

Collaborating for Impact:

Report on the

Joint Benefits of

the Community Action Program for Children (CAPC),

the Canada Prenatal Nutrition Program (CPNP), and

the Ontario Early Years Centres (OEYC)

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ACKNOWLEDGEMENTS

Collaborating for Impact: Report on the Joint Benefits of the CAPC, CPNP and OEYC.

The Joint Benefits Working Group consisted of representatives from the Public Health Agency of Canada, Ontario and Nunavut Region, the Ontario Ministry of Children and Youth Services (member from the Joint Management Committee), and CAPC, CPNP and OEYC projects. The goal of this joint project was to demonstrate how CAPC, CPNP, and OEYC projects have integrated their services at the ground level and have worked in collaboration with other system partners. The Public Health Agency of Canada (PHAC), Ontario and Nunavut Region, contracted with Tom Zizys to undertake this project, which included conducting interviews with CAPC, CPNP and OEYC project representatives in preparation for this report. The report was submitted by Tom Zizys to PHAC July 2007. Minor revisions were made to it.

We are pleased to share this report, which illustrates how these programs fit into the continuum of healthy child development programming currently available in the province of Ontario with CAPC and CPNP projects, OEYC centres and other relevant stakeholders.

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EXECUTIVE SUMMARY

There currently exists in Ontario a wide array of pre-natal, post-natal, early child development and family support programs, involving federal, provincial and municipal government initiatives. These are delivered through a variety of community-level agencies and partnerships. This report limits its focus to three important programs, namely:

- The federal Community Action Program for Children (CAPC);
- The federal Canada Prenatal Nutrition Program (CPNP); and
- The provincial Ontario Early Years Centres (OEYC).

Each of these programs promote distinct yet complementary goals, the end purpose being the healthy development of young children:

CAPC supports the healthy development of children aged 0 to 6 years old, and their families, who are facing difficult life circumstances.

CPNP provides access to programs and services for pregnant mothers who are most at risk of having unhealthy babies because of poor health and nutrition.

OEYC act as a central access point for all parents and caregivers of children aged 0 to 6 years of age seeking early learning programs, services and supports, with a common set of universal programs and services for children and families.

The CAPC and CPNP programs were created in the early 1990s as part of a national initiative. CAPC and CPNP programs are geographically dispersed in Ontario and do not cover the entire province. OEYC, which were established beginning in 2002, are intended as universal programs targeting all families and all parts of the province.

The purpose of this report was to examine how CAPC, CPNP, and OEYC initiatives have integrated their services at the ground level, to identify practices that enhance the continuum of services and supports available in a community, particularly for at-risk families.

CAPC and CPNP non-Aboriginal projects are the primary focus of this report.¹ Given that these programs concentrate on at-risk families, the major attention of this report has been to examine how CAPC, CPNP and OEYC work together to address the needs of at-risk families. “At-risk” is most often expressed in terms of isolation (either geographic remoteness or lacking connection with others), identity (for example, young single mothers) and/or social exclusion (the presence of social and class divisions within a community).

¹ In Ontario there is a distinction between non-Aboriginal and Aboriginal projects, with two separate streams of funding for each. This report reviewed only the non-Aboriginal projects.

The pre-natal and early childhood service needs of families will vary, but often families experiencing risk factors typically require more intensive attention. CAPC and CPNP projects complement OEYC services by:

- Undertaking more targeted outreach to at-risk families;
- Contributing another layer of services for those who have greater needs;
- Providing further resources by which to reach geographically remote, socially isolated or socially excluded families;
- Where appropriate, working with OEYC to help at-risk families make the transition to mainstream services.

Community agencies deliver CAPC and CPNP projects and OEYC programs drawing on a wide variety of service models. The multiplicity of project and program designs means that there is no one model that easily describes how CAPC, CPNP and OEYC work together. This is a testament to the creativity of communities across Ontario in adapting and integrating these programs to suit local circumstances.

The focus on integration of services is important because individuals and families have multiple needs that evolve over time, and no one agency is capable of addressing each of those needs. In order to support the whole person and the whole family, agencies must work together to ensure that clients can access the type of service they require when they need it. Funding, particularly from government programs, is earmarked for specific clients or purposes, but clients come with multiple needs, and needs that evolve over time. Community agencies must play the function of brokers, matching funding programs that are delivered through jurisdictional and departmental silos to clients whose needs are not restricted in the way that individual programs may define them. CAPC, CPNP and OEYC regularly work together to address the needs of the communities they serve.

The goal of integration is a challenging one, by reason of geography, the degree to which the programs focus on the same client, the management structure for delivering the services (a single agency or consortium versus separate agencies) and the overall propensity of a given community to engage in collaboration.

CAPC and CPNP are defined as programs that target at-risk populations, and OEYC are clearly mandated to serve all families. It would be an inaccurate over-simplification to say that where CAPC or CPNP projects are in place, that they serve the at-risk populations, leaving the OEYC to deliver their services to average, mainstream families. It is quite apparent in practice that across all communities, many at-risk families feel comfortable accessing OEYC, relying on the staff found in these centres. Obviously, in many communities where no CAPC or CPNP project is operating, OEYC must serve those needs.

However, for a number of at-risk parents and families, the prospect of attending a mainstream service is more daunting and the need to receive a higher level of service or a more targeted service is far more pronounced. In these circumstances, many feel more

comfortable taking advantage of the presence of CAPC or CPNP. Moreover, the availability of CAPC and CPNP projects means that, together with the OEYC program, communities are able to devote more resources to those families who truly need a higher level of service.

In numerous ways, CAPC, CPNP and OEYC programs strive in a collaborative fashion to help at-risk families move from a reliance on targeted programs to using mainstream services. The integrated approach of the collaborating service agencies often means that at-risk families may not even be able to distinguish where an at-risk program ends and a mainstream program begins.

Clearly, the added resources that CAPC and CPNP projects bring to a community can only help the local system of early childhood services. The existence of different streams of funding, each of which has a different focus, also creates the conditions for local variation and innovation. Were funding to come from only one source, there would be a tendency towards homogenization of programming, given the likelihood that such a program would be required to focus primarily on serving the mainstream population. It is the variety of funding sources that allows for local adaptability to meet the needs of the at-risk populations specific to that community.

Furthermore, the accumulated habits of cooperation and communication arising from the planning and implementation of CAPC and CPNP in the 1990s, made it easier in later years to undertake the planning and implementation of the OEYC, particularly on such sensitive questions as determining the allocation of lead and satellite functions among agencies.

Overall, the presence of CAPC and CPNP projects helps OEYC have a wider and deeper impact by bringing more intensive and targeted services to at-risk families, by making it possible for OEYC resources to reach further, and by facilitating more linkages among services and among agencies.

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INTRODUCTION

Purpose of the Report

Over the past year, representatives from the Public Health Agency of Canada, Ontario and Nunavut Region, the Ontario Ministry of Children and Youth Services, CAPC and CPNP projects and OEYC programs came together to explore how CAPC, CPNP, and OEYC initiatives have integrated their services at the ground level and how they have worked in collaboration with other system partners.² This group, which came to be known as the Joint Benefits Working Group,³ contracted a consultant to carry out a study to compare collaborative practices across the province in order to determine and articulate the joint benefits of these programs.

It is important to understand the context of these programs in order to appreciate the purpose of this study. The CAPC and CPNP programs were created in the early 1990s, as part of a larger national initiative, to support communities to put programming in place for at-risk pregnant women, mothers and their families. While they are geographically dispersed across Ontario, they do not cover the entire province, and when present in a given jurisdiction (for example, a city or a public health unit area), they often provide services for a portion of that area. OEYC, which were established beginning in 2002, are intended as universal programs targeting all families and all parts of the province.

It was apparent to the Joint Benefits Working Group that these programs had developed practices and working relationships that strengthened their abilities to meet their separate mandates, as well as enhanced the continuum of services and supports available to families in their communities.

This report describes these joint benefits.

Methodology

The study relied primarily on interviews with key informants from CAPC, CPNP and OEYC initiatives from across the province, typically involving either executive directors of the sponsor agencies or the lead staff manager responsible for the program or project.

In addition, because the emphasis was on the interaction and collaboration between CAPC and CPNP projects on the one hand and OEYC programs on the other, almost all of the interviews focused on communities where there existed either a CAPC or a CPNP project or both, and in most instances the interviews were conducted with individuals

² The acronyms represent the following: CAPC = the federal Community Action Program for Children; CPNP = the federal Canada Prenatal Nutrition Program; OEYC = the provincial Ontario Early Years Centres.

