Families First: A Process and Outcome Evaluation of Nurse, Home Visitor and Parent Perspectives

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EXECUTIVE SUMMARY

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BabyFirst (now Families First) is a supportive home visiting program for families assessed as at-risk for the provision of adequate care for pre-school children (birth to six years old) through a two-stage standardized universal screening process conducted by public health nurses. It was implemented in 1999 by the inter-departmental provincial government Child and Youth Secretariat (now Healthy Child Manitoba) through regional health authorities throughout the province. The home visiting is delivered by trained non-professional peer home visitors, who receive supervision and consultation from public health nurses. The home visitors work is guided by a curriculum, and public health nurses are available for intervention if their expertise is required. The stated goals of the program are to:

- facilitate families' abilities to ensure the physical health and safety of their children;
- enable parents to build on their strengths and to foster the development of secure attachment with their child/children;
- support parents in their role of nurturing their children and providing appropriate social, physical and cognitive stimulation for their children, and
- facilitate families' connections with community resources and build a sense of belonging in their communities (Healthy Child Manitoba, 2003).

This study involves a qualitative evaluation of the process and outcomes of the program based on intensive semi-structured interviews with key stakeholders (N=124), including public health nurses (n=33), home visitors (n=32) and parents (n=59) from four regions, which include urban, rural and remote settlements. It contains the following components in addition to a description of the socio-demographic characteristics of participants:

- Public Health Nurses' and Home Visitors' views on the goals and objectives of the Families First program;
- Public Health Nurses' and Home Visitors' views on program activities;
- Public Health Nurses' and Home Visitors' views on the strengths and limitations of the program;
- Public Health Nurses' and Home Visitors' views on the success of the Families First program in improving parenting skills;
- Parental experiences with the program, and
- Recommendations from Public Health Nurses, Home Visitors and Parents for improving the program.

Public health nurses and home visitors did not distinguish between goals and objectives, and generally stated the goals of the program in a manner which was a

specification of the official goals. However, public health nurses expanded on the official goals in mentioning the reduction of child maltreatment. Following are the goals and objectives mentioned by public health nurses and home visitors:

- Individuation and tailoring (mentioned only by home visitors);
- Outreach and inclusiveness;
- Strength Enhancement;
- Social Support;
- Relationship Enhancement;
- Parental Capacity Enhancement;
- Healthy Child Development, and
- Reduction of Child Maltreatment (mentioned only by public health nurses)

Both public health nurses and home visitors described themselves as providing both direct delivery of program components and program support functions. Public health nurses' direct service functions were more specific than the generalized role of the home visitors, and included: a) implementation of the two stage program eligibility screening process, b) direct service to families in response to concerns raised by the family or home visitors, c) referral to and liaison with physicians and other service providers, and d) provision of primary care services to program families through other roles and programs. Home visitors' direct service functions included: a) home visits, b) educational and networking group activities, and c) arranging referrals for various kinds of formal and informal support, and advocating with other services. Public health nurses' program support activities were more supervisory and administrative than those of home visitors, and included: a) provision of supervision or consultation to home visitors, b) provision of consultation to other public health nurses, c) conducting program management activities, and d) training of home visitors and public health nurses. Home visitor's program support functions included: a) participation in supervision, b) participation in multi-program case conferences, c) participation in staff meetings, d) peer consultation and support, e) development and maintenance of community contacts, and f) assistance with administrative tasks. Concerns relate to the complexity of the public health staffing model and the significant documentation requirements.

Public health nurses' views on the program's strengths focused upon: (a) the program being strengths-based, (b) recognition of the home visitor as a definite asset of the program and (c) the training process for home visitors. Home visitors shared some of these views of program strengths, but also mentioned some unique areas: (a) that the program was strengths-based and voluntary, (b) that it had a strong curriculum, (c) that the program's strength was related to the strength of the relationships that are built, (d) that there was a strong system and structure upon which to rely, and (e) that the program builds links to the community. Public health nurses noted program limitations related to: (a) the program being voluntary, (b) the difficulties of delivering a program in rural/remote areas of the province, (c) the screening process, (d) the time and human resources available, (e) the universal versus targeted program approach, (f) issues related to home visitors, (g) transportation issues, (h) curriculum limitations, (i) training issues, and (j) clinical challenges, including relationships with child and family services authorities and turnover of home visitors. Home visitors noted limitations related to: (a)

tensions around how their roles are defined, (b) training and documentation, (c) limiting areas of the curriculum, (d) supervisory and office issues, and (e) issues related to their own employment futures.

Public health nurses and home visitors both found that the program was highly successful in improving parenting skills. Public health nurses defined this success in terms of: (a) parental readiness, (b) parental learning, (c) enhanced parent-child relationships, and (d) reduction of parental stress and enhanced coping. They also noted the need to provide feedback to home visitors. Home visitors defined program success in terms of: (a) meeting the goals of Families First, (b) 1) long and 2) short term success, (c) reduction of stress and enhancement of coping skills, (d) enhancement of the parent-child relationship, (e) enhancement of parental self-esteem, (f) improved connection to the community, (g) measuring success over time, and (h) success in building trust within the home visitor-parent relationship.

Parents generally reported being introduced to the program by the public health nurse or through an outreach effort. Reasons for enrollment included child-related difficulties, the desire for help in the home, perceived deficient knowledge of child care, and the desire for a confidential party for interaction. Provision of medically-oriented information was most desired from home public health nurses. Home visitors were valued for the support and information they provided and for their non-judgmental attitude. All parents expressed satisfaction with the program and defined benefits in terms of the resources and information provided, transmission of child development knowledge, improvement in safety issues, skills acquired, the parents' groups, and the companionship secured.

Regarding program improvements, public health nurses advocated more preparatory and ongoing training for both public health nurses and home visitors, increased resources for staffing, more consistent application of program standards, extended coverage, improved collaboration with other services, streamlining documentation requirements, redesigning the parent survey stage of the screening process, and ameliorating workplace risk for home visitors. Home visitors also suggested curriculum improvements, streamlined documentation and action to improve their job satisfaction. Parents requested longer home visits, more group activities and more experienced home visitors. They also requested more groups and curriculum features tailored to fathers, a daycare component, transportation, collaborative interventions with other agencies, and more promotion of the program.

The overall conclusion was that there is strong evidence from multiple perspectives that the program is meeting its official goals. The findings also indicate that the effectiveness of the program could be increased if there were more resources available to adequately meet the counseling needs of parents, earlier (prenatal) family involvement, streamlined documentation requirements, access to additional curriculum resources or a means of locating them, consideration of universal eligibility, and more comfort built into the screening process to encourage provision of valid information on risk factors.

The program's effects are relevant to reducing the risk for child maltreatment by reducing parental stress, improving parental self-efficacy, enhancing parental empowerment, and through

the provision of nonjudgmental support. Enhancing community connectedness and/or reducing isolation may also be significant contributors to reducing a parent's risk for abusive behavior towards a child.

Introduction

Prevention of Child Maltreatment

From a child welfare perspective there is reason to be concerned with how we are parenting our children and how programs designed to serve families are impacting the lives of children. In Canada there are 76,000 children in care with 23,000 of those within the Prairie Provinces alone (Farris-Manningway & Zandstra (2003). Of the 23,000 children in care on the prairies, Aboriginal children are overrepresented. In Manitoba, Aboriginal children made up nearly 80% of children living in out-of-home care (Gough, Trocme′, Brown, Knoke & Blackstock, 2005). Manitoba, compared to other provinces, also has one of the highest rates of children in care 470 per 100,000. Manitoba and Saskatchewan have the highest rates in Canada for hospitalizations related to child abuse and neglect at 63 and 67 per 100,000 respectively, compared to a Canadian rate of 34/100,000 (CICH, 2000). The Applied Research Analysis Directorate of Health Canada (2004) notes that the health sector plays an important role in reducing the burden of child maltreatment through preventative programs, identification and referral, and treatment.

Baby/Families First Program

In 1999 Healthy Child Manitoba adopted a home visiting model which utilized lay home visitors to provide support to overburdened families and families at risk for child maltreatment. BabyFirst, as it was then known, was provided throughout the province in an effort presumably to attempt to change the lives of children through the provision of family support.

The program, which was renamed to Families First (FF) in March 2005 was designed to provide a supportive home visiting program to families described as over-burdened or at-risk. The program's goals are to: (1) facilitate families' abilities to ensure the physical health and safety of their children, (2) enable parents to build on their strengths and to foster the development of secure attachment with their child/children, (3) support parents in their role of nurturing their children and providing appropriate social, physical and cognitive stimulation for their children and (4) to facilitate a families' connections with community resources and build a sense of belonging in their communities (Healthy Child Manitoba, 2003).

Parents/families are screened either pre-natally and/or shortly after the birth of the child through which a number of factors contribute to the determination of the family as being at-risk and/or overburdened. The screening tool focuses on an number of areas including: substance abuse by one or both parents, parental experience of abuse or neglect as a child, experiencing a significant level of social isolation, parental education less than grade 12, unstable housing, family or marital problems, lack of support systems, one or both parents being unemployed, inadequate family income to afford the necessities of life (food, medication, dental care etc.), and lack of access to transportation. Since implementation in 1999 there have been increasing numbers of parents utilizing this resource. During the 2001-2002 time period 825 families participated with an increase to

1,114 in 2002-2003 (Healthy Child Manitoba, 2003). The program is voluntary but also operates to provide creative community outreach to families to encourage their participation.

As there has been considerable investment in the adoption of this model of service delivery it is imperative to assess how the program is being implemented, whether its goals and objectives are being met and to determine its impact in terms of parental response.

Nurse Home Visiting

Nurse home visiting has a long history of being an important component of public health for over 100 years (Hanks & Smith, 1999). With an ever-increasing population of high need families it is logical that public health has turned to alternate service providers to compliment and/or extend the reach of public health nurses. Utilizing peer parents as home visitors has been adopted across numerous provinces and states (MacMillan, 2000a). Research attempting to quantify the impact of lay home visitors has been less encouraging, as typically effects on reducing child maltreatment are stronger with nurse home visitors than they are for lay home visitors (MacMillan, 2000b; Olds et al. 2002).

Home visiting research is decidedly complex with many variants across studies making it difficult to build a solid body of evidence. Studies vary across type of home visitor (nurses, lay persons, developmental specialists etc.), measures (which can range from rates of immunization, length of breastfeeding through to rates of behavioral disorders in teens) and research design (usually with many design flaws). Studies with randomized controlled designs (RCDs) are much fewer in number, which further contributes to our lack of clarity in the area. Reliance on RCDs has been challenged by Hahn, Mercy, Biluka and Briss (2005) who note that data from studies other than RCDs can provide convincing evidence when for instance RCDs are contaminated, underpowered or have other problems preventing the answering of certain questions. In the area of child abuse it can be difficult to deliver services using a RCD. In the home visiting area, Hahn et al. (2005) conclude that the nature and quality of program implementation is a more critical factor in evaluation of intervention effectiveness.

Few studies have examined in detail the nature of the relationship between the home visitor and the parent, nor have they looked in detail at the differences in the way home visitors and nurses deliver services to overburdened at risk families. Nor do studies focus on differences in what nurses and home visitors provide and/or how what they provide contributes to the reduction of child maltreatment.

Research is accumulating however, demonstrating that nurse home visitors do produce positive effects. Nurse home visitors, in a randomized controlled trial were found to improve maternal-infant interactions (increased positivity) and to contribute to improved scores on measures related to the home environment, one of which assessed the promotion of healthy development and positive maternal-child attachment (Armstrong, Fraser, Dadds, & Morris, 1999). Home visiting by nurses has been found to have positive

impacts on infant health at a one year post birth (Koniak-Griffen, Anderson, Brecht, Verzemnieks, Lesser & Kim, 2002) and at two years post birth (Koniak-Griffen, Anderson, Brecht, Verzemnieks, Lesser, Kim & Turner-Pluta, 2003). Additionally, a positive impact of intense home visitation by community health nurses has been found in the reduction of the scores for child abuse potential (Cerny & Inouye, 2001).

