Infants and Toddlers Living in At Risk Environments Community Protocol

1. Purpose

The purpose of the Infants and Toddlers Living in At Risk Environments Community Protocol is to establish and implement interagency collaboration that will help to ensure early detection and intervention of neglect, harm or threat of harm and possible death of infants and toddlers under the age of three (3). The prenatal period will also be taken into consideration in the provision of collaborative services to the yet unborn infant

Collaborative case planning including discharge planning should be utilized to assist parents/caregivers and to support the child's ongoing development and well-being.

2. Background/Framework

Identifying and protecting infants and toddlers is a community responsibility that relies on collaboration. In response to concerns raised by Brant service providers and the recommendations arising from the Coroner's Inquest into the circumstances surrounding the death of Jordan Heikamp, the Brant community developed the *Infants Living in At Risk Environments Protocol 2004* that included a tool to assess the risk of young children in our community. The Protocol relied heavily on the tool and the support of a Coordinator position. It has been identified that the previous Protocol was underutilized for various reasons including, but not limited to, the loss of funding for the Coordinator position, and changes to internal agency processes.

In 2014, the Children and Youth Services Committee acknowledged the importance of community collaboration to address young children at risk, and requested the formation of a working group to review and modify the Infants Living in At Risk Environments Protocol. Brant Family and Children's Services has created documents for internal use that were deemed useful documents for the community (Refer to *Appendix 1*, *Practice Guidelines for Infants in Family Service Cases including Collaboration with Community Service Providers*, and Appendix 2, *Best Practice Document Safe Sleeping Environments for Infants*).

Additionally the *Brant Community Service Collaboration Protocol* (available at www.contactbrant.net - Community Information/Information Resources/Information for Professionals tab) should always be considered as a framework for community collaboration.

3. Guiding Principles

The community Protocol is guided by the following principles:

3.1. Child protection is a shared community responsibility.

3.2. The safety and well-being of the infant and toddler is paramount and needs to be of primary importance.

3.3. Infants and toddlers are our most vulnerable population since they are more isolated than school-aged children and more dependent on their caregivers for nurturing and care.

3.4. The more medically fragile the infant/toddler, the more vulnerable she or he is to harm by commission or omission.

3.5. The prenatal period will also be taken into consideration in the provision of collaborative services to the yet unborn infant.

3.6. Caregivers will be considered active participants in the collaboration.

3.7. The caregiver's ability to nurture the infant/toddler in a manner that promotes healthy growth and development can be strengthened and supported.

3.8. The caregiver's culture, religion and traditions will be respected

3.9. Agency service mandates and limitations will be respected.

4. Practice Guidelines

Our collective experience in our community has taught us that family and child focused planning, and interagency collaboration and communication is crucial to ensure the wellbeing of all Infants and Toddlers connected to services.

The illusion that safety is found in services cannot continue to permeate practice; instead, timely and intentional community collaboration mitigates risks and increases the likelihood of enhanced safety.

The Brant Children and Youth Services Committee's *Community Service Collaboration Protocol* (available at: www.contactbrant.net) outlines practices that are applicable to this Infants and Toddlers at Risk Protocol. The following outlines what collaborative practices should look like:

- Community Collaboration will ensure that services for children/youth and their families are coordinated and complementary; avoid duplication and contradiction; and consistently work towards meeting the child/youth and family goals in a manner that is consistent with their values and preferences.
- Children and families will receive coordinated support when they receive multiple agency services that ensure service providers are working together in a collaborative manner to meet their needs.
- Each staff involved in provision of services takes a role in establishing links among service providers and informal supports, across all sectors, and ensures coordination of the overall implementation of the individual's single plan of care.
- Inter-agency communication will be initiated by community staff when a child is identified as having involvement with two or more service providers. Interagency communication and coordination will be on-going, and will be integrated with other sectors involved with the child and family.
- Staff providing service to a child/youth will implement, deliver and coordinate services within their own agency's mandate, as well as regularly communicate with other agencies involved with the child/youth/family to develop a coordinated service plan as well as monitor outcomes.
- Staff providing service will support families/caregivers to engage with other services, including facilitating referrals to voluntary services and sharing

information so they don't have to repeat their story/help ensure the full story is relayed.

- Staff involved in provision of services will be aware of and honour the existing community referral processes (e.g., case conferencing/case planning meetings, Case Resolution, RPAC, etc.), Protocols, and service agreements.
- Community response is part of the on-going collaborative work of our community. Through the collaborative process of working together, service providers support integrated delivery of services for children, including those with complex special needs.
- Supports should focus on existing community-based services and recognize best practices.
- **In cases of potential imminent risk of harm to self or others, safety trumps privacy.** In cases where there are concerns of risk factors, the timeliness of information gathering is essential and includes information gathering and sharing from others. (Refer to *Community Threat Risk Assessment Protocol* developed by the Grand Erie District School Board with community stakeholders, www.granderie.ca - Board/Protocols tab).

