Revised November 2010

A Quick Reference Guide For Early Years Professionals

Red Flags

For Infant, Toddler and Preschool Children

HEALTHY BABIES HEALTHY CHILDREN
WORKING TOGETHER FOR CHILDREN

ML MIDDLESEX-LONDON HEALTH UNIT

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Red Flags Working Group Acknowledgements

The Simcoe County Early Intervention Council developed and distributed the original Red Flags document in March 2003. The document was reviewed and revised by the York Region Early Identification Planning Coalition and supported by York Region Health Services, April, 2004.

Public Health Nurses of the HBHC- Early Identification Committee of the Middlesex-London Health Unit adapted the initial Red Flags with the assistance of many community agencies in April 2006. The first revision was in September 2008 and the second revision was in November 2010.

Special thanks go out to these agencies for their assistance with the last revision.

All Kids Belong, Merrymount

Autism Intervention Program – South West Region

Children's Aid Society of London and Middlesex

Vanier Children's Services

Middlesex-London Health Unit

Ontario Early Years Centre

Pediatric Acquired Brain Injury Community Outreach Program

Thames Valley Children's Centre

TykeTALK

CNIB Southwest Region

Child and Parent Resource Institute

Investing in Children

For further information, please contact Heather Lokko, Manager of Child Health Program at the Middlesex-London Health Unit at 519-663-5317, ext. 2373 or at heather.lokko@mlhu.on.ca

Red Flags Document

Introduction

The Early Years Council of Middlesex-London gives high priority to the earliest possible identification of children with special needs or children who are at risk of delayed development. The early years of development from conception to age six, particularly the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life.

This “Red Flags” document has been adapted with permission from "Red Flags for Infant and Preschool Children", Simcoe County, March 2003, and “Red Flags for Infant, Toddler and Preschool Children, York Region, April 2004.

This “Red Flags” document facilitates timely and effective linking of those children to the appropriate assessments and services**. Time is of the essence!**

What is "Red Flags"?

"Red Flags" is a reference guide for use by professionals who work with young children and their families. “Red Flags” outlines a range of functional indicators that monitor healthy child development. It should be used in conjunction with a validated screening tool such as the Nipissing District Developmental Screen. "Red Flags" is intended to assist in the determination of when and where to refer for additional advice, formal assessment and/or treatment.

Who should Use "Red Flags"?

"Red Flags" is intended to be used by any professional working with young children and their families. A basic knowledge of healthy child development is assumed. The presence of one or more "Red Flags" in any area suggests that a child may be at risk, and further investigation may be required.

If you have any concerns about a child as you review "Red Flags”, please contact any professional agency in the Resources Section of this Document.

Special Note

In the “Where to go for help” sections, it is often suggested to advise parents to contact their physician. Due to a shortage of physicians in Middlesex-London, many parents may not have access to a physician. If that is the case, please refer them to another health care provider, i.e. nurse practitioner, walk in clinic.

New This Year

A laminated Referral Map “Are you concerned about an Infant, Toddler or Preschool Child’s Development” has been developed by the Child and Youth Network for London. This Referral Map is meant to compliment Red Flags.
To download the Referral Map go to:
http://www.london.ca/Child_Youth_Network/PDFs/ReferralMap1.pdf

How to Talk to Parents about Sensitive Issues

One of the most difficult parts of recognizing a potential difficulty in a child's development is sharing these concerns with the parents/caregivers. It is important to be sensitive when suggesting that there may be a reason to have further assessment done. You want parents/caregivers to feel capable and to be empowered to make decisions. There is no one way that always works best but there are some things to keep in mind when addressing concerns.

- Be sensitive to a parent/caregiver's readiness for information. If you give too much information when people aren't ready, they may feel overwhelmed or inadequate. You might start by probing how they feel their child is progressing. Some parents/caregivers have concerns but have not yet expressed them. Having a parent use a tool such as the Nipissing District Developmental Screen may help open the way for discussion. It may help to specify that the screening tool is something given to many parents to help them look at their child's development more easily and to learn about new activities that encourage growth and development.
- Be sure to value the parent/caregiver's knowledge. The ultimate decision about what to do is theirs. Express what it is that you have to offer and what they have to offer as well. You may say something like: "I have had training in child development but you know your child. You are the expert on your child". When you try to be more of a resource than an "authority", parents/caregivers feel less threatened. Having the parents/caregivers discover how their child is doing and whether or not extra help would be beneficial is best. You may want to offer information you have by asking parents/caregivers what they would like to know or what they feel they need to know.
- Focus on strengths first. Try to balance the concerns you raise with genuine positives about the child (e.g. "Johnny is a real delight. He is so helpful when things need tidying up. I have noticed that he seems to have some trouble . . .").
- Be genuine and caring. You are raising concerns because you want their child to do the best that he/she can, not because you want to point out "weaknesses" or "faults". Approach the opportunity for extra help positively; "you can get extra help for your child so he/she will be as ready as he/she can be for school".
- Your body language is important; parents may already be fearful of the information.
- Have the family participate fully in the final decision about what to do next. The final decision is theirs. You provide only information, support and guidance.
- Give the family time to talk about how they feel – if they choose to. If you have only a limited time to listen, make this clear to them, and offer another appointment if needed.
- Don't entertain too many "what if" questions. A helpful response could be "*Those are good questions. The professionals who will assess your child will be able to answer them. This is a first step to indicate if an assessment is needed".*
- Finally, it is helpful to offer reasons why it is not appropriate to "wait and see":
    - Early intervention can dramatically improve a child's development and prevent additional concerns such as behaviour issues.
    - The wait and see approach may delay addressing a medical concern that has a specific treatment.
    - Early intervention helps parents understand child behaviour and health issues, and will increase confidence that everything possible is being done to ensure that the child reaches his/her full potential.

Attachment

Children's Mental Health research shows that the quality of early parent-child relationships has important impact on a child's development and his/her ability to form secure attachments. A child who has secure attachment feels confident that he or she can rely on the parent to protect him or her in times of distress. This confidence gives the child security to explore the world and establish trusting relationships with others. As a result, current mental health practice is to screen the quality of the parent-child interactions. Early life experiences which are confusing, frightening and isolating emotionally for children, can create insecure attachment between a parent(s) and child. When children display developmental difficulties, e.g. autistic spectrum disorders, etc., difficulties in parent-child interaction often occur for differing reasons and should be distinguished from insecure attachments resulting from confusing emotional events in a child's life.

The following items are considered from the **parent's perspective,** rather than the child's**. If a <u>parent</u> states that one or more of these statements <u>describe their child</u>, the child may be exhibiting signs of an insecure attachment; consider this a red flag:**

0-8 months	❑ Is difficult to comfort by physical contact such as rocking or holding ❑ You feel that the child does things or cries just to annoy you
8-18 months	❑ Does not reach out to you for comfort ❑ Easily allows a stranger to hold him/her
18 months – 3 years	❑ Is not beginning to develop some independence ❑ Seems angry or ignores you after you have been apart ❑ Does not display normal affection or comfort seeking behaviours (applies to all ages following when child initiates these behaviours)
3–4 years	❑ Easily goes with a stranger ❑ Is too passive or clingy with you
4–5 years	❑ Becomes aggressive for no reason (e.g. with someone who is upset) ❑ Is too dependent on adults for attention, encouragement and help

Problem Signs… if a <u>mother</u> or primary caregiver is <u>frequently displaying</u> any of the following, consider this a red flag:

- ❑ Being insensitive to a baby's communication cues
- ❑ Often unable to recognize baby's cues
- ❑ Provides inconsistent patterns of responses to the baby's cues
- ❑ Frequently ignores or rejects the baby

Attachment (continued)

- Speaks about the baby in negative terms
- Often appears to be angry with the baby
- Often expresses emotions in a fearful or intense way

WHERE TO GO FOR HELP?

If there are concerns, advise the parents to contact their physician or pediatrician. Parents can self refer to Madame Vanier Children's Services at 519-433-0334.

Gross Motor

Healthy Child Development…if a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

By 3 months
- ❑ Lifts head up when held at your shoulder
- ❑ Lifts head up when on tummy

By 4 months
- ❑ Keeps head in midline and bring hands to chest when lying on back
- ❑ Lifts head and supports self on forearms when on tummy
- ❑ Holds head steady when supported in sitting position

By 6 months
- ❑ Rolls from back to stomach or stomach to back
- ❑ Pushes up on hands when on tummy
- ❑ Sits on floor with support

By 9 months
- ❑ Sits on floor without support
- ❑ Moves self forward on tummy or rolls continuously to get item
- ❑ Stands with support

By 12 months
- ❑ Gets up to a sitting position on own
- ❑ Pulls to stand at furniture
- ❑ Walks holding onto hands or furniture

By 18 months
- ❑ Walks alone
- ❑ Crawls up stairs
- ❑ Plays in a squat position

By 2 years
- ❑ Walks backwards or sideways pulling a toy
- ❑ Jumps on the spot
- ❑ Kicks a ball

By 3 years
- ❑ Stands on one foot briefly
- ❑ Climbs stairs with minimal or no support
- ❑ Kicks a ball forcefully

By 4 years
- ❑ Stands on one foot for one to three seconds without support
- ❑ Goes up stairs alternating feet
- ❑ Rides a tricycle using foot peddles
- ❑ Walks on a straight line without stepping off
- ❑ Avoids climbing, jumping, uneven ground or (mild) roughhousing

By 5 years
- ❑ Hops on one foot
- ❑ Throws and catches a ball successfully most of the time
- ❑ Plays on playground equipment without difficulty and safely

Gross Motor (continued)

Problem signs…if a child is <u>experiencing</u> any of the following, consider this a red flag:

- Baby is unable to hold head in the middle to turn and look left and right
- Unable to walk with heels down four months after starting to walk
- Asymmetry for gait, walking and running (i.e. a difference between two sides of body)
- Body too stiff or too floppy
- Child falls or trips frequently, when walking is established
- Child appears to have difficulty overall coordinating movements

WHERE TO GO FOR HELP?