³ The list of the members of the Joint Benefits Working Group is included as Appendix A to this report.

associated with the CAPC and/or CPNP project. The rationale for this approach was to determine the benefits of the CAPC and CPNP programs working with OEYC programs.

In order to ensure a representative sample of program models and project communities, a cross-section of locations was selected. The following table illustrates the mix of target interviews:

Table 1: Distribution of interviews for study

	Rural/ remote	Rural & urban	Urban
CAPC stand alone		1	3
CPNP stand alone	1	2	2
Combined CAPC/CPNP	4	2	1
CAPC stand alone & co-sponsored with OEYC			1
CPNP stand alone and co-sponsored by OEYC			1
Combined CAPC/CPNP and co-sponsored with OEYC	1	1	1
OEYC stand alone	1		2
TOTAL	7	6	11

Table 1 demonstrates the mix of program configurations and geographic variety, but also reaffirms that the primary perspective of this report is through the lens of CAPC and CPNP programs.

In addition the study reviewed materials about the CAPC, CPNP and OEYC programs relying on background reports and information available on the respective program websites.

Telephone interviews were conducted in the months of February and March 2007.⁴ Interviewees were sent the list of questions in advance, which sought broad information about the sponsor agency, the nature of the interrelationship between the local CAPC and CPNP projects and OEYC programs,⁵ the degree of integration among these programs, the factors that explained this level of integration and the ability of

⁴ The list of interviewees is included as Appendix B to this report.

⁵ See Appendix D

these agencies to serve the needs of at-risk families. (The list of questions is included in Appendix C of this report).

The results of these interviews formed the basis of this report. Throughout the study, the Joint Benefits Working Group provided on-going direction and advice to the consultant through regular conference calls.

DESCRIPTION OF PROGRAMS

There currently exists in Ontario a wide array of pre-natal, post-natal, early child development and family support programs, involving federal, provincial and municipal government initiatives, being delivered through a variety of community-level agencies and partnerships. This report limits its focus to three important programs, namely:

- The federal Community Action Program for Children (CAPC);
- The federal Canada Prenatal Nutrition Program (CPNP); and
- The provincial Ontario Early Years Centres (OEYC).

Each of these programs promote distinct yet complementary goals, the end purpose being the healthy development of young children:

CAPC supports the healthy development of children aged 0 to 6 years old, and their families, who are facing difficult life circumstances.

CPNP provides access to programs and services for pregnant mothers who are most at risk of having unhealthy babies because of poor health and nutrition.

OEYC act as a central access point for all parents and caregivers of children aged 0 to 6 years of age seeking early learning programs, services and supports.

An important distinction is that CAPC and CPNP mostly fund geographically limited projects that typically serve specific neighbourhoods or communities, targeting at-risk families, while OEYC are a universal program intended to cover the entire province.

Community Action Program for Children⁶

Both the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) formed part of the Canadian government's response to the recommendations of the 1990 United Nations World Summit for Children.

⁶ Information for this section is taken from: goals page of the Community Action Program for Children, Public Health Agency of Canada <http://www.phac-aspc.gc.ca/dca-dea/programs-mes/capc_goals_e.html> accessed April 13, 2007; Public Health Agency of Canada, Canada Prenatal Nutrition Program – Community Action Program for Children, *Tracking Our Progress: Renewal 2003*; Public Health Agency of Canada, *Community Action Program for Children (CAPC), Canada Prenatal Nutrition Program (CPNP) and the Government of Canada* (2006).

Established in 1992, CAPC provides support to community coalitions to deliver programs that address the health and development of children (0-6 years) who are living in conditions of risk. “Conditions of risk” may refer to a number of circumstances. One way of defining these involves identifying specific target populations. These include the following:

- Children living in low income families;
- Children living in teenage-parent families;
- Children experiencing developmental delays, social, emotional or behavioural problems;
- Abused and neglected children;
- Métis, Inuit and off-reserve First Nations children;
- Children of recent immigrants and refugees;
- Children in lone-parent families; and
- Children who live in remote and isolated communities.

Box 1 -- Example of a CAPC Program: The Growing Together in Peel Project provides an extensive variety of partners, programs and locations to meet the diverse needs of the communities it serves. Operating in 11 locations (ranging from multi-service agencies to a community kitchen located in a primary school, from mobile sites in more sparsely populated parts of the region to a program in a social housing complex), the program includes drop-ins and play groups for parents and children, structured programs on child development, and a young parents’ group focusing on parenting skills.

Common program elements include family resource centres, parenting classes, parent child groups and home visiting. In addition, CAPC programs place a strong emphasis on building community capacity to undertake community engagement and system planning. Each project has the flexibility to develop programs unique to that community. This can range from access to employment or housing, arts and drama programs for parents and children, to parent relief so parents have temporary childcare.

Currently, there are 40 CAPC non-Aboriginal projects in Ontario.⁷ Total CAPC funding for Ontario is \$17 million per year.

⁷ In Ontario there is a distinction between non-Aboriginal and Aboriginal projects. In addition to these non-Aboriginal projects, there are a further 45 CAPC Aboriginal projects. This report reviewed only non-Aboriginal projects.

Canada Prenatal Nutrition Program⁸

CPNP was established in 1994 to address the need for early intervention to assist pregnant women in vulnerable life situations. CPNP aims to reduce the incidence of unhealthy birth weights, improve the health of both infant and mother and encourage breastfeeding. Over 95% of projects target pregnant women living in poverty, teens, or women living in isolation or with poor access to services. Other client groups targeted include women who abuse alcohol or drugs, live with violence, women with gestational diabetes, Aboriginal women, and immigrant and/or refugee women. Almost every program offers food supplements (including provision of groceries and/or vouchers for perishables) vitamin supplements, breastfeeding support, and one-to-one nutrition counselling. Other services offered include education and counselling on lifestyle issues, food preparation training, transportation, childcare, access to foodbanks and referral to other services.

Box 2 -- Example of a CPNP Program: The Hastings and Prince Edward Counties Health Unit calls their CPNP program *Food for You, Food for Two*. They conduct two weekly drop-ins, one in Bancroft and one in Trenton, each staffed by a dietician as well as a public health nurse. The Bancroft site is located in a satellite location of the Hastings-Frontenac-Lennox-Addington Ontario Early Years Centre, while the Trenton site is in a satellite location of the Northumberland Ontario Early Years Centre. Each drop-in serves pregnant mothers and offers weekly educational themes. If a mother requires childcare for other children, it is provided free. As well, transportation is arranged for those who need it. Every week, each mother receives a healthy snack as well as a voucher for nutritious food. In addition to getting these supports and the opportunity to interact with professionals, participants also benefit from the ability to socialize and network with other mothers.

Currently there are 47 non-Aboriginal CPNP projects in Ontario.⁹ Total CPNP funding in Ontario is \$8.37 million per year.

⁸ Information for this section is taken from the goals page of the Canada Prenatal Nutrition Program, Public Health Agency of Canada <http://www.phac-aspc.gc.ca/dca-dea/programs-mes/cpnp_goals_e.html>, accessed April 13, 2007.

⁹ As with CAPC, there are non-Aboriginal and Aboriginal projects. In addition to the non-Aboriginal projects, there are a further 32 CPNP projects specifically for Aboriginal women. Again, this report reviewed only non-Aboriginal projects.

Ontario Early Years Centres¹⁰

Ontario Early Years Centres (OEYC) were established by the Province of Ontario¹¹ as a result of recommendations flowing from the landmark *Early Years Study* (1999), co-chaired by the Honourable Margaret Norrie McCain and Dr. Fraser Mustard.

OEYC provide a variety of programs and services to enhance the healthy development and readiness to learn of children up to the age of six and to support parents and caregivers in their roles. OEYC are accessible to all families and offer a mix of universal supports that address common needs, such as early learning programs and parenting information resources. They also offer targeted programs and services tailored to community-identified needs. Each Ontario Early Years Centre is community-planned and community-driven, and each Centre differs from one another in its location, staff mix, range of other services provided, and the way it organizes and delivers core services. This variation helps the Centres meet the needs of their local community.

Centres offer a common set of core or universal programs and services for children and families including:

- Early learning activities for children, such as literacy and numeracy
- Parent resources, information and training on topics such as healthy child development
- Pre and post natal resources, information and training
- Outreach to encourage parent participation
- Monitoring program effectiveness and tracking community progress in improving child development outcomes
- Information about and linkages for families to services external to the Centre.

