

# CAMH COMMUNITY ENGAGEMENT FRAMEWORK

**camh**

Centre for Addiction and Mental Health

A Pan American Health Organization /  
World Health Organization Collaborating Centre

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This document was prepared by the Community Engagement Office within the Department of Communications and Partnerships at the Centre for Addiction and Mental Health.

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# PURPOSE OF THIS DOCUMENT

This document identifies core principles of community engagement and describes a framework for informing and supporting programs, leaders and teams in their community engagement activities. It is based on a literature review of best practice with a focus on the Canadian health care context, but also draws from other western health systems. The document is intended as a guide to inform engagement planning and initiatives, as well as to provide further resources, checklists and links to practical tools and templates.

CAMH has a long history of collaboration and engagement with key internal and external stakeholders. We recognize that community engagement is integral to manifesting our values of Courage, Respect and Excellence. Community engagement is fundamental to effective planning, service design and evaluation, and is a central component of quality, accountability and equity. As [Vision 2020](#), CAMH’s strategic plan, states, CAMH is “dedicated to transforming the lives of people living with mental illness and addictions. We aim to do this—first and foremost—through respectful and caring partnership with those we serve” (CAMH, 2012, p. 1).

Who does community engagement? Like safety, privacy and quality, engagement with key partners and stakeholders touches every program and service at CAMH. While some staff roles specifically focus on engagement, in practical terms, every program plan, significant service shift, key partnership and system collaboration requires community engagement. Thus, while community engagement is not a centralized function at CAMH, the Department of Communications and Partnerships developed this document as a resource to support and inform the range of local engagement initiatives undertaken throughout the hospital.

# DEFINING ENGAGEMENT AND COMMUNITY

The literature on community engagement is rich and draws from community development, health service delivery, system design, patient activation/engagement and citizen engagement, among other fields of study and practice. The terms “community” and “engagement” are broadly defined in the literature and in this document.

## Community

At CAMH, engagement with community is broadly defined and can include internal and external stakeholders; it may involve patients, families, staff, area residents and businesses, other service providers, agencies and networks, as well as health system partners and beyond.

In its [community engagement planning tool](#), the Local Health Integration Network ([LHIN], 2011) defines community as “patients and other individuals in the geographic area of the network, health service providers and any other person or entity that provides services in or for the local health system, as well as employees involved in the local health system” (p. 5). It defines stakeholders as:

*individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by the project, or anyone that may exert influence over the project or its results is considered a project stakeholder.*  
(LHIN, 2011, p. 5)

Communities are also framed in terms of geographic proximity, communities of interest, common characteristics or shared beliefs (Ministry of Health and Long-Term Care [MOHLTC], 2006a).

# Engagement

While there is no consistent definition or single model of community engagement, there is consensus on some core components. The fundamental principle is that those who are affected should have a say and that engagement builds both better health outcomes and health services and systems. A frequently cited definition of community engagement in the health literature comes from the [U.S. Centers for Disease Control and Prevention](#) (n.d.): “Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.” More locally, the [Toronto Central LHIN](#) (2011) defines community engagement as “the meaningful involvement of individuals and communities for a variety of purposes, including defining issues and needs, considering solutions, establishing priorities and implementing a program, project or service change” (p. 3).

Community engagement is both a range of activities and a process that aims to enhance stakeholder/community participation in health services and systems. Participants work collaboratively to incorporate different knowledge, values, perspectives and experiences in order to inform or make decisions, and to support or take action, with the ultimate goal of enhancing co-ordination, integration and continuity of care that lead to improved health outcomes.

# COMMUNITY ENGAGEMENT DRIVERS AT CAMH

Community engagement is a practice we embrace for its inherent benefits and principle of inclusion. However, it is important to understand that there are also significant system drivers and requirements for community engagement in the hospital sector. A few of these drivers for CAMH are outlined here.

Community engagement aligns with the six strategic directions outlined in [Vision 2020](#) (CAMH, 2012), particularly #2: “Earn a reputation for outstanding service, accountability and professional leadership” and the aim that at CAMH “all of our work is driven by and aligned with our values and principles.” Community engagement also aligns with direction #6: “Drive social change,” which includes championing health equity, social justice and inclusion; fighting prejudice and discrimination through partnership and engagement; and striving for more accessible and effective treatment, health promotion and prevention across Ontario.

Community engagement is integrated within CAMH’s strategic planning and quality improvement work. Engagement with key stakeholders was integral to the development of [Vision 2020](#) (CAMH, 2012) and to the clinical program realignment process: Stakeholder engagement is part of the clinical program three-year plan and the annual Quality Improvement Plan.

From the policy and system level, some important drivers leverage community engagement work at CAMH. Engagement is integrated within [Accreditation Canada](#) (2014), including in the leadership standard “Planning and designing services,” and in the quality dimensions, including “Population focus” and “Client centred services.” It is anticipated that community engagement will be elevated to a required organizational practice in the near future.

The [\*Excellent Care for All Act\*](#) (MOHLTC, 2010) outlines a number of requirements related to engagement, including a patient relations process to address and improve the patient experience and quality improvement reporting. Furthermore, the [\*Local Health System Integration Act\*](#) (MOHLTC, 2006b) articulates a number of expectations of community engagement:

- “Each health service provider shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services” (c.4, s16 (6)).
- The Act requires each LHIN and health service provider to “separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services” (c.4, s24).