There appears also to be long-term positive impacts of nurse home visiting. Results of a follow-up study by Eckenrode et al (2001) found that prenatal and infancy home visiting by nurses can moderate the risk of child maltreatment as a predictor of conduct problems and antisocial behavior among children born into at-risk families. Additionally, Lang (2001) reported that visiting nurses have reduced child abuse and neglect by up to 80-percent over a 15 year period among a group of low-income, unmarried women during their pregnancies and when home visiting was provided within the first two years of their babies' lives. Further evidence of sustained benefits for mother and child have been found with nurse home visiting provided through the first two years of the child's life (O'Conner, 1998) who found that women who received nurse home visits had fewer subsequent pregnancies, were less likely to neglect or abuse their children, were less likely to be dependant on welfare, or to engage in criminal behavior .

Elkan (2000) undertook a major review of the home visiting literature where the conclusion was that there was evidence to suggest home visiting was associated with "improvement in parenting skills, improved quality of the home environment, decreased child behavior problems, increased intellectual development, decreased unintentional injuries, decreased home hazards, increased detection of postpartum depression, increased the quality of social support to parents and improved rates of breastfeeding" (as cited by Chalmers et al. 2004 p. 17).

In a synthesis of qualitative nurse home visiting research McNaughton (2000) found that "building and preserving the relationships with the client is the central focus of home visiting and provides a foundation for problem identification and problem solving. The goals of home visiting relate to empowering mothers, supporting their independence and decision-making." p. 405.

The training background is important to the provision of home visitor services and their ultimate impact. In an evaluation of the prevention of child maltreatment through community nursing Brown (1995) found that few health visitor interventions were deemed a success. Brown concluded that greater support and training is required for community nurses if they are to be used to prevent child abuse and neglect.

The capacity of nurses in the public health arena to provide the intensity of home visiting required to impact and prevent child abuse and neglect may be well beyond their availability to families. It is perhaps in relation to this factor, availability or lack thereof that use of lay home visitors has been a choice public health had to make as available resources do not meet the needs of the population of concern.

There are some studies that have compared nurses and paraprofessionals. Korfmacher, O'Brien, Hiatte, & Olds (1999) examined differences and found that on average, nurses completed more visits than paraprofessionals and spent a greater proportion of time on physical health issues during pregnancy and parenting issues during infancy. Paraprofessionals by contrast conducted visits that lasted longer and spent a greater proportion of time on environmental health and safety issues. The authors noted importantly, that nurses and home visitors even when using the same model provide home visiting services in very different ways.

Peer Home Visitors

In an examination of the experiences of parents of children with special needs Ainbinder, Singer, Sullivan, Powers & Santelli (1998, p.99) found that parent to parent support "created a community of similar others trained to listen and be supportive…provides an opportunity for matched parents to experience equality and mutuality in their relationship" with the supporting parent being considered a "reliable ally".

In a study of a nurse-managed community worker team, Barnes-Boyd, Fordham and Nacion (2001) found that the use of community workers as part of a home visiting team was as effective as the nurse-only team in meeting the needs of families at risk for poor infant outcomes. This study compared the first 666 participants in the program to those participants in the prior program that utilized only nurses. The results supported the potential to achieve desired outcomes in a cost effective manner.

In a randomized controlled trial, home-based peer counseling to increase breastfeeding rates for low birth weight babies, Madeiro, Puccini, Atalah et al. (2005) found positive effects. The intervention significantly increased exclusive reliance on breastfeeding and delayed the introduction of formula. While this is a very specific effect it is indicative of what can be achieved when task and outcome measures are well formulated.

Roles of home visitors are usually directed towards provision of support and delivery of a curriculum designed to enhance healthy child development and improve parenting skills. Support delivered at times of crisis for the parent can begin to move into therapeutic interactions, which are outside the scope or skill set for most home visitors. Nevertheless, some of the impact lay home visitors have may be in the domain of lay therapy. In a study of the impact of lay therapy intervention with families at risk for parenting difficulties functional improvement occurred in four categories (social support, self-esteem, confidence as a parent and affective relationships) Gray, Spurway & McClatchey (2001). Family conflict was one area that remained unaffected. It is thus important to consider a wide range of potential impact to clarify the contributions being made by home visitors.

Fathers have been included far less in the research. However they too have been found to benefit from parental support. McBride (1991) found an increased sense of competence, less social isolation, less depression and reduced stress in the treatment

group compared to controls. With the move to a family focus fathers become more included so it is important to monitor how they respond to the FF program.

Conclusion

In general we can conclude that home visiting programs are producing a variety of effects, most positive and sustained across time. It has been less encouraging that the literature has been unclear and even negative (absence of effects) pertaining to lay home visitors. This study affords an opportunity to not only examine the success of the FF program in meeting its goals, but also affords an opportunity to examine the perceptions of nurses and home visitors, their activities and needs. Having a better sense of what each provides within the Families First program may aid in the clarification of measurement issues which can further our understanding of how each type of program provider is contributing to the reduction of child maltreatment.

This study had two primary methodologies, quantitative and qualitative. In the quantitative study efforts were directed at building a data base communication system that would link three primary databases in Manitoba (Health Care Utilization, Healthy Child Manitoba and Manitoba Child Welfare). The system developed would then be used to analyze available information on 250 Families First participants in Manitoba. A separate report has been produced for this material (Frankel & Ek, 2006).

This report outlines the results of the qualitative portion of the study and was designed to compliment a study undertaken in Winnipeg (Chalmers et al., 2004). This study investigated the experiences of parents, home visitors and Public Health Nurses with the program. Through this extension, to rural and northern environments, Healthy Child Manitoba would have a broader base of information to guide their review of the program.

This report will describe seven areas of results:

1. Descriptive statistics related to the Characteristics of Informants
2. Public Health Nurses and Home Visitor's views on the goals and objectives of the Families First program;
3. Public Health Nurses and Home Visitor's views on program activities;
4. Public Health Nurses and Home Visitor's views on the strengths and limitations of the program;
5. Public Health Nurse and Home Visitor's views on the success of the Families First program in improving parenting skills;
6. Parental experiences with the program and
7. Recommendations from Public Health Nurses, Home Visitors and Parents for improving the program.

Method

Design

This study used a qualitative framework to describe the Families First program. The focus of this evaluation was on the perceptions of those involved in the program in four other Regional Health Authorities in Manitoba.

Setting

This study was conducted within four Regional Health Authority (RHA) areas including Assiniboine RHA, Brandon RHA, Burntwood RHA, and Parkland RHA.. Parkland and Assiniboine RHA would reflect rural conditions, Burntwood is remote and Brandon would be classified as a rural-urban environment.

Data Collection

Following the methodology of the Winnipeg study (Chalmers et al., 2004), in-depth semi-structured interviews were conducted using samples of parents, home visitors, and public health nurses that participated in the program. The addition of probe questions was made to elicit detailed descriptions of the program from participants. The ethical review process is described in Appendix B. Interviews were conducted by the research coordinator, three research assistants and the principal investigator. Duration of the interviews ranged from three quarters of an hour to one and one half hours. The majority of public health nurse and home visitor interviews took place in the Families First research office via teleconference. The remainder of these interviews occurred at the RHA district office in the respective region where the public health nurse or home visitor worked. Parents were interviewed in their respective district RHA office, or in their homes based on convenience. Data collection began on February 15, 2005 and ended June 30, 2005. All interviews were tape recorded and fully transcribed. In addition to the interview, demographic data were collected for each participant.

Sample

The sample consisted of 124 participants from the four major community care regions including, 37 from the Assiniboine RHA, 22 from the Brandon RHA, 32 from the Burntwood RHA, and 33 from the Parkland RHA. As in the Winnipeg sample (Chalmers et al., 2004) the rationale for sampling providers, and parents from the four RHA's was to ensure sufficient data to reveal any differences in implementation or regional factors that may have affected the perceptions of the study's participants. The sample breakdown is provided in Table 1 (see Appendix A). Please note that in the tables provided in Appendix A, Winnipeg statistics are provided, though shaded. They are provided for broad comparison but were not collected as part of this study.

Recruitment

Public Health Nurses and Home Visitors: Five RHA's were approached through a letter requesting participation and were provided with a copy of the proposal and questions that would be asked of parents, Public Health Nurses and home visitors. Each region took the proposal through its individual ethics committees and/or executive council that approved or disapproved of the respective regions' participation. Only one

region declined involvement due to other evaluations currently underway to avoid over stressing their employees. Once each region approved its involvement the coordinators responsible for the BabyFirst/Families First program provided home visitors and Public Health Nurses with letters soliciting their voluntary participation in interviews. They were also provided with demographic questions and a research consent form which they returned to our research office with contact information. At that point the research coordinator scheduled a convenient time for the interview.

Parents: Home visitors were asked to inform parents of the study, a descriptive outline was provided along with contact information. The home visitor and/or the parents themselves contacted the research coordinator who scheduled an interview at a convenient time and location.

Results

1. Description Of The Participants:

Public Health Nurses: A majority of public health nurse respondents were Caucasian (90.9%) and female (96.9%), while 9.1% of respondents were Aboriginal, and 3.1% were male. Collectively, their average age was 43.6 years, standard deviation (SD) 8.7. Married nurses accounted for 78.8% of respondents, and 81.8% of nurses had children. Nurses reported an average of 18.5 years of nursing experience (SD = 10.6), and most had a long history of experience with public health (mean = 10.5; SD = 9.3). Two-thirds of nurses were employed part-time (63.6%), and worked an average of 25.3 hours per week. The remaining nurses reported full-time employment. Nurses all reported having either a diploma in nursing (54.5%) or a bachelor of nursing (63.6%); with 24.2% reporting they had both. Several nurses reported having other degrees (15.2%); and other diplomas (21.2%) including certificate of adult education, operating room nursing certificate, education as a medical records technician, and office administration qualifications. Nineteen nurses identified themselves as lead roles in the program. Many of the interviewees had lengthy experience with Families First (mean = 44.3 months; SD = 25.1). Estimates of the number of families that respondents had seen during their tenure in the program had a range of 1 to 300 (mean = 33.4; SD = 54.1). Estimates of the number of home visitors each public health nurse had seen ranged from 2 to 21 (mean = 5.4; SD = 3.5).

No major differences were found between nurses from different RHA's. Notable exceptions included more nursing experience for members of the Assiniboine RHA, and more years of education for members of the more urbanized Brandon RHA. For a breakdown of the statistics by RHA as well as a comparison of Winnipeg statistics see Table 2 in Appendix A.

Home Visitors: Thirty-two home visitors were interviewed; 93.8% of whom were female. Ten (31.3%) respondents were Aboriginal and were more or less evenly distributed throughout districts, with the exception of the northern, Burntwood RHA, which reported 80% Aboriginal descent. The average age of the home visitors was 36.2

years (SD = 9.3), with comparable averages for each district. Eighty percent of this sample was married, and 97% had children that ranged in age from 2 to 28 years in age. The average education for home visitors was 14.3 years (SD = 1.7), with the only notable difference being a comparatively lower 11.8 years (SD = 1.1) for Burntwood RHA. Post-secondary education experience included early childhood education (7), bachelor of education (2), comprehensive health care aid certificate (1), and legal assistant training (1). Thirty-four months was the average duration of experience with the Families First program (SD = 23.2). Notably the average amount of experience was considerably lower only for Parkland RHA (mean = 27). Estimates of the number of families home visitors worked with ranged from 1 to 72 (mean = 23.1; SD = 17.9), but as in the Winnipeg study (Chalmers et al., 2004) no one could recall this with certainty. For complete statistics by RHA, see Table 3 in Appendix A.

Parents: Fifty-nine mothers in total volunteered to be interviewed, and no fathers directly participated. Participating mothers reported a young average age of 24.61 years (SD = 6.54). Aboriginal mothers accounted for 55.9% of participants, 39.0% of mothers identified as Caucasian, one respondent (1.7%) identified as Black, and two (3.4%) did not wish to identify their cultural background. Average years of education for the sample was 10.8 (SD = 1.76). Married and common-law relationships accounted for 55.9% of mothers' marital status; 39.0% reported being single and never married; and 3 (5.1%) of mothers said they were separated or divorced. Other children were present in 55.9% of the families, and ranged in age from 6 months to 18 years in age. Full-time homemaker was the most common report of occupational status (46.6%), 19.0% said they were unemployed, 12.1% were working full or part-time, 10.3% were on maternity leave from work, three were on provincial assistance, and two each reported being students or self-employed.