There are 103 OEYC which operate over 1000 satellite locations and, in some cases, mobile programs serving children and families across the province. Total OEYC funding in Ontario is \$64.3 million per year.

DELIVERY OF CAPC, CPNP AND OEYC PROGRAMS

The basic description of what each of the programs is supposed to do is relatively straightforward. How these programs are actually delivered and how they interrelate in

¹⁰ Information for this section taken from two sources: Home page of the Ontario Early Years program <<http://www.ontarioearlyyears.ca/oeyc/en/home.htm>>, accessed April 13, 2007; Harry Cummings and Associates, *Ontario Early Years Centres Implementation Review*, Ministry of Children and Youth Services, November 2004.

¹¹ Through federal transfer payments made directly to the province under the Canada Health and Social Transfer.

practice is a much more complex proposition, simply because of the tremendous variety of circumstances found in any given community. Thus, the geographic nature of the community (urban, rural, remote), the needs of the population being targeted, and the experience of collaboration and inter-agency partnerships in that community each affect how CAPC, CPNP and OEYC are delivered in that location and, in particular, the interrelationship between these programs.

This diversity of approaches illustrates the various ways in which communities respond to the programming opportunities offered through CAPC, CPNP and OEYC. In many instances, communities manage to create a highly integrated continuum of services for families, even where different agencies may be implementing CAPC, CPNP and OEYC initiatives.

To understand how these programs operate, one needs to understand:

- What kind of organizations deliver them;
- How these programs are managed; and
- What factors affect the degree of integration among these different programs.

What kinds of organizations deliver these programs?

A wide array of organizations delivers these three programs, but clearly a common feature is their engagement with parents and children. In many instances, family resource programs or specialized children services' agencies are prominent in the delivery of these programs. As well, multi-service community agencies are often involved.

Because of the emphasis that CAPC placed on proposals that were community-based and that reflected local partnerships, a number of CAPC projects are structured as inter-agency coalitions, where the responsibility for the project is shared collectively among many agencies, with each partner being involved in some aspect of its delivery.

In the case of CPNP, because of the program's primary emphasis on health and nutrition, public health authorities are often either leading the project or contributing staff to its implementation.

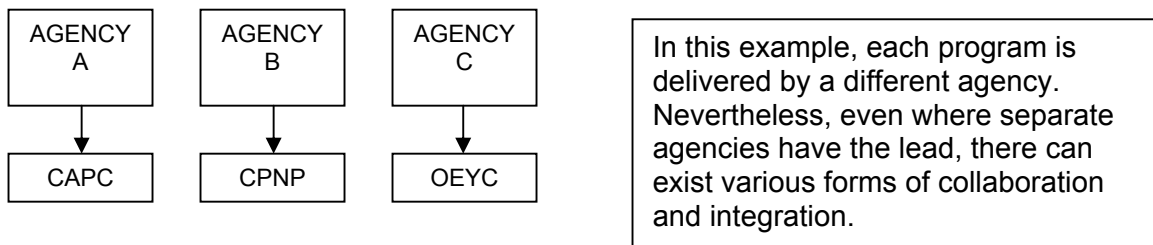
OEYC are hosted by family resource centres, childcare agencies, municipalities and multi-service organizations such as newcomer services, employment, housing or health services. Some of the centres are hosted by school boards, sport/recreational organizations, child welfare agencies, children's mental health agencies, agencies serving people with disabilities, and other social service agencies.

Variety of program relationships

How these programs are actually managed in any given community varies greatly. To explain this issue, it will be helpful to illustrate the different configurations by way of the following diagrams.

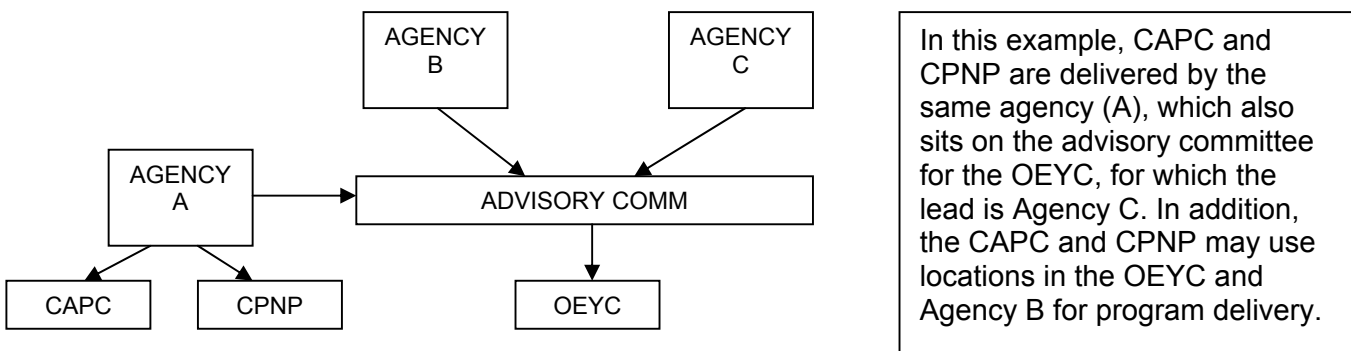
Sometimes it is a simple matter of a different agency having the lead responsibility for each of these programs (as illustrated in Diagram 1), although this was the case in only a few of the communities examined in the course of the interviews undertaken for this study:

Diagram One: Simple Model of Delivery of CAPC, CPNP and OEYC

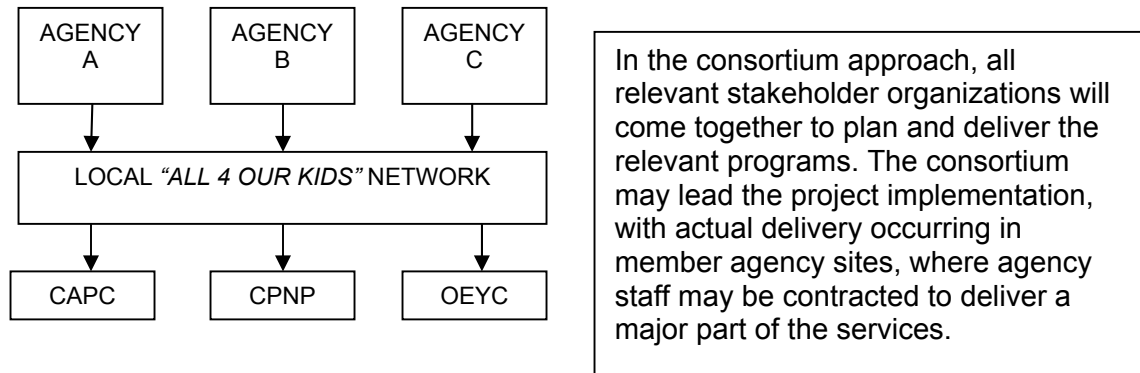


More likely, while several agencies may separately be involved in leading the projects, the actual management or governance structure is often much more inter-related (Diagram 2).

Diagram Two: Inter-related Model of Delivery of CAPC, CPNP and OEYC



In some instances, all the relevant stakeholders have come together to collectively plan and jointly implement these programs (Diagram 3).

Diagram Three: Consortium Model of Delivery of CAPC, CPNP and OEYC

Thus, these three programs will manifest themselves in the following permutations:

- CAPC stand alone;
- CPNP stand alone;
- OEYC stand alone;
- Combined CAPC/CPNP;
- CAPC stand alone and co-sponsored with OEYC;
- CPNP stand alone and co-sponsored with OEYC;
- Combined CAPC/CPNP and co-sponsored with OEYC.

Factors affecting the integration of services

Integration of services refers to the degree to which services, as well as the agencies that deliver those services, connect and interact with each other when meeting the needs of their target clients. The rationale behind integration of services rests on the view that individuals and families have multiple needs that evolve over time, and that no one agency is capable of addressing each of those needs. In order to support the whole person and the whole family, agencies must work together to ensure that clients can access the type of service they require when they need it.¹²

Indeed, community agencies of whatever sort are regularly in the position of having to knit together resources to match the needs of their clients. Funding, particularly from government programs, are earmarked for specific clients or purposes, but clients come with multiple needs, and needs that evolve over time. Community agencies must play the function of brokers, matching funding programs that are delivered through jurisdictional and departmental silos to clients whose needs are not restricted in the way that individual programs may define them. Thus, the need to be creative and to be able to adapt is a

¹² This discussion relies on Bruce Ryan and Ron Robinson, *Service Integration in Ontario: Critical Insights From the Service Community*, presented to the Ontario Ministry of Children and Youth Services (2005).

constant way of life for service agencies, and integrating their programs with other service providers is just one strategy for better serving their communities.