If there are concerns, advise the parents to contact their physician or pediatrician or call Thames Valley Children's Centre at 519-685-8716. For children under two years old, families can self refer to Developmental Resources for Infants (DRI) at 519-685-8710. For more information, go to www.tvcc.on.ca.

Fine Motor

Healthy Child Development…if a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

By 2 months
- ❑ Sucks well on a nipple
- ❑ Holds an object momentarily if placed in hand

By 4 months
- ❑ Brings hands or toy to mouth
- ❑ Turns head side to side to follow a toy or an adult face
- ❑ Brings hands to midline while lying on back

By 6 months
- ❑ Eats from a spoon (e.g. infant cereal)
- ❑ Reaches for a toy when lying on back
- ❑ Uses hands to reach and grasp toys

By 9 months
- ❑ Picks up small items using thumb and first finger
- ❑ Passes an object from one hand to the other
- ❑ Releases objects voluntarily

By 12 months
- ❑ Holds, bites and chews easily masticated foods (e.g. crackers)
- ❑ Takes things out of a container
- ❑ Points with index finger
- ❑ Plays games like peek-a-boo
- ❑ Holds a cup to drink using two hands
- ❑ Picks up and eats finger foods

By 18 months
- ❑ Helps with dressing by pulling out arms and legs
- ❑ Stacks two or more blocks
- ❑ Scribbles with crayons
- ❑ Eats foods without coughing or choking

By 2 years
- ❑ Takes off own shoes, socks or hat
- ❑ Stacks five or more blocks
- ❑ Eats with a spoon with little spilling

By 3 years
- ❑ Turns the pages of a book
- ❑ Dresses or undresses with help
- ❑ Unscrews a jar lid
- ❑ Holds a crayon with fingers
- ❑ Draws vertical and horizontal lines in imitation
- ❑ Copies a circle already drawn

By 4 years
- ❑ Holds a crayon correctly
- ❑ Undoes buttons or zippers
- ❑ Cuts with scissors
- ❑ Dresses and undresses with minimal help

Fine Motor (continued)

By 5 years

- Draws diagonal lines and simple shapes
- Uses scissors to cut along a thick line drawn on paper
- Dresses and undresses without help except for small buttons, zippers, snaps
- Draws a stick person

Problem signs…if an infant or toddler is <u>experiencing</u> any of the following, consider this a red flag:

- Infants who are unable to hold or grasp an adult finger or a toy/object for a short period of time
- Consistently ignores or has difficulty using one side of body; or uses one hand exclusively

WHERE TO GO FOR HELP?

If there are concerns, advise the parents to contact their physician or pediatrician or call Thames Valley Children's Centre at 519-685-8716. For children under two years old, families can self refer to Developmental Resources for Infants (DRI) at 519-685-8710. For more information, go to www.tvcc.on.ca.

Hearing

Healthy Child Development…if a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

0-3 months
- Startles, cries or wakens to loud sounds
- Moves head, eyes, arms and legs in response to a noise or voice
- Smiles when spoken to, or calms down; appears to listen to sounds and talking

4-6 months
- Responds to changes in your voice tone
- Looks around to determine where new sounds are coming from; responds to music

7-12 months
- Turns or looks up when her/his name is called
- Responds to the word "no"; listens when spoken to
- Knows common words like "cup", "shoe", "mom"
- Responds to requests such as "want more", "come here"

12 months- 2 years
- Turns toward you when you call their name from behind
- Follows simple commands
- Tries to 'talk' by pointing, reaching and making noises
- Knows sounds like a closing door and a ringing phone

2-3 years
- Listens to a simple story
- Follows two requests (e.g. "get the ball and put it on the table")

3-4 years
- Hears you when you call from another room
- Listens to the television at the same loudness as the rest of the family
- Answers simple questions

4-5 years
- Pays attention to a story and answers simple questions
- Hears and understands most of what is said at home and school
- Family, teachers, babysitters, and others think he or she hears fine

Problem Signs…if a child is <u>experiencing</u> any of the following, consider this a red flag:

- Early babbling stops
- Ear pulling (with fever or crankiness)
- Does not respond when called
- Draining ears
- A lot of colds and ear infections
- Loud talking

Hearing (continued)

WHERE TO GO FOR HELP?

Hearing and Speech go together. A problem with one could mean a problem with the other. If there are concerns, or more information is needed, advise the parent to contact their physician for a referral to an audiologist, or contact an audiologist directly. Up to 24 months of age, contact the Infant Hearing Program at 519-663-5317 ext. 2224 if a permanent childhood hearing loss is suspected.

Sensory

Sensory integration refers to the ability to receive input through all of the senses - taste, smell, auditory, visual, touch, movement and body position, and the ability to process this sensory information into automatic and appropriate adaptive responses.

Problem signs…if a child's responses are <u>exaggerated</u>, <u>extreme</u> and <u>do not seem typical</u> for the child's age, consider this a red flag:

Visual

- Avoids eye contact
- Squinting, or looking out of the corner of the eye
- Staring at bright, flashing objects
- Sits or looks at screens or objects very closely
- Appears to have difficulty seeing things within short range (may bump into things within their path)

Taste/Smell

- Avoids certain tastes/smells that are typically part of a child's diet
- Chews/licks/ingests non-food objects
- Gags easily
- Picky eater, especially regarding textures

Movement and Body Position

- Continually seeks out all kinds of movement activities (being whirled by adult, playground equipment, moving toys, spinning, rocking)
- Becomes anxious or distressed when feet leave ground
- Poor endurance – tires easily; Seems to have weak muscles
- Moves stiffly or walks on toes; Clumsy or awkward, falls frequently
- Does not enjoy a variety of playground equipment
- Enjoys exaggerated positions for long periods (e.g. lies head-upside-down off sofa)

Auditory

- Responds negatively to unexpected or loud noises
- Is distracted or has trouble functioning if there is a lot of background noise
- Enjoys strange noises/seeks to make noise for noise sake
- Seems to be "in his/her own world"

Sensory (continued)

Touch

- Becomes upset or cannot tolerate routine grooming (hair cutting, face washing, fingernail cutting, teeth brushing)
- Has difficulty standing in line or close to other people; or stands too close, always touching others
- Is sensitive to certain fabrics or textures or regularly rubs specific textures or holds objects continually in hands (paper, elastics, specific objects)
- Fails to notice when face or hands are messy or wet
- Craves lots of touch: deep pressure, long-sleeved clothing, hats and certain textures

Activity Level

- Always on the go; difficulty paying attention
- Very inactive, under-responsive and lethargic

Emotional/Social

- Needs more protection from life than other children
- Has difficulty with changes in usual routines or in transitioning from one activity to another
- Is stubborn or uncooperative; gets frustrated easily
- Appears very sad or unhappy a good bit of the time
- Displays very inconsistent moods (very happy to very sad)
- Has difficulty making and sustaining friends; little interest in peers or their activities
- Has difficulty understanding body language or facial expressions
- Does not feel positive about own accomplishments

WHERE TO GO FOR HELP?

If there are concerns, advise the parents to contact their physician or pediatrician or call Thames Valley Children's Centre at 519-685-8716. For children under two years old, families can self refer to Developmental Resources for Infants (DRI) at 519-685-8710. For more information, go to www.tvcc.on.ca.

Social Emotional

Problem signs…if a child is <u>experiencing</u> any of the following, consider this a red flag:

0-8 months

- Failure to thrive with no medical reason
- Parent and child do not engage in smiling and vocalization with each other
- Parent ignores, punishes or misreads child's signals of distress
- Parent pulls away from infant or holds infant away from body with stiff arms
- Parent is overly intrusive when child is not wanting contact
- Child is not comforted by physical contact with parent

8-18 months

- Parent and child do not engage in playful, intimate interactions with each other
- Parent ignores or misreads child's cues for contact when distressed
- Child does not seek proximity to parent when distressed
- Child shows little wariness towards a new room or stranger
- Child ignores, avoids or is hostile with parent after separation
- Child does not move away from parent to explore, while using parent as a secure base
- Parent has inappropriate expectations of the child for their age

18 months – 3 years

- Child and parent have little or no playful or verbal interaction
- Child initiates overly friendly or affectionate interactions with strangers
- Child ignores, avoids or is hostile with parent when distressed or after separation
- Child is excessively distressed by separation from parent
- Child freezes or moves toward parent by approaching sideways, backwards or circuitously
- Child alternates between being hostile and overly affectionate with parent
- Parent seems to ignore, punish or misunderstand emotional communication of child
- Parent uses inappropriate or ineffective behaviour management techniques

Social Emotional (continued)

3–5 years

- Child ignores adult or becomes worse when given positive feedback
- Child is excessively clingy or attention seeking with adults, or refuses to speak
- Child is hyper vigilant or aggressive without provocation
- Child does not seek adult comfort when hurt, or show empathy when peers are distressed
- Child's play repeatedly portrays abuse, family violence or explicit sexual behaviour
- Child can rarely be settled from temper tantrums within 5-10 minutes
- Child cannot become engaged in self-directed play
- Child is threatening, dominating, humiliating, reassuring or sexually intrusive with adult
- Parent uses ineffective or abusive behaviour management techniques

WHERE TO GO FOR HELP?