Families were enrolled in the program for an average 18.1 months (SD = 15.6), and 76.3% of families were enrolled post-natal. Mothers reported between 1 and 4 home visitors, with 62.7% reporting they had 1 home visitor throughout the duration of their involvement with Families First. In addition, mothers reported seeing between one and five public health nurses. Children enrolled in the program were on average13.6 months of age (SD = 11.55). Most RHA's were similar in terms of parental demographics, however mothers in Burntwood and Brandon RHA's were notably younger than those in Assiniboine and Parkland RHA's, and enrolled children were considerably younger in the Burntwood sample as compared to the others. Cultural background also differed with Burntwood and Parkland RHA's primarily composed of parents identifying as Aboriginal, and parents in Assiniboine and Brandon RHA's identifying mostly as Caucasian. For a complete breakdown of these results see Table 4 in Appendix A.

2. Public Health Nurse and Home Visitor Views on the Goals And Objectives of the Family First Program

Identifying program providers' views of program goals and objectives is important as these are prime determinants of their behavior related to program delivery.

Home visitors and public health nurses did not seem to discriminate between goals and objectives as indicative of different orders of generality, but there was a large range in the kinds of goals and objectives that they identified. The following themes characterize the various dimensions that home visitors and public health nurses consider in relation to the definition of program goals and objectives.

Public health nurses viewed the goals and objectives of the program similarly to home visitors, but did not mention individuation and tailoring of the goals and objectives of the program to the needs, circumstances and capacities of each family. Perhaps this is because the public health nurses, as managers and professionals, are more focused on overall program goals and objectives, and because they have less intense and extensive contact with the families. In addition some public health nurses did mention the reduction of child maltreatment, which was not mentioned by any home visitors.

A. Individuation and tailoring: Many home visitors described the necessity of tailoring the goals and objectives of the program to the needs, circumstances and capacities of the families. At its extreme this meant that general goals and objectives for the entire program could not be articulated, but only those generated for a particular family.

B. Outreach and inclusiveness: This involves the role of the program in actively recruiting families exhibiting various risk factors and its purpose in serving various kinds of families from various ethno-cultural backgrounds. Public health nurses tended to conceptualize outreach in more conceptual terms than home visitors, framing this in terms of secondary prevention and population health promotion. They also focused more on the role of screening, which they implement, in targeting the program.

C. Strength Enhancement: From the perspective of some home visitors, this theme relates to the purpose of the program in helping families to identify their values and strengths, and then in helping them to enhance strengths and make them available in the parent-child context. This approach was not universally endorsed by all home visitors, some of whom perceived program goals in terms of ameliorating client deficits. Public health nurses defined the strengths approach in terms of a belief component (that program parents want to be and can be "good parents"), a client-centered component (that the program should be oriented towards the family's goals), a self-help component (that the family should be able to solve problems independent of the program) and a relativistic norm of being non-judgmental.

D. Social Support: This theme involves support of various kinds: affective (positive emotional reinforcement), cognitive (problem solving) and instrumental (accomplishment of child care tasks). It is conceived both in terms of:

1) Direct support from the program and

2) Arranging support from various community formal and informal resources.

Public health nurses were more oriented to arranging external community support, especially from formal sources of help.

E. Relationship Enhancement: This theme focuses on the role of the program in strengthening family-functioning. It contains two sub-themes:

1) Enhancing Functioning of the Whole Family

2) Promoting Strong Parent-Child Relationships

Public health nurses focused much more than home visitors on enhancing the functioning of the family as a unit. In terms of parent-child relationships, home visitors were more focused on parental empathy.

F. Parental Capacity Enhancement This theme focuses upon building the personal capacity of parents, usually mothers, It contains two sub themes:

1) Transmission of State of the Art Child Development Knowledge

2) Teaching of Parenting and Problem-Solving Skills

Only home visitors referred to general problem solving skills

G. Healthy Child Development: This theme focuses on the ultimate goal of the program as promoting healthy child development, including school readiness. Home visitors were much more focused on school readiness than public health nurses were.

H. Reduction of Child Maltreatment: This focuses on prevention of child abuse and neglect. This theme, was only identified by public health nurses.

It should be noted that these goals and objectives articulated by program providers are consistent with and constitute a specification, and in one case, reduction of child maltreatment an expansion of official program goals.

2(a). Views of Public Health Nurses:

Following are explications of each theme as expressed by public health nurses. Note that public health nurses did not note a) individuation and tailoring.

A. Individuation and Tailoring: Public health nurses did not make comments that related to this area though home visitors did. These are presented within the next section, views of home visitors.

B. Outreach and Inclusiveness: Public health nurses conceptualized active outreach in more theoretical terms than home visitors did. They perceived the goals and objectives of the program specifically in the context of secondary prevention, which requires screening for risk in order to target resources, and also in terms of population health promotion. One nurse put it as follows:

> *My basic understanding is that it's felt that if we can get in on the ground level, or to these families when the babies are very young and by giving intense visitation with home visitors and do some teaching in terms of positive parenting and focusing on their strengths then that can make a difference in terms of 1) the child upbringing, as well as the parent's ability to parent in a positive environment.*

Other nurses discussed the role of screening and targeting:

> *... we have a universal kind of screen that we use, so that we're trying to get systematically out to the families. So, there's a system in place, and it's not random, and it's very consistent*

> *...to reach all of the them, in a standard way to all the families through the screening process. Identify the families most in need and offer home visiting programs*.

One nurse outlined benefits of the screening even when it is not connected with home visiting. She uses the case of First Nations families living in First Nations communities to outline what is lost when the screening is not done:

> *I guess if I could say one thing about that, you kind of feel, the First Nations families don't have access to this, right? So, when we have a First Nation family that has moved off reserve and comes, say it's not within the three months of the baby being born; then, we don't have that universal screen to look back to. And that's a really nice tool to have and say "how are they coping, how are things going right at the time of the birth of the child?" And that's the first step towards the program, so that we can offer, and even if we can't offer home visiting, the public health nurses, through the screen, it gives them the opportunity to look at what other supports..*

Another nurse clearly described the goals and objectives at a population rather than individual family level:

> *...but also on the larger picture of things it is a population based approach to get to high risk clients and hopefully change the health outcome of that population.*

In terms of ethno-cultural inclusiveness, one public health nurse was frustrated with what she saw as a disrespectful attitude of Aboriginal families:

> *For example, we used to have Healthy Baby sessions in (Name of Aboriginal community). We'd phone the people up to ask if they we're going to there and they'd go, "Yes, yes." Then you would travel up there and nobody shows up. So we've deleted having these sessions up there four months ago because nobody showed up. The powers that be – we're controlled by (Location of head office) here – told us to concentrate on (Another town) only because nobody shows up at (Name of Aboriginal community, we won't have them there anymore. So there you go again.*
>
> *I think it's only right when you travel an hour to go there and an hour to come back. We used to wait – they told us to wait 45 minutes to see if anyone shows up, that's three hours of our day doing nothing where we could be doing other work. I don't know if you see where I'm coming from.*

In response to an interviewer's probe about two cultures adapting this nurse said:

> *Well, would you adapt to the Indian culture or would Aboriginals adapt to white society?*
>
> *Like I said I worked with the people we have up north. You work on Indian time, we do what we can do but it's a band-aid situation.*

Perhaps to place her comments in context, the nurse did mention that participation rates could be problematic, even in non-Aboriginal communities.

> *… It's a pretty good turn out but when some of the other nurses had gone, nobody showed up. So it's variable, too, here in town.*

C. Strength Enhancement: Many public health nurses described the goals and objectives of the program as strengths-based. One nurse saw this as entirely consistent with conventional public health practice:

> *Some of it is just basic knowledge for us public health nurses, too, because we always try to bring out the strengths – it's a strength based program. That's what we try to do with the clients. Really Baby First isn't different from the way we work with any other clients.*

However, another public health nurse saw the program's strength-based orientation as contrasting with the expert orientation of much health care delivery:

The other thing that I see the program doing is truly developing that strength based approach in how we do business in public health. .... It's taking us more away from that expert model that we have always had in health care.

Many nurses understood the strengths orientation primarily in terms of the belief that program parents wanted to be and could be good parents:

... to make them realize that they can be good parents because ultimately that's what they want is to be the best parents that they can be. It has some down to earth concepts about problem solving and communication and going through values with clients so that we can understand where we are at and help us to step back and help them to do it on their own with a bit of support.

Ultimately you know that every parent loves their child and that they want to be the best parent that they can be.

It is a strengths-based program and is focused on the strengths that families have….It is really there to be a support to the families and to help them through the parenting and to help them with their strengths in mind to help them to develop their children to the best of their abilities.

Other nurses focused their primary understanding of the strengths-based nature of the program upon its orientation towards the families' goals:

...helping them to identify some goals that they want and work towards their goals.

...provide them with support for the families to identify the goals that they'd like to achieve and have the home visitors and public health be able to help them succeed in their goals.

Another nurse saw the self-help nature of the program as indicative of its strengths orientation:

I think it's trying to help families help themselves. It's not taking over things that they can do but providing information and resources so that they can take responsibility for looking after their children

However, yet another nurse pointed out that action not driven by client preferences would have to be taken if children were assessed to be at risk:

The program is a lot client driven; what the client needs is important. Or when the home visitor sees a need i.e. baby slapped on the bum then its client driven or assessment driven.

Finally, one nurse saw the program's non-judgementalism as central to its strengths-based approach:

It is a parenting support program, non judgmental. We work with families as to their needs and what works for them and build on their strengths.

D. Social Support: Many public health nurses articulated the goals and objectives of the program in terms of social support. Although they mentioned both support directly delivered by the program and the program enabling community support, they were more focused than the home visitors were upon community support. The nurses' emphasis was especially on arranging for formal support.

1) Direct Support from the Program: Some public health nurses articulated the goals and objectives of the program in terms of its purpose of directly supporting families:

It provides positive reinforcement of the family… a support program for the family.

positive support for families who are maybe overburdened or overstressed.

One public health nurse described direct provision of cognitive and instrumental support, but also suggested that external support was sometimes necessary:

From what I understand it is a family support program which could be a variety of things i.e. coaching in parenting skills, dealing with parenting issues, may sometime include getting Child and Family Services involved because ultimately it is the child that is important.

2) Arranging Support from Formal and Informal Community Resources: One nurse noted that the goals and objectives of the program included the intention to "connect the families to resources as needed." Others put this more in terms of "helping families to make connections to other community resources" or "networking of community resources" or "looking at support systems." Yet another nurse saw facilitating community support as one of the main functions of the home visitors, partially to limit dependence on temporary home visitor support:

The other main goal and objective is to connect parents with community resources. Not wanting the home visitor to become their main support but to try and get them connected with other parents in the community, other programs, other resources in the community that they can utilize. Our home visitors do an awesome of trying to connect their families with other things that are going for parents in the community.

Another public health nurse articulated the important influence of community support on children as a rationale for the program attempting to influence the effectiveness of community support in general:

> *As everyone knows it takes a community to raise a child. I don't usually say that to the families; but raising a child is not a solo thing. There is many people in the community that make impressions on our children and working together home visitors can help support parents and be a resource for other community agencies.*

Yet another nurse placed connections with communal sources of support in a preventive context:

> *Yes, it is preventative – I don't know if we'd call it screening – it's just that the program in the long run, the healthier the families are, the more problems are prevented. Overall I guess that's what you're getting at. If a family is really well connected and has the resources in place that they need then they're going to do better as a family.*

Similarly, one nurse discussed the organization of community support in terms of family health:

> *The program itself is to help give resources or help the families navigate resources to assist them to have a healthy family.*

Formal community resources were sometimes identified as sources of instrumental support:

> *And to hopefully facilitate or advocate for families if there is certain needs, whether it be medical or financial. ...Sometimes it's working with a family to help them locate adequate housing. If the families don't have telephones, actually a lot of my families don't, and they are not living in suitable housing what do they do? Do they know about the Residential Tenancies Act?*

Informal peer support was also sometimes explicitly identified:

> *I guess other than referring them to appropriate resources a lot of it is encouraging appropriate socializing.*

E. Relationship Enhancement: Public health nurses described program goals and objectives related to both parent-child dyads and the family as a unit. However, they focused on the entire family unit much more than home visitors. With regard to enhancement of the parent-child dyad, both home visitors and public health nurses discussed attachment, but only home visitors discussed empathy.