At CAMH, community engagement is also reflected in the organization’s [practice framework](#), which ensures a commitment to “family-focused” and “client-centred practice” (CAMH, n.d.[a]).

# SCALE, LEVEL AND FORM OF COMMUNITY ENGAGEMENT

Engagement can be a part of every level of health service delivery, design and evaluation, and can be organized in a wide variety of ways. In developing an engagement strategy, several key questions need to be addressed. The first question, of course: What are you trying to achieve? What is your purpose? While recognizing that sometimes the specific goals and outcomes may shift as part of the consultation and engagement process, we nevertheless begin by a drive to meet an objective. Once the broad objective is established, the engagement strategy needs to determine:

- What level of the system are you engaging?
- What degree of power sharing along a continuum of collaboration is most appropriate?
- What specific form or strategy will the engagement take?

These concepts are explained below.

## Scale/System Levels of Community Engagement

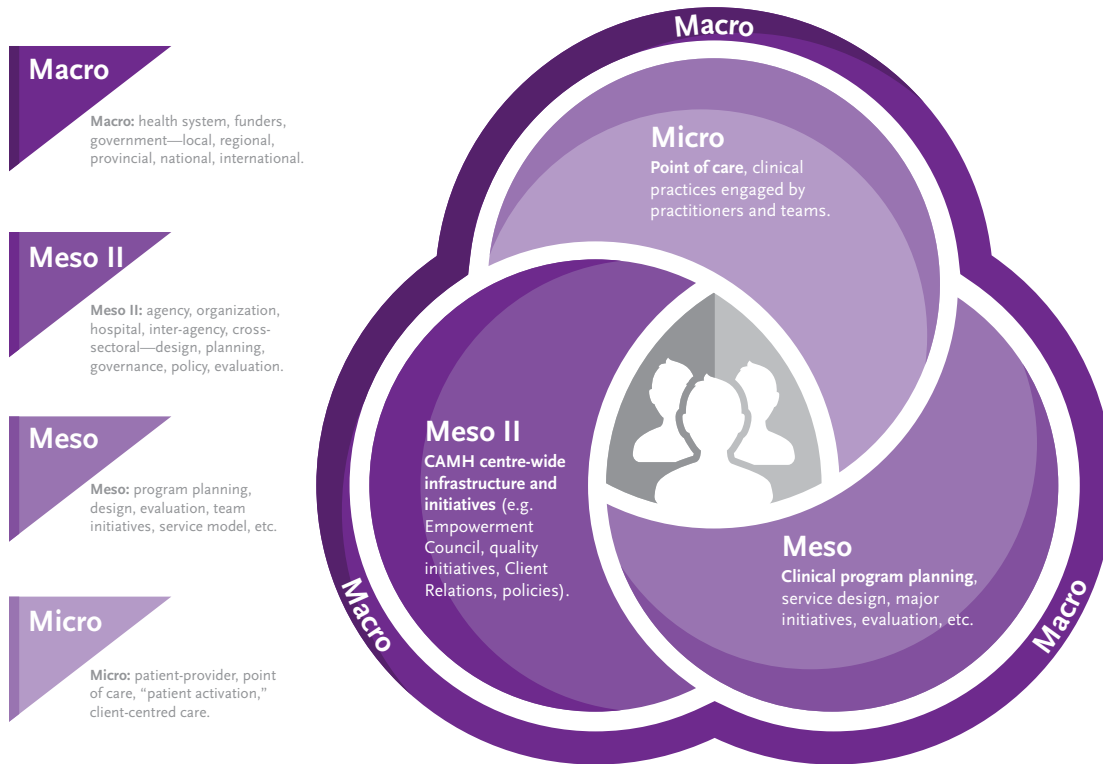
Identify the scale or system level for the engagement strategy:

- **Micro:** patient–provider, point of care, “patient activation,” client-centred care
- **Meso:** Program planning, design, evaluation, team initiatives, service model, etc.
- **Meso II:** agency, organization, hospital, inter-agency, cross-sectoral—design, planning, governance, policy, evaluation
- **Macro:** health system, funders, government—local, regional, provincial, national, international.

In practice, an engagement strategy may cross-pollinate this continuum from micro to macro. For example, a point-of-care patient survey may also lead to a program design innovation. However, it is important to formulate your strategy with a sense of the appropriate targeted level or scale.



The graphic below illustrates how micro/meso/meso II/macro engagement initiatives for engagement might look.



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## CONTINUUM AND FORM/STRATEGY OF ENGAGEMENT

There are many levels of possible engagement with stakeholders, ranging from the most basic dissemination of information to co-design and co-ownership of a project. Determining where your engagement strategy best fits will depend upon the goal and degree of shared decision-making you commit to. Levels of intensity of engagement and their specific forms are described in the literature in a variety of ways as operating along a continuum, from the most basic level to full partnerships. A commonly cited model, used by the [LHIN Collaborative](#), describes the continuum in this way: Inform, Consult, Involve, Collaborate, Empower or Co-create/co-own (Engaging People Informing Care [EPIC], n.d.). Where the literature on community development models emphasizes the ultimate goal of empowerment, the health planning literature more often refers to the highest level of engagement as co-creation/partnership. This continuum is a variation of the “spectrum of public participation” developed by the International Association for Public Participation (2007). It is outlined below, along with examples of specific forms the engagement strategy could take. A wide range of strategies is available to help you optimally engage and meet your goals.