If there are concerns for children up to the age of three, advise parents to contact the Health Connection for referral to the Healthy Babies Healthy Children Program, at 519-850-2280. Parents can refer children from birth to six to Vanier Children's Services at 519-433-0334. For concern about child protection, contact the Children's Aid Society of London and Middlesex at: 519-455-9000

Speech and Language

Healthy Child Development…if a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

0-3 months

- Cries and grunts; has different cries for different needs
- Makes a lot of "cooing" and "gooing" sounds, using primarily vowels with varying inflection

4-6 months

- Makes a variety of vowel sounds
- Lets you know by voice sounds to do something again
- Makes "gurgling" noises
- Laughs in response to adult's laugh and smiles
- Imitates some sounds made by adults

7-12 months

- "Performs" for social attention
- Waves hi/bye (emerging)
- Gives a few very familiar objects on verbal request
- Uses a lot of different voice sounds when playing
- Uses voice sounds to get and keep your attention
- Copies sounds like a "click" or a "cough"
- Plays social games like "peek-a-boo"
- Babbles repetitive consonant and vowel sounds like "dada", "mama"

12-18 months

- Tries to copy your sounds and words
- Uses a vocabulary of a minimum of 10 spoken words
- Understands "no" and shakes his/her head
- Will reach or point to something wanted while making a sound
- Understands simple directions or questions like "where is your nose?"
- Waves bye-bye
- Uses more new words every week
- Makes a variety of consonant sounds (p, b, m, n, d, g)

18 months-2 years

- Tries to copy your words
- Uses a variety of words
- Uses 50 or more words and combines 2 words
- Follows novel commands without gestures
- Follows directions with 2 objects and one action
- Takes turns in a conversation
- Uses toys for pretend play
- Understands more words than he/she can say

Speech and Language (continued)

2-3 years

- Responds to simple questions
- Understands location words like “in”, “on” and “under”
- Identifies some objects by their functions
- Tries to talk, even if you don't understand
- Uses phrases with 2-3 words like "Want juice" or "Mommy go now"
- Uses 200 or more words; asks a lot of questions
- Uses pronouns, like “I’, “me”
- Speaks clearly enough to be understood about 2/3 of the time
- Uses at least 400 different words

3-4 years

- Talks about what happened at a friend's house or at school
- Says most words right except perhaps r, th, s, ch, j and v sounds
- Uses sentences with 4 or more words
- Uses 900-1000 different words
- Speech is understood by all listeners
- Tells a simple story

4-5 years

- Speaks clearly enough to be understood by people outside the family
- Uses long sentences like "she climbed the ladder and got the cat"
- Tells and retells detailed stories in a cohesive way, so others can understand
- Understands long verbal directions
- Understands spatial relationships – “on top of”, “in between”, “behind”, “in front of”, etc.
- Explains concepts using words – “What is a cup? What is a car?”
- Understands the concept of rhymes; able to make own rhymes
- Able to associate a letter with the sound it makes
- Understands many descriptive words
- Uses most consonant and vowel sounds correctly

Problem signs…if a child is <u>experiencing</u> any of the following, consider this a red flag:

- Stumbling or getting stuck on words or sounds (stuttering)
- Ongoing hoarse voice
- Excessive drooling not associated with teething
- Problems with swallowing, chewing, or eating foods with certain texture (gagging). See also Feeding and Swallowing section
- By age 2½, a child’s words are not understood except by family members
- Lack of eye contact and poor social skills for age
- Frustrated when verbally communicating

Speech and Language (continued)

WHERE TO GO FOR HELP?

If there are any concerns, advise the parent to contact tykeTALK, The Thames Valley Preschool Speech and Language Program, at 519-663-0273 or 1-877-818-8255 or visit the website at www.tyketalk.com.

Vision

Healthy Child Development… if a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

0-3 months

- Focuses on your face, bright colors and lights; follows slow-moving, close objects
- Blinks when bright lights come on or if a fast moving object comes into close view; watches as you walk around the room
- Looks at hands and begins to reach out and touch nearby objects

4-6 months

- Tries to copy your facial expression
- Reaches for objects when playing with you
- Grasps small objects close by
- Follows moving objects with eyes only (less moving of head)

7-12 months

- Plays games like 'peek-a-boo', 'pat-a-cake', 'waves bye-bye'
- Reaches out to play with toys and other objects on own
- Moves around to explore what's in the room; searches for a hidden object
- Searches for a hidden object
- Follows objects as they move from above head to feet

12 months-2 years

- Moves eyes and hands together (e.g. stack blocks, place pegs)
- Judges depth e.g. climbs up and down stairs
- Links pictures with real life objects

2-3 years

- Sits a normal distance when watching television
- Follows moving objects with both eyes working together (coordinated)

3-4 years

- Knows people from a distance (across the street)
- Uses hands and eyes together (e.g. catches a large ball)
- Builds a tower of blocks, string beads; copies a circle, triangle and square

4-5 years

- Knows colours and shadings; picks out detail in objects and pictures
- Holds a book at a normal distance

Problem Signs…if a child is <u>experiencing</u> any of the following, consider this a red flag:

- Blinking and/or rubbing eyes often; a lot of tearing or eye-rubbing
- Headaches, nausea, dizziness; blurred or double vision
- Eyes that itch or burn; sensitive to bright light and sun

Vision (continued)

- Unusually short attention span; will only look at you if he or she hears you
- Avoidance of tasks with small objects
- Turning or tilting head to use only one eye to look at things
- Covering one eye; has difficulty, or is irritable with reading or with close work
- Eyes that cross, turn in or out, move independently
- Holding toys close to eyes, or no interest in small objects and pictures
- Bumping into things, tripping; clumsiness, restricted mobility
- Squinting, frowning; pupils of different sizes
- Redness, soreness (eyes or eyelids); recurring styes; discoloration
- Constant jiggling or moving of eyes side-to-side (roving)
- Has difficulty seeing in the dark/at night

WHERE TO GO FOR HELP?

If there are any concerns, advise the parents to arrange for an eye exam immediately with an optometrist. **By the age of 3, all children should have their eyes checked by an optometrist.** OHIP will cover a visit to an optometrist once yearly until 19 years of age. Children who have been diagnosed with or who are suspected of being blind or having low vision should be referred to the Blind Low Vision Early Intervention Program @ 519-663-5317, ext. 2224 or CNIB @ 519-685-8420 for supports and services.

Abuse

Although not conclusive, the presence of one or more the following indicators of abuse and neglect should alert parents and professionals to the possibility of child abuse. There are four types of child abuse: neglect, physical abuse, emotional abuse and sexual abuse. However, these indicators should not be taken out of context or used individually to make unfounded generalizations. Pay special attention to duration, consistency, and pervasiveness of each characteristic.

If there are suspicions, you are legally obligated to consult with or report to the Children's Aid Society of London and Middlesex at 519-455-9000. Professionals must also report any incidence of a child being exposed to adult conflict and/or partner violence where the child is injured or is at risk of physical or emotional harm. For related medical issues, contact the family physician or paediatrician. Acute injuries may require that the child be taken to the emergency department at the closest hospital.

POSSIBLE INDICATORS OF NEGLECT

PHYSICAL INDICATORS IN CHILDREN	BEHAVIOURAL INDICATORS IN CHILDREN	BEHAVIOURS OBSERVED IN ADULTS WHO NEGLECT CHILDREN
❑ an infant or young child may: • not be growing as expected • be losing weight • have a "wrinkly old face" • look pale • not be eating well ❑ not dressed properly for the weather ❑ dirty or unwashed ❑ bad diaper rash or other skin problems ❑ always hungry ❑ lack of medical and/or dental care ❑ signs of deprivation (e.g. hunger, diaper rash) which improve with a more nurturing environment	❑ does not show skills as expected for child's age and stage of development ❑ appears to have little energy due to lack of sleep or lack of proper nutrition ❑ cries very little ❑ does not play with toys or notice people ❑ does not seem to care for anyone in particular ❑ may be very demanding of affection or attention from others ❑ older children may steal ❑ takes care of a lot of their needs on their own ❑ has a lot of adult responsibility at home; may be required to look after younger siblings beyond what is normal ❑ hoards and hides food ❑ discloses neglect (e.g. says there is no one at home)	❑ does not provide for child's basic needs ❑ has a disorganized home life, with few regular routines (e.g. always brings the child very early, picks up the child very late, meal times are not predictable) ❑ does not supervise the child properly (e.g. leaves the child alone, in a dangerous place, or with someone who cannot look after the child safely) ❑ may indicate that the child is hard to care for, hard to feed, describes the child as demanding ❑ may attribute adult negative motivations to actions of child- e.g. reports child out to get the parent, child not like the parent ❑ may say the child was or is unwanted ❑ may ignore the child trying to be loving ❑ has difficulty dealing with own personal problems and puts own needs before care of the children ❑ is more concerned with own self than the child ❑ is not very interested in the child's life (e.g. fails to use services offered or to keep child's appointments, does not do anything about concerns that are discussed)