5. Responsibilities of Service Providers Working with Infants/Toddlers/Families

Under the Duty to Report legislation, community professionals must identify any concerns of abuse or neglect immediately to Brant Family and Children's Services.

Safety is found in timely and intentional communication, collaboration, and solid planning together with all those involved. Community professionals should:

- Pay attention; be aware of infants and toddlers within the family context.
- Gather information – be aware of risk factors and ask questions.
- Close the loop – communicate with others and develop an immediate temporary safety plan.
- Collaborate by bringing people together and ensuring appropriate assessments are completed.
- Follow-up and document the responsibilities of each participant.

5.1. **Pay attention; gather information**:

Agencies will use their own assessment/screening tools to consider the infant/toddler and family's risk and mitigating protective factors (refer to Risk Factors, Appendix 3). Professionals should consider these risk factors and protective factors in their decision making to develop their next steps including an action plan.

Risk Factors:

- Prenatal, birth and development (low birth weight, prematurity, multiple births, medical conditions, exposure to alcohol and drugs, social and emotional development, motor skills, vision, hearing, cognitive development)

- Parenting (minimal prenatal care, caregiver under the age of 19, attachment concerns)
- Caregiver Limitations (mental health issues, alcohol or drug use, medical/physical conditions, cognitive/developmental)
- Caregiver History (history of child abuse or family violence, other children in care of FACS or relatives, poor supervision of older siblings, history of being deceptive or resistant with professionals)
- Environment (caregiver resides with more than one non-family member who have less than one year involvement, housing, history of homelessness, bed meets Health Canada regulations)
- Support Systems (limited abilities in getting support, isolated, perceived support system involved in criminal/antisocial activities)

Protective Factors:

- Infants/toddlers are seen by a physician for regular assessments, medical appointments and immunizations
- Reliable formal or informal supports are in place
- Caregiver has insight into risk factors
- Caregiver is receptive and actively working with service providers to address identified risks
- Caregiver is a reliable 'historian' engaging in open and honest communication with service providers
- Caregiver maintains regular contact with appropriate service providers e.g. primary care practitioner, social worker, public health nurse
- Caregiver demonstrates effective problem solving skills, decision-making skills, the capacity for learning new skills and information.

5.2. **Determine Action Plan:**

When a community professional identifies concerns that an infant/toddler under the age of 3 years is living in an at risk environment, they will engage the family in consenting to get other agencies involved in their support and planning.

Community professionals will identify the level of risk and take appropriate action:

- **Level 1: Imminent Risk – Immediate Needs** – For imminent risk concerns refer to Brant Family and Children's Services, or Emergency Services (immediate medical attention, police)
- **Level 2: Supportive Needs –** For identified risk concerns that do not pose imminent risk :
    - Customize a **Safety Plan** with the family before leaving the appointment (refer to Appendix 4).

- Refer to Healthy Babies Healthy Children at the Brant County Health Unit to complete a comprehensive family assessment and provide services as appropriate.
- Identify the involvement of current community services; contact and communicate with these current service providers to discuss and ensure the integration of services.
- Support the family in linking to other appropriate community service providers that will support the caregiver/child/family's well-being
- Support the family in the on-going coordination of services.
- Consult with Brant Family and Children's Services regarding any concerns of risks, including if the family does not consent to additional services.

5.3. **Collaborate; follow-up; and document**:

Community professionals must ensure formalized collaboration and communication between caregivers and service providers, including case conferencing as needed.

Each community professional will do their part in the support plan, and actively engage in on-going communication and collaboration. Collectively:

- Identify the primary community "service coordinator" who will take the lead in each family's coordination of services. This person may change over time.
- Identify who will do what – it's a community responsibility.
- Collectively review the risk and protective factors, as well as the action plan.
- Identify other community services to be involved and, with consent, support the referral to these services. Identify who will support the connection and engagement to other services. (Refer to Appendix 3 for community support services).
- Follow-up with a phone call to the referred agency to identify if the family will be admitted to services or if there is a waiting period.
- Identify next steps if other services will not be involved, or identify other supports to the family until new services can begin if there are wait lists.
- Regularly schedule community Case Conferences, Teleconferences or other forms of regular communication and coordination. Take minutes of these collaborative meetings and distribute to participants.
- Document all contact, goals, planning outcomes, and who is doing what, according to internal agency procedures.
- Address challenges and barriers to service by working collaboratively with community stakeholders.

- Support the transition to new services and coordinate discharge from a service when their mandate has been met.

5.4. **Close the Loop**:
Always remember to 'Close the loop'. Reassess risk and protective factors, and the community action plan.

6. **Privacy and Confidentiality**

There are two main pieces of privacy legislation in Ontario: PHIPA (*Personal Health Information Protection Act, 2004*) and FIPPA (*Freedom of Information and Protection of Privacy Act, 1990*). In addition, both the Youth Criminal Justice Act (2002) and the Child and Family Services Act (1990) speak to information sharing on behalf of children and youth. The general intent of access to information and protection of privacy legislation is to limit the sharing of personal information without the consent of the person. Wherever possible and reasonable, consent should be obtained. Community professionals will educate families on the importance of sharing information to receive community supports and assistance.