## **Inform**

This engagement strategy provides stakeholders with balanced and objective information that will help them to understand the problem, alternatives, opportunities and solutions. It involves a one-way flow of information from the instigating organization to the stakeholders. This strategy is used when a decision has already been made and the objective is to ensure that information is transmitted clearly to those who might be affected. Examples include websites, newsletters, fact sheets and brochures, open house, briefings and e-mail updates.

## **Consult**

In this strategy, stakeholders are consulted on draft plans or on issues. Their feedback influences decisions. The flow of information is still primarily one way—but this time from the stakeholders to the instigating organization. Consulting is used when the objective is to gather information from a variety of stakeholders that the instigating organization will use in making its decision. Examples include focus groups, surveys, interviews, invited stakeholder comment via social media, interactive websites, questionnaires, Q&A, discussion groups, public meetings and open house.

## **Involve**

This strategy involves working directly with stakeholders on planning and policy processes to ensure their concerns and aspirations are consistently understood and considered. This is a two-way flow of information between the instigating organization and stakeholders. This strategy is used when the decision rests with the instigating organization, but with the intent to actively involve stakeholders in developing solutions. Examples include workshops with clear input and dialogue built in, open-space meetings, focused conversations, short-term advisory groups and planning committees.

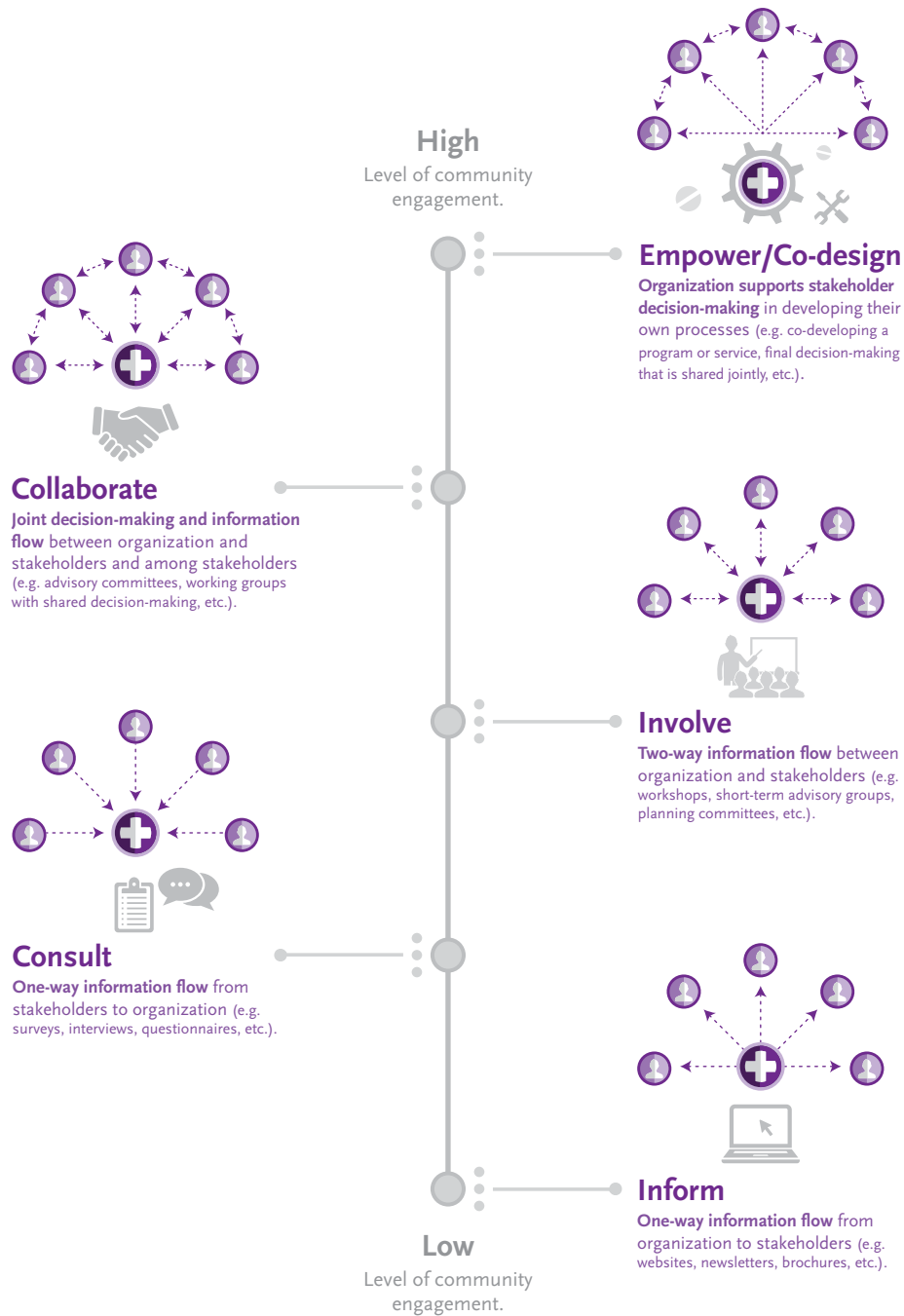
## **Collaborate**

Collaboration involves partnering with stakeholders in each aspect of decision-making, including developing alternatives and identifying the preferred solution. The flow of information happens not just between the instigating organization and the stakeholders, but among the stakeholders themselves. Collaborating is used when the instigating organization wants to work together in a joint process with stakeholders throughout the engagement. Examples include advisory committees, facilitated consensus building, planning retreats and working groups with shared decision-making.