Possible Indicators of Physical Abuse

PHYSICAL INDICATORS IN CHILDREN	BEHAVIOURAL INDICATORS IN CHILDREN	BEHAVIOURS OBSERVED IN ADULTS WHO ABUSE CHILDREN
❑ a lot of bruises in the same area of the body ❑ bruises in areas on the body that are not typical of childhood play (e.g. bruises on face, torso, upper back, head) ❑ bruises in the shape of an object (e.g. spoon, hand/fingerprints, belt) ❑ burns: • from a cigarette • in a pattern that looks like an object (e.g. iron) ❑ wears clothes to cover up injury, even in warm weather ❑ patches of hair missing ❑ signs of possible head injury: • swelling and pain • nausea or vomiting • feeling dizzy • bleeding from the scalp or nose ❑ signs of possible injury to arms and legs: • pain • sensitive to touch • cannot move properly • limping ❑ breathing causes pain ❑ difficulty raising arms ❑ human bite marks ❑ cuts and scrapes inconsistent with normal play ❑ signs of female genital mutilation (e.g. trouble going to the bathroom)	❑ cannot remember how injuries happened ❑ the explanation of what happened does not match the injury ❑ refuses or is afraid to talk about injuries ❑ is afraid of adults or of a particular person ❑ does not want to be touched ❑ may be very: • aggressive • unhappy • withdrawn • obedient and wanting to please • uncooperative ❑ is afraid to go home ❑ runs away ❑ is away a lot and when comes back there are signs of healing injury ❑ does not show skills as expected ❑ does not get along well with other children ❑ tries to hurt him/herself (e.g. cutting oneself, suicide) ❑ discloses corporal punishment, hitting that results in injuries, abuse, or threats	❑ does not tell the same story as the child about how the injury happened ❑ may say that the child seems to have a lot of accidents and/or is clumsy ❑ severely punishes the child ❑ cannot control anger and frustration ❑ expects too much from the child ❑ talks about having problems dealing with the child ❑ talks about the child as being bad, different or "the cause of my problems" ❑ does not show love toward the child ❑ delays seeking medical attention for injuries or illnesses ❑ has little or no help caring for the child and reports feeling overwhelmed, isolated, fatigued

Possible Indicators of Sexual Abuse

PHYSICAL INDICATORS IN CHILDREN	BEHAVIOURAL INDICATORS IN CHILDREN	BEHAVIOURS OBSERVED IN ADULTS WHO ABUSE CHILDREN
❑ a lot of itching or pain in the throat, genital or anal area ❑ underwear that is bloody ❑ injury to the breasts or genital area: • redness • bruising • cuts • swelling	❑ engages in sexual behaviours that is beyond the child's age and stage of development ❑ knowing more about sex than expected ❑ details of sex in the child's drawings/writing ❑ sexual actions with other children or adults that are inappropriate ❑ very demanding of affection or attention, or clinging ❑ refuses to be undressed, or when undressing shows fear ❑ tries to hurt oneself (e.g. uses drugs or alcohol, eating disorder, suicide) ❑ discloses sexual abuse, exposure to pornography, or inappropriate touching from adult or older caregiver	❑ may be very protective of the child that results in the child being isolated from adults and peers ❑ may be jealous of the child's relationships with others ❑ does not like the child to be with friends unless the parent is present ❑ talks about the child being "sexy" ❑ touches the child in a sexual way ❑ may use drugs or alcohol to feel freer to sexually abuse ❑ allows or tries to get the child to participate in sexual behaviour

Possible Indicators of Emotional Abuse

PHYSICAL INDICATORS IN CHILDREN	BEHAVIOURAL INDICATORS IN CHILDREN	BEHAVIOURS OBSERVED IN ADULTS WHO ABUSE CHILDREN
❑ the child does not develop as expected ❑ often complains of nausea, headaches, stomach aches without any obvious reason ❑ wets or dirties pants ❑ is not given food, clothing and care as good as what the other children in the same family get ❑ may have unusual appearance (e.g. strange haircuts, dress, decorations)	❑ is unhappy, stressed out, withdrawn, aggressive or angry for long periods of time ❑ goes back to behaving like a young child (e.g. toileting problems, thumb-sucking, constant rocking) ❑ tries too hard to be good and to get adults to approve ❑ tries really hard to get attention ❑ tries to hurt oneself ❑ criticizes oneself a lot ❑ does not participate because of fear of failing ❑ is afraid of what the adult will do if he or she does something the adult does not like ❑ runs away ❑ has a lot of adult responsibility ❑ discloses abuse	❑ often rejects, insults or criticizes the child, even in front of others ❑ does not touch or speak to the child with love ❑ talks about the child as being the cause for problems and things not going as wished ❑ talks about or treats the child as being different from other children and family members ❑ compares the child to someone who is not liked ❑ does not pay attention to the child and refuses to help the child ❑ isolates the child, does not allow the child to see others both inside and outside the family (e.g. locks the child in a closet or room) ❑ does not provide a good example for children on how to behave with others (e.g. swears all the time, hits others) ❑ calls the child names, puts the child down, over critical of child and child's behaviours ❑ lets the child be involved in activities that break the law ❑ uses the child to make money (e.g. child pornography) ❑ lets the child see sex and violence on TV, videos and magazines ❑ terrorizes the child (e.g. threatens to hurt or kill the child or threatens someone or something that is special to the child) ❑ forces the child to watch someone special being hurt ❑ asks the child to do more than he/she can do

Indicators of Witnessing Family Violence

PHYSICAL INDICATORS IN CHILDREN	BEHAVIOURAL INDICATORS IN CHILDREN	BEHAVIOURS OBSERVED IN ADULTS
❑ the child does not develop as expected ❑ often complains of nausea, headaches, stomach aches without any obvious reason ❑ fatigued due to lack of sleep or disrupted sleep ❑ physical harm, whether deliberate or accidental, during or after a violent episode, including: • while trying to protect others • are a result of objects thrown	❑ may be aggressive and have temper tantrums – uses aggression with peers and siblings ❑ may show withdrawn, depressed, and nervous behaviours (e.g. clinging, whining, a lot of crying) ❑ acts out what has been seen or heard between parents; discloses family violence; may act out sexually ❑ tries too hard to be good and to get adults to approve ❑ afraid of: • someone's anger • one's own anger (e.g. killing the abuser) • self or other loved ones being hurt or killed • being left alone and not cared for ❑ problems sleeping (e.g. cannot fall asleep, afraid of the dark, does not want to go to bed, nightmares) ❑ bed-wetting; food-hoarding ❑ tries to hurt oneself; cruel to animals ❑ stays around the house to keep watch, or tries not to spend much time at home; runs away from home ❑ problems with school ❑ expects a lot of oneself and is afraid to fail and so works very hard ❑ takes the job of protecting and helping the mother, siblings ❑ does not get along well with other children	❑ abuser is aggressive with others, uses aggression to get own way ❑ may harm pets ❑ abuser has trouble talking and getting along with others ❑ abuser uses threats and violence (e.g. threatens to hurt, kill or destroy someone or something that is special; cruel to animals) ❑ is physically, emotionally and economically controlling of his/her partner ❑ forces the child to watch a parent/partner being hurt ❑ abuser is always watching what the partner is doing ❑ abuser insults, blames, and criticizes partner in front of others ❑ jealous of partner talking or being with others ❑ abuser does not allow the child or family to talk with or see others – isolates the family from extended family and friends ❑ the abused person is not able to care properly for the children because of isolation, depression, trying to survive, or because the abuser does not give enough money ❑ holds the belief that men have the power and women have to obey ❑ misuses drugs or alcohol ❑ discloses family violence ❑ discloses that the abuser assaulted or threw objects at someone holding a child

Dental

Risk Factors for Early Childhood Tooth Decay…the <u>presence</u> of one or more of these risk factors should be considered a red flag:

Prolonged exposure of teeth to fermentable carbohydrates

(includes formula, juice, milk and breast milk)

- Through the use of bottle, sippy cups, plastic bottles with straws
- High sugar consumption and frequent snacking
- Sweetened pacifiers
- Long term sweetened medication
- Going to sleep with a bottle/sippy cup containing anything but water
- Prolonged use of a bottle beyond one year
- Breastfeeding or bottle feeding without cleaning teeth
- Continual use of bottle/sippy cup containing anything but water

Physiological Factors

- Factors associated with poor enamel development, such as prenatal nutritional status of mother and child, poor prenatal health, and malnutrition of the child
- Possible enamel deficiencies related to prematurity or low birth weight
- Mother and child's lack of exposure to fluoridated water
- Window of infectivity: transference of oral bacteria from parent/caregiver to the child between 19-31 months of age, through frequent, intimate contact or sharing of utensils

Other Risk Factors

- Poor oral mouth cleaning
- Sibling history of early childhood tooth decay
- Lack of education of caregivers
- Lower socioeconomic status
- Limited access to dental care
- Deficits in parenting skills and child management
- Stressed parents who use a bottle/sippy cup to settle the child
- Single parents

WHERE TO GO FOR HELP?

If there are concerns, advise parents to contact their dentist, or Dental Services at Middlesex-London Health Unit, at 519-663-5317 ext.2231. For referral to the Healthy Babies, Health Children Program, contact the Middlesex-London Health Unit, Health Connection at 519-850-2280. For nutritional concerns, see Nutrition, or Feeding and Swallowing Sections

Family and Environmental Stressors

If any one of these stressors is found, this could affect a child's normal development and should be considered a red flag.

Parental Factors

- History of abuse – parent or child
- Health problems
- Substance abuse
- Partner abuse
- Difficulty controlling anger or aggression
- Feelings of inadequacy, low self-esteem
- Lack of knowledge or awareness of child development
- A young, immature, developmentally delayed or inexperienced parent
- History of postpartum depression
- History of crime
- Lack of parent literacy

Social/Family Factors

- Family breakdown
- Multiple births
- Several children close in age
- A special needs child
- An unwanted child
- Personality and temperament challenges
- Mental or physical illness of a family member
- Alcohol or drug abuse
- Lack of a support network or care giving relief
- Inadequate social services

Economic Factors

- Inadequate income
- Unemployment
- Business failure
- Debt
- Poor housing or eviction
- Change in economic status related to immigration

WHERE TO GO FOR HELP?

If families indicate that they are stressed by one or more of the red flags, services and supports may be available through Healthy Babies Healthy Children at the Middlesex-London Health Unit, (519) 850-2280 or the Children's Aid Society of London and Middlesex (519) 455-9000.