- Knowledgeable consent is required for the collection, use, and disclosure of personal information unless authorized by law without consent including where a search warrant, court order or summons/subpoena has been issued, or where necessary, to prevent significant harm.
- Consent is knowledgeable if it is reasonable in the circumstances to believe that the individual knows the purposes of the collection, use or disclosure, and that they may give or withhold consent.
  Best practice for ensuring consent is knowledgeable includes describing to the individual:
  - ✓ Who the information will be shared with
  - ✓ What information will be disclosed
  - ✓ The purpose for sharing the information
  - ✓ That consent may be withdrawn at any time
  - ✓ The circumstances under which information can be shared without consent.
- Consent must be from a capable individual who, regardless of age, can consent or refuse consent to the collection, use and disclosure of their own information; capacity is the ability to understand the information that is relevant to deciding whether to consent to the collection, use, or disclosure, and the ability to appreciate the reasonably foreseeable consequences of giving, not giving, or withholding or withdrawing consent.
- Consent is a process, not simply a form. Professionals will provide an opportunity to ask questions and provide answers to client's questions.

Establishing rapport and trust are key to gaining consent to engage families with other services. Community professionals need to recognize the value of other services themselves to enable the conversation with families about engaging with other services. Community professionals also need to recognize that fear can present as resistance; having the 'hard conversation' is difficult yet necessary; and opportunities of supports can provide hope.

In cases of potential imminent risk of harm to self or others, safety trumps privacy. "Challenges to the privacy legislation through the Supreme Court of Canada resulted in the decision that in cases of potential imminent danger, ***safety trumps privacy."*** (Grand Erie District School Board *School and Community Threat/Risk Assessment Protocol* June 2014). In these cases, information sharing will be based on the principle of 'need to know' which respects the individual's rights to privacy and the safety of all.

7. **Protocol Review**

This Protocol will be reviewed and supported annually at the Children and Youth Services Committee and the Best Start Network to address the practice outlined by the Protocol and identify any revisions required.

Staff training, and orientation and regular review is the responsibility of each member organization of these community committees.

- A training and orientation tool, the *Community Protocols and Processes Electronic Orientation Tool* (available at: www.contactbrant.net) on community protocols is provided by the Children and Youth Services Committee for all organizations to use and is available on the Contact Brant website. The Children and Youth Services Committee also offers occasional community training/orientation sessions.
- The Healthy Babies Healthy Children Liaison Nurse can provide assistance in training and orientation.
- Appendix 5 is a Flow Chart summarizing this Protocol.
- Appendix 6 summarizes places to get information on Brant services, as well as lists many organizations providing services/resources to infants, toddlers and their families.

BRANT FACS PRACTICE GUIDELINES FOR INFANTS IN FAMILY SERVICE CASES INCLUDING THE COLLABORATION WITH COMMUNITY SERVICE PROVIDERS

Preamble

The Brant CAS shares with the community the responsibility for protecting infant children and strengthening families. We will work in collaboration with the community to achieve this purpose. This philosophical stance is based on the following best practice beliefs;

- Child protection is a shared community responsibility
- Infants are our most vulnerable population since they are more isolated than school-aged children and more dependent on their caregivers for nurturing and care
- The more medically fragile the infant, the more vulnerable she or he is to harm by commission or omission
- Caregivers should be considered active participants in the collaboration
- Interventions, assessment and expectations must include both parents whenever possible and always include an assessment of the child's development
- The safety and wellbeing of the infant will take precedence over any other client consideration in the delivery of services to those families living in at-risk environments
- The caregiver's ability to nurture the infant in a manner that promotes healthy growth and development will be strengthened and supported where possible
- The caregiver's culture, religion and traditions will be respected
- Prevention and early identification have a positive impact on infant health and development and, as such, the prenatal period will also be taken into consideration in the provision of collaborative services to the yet unborn infant.

It takes a village to raise a child. Child death reviews have taught communities that interagency collaboration and communication is crucial to ensure the wellbeing of all infants connected to services. The illusion that safety is found in services cannot continue to permeate practice; instead, we know that safety is found in solid planning together with all those involved or wishing to be involved in a child's life.

As such, the Brant CAS through its case management principles will always consider, whenever and wherever possible and practical, the institution of collaborative services to children less than 36 months of age. These include our own internal agency programs and services as well as those administered by our community partners.

Procedures

Collaboration ensures that communication between caregivers and service providers working with the infant and his/her caregivers is formalized through regularly scheduled SOS Family Informed Meetings or Community Case Conferences or Community Protocol Conferences. (See Brant County Protocol to Protect Infants Living in High Risk Environments) The planning outcome from these collaborative meetings are documented within the agency file and copies provided to each participant.