Integration of these services will be discussed at greater length later in this report, but for now the factors that may affect the degree of integration will be highlighted, as further explanation for the variety of ways in which these programs are delivered.

Geography. Geography has a great bearing on the degree to which services can or cannot be integrated. In remote areas, with great distances between facilities, the real impact of these programs is their ability to provide a minimum level of services to families in need. For example the catchment area for the Porcupine District Health Unit that delivers the CPNP *Healthier Mothers, Healthy Babies* program covers a territory the size of England!

In addition to the obstacles posed by distance, these various programs often have the additional geographic challenge of differing catchment boundaries. CPNPs often follow the catchment area of public health units. CAPC catchment areas vary substantially, from entire regional municipalities to a few neighbourhoods. While OEYC are mandated to cover the entire province, CAPCs and CPNPs operate as projects, and their combined catchment areas do not extend across the entire province; as a result, there are many communities where CAPC or CPNP projects do not exist. Finding the appropriate linkages between agencies delivering their programs can often only happen on a site-by-site basis.

Client focus. The degree to which these services can be linked also depends on the degree to which these services are focusing on the same client. More will be said on the topic of serving at-risk populations later in this paper; however it must be stated that at-risk clients often do need distinct, separate services, as well as support in accessing mainstream services. This has implications for how and when linkages between services can happen.

This distinction is particularly apparent where a program has a specialized target population. For example, one combined CAPC/CPNP works with a unique community, typically families from a rural background, lacking English language and sometimes literacy skills. This population forms a distinct religious, linguistic and cultural group, who are many steps removed from being able or willing to take advantage of mainstream services.

In a similar way, many young, sometimes teen, often single moms also seek services that cater to them as a distinct group. Not only do they feel more comfortable among their peers, they are also looking for services for themselves as young women, and not only services and supports in relation to their roles as mothers and caregivers. Again, in such a circumstance the first need may be to support this distinct population, with the integration into mainstream services an eventual second goal.

Management structure. Where one agency has the contract to deliver the CAPC, CPNP and OEYC services in a community, it is much easier to imagine that the structure of the service delivery could be designed in such a way that families experience it as an integrated whole. In this case the same locations and the same staff deliver a continuum of services, starting with programs for pregnant mothers through to parenting classes and early childhood development activities as the children age.

Similarly, where agencies come together to form a consortium or partnership to plan for and implement these several programs, it is easier for agencies to coordinate their offerings, including the locations for the programming, when it is negotiated in advance.

This is not to say that individual agencies that have received separate funding, one for a CPNP project, another for a CAPC project and a third for the local OEYC programming, cannot develop the linkages and staff coordination to offer an integrated whole to families. But as Box 3 on the following page suggests, combined forms of management, either through single agency delivery or a consortium approach, do tend to result in higher levels of service integration.

Box 3 – Levels of service integration: During the course of the interviews, respondents were asked to rate the level of integration of services among CAPC, CPNP and OEYC in their community. To assist them, the following scale was provided:

Awareness: We are generally aware of what other organizations are doing, and sometimes refer clients for specific needs

Intermittent Communication: We sometimes communicate with other agencies about what we or they are doing, especially when we are submitting a proposal for funding

Formal Communication: We meet on a regular basis with other organizations and exchange information

Cooperation: We are very mindful of what other agencies are doing and plan our programs with that in mind

Collaboration: Together with other agencies, we jointly discuss and plan what services we offer

Project partnering: We sometimes or often propose joint projects with other agencies, based on on-going joint discussions and planning

Fusion: We have integrated our programs with other agencies so that clients would not even be aware that there are multiple partners providing a particular array of services

The responses were grouped into three categories, where “I” represented the lowest level of integration and “III” the highest. The table below illustrates that while the degree of program management does not conclusively determine the level of integration, there is a tendency that the greater the degree of joint management of the programs, the more likely it is that there will be a higher level of service integration.

Table 2: Model of delivery and level of service integration (N=20)*(I = lowest integration, III = highest)*

	I	II	III
CAPC stand alone	1	1	1
CPNP stand alone	1	3	1
Combined CAPC/CPNP	1	2	3
CAPC stand alone & cosponsored with OEYC			1
CPNP stand alone & cosponsored with OEYC			1
Combined CAPC/CPNP & cosponsored with OEYC			4

Even where there is a combined management structure, the degree of service integration may vary within the program. For example, in one combined CAPC/CPNP co-sponsored with an OEYC, the degree of integration depends on the actual location: even though the CAPC programming is delivered in various OEYC locations. In one OEYC site, the CAPC programming is co-facilitated using CAPC and OEYC staff, in another, CAPC staff provides the parent education while the OEYC staff provide early childhood programming for the children, and in a third, CAPC staff provide all the staffing.

Propensity to collaborate. It was apparent from the interviews that in some locations the level of service integration was very strong, but in other locations it was not what it could be. That propensity to collaborate was related to a number of factors: prior history (were earlier partnership experiences good or bad), corporate cultures (some organizations have a greater willingness to partner), personalities (some individuals simply work better with others), or misunderstandings about appropriate roles.

Summary

How CAPC, CPNP and OEYC interact depends on many factors, including catchment area geography, target populations, management structures and the propensity to partner. In large measure, these programs respond to the needs and circumstances of the communities they are found in, and for that reason will appear in different shapes and forms. How these programs interact and serve their respective missions will be examined in further detail in the following section.

OPERATING IN A MULTIPLE PROGRAM ENVIRONMENT

The CAPC and CPNP are specifically mandated to target at-risk populations. OEYC have a universal mandate, to serve all populations across the province. How do the CAPC and CPNP projects interact with OEYC?

It would be a great over-simplification to say that where CAPC or CPNP projects are in place, that they serve the at-risk populations, leaving the OEYC to deliver their services to average, mainstream families. It is quite apparent in practice that across all communities, many at-risk families feel comfortable accessing OEYC, relying on the staff found in these centres. Obviously, in many communities where no CAPC or CPNP project is operating, OEYC must serve those needs.

However, for a number of at-risk parents and families, the prospect of attending a mainstream service is more daunting and the need to receive a higher level of service or a more targeted service is far more pronounced. In these circumstances, many feel more comfortable taking advantage of the presence of CAPC or CPNP. Moreover, the availability of CAPC and CPNP projects means that, together with the OEYC program, communities are able to devote more resources to those families who truly need a higher level of service.

Also, in numerous ways, CAPC, CPNP and OEYC programs strive in a collaborative fashion to help at-risk families move from a reliance on targeted programs to using mainstream services. The integrated approach of the collaborating service agencies often means that at-risk families may not even be able to distinguish where an at-risk program ends and a mainstream program begins.

There is no doubt that, in some circumstances, certain at-risk families would likely not get appropriate services were the at-risk targeted programs not in place. And it is also the case that for some at-risk families, they would find it very difficult to access some mainstream services without the deliberate support by the CAPC, CPNP and OEYC to help them make the transition. The degree to which communities accomplish these goals certainly varies, but on balance, the higher the degree of interaction and integration between these programs, the greater the likelihood that all families ultimately benefit from these services.

This section further describes the nature of the at-risk populations and demonstrates how the CAPC, CPNP and OEYC together address their needs.

What does “at-risk” look like?

The intersection of the work of the CAPC, CPNP and OEYC is among the at-risk populations of their communities. How does this “at-risk” nature manifest itself?

Isolation. In the previous section, mention was already made of the issue of dispersed services in rural and remote parts of the province. Pregnant women and mothers with young children are considered at-risk in locations where they have difficulty accessing services appropriate to their needs. This risk is greater for those who do not have access

to transportation, either their own private auto or the ability to pay for a taxi or public transportation (or where there is no adequate public transportation).

These circumstances are made worse when the woman's partner is away for extended periods of time because of work. In Kapuskasing, for example, men often seek employment further north or in Alberta because of the scarcity of local jobs.

Isolation may not only reflect a condition of geography. For some programs in Toronto's immigrant neighbourhoods, the hardest challenge is reaching parents living in social housing who have no social networks and are coping with extreme detachment from others. One program described how staff spent seven months convincing a mother to feel comfortable enough to leave her home to visit a local library. The mother was overcoming such barriers as lack of English language skills, extended periods of isolation while her husband was away at work, possible post-partum depression, and a fear of leaving the house.