## **Empower/Co-design**

This strategy actively supports stakeholders in developing their own processes and structures necessary to identify issues and implement solutions. The ideal is to have no difference in status between organizations involved in the process. Empowering is used when there is a true partnership that is “owned” by the community. The instigating organization may be in a position to support that partnership by providing skills, training or resources, but has no greater voice in decision-making than other stakeholders. Examples include formal partnership agreements with resource-sharing and decision-making authority, voting rights at key decision tables, co-developing a program or service and final decision-making that is shared jointly in the venture (e.g., program design).

The typology graphic below illustrates the continuum influence of engagement and the form the engagement strategy could take.



Adapted from: International Association for Public Participation. (2012). [Principles of community engagement](#).

In developing a community engagement initiative, another lens to consider is to examine length, breadth and depth as core dimensions of the process (MOHLTC, 2006a):

- **Length of engagement:** How long will communities be involved in the engagement?
- **Breadth of engagement:** How broadly will the community or communities be engaged? Just a few people and communities, or many people and communities?
- **Depth of engagement:** Will communities be engaged only in a shallow way—occasional consultation, for example—or in more profound ways, such as partnership?

## Always Events: A Community Engagement Checklist

In planning a community engagement strategy, there are a few fundamentals that form an engagement checklist. The checklist will help ensure you consider the major components in your planning process, but there are of course many nuances and options within each step.

- Why are you engaging? Define your goals and objectives.
- Identify what is non-negotiable (e.g., core mandate, funder or practice requirement).
- Establish what level of the health system or service you are targeting (e.g., micro: patient engagement point of care; meso: clinical program planning).
- Determine where on the continuum of influence your engagement strategy fits: inform—advise—consult—a vote at the table—shared authority and decision-making—legal partnership/co-own.
- What specific forms or strategies will be applied?
- Define the duration of the engagement.
- Develop a communications plan.
- Define and secure resources required.
- Develop a conclusion and exit strategy.
- Evaluate.
- Ensure an equity lens is applied consistently: Where are gaps in service? Understand social determinants of health and health equity priority populations and health issues. What voices or communities are underrepresented? How does this shape your engagement process and strategy?

### COMMON CHALLENGES

- Establishing a common goal and process with diverse stakeholders with multiple interests
- Assessing what the right strategy is and which partners will to help meet your goals
- Clarity of power and decision-making
- Recruitment, readiness and support of participants, especially for more intense roles with more power
- Support and accountability for an agreed-upon process
- Consistent and effective communication
- Appropriately connecting the individuals involved back to the community, groups, staff or leadership to create change

- A mandate that does not mesh with stakeholder wishes
- Issues of representation and diversity of perspectives, including adaptability to community-based needs, breadth of diversity of social location and experience among stakeholders, patterns of power and hierarchy across communities and the health system
- Effective evaluation

# PRINCIPLES OF COMMUNITY ENGAGEMENT

**W**e need foundational principles to inform and guide our engagement work. There are many iterations of core principles for community engagement work in the literature, but the themes of transparency, efficacy, inclusion, equity and impact are fundamental to most models. These principles can not only guide the development of the strategy, but can also help when problem-solving challenges occur.

On a practical level, we can assess our initiative and strategies and ask to what extent we are honouring these core principles. As is the case in [CAMH's ethics framework](#), these principles are not prescriptive; rather, they can help us to navigate the occasionally complex issues that may arise. Addressing the equity and inclusion requirement, the MOHLTC (2012) developed the [Health Equity Impact Assessment](#) as a decision tool for organizations, hospitals and programs to use in their planning processes to support improved health equity.

The [MOHLTC's health planning toolkit](#) (2006a) groups the core principles into four categories: effectiveness, inclusion, clarity and respect.

## EFFECTIVENESS

- Engage early enough to make a difference.
- Resource the strategy properly.
- Be prepared to pay attention to the results.
- Monitor and evaluate the strategy's effectiveness.

## INCLUSION

- Build in ethnocultural diversity.
- Eliminate physical, psychological and socio-economic barriers to participation.

## CLARITY

- Be transparent in terms of purpose and communication.
- Be transparent about how results will be used.
- Develop a clear but flexible project strategy.

## RESPECT

- Be the community's partner, not its master.
- Use tools acceptable to the participants.
- Hear what people say, not what you want to hear.
- Create realistic timelines.

For more examples of community engagement principles, see Appendix A.