1. All cases that have an infant less than 36 months of age with an open file to our agency, whether it is considered ‘protection’ or ‘non-protection’ must consider the involvement of an early years professional. This decision and rationale should be made in consultation with a Service Manager, early years professionals and the caregivers themselves. The consultation should be documented in the social work case notes.
2. Should the worker become aware that the infant and family are not involved with any early years professionals, the worker will consider the following and engage along with the caregiver, the manager and any other service providers as the assessment/investigation indicates involvement of Public Health, Lansdowne, our Child Development Unit, PCI, Teen Parenting, pediatrician, family doctor.
3. As a step of each new investigation during the worker’s initial home visit, the sleeping environment of an infant will be assessed utilizing the Safe Sleeping criteria .The caregivers will be cautioned about bed sharing and ensure that the crib or bassinet or cradle is safe and meeting Health Canada regulations.
    a) The safest place for an infant to sleep is in a crib/bassinet /cradle located in their caregiver’s room for the first 6 months of their life.
    b) The worker will determine, in consultation with the manager, other early years’ professionals, and the caregiver, the frequency of sleep environment reassessments. This decision will be reflected in case notes and SOS/case planning minutes.
4. Safe Sleeping Information for Infants document will be reviewed by the worker. The worker will review the document with the caregivers. The educational and resource information will be provided to the caregivers and alternative caregivers in a manner that recognizes literacy, learning styles, and language and culture.

    Best Practice Document
5. All infants shall be seen while awake and during an active period for the purpose of assessment of risk and strengths. Infants should be seen during regular care routines such as feeding, bathing time, and diaper changes.
6. The worker will collect information from the caregiver during the assessment phase with respect to the family doctor, pediatrician, nurse practitioner, walk-in clinics, specialists, involvement with Healthy Babies, Public Health, Lansdowne, and any other early years professionals involved with their baby and their family.
7. The worker will confirm the involvement of the identified community service providers. The worker will confirm that the caregivers are meeting the expectations of each community service provider related to the care of any infants and note any concerns of those providers.
8. The worker shall ensure infants are seen for regular well baby assessments, medical appointments and immunizations. Workers are expected to independently confirm such attendance with health care providers and documenting in case notes and case conferencing/SOS minutes.
9. The worker will review and consider the collaborative approach suggested by the Brant Community Protocol to Protect Infants Living in At Risk environments.

10. Assessment tools to assist caregivers to assess their child's current functioning, such as the scales, should be considered by the child protection worker to track the social, emotional and physical development of infants. The information gleaned from assessments will be used to inform the safety and service planning for the child.
11. The worker will develop through a case conference, SOS meeting or formalized Community Protocol meeting and articulate in the case file the frequency of their visits with the caregivers and infants less than 36 months of age.

    This will be determined based upon the social work assessment and in consultation with the manager, any early years professional, the caregivers and all involved extended family and social networks. The plan will be documented clearly in the case notes and SOS/case planning minutes.
12. Decisions to discharge the child and family from services will be made within the collaborative case planning structure and articulated in those documents.
13. Mothers should be supported in their decision to breastfeed and be referred to services that can offer assistance, education and resources to support nursing unless contraindicated by a physician.
14. Breastfeeding should be fully supported when establishing in care arrangements for infants unless contraindicated by a physician.
15. For those in the care of the Brant CAS, infant centered access arrangements need to be considered. When at all possible access should occur in the foster home when appropriate in order to minimize disruption to the infant.
16. Inclusive foster care should be utilized whenever a child under 3 years of age is in care.
17. Very young infants or medically compromised infants should be discharged from care and hospital at the beginning of a week so necessary supports can be put into place. Very few supports are available over the weekend. Monday discharges permit the necessary time to ensure that supports are put into place.
18. Collaborative case planning /discharge planning should be utilized to assist the caregivers to have a child returned home with the best planning in place to support the child's ongoing development and well-being.

Brant FACS: BEST PRACTICE DOCUMENT

SAFE SLEEPING ENVIRONMENTS FOR INFANTS

January 2013

A Brief Historical and Cultural Context

The factors that influence the sleeping arrangements of infants and children are a combination of parental values, socioeconomic factors and cultural diversity. The practice of bed sharing is not uncommon in our society and remains the routine sleeping arrangement in most of the world's non-industrialized cultures. In traditional cultures, babies are kept near their mother. Mothers in non-western cultures who traditionally sleep with their children say that they do so to monitor them, keep them safe, to facilitate breastfeeding and simply to be near them. The North American emphasis has traditionally been on having children sleep in their own beds, which is thought to play an important role in the child's ability to learn to separate from the parent and see himself/herself as an independent individual.

