAS was relied on too often to chair Community Plan conferences. Other agencies can be encouraged to take on the role of chair. For example, if a professional from a community agency other than CAS has been involved with the family for a longer period of time than CAS, then that professional should initiate the Community Plan.

- There was a wide range of abilities among Community Plan coordinators and varying expectations of how Community Plan meetings should proceed.

- There was some concern about the frequency of Community Plan meetings and/or how often Community Plans should be updated.

- There was uncertainty about whether or not non-involved agencies can be invited to Community Plan meetings to introduce them to parents/caregivers for the first time.

(3) Interagency Communication

Interagency communication was identified as a challenge throughout the Community Plan process:

- Sometimes Community Plan questionnaires were not forwarded to other agencies involved in providing services to the parent/caregiver and/or infant.

- Keeping agencies informed of Community Plans was difficult. One participant noted:

"At times it can be difficult to keep all of the agencies on the same page. When changes occur in a family this is not always communicated to everyone involved (all agencies)"

- There was insufficient sharing of information about the roles of different agencies. More dialogue is required to communicate the roles of different agencies.

(4) Parent/Caregiver Involvement in Community Plan Conferences

Several challenges were noted about parent/caregiver involvement in Community Plan conferences:

- Community plan conferences can be traumatizing for parents/caregivers. It can be overwhelming for them to hear about the concerns from all service providers. In one particular case, a participant shared:

"[The] client got upset because [an agency] wanted them involved in programs; [This had a] very negative influence on Community Plan; clients feel overwhelmed and drop out"

- Parents/caregivers need to feel comfortable in the meetings and be involved in deciding who is invited to the meetings.

- There was hesitancy on the part of some service providers involved in Community Plan conferences to express concerns to parents/caregivers about risk factors and progress. Participants described the following challenges:

"At times, negative information about the client is shared among service providers after the client has left the meeting. This information is usually valuable for the client to hear and necessary for the client to hear to appropriately evaluate their progress on goals."

"That some professionals still look at the society worker to be the one to advise [the client of] the risks because the professionals who have expressed concern to CAS are unwilling to acknowledge this concern when around the client so as not to lose their trust or have an affect on their relationship."

- There were concerns about parents/caregivers commitment level to follow through with the agreed upon plan.

- Some parents/caregivers have not been forthcoming in sharing information with service providers. Participants shared the following challenges:

"If mom knows of the Community Plan may be somewhat deceptive to try and get CAS or shelter out of life (defensive)"

"[There was a] Name on Community Plan when the professional had not had any contact in a long-time; client had indicated to the Community Plan Coordinator that a particular staff member at an agency had ongoing contact with the client, but this was not the case"

- There is an ongoing need for open communication among agency service providers regarding Community Plans in order to prevent situations that can result in a breakdown of trust between professionals and the parents/caregivers involved in the Community Plan.

(5) Differing Agency Treatment Philosophies

Some agencies have different treatment philosophies that are not aligned with the philosophy that governs the Community Plan. Some agencies viewed the plan as reactive rather than preventative in nature. While the goal of the Community Plan initiative is to ensure the interests of the infant are met, sometimes the Community Plan conferences are directive towards parents. This approach may be different from the philosophies of some agencies within the community, which presents challenges in how agencies work together.

Areas for Improvement in Implementing the Community Plan

Evaluation Question 4: What areas are there for improvement in how agencies work together to implement the Community Plan?

In addition to the suggestions that participants noted when discussing the challenges that they face in implementing the Community Plan, they specified several areas for improvement in how agencies work together to implement the Community Plan. Areas for improvement have been grouped into the following five categories: (1) Community Plan initiation and client consent, (2) involvement in Community Plan conferences, (3) education and training needs, (4) Community Plan coordination and interagency communication, and (5) use of terminology and language considerations.

(1) Community Plan Initiation and Client Consent

There were several areas for improvement mentioned about the timing and process of obtaining consent from parents/caregivers.

- It is beneficial to start the Community Plan process prenatally (e.g. 32 weeks) and obtain consent from the parent to inform other service providers. However, it was noted that the duty to report requirement is limited to after the birth of the baby.

- Some parents/caregivers are hesitant or refuse to sign consent. Often, agency staff have the most concerns with parents/caregivers who refuse to give their consent. Parents/caregivers have also been hesitant to sign consent for larger agencies (e.g. hospitals).

(2) Involvement in Community Plan Conferences

Some participants suggested ways in which the Community Plan conferences could be improved with the participation of additional members:

- Non-involved agencies could be invited to Community Plan conferences in order to introduce them to parents/caregivers

- An 'objective outside party' could attend Community Plan conferences to observe meetings, explore areas where there may be blind spots, and discuss points of difficulty.

- It would be beneficial to have more participation of informal supports (e.g. relatives and neighbours) of the parents/caregivers at the Community Plan meetings. One participant explained how:

"Informal supports can help communicate with agencies involved or fill gaps in support / resources"

(3) Education & Training Needs

Participants provided suggestions for their learning needs:

- More education is needed on the Community Plan questionnaire and the spectrum of risk that is inherent in the questionnaire.
- Providing 'refreshers' at staff meetings on the Community Plan process and protocol may provide opportunities for learning and discussion about challenges.
- There is a need for additional opportunities for agencies to learn about one another, to understand each other's mission and capacity, and to clarify the roles of professionals involved in Community Plans.

(4) Community Plan Coordination & Interagency Communication

Communication is key to the Community Plan process. Participants offered several suggestions with regards to improving the communication and Community Plan coordination among service providers.

- A system of regular communication needs to be established between agencies to discuss Community Plan progress, and to discuss referrals and follow-ups.
- There is a need for a coordinator for the Community Plan initiative in order to keep agencies informed.
- Community Plan Questionnaires need to be passed onto other agencies in order to facilitate communication, follow-up and mobilize supports.
- A reasonable turn-around time for the distribution of minutes of Community Plan conferences needs to be established.
- There is a need for service providers to respect other agencies' missions and capacities.
- During Community Plan conferences, if service providers have concerns about parents/caregivers and their infants well-being, they need to bring them forward during the meeting and/or support and backup the other service providers who are bringing their concerns forward during the meeting.
- While the health of the infant is discussed during Community Plan conferences, there should be an increased focus placed on infant health and well-being.

(5) Use of Terminology and Language Considerations

There are many terms and professional jargon that service providers use. It was recommended that service providers need to watch their language when referring to "high risk plans" or "high risk infants" as it may be insensitive to the needs of parents/caregivers. More education and training may be required to ensure that Community Plan conferences are inclusive, and sensitive to parent/caregivers.

Gaps in Services

Evaluation Question 6: What gaps in service currently exist in London and Middlesex County in relation to protecting infants living in high-risk environments?

Focus group participants identified several gaps in service that exist within the implementation of the Community Plan and also described several broader systemic issues that impact the health and well-being of infants living in high risk environments.

Interagency Communication and Agency Implementation of the Community Plan

There is a need for improved communication among many service providers in order to ensure effective implementation of the Community Plan.

- Hospitals and shelters need to communicate regarding the discharging of infants from the hospitals. Sometimes there is a lack of "*post departure coordination and continuity*".
- Maintaining communication with physicians providing care to children involved in Community Plans is needed.

- There is a need to have representation and involvement from other professionals, such as representation from the adult mental health sector and education sector.
- Improvements need to be made to ensure that services continue after parents/caregivers have left the shelter and/or discontinued services from a Public Health Nurse.
- Services need to be provided in a timely manner before crisis occurs.

Service Gaps and Broader Systemic Issues

Participants described several gaps and broader system-level issues that affect the health and well-being of parents/caregivers and their infants. These issues have been categorized according to several social determinants of health, including (1) income and social status, (2) physical environments, (3) healthy child development, and (4) health services. The interrelationships between the systemic issues as described by focus group participants, and those found in the Community Plan data are highlighted.

(1) Income and Social Status

Poverty is a major issue experienced by many parents/caregivers. It was noted that there are inadequacies with the financial support provided by Ontario Works. Families also have difficulty finding affordable and adequate housing. This finding is mirrored in the results of the Community Plan Questionnaire that suggest approximately 1 in 5 parents/caregivers (22.3%) are without residence or are living in housing that is substandard.

In addition, there is often a lack of funds for transportation (e.g. bus tickets). Accessible and flexible daycare spots are also difficult to find for many parents. Participants noted the following challenges that parents/caregivers face:

"There is a fear among some parents of daycare being cut off to attend other meetings/treatment"

"There are not enough services for young mothers. It is difficult when we ask them to ensure they have the means to parent a baby when they often can't get adequate housing when under 18 years old and haven't finished high school and therefore, cannot find a job. More schools where they could go with childcare available on site would be beneficial"

(2) Physical Environments

In order to promote safe and healthy physical environments for parents and children, living environments that are unsafe need to be attended to "*by promoting inter-community support systems*". Programs such as Neighbourhood Watch can be strengthened, and community workers who take on active roles in their communities can be supported. Parents/caregivers living in rural areas face challenges in seeking support as a result of the limited resources that are available in their geographic location. Many people who live in rural areas often need to access the resources that are available in the city, but face difficulties in getting to the city because there is no bus system and limited transportation services. For example, parents/caregivers who need to use a taxi to travel to London, may know their taxi driver because of the small rural community in which they live.

(3) Healthy Child Development

In order to support the health and well-being of infants and children, there is a need for more supports to ensure that children are being fed adequate, nutritious diets. This identified gap is reflected in the Community Plan Questionnaire data which reported that 6.9% of parents/caregivers demonstrate a lack of knowledge about adequate nutrition.

More promotion and dialogue also needs to take place on the issue of violence against infants and children because of the detrimental impacts that it has on their health and well-being. The results from the Community Plan Questionnaires also highlight that two out of five parents/caregivers screened have a history of family violence within their current or past relationships.

There is a lack of services and supports for parents with developmental challenges, mental challenges and brain injuries. Furthermore, parent-capacity assessment is also lacking.

(4) Health Services

Access to health services is important for the health and well-being of parents/caregivers and their children. There is a need for greater access to primary health care. Participants also mentioned the need for a women's-only withdrawal management services (e.g. safe methadone clinic). Findings from the Community Plan Questionnaire report that almost 1 in 10 parents/caregivers (9.5%) report that

their child was exposed to alcohol or drugs prenatally. These findings suggest that more work is needed to address substance abuse problems among women.

Impacts of the Community Plan on the Health and Well-Being of Infants living in High-Risk Environments

Evaluation Question 6: What has been the impact of the Community Plan on the provision of services to infants living in high risk environments? Does the Community Plan promote the health of infants living in high risk environments? If so, how?

Analysis of focus group data provided evidence that the Community Plan promotes the health, safety and well-being of infants living in high risk environments and follows the Community Plan principles and objectives established at the outset of the initiative. Listed below are the principles and objectives [highlighted in borders] of the Community Plan and feedback from focus group participants that demonstrate how the principles and objectives are being fulfilled.