# CONTEXT: COMMUNITY ENGAGEMENT IN CANADA AND AT CAMH

Where does Canada fall on the continuum of community engagement in health planning and delivery? In true Canadian fashion, we are probably somewhere in the middle in terms of the formal requirements for and extent of community engagement, particularly in the hospital sector. Some examples of requirements in other western countries demonstrate a more rigorous expectation of community, including patient and family, engagement. For example:

- U.S. hospitals have to demonstrate “community benefit” in order to maintain their tax status (Burke et al, 2014).
- Patient and community engagement in the UK, New Zealand and Australia is more integrated and formally required within program and service planning and delivery (“Better patient engagement,” 2012).
- In the UK, New Zealand and Australia, engagement must demonstrate a strong health equity, cultural competence lens.
- Scotland has national standards for community engagement in health (Communities Scotland, 2005).
- In Canada, a Change Foundation (2014) report on patient and family advisory councils found that only 33 per cent of hospitals had these councils.

However, it can be argued that the mental health sector has a unique history of client and family advocacy and engagement, and highly active stakeholder groups. At CAMH, this involvement has translated into innovative structures and supports. These include the Empowerment Council, which engages in systemic advocacy and is a voice for clients; the Client Bill of Rights; the [Health Equity Impact Assessment](#) (MOHLTC, 2012); and the CAMH Constituency Council, which is a provincial advisory group of diverse stakeholders that informs our strategic plan and advises the Board of Trustees, and that has a strong history of family engagement. There is a wide range of engagement work at various levels of CAMH programs and services, from point-of-care patient engagement, to clinical program planning engagement with clients, families, community partners and the health system, to overarching hospital initiatives and strategies.



Below are examples of this engagement work.

#### CAMH-WIDE STRUCTURES

- Client Satisfaction Survey and Quality Assurance (and dissemination and response strategies)
- [Client Relations Office](#)
- [Constituency Council Advisory](#) (with client, family and other stakeholder groups)
- [Empowerment Council](#)
- Family engagement initiatives
- Empowerment Council / Family Council Liaison Committee
- Policy examples (e.g., honorarium for client and family participation)
- [Bill of Client Rights](#)

#### AT THE PROGRAM LEVEL

- Peer support workers
- First Impressions team
- Strengthening Families
- Redevelopment consultation process with range of stakeholders
- Best Practice Spotlight Organization that ensures client and family engagement in all best practice guidelines
- Client and family education inventory
- Complex Mental Illness inpatient focus groups on inpatient programming
- Provincial System Support Program's service collaboratives (e.g., ["Peer Positive" Northwest Toronto Service Collaborative](#))
- Aboriginal community engagement
- A wide range of program-specific initiatives (e.g., program advisory committees, focus groups, engagement at key stakeholder tables/forums)

# EVALUATION

**E**valuation is a critical aspect of a robust engagement initiative. The literature on evaluation for community engagement is extensive but still emerging, with debate and discussion about models, strategies and best practice. Evaluation and measurement is an entire field of study in health and in community development. In the health field, as quality improvement initiatives and reporting become more robust, we can expect to see the field of engagement evaluation continue to develop (e.g., [Public Health Ontario](#), 2015).

There are some fundamental features and approaches to community engagement evaluation that can inform our strategies. Evaluation strategies can range from very simple (e.g., participant surveys, tracking the number of meetings held) to quite sophisticated (e.g., measuring the health impact of a health behaviour change initiative such as smoking cessation). The thing to keep in mind is that the evaluation strategy should be proportionate to the scale of the engagement—a modest engagement should not require an elaborate evaluation strategy and vice versa.

## Types of Evaluation

Evaluation measures can be qualitative, quantitative or a mixture of both. They can also focus on the success/efficacy of the process: How are we doing as we go?, as well as on the outcomes: Did we meet our goals? Many community engagement initiatives focus on process indicators and self-reporting, for example, on perceptions of inclusion and effectiveness. Evaluation strategies are often framed as either formative, process or summative.

**Formative evaluation** is created during the program planning phase, before implementation. It aims to ensure the program is based on stakeholder needs, and is using appropriate strategies, procedures and materials. Some examples of formative evaluation are situational assessments, developing a logic model, pre-testing materials or products and audience analysis.

**Process evaluation** is used when a program or initiative is under way, and examines the tasks, procedures and processes involved. It is tied to progress toward the project goals. Examples of process evaluation include surveys and audits of stakeholders and service users, quality feedback from users, determining the number of meetings/forums or other concrete steps met in the plan, and identifying benefits reported by participants.

**Summative evaluation** is completed at the end of the project to determine whether the goals were met and whether the project was effective. It can focus on short-, medium- or long-term outcomes. It asks: What difference did this initiative make? Examples of summative evaluation include measuring changes in attitude, knowledge or behaviour; changes in health status; policy changes; and conducting impact assessments and cost-benefit analyses.

## EXAMPLES OF PROCESS AND OUTCOME INDICATORS

### Process indicators

- Community/partner involvement (e.g., number, diversity, frequency of attendance, turnover)
- Planning products (e.g., written objectives, partnership agreements, establishing committees or advisory groups, terms of reference)
- Financial resources (e.g., new funding to address local health issues)
- Services provided (e.g., classes, programs, workshops, educational reports, publications)
- Referrals facilitated with community partners (number and kind of referrals in and out)
- Benefits to participants (e.g., individual skill development, expanded social networks, sense of empowerment)
- Advocacy activities (e.g., letters to politicians, depositions at city hall)

### Outcome indicators

- Community partner satisfaction (with hospital relationship)
- New or modified services or programs (e.g., homeless infirmary, screening program for newcomers)
- New or modified practices or policies (e.g., city bylaws to reduce vehicle idling or ban pesticide use, community partnership policy)
- Improved client outcomes (e.g., enhanced follow-up care post-discharge, reduced ER admissions for particular populations)
- Improved health outcomes among specific populations (e.g., lower rates of tuberculosis and hepatitis C in a high-risk neighbourhood)

For specific information about models and theories of evaluation, see the “Other Evaluation Resources” section on page 21.