The term SUDI (Sudden Unexpected Death in Infancy) describes situations when infants die suddenly and unexpectedly. There are detailed protocols for the investigation of these deaths. The investigation may provide definitive cause and manner of death; however, at times, these may remain undetermined despite thorough and exhaustive investigations. When there are no identifiable concerns, including arising from review of the sleep circumstances, the death may be attributed to SIDS (Sudden Infant Death Syndrome). When concerns are identified or there are potential concerns about the sleep environment, the cause and manner of death will remain undetermined. These deaths have historically been described as Sudden Unexpected Death in Infancy (SUDI); however, this term has been utilized and interpreted in a variety of ways. The Office of the Chief Coroner is now characterizing the cause and manner of these deaths as undetermined and will list the sleep related circumstances as a potential contributing factor if indicated.

Understanding the family dynamics and the reasons for choosing a particular sleeping environment, in conjunction with the awareness of dangerous bed sharing practices, are all important considerations in offering guidance to parents in their choice for sleeping arrangements. No sleep environment is completely risk free, but much can be done to educate parents on the provision of safer sleeping environments for their infants. The advice given must be guided by the available evidence-based data, which indicate that when infants sleep in their own crib, they are significantly safer than when they bed share.

We have learned much from the examination of SIDS and SUDI's. Those lessons learned have become the foundation of Safe Sleep Practices provincially, nationally and internationally (Canadian Paediatric Committee February 2011).

As our knowledge is always developing, the reader is encouraged to review this document, the attachments and to consider seeking out updates from the Canadian Paediatric Committee and Health Canada to ensure we are utilizing the most current literature.

- Health Canada
  www.hc-sc.gc.ca/cps-spc/index-eng.php
- Caring for Kids
  http://www.caringforkids.cps.ca/handouts/safe_sleep_for_babies
- Canadian Paediatric Society
  http://www.cps.ca/en/
- Canadian Foundation for the Study of infant Deaths
  www.sidscanada.org
- Public Health Agency of Canada
  www.publichealth.gc.ca/safesleep
- Low Birth Weight & Preterm Multiple Births
  http://www.beststart.org/resources/lbw_aware/pdf/19422_Beststart_E_singles.pdf

Our Agency Position on Safe Sleeping Practice

The safest place for an infant to sleep is alone in a crib, in the bedroom of the parent or caregiver for the first 6 to 12 months. Cradles and bassinets meeting Canadian safety regulations are also safe places to an infant to sleep when directed by the manufacturer (for age and weight limitations). Infants and young children should never be placed to sleep on unstable surfaces such as a standard bed, water bed, air mattress, sofa, futon or armchair.

Key Messages from the Canadian Paediatric Society

1. The safest place for babies to sleep is in their own cribs and in the parent's room for the first six months of life.
2. The crib should meet Canadian government safety standards.
3. Infants should be placed to sleep on their back.
4. Other than a firm mattress and fitted sheets there is no need for extra items in the crib. This means no toys, blankets, pillows or bumper pads. Extra items in the crib could increase the risk of injury due to suffocation.
5. Infants less than one year of age should not sleep in an adult bed, couch, futon, pillow, water bed, chair, bean bag chair or air mattress.
6. Infant car seats are for travel and should not be utilized as a substitute for proper infant sleep surfaces such as an approved crib or bassinet. Do not leave babies sleeping on any surface not designed for safe sleep.
7. Do not smoke around infants and children. Infants and children should not be exposed to cigarette or other forms of smoke in their living environments or in any confined spaces such as a motor vehicle.
8. Bed sharing is unsafe because babies can suffocate if they become trapped between the sleeping surface and the parent or another object. Bed sharing (sharing a sleep surface) should be replaced by room sharing (sleeping in the same room).

Principles for Safe Sleep and Modifiable Risk Factors to reduce unexpected infant deaths

1. Infants placed on their back to sleep, for every sleep, have a reduced risk of unexpected death.
2. When the child is able to roll/turn herself/himself, it is not necessary to correct the child to their back, unless medically recommended.
3. Preventing exposure to tobacco smoke, before and after birth, reduces the risk of unexpected death in infancy. Infants who are exposed to second-hand smoke after birth are also at greater risk of SIDS and the risk increases with the level of exposure. Provide a smoke-free environment for the infant.
4. The safest place for an infant to sleep is in a crib, cradle or bassinet that meets current Canadian regulations. Other than a firm mattress and a fitted sheet, there is no need for extra items in the crib, cradle or bassinet. Strollers, swings, bouncers and car seats are not intended for infant sleep. Do not leave infants sleeping on any surface not designed for safe seep.
5. Overheating is a risk factor for SIDS. Infants are safest when placed to sleep in a fitted, one-piece sleepwear that is comfortable at room temperature and does not cause them to overheat. Do not overwrap a baby.
6. Infants who share a room with a parent or caregiver have a lower risk of SIDS. Room sharing refers to a sleeping arrangement where an infant's crib, cradle or bassinet is placed in the same room and near the parent or caregiver's bed. Infants must not share a sleeping surface with an adult or another child - this includes such locations as an adult bed, sofa or armchair. Sharing of a sleep surface also increases the risk of entrapment, overheating, over laying and suffocation.
7. Breastfeeding provides a protective factor for SIDS. Any breastfeeding for any duration provides a protective effect for SIDS, and exclusive breastfeeding offers greater protection. Caregivers should be encouraged to breastfeed whenever possible.