Reflections on the Guiding Principles and Objectives of the Community Plan

The paramount guiding principle for the Community Plan is the recognition that the safety and well-being of the infant takes precedence over any other client consideration in the delivery of service

The Community Plan has provided a new mechanism to promote infant health and well-being that did not exist before. Participants identified that the preventative and early interventions that are provided help to ensure the health of infants. One participant explained:

"It gets more eyes and ears in the infant's home on a regular basis, monitoring the baby's health and reporting issues earlier and more quickly if issues arise."

Several participants noted that the Community Plan provides a helpful reminder of the importance of placing the infants' health in the forefront. For some service providers, the focus on treating the infant as the primary client reflects a paradigm shift. The focus is now placed on the infant as opposed to the parent/caregiver or the entire family unit. For other service providers, this focus is consistent with their previous model of service delivery. Pre-natal concerns can also be addressed with the initiation of a Community Plan before the infant arrives.

There were a few participants who indicated that they were not sure if the Community Plan promotes the health of high-risk infants. One participant noted that it may promote their health, but it is *"more like catching up to what should happen"*. Another participant stated that whether or not the Community Plan promotes the health of high-risk infants depends on the following factors:

"...it depends on the infant, the reason the file is open and whether the parents are open to working with people and acknowledging the need for services."

Service delivery partnerships are essential for ensuring the safety and well-being of infants in high risk environments

The Community Plan process has resulted in an expanded range of community partnerships. As a result of the collaboration and cooperation among service providers, participants described improvements in their relationships with other agencies and increased sharing of responsibilities. The partnerships that are formed during the Community Plan process have resulted in service providers being more aware of what services are being provided and being held more accountable for their tasks. Participants also noted a sense of confidence that they feel in knowing that there are other service providers looking out for the well-being of the infant. One participant described the following:

"It allows me as a child protection worker to go home at night knowing that there is someone else attending the home and ensuring the infant is being weighed and followed by a physician"

Ongoing communication of each community partner's interventions is essential to ensuring the safety and well-being of the infant

Participants described many improvements in interagency communication that have resulted from the implementation of the Community Plan.

- Ensures that the discussion is focused on the needs and well-being of the infant.

- Provides a process to discuss inter-agency challenges.
- Increases connections with other agencies.
- Provides opportunities for networking.
- Improves awareness of service providers' roles and capacities.

One participant highlighted several benefits that have resulted from the enhanced communication and coordination:

"The Plan has really helped to coordinate services and to determine who will provide what service. It also helps with information sharing. When the Plan is discussed with the client and all the service providers, everyone hears the same direction/information and this aids with clarity. Giving everyone a copy of the Plan helps to keep goals at the front of everyone's mind and that helps to keep services direct and focused."

The coordination and collaboration between service providers involved in Community Plan provides a 'safety net' for infants and families. One participant noted the following scenario:

"Initiated a Community Plan when mom was leaving shelter; acted like a safety net; helps clients not slip through cracks."

Recognize the importance of strengthening and supporting the caregiver's ability to nurture the infant in a manner that promotes optimal growth and development

The Community Plan conferences offer support for the whole family and provides opportunities for parents to share stressors that they are dealing with in their lives.

Ensure that the interventions of the service provider support and encourage effective communication as a key concept in the delivery of their services

The Community Plan conferences reduce the barriers between services providers and parents/caregivers by providing opportunities to ask questions of one another that may not have been asked previously, and to gain access to information that may never have been known.

Build on the caregivers strengths and provide community supports in a coordinated manner

Through the Community Plan process, there is an increased awareness of the parents/caregiver's situation. Participants noted that for some parents/caregivers it is easier for them to share their concerns and issues with some service providers than with others. The partnerships that exist allow service providers to provide more support for parents/caregivers with the increased knowledge and information about their situations. There is also coordination among service providers with the attempt to keep infants with parents/caregivers as much as possible.

Ensure that interventions are respectful of the caregiver's culture, religion, background and traditions

There were no specific comments discussed by focus group participants in relation to this particular principle. Although, anecdotal evidence at the Executive Committee level suggests that the agency service providers discuss Community Plan interventions with parents/caregivers on a case-by-case basis to ensure that they are respectful of various forms of diversity among parents/caregivers.

Ensure the interventions are respectful of the caregiver's physical, mental and developmental status

The Community Plan conferences offer information and education to parents/caregivers about child development. One participant explained:

"[The Community Plan conferences] help parents know what is expected of child development; what we think of as basic is not always known by parents."

The Community Plan conferences also result in the generation of ideas and suggestions that may not have been possible without the joint participation of various service providers, parents/caregivers and informal supports.

Ensure that services are coordinated with duplication of services kept to a minimum

The Community Plan process promotes cooperation and joint responsibility among all parties involved in order to reduce duplication in services. One participant explained:

"When all parties involved are working together with open communication and going forward on the same page, the Community Plan is a very helpful tool in child protection."

Ensure that access for children and caregivers to appropriate services and supports is a paramount consideration for service providers

Through the Community Plan process, referrals are made for parents/caregivers and their infants that may not have happened had there not been the existence of the Community Plan.

Support an information management system that is based on partnership and is respectful of confidentiality

The Community Plan service delivery model provides guidance and structure in order to protect infants living in high risk environments. The mechanisms in place to gather information from parents/caregivers and service providers are beneficial. For example, the Community Plan questionnaire is a useful tool because it helps to focus the assessment. The questionnaire is also helpful in monitoring and tracking the health of infants during the Community Plan conferences.

LIMITATIONS

There are several limitations and considerations to keep in mind when interpreting the Community Plan data as gathered from the Community Plan Questionnaire and the Community Plan Audit Form. First of all, the findings represent only the forms that were submitted to program evaluators over the course of the four-year initiative. There may be outstanding forms that were not submitted for the period between June 1, 2003 and June 30, 2006. Secondly, for some of the questions on both tools, there is missing or incomplete data. For one reason or another, the forms were not completed consistently within and across agencies. Thirdly, difficulties in tracking clients from one agency to another may have resulted in the duplication of Community Plan Questionnaires. As a result, there may be slightly more Community Plan Questionnaires reported than the number of actual infants screened. Lastly, there have been several revisions to the forms over the course of the four-year period with the aim of improving the identification of risk factors and furthering our understanding of the infants who are at risk of living in high risk environments. For some questions, there is data only for a certain time period, because the particular question was either removed from the forms or added to the forms. Overall, the findings represent general trends in the Community Plan data.

There are limitations to this evaluation that need to be acknowledged. Within the first six months of the Community Plan initiative a formative evaluation was conducted that involved individual focus groups conducted at several agencies who were involved in the Community Plan process. Due to limited time and resources individual focus groups conducted at each agency involved in the Community Plan were not possible during the fourth year of the initiative. An alternative process of conducting focus groups during an already established Liaison Committee meeting was established. While Liaison Committee members were encouraged to obtain feedback from other front line staff members in their agencies, it is uncertain to what extent that Liaison Committee members consulted with other staff members. As a result, focus group data was obtained primarily from Liaison Committee members. In a few instances that are known, Liaison Committee members who where not able to attend the focus groups, gathered feedback from other staff members in their agency.

SUMMARY

Over the course of the four year initiative, there were 1920 Community Plan Questionnaires completed and returned with approximately three-quarters (74.8%; 1437/1920) submitted by CAS staff. The high frequency of Community Plan Questionnaires completed by CAS is now reflected in their current policy of screening all infants under the age of 24 months, regardless of whether or not there is a suspected level of risk to the infant. The most common risk factors identified relate to the infants' environment: history of violence in the caregiver's current or past relationships, the caregiver having no residence or living in substandard housing, and the caregiver having a history of homelessness or moving frequently. Risk factors related to the emotional health of the caregiver and impaired family support system were also among the most frequently reported.

Many of the risk factors that are more frequently reported reflect the nature of the clients that several of the agencies serve. For example, shelters for abused women provide services to women who may be in abusive relationships and/or experience homelessness. Other risk factors that are less frequently reported may be factors that are more difficult for service providers to determine and are more sensitive topics, such as those related to the caregiver's cognitive ability, use of physical punishment with their children, and putting their needs over the needs of their children.

Of the 812 Community Plan Audit Forms that were completed and submitted, 441 new Community Plans were initiated over the four-year period. Almost all Community Plans are coordinated by CAS staff. Most Community Plans are reviewed one to two times, and as many as 17 reviews have been completed on some Community Plans. In these particular cases, the child may be four or five years old, but the community process continues and becomes known as a case conference. Continuing with the process in many cases is seen as beneficial by the family involved because it continues to promote the health and well-being of the child, and in some cases addresses the needs of other children in the family who may be living in a high risk environment.

The focus groups provided a way for service providers to share their experiences of implementing the Community Plan and to discuss the impact that the initiative has had over the last several years. Participants described several factors that support their participation and communication between agencies, including: Liaison Committee representatives, Liaison Committee Meetings, the Community Plan Coordinator, education/training opportunities, Community Plan conferences, and program evaluation activities.

Several challenges involved in the Community Plan process were also noted by focus group participants and are evident from the Community Plan data collection tools. Ensuring that staff members are adequately trained to implement the community plan process was noted as a challenge especially among agencies were turnover rates are high. There are differing perceptions of risk with regards to completion of the Community Plan Questionnaire. Furthermore, it is difficult for service providers to track agencies that parents/caregivers currently have connections with. Several concerns were expressed about Community Plan Conferences in terms of scheduling, recording, chairing, distribution of minutes, frequency of updates, and participation of community agencies.

Participants identified evidence to suggest that the Community Plan has improved the identification and referral of infants living in high risk environments and has increased the coordination of services to support parents/caregivers. The Community Plan provided a new mechanism to identify and address infant risk factors that did not exist before the use of the Community Plan Questionnaire assessment process and Community Plan conferences.

There is a heightened awareness level among service providers of the risks and conditions that impact infant safety and well-being. The plan provides a helpful reminder of the importance of placing infants' health in the forefront.

The ongoing participation of agencies in the Community Plan Process demonstrates their commitment to continue to work towards the common goal of protecting infants. Over the course of the initiative, there has been an increase in the number of agencies participating in the Community Plan conferences and an expansion in the variety of sectors represented, including social services, education, health care, daycare, and probation. Focus group participants identified that the Community Plan helps to improve inter-agency communication by focusing on the identified risks and interventions; establishing a process to discuss inter-agency challenges, providing opportunities for networking; and by improving awareness of service provider roles and capacities.

Focus group participants noted that barriers between service providers and parents/caregivers have been

reduced by providing opportunities for both parties to ask questions of one another that may not have been asked previously. The generation of strategies that results from Community Plan meetings may not have occurred prior to the development of the initiative as a result of the joint participation of various service providers, parents/caregivers and informal supports. Furthermore, the cooperation and joint responsibility among all parties involved reduces duplication in services, in order to address the identified risk factors.

As the number of agencies participating in the Community Plan initiative increases, there is an ongoing need to have a Community Plan Coordinator to provide a variety of coordination and administrative tasks essential for the implementation of the initiative. These tasks include the following: facilitate communication with service providers involved in the Community Plan, outreach to agencies in order to educate and/or recruit service providers to participate, provide administrative support to the Liaison Committee and Executive Committee, coordinate training and educational opportunities, and respond to requests for information and education from other communities interested in our Community Plan process.