# CONCLUSION

CAMH has a long history of collaboration and engagement with key internal and external stakeholders. We recognize that community engagement is integral to effective planning, service design and evaluation, and as a component of quality, accountability and equity. Community engagement is undertaken by many programs and services at CAMH, as well as at the hospital- and health-system levels. Our approach to engagement is consistent with the CAMH values of Courage, Respect and Excellence, and is anchored in best practice. This framework document serves as a guide to support leaders, programs and teams in their engagement planning and initiatives. Effective community engagement takes place across the organization. It strengthens our partnerships and improves care and supports for the people we serve. Indeed, community engagement is a key component of the success of CAMH's Vision 2020.

# Bibliography

- Accreditation Canada. (2014). [QMentum Program: Standards—Leadership](#). Ottawa: ON.
- [Better patient engagement: Crucial to future of health care](#). (2012, March 4). *The Globe and Mail*. Editorial.
- Burke, J.G., Truong, S., Albert, S., Steenrod, J., Gibert, C., Folb, B., . . . James, E. (2014). [What can be learned from the types of community benefit programs that hospitals already have in place?](#) *Journal of Healthcare for the Poor and Underserved*, 25 (Suppl.), 165–193.
- Canadian Institutes of Health Research. (2012). [Citizen Engagement in Health Casebook](#). Ottawa: Author.
- Centers for Disease Control and Prevention (US). (1997). [Community engagement: Definitions and organizing concepts from the literature](#). In: *Principles of Community Engagement* (1st ed.). Atlanta, GA: Author.
- Centre for Addiction and Mental Health (CAMH). (2012). [Vision 2020 Strategic Plan](#). Toronto: Author.
- Centre for Addiction and Mental Health (CAMH). (n.d.[a]). [CAMH Practice Model of Care](#). Toronto: Author.
- Centre for Addiction and Mental Health (CAMH). (n.d.[b]). [e-GPS: Ethical Guideposts for Principles Solutions](#). Toronto: Author.
- Change Foundation. (2014). [Patient/Family Advisory Councils in Ontario Hospitals: At Work, in Play](#). Toronto, Author.
- Communities Scotland. (2005). [National Standards for Community Engagement](#). Edinburgh, UK: Author.
- Engaging People Improving Care (EPIC). (2009). [CE goals](#).
- Gardner, B. (2006). [Policy Challenge Paper: Effective and Responsive Community Engagement](#). Toronto: Wellesley Institute.
- International Association for Public Participation. (n.d.). [Principles of community engagement](#). Louisville, CO: Author.

International Association for Public Participation. (2007). [IAP2 spectrum of public participation](#). Louisville, CO: Author.

Local Health Integration Network (LHIN). (2011). [LHIN Community Engagement Guidelines and Toolkit](#). Ottawa: Author.

Ministry of Health and Long-Term Care (MOHLTC). (2006a). [Module 5: Community engagement and communication](#). In: *The Health Planner's Toolkit*. Toronto: Author.

Ministry of Health and Long-Term Care (MOHLTC). (2006b). [Local Health System Integration Act](#). Toronto: Author.

Ministry of Health and Long-Term Care (MOHLTC). (2010). [About the Excellent Care for All Act](#). Toronto: Author.

National Collaborating Centre for Methods and Tools. (2008). [Partnership Self-Assessment Tool](#). Hamilton, ON: McMaster University. (updated 27 April, 2010).

National Health Service (UK). (2013). [The Power of Partnership. How to Seize Potential: A Practical Guide to Forming and Maintaining Partnerships in Healthcare](#). London, UK: Author.

National Institutes of Health (US). (2011). [Principles of Community Engagement](#) (2nd ed.). Bethesda, MD: Author.

Toronto Central LHIN. (2011). [Community Engagement Toolkit for Health Service Providers and the Toronto Central LHIN](#). Toronto: Author.

## Other Evaluation Resources

[American Evaluation Association](#)

[Better Evaluation](#)

[Canadian Evaluation Society](#)

Canadian Mental Health Association–Ontario. (n.d.). [Element 5: Developing a program and evaluation plan](#). In: *Workplace Mental Health Promotion: A How-To Guide*. Toronto: Author.

[Department of Health and Human Services](#) (Australia)

[National Collaborating Centre for Methods and Tools](#)

[Partnership Self-Assessment Tool](#) (also known as PET: Partnership Effectiveness Tool)

Public Health Ontario. (2015). [\*Building Evaluation Capacity in Ontario's Public Health Units: A Locally Driven Collaborative Project\*](#)

[Scottish Community Development Centre](#)

Vancouver Coastal Health Authority. (2013). [\*Community Engagement Framework\*](#)

# Appendix A: Planning Toolkit and Principles

## DETAILED PLANNING STEPS

For a detailed explanation of the essential steps in planning and executing an engagement strategy, see section 3 of [Module 5: Community engagement and communication](#) in *The Health Planner's Toolkit* (MOHLTC, 2006a).