It is our responsibility as a child welfare organization, where the best interest of the child is paramount, to ensure we follow the guidelines and case note these discussions being mindful of preventative measures for infants in families we are serving. There will be families who will continue to bed share despite warnings. As a child welfare organization, our obligation is to provide information, education and consultations with community partners who specialize in early years services so families receive congruent and consistent messaging upon which to base their decisions with respect to their infants. The following are recommendations for child welfare workers when they are working with young children (36 months and younger) in the home:

1. The worker will discuss risk factors for unexpected infant death with parents and ways to reduce these risks. The worker will inquire routinely if there are other caregivers/alternative caregivers (grandparents, babysitters) who would benefit from this information and determine with the parent/caregiver how best to provide this information.
2. As a step within any new investigation during the workers initial home visit, the sleeping environment of an infant will be assessed utilizing the Safe Sleeping

criteria. The worker will determine, in consultation with their manager, other early years professionals and the caregivers, the frequency of sleep environment reassessments.

3. A safe sleep assessment should occur at each case reopening and whenever a new investigation is warranted on an open case.
4. Infants under 6 months of age should be observed while the worker is having contact with the parents or caregivers. Infants should be seen while awake and during an active period for the purpose of investigation and assessment of strengths and risks. Infants should be seen during regular care routines such as feeding times, bathing time, diaper changes, play/tummy time.
5. When a worker becomes aware that risk factors for unexpected infant death are present, they should consider a range of appropriate responses based on good practice and professional judgment. Responses may include, but are not limited to:
    - Direct discussion with family concerning risk factors.
    - Provision of written educational material at a reading level that can be understood by the caregiver.
    - Consultation with Public Health, Healthy Babies, Tele-Health and/or Other Early Years Professionals.
    - Referral to Public Health, Healthy Babies, Lansdowne Children's Center, Child Development Unit or other Early Years Professionals.
    - Assistance for provision of material goods to assist the reduction of risk factors, i.e. crib.
6. Mothers should be supported in their decision to breastfeed and be provided with assistance, education and resources to support nursing unless contraindicated by a physician.
7. Prior to reunification of an infant with his or her family, workers will discuss risks factors for unexpected infant death to reduce risk to babe.
8. As very few supports are available on the weekend, it is recommended that very young infants or medically fragile infants should be discharged from care at the beginning of the week, so necessary supports can be put in place.
9. A safe sleep assessment should be completed and documented prior to the child's return home.

RISK FACTORS			
Prenatal, birth and development:			
	Low birth weight		Social and emotional development
	Prematurity		Motor skills
	Multiple births		Vision
	Medical conditions		Hearing
	Exposure to alcohol and drugs		Cognitive development
Parenting:			
	Minimal prenatal care		Attachment concerns
	Caregiver under the age of 19		
Caregiver Limitations:			
	Mental health issues		Medical/physical conditions
	Alcohol or drug use		Cognitive/developmental
Caregiver History:			
	History of child abuse or family violence		Poor supervision of older siblings
	Other children in care of FACS or relatives		History of being deceptive or resistant with professionals
Environment:			
	Caregiver resides with one or more non-family members who have less than one year involvement		Infant's bed does not meet Health Canada regulations
	Housing		History of homelessness
	Residing in a shelter		
Support Systems:			
	Limited abilities in getting support		Isolated
	Perceived support system involved in criminal/antisocial activities		
Other:			
PROTECTIVE FACTORS			
	Infant/toddler seen by a physician for regular assessments, medical appointments and immunizations		Caregiver demonstrates effective problem solving skills, decision-making skills, and the capacity for learning new skills and information
	Reliable formal or informal supports are in place		Caregiver engages in open and honest communication with service providers
	Caregiver has insight into risk factors		Caregiver maintains regular contact with service providers
	Caregiver receptive & actively working with services to address identified risks		
	Other:		