In October 2006, a new training package for implementing the Community Plan was launched in order to provide orientation to new staff members and to update current staff on the process. This package includes an updated Community Plan Manual, an interactive DVD, video clips of an initial Community Plan meeting and a follow-up meeting, as well as Community Plan resources and documentation. It is also a goal of the Executive Committee to make this training package available to other communities across the province who are interested in this Community Plan model. Over the course of the initiative, many other communities have expressed an interest in learning about the Community Plan process in Middlesex-London. As a result, members of the Executive Committee have been involved in outreach activities with other communities, including Children's Aid Societies, public health units, and professional conferences provincially and internationally.

While conclusions can be drawn about the short-term impacts of the Community Plan on the coordination of services, further investigations are required in future years to determine the long-term impact of this initiative on promoting the health and safety of infants living in high risk environments. To determine long-term impact of such an initiative, investigations would need to assess mortality rates and quality of life of infants who live in high risk environments within Middlesex-London.

The results of this evaluation suggest that the Community Plan initiative appears to be helpful in identifying infants living in high risk environments and subsequently, initiated an interagency communication process to support parents/caregivers and service providers to reduce the risk of infant harm and mortality. The multiple and interrelated risk factors that are experienced by many parents/caregivers and infants involved in the Community Plan process reflect underlying social and economic determinants of health. Parents/caregivers and infants experiencing poverty, homelessness, impaired social support systems, and violence within their family environments are at greater risk for negative health outcomes. The existence of interagency partnerships within the Community Plan provides the impetus for a coordinated approach and intersectoral policy development that is needed to reduce the health disparities that are experienced by parents/caregivers and their infants.

Recommendations

While there is evidence from this evaluation to suggest that the Community Plan has positively impacted interagency communication and service delivery coordination, there are several areas of the Community Plan process that require further attention and provide opportunities for enhanced training and communication among service providers. The Executive Committee plans to work together with the Liaison Committee and other community agencies as required in order to address the areas for improvement that were noted in this evaluation, and to ensure sustainability of the Community Plan in Middlesex-London. The following recommendations are provided:

1. Consider modifications to Community Plan tools and process as identified in the process and outcome evaluation.

2. Develop a plan to address challenges in ongoing implementation and sustainability of the Community Plan process.

3. Obtain ongoing resources for the sustainability of the Community Plan process and training, including the continuity of the Community Plan Coordinator role.

4. Continue to support ongoing education and training opportunities in the Community Plan.

5. Pursue options for continuing the evaluation component of the Community Plan as the evaluation of the Community Plan ends at the end of December 2006 with the completion of the Early Childhood Development fund.

6. Work with community agencies to identify the gaps in service and knowledge that exist within the community with regards to the protection of infants living in high risk environments.

7. Work with community agencies to advocate and pursue strategies to address gaps in service that exist in the area of protecting infants living in high risk environments with a particular focus on addressing social and economic determinants of health.

8. Continue to expand the use of the Community Plan within the community by reaching out to recruit new agencies not currently involved in the Community Plan process.

REFERENCES

Community Plan for Protecting Infants in High-Risk Environments in London and Middlesex County: Community Plan Manual. May 2004.

Summers, N. & Huffman, M. (2003). Family Abuse Prevention Project: Evaluation Plan. Middlesex-London Health Unit (MLHU).

Radcliffe, D. (2004). The Community Plan for Protecting Infants in High Risk Environments in London and Middlesex County: A Formative Evaluation. London, Ontario: Middlesex-London Health Unit.

The Community Plan for Protecting Infants in High Risk Environments in London and Middlesex County: Appendices

Appendix A: Infant Community Plan Questionnaire

Caregiver 's ID/name: __________ Gender:_____ Caregiver's Age:_____ Infant's Age: *See Instructions on Back*

FACTORS RELATED TO INFANT An infant is a child less than 24 months of age. Prenatally please complete when gestation is 20 weeks or more.	**Check (√) if factor is indicated. Add comments if any.**
1) Caregiver told (or tells you) that the infant was premature or low birth weight when born.	
2) Problems with feeding (breast or bottle, or with baby foods)	
3) Exposure to alcohol, tobacco and/or non-prescription drugs during pregnancy	
4) Medical conditions i.e. Fetal alcohol syndrome, HIV, respiratory problems, chronic conditions, medically fragile, excessive irritability	
5) The infant does not appear clean and healthy.	
6) Primary caregiver reports the infant has not received regular medical care.	
FACTORS RELATED TO THE PRIMARY CAREGIVER INDICATE IF THE CAREGIVER IS A PARENT ☐ GRANDPARENT ☐ OTHER FAMILY MEMBER ☐	FRIEND ☐
1) Mother did not have adequate prenatal care (i.e. little or no medical care, inadequate nutrition).	
2) Observations of Primary Caregiver/child interactions indicate concerns i.e. physical contact occurs only for feeding, diapering, bathing, unresponsiveness to child's crying and/or frustration expressed with the child.	
3) Primary Caregiver has diagnosed psychiatric illness and may or may not be receiving or complying with treatment.	
4) Primary Caregiver demonstrates signs of emotional health concerns such as frequent loss of control and depressive symptoms.	
5) Primary Caregiver is unable to provide adequate care to the child due to substance use.	
6) Previous children in the care of CAS; or the care of others.	
7) Primary Caregiver(s) has cognitive and/or developmental characteristics that seriously impact their ability to provide care for the child.	
8) Primary Caregiver demonstrates a lack of knowledge about adequate nutrition.	
9) Primary Caregiver does not read and respond to the infant's emotional cues, has inappropriate age expectations; and/or displays reluctance or resistance to education around care of the child.	
10) Primary Caregiver assigns adult motives for the child's behavior which are not appropriate (i.e. infant is crying just to get attention); and/or views the infant in a negative way.	
11) Use of physical punishment as a child management strategy, and/or out of frustration.	
12) Primary Caregiver is known to be deceptive with professionals in regards to the child(ren).	
13) Primary Caregiver seems to put the needs of self before the needs of the infant.	
FACTORS IN THE ENVIRONMENT	
1) Primary Caregiver is without residence, or housing is substandard and/or potentially hazardous to the infant i.e. lack of heat or plumbing, inadequate provisions for the child, etc.	
2) There is a history/evidence of family violence within the Primary Caregiver's current or past relationships.	

3) Older siblings are poorly supervised and frequently left alone with the infant; or the chid(ren) are left with inappropriate caregivers.	
4) Primary Caregiver resides with more than one non-family member and has a short history (less than one year) of involvement with these individuals.	
5) Primary Caregiver has a history of homelessness, or has moved residences frequently (more than twice a year).	
FACTORS RELATED TO SUPPORT SYSTEMS	
1) Primary Caregiver' s ability to get support from their family is impaired.	
2) Primary Caregiver is isolated and identifies few, if any, pro-social supports.	
3) Primary Caregiver is isolated from own cultural community (voluntary or non-voluntarily).	
4) Primary Caregiver's perceived support system is involved in criminal or antisocial activities, which impacts efforts to care for the child.	
Additional Comments:	

This Questionnaire is not a risk assessment tool. Instead it is a guide to use that will help you consider those factors that have been shown to indicate risk. You are probably already asking most of these questions. The purpose of the Community Plan for High Risk Infants is to establish an interagency process that ensures professionals are working collaboratively to promote optimal safety, growth and development of infants under twenty-four months of age who are identified as living in high-risk environments.

Questionnaire completed by____________________**Agency:**____________________**Date:** __________

Caregiver known for: 48 hours ☐ 72 hours ☐ 7 days or more ☐

Circle the information source: file(s); caregiver(s); agency staff/ referral (name)____________________

Consultation/discussed with ____________________**No follow up required** ☐

Follow up required: ☐ Follow up will include:
- **Referral to CAS (as per duty to report)**
- **Initiation of a Community Plan**
- **Further Assessment**

Is the family currently involved in a Community Plan? Yes ☐ **No** ☐ ***If yes, Coordinator's Name***: __________

Instructions:

a) Set the stage for interview with caregiver. (a calm, relaxed and non-judgmental "kitchen table" discussion versus a formal interview) . May be completed at time of intake to your agency or over a few visits as established by your agency policy.
b) Explain the purpose of the questionnaire and your professional obligation if you think the infant is in need of protection. This questionnaire is intended to focus on the individual needs of the child and to direct the agency/staff completing it the Community Plan. It does not replace any formal screening or assessment tool that you are required to complete.
c) Complete the questionnaire, observing the interactions/reactions of the caregiver to the child.
d) Notify CAS (with the caregiver's knowledge and in their presence if possible) without delay if you think the child is in need of protection. If you are unsure of your duty to report consult immediately with a supervisor, or your agency Community Plan Liaison.

e) Indicate on the form if any follow up is indicated. If none, file the questionnaire in accordance with your agency's policies, and consult with a supervisor as required.
f) Where follow up other than a Community Plan is indicated, record what the plan is in the comments area. (see Manual for more information)
g) If a Community Plan is required indicate who the Community Plan Coordinator will be. (usually the interviewer/person completing the questionnaire).
h) If CAS has ongoing involvement with the family CAS will be the ongoing Community Plan Coordinator. However the continued involvement/participation/coordination of all services involved is beneficial.
i) If conflict arises between (i.e. differing views of the plan required to go forward) the Community Plan for High Risk Infants (see Conflict Resolution) or the Community Plan Liaison for your agency should be consulted.
j) Black out Caregiver's Name/ID (for confidentiality) and forward a copy of the form to your Community Plan Agency Liaison.

Remember: If you have reasonable and probable grounds to suspect a child is in need of protection you must report your concerns to the Children's Aid Society.

Appendix B: Community Plan Conference Summary Sheet

Current Community Plan Meeting

Infant's Name:

Date of Community Plan Meeting (dd/mm/yy):

Please indicate if this is the: Initial Plan_____ or Review (If review - then indicate review number)

Termination ☐ Reason for Termination:

The Family: Mother's Name: Father's Name:		**The Community Team:** Community Plan Coordinator: Agency: Phone/Fax:		
Children's Names:	Date of Birth:	Member:	Agency:	Phone /Fax
Address:				
Telephone:				

Goal	Action	By whom/when	Outcome: Describe if goal is Ongoing, Completed or Abandoned

Next Review Date:__________ Time:______ Location of Community Plan Review Meeting: __________

Form Completed by:__________

Appendix C: Community Plan Audit Form

Date of Community Plan Meeting(dd/mm/yy):________________

Circle the number(s) representing the agency (agencies) who have a role in the Community Plan:
(Please include **ALL** of the agencies involved)

1. Children's Aid Society	2. Merrymount
3. Salvation Army Bethesda Centre	4. Middlesex-London Health Unit
5. Glen Carin Resource Centre	6. Rotholme
7. Youth Action Centre	8. Women's Community House
9. Women's Rural Resource Centre (Strathroy)	10. St. Joseph's Health Centre
11. heartspace	12. Intercommunity Health Centre
13. London Health Sciences Centre	14. Zhaawanong
15. At^losha	16. Thames Valley Children's Centre
17. Community Living London	18. Child/Parent Resource Institute (CPRI)
19. Childreach	20. Families First
21. C.S.C.N.	22. Kid's Ark Daycare
23. John Howard Society	24. Ontario Early Years Centre
25. London Crisis Pregnancy Centre	26. Youth for Christ
27. Vanier	28. WOTCH
29. LEAP	30. PACT
31. Physician (Name)	31. Other (Please state organization or person's name):

Agency of the Community Plan Coordinator	
Initial Community Plan Meeting? YES: NO:	
Follow up Community Plan Meeting? YES: NO:	
Number of reviews completed during this Community Plan (if known by agency completing this form).	
Date of Community Plan termination *if indicated* (dd/mm/yy)	
Reason for Termination	

Additional comments about Community Plan Process:

Appendix D: Information Letter and Informed Consent Sheet

Family Abuse Prevention
Liaison Committee Discussion Group Session
Information and Consent Form

Background:
Middlesex-London Health Unit is currently evaluating the Family Abuse Prevention Project to understand the impact of the Community Plan on the provision of services to infants living in high risk environments. As a front-line service provider who is involved in the Community Plan process, we would like to find out how your involvement in the Community Plan has impacted the coordination of services, and subsequently influenced infant safety and well-being.