1) Enhancing Functioning of the Whole Family: This purpose of the program was often stated in terms of family health:

To promote a healthier family

There is a focus on healthy families, building strength to keep the family healthy

Basically, the end result of the outcome that we want to see is that we have healthy families

Sometimes family health was combined with such other factors as strength and optimal development:

Of course it is most optimum potential for families and ….So that's overall what we want is for potentially the most healthy and happy and best-developed families you can have.

I believe it's overall to strengthen the families in our community so that we can assist the families to the best of their abilities.

One nurse mentioned managing conflict and values clarification:

…enhance family functioning – how they handle disputes and disagreements within the family and what they know about each other's values, building morality in children…

2) Promoting Strong Parent-Child Relationships: Some public health nurses did mention enhancing the parent-child relationship as a purpose of the program:

The goals are initially to promote parent-child relationships in the families.

We're working on parent-child relationships, trying to be someone who helps to develop those relationships between the parents and the child, to work towards the best outcome for the child.

This was sometimes described as taking precedence over broader family functioning issues:

…we're looking at the parent/child relationship, and then just the family functioning problem solving skills, building relationships, things like that

Parent-child relationship enhancement was also sometimes discussed in the context of improving attachment:

The goals are definitely building attachment, building positive attachment between parents and families

One of the things is to promote a positive parent-child relationship. To build a strong attachment between the parent and child,

F. Parental Capacity Enhancement: Public health nurses focused on both knowledge transmission and skill training as purposes of the program.

1) Transmission of State of the Art Child Development Knowledge: Some nurses described the child development knowledge transmitted in broad and generic terms:

...to bring them information – for the parent to learn about child development.

...to give parents information about parenting

The goals and objectives of the program as I understand them is that we provide them with all the information to enhance their child's lives and rearing their child into the system.

...to give them (families) teachings in raising children.

Others focused on neurological development:

This… in a common sense way helps us to teach parents and to work with parents so that they learn about early childhood development and brain development

As far as some of the new research around the brain based development to really help families to see how children develop, just to help them gain a stronger understanding and knowledge of child development so that they know better what they can do for the best outcome of the child.

One nurse focused specifically on teaching about child health:

Well certainly to improve parents' ability to parent and to give them support and to teach about different aspects of health.

Another nurse described the purpose of the program as related to helping parents to obtain information which is both accurate and relevant:

That's probably part of the goals and objectives – to get accurate information and to help parents when they're looking for information on certain areas. To help them to find information that's good and useful information, too.

She went on to explain the dilemma parents often face when confronted with contradictory information through recounting a conversation with a home visitor with whom she works:

> *I said "For parents who have no background on anything to do with raising children, child-development or discipline, how do they know what to pick, what to choose and what is good information, and what's not good information?" You know there's so much information out there and it's not always the same information so as a parent it makes it tough to weed through all that to know what's good and what's not good information to give parents information about parenting.*

She gave two examples of contradictory information. One related to the use of time outs.

> *We were just discussing, my home visitor and I, this morning – there was a parenting course going on here last Saturday and again this Saturday – and it's based on a book called How to Talk So Your Children Will Listen, And How to Listen so Your Children Will Talk. Our home visitor attended the session last Saturday and the one thing that they advocate is not to use a time-out. Now there's a book out there, 1-2-3 Magic, that's very well-known and widely used, that does talk about using the time-out – to do the counting and then use the time-out. We've advocated time-outs for a long time.*

The other related to the use of corporal punishment:

> *And then there is another book through one of our churches here that's come out, called To Train-Up A Child and it is really focused on corporal-type punishment – it's not a good resource at all – but it's out there, it's in our community. And one of our churches ran a parenting course around this book.*

2) Skill Training: Many public health nurses referred to the purpose of the program in terms of providing training in parenting skills. Unlike home visitors, they did not refer at all to training in general problem solving skills. One nurse referred to new parents, who presumably had not gained skills through experience:

> *Basically it's a support for new parents. It helps them to build their skills in parenting*

Another nurse referred to high risk families who presumably exhibited deficiencies in their skill repertoires:

> *It's for high-risk parents or high-risk families to improve their parenting skills for the benefit of the baby and hopefully in the future have less high-risk families.*

The acquisition of parenting skills was sometimes associated with positive parenting:

… focus on positive parenting and skills and safe nurturing homes and support growth and development of children.

The program's goal is to foster positive parenting.

Alternately, skill acquisition was associated with bonding and forming high quality relationships:

Helping them with parenting skills promoting bonding, positive relationships with their children.

G. Promotion of Healthy Child Development: Many public health nurses did refer to the promotion of healthy child development as the ultimate purpose of the program, as was the case for home visitors. However, nurses were less focused than home visitors on school readiness or success.

Some nurses took this program purpose as self-evident:

…enhance the growth and development of children in high risk families

We're looking at healthy childhood growth and development.

One nurse connected healthy child development with global health:

To produce healthier children and a healthier world.

Another nurse provided a preventive rationale:

In that you would have healthy child development and perhaps avoid some later problems in life that may have happened.

Some nurses linked development with safety:

…so it's in relation to the children's growth and development and safety

One nurse alluded to developmental milestones:

To have their children develop on time.

Only one nurse linked development to learning, but did not refer directly to school readiness or success:

It's also looking at encouraging healthy child development and learning. Another aspect is promoting physical health and safety

H. Reducing Child Maltreatment: Unlike home visitors, some public health nurses referred directly to the purpose of the program in reducing child maltreatment. One nurse broadly framed the goal of the program as to

…prevent child abuse of any kind.

Another referred more narrowly to abuse in the home:
…decrease child abuse in the home

Another saw this as an indirect purpose of the program:

Indirectly, the end result is to reduce child abuse, that's what we want to see.

Presumably, she felt that child maltreatment would be reduced if relationships, parenting capacity and support to the family were enhanced.

2 (b). Views of Home Visitors:

Following are explications of each theme as expressed by home visitors.

A. Individuation and Tailoring: The goal of the program in meeting the unique needs of every family was described by one home visitor as follows:

…it's really based around the family and the family's needs, so every family is unique and different and what it is they value , and what it is their goals and objectives are, It's meeting them where they're at…

Another home visitor put it this way:

I think the goals and objectives are to, depend on the family….You are always changing the program, well me anyways, to meet the needs of the parents.

Yet another home visitor conceptualized program goals in terms of the particular goal for each visit with each family:

Typically, each time you go in there it could be a small goal, it could be a goal of getting a child to sleep in their own bed, weaning baby from breast to bottle, or going back to school or getting a car……The goals and objectives of the Baby First program seem to vary.

B. Outreach and Inclusiveness: This theme combines active case finding with the ability to serve families with a broad range of characteristics. One home visitor described the goal of the program simply as follows:

> *What I do is to ensure that we're getting out to families that are high risk or have high need….*

Another home visitor explained:

> *We are trying to systematically reach out to families in our area.*

The inclusiveness of the program was described by one home visitor as follows:

> *It is a program for everyone….it is a program that is for all families. Black, white or purple, its (a) good program because it helps to let everyone that parenting skills are important and how we teach our children is how they become adults.*

C. Strength Enhancement: Some home visitors described the program in terms of enhancing the strengths which parents already possess, while others characterized it more in terms of the remediation of deficits or pathology. A home visitor expressed the former orientation as follows:

> *It's a strengths-based program, the goals of the program is work with the values and strengths of families that we see…. We are not there to teach them things or get them out of situations; we help them to come up with those ideas,*

Another home visitor used similar terms:

> *One of the goals is to work with families in a strength-based manner, to help them build on what they already have and encourage them to do things on their own.*

Yet another home visitor was very explicit about the strength-based purpose of the program:

> *My understanding of the goals and objectives is to help families recognize that they have all the solutions to their problems to themselves.*

Another home visitor used the concept of empowerment in describing the over-arching goal of the program:

> *Overall, I think it's a generic type goal to empower parents.*

However, this strengths orientation was not universal. Some home visitors used language of risk, deficit and pathology to describe the program. One said:

What I do is to ensure that we're getting out to families that are high-risk, or have high need...

Another home visitor focused on skill deficits:

The way I understand it, it's to give them the skills they didn't see modeled in their own home; that they probably don't or didn't have access to quality parenting

A third home visitor referred to addictions:

A lot of our families are affected by alcohol…makes it a little difficult.

Yet another home visitor specifically rejected what she sees as a pathological orientation based on a class bias.

My understanding when we first started, we were told these are high risk families….I would say everybody is at risk. It doesn't matter how much money you make or how much money you don't make because even rich people have problems.

Strength versus deficit-based models represent very different orientations to the program, its purpose and its clients.

D. Social Support: Many home visitors conceptualized the goals and purposes of the program in terms of the provision of social support. There was, however, significant variation in identification of the sources of the support and of its functions.

1) Direct Social Support from the Home Visitor: Many of the home visitors described the purpose of the program in terms of the support that was provided by them directly to parents, and especially to mothers. One function of this support was improvement of parents' affect, such as through reinforcing their sense of competence:

A lot of the ones (parents) that I have, they're doing it, but just to (have someone) recognize it, to bring it out more, to make them feel confident more, to accentuate the positives with them…

We want parents to feel good about their parenting. I spend more time talking about the great things they are doing. Support of parents…

Another home visitor described:

…cutting down on the isolation that some high stress families feel.

Yet, another home visitor described how she provided low-key instrumental support to make the family home a safer physical environment for young children:

The goal and objective, in my opinion, is to-inform them about things that they're not aware of in such a way that they came up with it themselves….For example, if I saw an outlet with no safety plug, and the child is at crawling stage and objects on the floor could be used to poke in their eye…I would somehow, without the parent feeling like I'm pointing negative things out, I would be taking the conversation and moving it into the safety area, and I would go "I remember a story about a child who did that." I would bring it out in story format…"I might even get a hold of those plugs for you"….

An additional home visitor described the provision of cognitive support:

It's a support program. To support parents in their parenting skills…

However the provision of cognitive support poses somewhat of a dilemma because:

"Our role mainly is support. We are not there to give advice."

2) Arranging Support from Formal and Informal Community Resources: Home visitors also described the purpose of the program as helping to link client families to peer support and formal support in the community. For example, one home visitor described strengthening the peer support systems of socially isolated families as follows:

Those who are isolated you may need to strengthen their support systems. With our parties and stuff we do, it gives them the opportunity to, and look forward and network with other parents.

Another home visitor made a similar point, referring especially to the case of unmarried young mothers:

'Cause a lot of young mothers we get come in from out of town and have left their local communities because they're pregnant and they feel ostracized in their community so they come to Brandon. It's a big city, so again just connecting them with resources we have in the city, and trying to help them network with other young mothers.