Identity. Sometimes, belonging to a specific demographic or cultural group means that mainstream services will not be as suitable or accessible as it is for others. The need for CAPC and CPNP programs targeting the Aboriginal population is a clear example of this. As noted earlier, young, often single, moms feel less comfortable attending mainstream programs.

“The young, teen moms don't want to integrate with other parents. The teen moms want programs directed at them too, not just their kids.”

“These girls don't want people to know they're pregnant, so they may not even see a doctor until they deliver. A lot of them are single moms in not very stable relationships.”

Not only do many of the CAPC and CPNP programs have separate groups for young mothers¹³ or pay special attention to young mothers,¹⁴ but also sometimes the entire program's focus is only on young parents.¹⁵

¹³ For example, Haldimand-Norfolk's CAPC and CPNP *Healthy Moms Eating Well for 2*; Peel Region's CAPC *The Growing Together in Peel Project*; Peterborough's combined CAPC/CPNP *Brighter Futures/Babies First*; London's CPNP *Smart Start for Babies: Prenatal Advantage*; Renfrew's CPNP *Best Start Prenatal Nutrition Program*; North York's CAPC/CPNP *Building Brighter Futures/Prenatal Nutrition Program*; Etobicoke's CPNP *Eating for Two*; Durham Region's CAPC *Family & Community Action Program of Durham Region*; and Hamilton's *Prenatal Nutrition Program*.

¹⁴ As with Hastings and Prince Edward Counties' CPNP *Food for You, Food for Two*; Timiskaming's combined CAPC/CPNP *Brighter Futures: Children Matter/Special Delivery PNP*; and the *Family Education and Support Program for Low German Families*.

¹⁵ As is the case with Ottawa's combined CAPC/CPNP *Brighter Futures for Children of Young/Single Parents/"Buns in the Oven"* programs.

Similarly, many recent immigrants typically require special outreach and familiarization through local, community-based organizations that they are comfortable with before they will participate in mainstream programs. A number of CAPC and CPNP programs, particularly in the Greater Toronto Area, Hamilton, Ottawa and other urban regions, focus on enhancing communication and trust with these newcomer populations.

Social exclusion. One striking observation was the frequency with which at-risk mothers experienced a sense of difference when in the presence of mainstream mothers, resulting in feelings of discomfort. In these examples, those who were at-risk often felt a sense of exclusion from the mainstream, and in more than one community, mainstream populations tended to exclude the at-risk. This was an observation that arose among interviews from across the province (general locations are noted to give a sense of the prevalence of these attitudes in different locations across Ontario):

“In two of our locations, we were having the higher income moms rolling their eyes when talking about the at-risk participants.” (Northern Ontario town)

“The parenting style of the at-risk mothers ostracizes them – the other mothers get on their case.” (GTA outer suburb)

“Our clients [CPNP] feel looked-down upon when they attend a mainstream program. They see these mothers with their nice vans, who have babies with matching sets of clothes, and that makes them feel inadequate.” (Southwestern Ontario)

“Our families have immediate needs that have to be addressed, like where the next meal is coming from, or how to fight an imminent eviction, as opposed to developing a good bedtime routine.” (Toronto inner suburb)

“A number of our participants [CAPC program] feel uncomfortable going to the mainstream programs. They say most of the people there are couples, and many of ours are single, or they have a boy friend who is not the father, or they have children from different dads, and they feel they are being judged.” (Northern Ontario town)

“Many of our families [CAPC/CPNP] do not feel as comfortable in a mainstream location. The class distinctions in this community can be quite severe. The variations in income create these divisions.” (Southwestern Ontario)

Meeting their mandates through partnership

CAPC and CPNP programs have a mandate to target specific at-risk populations. Yet because OEYC serve all populations and because all three of these programs seek to ensure some integration of services, there are numerous ways in which together these programs meet their own mandates while also ensuring that all children and families get the services they need. This section explores how these three programs fulfill these goals. Working together, their respective resources have greater reach, they are able to provide more appropriate services to those who require them, and they help individuals overcome barriers that otherwise would prevent them from accessing these services.

Greater geographic reach. The existence of CAPC and CPNP programs means that these services, together with those of OEYC, are more likely to reach families that are geographically distant from services. For example:

- The CAPC Toy Bus, a van that allows for mobile programming to be set up in more remote communities in eastern Ontario's Renfrew County, makes it possible for the local OEYC to deliver satellite services;
- In the northern community of Smooth Rock Falls (population, including surrounding area: 5507), the three programs together fund one staff person who delivers the different services to different population segments in that community (there would not be sufficient demand or funding for a separate staff person for each of the three programs);
- Among various CAPC and CPNP sites, transportation allowances or project vans ensure that participants can attend centrally-located programs; in some instances, these programs are scheduled just before regular OEYC programs in the same location, so that participants can use the provision of transportation to access additional programming.

In numerous remote communities, the presence of CPNP staff allows for one-on-one visits to take place, ensuring that isolated pregnant women and new mothers receive proper health, nutrition and breastfeeding counselling. Even in less severely remote areas, home visits are often necessary as participants will not attend a service location if it is one community over from theirs, feeling they do not belong to that area.

Services more appropriate to the needs. Those who are at-risk require a level of service that is more intensive, either in terms of the frequency of the service, the geographic proximity of the service, the accessibility of the service or added features that allow the service to address a wider range of needs. Where CAPC or CPNP projects are in place, extra efforts can be undertaken to support at-risk families. For example:

- Even where the service is universal, it is the *level of service* that varies – those clients with no risk factors may be seen again in six months, while others will get more frequent visits, once every four weeks on average;
- “At risk clients are not exactly beating down the door to get services – one has to go to where they are,” which means locating services in social housing projects or providing community kitchens to draw participants in;
- “One needs to wrap the services around the at-risk participant,” that is, addressing other needs such as housing concerns or questions about employment, in addition to providing advice on child development and the parenting needs of the families; again, where CAPC or CPNP projects are available, more resources can be directed to serve these broader needs;
- The targeted programs are far more able to focus on specific population groups, such as teen mothers, or provide appropriate services to marginalized groups (newcomers, gay parents); this includes providing life skills programs, settlement assistance and in the case of young moms in Peterborough, helping them earn a high school diploma;
- Targeted programs often use participants as program aides, who help other participants feel more comfortable with their services; for example, in Durham Region, graduates of the breastfeeding program come back to meet with new participants, and some receive special training to provide peer support, leading to better outcomes; in North York, community parents are used to co-facilitate the CPNP program, helping to interpret the information in a culturally appropriate way;
- Staff in targeted programs often have more experience and more familiarity with at-risk participants (“Our staff are comfortable asking about food security, domestic violence, or alcohol and drug abuse; often if you’re comfortable asking the question, then people are comfortable answering; I’m not sure that staff in mainstream services would be as comfortable asking those questions, and I’m also not sure that at-risk participants would be comfortable answering such a question in a group where they may get stigmatized for their answer.”)

Targeted and universal. Several respondents made the point that together these programs complement each other, thus ensuring a complete continuum of services:

“If there is no special space for marginalized families, then they often get pushed out of universal services.”

“Our [CPNP] service is open to everyone. But if a middle class woman attends, she will likely not return, feeling this is not the place for her. All our partners know our intention is to serve those at-risk, so there is some informal screening

done by those making referrals. Even though we act like we are universal, we end up serving the at-risk.”

“Everyone can get service in our [CPNP] program, but what is different is the level of service that a person gets. So while the service is universal, no one is *identified* as ‘at risk,’ and any one participant does not know the level of service anyone else is getting, unless they ask. So we have an integrated, universal service, and we provide a higher level of service to those who need it.”

“We have people steered to us [CAPC] by the OEYC because they know that we can provide those participants with the extra services they require.”

“One needs to view universal and targeted programming as being complimentary. It is not a question of targeted *or* universal, or of targeted *versus* universal, but rather targeted AND universal.”

Overcoming social exclusion. Targeted programs such as CAPC and CPNP often help participants overcome their feelings of difference and exclusion, and allow them to make the transition to mainstream services. As one OEYC put it, “the CAPC can focus their resources and attention on the families they serve, and working with us they can help integrate them with other families.”