What will happen in this discussion group:
We will be asking you questions about successes and challenges of the Community Plan process, including anticipated and unanticipated outcomes. The discussion group will involve approximately 8 to 10 participants, and will take approximately 45 minutes to 1 hour in length. We will be recording the discussion on flip-chart paper. Participants may express views during this discussion group that may be considered confidential. As a result, participants agree not to discuss what is said during the discussion group outside of the session.

Participant Rights:
Your participation in this evaluation is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the discussion group session at any time. If you decide not to participate, your decision will not affect your position within your agency nor your involvement in the Community Plan initiative.

Confidentiality:
Individual names and agency names will not be associated with the information in any way. All responses will be kept anonymous.

Publication of the Findings:
Summary results of the discussion groups and other evaluation measures will be used to document aspects of the Community Plan initiative. A summary of the evaluation findings will be available to you through the Liaison Committee.

Consent

I have read and understand the above information letter and voluntarily agree to participate in this evaluation. I understand that anything I say or write will be kept confidential and that my name or agency's name will not be associated with my responses in any verbal or written report on the evaluation. I understand that I may choose at any time to not answer any question that I do not want to answer. I agree to participate in this discussion group.

______________________	______________________	______________
Participant's Name (please print)	Participant's Signature	Date
______________________	______________________	______________
Witness	Witness Signature	Date

Thank you for your participation in this evaluation.

Contact person for questions regarding the evaluation:
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Appendix E: Focus Group Questions

Liaison Committee Discussion Group Questions for May 30th, 2006

We encourage you to consult with co-workers and other front-line staff members to gather feedback on these discussion questions for our May 30th Liaison Committee Meeting.

Purpose of Evaluation:
To evaluate the impact of the Community Plan on the provision of services to infants living in high risk environments.

Goals of Discussion Group Sessions:

- To assess how the interagency process and development of partnerships has made an impact on the provision of services to infants living in high risk environments
- To determine how collaboration, coordination and mobilization of resources among agencies has made an impact on the provision of services to infants living in high risk environments
- To determine how the communication and support among partners involved in the Community Plan initiative has made an impact on the provision of services to infants living in high risk environments

Discussion Group Questions:

1. **What has been the impact of the Community Plan on the provision of services to infants living in high risk environments?** (Probe: What changes did you and/or your agency make to implement the Community Plan?, Probe: What impact does the Community Plan process have on your relationships with other agencies?)

2. **What challenges, if any, currently exist in the Community Plan?**

3. **What areas are there for improvement in how agencies work together to implement the Community Plan?**

4. **What gaps in service currently exist in London and Middlesex County in relation to protecting infants living in high-risk environments?**

____
____
____
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5. **What parts of the Community Plan process have been helpful for supporting the agencies participating in the Community Plan process and enhancing communication?** (Probe: For example, education/training opportunities, liaison committee meetings, liaison committee representatives)

____
____
____
____
____
____
____

6. **Does the Community Plan promote the health of high-risk infants? If so, how?** (Probe: Does the use of the screening tool promote the health of high-risk infants? If so, how?, Probe: Does the Community Plan conferences promote the health of high risk infants? If so, how?)

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____

7. **Do you have any other comments to add about the Community Plan?**

____
____
____
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Appendix F: Summary Report of Community Plan Questionnaire Data from June 1, 2003 to June 30, 2006

Number of Community Plan Questionnaires Completed At Each Agency

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)		Jan-June 2005		July – December 2005		Jan-June 2006		Total Frequency	Total % of tools (n=1920)
Agency	Frequency	%	Frequency	%	Frequency	%	Frequency	%		
Children's Aid Society	636	67.3	272	86.3	250	83.6	279	77.3	1437	74.8
Child/Parent Resource Institute –Home Visiting Program for Infants (CPRI-HVPI)	0	0	2	0.6	0	0	5	1.4	7	0.4
Glen Cairn Community Resource Centre	13	1.4	0	0	0	0	0	0.0	13	0.7
Women's Community House (WCH)	38	4	14	4.4	12	4	3	0.8	67	3.5
heartspace	42	4.4	1	0.3	6	2	5	1.4	54	2.8
Merrymount Children's Centre	1	0.1	0	0	0	0	1	0.3	2	0.1
Rotholme Women's and Family-Shelter	61	6.5	22	7	21	7	59	16.3	163	8.5
Salvation Army Bethesda	19	2	0	0	5	1.7	0	0.0	24	1.3
St. Joseph's Health Centre	41	4.3	0	0	1	0.3	0	0.0	42	2.2
Unknown	28	3	0	0	0	0	0	0.0	28	1.5
Women's Rural Resource Centre (WRRC)	19	2	3	1	4	1.3	7	1.9	33	1.7
Youth Action Centre (YAC)	46	4.9	1	0.3	0	0	0	0.0	47	2.4
Zhaawanong Shelter	1	0.105	0	0	0	0	2	0.6	3	0.2
Total	945	100	315	100	299	99.9	361	100	1920	100.0

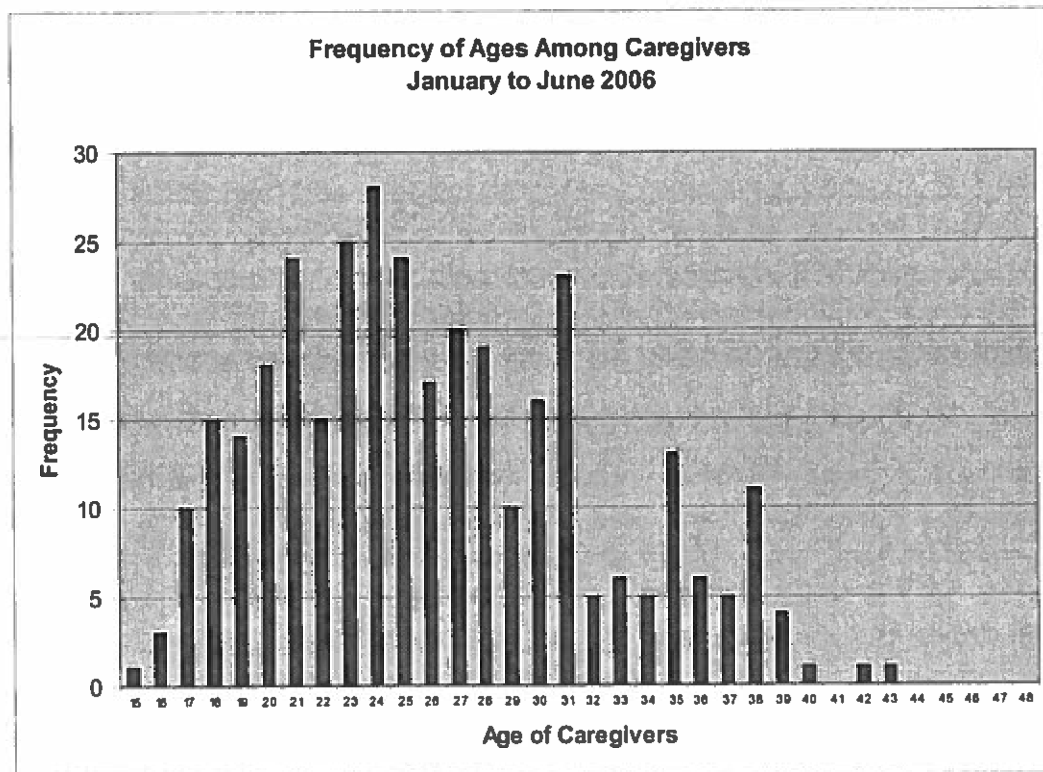
Caregiver Gender (Available on New 2006 Questionnaire Form Only)

	Jan-June 2006	
Caregiver Gender	Frequency	%
Female	67	97.1
Male	0	0
No Response	2	2.9
Total	69	100

Caregiver Age

	Post-Pilot – Dec 2004 (n=294)	Jan – June 2005 (n=260)	July – Dec 2005 (n=273) [1]	Jan – June 2006 (n=340)
Average Age of Caregivers	25.95	25.37	26.8	25.9
Median Age	Not Available	Not Available	25.9	25
Mode (most frequently reported age)	Not Available	Not Available	22	24
Maximum Age	52	62	48	43
Minimum Age	16	15	15	15

Note: [1] There were 5 screening tools that indicated ages for two caregivers.



Age of the Infant (Available on New 2006 Questionnaire Form Only)

The average age of the infant at the time of the questionnaire administration is 13 months.