Yet another home visitor described the purpose of the program generically as:

To connect families with the resources in the community and give them a sense of belonging to a community…

A fourth home visitor referred explicitly to helping to empower families to secure contact with formal resources which are relevant to the families' self-expressed needs:

> *Within the course of a home visit I will set out what the family, just through talking, whatever they've identified that they may need. So I'll provide them with a mental health worker's phone number and then put it back to the parent to make the contact, because to me that's supporting them. I don't want to do it for them. Most of my time is spent helping the parents decide what it is they need and if they don't have the contact numbers I can provide them.*

Other home visitors directly made referrals

> *…in times when families really need a lot of referrals it is really time consuming, a lot of phone tag, voice mail is really good, except and it's difficult with cutbacks to every area trying to find the appropriate one.*

or reported to supervisors or public health nurses who directly made referrals:

> *I usually don't make too many referrals. I quite often will be talking with public health nurses or with the supervisor and giving them information, and then usually the referrals happen in that direction,*

Interestingly, one home visitor described the possible negative effects on connection with community sources of support if families became too dependent on support from the Baby First/ Family First Program:

> *An issue I have brought up before is I have certain families that, if they could be, would stay on the program for five years. Just because for them that is the support they need. If that's the case I don't feel like I'm doing my job. Because for me I do the best I can to connect them with other families that I have…I don't want them to think that if they have something go wrong the first person they should phone is me.*

E. Relationship Enhancement: Many home visitors described the purpose of the program from the perspective of improving parent-child relationships and a few referred to strengthening the entire family unit. With regard to the former, one home visitor simply described the goal of the program as "To promote positive parent-child relationships." This was generally defined in terms of promoting social and affective proximity between parents and children, Goals and objectives were specified as helping parents to "connect" or "bond" or "empathize" with their children or "to get involved in their children's' lives". The idea of helping parents to "foster the development of a secure attachment with their child" was also discussed.

One home visitor described the goal of the program in terms of helping family members to develop positive attitudes toward other family members as a way of

enhancing the integrity of the family as a unit. Tolerance and respect were seen as the necessary attitudinal ingredients:

> *I think my goal with the program is for every family I am involved with that they will learn to be more tolerant and respectful of each other as a family. Learn to be a stronger family unit, not necessarily following everything that we are talking about in the program, just a stronger family unit.*

Another home visitor suggested that autonomy was the desired outcome of strengthening families:

> *Basically trying to get families self-sufficient, kids, moms and dads spending time together. Just making stronger families.*

F. Parental Capacity Enhancement: Most home visitors described the goals and objectives of the program in terms of parental capacity building. They described both knowledge transmission and skill training.

1) Knowledge Transmission: Many home visitors were especially enthusiastic about the purpose of the program in transmitting state of the art knowledge about child development. One said:

> *I think the information is really neat. I never knew any of this stuff when I had my kids, and now I'm a grandma, so I share it with my daughters. It's actually really interesting with all the new research and stuff that they've done. I love to share that information because it's interesting.*

Home visitors felt that information about intellectual, affective and social development was especially important:

> *All this stuff, like brain builders, cause and effect, emotional, and social development, what is it? It's good.*

The central rationale for knowledge transmission was to increase parents' understanding of the needs of their children:

> *To really connect moms with the needs of their children. To make parents aware this little bundle of joy is going to grow up and you're the number one teacher. Brain growth and what's happening; development and what to expect; and really to make parents not just think that these kids are not just going to grow up on their own.*

Another home visitor suggested that normative information about child development could have a normalizing effect.

Some people tend to want to hold on to their children as long as they can. Helping them know that this is a normal; procedure. You have to let children go through these normal steps.

2) Skill Training: Many home visitors described the purpose of the program primarily in terms of teaching the parents various skills or reinforcing or improving the performance of skill repertoires that they already possessed. This is, of course, consistent with the strengths-based approach of the program and with the stated prohibition on advice giving. Advice giving might obviate the need and erode the confidence to acquire or improve skills.

Parenting skills were most commonly mentioned. One home visitor described the goal of the program as "to work with families to help better their parenting skills." Another described it in more strength based terns as "to enhance the parenting skills that they already have." Skills in empathic understanding were seen as especially important by some home visitors:

We work on e-parenting, empathy parenting. We really work on that, getting the parents to feel how the children are feeling….

Positive parenting and discipline were also mentioned. A few home visitors also described the purpose of the program in terms of improving parents' general problem-solving skills. One saw enhancement of problem solving capacity as central to the program's strength-based approach:

…to get parents to look at their values, what's important to them, and discover their own strengths, to problem solving skills. We are not there to teach them things or to get them out of situations. We help them to come up with those ideas. They can work things through for themselves, if they hit a crisis, or not even a crisis, just a discipline issue or toilet training, that they develop the tools to thing of solutions for themselves.

G. Healthy Child Development: The ultimate goal and rationale of the program was often phrased according to developmentalist logic:

We are there to support child development…facilitating healthy child growth…

Children are the next generation and we want them to be raised in a safe and secure environment.

How we teach our children is how they become adults.

The more proximate developmental goal of school readiness was also explicitly mentioned by some home visitors:

Another one of the goals is to, basically get the children more ready for school and have a better chance when they get to school.
...we're trying to help the parents parent their children to go into school. We want their children to be ready for kindergarten when they go to kindergarten.

H. Reducing Child Maltreatment: Home visitors did not refer to this area.

3. Public Health Nurses and Home Visitor Perceptions of Program Activities

A description of the actual activities of program providers is useful in understanding the way that the program is implemented, and especially in identifying dilemmas.

Both home visitors and public health nurses are involved in direct service and program support functions. Public health nurse direct service functions are more narrowly focused on screening and dealing with specific problems than are those of home visitors. Public health nurse program support functions are more focused on program administration. Many also provide supervision and consultation to home visitors.

3(a). Public Health Nurse Activities:

There is significant variation in the Baby/Family First activities performed by public health nurses. There are three factors which structure this variation. First, the public health nurse roles are organized differently in different regions. There are three roles involved a) formal supervisor of the home visitors and coordinator of program administration, b) lead nursing role consultant to the home visitors and sometimes other public health nurses, but without formal supervisory responsibility, and c) nursing roles, and sometimes case manager, with a particular family. Depending on scale, geography and regional health authority administrative structures, sometimes one public health nurse plays all three roles, and some public health nurses play none of them. Second, and following from this, in addition to inter-regional variation, a public health nurse's program activities within a region vary according to the program role she plays. Third, most public health nurses interviewed do not work exclusively with the Baby First/ Family First program. They often perform other public health primary care roles, such as conducting baby clinics and providing immunizations. When these involve Baby First/Family First families, some public health nurses consider them part of their Baby First/Family First program activity and some do not.

Nevertheless, for many public health nurses, the Baby First/Family First program makes large demands upon their time. The supervisor interviewed below notes the tension that flows from the difficulty of accommodating these time demands within the range of public health nursing tasks. She also describes problems related to the required re-orientation of the public health role

It's taken awhile for the public health program in general to buy into this program because it's created a lot more work for public health

nurses. It's not to say that it is work that we shouldn't be doing it's just work that has fallen off the plate because we didn't have time. It's shifting public health back to a more traditional public health role, which isn't bad but it is time consuming. So there's been some resentment perhaps, around that.

Perhaps these tensions have contributed to the following reaction of one public health nurse to part of the program's monthly reporting requirement.

Yes we have to fill out the monthly form that they have. They always ask questions like, "What more can the public health do?" Again, to me it's repetitious and redundant; it's always the same questions. What more can public health do? We don't seem to have the answers for that? What more can we do with these people if they don't attend – if they don't show the initiative? I think there's a question there that we go through every month and it's always the same thing.

Her comments focus on blaming the client rather than implementing a strength-based empowerment approach.

Like home visitors, public health nurses' activities can be dichotomized between (A). direct service functions and (B) program support functions.

Although *direct service functions* often involved contact with client families, this is not necessarily the case. What they do constitute is delivering and documenting the service episodes which constitute the program. These are of four types: 1) implementation of the two stage program eligibility screening process, 2) direct service to families in response to concerns raised by the family or home visitors, 3) referral and liaison with physicians and other service providers, and 4) provision of primary care services to program families through other roles and programs. Like home visitors, public health nurses refer to the documentation requirements as substantial.

I have a chart where everything is on there. Like the screening form is on there, the in-depths on there and then the evaluations components. Like the consents and that kind of thing. There are papers like crazy, you wouldn't believe it. Then the home visitor has her own chart. So after a visit she has to do paper work and so do I.

Program support functions are more generic and not solely connected to particular service episodes. They involve enhancing program operations through: 1) provision of supervision or consultation to home visitors 2) provision of consultation to other public health nurses, 3) conducting program management activities, and 4) training of home visitors and public health nurses. (Table 6 in Appendix A displays these activities).

A. Direct Service Functions:

1) Screening and Eligibility Activities: Screening and eligibility establishment involves a two stage process, often implemented in connection with post-natal visits. One nurse describes this as follows:

> *There's certainly the screens that we do on any post-natal and usually we're doing a number of post-natals per week so we're doing that screen on everyone of those. And often that's leading to the more involved in-depth assessment that is done as well.*

Another nurse describes the flow of the process itself in these terms:

> *For every post-partum referral we get, we have an initial assessment that's part and parcel of the home visit so that would be the initial activity that we did with that family. Depending on the score that comes out of that baby visit, if they require an in-depth assessment then depending on the visit itself, we might set up another appointment to come back to do the in-depth assessment.*

She goes on to describe how this process must be accommodated to the realities of a particular family and a particular region:

> *In some homes, we just might continue on and do the in-depth right there and then, depending on the situation and how the home visit is going. If it's in an outlying area and you're not going to be back in another week you might just do it right there. If it's a closer proximity to our office, we might make arrangements to come back another time. If there are ten people in the house and it doesn't work out to do that in-depth right then, you might reschedule it as well. For every visit, that's what I would do, kind of on a weekly basis.*

This screening process can involve important clinical judgment:

> *Basically the screening part, once they score positive on that – three or above – or if they have a clinical positive, which is using our judgment as far as something is going on in the family and we need to have a further in depth screening. That's the parent interview, and that is more in depth screening as far as what risk factors the family has and once that's done and the scoring is done and they screen positive then we go on to setting them up in the program.*

This clinical judgment can lead to the need for consultation, especially for neophyte practitioners:

> *Also being a resource for some of the nurses, especially some of the newer nurses who haven't done the parent surveys as often. They often*

come to me with questions such as "How should I score this? Or what does this mean?"

Yet another public health nurse describes the time demands of the second stage of the screening process and the difficulty in accommodating them:

The survey itself requires a lot of time that I find overwhelming because when we do the initial visit, you try to develop a rapport with the client. Number two, you're there as a public health nurse to do your post-partum assessment and teaching with the baby as well as do the screening, and you are gleaning a fair amount of information there. Often you have to go back one or two more times because it's too much to do at the first visit. The mom is exhausted for one thing and very emotional. It's a huge amount of work, which I can see the need for, but it's a huge amount of work out of our time. I don't begrudge that time because we do need to know that information but it's a huge component of our job.

As one supervisor explains, these time demands can be a part of the explanation for some nurses' reluctance in screening:

And then there's been difficulties with nurses not screening families who have certain factors that are identified on the screening because if they screen low enough you do have to go the next step and do the parent survey. We have one nurse in the region who has never done a parent survey in the six years she has been involved in the program – never. So we're still dealing with some of those issues.

But, she notes that the other factor involved is discomfort with asking sensitive questions:

It's a couple of different things. I think it's a coping mechanism because of the time pressures. With some nurses they weren't comfortable asking these really personal questions or what we believe are very personal questions. It's a part of good public health practice if we're going to be providing the type of service to families that we should be. But when you're asking people about whether or not they've ever been abused, physically or sexually, or whether they believe they have an addiction problem – those are hard questions. How do you do that without offending somebody and still get accurate information? It's very difficult and we didn't have a comfort level with that. Certainly the training helps us get there but the other thing you need to do to get there is just get out and do it and find what works with you and talk with your peers about it – find out what works for them. But that is time consuming again. There have been a couple of different factors at play here. It's the coping, because of the time pressures, and then it's been the level of comfort with probing into a

person's past history and their current situation to that degree. We're still struggling with that on some levels.

This supervisor was asked if this problem could be ameliorated through another level of training or through experience. She responded that both more training and experience were required, but that support from an authoritative supervisor rather than a peer nurse was required for the appropriate lessons to be learned from experience:

I think both. They tried the advanced parent survey training which – the training that they had didn't really address the issues so it really wasn't that useful. We need something different. But at the same time we're hoping that this shift towards peer support into my capacity will make that support happen a bit more readily because it will remove your co-worker from quizzing you on certain areas of the assessment that you never address. You always seem to forget to ask about this. You never ask about the baby's father so we never have a picture of the father. So when you're co-worker is doing that it starts to set up a relationship that can get uncomfortable. That's what we've been experiencing here to a degree. So by taking that away from the lead nurses and putting it into my position where that is my role because I will be doing all the performance appraisals on all the public health nurses. So it fit's in with the performance appraisal piece as well.