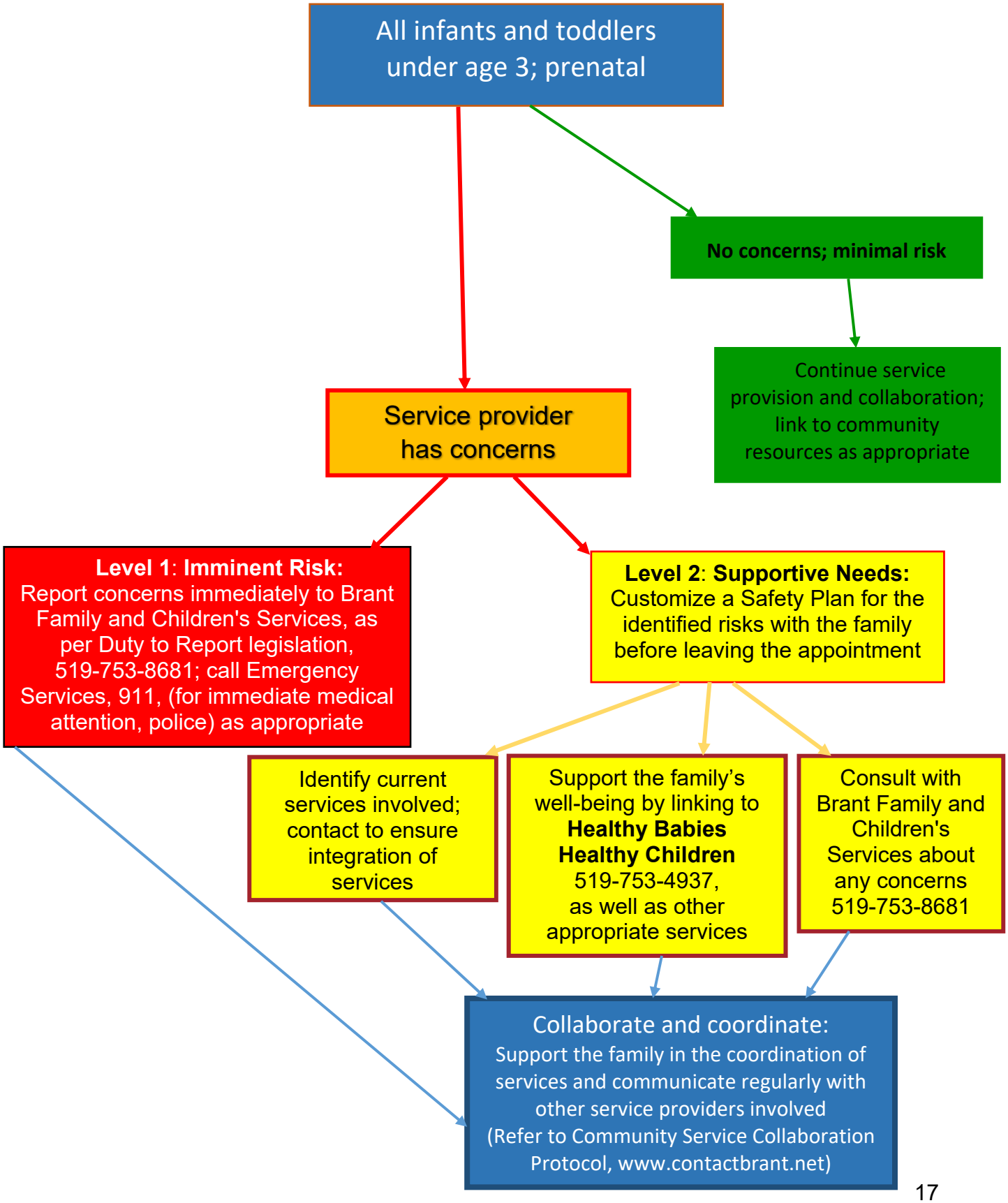
Risk Checklist

Level 1: Imminent Risk
☐ Report concerns to Brant FACS
☐ Call Emergency Services/Police, as appropriate
☐ Collaborate and Coordinate Support the family in the coordination of services and communicate regularly with other service providers involved (refer to Community Service Collaboration Protocol)
Level 2: Supportive Needs
☐ Customize a Safety Plan
☐ Identify other service providers involved
☐ Link to Healthy Babies Healthy Children
☐ Consult with Brant FACS
☐ Collaborate and Coordinate Support the family in the coordination of services and communicate regularly with other service providers involved (refer to Community Service Collaboration Protocol)
Level 3: Minimal Risk
☐ Continue service provision and collaboration
☐ Link to community resources as appropriate

Safety Plan

Concerns	Strengths	Actions	Who is Responsible	Timeframe/Date

Flow Chart for Collaboration
for Infants and Toddlers Living in At Risk Environments



For Information on the Brant Infant/Toddler and Family Resource System

Specialized Support Services

Call Contact Brant
519-758-8228
www.contactbrant.net

- Autism Intervention
- Child Development
- Speech and Language
- Occupational Therapy
- Physiotherapy
- Hearing and Vision
- Child Mental Health
- Child Protection and Parenting Support
- Fetal Alcohol Spectrum Disorder
- Healthy Babies
- Dental
- Nutrition
- Social/Emotional/Behavioural
- Intellectual/Developmental

Programs for Infants and Toddlers

Call Ontario Early Years Centre Brant
519-759-3833
www.eycbrant.ca

- Best Start Centres
- Child Care Centres
- Family & Literacy Centres
- Ontario Early Years Centre and sites
- Private Home Day Care

Family Support Services

Call Contact Brant
519-758-8228
www.contactbrant.net

- Addictions
- Child and Family Support
- Food security
- Housing and Shelters
- Income and Child Tax Programs
- Libraries
- Medical/Health Centres
- Mental Health
- Parenting Programs
- Settlement & Immigration

Also check out:
- Your Guide publications or www.contactbrant/yourguide.net
- www.bhn-info.ca
- Call 2-1-1 for service information