	Jan-June 2006	
Infant Age	**Frequency**	**%**
prenatal - 22 weeks	1	1.4
1 month	1	1.4
1.25 months (5 weeks)	1	1.4
1.5 months (6 weeks)	3	4.3
2 months	7	10.1
2.25 months (9 weeks)	1	1.4
2.5 months (10 weeks)	1	1.4
3 months	2	2.9
4 months	1	1.4
5 months	1	1.4
7 months	3	4.3
9 months	4	5.8
10 months	4	5.8
11 months	1	1.4
12 months (1 year)	14	20.3
13 months	2	2.9
16 months	1	1.4
17 months	2	2.9
20 months	1	1.4
24 months (2 years)	14	20.3
No response	4	5.8
Total	69	100

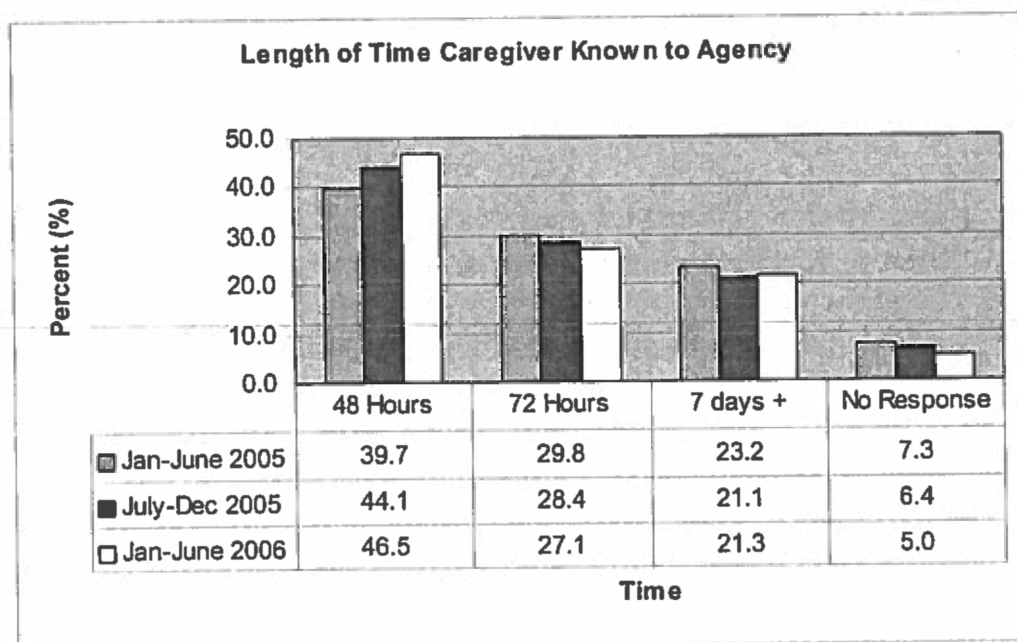
Caregiver Status

	Post-Pilot – Dec 2004 (12 months)		Jan-June 2005		July – December 2005		Jan-June 2006		Total Frequency	Total % of tools (n=1920)
Caregiver Status	Frequency	%	Frequency	%	Frequency	%	Frequency	%		
Parent	324	89.2	272	92.2	258	84.9	334	92.5	1188	89.8
Grandparent	2	0.6	4	1.4	5	1.6	2	0.6	13	1.0
Other Family	3	0.8	0	0	0	0	0	0	3	0.2
Unknown	34	9.4	19	6.4	41	13.5	25	6.9	119	9.0
Total	363	100	295	100	304	100	361	100	1323	100

Note: This data is based on results from the Portrait Screening Tools only.

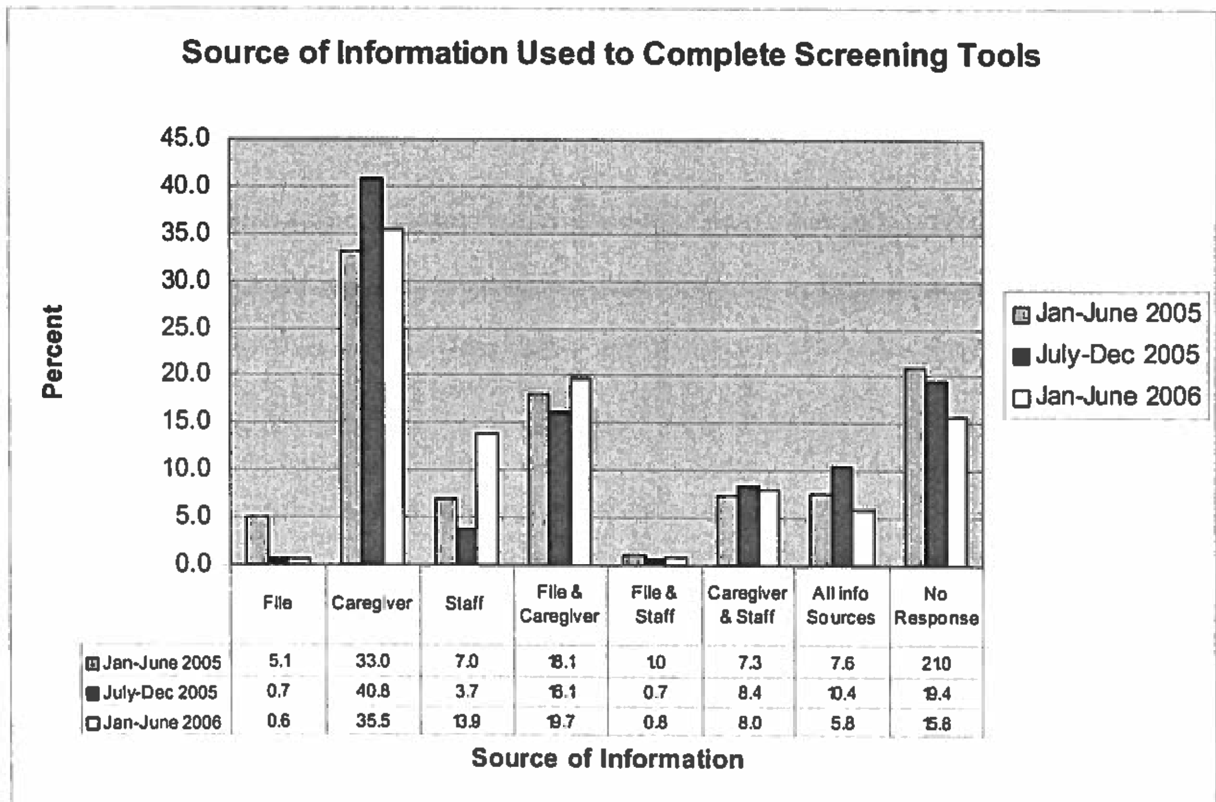
Length of Time Caregiver Known to Agent

Length of Time Caregiver Known to Agent	Jan-June 2005		July – December 2005		Jan-June 2006		Total Frequency	Total % of tools (n=1920)
	Frequency	%	Frequency	%	Frequency	%		
48 Hours	125	39.7	132	44.1	168	46.5	425	43.6
72 Hours	94	29.8	85	28.4	98	27.1	277	28.4
7 days +	73	23.2	63	21.1	77	21.3	213	21.8
No Response	23	7.3	19	6.4	18	5.0	60	6.2
Total	315	100	299	100	361	100	975	100



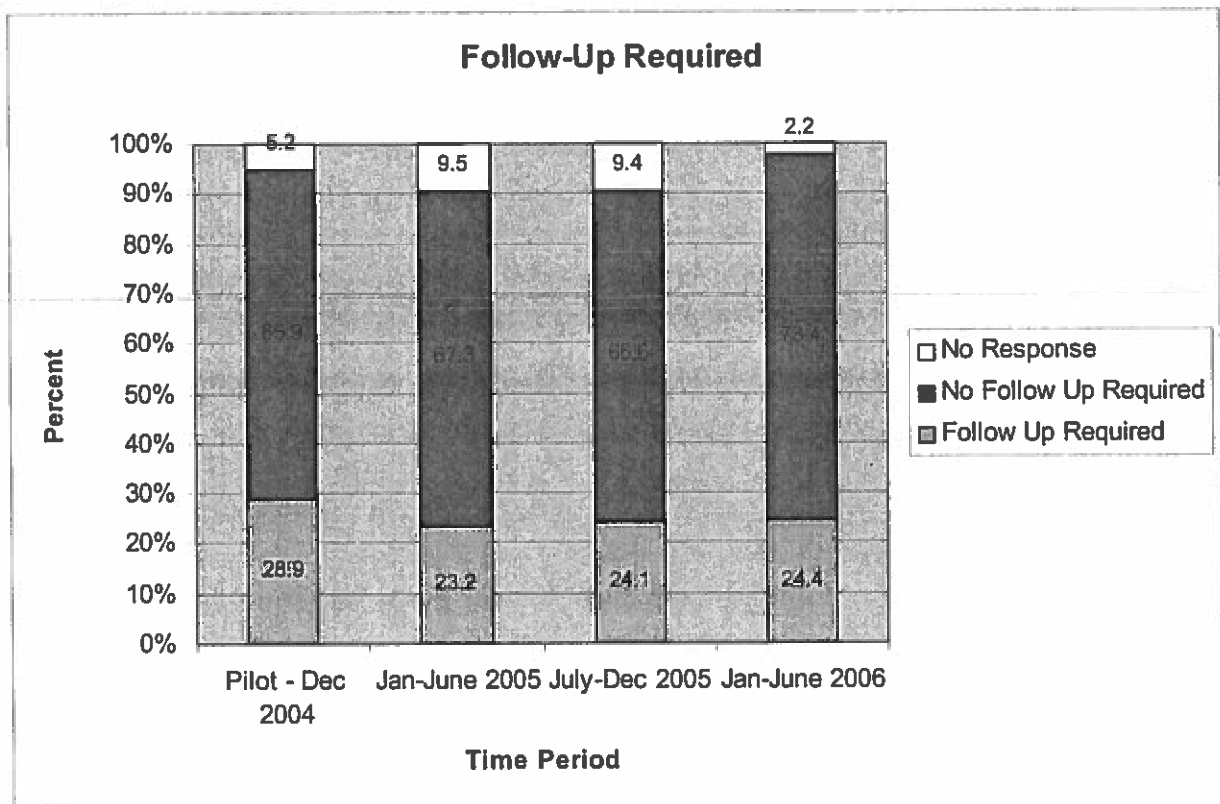
Source of Information Used to Complete Screening Tool

Source of Information	Jan-June 2005 Frequency	Jan-June 2005 %	July – December 2005 Frequency	July – December 2005 %	Jan-June 2006 Frequency	Jan-June 2006 %	Total Frequency	Total % of tools (n=1920)
File	16	5.1	2	0.7	2	0.6	20	2.1
Caregiver	104	33.0	122	40.8	128	35.5	354	36.3
Staff	22	7.0	11	3.7	50	13.9	83	8.5
File & Caregiver	57	18.1	48	16.1	71	19.7	176	18.1
File & Staff	3	1.0	2	0.7	3	0.8	8	0.8
Caregiver & Staff	23	7.3	25	8.4	29	8.0	77	7.9
File, Caregiver & Staff	24	7.6	31	10.4	21	5.8	76	7.8
No Response	66	21.0	58	19.4	57	15.8	181	18.6
Total	315	100	299	100	361	100	975	100