Another public health nurse reports that initial contact involves not only screening and eligibility assessment, but also provision of information and recruitment of the family into the program:

Initially I work quite intensely with families for the first couple of visits because families don't always know what the Family First program is about. They don't why they need a home visitor. We do parent surveys, we have a conversation with families – but we don't come out right at the beginning because we're not supposed to – come right and say, "We're going to ask you a series of questions." That would be defeating the purpose.

Once screening is completed, if it has not been done by the Baby First/Family First supervisor, a referral to the supervisor is made:

So once I've done the initial screening and then I have to go back for the in-depth then I would let the supervisor for the Baby First program know that this family is eligible and the supervisor takes it from there

2) Response to Program Family Problems: Public health nurses sometimes become directly involved in service provision with families involved in Baby First/Family First, either because of direct contact from parents or because of issues

raised by the home visitors. These involvements also seem to be problem-specific as opposed to the more diffuse and generic service role of the home visitors.

> *Then the parents themselves contacting myself or drop-ins on certain issues periodically.*

> *I don't know how many times a week but we get some of our Baby First clients that will just call us and ask us some typical questions. Questions such as toilet training or whatever, that they've talked with their Baby First home visitor, but they're calling to get some more hints. Or if they're having feeding problems, or breastfeeding problems then they'll give us a shout.*

When the service request comes from the home visitor, the public health nurse sometimes plays a residual role:

> *The Baby First home visitors are so good as well that they pretty much answer a lot of their questions and they get back to us. If they can't then we just call the girls.*

However, the public health nurse may sometimes assume a primary role:

> *...or if the home visitors have a problem. When I did go on the one visit there was an issue with the child and food and proper eating so I kind of took over that visit....*

The differences in approach may be indicative of different orientations to the home visitor role. Some public health nurses will also become involved when families disconnect from the program and the home visitors have not been successful at re-connecting them:

> *If they're (the families) constantly not being there when the home visitor goes, then after three months of her trying, with out-reach packages and stuff like that, I'll send a letter and ask them if they are still interested in the program and let them know that it is voluntary and if they choose not to be, that's fine. We're here if they choose to reconnect with us....I don't like to see them leave, but I don't think it's right that the home visitor keeps going and there's nobody there when she could be used maybe somewhere else. We're fortunate here we don't have a waiting list, but some program, I guess do.*

3) Referral and Liaison Activities: Public health nurse activities seem to sometimes include involvement in initial referrals, ongoing liaison over problems and ongoing case coordination where multiple service programs and providers are involved.

Some public health nurses assume a direct role in making referrals, especially when a need is identified by the home visitor: This may involve direct contact with the family:

You have to follow through and the public health nurse will meet with the home visitor and refer to appropriate resources. Possibly work with the family to link up to the appropriate resources. Sometimes making some phone calls if the family does not have a telephone; things like that, no phone, no transportation. Then you are trying to help the family and work with the family to sort things out as to what can work.

Public health nurses are also sometimes involved in ongoing coordination with physicians as the result of identified problems:

Or if there is concern that maybe I have to even where the home visitor comes up with a concern and maybe I will have to be the coordinate between the doctors and family and myself to help work out a problem or an issue.

In addition, some public health nurses are involved in ongoing case oriented coordination of multiple service providers:

…consulting with other services and agencies, for example, we have a few families where it's not just Baby First that's involved with that family, but there might be Mental Health involved, there might be Child and Family Services. Just spending time on the phone, consulting with other workers that are involved with that family just to make sure that we're all on the same page.

4) Provision of Primary Care through Other Roles: Some, but not all, public health nurses considered provision of primary care services from other programs for families enrolled on the Baby First/Family First Program as part of their Baby First/Family First activities. Many spoke of Baby Clinics and immunizations:

For the families themselves, mostly my follow up with them is through Baby Clinic where I see them at Baby Clinic.

Depending upon the week, but quite often what I do is usually follow my BF families to baby clinics. They usually occur once a month, or once every two months they attend a baby clinic appointment that is a half hour appointment where we go over growth and development and nutrition and stuff like that. If it's a family that's unable to come in to the office for a baby clinic appointment then I follow them with a home visit. Within every three months, I make sure that I visit that family at least once…I try to make sure that children's immunization is kept up-to-date. We check and make sure about family planning and if that's being followed.

One public health nurse, who works out of a health resource centre, perceives Baby First/Family First as part of an integrated primary care service delivery system oriented to the needs of the mothers involved.

> *I guess because of my role, I am a community health nurse at a health resource center my role is very, we do primary care, so that is just one component of the type of care that I deliver and probably what the family that I have accesses. They access all of the components of it. Basically I am in touch with the family more often than some public health nurses are because she will come in here for immunization, she will come in here with her child to just stop in and say hello or for baby weights. I also have other health education material, just for a real support as far as what is going on in her life. Helping her learn some of the decision making skills or problem solving skills and those type of things. She doesn't just come to see me but also to pop in and say hello and visit with our secretary and the other nurse that's here. She seems to feel very comfortable in doing that. She will use the public computer and we will talk about all sorts of different problems that are going on with her. She also comes in for assessments of the baby as far as baby head and eye infections. We will take a look at that and then we will refer her on the physician who comes up here every two weeks. We have also helped her get in touch with the food bank because of financial problems. We have also helped give her information as far custody and support from the baby's father. Those are the things I do with the program in mind. It's all part of the same program…*

However, this can lead to dilemmas in determining what information gained from other program roles that the public health nurse should share with the home visitor:

> *As far as not breaking any confidentiality things are going on outside the program with mom, sometimes I find its fuzzy as far as how much information I should be sharing with the visitor. Because I see the mom on the basis for her own health, because I could be doing blood work or treatment or she is coming in for headaches or those kinds of things. There is that type of overlap that the other health nurses don't receive because they aren't privy to that kind of medical information.*

B. Program Support Functions:

1) Supervision and Consultation to Home Visitors: Many public health nurses formally supervise home visitors, in that the home visitors are accountable to them for their performance. Others provide consultation, where no such accountability exists. In the latter case performance issues must be referred to the supervisor. Sometimes consultation is provided in a formal program role and sometimes in relation to the nurse's responsibility for a particular case. Supervision and formal consultation occur both on a scheduled, regularized basis and on an ad

hoc basis. Consultation and supervision are described as case-based, rather than focusing on development of the consultee or supervisee or organizational improvement.

One supervisor described this activity as follows:

Sixty to seventy percent of my time would be with direct supervision, and kind of trouble shooting, you know, support to home visitors…

However, she also notes that program administration demands often allow only forty percent of her time for supervision.

Another public health nurse communicates the intensity of supervision:

For me it's everyday, pretty much. I work three-quarters time, so I do at least two hours a week supervising each home visitor and we have six right now. I usually spend close to half a day with each of them.

Yet, another public health nurse notes the occurrence of frequent on-demand supervision:

Yes, and the home visitors come quite frequently outside of their scheduled supervision time – I see probably each of them at least once a day for just a quick questions like, "I have this going on, what would you recommend?

Supervision often involves review of home visitors' logs of their visits and can also involve direct observation in "shadow visits."

One supervisor described the function of these "shadow visits" as follows:

...this month I've done two shadow visits; I've come with the home visitor into the home and just observed. It just gives me an opportunity to see how, well, one: to meet the family, if I haven't met the family, because not all the families are my families, like, they don't all come from my area and I'm not the public health nurse for all these families, some families I don't know, so it's good for me to go and meet the families, just to see how their interacting with each other and how my home visitor is getting the program across to the families.

Supervisors, who are not managers of all cases sometimes take the role of keeping case managers informed of what is discussed in supervision.

A nurse providing consultation described it as follows:

...but, I do see my Baby First home visitor every week, if there are concerns we address them about the families but we do meet and sit down once a month and discuss/review each family situation. If there's

any concerns or issues that she has then we'll address those. Maybe just tossing ideas around. I'm not the supervisor. The home visitor has a different supervisor.

The following nurse explains the importance of co-location in consultation:

Also we are in the same building as our home visitors, so regularly, once or twice at least during a week, one of the three Home visitor would be coming to me with a concern about one of my families and talking through with the home visitors what the plan could be and how she could deal with these situations. Our supervisor only works a (point six) and she also has other responsibilities so she's not always here, so a lot will end up falling back onto the public health nurse, as well.

2) Consultation with Other Public Health Nurses: Some nurses, especially those with lead role programmatic responsibility describe the provision of peer consultation to other public health nurses about families in their caseloads that are enrolled in the program. This occurred most often in relation to implementing the second stage of the screening process.

However, one supervisor notes the tension involved when nurses with more grounding in the program advise their peers:

You have got public health nurses that have some lead role responsibility to the program and have developed a higher level of expertise in the program than other public health nurses and they can support the other public health nurses to build their skills in doing the interviews with the families. They would do this by reviewing the other parent surveys that are done and then having a conversation with the other public health nurse…The other concern was that because the nurses with the lead role responsibility are also involved in the day-to-day public health programs as well. So they not only have these additional responsibilities and level of expertise but they are also peers on a day-to-day basis with the other staff members. What we've had difficulty with, and in my various roles, were feelings of tension between some nurses with supervisory responsibilities and some of the nurses who have not been involved in the same capacity.

This has led to the appointment of the supervisor as a clinical services manager to provide support to nurses using the authority of supervisor and avoiding tension among public health nurse peers.

3) Program Management Activities: Those involved in program management functions referred to communication of province-wide program information, coordination, policy development, performance appraisal, and evaluation. One manager put it this way:

Coordinating stats, record keeping and program development. We have team meetings [and] we also sit on the provincial coordinators and meet four times a years to provide direction for the provincial programs.

The supervisor appointed as clinical services manager mentioned above described her current managerial role in terms of vertical communication

My activities are very minimal right now related to the program. What a week might look like is I attend a provincial meeting in Winnipeg and then following that I will set up a meeting with the lead role nurses here to be their communication link for what is going on provincially and have discussions around the new things that are coming up. I guess at any point in time I get phone calls from any of the lead nurses for support or questions and clarifications, on the forms that are being used or a discussion about a difficult family, needs for resources for the home visitors or training sessions for themselves and the home visitors. Those kinds of conversations are on going so I could have one in a week or I could have nothing for two or three weeks, or I could have five in a week

Another manager described how time-consuming these functions are:

Thirty percent of my time is program coordination/program development, I don't know how you want to call it; you know, the stats, the evaluation process, policy development, guidelines, that kind of stuff, meetings, that kind of stuff. So if we divided it, (pause) maybe we should put that sixty/forty, because that's more likely, because I think sometimes the whole program development stuff really cuts into what should be supervision time. The way it should be is sixty/forty.

The newly appointed clinical services manager describes the operation of performance appraisal of nurses involved in Baby First/Family First as cohering with the strengths-based model of the program:

I suppose because of my background in the program I'm very conscious about taking a strength-based with the performance appraisals. I'm hoping that we will be able to address this in a non-threatening way that's based more on skill building and building strengths in your practice.

She hopes that this approach will obviate the need for peer nurse supervision with its inherent tensions:

But it will take the pressure off the co-worker to be doing that. Then, they can resent me if they want, it's just a part of being a manager but it won't break down the rapport between the team and the office.

Several nurses described their roles in evaluation of the program, either through informal program monitoring at the local level or through collection of data for the centralized province-wide evaluation:

Sometimes I like to just speak with families, too, and ask them what their opinion is and if they see that there is anything that they would like (to be done) differently.

We do safety screening where we will go out to the home and do a screening and then send that in as part of the evaluation component.

4) Training Home Visitors and Public Health Nurses: A few nurses mentioned training as among their activities. One nurse described this from the perspective of the trainer:

We provide skill development in doing parent surveys. We also train public health nurses and home visitors and supervise other supervisors that we trained and provide feedback and build their skills.