Feeding and Swallowing

Healthy Child Development…if a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

0-3 months

- 1:1:1 or 2:1:1 ratio of suck-swallow-breathe (SSB) pattern
- At the start of a feeding, SSB should be about 1minute before a breath
- Mid feeding, SSB pattern should shorten to about 7-10 bursts of SSB with short pauses for breath
- End of feeding, 3-4 bursts of SSB with slightly longer pauses for breath
- Slight amount of liquid lost from corners of mouth
- Finish 8 ounce bottle in 30-40 minutes

4-6 months

- Bottling pattern should remain consistent as above
- No liquid loss from corners of mouth
- If purees introduced at this time, minimal lip closure on spoon
- Tongue movement back to front
- Fair amount of food loss from lips
- Anticipate some gagging and coughing with introduction of new purees

6-8 months

- Efficient bottling pattern continues
- If started on sipper cup, very little liquid taken
- Primarily biting pattern on spout of sipper cup
- May have a lot of liquid loss
- With purees, should see lip closure on spoon and mouth open after spoonful
- Tongue should remain primarily behind the lips
- Tongue should rest quietly as spoon is presented
- Tongue should be cupped, not flat or bunched
- Minimal food loss when eating purees
- When small lumps in purees are first introduced, expect gagging and coughing

9-12 months

- Efficient bottle pattern continues
- Within this period should acquire suction on the sipper cup
- Wide open jaw with biting on open cup, expect significant liquid loss
- With spoon foods, good lip closure with slight food loss at corners of mouth
- Subtle tongue protrusion with introduction of finger foods (i.e., cookie) – tongue will mash foods against roof of mouth
- If child places food in mouth, food will be put at mid-line with a lot of food loss
- If caregiver places food at side of mouth, early up/down chewing or munching pattern should be seen

12-18 months

- Should be efficient with sipper cup
- Occasional coughing when drinking from open cup
- Should be able to drink without biting on cup
- Able to take bites out of food
- Starting to move foods to both sides of mouth
- Primarily self-feeding with spoon and fingers
- Food loss should be minimal
- Tongue protrusion should only occur with very large bites of food or very chewy foods
- Gagging and coughing should be minimal even with new food introduction

18 – 24 months

- Good lip closure
- Tongue should move on its own separate from the jaw (i.e., lick lips)
- Consistent rotary chewing
- Good lip pursing to prevent food loss

Safety Risk Factors

- Recurrent chest infections
- Poor weight gain despite adequate intake
- Refusal to eat (panicked look, pulling away from food)
- Chest sound noisy or wheezy with oral feeds
- Coughing during swallowing (may still be aspirating without any coughing)
- Apnea during swallowing (child stops breathing for longer than usual)
- Changes in face colour – can be flushed or pale around eyes or mouth or full face

WHERE TO GO FOR HELP?

For self-feeding, see Fine Motor Skills Section. For nutritional concerns, see Nutrition Section.

If there are any concerns about feeding and swallowing, contact the Thames Valley Children's Centre at 519-685-8716 or go to www.tvcc.on.ca. For children under two years of age, families can self refer to Developmental Resources for Infants (DRI) at 519-685-8710 or tykeTALK, The Thames Valley Preschool Speech and Language Program, at 519-663-0273 or 1-877-818-8255 or visit the website at www.tyketalk.com.

Literacy

Literacy begins at birth. Family literacy encompasses the ways parents, children and extended family members use literacy at home and in their community. It occurs naturally during the routines of daily living and helps adults and children 'get things done' - from lullabies to shopping lists, from stories to the passing on of skills and traditions. Parents have always been their children's first and most important teachers.

If a child is <u>missing</u> one or more of these expected age outcomes, consider this a red flag:

0-12 months (arranged chronologically)

- Listens to parents/caregivers voice
- Imitates sounds heard
- Seems to understand some words (e.g. bye-bye)
- Responds to a song, rhyme or story
- Understands short instructions (e.g. "Find the ball?")
- Demonstrates a preference for certain books or rhymes
- Begins to play simple games such as peek-a-boo
- Looks at pictures of familiar objects
- Vocalizes and pats pictures
- Shows interest in looking at books

12-18 months

- Points at picture with one finger
- May make same sound for particular picture (labels)
- Points when asked, "where's….?"
- Turns book right side up
- Gives book to adult to read
- Holds books and turns pages

By 2 years

- Fills in words in familiar stories
- Pretends to read books
- Recognizes specific books by their cover
- Recites parts of well known stories
- Scribbles with crayons

By 3 years

- Sings simple songs and familiar rhymes
- Knows how to use a book (holds/turns pages properly, starts at beginning, points/talks about pictures)
- Looks carefully at and makes comments about books
- Fills in missing words in familiar books that are read aloud
- Holds a pencil and uses it to draw/scribble
- Guesses at what comes next in a story
- Learns to handle paper pages
- Goes back and forth in books to find favourite pictures
- Coordinates text with picture
- Protests when adult gets a word wrong in a familiar story
- Reads familiar books to self
- Begins to count
- Knows the difference between big and little

Literacy (continued)

By 3-4½ years (end of JK)

- Recites nursery rhymes and sings familiar songs
- Makes up rhyming words
- Reads a book by memory or by making up the story to go along with the pictures
- Can guess what will happen next in a story
- Retells some details of stories read aloud but not necessarily in order
- Holds a pencil and uses it to draw or print his/her first name along with other random letters
- Understands that print carries a message
- Identifies familiar signs and labels
- Names colours
- Talks about experiences
- Can make up stories
- Counts from 1 to 10

By 4½ - 5½ years (end of SK)

- Knows parts of a book
- Understands basic concepts of print (difference between letters, words, sentences, how the text runs in a left to right, top to bottom fashion)
- Makes predictions about stories; retells the beginning, middle and end of familiar stories
- Reads simple pattern books smoothly pointing to the individual words while reading
- Reads some familiar vocabulary by sight (high frequency words)
- Points to and says the name of most letters of the alphabet when randomly presented (upper and lower case); recognizes how many words are in a sentence
- Breaks down three-sound words into individual sounds in spoken language (e.g. c-a-t)
- Understands the concept of rhyme; recognizes and generates rhyming words
- Changes a sound in a word to make a new word in familiar games and songs
- Prints letters (by copying, in his/her full name, when attempting to spell words)
- Makes connections between his/her own experiences and those of storybook characters

Literacy (continued)

WHERE TO GO FOR HELP?

If there are concerns, advise the parents to contact: Early Literacy Specialists through the Ontario Early Years Centres at 519-433-8996 ext. 231 (London), 1-888-561-2080, Ext. 2 (Lambton, Kent, Middlesex), 519-348-8618 (Perth, Middlesex), or talk to the Kindergarten teacher at school.
Literacy issues may also be the result of difficulties with speech, language, vision, or learning. Refer to the sections on Speech and Language, Vision, and Learning Challenges.

Nutrition

If a child <u>presents</u> one or more of the following risk factors, consider this a red flag:

0-6 months

- Not producing an average of six heavy, wet diapers per 24 hours (from six days on)
- New born not being fed whenever they show signs of hunger
- Breastfed or partially breastfed infant is not receiving a vitamin D supplement
- Infant formula is not iron fortified
- Powdered infant formula is fed to infants who are premature, have low birth weight or weakened immune system (recommended they follow specific advice from the doctor or health care professional)
- Powdered infant formula is not being prepared according to 2010 Health Canada recommendations.
- Cow's milk and other beverages (e.g. fruit juice, herbal teas etc.) or food other than breast milk or iron-fortified formula are given
- Distilled, carbonated or mineral water is being used to make formula
- For the first 4 months, water for making infant formula or drinking is not brought to a rolling boil for two minutes and equipment is not being sanitized
- Expressed breastmilk and formula are not being stored (room temperature, refrigerator or freezer) in a safe and sanitary way
- Infant formula is not being mixed correctly (i.e. correct dilution)
- Liquids (including water) or solids other than breastmilk or iron-fortified infant formula are given before four months (preferably six months)
- Unsafe foods are given (e.g. honey, egg white, cow's milk, herbal tea)
- Infant cereal is being added to baby's bottle
- Food or drink is being given to pacify baby or baby bottle is given to baby in bed

6-12 months

- Iron rich foods have not been introduced by 7 months (iron-fortified infant cereal, pureed meat or alternatives)
- Cow's milk is given instead of breastmilk or iron fortified infant formula before nine months
- Low-fat milk (2% or skim), soy, rice or other vegetarian beverage is given regularly
- Breastfed or partially breastfed infant is not receiving a vitamin D supplement
- Drinking more than 4 oz (1/2 cup) of juice per day
- Fruit drinks, pop, coffee, tea, cola, hot chocolate, herbal tea, herbal products, egg whites or honey are given
- Food or drink is being given to pacify baby or baby bottle is given to the baby in bed
- Infant if fed using a propped bottle
- Infant is not eating willingly or parents imply that they are force feeding

Nutrition (continued)

6-12 months cont'd

- Consistently refuses lumpy or textured foods at 10 months
- Infant is not supervised while feeding
- Serial measurements for weight for age, length for age and weight for length drop unexpectedly < 3rd percentile on WHO for Canada Growth Charts
- Serial measurements for weight for length are >97th percentile on WHO for Canada Growth chart
-

1-2 Years

- Drinking less than 16 oz or more than 24 oz of milk per day
- Skim milk, or soy, rice or other vegetarian beverages are regularly given before the age of 2
- Drinks excessive amounts of other calorie-containing fluids, e.g.100 % juice (more than four to six ounces per day)
- Fruit beverages/drinks or pop is given
- Drinking liquids primarily from a baby bottle
- Not eating a variety of table foods from the four food groups
- Consistently refuses lumpy or textured foods
- At 15 months does not finger or self feed
- Parents are not recognizing and responding to the child's verbal and non-verbal hunger cues
- Spending a long time at meals (e.g. an hour)
- Eating meals watching television
- Child not supervised during feeding
- Food is used as a reward, punishment or to pacify
- Child is allowed to graze all day
- 3 meals and 2-3 snacks are not being provided
- Serial measurements for weight for age, length for age and weight for length drop unexpectedly < 3rd percentile on WHO for Canada Growth Charts
- Serial measurements for weight for length are >97th percentile on WHO for Canada Growth chart