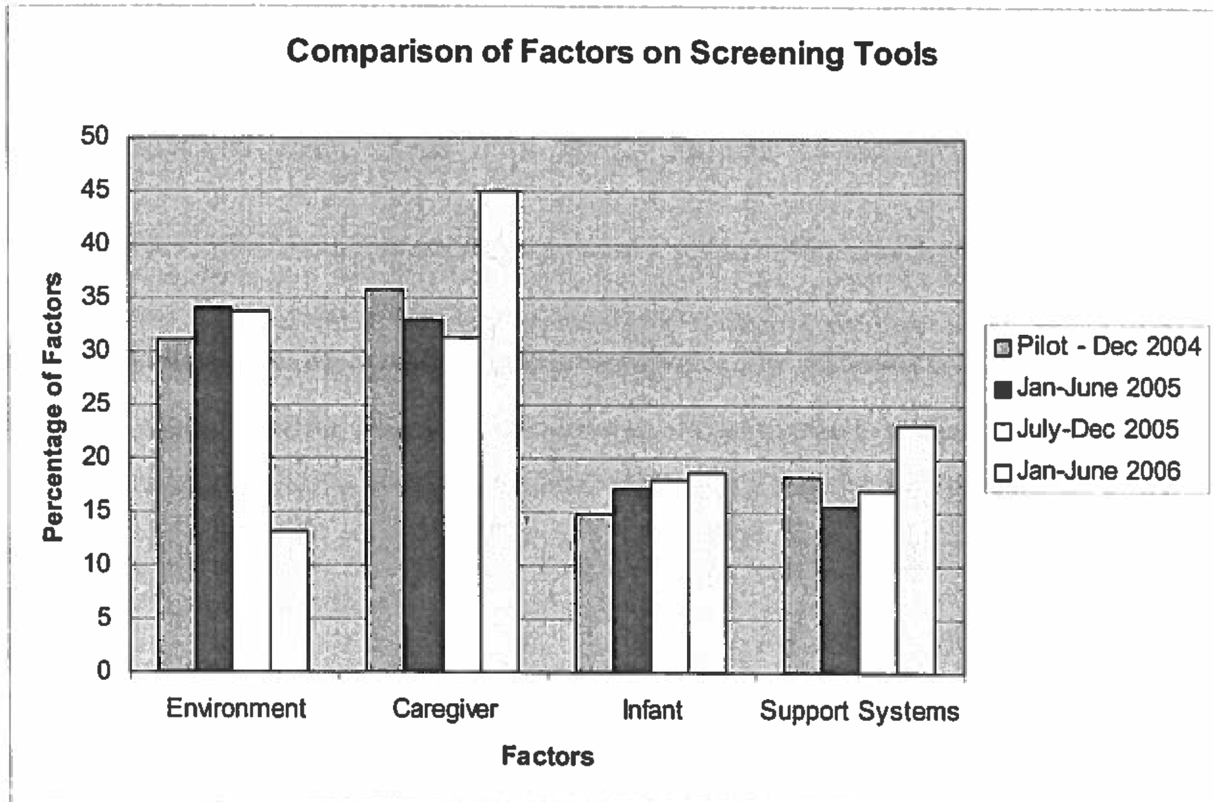
Follow-Up Required

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)		Jan-June 2005		July – December 2005		Jan-June 2006		Total Frequency	Total % of tools (n=1920)
	Frequency	%	Frequency	%	Frequency	%	Frequency	%		
No Follow Up Required	623	65.9	212	67.3	199	66.1	265	73.4	1299	67.6
Follow-Up Required	273	28.9	73	23.2	72	24.1	88	24.4	506	26.4
Unknown* based on pilot phase only (June-Dec 2003)	49	5.2	30	9.5	28	9.4	8	2.2	115	6.0
Total	945	100	315	100	299	100	361	100	1920	100.0



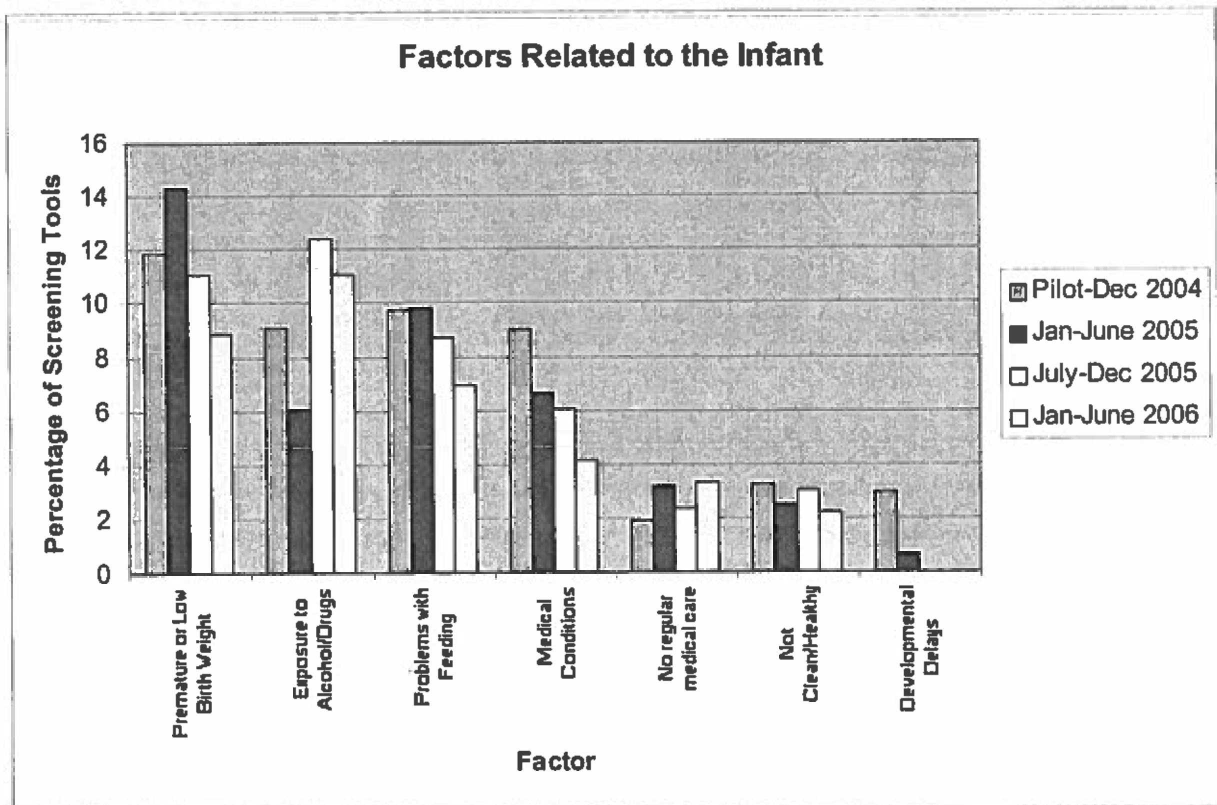
Comparison of Factors on Screening Tool

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)		Jan – June 2005		July – Dec 2005		Jan – June 2006		Total Frequency	Total % of tools (n=1920)
FACTOR	Frequency	% of factor	Frequency	% of factor	Frequency	% of factor	Frequency	% of factor		
Environment	892	31.1	269	34.1	245	33.7	93	13.2	1499	78.1
Caregiver	1029	35.8	260	33.0	228	31.4	318	45.0	1835	95.6
Infant	425	14.8	136	17.3	130	17.9	132	18.7	823	42.9
Support Systems	526	18.3	123	15.6	124	17.1	164	23.2	937	48.8
Total	2872	100	788	100	727	100	707	100	5094	



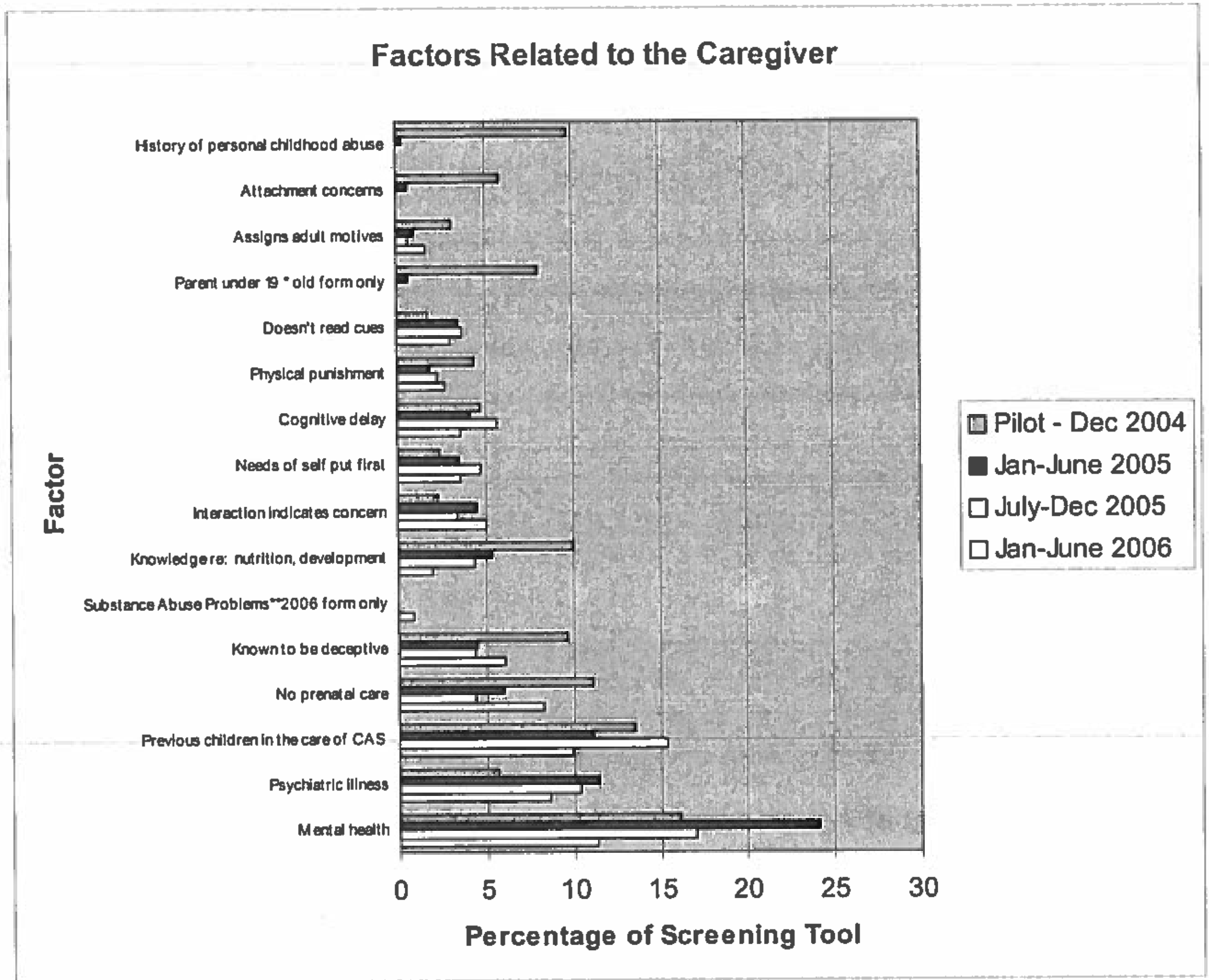
Factors Related to the INFANT

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)			Jan – June 2005			July – Dec 2005			Jan – June 2006			Total Freq-uency	Total % of tools (n=192[illegible]
Risk Factors Related to INFANT	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of screening tools	n	% of factor	% of tools		
Premature or low birth weight	112	24.8	11.9	45	33.1	14.3	33	25.4	11.0	32	24.2	8.9	222	11.6
Exposure to alcohol	86	19	9.1	19	14	6.0	37	28.5	12.4	40	30.3	11.1	182	9.5
Feeding problems	92	20.4	9.7	31	22.8	9.8	26	20	8.7	25	18.9	6.9	174	9.1
Medical condition	85	18.8	9.0	21	15.4	6.7	18	13.8	6.0	15	11.4	4.2	139	7.2
No regular medical care	18	4	1.9	10	7.4	3.2	7	5.4	2.3	12	9.1	3.3	47	2.4
Appearance	31	6.9	3.3	8	5.9	2.5	9	6.9	3.0	8	6.1	2.2	56	2.9
Developmental Delays * Old Form Only	28	6.2	3.0	2	1.5	0.6	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	30	1.6
Total	452	100	-	136	100	-	130	100	-	132	100	-	850	