“For many it is a comfort level – they feel that other people are not like them. We try to make them comfortable with those other people. We need to change their comfort level so that they can interact with others. A lot of this has to do with confidence in themselves. For many of them, this is the first time when they might be feeling competent. Up until now, they haven’t felt competent in school; they haven’t felt competent within their family setting. Once we give them some knowledge and understanding about child development, some skills, some tools, they start feeling some competence, and they are able to absorb more. And that sense of *competence* leads to *confidence*, including the ability to interact with others.”

“With individual home-visiting, we are able to focus on building the parenting skills of our participants, so that they develop the confidence in themselves and feel more comfortable in attending mainstream services.”

“Ultimately, people need to know how to access mainstream programs, because eventually their kids will be going to school. Parents who have traditionally had bad experiences with school will, one way or another, convey that impression to their children. Our CAPC school preparation program provides them with a positive opportunity to get to know schools and teachers, to help break that cycle of negative images about school.”

SPECIFIC EXAMPLES OF BENEFITS

There are a number of areas where the existence of these multiple funding streams confirms the familiar adage that the whole is greater than the sum of the parts. These include:

- The ability to provide more intensive, targeted outreach to at-risk families;
- The capacity to support at-risk families making the transition to mainstream services;
- The increased opportunity to adapt to local circumstances or to innovate;
- The increased collaboration.

Strategies for conducting outreach to at-risk mothers and families

Time and again, respondents noted the challenges of reaching at-risk participants:

“To get the at-risk participant, you have to go to them.”

“CAPC clients are hard to get out to services, because they’re isolated, because transportation is often a challenge for them, and because they don’t think they need the service.”

“High needs groups aren’t beating a path to services – they’re more concerned with getting through the day.”

“It is hard to reach at-risk families in rural areas – they don’t go to the services, you have to go to the person.”

CAPC and CPNP use a variety of common strategies to reach at-risk participants:

- Visits and mail-outs to hospitals, doctor’s offices, obstetricians and midwives;
- Referrals from other agencies;
- Free articles in community newspapers;
- Advertisements in newspapers and on the radio;
- Posters and pamphlets;
- Liaising with Children’s Aid, family health teams and social workers in hospitals;
- Information on websites;
- Inserts in Ontario Works cheque mail-outs.

But by far the most effective form of outreach is word-of-mouth. Close to half of the respondents indicated that word-of-mouth was their most common source of referrals.

CAPC and CPNP programs also use some fairly unconventional means of reaching at-risk families, such as:

- Having outreach workers walk the streets and talk to people with strollers;
- Going to laundromats and the corner stores to find mothers;
- Using multilingual agency staff to approach newcomer families in the neighbourhood;
- Attending alternative schools to reach young mothers.

In addition to concentrating their resources on targeted and intensive outreach, programs whose focus is the at-risk population typically develop the credibility, reputation and connections among the communities to attract their client group.

Yet even where CAPC and CPNP projects concentrate their recruitment efforts towards at-risk populations, they also benefit from the publicity generated by OEYC. Respondents noted that OEYC have raised awareness in local communities about the importance of child development and the availability of appropriate services, and that in itself makes it easier for the targeted programs to conduct outreach and to seek out referrals. As well, OEYC regularly refer clients to CAPCs and CPNPs where appropriate.

Strategies for helping at-risk families make the transition to mainstream services

It is very clear to CAPC and CPNP staff that many of their participants feel uncomfortable with mainstream services, as the frequency of comments about support for transition attest. As a result, CAPC, CPNP and OEYC staff very deliberately help at-risk families make the transition to mainstream OEYC programs. Their strategies include:

“We use the OEYC location so people start becoming comfortable with that place.”

“The CPNP family home visitor might accompany the participant to an OEYC, or if our CPNP staff is giving a talk at an OEYC, her participants will be invited so that there is a familiar face for them.”

“Our volunteer will drive them to an OEYC to connect them with that service.”

“It helps if the person providing childcare for an OEYC program is the same one for our CAPC, so when our clients go to the OEYC they are comfortable with that person.”

“We have an OEYC staff person come out to our program, and then we’ll take our participants over as a group to the OEYC when that staff person is on duty.”

“We schedule the OEYC parenting program right after the CPNP program, so CPNP participants can get familiar with OEYC staff. It also allows us to take advantage of the free transportation that brought the CPNP participants in.”

“We share staff training among our CAPC, CPNP and OEYC partners so that the OEYC staff are in a better position to interact with the at-risk clients.”

“We work on the individual skills of our participants, to build their confidence and self-esteem, so that they will feel more comfortable when attending mainstream services.”

A number of communities transition CPNP participants into CAPC programs, and use the CAPC program as the vehicle for helping families further transition into OEYC.

“Our CPNP staff does the intake for the CAPC program, ensuring that mothers transition to CAPC.”

“We used to have CAPC staff come to the CPNP location, but that wasn’t enough; instead, we had to use CPNP staff to accompany CPNP participants and go as a group to do a visit to the CAPC program site.”

“Our OEYC offers some specialized programming after the CPNP session, although they will also likely steer them to the CAPC program, because of the other services they can get there.”

Respondents find these transition strategies are usually effective. Many locations noted that there was a greater likelihood that if a mother attended a CPNP program, she was more likely to end up later at an OEYC, because she felt more comfortable with that service and more confidence in herself. It was important, however, to use the strategies mentioned above, of familiarizing her with the staff and with the location.

“Once people see all the services available at an OEYC, they are more likely to go, as opposed to following a verbal referral.”

“If they get familiar with the staff, they will eventually become comfortable with the location.”

As noted, this requires a conscious effort, which depends on dedicated resources and staff who take on this task.

“Without the extra program [CAPC] we wouldn’t be able to support their transition.”

“If there wasn’t a CAPC, these families would fall between the cracks.”

“We need to assess when they are ready to make the transition [to a mainstream service]. We don’t want to set them up for disappointment.”

“We use the CAPC to help transition mothers to the mainstream. For some, it takes a few months, for others a few years.”

For some, the transition can be very difficult, if not near impossible. For newcomers who acquire very little English, the language barrier feels daunting. In remote areas, the lack of transportation may prevent someone from attending a service. For some teen moms, their desire to be among their peers and their discomfort in the presence of older mothers means they could miss out on much needed services and supports. The added resources of CAPC and CPNP projects, their specific focus on at-risk populations, and the combined efforts of CAPC, CPNP and OEYC staff to help these participants make the transition to mainstream programs can often mean the critical difference for an isolated mother.

Local adaptation, local innovation

The existence of different streams of funding, each of which has a different focus, creates the conditions for local variation and innovation. Were funding to come from only one source, there would be a tendency towards homogenization of programming, given the likelihood that such a program would be required to focus primarily on serving the mainstream population. It is the variety of funding sources that allows for local adaptability to meet the needs of the at-risk populations specific to that community.

While CAPC and CPNP have well-articulated goals and a relatively common set of program activities, there does exist a fair degree of local variation, reflecting both adaptation to the local circumstances and innovation to address local needs.

Variation in CPNP programming. In most communities, CPNP offers both pre-natal and post-natal programming, with the post-natal portion running for six months after the birth of the baby. However, not all locations follow the same pattern. In one Eastern Ontario location, for example, the local CPNP project decided that it was more important to provide the widest coverage for pre-natal services and, in order to do this, it does not provide a post-natal component to its CPNP program. Instead, public health nurses attend CAPC and OEYC locations to offer post-natal support, with this service supported by the budget of the local public health unit (which it is able to do because the across-the-board presence of the CPNP in the pre-natal stage frees up some of its resources). In other instances, the CPNP post-natal programme period is longer: the CAPC program in East

Hamilton provides additional support to the local CPNP so that the post-natal program extends until 9 months, while additional funding in Etobicoke allows for a mother to continue in the local CPNP post-natal program until her baby is anywhere from 4 to 12 months old.

Adjusting to geography. As has been noted earlier, remote locations sometimes need to make adjustments to reflect the challenges of distance. Thus, in isolated communities, the same staff person may deliver the local CAPC, CPNP and OEYC programs, or pre-natal program groups for pregnant mothers may be combined with programs for mothers with children aged 0-6 years old, to ensure there are enough parents to form a group. Smaller communities will typically have smaller agencies, resulting in shorter organizational “ladders” to climb when it comes to facilitating collaboration between agencies and to promoting integration of services.