See attached list of key service providers

Key Service Providers in the Brant Infant/Toddler and Family Resource System

Service Provider	Description	Contact Information
Aboriginal Health Centre De Dwa Da Dehs Nye>s	Assists Aboriginal people in accessing culturally appropriate preventative and primary health care	519-752-4340 aboriginalhealthcentre.com
Best Start Centres	Parent support and early child development programs. Free, drop-in, parent-child interactive centres	519-759-3833 www.ourbeststart4brant.ca
Brant County Health Unit	Dental services: regular dental care for children 17 years of age and younger who meet financial eligibility. Healthy Babies Healthy Children- A free support for expectant parents and/or families with children from birth to school entry. Prenatal classes for adults and teenagers. Sexual Health Clinic Quit Clinic for tobacco cessation	519-753-4937 x 450 519-753-4937 x 464 519-753-4937 x 471 519-753-4937 x 455 www.bchu.org
Brant Family and Children's Services (FACS)	Parenting support to families. Community parenting groups and Family Resource Centres. Child protection services. Foster care and adoption.	519-753-8681 www.brantfacs.ca
Brantford Native Housing	Subsidized housing in Brantford provided for low income native families & support services	519-756-2205 www.brantfordnativehousing.com
City of Brantford Social Services	Financial assistance through Ontario Works. Subsidized housing through City of Brantford Housing Department	519-759-7009 519-759-3330 www.brantford.ca
City of Brantford Child Care Services	Financial assistance for child care costs	519-756-3150 www.brantford.ca
City of Brantford Parks and Recreation	Recreation and leisure activities for all ages. Financial assistance for qualified applicants	519-756-1500 www.brantford.ca
Community Legal Clinic	Provides legal information and legal representation.	519-752-8669 www.bhnlegalclinic.ca
Contact Brant for Children's and Developmental Services	Single point of access for children's developmental services including Autism, and children's mental health services. Registration for Triple P (Positive Parenting Program) groups or seminars offered by community agencies.	519-758-8228 www.contactbrant.net
Family Counselling Centre of Brant	Counselling and support for families and children	519-753-4137 www.fccb.ca
Grand River Community Health Centre	A non-profit, primary health care provider for vulnerable community members	519-754-0777 www.grandriverchc.ca
Lansdowne Children's Centre	Supports children, youth and their families with physical, developmental or communication needs. Brant County Preschool Speech and Language Program (Talking Tots)	519-753-3153 519-753-7453 www.lansdownecentre.ca

Brantford Public Library	Free borrowing of books, magazines, videos, CDs, books on tape, for children and parents. Computer access, activity programs for children	519-756-2220 www.brantford.library.on.ca
County of Brant Public Library	Free borrowing of books, magazines, videos, CDs, books on tape, for children and parents. Computer access, activity programs for children	519-442-2433 www.brant.ca
Nova Vita	24 hour crisis line. Safe, emergency shelter for women and children. Counselling and safety plan assistance. Group counselling for men	519-752-HELP 519-752-4357 www.novavita.org
Ontario Disability Support Program	Long term financial assistance	1-866-729-2228 www.mcss.gov.on.ca
Ontario Early Years Centre Brant	Free services for parents, caregivers, educators and young children 0-6 years. Drop-in programs, workshops, Quality Child Care information.	519-759-3833 www.eycbrant.ca
Parenting and Family Literacy Centres (BHNCDSB and GEDSB)	Drop-in centres that provide a play environment where parents and children can learn through play.	519-720-5149 www.granderie.ca
Sexual Assault Centre	24 hour crisis line and ongoing support and counselling	519-751-3471 www.sacbrant.ca
Brant Haldimand Norfolk Catholic District School Board (BHNCDSB)	Kindergarten Registration information	519-756-6505 www.bhncdsb.ca
Grand Erie District School Board (GEDSB)	Kindergarten Registration information	519-756-6301 www.granderie.ca
Conseil scolaire de district catholique Centre-Sud (French Catholic School Board)	Kindergarten Registration information Sainte-Marguerite-Bourgeoys is the French Catholic school in Brant.	519-756-4750 www.csdccs.edu.on.ca
St. Leonard's Community Services	Immediate crisis support and/or counselling for individuals experiencing an addictions, mental health or situational crisis.	519-759-7188 for 24/7 crisis support www.st-leonards.com
Victim Services of Brant	Emotional support to victims and survivors. Practical assistance via accompaniment to appointments and court.	519-752-3140. After hours call 519-756-7050 www.victimservicesbrant.on.ca
Woodview Mental Health and Autism Services	Individual and family counselling, group counselling for children and youth age 0 - 18. Referrals are made through Contact Brant.	752-5308 Referrals: 519-758-8228 www.woodview.ca
YMCA Employment, Education and Immigrant Services	Connect with the wide range of services for newcomers to Canada; literacy and basic skills programs.	519-752-4568 www.ymcahbb.ca