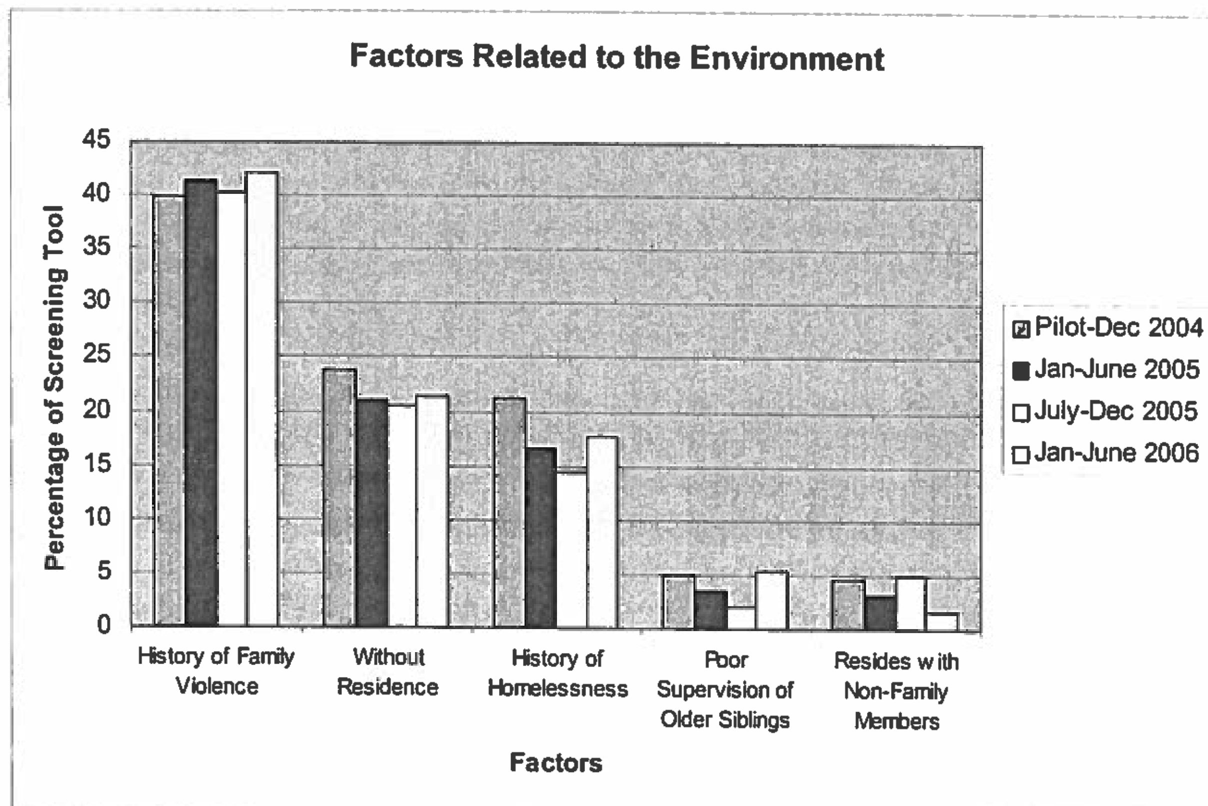
Factors Related to the CAREGIVER

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)			Jan – June 2005			July – Dec 2005			Jan – June 2006			Total Freq-uency	Total % of tools (n=1920)
Risk Factors Related to CAREGIVER	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of tools		
Mental health	153	14.9	16.2	76	29.2	24.1	51	22.4	17.1	41	17.0	11.4	321	16.7
Psychiatric illness	54	5.2	5.7	36	13.8	11.4	31	13.6	10.4	31	12.9	8.6	152	7.9
Previous children in the care of CAS	128	12.4	13.5	35	13.5	11.1	46	20.2	15.4	36	14.9	10.0	245	12.8
No prenatal care	105	10.2	11.1	19	7.3	6.0	13	5.7	4.3	30	12.4	8.3	167	8.7
Known to be deceptive	92	8.9	9.7	14	5.4	4.4	13	5.7	4.3	22	9.1	6.1	141	7.3
Substance Abuse Problems** 2006 form only	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	3	1.2	0.8	3	0.2
Knowledge re: nutrition, development	95	9.2	10.1	17	6.5	5.4	13	5.7	4.3	7	2.9	1.9	132	6.9
Interaction indicates concern	22	2.1	2.3	14	5.4	4.4	10	4.4	3.3	18	7.5	5.0	64	3.3
Needs of self put first	23	2.2	2.4	11	4.2	3.5	14	6.1	4.7	13	5.4	3.6	61	3.2
Cognitive delay	44	4.3	4.7	13	5	4.1	17	7.5	5.7	13	5.4	3.6	87	4.5
Physical punishment	41	4	4.3	6	2.3	1.9	7	3.1	2.3	10	4.1	2.8	64	3.3
Doesn't read cues	17	1.7	1.8	11	4.2	3.5	11	4.8	3.7	11	4.6	3.0	50	2.6
Parent under 19 * old form only	76	7.4	8.0	2	0.8	0.6	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	78	4.1
Assigns adult motives	30	2.9	3.2	3	1.2	1.0	2	0.9	0.7	6	2.5	1.7	41	2.1
Attachment concerns	56	5.4	5.9	2	0.8	0.6	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	58	3.0
History of personal childhood abuse	93	9	9.8	1	0.4	0.3	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	94	4.9
Total	1029	99.8	-	260	100	-	228	100	-	241	100	-	1758	


Factors Related to the Caregiver
History of personal childhood abuse
Attachment concerns
Assigns adult motives
Parent under 19 * old form only
Doesn't read cues
Physical punishment
Cognitive delay
Needs of self put first
Interaction indicates concern
Knowledge re: nutrition, development
Substance Abuse Problems**2006 form only
Known to be deceptive
No prenatal care
Previous children in the care of CAS
Psychiatric illness
Mental health
Factor
0
5
10
15
20
25
30
Percentage of Screening Tool
Pilot - Dec 2004
Jan-June 2005
July-Dec 2005
Jan-June 2006

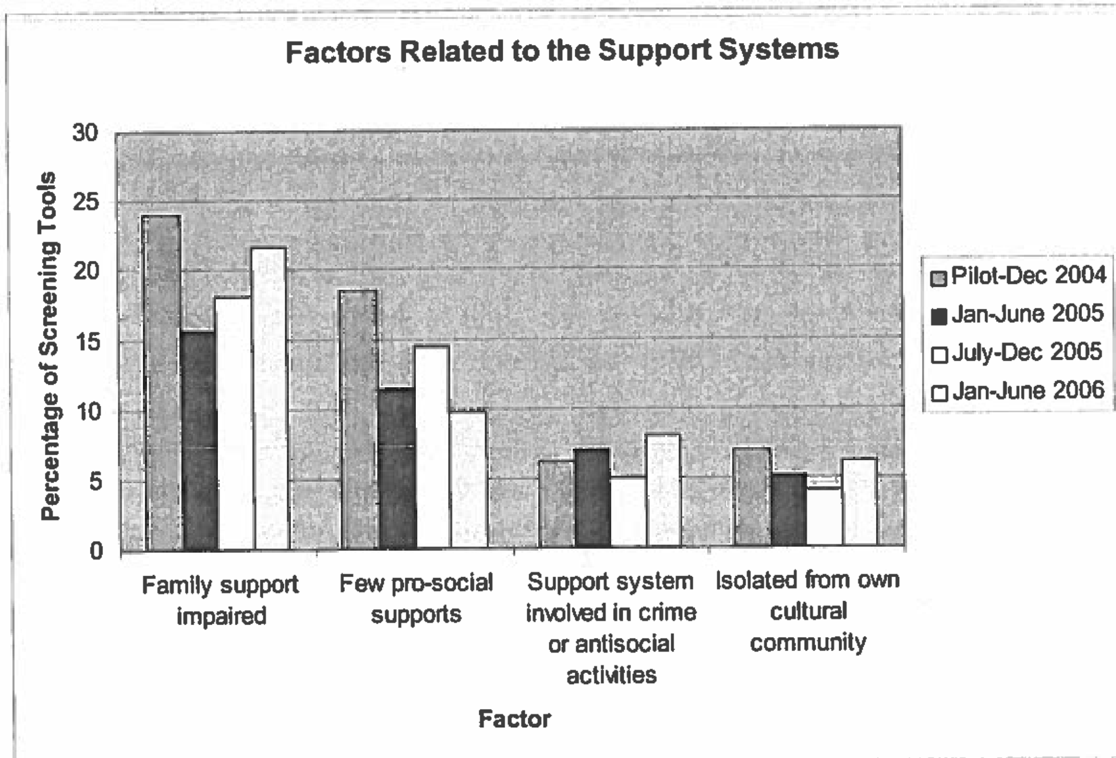
Factors Related to the ENVIRONMENT

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)			Jan – June 2005			July – Dec 2005			Jan – June 2006			Total Freq-uency	Total % of tools (n=1920)
Risk Factors Related to ENVIRONMENT	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of tools		
History of family violence	376	42.2	39.8	130	48.3	41.3	120	49	40.1	152	47.8	42.1	778	40.5
Without residence, or substandard	225	25.2	23.8	66	24.5	21.0	61	24.9	20.4	77	24.2	21:3	429	22.3
Homelessness history	200	22.4	21.2	52	19.3	16.5	43	17.6	14.4	64	20.1	17.7	359	18.7
Older siblings poorly supervised	47	5.3	5.0	11	4.1	3.5	6	2.4	2.0	19	6.0	5.3	83	4.3
Resides with 1 or more non-family	44	4.9	4.7	10	3.7	3.2	15	6.1	5.0	6	1.9	1.7	75	3.9
Total	892	100	-	269	100	-	245	100	-	318	100	-	1724	



Factors Related to the SUPPORT SYSTEM

	Pilot (June-Dec 2003) – Dec 2004 (1.5 years)			Jan – June 2005			July – Dec 2005			Jan – June 2006			Total Freq-uency	Total % of tools (n=1920)
Risk Factors Related to SUPPORT SYSTEM	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of tools	n	% of factor	% of tools		
Family support impaired	227	43.2	24.0	49	39.8	15.6	54	43.5	18.1	78	47.6	21.6	408	21.3
Few pro-social supports	175	33.3	18.5	36	29.3	11.4	43	34.7	14.4	35	21.3	9.7	289	15.1
Support system involved in crime or antisocial activities	58	11	6.1	22	17.9	7.0	15	12.1	5.0	29	17.7	8.0	124	6.5
Isolated from own cultural community	66	12.5	7.0	16	13	5.1	12	9.7	4.0	22	13.4	6.1	116	6.0
Total	526	100	-	123	100	-	124	100	-	164	100	-	937	