Innovative programs and approaches. The variety of programming among CAPC and CPNP sites illustrates how local creativity meets local challenges:

In *Haliburton*, the desire to focus on effective outcomes for families has led the local agency delivering the CAPC and CPNP programs to develop a matrix of domains, to help staff and partner agencies focus on the outcomes they are seeking to achieve with their various activities. The matrix has five domains: communication with yourself and with your child; self-help; social networking; problem solving; and recognition of one’s own needs.

In *Peterborough*, the local CAPC supports a school program for young mothers; the program provides childcare and parenting support, together with a teacher. Participants attend the program four days a week, with the goal of earning their high school diploma, but they also acquire life skills and parenting skills.

The CAPC *Program Without Walls (Toronto)* uses art and drama programs for parents as well as for children to attract participants. They also provide training for participants to enable their employment as home childcare providers.

In *Grey-Bruce Counties*, the CAPC and CPNP programs train volunteers in their cradle-link program and match them with participants, carrying out home visits to help pregnant and new mothers learn about and adjust to their new roles.

In *Hamilton*, the CAPC program provides literacy training for parents who need it so that they can keep up with their children in their reading programs.

The CAPC program in *Smooth Rock Falls* has a gym night for kids, to attract fathers and involve them in physical activities with their children.

In addition, many of these programs employ a wide range of packaged lessons to address common early childhood and parenting issues, drawing on other resources to support their programming. The seminars and workshops they deliver cover such topics as: breastfeeding; infant stimulation; parenting; school readiness; playing with children; and so on.

As noted earlier, many programs use former participants as peer mentors and program aides. In Haliburton, peer mentors accompany participants on hospital visits; in Durham, peer mentors have proven to be very successful with breastfeeding support; Hamilton CPNP and North York CAPC engage peers in meeting facilitation and, when possible, to communicate with participants in other languages. In several programs, local participants are involved in advisory committees for the programs or for specific locations, ensuring local input to programming.

What is striking is how the local variability in programming is dependent on local circumstances. Thus, despite one agency having responsibility for CAPC and CPNP projects and the OEYC program in a given locality, how those services are delivered may vary even within that catchment area. For example, in the former city of Etobicoke (now part of Toronto), a consortium of agencies holds the lead for the CAPC project with different agencies taking the lead for the local OEYC. How the CAPC and CPNP are delivered varies among these partners. Similarly, in Durham Region, the YMCA has the lead for CAPC, and also manages three OEYC. Yet, because Durham Region encompasses newcomer urban communities and remote rural hamlets, the CAPC programming looks different across Durham Region depending on where and to whom they are delivered.

Groundwork for collaboration

A number of respondents noted that the expectation for partnerships and community engagement that typified CAPC projects in particular, and to a lesser extent, CPNP projects, often laid the foundation in their areas for later collaboration and integration of services when OEYC were introduced. These mechanisms for collaboration took several forms:

- In some instances, CAPC projects either led to the formation of a local “table” on children’s services, or confirmed the value of one already in existence, which later made it the natural body to act as the OEYC advisory committee;
- In other instances, the creation of a consortium of agencies to implement the local CAPC and CPNP programs meant that a coordinator was in place to facilitate discussions relating to OEYC;

- Further, the accumulated habits of cooperation and communication arising from the planning and implementation of CAPC and CPNP often made it easier in later years in those communities for agencies to undertake the planning and implementation of the OEYC, particularly on such sensitive questions as determining the allocation of lead and satellite functions among agencies.

EXAMPLES OF THE INTEGRATION OF THESE PROGRAMS IN ACTION

The paper has thus far identified specific practices among different programs to illustrate the joint benefits of the CAPC, CPNP and OEYC services. In this concluding section, two program locations will be described, to give concrete examples of how CAPC, CPNP and OEYC connect on the ground in two communities.

Etobicoke

Etobicoke was a former city that now makes up the western portion of the City of Toronto. With a population of over 325,000 residents, its neighbourhoods incorporate a range of incomes, including concentrations of social housing as well as newcomer settlement areas.

When proposals were first invited for the CAPC program in the early 1990s, the three distinct regions of Etobicoke (the south, middle and north areas) separately started organizing to submit their own proposal. Each group came to the realization that three separate proposals from one medium-sized city were unlikely all to be funded, whereas one large proposal, covering the entire city, had a greater chance of succeeding. So was born the *Etobicoke Brighter Futures Coalition*, the network now cooperating on all early childhood development planning for Etobicoke, representing over 40 agencies, including family resource centres, community health centres, child care centres and other types of organizations. CAPC funding supports a coalition staff person who carries out program coordination, proposal development and program support (although the services are delivered by front-line staff of member agencies).

Etobicoke's CAPC program graphically reflects the distinct regions that make up Etobicoke. In the north, the program targets the newcomer populations in the social housing projects, focusing on such services as school readiness for newcomer children. In the south, where the low-income population is much more dispersed among basement apartments and walk-ups, more effort is placed on outreach, home-visiting and parent relief, to reach and serve isolated families. In the more affluent middle part, the project engages in many smaller initiatives for isolated pockets of at-risk families, for example, reading circles, a donations cupboard, and parent support for parents who have children

with special needs. As well, there is a pre-school program for developmentally challenged children that serves all of Etobicoke.

Etobicoke's CPNP program, *Eating for Two*, similarly has Etobicoke-wide coverage. Together with other resources provided by local community health centres, the program is able to offer pre-natal support (up until when the baby is four months old), followed by an extended post-natal service (for mothers with babies 4-12 months old). As well, there is separate programming for teen mothers.

The existence of the Etobicoke coalition, with separate planning tables for the three sections of Etobicoke, made planning particularly easy when the Ontario Early Years Centres were introduced. By the second meeting of the three area groups, consensus was reached for which agencies would take the lead for the Early Years Centres in the three Etobicoke ridings of Etobicoke North, Etobicoke Centre and Etobicoke Lakeshore.

The coalition is able to coordinate proposals for supplemental funding to augment the services provided by the CAPC, CPNP and OEYC programs. As well, with integrated planning and strong linkages between these programs and the agencies delivering them, staff is able to support families moving from CPNP into CAPC or directly into OEYC services. Staff is well aware of the range of services available and can guide families to the programming that is appropriate to their needs. As well, with this coordinated approach, agencies are able to undertake more intensive outreach to find families in need, as well as support them through the transition from targeted to mainstream programs.

Grey and Bruce Counties

Grey and Bruce counties make up part of the agricultural belt of southwestern Ontario, straddling the shores of Lake Huron and Georgian Bay. Together they comprise an area and population slightly larger than that of Prince Edward Island. The population is dispersed among one larger town (Owen Sound) and several smaller towns, as well as numerous hamlets and isolated farms.

This geographic reality has given rise to collaborative and creative approaches to make program dollars stretch further. For example the CAPC program, *Bruce Grey Brighter Futures*, has instituted a home visiting service that relies on volunteers from the community. The volunteers receive twelve hours of intensive training, and are supervised by Registered Nurses, who are also available for phone consultations with the volunteers or to conduct a home visit themselves, if the client requires it. The *CradleLink* home visiting program volunteers also provide drives to the program and sometimes assist with childcare.

In addition, both the CAPC and CPNP run separate group sessions in various communities across the catchment area. A number of these are located in OEYC sites. The CAPC program's sessions are community-based parent support groups, called *Parent Mutual Aid*. Their activities include community kitchens and cooking classes, discussions, as well as social and educational outings. These are supplemented with childcare, so that parents can receive some relief as well as be able to devote their full attention to receiving information and to connecting with other parents.

This foundation of wide-spread community reach and engagement meant that when it came to planning the OEYC, special attention was given to ensuring it was as geographically accessible as possible. OEYC funding was spread among numerous partners, so that it is claimed that anyone living in Grey or Bruce counties is within 15 minutes of an OEYC service, quite an accomplishment in this vast, rural area. As well, *CradleLink* volunteers help families connect with mainstream services, including sometimes personally driving them to an OEYC and helping to build up their comfort level with the location. The knowledge and information that participants acquire in the CAPC and CPNP programs gives them the confidence in those settings, and their familiarity with the location and some staff further puts them at ease.

CONCLUSION

The CAPC and CPNP programs were created in the early 1990s to support communities to put programming in place for at-risk pregnant women, mothers and their young families. OEYC, which were established later, are intended as universal programs targeting all families and all parts of the province.

This report demonstrates how these CAPC and CPNP projects and OEYC programs have developed practices and working relationships that both strengthen their abilities to meet their separate mandates as well as enhance the continuum of services and supports available to families in their communities.