2-5 Years

- Drinking less than 16 oz or more than 24 oz of milk per day
- Consuming excessive amounts of other calorie-containing fluids, e.g. juice (more than four to six ounces per day), pop and fruit drinks
- Drinks liquids primarily from a baby's bottle
- Does not eat a varitiey of table foods from the four food groups
- Does not eat at regular time thorought the day (breakfast, lunch, dinner plus 2 -3 snacks between meals)
- Child is not supervised while eating
- Food is used as a reward, punishment or to pacify
- BMI for age is less than the 3rd percentile
- BMI for age is greater than or equal to the 97th percentile
- More than 2 hours of TV watching a day
- NutriSTEP (parent administered nutrition screen for 3-5 year olds) score of 26 or greater (e.g. high nutrition risk)

General Risk Factors

- Serial growth measurements have unexpectedly changed (unexpected and/or unexplained weight loss or gain)
- Use of baby bottle made from bisphenol A (BPA)
- Food allergy or food intolerance that result in food restrictions
- Problems with sucking, chewing, swallowing, gagging, vomiting or coughing while eating
- Family is experiencing problems around feeding – mealtimes are unpleasant: infant/child refuses many foods, or drinks excessive fluids throughout the day so is not hungry at mealtimes. Parent imply that they force-feed or offering inappropriate amounts of food
- Suffers from tooth or mouth problems that make it difficult to eat or drink
- Has a medical problem that may be related to diet such as iron deficiency anemia, constipation, obesity or body image issues.
- Excludes all animal products including milk and eggs and diet is not well planned
- Unsafe or inappropriate foods are given (e.g. raw eggs, unpasteurized milk or cider, herbal tea, pop, fruit drink, coffee, alcohol, foods that are choking hazards)
- Eats non food items
- Home has inadequate food storage/cooking facilities
- Parent or care provider is unable to obtain adequate food due to financial constraints

Choking

Hard, small and round, smooth and sticky solid foods can block a young child's airway. The following foods are **not safe** for infants and children under 4 years of age:

- popcorn,
- hard candies,
- gum, cough drops,
- raisins,
- peanuts and other nuts,
- sunflower seeds,
- fish with bones and
- snacks using toothpicks or skewers.

The following foods are **safer** for infants and young children when they are prepared as described:

- wieners diced or cut lengthwise,
- grated raw vegetables or fruit,
- fruit with pits removed,
- chopped grapes, and
- peanut butter spread thinly on crackers or bread.

Peanut butter served alone on a spoon is potentially unsafe because it can stick in the palate or posterior pharynx leading to asphyxia.

WHERE TO GO FOR HELP?

If there are any concerns, advise the parent to call their physician/ pediatrician or health care provider. For more information about nutrition, call at the Middlesex-London Health Unit, Health Connection at 519-663-5317 ext. 2280 or visit our website at www.healthunit.com or www.caringforkids.cps/eating or www.eatrightontario.ca . You can also call Eat Right Ontario at 1-877-510-5102 and speak with a Registered Dietitian. If you are interested in obtaining a copy of NutriSTEP (Parent administered nutrition screen for 3-5 year olds) and the associated referral map, call the Health Connection at 519-663-5317 ext. 2280.
Nutrition difficulties that are perceived as behavioural can sometimes be a developmental issue; refer to the section on Feeding and Swallowing.

Postpartum Mood Disorder

Parental mental illness is a significant factor that can place children's development and health at risk. The following statements are reflective of the parent's ability to be attentive, attuned and able to respond sensitively to the infant.

If the parent states that one or more of these statements are true, consider this a red flag:

- Feelings of profound sadness, loneliness or inadequacy
- Extreme irritability, frustration or anger
- Feelings of hopelessness, guilt, sadness or emptiness
- Ongoing exhaustion
- Loss of appetite or overeating
- No interest or pleasure in the infant
- Anxious or panicky feelings
- Thoughts about hurting self or baby
- Crying for no reason

The presence of any one of the following risk factors should alert health professionals that the client may be at risk for postpartum mood disorders (e.g. anxiety, obsessive compulsive disorder, depression, etc.)

- Unrealistic expectations (e.g. "This baby will not change my life.")
- Social isolation; real or perceived lack of support (e.g. "I have very little contact with my family or friends.")
- Family history of depression or mental illness
- Perfectionist tendencies (e.g. "I like to have everything in order.")
- Sees asking for help as a weakness (e.g. "I'm not used to asking anyone for help. I like to do things myself in my own way.")
- Personal history of mood disorder (e.g. "I had postpartum depression/anxiety with my first child.")
- Personal crisis or losses during last 2 years (e.g. death of a parent)
- Severe insomnia (e.g. "I can't sleep when the baby sleeps.")
- Possible obsessive thinking/phobias/unreasonable fears (e.g. "I am afraid to leave the house", the mother stays home for weeks, or is afraid of being in a crowd or travelling in a bus or car)
- Substance abuse (e.g. "I drink alcohol or smoke dope, etc. to kill the pain.")
- Scary thoughts of harm (e.g. "I'm scared of knives.", "I see the bath water turn into blood."; "I'm afraid to stand by the window because the baby might fall.")
- Suicide risk (e.g. "This baby would be better off without me"; "I am not worthy to have this child"; "I am such a burden to my family."); sudden change of mood or giving away of possessions
- Possible history of abuse or neglect (e.g. "I would never leave my baby with anyone else. I would not trust anyone.")
- Psychotic episodes (e.g. "The devil (or other religious figure) told me he/she would tell me what to do with my baby.") ****This situation requires immediate medical attention.**

Postpartum Mood Disorder (continued)

WHERE TO GO FOR HELP?

If there are health concerns, advise the woman/family to contact her physician. Contact the postpartum depression help-line at 519-672-HOPE (4673) or visit www.helpformom.ca. Contact the Middlesex-London Health Unit at 519-850-2280 for referral to the Healthy Babies/Healthy Children Program. **Contact Children's Aid Society of London and Middlesex at 519-455-9000 if the child's safety is a concern.** For crisis intervention, call the London Mental Health Crisis Service at 519-433-2023 or encourage the client to visit the local hospital emergency department.

Autism Spectrum Disorder

Autism is typically considered to be a lifelong neuro-developmental disorder characterized by impairments in *all* of the following areas of development: communication, social interaction, restricted repertoire of activities and interests and behaviours. Each child has a unique presentation. Some other behaviours which are also common include difficulties in eating, sleeping, unusual fears, learning problems and/or intellectual disability, repetitive behaviours, self-injury and peculiar responses to sensory input. Typically, autism therefore represents a pattern of behaviours. As there is no one specific behaviour which identifies autism, it is important to look at a child's overall developmental pattern and history to ensure that the behaviours are not better accounted for by other developmental conditions or syndromes (for example, developmental handicap, speech and language disorder, fetal alcohol spectrum, mental health or behavioural issues). A diagnosis of autism is provided when the difficulties are not better accounted for by another developmental or medical condition. A diagnosis of autism should differentiate between conditions. Typically a diagnostic assessment includes a variety of tests and measures which examine autism symptoms, social adaptive skills, intellectual assessment, developmental history, and the contribution of other conditions.

If the child <u>presents</u> any of the following behaviours, consider this a red flag:

Social Concerns

- Doesn't smile in response to another person
- Delayed or abnormal imaginative play – lack of varied, spontaneous make-believe play relative to the child's *developmental* age
- Plays alone, decreased interest in other children
- Little or no interactive play with children of a similar age (skills depend on the developmental and chronological age of the child)
- Inconsistent, poor or fleeting eye contact or unusual visual interests - this does not mean eye contact is absent.
- Less showing, giving, sharing and directing others' attention than usual for a child of that age.
- Any loss of social or other skills at any age (skill regression)
- Prefers to do things for him/herself rather than ask for help
- Awkward or absent greeting of others and/or difficulties understanding normal social exchanges (relative to developmental level)

Communication Concerns

- Language is often delayed but is characterized by abnormal communication features, as below (language delays often occur without autism being present)
- Unusual pattern of language or communication - repeating phrases from movies, echoing other people (echolalia), repetitive use of phrases not due to developing language, odd intonation, lack of pronoun use, reading skills above functional communication abilities (hyperlexia)
- Poorly developed pointing response, i.e. child may point only for things he wants, may have a vague point or no point at all.

Autism Spectrum Disorder(continued)

- Poor comprehension of both verbal and nonverbal communications (words and gestures)
- Any loss of functional or developed language skills at any age (regression), but particularly between 15 and 24 months; this does not refer to words which are 'outgrown'
- Inability to carry on a conversation (relative to the child's age as well as developmental level of ability)

Behavioural Concerns

- Excessive behaviours, such as tantrums or self-injury, due to lack of ability to communicate, interruption of routine, or interruption of repetitive behaviours
- Narrow or restricted range of interests that he/she engages in repetitively that interfere significantly with day to day functioning
- High pain tolerance
- Lack of safety awareness (i.e. climbs on high objects, runs on the road, walks over objects or people in the room)
- Insistence on maintaining sameness in routine, activities, clothing, etc.
- Repetitive hand and/or body movements: for example, finger wiggling, hand and arm flapping, tensing of fingers, complex body movements, spinning, jumping, etc.
- Unusual sensory interests - visually squinting or looking at things out of the corner of eye; smelling, licking, mouthing objects; hypersensitive hearing
- Unusual preoccupation or fascination with objects or their movement (e.g. light switches, fans, spinning objects, vertical blinds, wheels, balls)

WHERE TO GO FOR HELP?