Another public health nurse describes her experience in receiving training to facilitate her functioning in the program. This occurs partially through reading and partially through face to face information transmission:

The other thing we do is that there is a lot of reading that goes on as far as education materials as far as changes in the program and developments. There is quite a bit of reading that goes on. I would say that there is a fair amount of reading to do to keep in touch with what changes are going on. Also, as far as work goes we have meetings that we need to attend for further information and for further training.

3(b) Home Visitors' Activities:

Home visitors' activities can be dichotomized between (A) direct service functions and (B) program support functions. Although *direct service functions* often involved contact with client families, this is not necessarily the case. What they do constitute is preparing for, delivering and documenting the service episodes which constitute the program. Direct service functions are of three types: 1) home visits, 2) educational and networking group activities, and 3) arranging referrals for various kinds of formal and informal support, and advocating with other services.

Program support functions are more generic and not solely connected to particular episodes. They involve enhancing the capacity of home visitors, assuring program quality, and, sometimes, case finding. Program support functions include: 1) participation in supervision, 2) participation in multi-program case conferences, 3) participation in staff meetings, 4) peer

consultation and support, 5) development and maintenance of community contacts, and 6) assistance with administrative tasks. Table 5 in Appendix A describes the various activities in which the home visitors are involved.

A. Direct Service Functions

1) Home visits: Home visits constitute the most central, frequent and time consuming of all home visitors' activities. They are described as involving five related sets of activities: scheduling and re-scheduling, preparing for home visits, transportation to the home, assessment of the home environment, delivering the curriculum, and, finally, completion of documentation.

Some home visitors describe substantial effort involved in scheduling in a manner which will likely enhance the success of the visit:

> *Set home visit up, either through telephone or through mail. We try to get home visit set up…if it doesn't work the family will then notify us to reschedule, to make a date and time that fits for them. We learned in the past when we said "okay, I'm coming in at this date at this time so be there!" it's like the baby was up all night teething or whatever so they're not going to be up for the visit. And, they're going to be sitting there, in one ear and out the other, so they are not going to be fully listening at what we are bringing into the home.*

Then, if there was a "no-show" the public health nurse had to be informed by e-mail. This could occur multiple times over sixteen weeks.

> *Preparation is also extensive, especially when the parents are raising issues which are to be dealt with in the future according to the sequence of the parenting program curriculum:*
>
> *Basically, I will have a prep time where you get your stuff together; making sure you got all your information that is needed. We have a curriculum that we follow, so making sure you are in the correct spot, age appropriate. Making sure the information is relevant to the family. There…if it's something…that I go there for a visit and they are asking information on toilet training. So, if it's something that I haven't touched on in the curriculum, and then I'll pull something out of the curriculum or find some other information that we have to use.*

Another home visitor reported:

> *A lot of prep time for the activities that we bring in to the home…so whether it's making something, experimenting to see if it works,,, gathering activities to bring out. You may have to go shopping for supplies to bring to the home.*

Various home visitors described this preparatory process as taking between twenty minutes and one hour per family. One home visitor described spending her own time looking for information on topics that she could not find information on in the office, which does not have internet access,

Most home visits occurred in the family home, so driving to the home could take substantial time in large rural regions. Once she arrives, the home visitor must assess whether the plan she prepared can be carried out, or whether it has been superceded by events:

> *The families, you never know what you will find once you get to a family. The week before, I had one mom who found a dead body and we had to deal with that…….Like I know one week I went to a family's home where I had been seeing for a whole two years, and they had a baby that was born a week before that they were pregnant with and didn't tell me, "I'm stupid. I didn't notice that you were pregnant."*

Events are not generally so dramatic, and most often home visitors were able to implement the plan that they had developed for the home visit. These visits generally took approximately one hour. The visit usually contained some combination of two main elements. The largest usually involved knowledge transmission and skill building through the use of the child development curriculum and the other involved facilitation of engagement with formal and informal community support. However, as one home visitor pointed out, the effectiveness of all activities in the home visit were dependent on the development of a sufficient level of trust on the part of the parents:

> *The first and foremost thing is that they have to be able to trust you. Once they trust you, sometimes they open up to the fact that they maybe don't like where they are, but they are not willing to risk. The way I think of it is that you can't climb a ladder without letting go. They are afraid to let go, to move to the next rung, but they don't want to stay where they are.*

One home visitor described the curriculum activity as follows:

> *We have a curriculum and each curriculum comes with basic care and then social and physical development, play and stimulation. And, so it will be directed at the baby's age. So, for example, if the baby was fourteen months we would do the basic care thirteen to fifteen months activity that's focused around…it might be around basic care. If it was physical and brain development we were doing it might be to stimulate…It really depends on their age and where their at for what we do for the visit. For every visit we also do "daily do's. So for parent empathy , really focusing on parents and how great they are in understanding their baby's feelings and labeling their feelings for them…the "daily do's is what's really going to change parenting.*

Another home visitor described the activity of helping to arrange formal supports in the context of home visits as more informal, less planned and more responsive to what comes up in discussion:

> *Usually, its just while we are talking I'll encourage mom you use our local resource centre, Again, if a mom is having trouble maybe the women's shelter and things like that.. But, it's just in conversation. It's not set in black and white.*

One home visitor described the contact that she had with some families in addition to the visits:

> *Other parents are more that you just do your one hour a week visit and that is it, I do creative outreach. I do mail outs. I mail some calendars every month. I provide them with the latest information with Today's Parent and The Baby Encyclopedias. I have little inspirational poems I provide to them.*

Finally, the home visit activities had to be documented. Home visitors generally describe the documentation as quite extensive and tine consuming.

> *…charting, charting and more charting. It takes half an hour to chart a one hour visit so that's why it's ha, ha , ha. That's common. After six years I thought I would be faster, but that's common.*

Other home visitors reported that completing the log could take up to an hour per visit, and one reported that:

> *the logging is difficult to keep up with.*

Yet another home visitor put this in the context of the total program reporting requirements:

> *...filling out monthly calendar schedule, filling out ...here is a list: the Baby First weekly home visit plan, daily home visit log, there is a monthly log in each family per family, monthly stats, creative outreach forms, monthly family review with public health, home visiting monthly log that goes to the Winnipeg office…it's a separate sheet. Then there is Working Inventory Alliance, they are called WIA forms and those are intermittent. The home visitor fills them out about the parent and the supervisor. I don't know how often that one is, but the parent…Every so often you get a family after so many visits you have to fill one of those out.*

One public health nurse described the documentation required of the home visitors as onerous, as requiring more time than the value it produces, and as detracting from the level of service provided:

Yes. I do feel that the documentation that those home visitors have to make is almost over the top. Their documentation is more than adequate and I think it takes time away from the program and time they could spend with families or doing other things. I feel documentation is very important but could be streamlined somehow whether it is more of a tick off system, but it just goes on and on. They spend more time documenting than they do with families.

2) Educational and networking group activities: Some home visitors also spend significant amounts of time in designing, preparing for and delivering group activities. Although group activities all involve some potential for social support, some are explicitly designed for this purpose, while the primary purpose of others is to deliver education. The latter include "Nobody's Perfect", Rock and Read" "Mother Goose", "Play and Learn" , "Baby Steps" and "Getting Your Child Ready for School". These groups are reported to take approximately half a day of the home visitors' time to directly deliver. One home visitor described additional preparation for a group as follows:

Right now I am running a Mother Goose program…There is some preparation for that, picking out information, buying snacks, things like that.

Another home visitor indicated that follow-up and planning for the next group session took approximately three hours per session,

3) Referral and Advocacy: Some home visitors support families in contacting formal services, so they do not spend time making referrals outside of the home visits. Other home visitors rely on supervisors, case managers or public health nurses to make referrals. However, many spend significant time on referral and advocacy with other services, although this may vary according to caseload composition.

…when families really need a lot of referrals it is really time consuming…a lot of phone tags…Voice mail is really good: except…and it's difficult with cutbacks to every area trying to find the appropriate one.

One home visitor described her advocacy role:

I provide advocacy throughout the weeks. We phone Income Security to try and get Income Security to pay for some day care costs or we'll phone the day care.

She also described providing transportation to the food bank out of necessity.

B. Program Support Functions:

1) Supervision: Most home visitors report frequent and regular contact with supervisors. Scheduled supervision ranged from bi-weekly to weekly, with telephone and in-person contact in between if necessary. The regular meetings were reported to take from one to two hours.

2) Case Conferences: Case reviews occurred monthly with the lead public health nurse, and as required with other public health nurses, case managers and program providers involved with program families. Case conferences also sometimes involved the families. One home visitor described the benefits of the case reviews for her in terms of validation, consultation, risk management, and support:

> *...this was motivating. She really provided that support to us and helped us deal with our own personal values regarding this family. You know we don't want to walk out of this house leaving an unsafe place, but that was the best we could do. She was there to say "you did what you can and you write your report, and make sure it is objective and precise and you are protecting yourself in that way and it's up to the parent." She was really encouraging. She gave us alternate routes to work with the families.*

Another home visitor described the role of the lead public health nurse in providing affective and cognitive support through case conferences:

> *My lead nurse is just awesome. She is my inspiration. She really helps me when I start feeling a little frustrated or getting a little down because I'm not getting as many home visits as I like in a week. She really helps me get my head around exactly why I am doing it. She is really supportive in that way and she is really helpful with feedback. If I have any type of question she is really good about answering it. She is excellent.*

Another home visitor described the combination of mentoring and autonomy in the context of discussing cases:

> *She gives me a lot of freedom. She is always there if I need advice… I would consider her a mentor. She is very accessible.*

However, several home visitors suggested that public health nurses are not as available as would be desirable for case conferences because they are so busy.

3) Staff meetings: Many home visitors described staff meetings as providing opportunities for in-service education, coordination and group problem-solving:

> *...if we had a party or activity we run down on what went well, what didn't go well. Do we do it again or change the name?...We had one meeting where it was between us and Early Start and Special Services and Occupational Therapy, and sat down and talked about what we*

did, like a roundtable,,,, In August…we sit down and pick dates for all parties and activities…updates on what's going on…

4) Peer consultation and support: In addition to staff meetings several home visitors described opportunities for home visitors to provide each other with advice, information and support. This could come through face-to face group discussion or through written resources:

As home visitors we provide support to each other. If we go into a home and we come out feeling kind of low, if it seems like we are not doing enough for this family. Then, we come back and as home visitors we all get together. And, we say "you did your best and we just have to accept what each family is giving."

We have mini-meetings in the mornings…Home visitors kind of get together questions for each, let each other know what's going on…and keep each other in the know with each other

One home visitor described her initiative in creating a newsletter for other home visitors:

…I do a newsletter for the home visitors to keep them encouraged…some jokes and some inspirational sayings…some things that they've shared….I send hugs.

5) Development and maintenance of community contacts: Several home visitors discussed attendance at community events as a means to raise the community profile of the program, primarily for case finding purposes, and to become familiar with community resources.

I quite often drop into other mom's groups in town and sort of drop in and make an appearance. It's partly knowing what's out there, but it's getting to know the people in the community…

6) Administrative tasks: One home visitor described taking responsibility for "appropriate" administrative tasks when her caseload is not large.

4. Public Health Nurses And Home Visitors Views On The Strengths & Limitations Of The Family First Program

4 (a) Views on Strengths of the Families First Program:

4(a) i. Public Health Nurse Perceptions of Program Strength:

Public health nurse comments focused around three themes (A) the program being strengths-based, (B) recognition of the home visitor as a definite asset of the program and (c) the training process.

A. Strengths-based: The program itself is frequently regarded as being excellent and its focus on being a strengths-based, solution focused approach is viewed generally as a major strength.

it is strengths-based… regular contact with families has been really beneficial… the encouragement, it really focuses on the positives… it is nonjudgmental, client driven and very positive… it's solution-focused…allows you to problem solve with parents and empower them… the program provides resources for families… the curriculum is a strength… the topics covered… the Aboriginal community is saying "come" rather than us saying us need to get in there.. very well organized.