Appendix G: Summary Report of Community Plan Audit Form Data from June 1, 2003 to June 30, 2006

Community Plan Audit Form Data

	January – June 2006	July – December 2005	January – June 2005	Post-Pilot – December 2004 (12 months)	Pilot - June-Dec 2003 (6 months)	Total (Pilot to June 30, 2006)
Number of Audit Forms Completed	159	218	215	124	96	812
Total Number of New Plans	45	146*	101	56	93	441

* This includes 1 Initial Prenatal Community Plan Meeting

Summary Data of Agencies / Individuals Involved in Community Plans

	Jan – June 2006	July – December 2005	January – June 2005	Post-Pilot – December 2004 (12 months)	Pilot - June-Dec 2003 (6 months)
Total Number of Agencies / Individuals Involved	68	61	68	43	12 (other & physicians counted as one)

Number of Community Plans Terminated

Time Period	Number of Plans Terminated
January – June 2006	5
July – December 2005	9
January – June 2005	4
Post-Pilot – December 2004	7
Pilot	1
Total	**26**

- Between January and June 2006, there were five Community Plans terminated. The reasons cited for termination include the following (Note: Reasons were not cited for one termination).
  - Child is safe in mother's care; there is constant communication between all parties
  - Father is home to provide caregiving. Risk reduced.
  - Mother no longer involved with public health and appears to be doing well without this support. Mother and social worker will informally address all areas during visits.
  - Service providers have completed their involvement
- Between July to December 2005, there were nine Community Plans terminated. The reasons cited for termination include the following:
  - Child turned 2 years old, No other collaterals involved; no more risk concerns (n=3)
  - Child doesn't appear to be at risk
  - Case to be closed (n=2)
  - Client/mother completed service plan goals (n=2)
  - Caregiver unwilling to work with community partners
- Between January to June of 2005, there were four Community Plans terminated. The reasons cited for termination include the following:
  - Risks reduced
  - Family re-located outside of jurisdiction
  - CAS closing file
  - Child turning 2 years old

Breakdown of Agencies / Individuals Involved in Community Plans

	Jan-June 2006		July – December 2005		Jan-June 2005		Post-Pilot – Dec 2004 (12 months)		Pilot - June-Dec 2003 (6 months)		Total Freq-uency	Total % audit forms (n=812)
Breakdown of Agencies / Individuals	# meetings attended	% of meetings	# CP meetings attended	% of meetings	# CP meetings attended	% of meetings	# CP meetings attended	% of meetings	# CP meetings attended	% of meetings		
Children's Aid Society	153	96.2	216	99.1	212	98.6	120	96.8	87	90.6	788	97.0
Middlesex-London Health Unit	90	56.6	139	63.8	151	70.2	77	62.1	75	78.1	532	65.5
Other	72	45.3	128	58.7	95	44.2	43	34.7	34	35.4	372	45.8
Physicians	43	27.0	36	16.5	32	14.9	34	27.4	34	35.4	179	22.0
Merrymount	16	10.1	24	11.0	21	9.8	16	12.9	21	21.9	98	12.1
Salvation Army Bethesda	6	3.8	1	0.5	2	0.9	2	1.6	0	0	11	1.4
Women's Community House	4	2.5	8	3.7	8	3.7	3	2.4	3	3.1	26	3.2
Intercommunity Health Centre (IHC)	2	1.3	0	0	4	1.9	3	2.4	2	2.1	11	1.4
Youth Action Centre	0	0	2	0.9	4	1.9	4	3.2	4	4.2	14	1.7
Heartspace	0	0	4	1.8	6	2.8	5	4	0	0	15	1.8
SJHC	0	0	3	1.4	2	0.9	2	1.6	9	9.4	16	2.0
Rotholme Women's and Family Shelter	0	0	6	2.8	5	2.3	2	1.6	1	1	14	1.7
LHSC	1	0.6	1	0.5	2	0.9	3	2.4	4	4.2	11	1.4
WRRC	3	1.9	0	0	0	0.0	0	0	2	2.1	5	0.6
Glen Cairn	0	0	2	0.9	3	1.4	0	0	0	0	5	0.6
Prepared Childbirth	0	0	0	0	0	0.0	0	0	0	0	0	0.0
Thames Valley Children's Centre	4	2.5	14	6.4	Recorded as other	-	Recorded as other	-	Recorded as other	-	18	2.2
Families First	1	0.6	0	0	Recorded as other	-	Recorded as other	-	Recorded as other	-	1	0.1
John Howard Society	4	2.5	1	0.5	Recorded as other	-	Recorded as other	-	Recorded as other	-	5	0.6
Daycare	14	8.8	15	6.9	Recorded as other	-	Recorded as other	-	Recorded as other	-	29	3.6
Madame Vanier	3	1.9	7	3.2	Recorded as other	-	Recorded as other	-	Recorded as other	-	10	1.2
Child/Parent Resource Institute	11	6.9	4	1.8	Recorded as other	-	Recorded as other	-	Recorded as other	-	15	1.8
CSCN	2	1.3	11	5.0	Recorded as other	-	Recorded as other	-	Recorded as other	-	13	1.6
London Crisis Pregnancy Centre	1	0.6	0	0	Recorded as other	-	Recorded as other	-	Recorded as other	-	1	0.1
LEAP	3	1.9	1	0.5	Recorded as other	-	Recorded as other	-	Recorded as other	-	4	0.5

Number of Community Plan Reviews Completed

	Jan-June 2006		July – December 2005		Jan-June 2005		Post-Pilot – Dec 2004 (12 months)		Pilot - June-Dec 2003 (6 months)		Total Freq-uency
Number of Reviews Completed	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	
Initial Meeting	45	28.3	146	67	101	47	56	45.2	96	0	441
1	7	4.4	15	6.9	26	12.1	21	16.9	6	6.3	75
2	7	4.4	5	2.3	26	12.1	13	10.5	12	12.5	63
3	3	1.9	10	4.6	10	4.7	12	9.7	5	5.2	40
4	5	3.1	4	1.8	5	2.3	6	4.8	3	3.1	23
5	1	0.6	2	0.9	8	3.7	8	6.5	1	1	20
6	2	1.3	1	0.5	5	2.3	2	1.6	0	0	10
7	0	0	0	0	6	2.8	0	0	0	0	6
8	0	0	0	0	4	1.9	1	0.8	0	0	5
9	0	0	1	0.5	2	0.9	3	2.4	0	0	6
10	0	0	0	0	0	0.	1	0.8	0	0	1
11	0	0	0	0	1	0.5	0	0	0	0	1
12	0	0	1	0.5	2	0.9	0	0	0	0	3
13	0	0	1	0.5	3	1.4	0	0	0	0	4
14	0	0	2	0.9	0	0	0	0	0	0	2
15	0	0	1	0.5	0	0	0	0	0	0	1
16	2	1.3	0	0	0	0	0	0	0	0	2
17	2	1.3	0	0	0	0	0	0	0	0	2
Unknown	85	53.5	29	13.3	16	7.4	1	0.8	0	0	131
Total Nos. of Meetings	159	100	218	100	215	100	124	—	27	—	836
Total Nos. of Reviews	29		43		98		67		27		264

Coordinator of Community Plans

	Jan-June 2006		July – December 2005		Jan-June 2005		Post-Pilot – Dec 2004 (12 months)		Pilot - June-Dec 2003 (6 months)		Total Freq-uency	Total % audit forms (n=812)
Agency	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%		
CAS	153	96.2	215	98.6	210	97.7	119	96	76	79.2	773	95.2
MLHU	6	3.8	2	0.9	3	1.4	1	0.8	3	3.1	15	1.8
Other	0	0	0	0	2	0.9	1	0.8	0	0	3	0.4
Unknown	0	0	0	0	0	0	3	2.4	15	15.6	18	2.2
Merry-mount	0	0	0	0	0	0	0	0	1	1	1	0.1
WCH	0	0	1	0.5	0	0	0	0	0	0	1	0.1
YAC	0	0	0	0	0	0	0	0	1	1	1	0.1
Total	159	100	218	100	215	100	124	100	96	99.9	812	100.0

Agencies Involved in Community Plans
2003 to 2006

Health & Social Service Agencies and/or Professionals (n=75)

- Assertive Community Treatment (ACT)
- Addiction Services of Thames Valley
- Adolescent Outreach
- All Kids Belong
- Band Representative
- Boys' & Girls' Club
- Canadian Hearing Society
- Canadian Parapalegic Association
- Caring Dads
- Children's Aid Society
- Community Care Access Centre
- Changing WAYS
- Child Parent Resource Institute / Home Visiting Program for Infants (CPRI – HVPI)
- Childreach
- Church
- Children's Hospital of Western Ontario
- Canadian Mental Health Association
- Coda Health
- Crisis Health
- Community Services Coordination Network (CSCN)
- Dale Brain Injury Centre
- ECEC
- Epilepsy Support
- Families First
- Family Court Clinic
- Family Service London
- Glen Cairn Community Resource Centre
- Harmony House
- Healing Lodge
- heartspace
- Intercommunity Health Centre (IHC)
- John Howard Society
- Learning, Earning and Parenting (LEAP)
- London Health Sciences Centre
- Limberlost Chaplain
- London Crisis Pregnancy Centre
- Madame Vanier
- Merrymount
- Methadone Clinic
- Middlesex-London Health Unit (MLHU)
- N'Amerind Centre
- Oneida
- Oneida Band Representative
- Oneida Counsellor – Healing Lodge
- Oneida Human Services
- Ontario Works
- Onyota'aKa Healing Lodge
- Program of Assertive Community Treatment (PACT)
- Parkwood Hospital
- Prepared Childbirth
- Probation
- Regional Support Service
- Rehabilitation Management Inc.
- Reintegration Worker
- Registered Nurse
- Rotholme Women's and Family Shelter
- Salvation Army
- Salvation Army Bethesda
- Search Community Mental Health Services
- Second Stage Housing
- St. Joseph's Health Centre
- Skills Centre
- Smart Start For Babies
- Streetscape
- Thames Valley Children's Centre
- Victoria Family Medical Centre
- Victorian Order of Nurses (VON)
- Women's Community House (WCH)
- Wortley Village Medical Centre
- Western Ontario Therapeutic Community Hostel (WOTCH)
- Wrap Around
- Women's Rural Resource Centre (WRRC)
- Youth Action Centre (YAC)
- Youth for Christ
- Youth Probation Officer

Educational Institutions (n=7)

- Aberdeen Public School
- Bishop Townshend Public School
- Ekcoe Central Public School
- John P. Robarts Public School
- M B McEachren Public School
- Richmond Alternative School
- Richmond Language Centre

Physicians (n=36)

Daycares (n=13)

- Blossoms Daycare
- Chelsea Green Daycare
- Community Homes Daycare
- Daycare (Clarke Rd)
- Faith Day Nursery
- Glen Cairn Community Resource Centre
- Kids Works Childcare Care
- Little Red School House
- Salvation Army Village Day Nursery
- Village Day Nursery
- Western Day Care
- Whiteoaks Daycare
- Windy Woody Daycare