If there are any concerns, advise parents to arrange a referral to a paediatrician through their physician, or a developmental or clinical psychologist.

Behaviour

Children may engage in one or more problem behaviours from time to time. Some factors should be considered in determining whether the behaviour is truly of concern. These include:

- Injuring themselves or others
- Behaving in a manner that presents immediate risk to themselves or others
- Frequency and severity of the behaviour
- Number of problematic behaviours that are occurring at one time
- Significant change in the child's behaviour

If the child <u>presents</u> any of the following behaviours, consider this a red flag:

Self-Injurious Behaviour

- Bites self; slaps self; grabs at self
- Picks at skin; sucks excessively on skin/bangs head on surfaces
- Eats inedibles
- Intentional vomiting (when not ill)
- Potentially harmful risk taking (e.g. running into traffic, setting fires)

Aggression

- Temper tantrums; excessive anger, threats
- Hits; kicks; bites; scratches others; pulls hair
- Bangs, slams objects; causes property damage
- Cruelty to animals
- Hurting those less able/bullies others

Social Behaviour

- Difficulty paying attention/hyperactive; overly impulsive
- Screams; cries excessively; swears
- Hoarding; stealing
- No friends; socially isolated; will not make eye or other contact; withdrawn
- Anxious; fearful/extreme shyness; agitated
- Compulsive behaviour; obsessive thoughts; bizarre talk
- Embarrassing behaviour in public; undressing in public
- Touches self or others in inappropriate ways; precocious knowledge of a sexual nature
- Flat affect, inappropriate emotions, unpredictable angry outburst, disrespect or striking female teachers are examples of post trauma red flags for children who have witnessed violence

Noncompliance

- Oppositional behaviour
- Running away
- Resisting assistance that is inappropriate to age

Behaviour (continued)

Life Skills

- Deficits in expected functional behaviours (e.g. eating, toileting, dressing, poor play skills)
- Regression; loss of skills; refusal to eat; sleep disturbances
- Difficulty managing transitions/routine changes

Self-Stimulatory Behaviour

- Hand-flapping; hand wringing; rocking; swaying
- Repetitious twirling; repetitive object manipulation

WHERE TO GO FOR HELP?

If there are concerns about behaviour in conjunction with developmental delays, advise parents to contact their physician. Parents can self refer to Vanier Children's at 519-433-0334 for any behavioural concerns. If there are behavioural concerns, but no aggressive behaviour, parents can self refer to Child and Adolescent Services at 519-667-6640. Where self-stimulatory behaviour is a concern, a referral can be made to Thames Valley Children's Centre at 519-685-8680.

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term for the range of harm that is caused by alcohol use during pregnancy. FASD is not a diagnostic term. The diagnoses under FASD include: Fetal Alcohol Syndrome (FAS), Partial FAS (pFAS), Alcohol-related Neurodevelopmental Disorder (ARND) and Alcohol-related Birth Defects (ARBD).

FASD is preventable but not curable. Diagnosis can be a complex process as no single diagnostic test is available to confirm FASD. However, early diagnosis and intervention can make a difference.

The effects of FASD are not always obvious at birth. Children exposed prenatally to alcohol may or may not show characteristic physical or facial characteristics of FAS (low birth weight, small head circumference, small eye openings, thin upper lip, ear anomalies, flattened nose bridge, flat mid face, flattened ridges between base of nose and upper lip) depending on the prenatal timing of alcohol exposure. Characteristics of children affected by alcohol exposure are reflective of central nervous system damage. Often, behavioural and learning problems are not noticed until the child is old enough to go to school. The characteristics listed below are not a complete list. Parents need to contact their Health Care Providers for an assessment.

If a child <u>presents</u> any of the following characteristics, consider this a red flag:

Infants

- Low birth weight; failure to thrive; small size small head circumference and ongoing delayed growth
- Disturbed sleep; irritability; persistent restlessness
- Failure to develop routine patterns of behaviour
- Very quiet and not very responsive
- Bonding problems
- Failure to meet normal developmental milestones

Toddlers and Preschoolers

- Developmental delays
- Slow to acquire skills
- Sleep and feeding problems
- Sensory hyper-sensitivity (irritability, stiffness when held or touched, over reaction to injury, unable to tolerate tags in shirts, seams in clothing)
- Late development of motor skills – clumsy and accident prone
- Hyperactivity
- Low frustration tolerance
- Overly friendly behaviour

Fetal Alcohol Spectrum Disorder (continued)

JK/SK

- Learning and neuro-behavioural problems (distractible, poor memory, impaired learning, impulsive)
- Discrepancy between good expressive and poor receptive language (is less capable than he/she looks)
- Hyperactivity; extreme tactile and auditory defensiveness
- Information processing problems
- Difficulty reading non-verbal cues; unable to relate cause and effect; poor social judgement
- Significant motor and cognitive deficits
- Delays or lack of abilities in speech and language
- Trouble communicating needs

WHERE TO GO FOR HELP?

For more information on FASD, please see Best Start: www.beststart.org, www.alcoholfreepregnancy.ca, www.motherisk.org or contact Motherisk Alcohol and Substance Use in Pregnancy Helpline at 1-877-327-4636.
The message for all women is: There is no safe time, no safe amount or no safe kind of alcohol to drink while you are pregnant or trying to get pregnant.

Learning Challenges

Current research indicates that early appropriate intervention can successfully remediate many disabilities, particularly those related to reading. Parents are often the first to notice that "something doesn't seem right". The following is a list of characteristics that MAY point to a learning disability. Most people will, from time to time, see one or more of these warning signs in their children. This is normal.

Learning disabilities are related to difficulties in processing information:

- the reception of information
- the integration or organization of that information
- the ability to retrieve information from its storage in the brain
- the communication of retrieved information to others

If a child <u>presents</u> any of the following characteristics, consider this a red flag:

Receptive Language Characteristics	❑ Slow processing of information/slow to understand what is said ❑ Delayed receptive language (unexplained)
Expressive Language Characteristics	❑ Frequent difficulty retrieving words ❑ Persistent stuttering ❑ Echolalia (refer to the section on Autism Spectrum Disorder) ❑ Expressive language significantly higher than receptive skills
Play	❑ Lack of age appropriate play/trouble figuring out an age appropriate toy ❑ Inappropriate social skills (refer to the section on Behaviour) ❑ Signs of sudden withdrawal or depression; plays alone most of the time

Learning Challenges (continued)

General/Learning Readiness/Academic

- ❑ Significant attention difficulties
- ❑ Behaviour affecting ability to learn new things
- ❑ Sudden change in behaviour uncharacteristic for the individual
- ❑ Difficulties with pre-academic skills/concepts (e.g. colours, shapes)
- ❑ History of learning disabilities in family
- ❑ Indications of PDD/qualitative impairment in reciprocal social interaction, verbal/nonverbal communication, and a restricted or repetitive range of activities (refer to the section on Autism Spectrum Disorder)
- ❑ Delay in self-help skills (e.g. toileting) if not explained by another condition
- ❑ High risk medical diagnosis – risk for Learning Disabilities or cognitive delay, regression
- ❑ Inconsistent performance (can't do what he/she could do last week)
- ❑ Poorly focused and organized

WHERE TO GO FOR HELP?

If there are any concerns or for further information, advise the family to contact their physician or paediatrician for a vision and hearing assessment. The physician or paediatrician, or the school principal can refer to a psychologist. If there are behavioural or emotional concerns beyond the learning challenges, the parents can initiate a referral to Madame Vanier Children's Services at 519-433-0334.

Mild Traumatic Brain Injury

Changes in behaviour may be related to a mild traumatic brain injury (e.g. falls, accidents, medical treatment, sports injuries, shaken baby syndrome).

If the child <u>presents</u> with one or more of the following behaviours that are different from the child's norm, consider this a red flag:

Physical

- Nausea or vomiting
- Dizziness
- Headache
- Blurred or double vision
- Ongoing fatigue
- Decreased energy level
- Sleep problems
- Poor coordination and balance
- Changes in ability to smell, hear, see, taste
- Increased sensitivity to lights, sounds, distractions
- Changes in appetite
- Seizures
- Ringing in the ears

Cognitive Impairments

- Decreased attention and concentration
- Gets mixed up about time and place
- Memory problems
- Problems finding words or generating sentences
- Difficulties with problem solving
- Problems learning new information
- Concrete thinking, unable to think abstractly
- Slowed information processing speed
- Difficulties with multi-tasking

Behavioural/Emotional (Severe)

- Irritability; aggression
- Mood swings; impulsivity; confusion; distractibility; mind gets stuck on one issue
- Loss of self esteem
- Poor social judgment or socially inappropriate behaviour
- Decreased initiative or motivation
- Difficulty handling transitions or routines
- Personality change
- Withdrawal; depression; frustration
- Anxiety

Mild Traumatic Brain Injury (continued)

WHERE TO GO FOR HELP?

If a parent reports changes in their child's behaviour, advise them to contact their physician or paediatrician for medical assessment and a referral to an appropriate specialist. Information about services is also available through the Pediatric Acquired Brain Injury Community Outreach Program, 519-685-8704.