The pre-natal and early childhood service needs of families will vary, but often families experiencing risk factors typically require more intensive attention. CAPC and CPNP projects complement OEYC services by:

- Undertaking more targeted outreach to at-risk families;
- Contributing another layer of services for those who have greater needs;
- Providing further resources by which to reach geographically remote, socially isolated or socially excluded families;
- Where necessary, working with OEYC to help at-risk families make the transition to mainstream services.

Clearly, the added resources that CAPC and CPNP projects bring to a community can only help the local system of early childhood services. But the benefit is not only financial. The availability of three funding streams, each with a different focus, means that communities can more likely design their services to meet local needs.

The report illustrates how communities deliver CAPC and CPNP projects and OEYC programs in a wide variety of configurations. These configurations include individual agencies leading the delivery for these services, multiple agency leads for each service collaborating to create an integrated continuum of services, or multiple agencies forming a consortium which coordinates the planning and implementation of these services. The choice of delivery model depends on such factors as the geographic context of the community, the needs of the population being targeted, the capacity of local agencies, and the experience of collaboration and inter-agency partnerships.

This multiplicity of project and program designs means that there is no one model that easily describes how CAPC, CPNP and OEYC work together. This is a testament to the creativity of communities across Ontario in adapting these programs to local circumstances. The degree of service linkages and service integration, among separate lead agencies or through a consortium of agencies, speaks well of the capacity and willingness of agencies to partner and collaborate in meeting the distinct child development and parenting needs of families in each locality.

Overall, the presence of CAPC and CPNP projects helps OEYC have a wider and deeper impact by bringing more intensive and targeted services to at-risk families, by making it possible for OEYC resources to reach further, and by facilitating more linkages among services and among agencies.

APPENDIX A: JOINT BENEFITS WORKING GROUP

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Barb Lillico
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Supportive Initiatives for Residents in the County of Haliburton

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APPENDIX B: LIST OF INTERVIEWEES

Julie Burdon, Project Manager, Hincks Dellcrest Centre
Building Brighter Futures; North York Prenatal Nutrition Program (CAPC, CPNP)
North York

Wendy Carron, Director of Services, Early Childhood Services, Haldimand-Norfolk
REACH
Haldimand-Norfolk CAPC; Healthy Moms Eating Well for 2 (CAPC, CPNP)
Townsend

Marg Cox, Executive Director, East York and East Toronto Family Resources
East York Healthy Beginnings for Healthy Babies; Ontario Early Years Centre - Toronto-Beaches-East York and Toronto Centre-Rosedale (CPNP, OEYC)
Toronto

Kim Curran, Coordinator, The George Hull Centre for Children and Families
Etobicoke Brighter Futures Coalition (CAPC)
Etobicoke

Cathy Fortier, Project Manager, The Young/Single Parent Network
Brighter Futures for Children of Young Parents; "Buns in the Oven" Prenatal Nutrition Program (CAPC, CPNP)
Ottawa

Anita Harms, Coordinator, The Mennonite Central Committee (Ontario)
Family Education and Support Program for Low German Families; Mam und Bebi (CAPC, CPNP)
Langton

Elizabeth Shaver-Heeney, Public Health Nutritionist/CPNP Coordinator,
City of Hamilton
Hamilton Prenatal Nutrition Project (CPNP)
Hamilton

Betty-Ann Horbul, Nutritionist, Porcupine District Health Unit
Healthier Mothers, Healthy Babies / Mamans en meilleure santé, bébés en santé (CPNP)
Timmins

Carrie Horn, Manager of Early Years Services,
Hamilton East Kiwanis Boys and Girls Club
Ontario Early Years Centre - Hamilton East (OEYC)
Hamilton

Joanne King, Executive Director, Community Resource Centre (Killaloe) Inc.
The Toy Bus; Best Start Prenatal Nutrition Program (CAPC, CPNP)
Killaloe and area

Barb Lillico, Executive Director, Peterborough Family Resource Centre
Brighter Futures Peterborough; Babies First; Ontario Early Years Centre - Peterborough (CAPC, CPNP, OEYC)
Peterborough

Ruth Ann MacKay, Project Coordinator, Mississauga Parent Child Centre
Growing Healthy Together in Peel Project (CAPC)
Mississauga

Nicole McKinnon, Director, Hastings and Prince Edward Counties Health Unit
Food for You, Food For Two (CPNP)
Belleville

Pat Miller, Manager of Children's Services, Lamp Community Health Centre
Etobicoke Brighter Futures Coalition; Eating for Two; Ontario Early Years Centre - Etobicoke-Lakeshore (CAPC, CPNP, OEYC)
Etobicoke

Sarah Miller, Supervisor, Services Familiaux Jeanne Sauvé Family Services
Brighter Futures for North Cochrane District; Ontario Early Years Centre - Kapuskasing (CAPC, OEYC)
Kapuskasing

Elaine Pellerin, Program Coordinator, Middlesex London Health Unit
Smart Start for Babies: Prenatal Advantage Program (CPNP)
London

Gena Robertson, Executive Director, SIRCH Community Services & Consulting
Bright Starts for Haliburton, Kawartha Lakes and Northumberland (CAPC, CPNP)
Haliburton

Jo-Anne Robertson, Program Manager, The Macaulay Child Development Centre
Program Without Walls (CAPC)
Former City of York

Darlene Rose, Office Supervisor/Program Coordinator, Eastern Ontario Health Unit
Baby's Best Start (CPNP)
Cornwall

Jennifer Sells, Program Manager, Keystone Child, Youth and Family Services
Grey Bruce Mutual Aid; Healthy Beginnings; Ontario Early Years Centres - Grey and Bruce Counties (CAPC, CPNP, OEYC)
Owen Sound

Sandy Shaw, CAPC Coordinator, Social Planning and Research Council of Hamilton
Hamilton CAPC (CAPC)
Hamilton

Pat Spadetto, Coordinator, Timiskaming Child & Family Services
Timiskaming Brighter Futures: Children Matter; Special Delivery PNP (CAPC, CPNP)
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Ontario Early Years Centre - Nipissing (OEYC)
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Growing Together in Peel (CAPC)
Mississauga

APPENDIX C: INTERVIEW QUESTIONS

(February 2, 2007)

Joint Benefits of CAPC, CPNP and OEYC Report

Draft Questions for Interviewees

1. Briefly, can you describe the various programs being delivered through your organization or consortium of organizations. This includes:
 - What children-related services and activities being offered;
 - Other services or activities not directly related to children (for example, housing help services, newcomer settlement or ESL, income tax completions, etc.);
 - If a consortium, who are the participating organizations;
 - Who are the main funders for these programs;
 - What other organizations do you partner with and for what purposes.

2. Can you describe, within the context of your organization's work, what is the inter-relationship between CAPC, CPNP and/or OEYC (depending on which programs you are engaged with)?
 - What is the focus of these different programs and how do they interrelate?
 - What, if any, are the benefits of these separate programs, in terms of how they assist your organization in serving your clients? Can you elaborate on some specific benefits?

3. How would you describe the degree of integration between your organization and other organizations serving the same clients in the field of children's services:
 - Awareness: We are generally aware of what other organizations are doing, and sometimes refer clients for specific needs
 - Intermittent Communication: We sometimes communicate with other agencies about what we or they are doing, especially when we are putting a proposal for funding
 - Formal Communication: We meet on a regular basis with other organizations and exchange information
 - Cooperation: We are very mindful of what other agencies are doing and plan our programs with that in mind
 - Collaboration: Together with other agencies, we jointly discuss and plan what services we offer
 - Project partnering: We sometimes or often propose joint projects with other agencies, based on on-going joint discussions and planning

- Fusion: We have integrated our programs with other agencies so that clients would not even be aware that there are multiple partners providing a particular array of services

How do you feel the degree of integration contributes to your goal of serving your clients? What has contributed to the current level of integration? Do you feel the current level of integration is not enough, too much, or just about right? Why?

4. How important is it, in your view, to have an integrated approach to children's services in your community?

- Can you provide reasons for your answer.
- Is the relevance of integration of greater or lesser importance in the case of at-risk families? Why?

5. What, for you, are some of the best practices that you would highlight among the services or activities you promote?

- Can you elaborate on what makes a best practice (that is, why are you comfortable offering this example as a best practice, or what the evidence for your judgment)?
- What are the conditions or circumstances that contribute to making this best practice possible or feasible?

APPENDIX D: REFERENCES

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