## ENGAGEMENT TOOLKIT

For implementation toolkits, see the [LHIN Community Engagement Guidelines and Toolkit](#) (LHIN, 2011) and the [Community Engagement Toolkit for Health Service Providers and the Toronto Central LHIN](#) (Toronto Central LHIN, 2011).

## PRINCIPLES

Three excellent examples of principles that build on those identified by the MOHTLC (2006a) are provided by the LHIN (2011; Toronto Central LHIN, 2011), the Vancouver Coastal Health Authority (2003) and Communities Scotland (2005).

The LHIN has developed the [Community Engagement Toolkit for Health Service Providers and the Toronto Central LHIN](#) (Toronto Central LHIN, 2011) and the [Community Engagement Guidelines and Toolkit](#) (LHIN, 2011). The latter document describes the following principles of community engagement:

1. **Careful planning and preparation:** Through adequate and inclusive planning, ensure the design, organization and convening of the process serve both a clearly defined purpose and the needs of participants.
2. **Inclusion and demographic diversity:** Equitably incorporate diverse people, voices, ideas and information to lay the groundwork for quality outcomes and democratic legitimacy.
3. **Collaboration and shared purposes:** Support and encourage participants, government and community institutions and others to work together to advance the common good.
4. **Openness and learning:** Help everyone involved listen to one another, explore new ideas unconstrained by predetermined outcomes, learn and apply information in ways that generate new options and rigorously evaluate public engagement activities for effectiveness.
5. **Transparency and trust:** Be clear and open about the process, and provide a public record of the organizers, sponsors, outcomes and range of views and ideas expressed.



6. **Impact and action:** Ensure each participatory effort has real potential to make a difference, and that participants are aware of that potential.
7. **Sustained engagement and participatory culture:** Promote a culture of participation, with programs and institutions that support ongoing quality public engagement. (LHIN, 2011, p. 5)

The **Vancouver Coastal Health Authority** (2003) developed the [\*Framework for Community Engagement\*](#), which outlines 10 principles for community engagement:

1. Transparency of purpose, goals, accountabilities, commitments, expectations and constraints
2. Level and method of engagement based on appropriateness to the purpose
3. Clear, accessible, sufficient communication and information for involvement with issues and decision-making
4. Engagement in the process at the earliest point possible
5. Timelines that are realistic for the level of engagement appropriate to the situation and respectful of the communities with whom we engage
6. Engagement of the full diversity of communities impacted by the purpose, process and outcomes
7. Supports for “hard-to-reach” and/or marginalized communities to participate
8. Transparency of how engagement will affect and be used in decision-making
9. Responsiveness of decision-makers to community engagement
10. Evaluation and monitoring of the effectiveness of community engagement.

**Communities Scotland**, a department of the Scottish Executive (the regional government for Scotland), published [\*National Standards for Community Engagement\*](#) in 2005. The document outlines 10 standards:

1. **Involvement:** We will identify and involve the people and organizations who have an interest in the focus of the engagement.
2. **Support:** We will identify and overcome any barriers to involvement.

3. **Planning:** We will gather evidence of the needs and available resources and use this evidence to agree the purpose, scope and timescale of the engagement and the actions to be taken.
4. **Methods:** We will agree and use methods of engagement that are fit for the purpose.
5. **Working together:** We will agree and use clear procedures that enable the participants to work with one another effectively and efficiently.
6. **Sharing information:** We will ensure that necessary information is communicated between the participants.
7. **Working with others:** We will work effectively with others with an interest in the engagement.
8. **Improvement:** We will develop actively the skills, knowledge and confidence of all the participants.
9. **Feedback:** We will feed back the results of the engagement to the wider community and agencies affected.
10. **Monitoring and evaluation:** We will monitor and evaluate whether the engagement achieves its purposes and meets the national standards for community engagement.

# Appendix B: National Health Service (UK) Checklist

In 2013, the National Health Service in the UK released [\*The Power of Partnership. How to Seize the Potential: A Practical Guide to Forming and Maintaining Partnerships in Health-care.\*](#) The guide includes the following recommendations for entering into partnerships.