Community Resource Contacts

Service	Resource	Description	Phone #
Resource Consultants/ Early Intervention Worker	All Kids Belong (AKB)	This program offers a wide array of early childhood services for families with children who require extra support participating in community childcare settings in London and Middlesex.	519-434-8247 www.merrymount.on.ca
Infant Development	Developmental Resources for Infants (DRI)	DRI is a coordinating service that provides easy to access developmental resources for families and their children from birth to two. DRI coordinates a wide range of resources that supports growth and development. The DRI intake team listens and gathers information about each individual situation, concerns and needs in a wide variety of areas.	519-685-8710 www.familyinfo.ca
	Child & Parent Resource Institute (CPRI)	This children's centre is located in London and provides a variety of specialized services to children who have received assistance in their local community and find a need for more specialized diagnostic, assessment and short-term treatment services for developmental disabilities, emotional disturbances and behavioural disorders.	519-858-2774 www.cpri.ca
Health	Community Care Access Centre (CCAC)	Provides eligibility assessments/access to in-home health care and information and referral to community health and support services.	519-473-2222 www.ccac-ont.ca
	Middlesex-London Healthy Babies, Healthy Children (HBHC)	This is a provincially funded prevention/early intervention initiative to help families give their children the best start in life. It is an integrated community response to promote optimal growth and development of children: positive parent-child relationships, positive parenting, early stimulation of children and safe environments. Locally, Middlesex-London Health Unit administers the program.	519-663-5317, ext. 2280 www.healthunit.com
	Middlesex-London Health Unit (MLHU)	The health unit works to keep individuals, families and communities healthy through health programs and services and research. An example of services available for families include: Prenatal and Parenting Classes, Breastfeeding Clinics and Well Baby & Child Clinics at convenient locations throughout London and Middlesex. Telephone counseling, home visiting, school nursing, etc. may be provided. For more information on the services	519-663-5317, (8:30 a.m. - 4:30 p.m.) Infantline: 519-675-8444 (4:30-10 p.m. evenings & 10 a.m.-8 p.m. weekends/ holidays) Dental

Service	Resource	Description	Phone #
Health (continued)		provided see www.healthunit.com.	Services 519-663-5317, Ext. 2231 www.healthunit.com
	Pediatric Acquired Brain Injury Community Outreach Program (PABICOP).	The Pediatric Acquired Brain Injury Community Outreach Program operates out of TVCC, and serves 5 counties (London-Middlesex, Huron, Oxford, Elgin, Perth) providing follow-up for children/youth with an acquired brain injury.	519-685-8704, or 1-800-804-5363.
	Health Connection at Middlesex-London Health Unit	Health information and advice telephone service provided by public health staff.	519-850-2280 www.healthunit.com
Preschool Speech, Language and Hearing	tykeTALK (Speech and Language)	Thames Valley Preschool Speech and Language Program: • provides prevention, early identification/assessment and treatment for children from birth to school entry who are at risk for or have problems with speech and language development	519-663-0273 www.tyketalk.com
	Infant Hearing Program (IHP)	• conducts hearing screening for all newborn infants in the hospital or in the community • provides follow-up supports and services for all infants identified with permanent hearing loss including family support, audiology and communication development	519-663-0273
Rehabilitation Services (feeding, sensory, fine and gross motor)	Thames Valley Children's Centre (TVCC)	TVCC is regional rehabilitation centre for children and youth with physical disabilities, developmental delay, communication disorders and Autism Spectrum Disorders. Services are provided at the centre, in homes and at daycares. For more information go to www.tvcc.on.ca or phone 519-685-8716 (intake line)	519-685-8680 www.tvcc.on.ca
Addictions/ Mental Health	Addiction Services of Thames Valley (ADSTV) Heartspace Program	Heartspace offers education and treatment for substance-involved women who are pregnant and/or parenting, with children 0-6. Following an Addictions/Mental Health assessment, services may include: Treatment and Support, Parenting groups, Child Development Assessment and referrals, Basic Needs Support, Individual and Group Counseling, Child Minding and Transportation Assistance.	519-672-8989 www.adstv.on.ca

Service	Resource	Description	Phone #
Addictions/ Mental Health (continued)		Mothers must be seeking help regarding substance use and be willing to have their children participate in the programs.	
Behaviours/ Mental Health	Merrymount Children's Centre (MMCC)	Provides care for children birth to 12 years whose families are experiencing an emergency, crisis, stress or disruption situation. Services include flexible childcare, short-term overnight care, community outreach and parent support groups.	519-434-6848 www.merrymount.on.ca
	Vanier Children's Services	This is a children's mental health centre serving children with behavioural and emotional difficulties. It offers assessment, counseling and treatment for children and families.	519-433-3101 www.vanier.com
	Thames Valley Children's Centre Autism Program	TVCC is regional rehabilitation centre for children and youth with physical disabilities, developmental delay, communication disorders and Autism Spectrum Disorders. Services are provided at the centre, in homes and at daycares. For more information go to www.tvcc.on.ca or phone 519-685-8716	519-685-8680 www.tvcc.on.ca
	Community Services Coordination Network (CSCN)	Access to residential services funded by the Ministry of Children and Youth Services and/or the Ministry of Community and Social Services is through the Community Services Coordination Network(CSCN). The referral package is often completed by an agency that may already be assisting the family. Typically, CSCN becomes involved with families when an approach is required from more than one service provider or service system due to the complexity of their child's needs. Further information is available on our website at www.cscn.on.ca.	519-438-4783
Vision	Canadian National Institute for the Blind (CNIB) Blind-Low Vision Early Intervention Program (BLV)	Ontario's Blind-Low Vision Early Intervention Program is designed to give children who are born blind or with low vision the best possible start in life. Specialized family-centered services are available for children from birth to Grade 1. The program provides education and support for parents so they can encourage the healthy development of their children. Parents learn to help their children develop the skills they need for daily activities at home and in early learning and care settings. The Blind-Low Vision program offers three types of services:	519-685-8420 CNIB 519-663-5317 ext 2224 BLV

Service	Resource	Description	Phone #
Vision (continued)		1. Family support 2. Intervention services 3. Consultation services CNIB Early Intervention Specialists provide the Early Childhood Vision Consultant services for the Blind-Low Vision Early Intervention Program.	
Parent Supports	Children's Aid Society of London & Middlesex (CAS)	The organization is mandated under the Child and Family Services Act to investigate allegations of child abuse or neglect. The agency also provides family counseling and parent-child programs.	519-455-9000 www.caslondon.on.ca
	Ontario Early Years Centre (OEYC)	A place for parents and caregivers of children aged 0 to 6 to go to get information they need about their children's development and care. Centres provide free parent programs to support parents and caregivers, early learning and literacy programs, outreach activities, and links to other services and programs in the community. The Ontario Early Years Centres in Middlesex- London include: ♦ London North Centre (operated by Childreach), 265 Maitland St., London N6B 2Y3 ♦ London West (operated by London Children's Connection), 1019 Viscount Rd., c/o Jean Vanier Catholic School, London, N6K 1H5 ♦ London Fanshawe (operated by Merrymount Children's Connection), 1892 Dundas St. (at Clarke Rd.), London N5W 3G4 ♦ Perth-Middlesex, 40 Heritage Dr., Ilderton, ON N0M 2A0 ♦ Lambton-Kent-Middlesex, Strathroy Satellite, 80 Frank St., Strathroy, ON N7G 2R6	www.ontarioearlyyears.ca 519-434-3644 519-473-2825 519-455-2791 519-666-3227 519-245-8879

Service	Resource	Description	Phone #
Parent Supports Continued	Community Living London	Provides a broad range of supports for children with developmental disabilities including information, counseling and advocacy to families.	519-686-3000 www.cll.on.ca
	Inventory of Supports & Services for Families	Comprehensive and detailed list of parenting programs and resources in Middlesex-London	www.familyinfo.ca www.info.london.on.ca
	Childreach	Childreach is an early child development and parenting centre that provides families with support and resources to assist them in giving their children the best possible start in life to learn, play and grow. In partnership with families and our community, Childreach is committed to the healthy development of young children by providing learning opportunities, information and support. www.childreach.on.ca	519-434-3644 www.childreach.on.ca
	Child Care Fee Subsidy - City of London	London parents may be eligible for assistance with their child care costs for children 0-12 years of age. City of London buys childcare services from licensed childcare organizations throughout the city and parents choose the centre they want their children to attend. ChildCare Fee Subsidy application forms are available at any licensed child care centre under agreement with the City of London. A parent may also telephone the City of London Child Care office directly at (519) 661- 4834 or email to childcare@london.ca and a fee subsidy application will be sent to the caller the same day. Fee subsidy application forms are also available at the City of London ChildCare office, 151 Dundas Street, 4th floor, London ON (corner of Dundas and Richmond).	519-661-4834 www.info.london.on.ca
	Thames Valley Children's Centre (TVCC)	Thames Valley Children's Centre is a rehabilitation centre for children and youth with physical disabilities, developmental delay, communication disorders and autism spectrum disorders. Parent support includes counseling, parent groups, family resource centre, and service coordination. For more information go to the website at www.tvcc.on.ca	519-658-8560

Service	Resource	Description	Phone #
Parent Supports Continued	N'Amerind Friendship Centre – Aboriginal Family Support Program	The N'Amerind London CAPC site has been developed to attend to the needs of at Risk Urban Aboriginal Parents and their children between the ages of 6 months to 6 years old. To provide support and guidance in the early developmental learning years of the child. To provide parents with a social environment to meet other parents and for children to interact with one another. To have opportunity to share, learn, understand a better lifestyle for both parents and children. The environment is welcoming and provides a cultural setting for First Nation Families to find their identify and a place of belonging in the urban community. The daily programs are for these families and the intent is to provide holistic cultural programs and services based on the medicine wheel aspect. Providing advocacy and support yet empowering them to gain skills necessary to be the best parents they can be in raising our future generations of our First Nation Community.	519-672-0131 www.namerind.on.ca

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