## CHECKLIST: RECOMMENDATIONS FOR PUBLIC, PRIVATE AND THIRD SECTOR PARTNERS

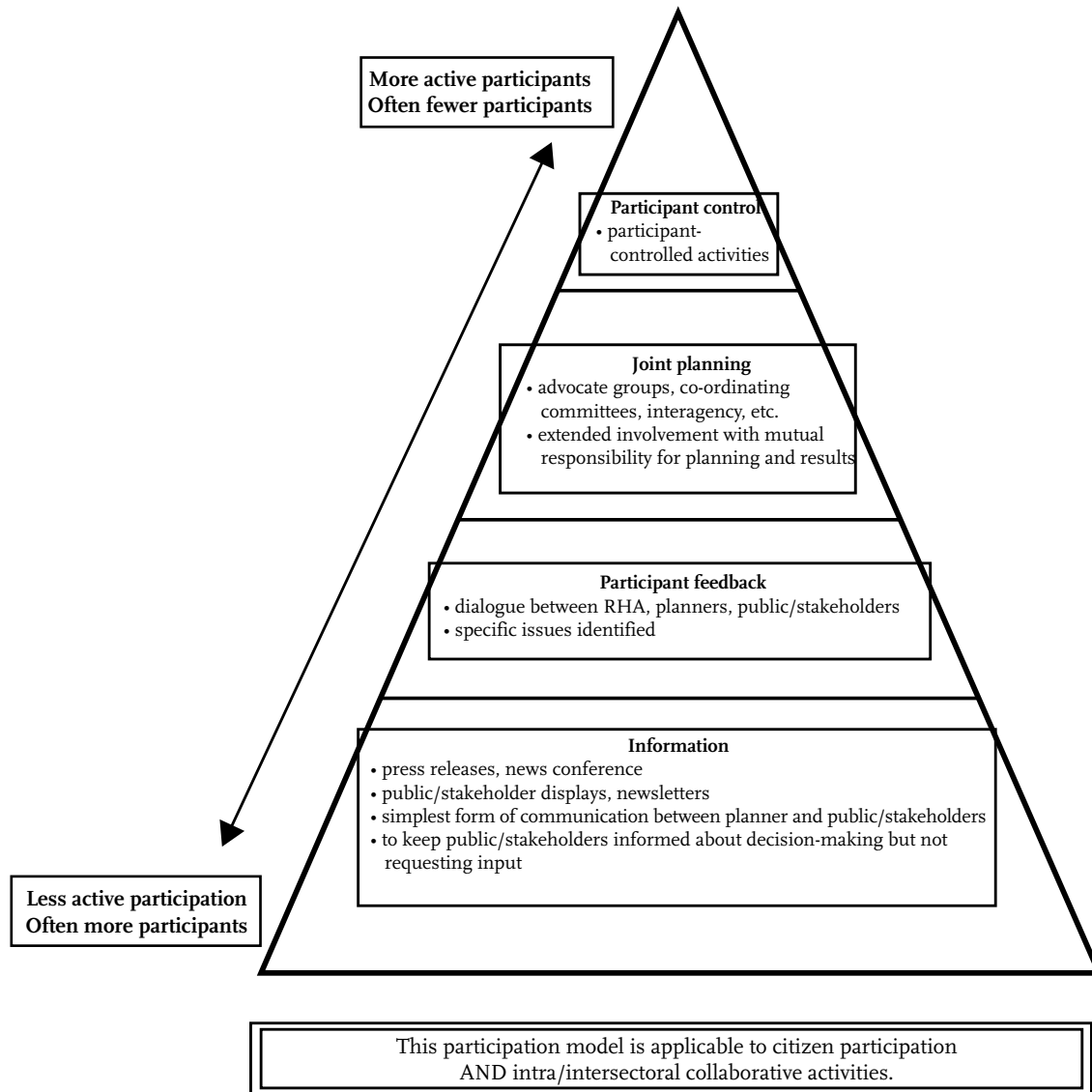
1. Be strategic. You need to **share a long-term vision** and an intent to effect significant change in the interest of patients.
2. If you are contemplating a partnership, **get talking to potential partners early**, before formal procurement starts—both to shape the service and to test how you might work together.
3. Understand each other and **avoid making assumptions**. Take time to appreciate each other’s particular culture and pressures, as well as how decisions are taken and by whom.
4. Be open about both risk and reward, and **support each other to address concerns or challenges** from stakeholders and shareholders. Have aligned PR plans and be alert not only to commercial risk but also political, clinical and reputational risk.
5. Create or look for service specifications that primarily **focus on outcomes** and procurement processes that include consideration of values and culture. Define measures of success.
6. It is sensible to **agree exit strategies** in the event that partnerships do not work out. This happens and demands rapid action. But also pay attention to metaphorical “Do not enter” signs like unrealistic timescales, lack of focus on sustainability or misalignment between desired outcomes and pricing.
7. Be honest about capability and competency, and **explore opportunities to draw in SMEs** to partnerships and build diversity into the supply chain.
8. Secure ongoing board support and **keep decision-making connected with delivery** through regular communication. Partnerships should be agreed by the board rather than created as an “executive experiment.”

9. Remember that **trust** and the **ability to have frank discussions are the hallmarks of good partnerships**. Avoid relying on one or two key individuals to drive the partnership forward.
10. **Share the successes** and lessons.

# Appendix C: Engagement Levels

## PARTICIPATION MODEL

Community development is inextricably linked to public participation and is expressed through various stages.



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# Appendix D: Community Engagement Planning Template

## THE COMMUNITY ENGAGEMENT TEMPLATE

Element	Defined information	Particulars
Use	<i>Planning or reporting on an initiative</i>	
Identity	<i>Initiative name and key contact</i>	
Outcome(s)	<i>What is to be achieved?</i>	
	<i>Why are you doing a specific community engagement?</i>	
Strategy	<i>Community capacity category</i>	
	<i>What will the level of the engagement be?</i>	
	<i>How is it to be achieved?</i>	
Responsibilities	<i>Who is responsible?</i>	
	<i>With which community are you engaging?</i>	
Implications	<i>What is the assessment of the risk/opportunity?</i>	
	<i>What is the strategy to reduce identified risks or realize opportunities?</i>	
Resources	<i>What resources are required to complete the initiative?</i>	
Timeline	<i>Have you identified check-point and completion dates?</i>	
Assessment	<i>What was achieved?</i>	
	<i>How was success measured?</i>	

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