B. Home Visitors: Public health nurse identified the significant role of the home visitors themselves as a strength of the program. Comments provided included:

the HVs- they helps us keep in close contact with the high-risk families-if they didn't have the HV in the home they (the parents) wouldn't be getting the information from anywhere…it provides intensive home visiting…

That the HVs are lay people, just like the families we work with more or less. They can relate to them well. …

the PHN-HV have a strength between them…

the creative outreach work is viewed as a positive…having a consistent HV has been really good

…the early contact with families is a strength…as an old PHN I used to have families that I used to worry about, you know, because you can't as a PHN to get out and visit those families on a regular basis and provide them with support-with this program I feel that support is there.

C. Training: Public health nurse had positive comments regarding HV training across most sites. There are some challenges however and these are discussed under limitations.

the training for the HV's has been a real strength… for the most part training occurs in a timely manner.

4(a) ii. Home Visitor Perceptions of Program Strengths:

Home visitors described a number of strengths of the program including (A) that it was a strengths-based, and voluntary program, (B) that it had a strong curriculum, and (C) that the program's strength was related to the strength of the relationships that are built, (D) that there was a strong system and structure upon which to rely and (E) that it builds links to the community.

A. Strengths-Based/Voluntary Nature: A number of home visitors noted the strengths- based nature of the program as one of its major positive qualities.

Because its strengths based, it meets people where they are at… we encourage them and tell them they are doing a good job, its strengths based…

it validates a parents feelings…they just need support, a little bit of supportive motivation…

the program is working with parents' positive attributes and building on those..

helping them be good parents… empowering, helping them understand that they have all the answers inside…

problem solving approach...sometimes I get just as much out of it as they did

as one home visitor described:

Everything we do is from a strengths-based focus. No matter where the family is at we have to find a positive and that is a very good experience, even for your own life. Always looking at the strength of everything instead of looking at negatives.

The strength of the program is that its voluntary-parents know they don't have to stay on, having it voluntary, you know they want to take part in the program-I think we would lose a lot of parents if it were required.

B. Curriculum: Varied aspects of the curriculum were discussed in relation to building strengths. Some of the comments included:

we have two different programs, the Growing Great Kids curriculum and the Small Steps Big Futures-it depends on what we are working on with the families, what age group you are at, so definitely the curriculum is a strength…

the program goes through all the different steps and stages and has evaluation tools that help as well.…

the information it provides, information they (parents) wouldn't be getting otherwise…

the curriculum gives us focus when we go into the home-we are not just there to visit…

the daily-do's, the four steps to building the child's self-esteem and the character builders which build on the social/emotional development of the child/family and empathy parenting which is really, really important to get parents to understand how their children are feeling and to put those feelings into words.

C. Relationship Oriented: The program's success is built upon the foundation of the relationship between the parent/family and the home visitor.

In time they develop trust in me and I think that makes things work so much better and I think families value that we are somebody that they can count on and they know we will not judge them for their mistakes

..the relationship part is important and its going to go on for three years…

the relationships we build-that's a huge strength-so many of the families we work with either haven't had good experiences with their own families or don't have a lot of friends, or have bad relationships…we encourage and praise

D. Team Process: Home visitor felt supported by the team process and by the structure of the system within which they work.

It's a team effort which is really important... there is no way that one HV could do everything by herself in a sense

we have supports, we got the training when we need it, we have the PHN's, the supervisors and we've got people above that to go to if we need and its pretty well connected with other areas we can get help with if there is some mental health issues or some addictions issues…

I like the support the program gives its employees, its not always easy"…help was often perceived as accessible "if she (supervisor) can accommodate you she will, she is very positive that way, very encouraging as well…very open…

having regular meetings, like with the other colleagues and hearing what they go through-its like a group sharing thing, for me that's a strength because it helps me understand and not feel alone in what I am encountering.

E. Links to the Community: Home visitor provided examples of this with respect to changed lives they see as a result of the program:

we connect people to community resources that they may not be aware of, or show them how to make better utilization of government

programs which reduces their isolation and provides a lifeline for them…

One of the families I am working with for a while has taken advantage of using the nursery school program and the literacy programs…I went to the literacy group with her for the first few, until she got comfortable….

I find a lot more families are going back to school or even to employment.

4 (b)Views On Limitations Of The Families First Program:

4 (b) i. Public Health Nurse Perceptions of Limitations of the Program:

Points made by public health nurses included the drawbacks associated with: (A) the program being voluntary, (B) the difficulties of delivering a program in rural/remote areas of the Province, (C) the screening process, (D) the time and human resources, (E) the universal versus targeted approach (F) issues related to home visitors, (G) transportation issues, (H) curriculum limitations, (I) Training issues and (J) clinical challenges.

A. Voluntary Nature of the Program: Connecting with all families has been challenging and reasons are diverse regarding why families decline participation. Sometimes it has been due to client movement within and between Regional Health Authorities. In other cases it is difficult to build trust and the creative outreach strategy appears to be one solution to this challenge. Some public health nurses were of the opinion that the program should be:

More mandated for child abuse, but I think all first time parents should get it.

Another public health nurse noted:

Its family dictated so if they choose to just not be available for the HVs--it's a hit and miss kind of thing-then they're not getting all the information that could benefit them in the long run.

B. Rural and Remote Areas: There are some challenges in rural/remote areas for the most part in relation to connecting with parents and travel demands.

In Northern Manitoba in particular one public health nurse notes:

Our demographics prove challenging with some families, they don't have cell phones, they live over an hour away causing the HV to make trips out there and the family isn't there.

This occurs in rural areas as well.

C. Screening: The screening was perceived as a limitation with some feeling that an in-depth interview should be done on everyone.

> *It is difficult explaining to people who are not going to get an HV the reasons why, at the point of evaluation….*

There are some concerns that some public health nurses may have a more difficult time gaining the trust of the client to conduct the screening process.

> *The screening process is only as good as the person who is doing the screening. There are some families that aren't getting screened in because they don't trust enough to share some of the things that we ask.*

Additionally the timing of the administration of the screening may be important in whether or not a person scores reflect accurately their needs. In one public health nurses' experience:

> *It's been my experience in the past that when I do the visit at the Day 6 post-partum…how that mom feels about her home situation with a brand new beautiful baby…and she has lots of support…they may feel differently about their life in 3 months time.*

> *The program…is not designed for reassessment at two or four month intervals…this has caused problems…if they want a reassessment at 3-months then they need to set the program up for that purpose.*

Screening also produces potential false negatives. This is described by one public health nurse as:

> *You have to have a certain score to come on to the program…but when you do the screening or assessment they don't really score in, but you know they need it…*

> *Certainly our overburdened families are a priority but there are ..lots of families out there that would really benefit from the ...information.*

D. Time: From public health nurses perspectives there is not enough time. The program is noted as having become "huge time-wise". Time spent on the program from a case manager standpoint is described as:

> *…consuming a lot of public health time. The program is a priority…you want to make sure you are supporting the HVs.*

Case managers are often responsible for more than the Family First program and feel stretched to their limits. This is exemplified by the following comment:

I feel like I'm jumping from issue to issue and I'm not really doing a good job of any of it because of time and workload constraints.

they are trying to make this a very standardized program which is great…unfortunately the supervisors or directors aren't buying in or acknowledging the amount of time that these standards need" in the sense "of giving enough staff resources to meet the expectations.

E. The Program Should be Universal: Repeatedly throughout the interviews, one of the big drawbacks noted by public health nurses is that the program would be valuable to all parents but logistically it can't be offered to everyone. This is perceived as a real limitation.

Every single family could benefit from this program, and the fact that we have to identify the riskier families, that's a limitation.

It's difficult to not offer the program when as a PHN you feel-I'd like to see all of my clients get the program.

F. Home Visitors: In all sites at least one public health nurse noted the need for more home visitors or saw difficulties that impacted the effectiveness of the home visitor as reflected in the following:

with the thought on the one hand that the more HVs … the more that could be provided but on the other hand there would need to have more supervisors.

For another PHN office space and location of PHNs relative to the HVs was not satisfactory (evident in more than one region):

…not having the connection with the HV was problematic

Public health nurses also noted that (in more than one region):

HVs are often in a crowded workspace making it difficult for confidentiality and even receiving messages from clients or from me.

Frequency of home visits was implicated in the following comment:

Having more HVs would ensure the families get a visit every week instead of every other week which is the case in the more remote areas of the Burntwood RHA.

G. Transportation/Connecting with Parent: A frustrating limitation is the transportation difficulties many parent participants encounter.

…providing transportation is not really empowering them, its more enabling them-- but the drawback is that they can't get to community

programs and meet people because they don't have a vehicle. Or they have a vehicle but the husband needs it for work.

Home visitors also have transportation issues as noted by one PHN as being a limiting factor within program delivery. If families live some distance and there is no way of ensuring they will be home the following situation can arise.

One of the big challenges…is just connecting with our families. As most of our families don't have phones and they live an hour away from the office-- you have to make the trip out there, and if they are not home or they haven't been able to phone you to cancel or whatever-- that is very draining on the HVs, it's draining on our staff because we are clocking up all this time and we are not being as productive as we should be.

These challenges have a negative impact on program delivery as one PHN noted (remote area):

They get a visitor every two weeks, not every week, that would be a limitation on the information they receive.

H. Curriculum Limitations: Some topics are difficult to incorporate into a families life and especially so when the family is in crisis. One topic that was problematic was that of nutrition:

While it made sense as a topic you wonder-- do they have access to this stuff?… eating well and stuff like that, I find it difficult.

Crises pose other difficulties as described by a PHN who noted:

Sometimes there are limits with the curriculum because our families often have issues and crises…I know we are supposed to focus on the curriculum but that's sometimes difficult for the family and the HV to actually accomplish when crises are happening.

I. Training: The training for and conducting of in-depth interviewing and assessments for public health nurses drew some comments regarding its limited nature and associated difficulties. First training was perceived as limited:

Supervision training…it was huge I had no idea about how to supervise… that plus all of the other things PHNs were supposed to do has to get fit into workload. …

Another challenge regarding training is getting the training for the HV's that they need in a timely manner.

One public health nurse identified additional training that the home visitors could make use of:

i.e. non-violent crisis intervention, ASSIST and a few others.

Additionally the educational background of the home visitors was viewed as a limitation, as one public health nurse describes:

Some of the skill levels or developmental or educational levels of some of the HVs that we've hired has been limited.

J. Challenges: The relationship with Child and Family Services is a stress point for some areas. Two issues emerged. One was reputational and the second a fear of losing the family. One public health nurse noted:

The Families First program is proud of its association with Public Health and draws from Public Health's positive profile in the community.

It appears that some effort is being expended on maintaining their positive image as evidenced in the following statement:

we are working very hard to counter the notion of "being a spy."

It was also noted as being a challenge to determine whether child and family services (CFS) needed to be involved as noted by one public health nurse:

I'm not always sure that CFS needed to be involved…CFS doesn't always have to be involved…some of the clients we see really hate CFS…when we do get them involved and they conclude their involvement is not warranted …we lose the family…the family then has nobody and trusts nobody...sometimes FF jumps the gun and involves CFS when they should not be involved.

One public health nurse further noted that some families are perceived as being really challenging. In these cases:

We don't always have the resources but CFS doesn't either.

Another challenge being faced by some areas is when they have home visitor staff turnover. One PHN described that the loss of families sometimes happens when home visitors leave their position.

They (the parents) have developed some certain degree of trust with a particular HV and they are not interested in expending all the energy to do that again with somebody new.

4 (b) ii. HomeVisitor Perceptions of the Limitations of the Program:

Home visitors raised a number of concerns related to (A) tensions around roles, (B) training and documentation, (C) limiting areas of the curriculum, (D) supervisory and office issues and (E) issues related to their own futures.

A. Roles: There are clear struggles for the home visitor related to the definition of coaching versus counseling. This is best exemplified in the following comments:

One struggle that we continually have is that as we get to know these families and they learn to trust us, so lots of issues come up besides just toilet training. The tension always is that we are trained in communication skills but we are not supposed to be counselors….we are trained in asking certain questions, the tension always is when do you flip into making a referral..

Another home visitor noted:

…you have got to be really focused…I will let them vent, but at the end of the day your main job is to work on GGK (Growing Great Kids), you have to find a way...you have to be careful how you word things, you can't just say 'How was your week' because they will go off on a tailspin…

Another noted boundary issues:

It's supposed to be a professional relationship but I see these people more than I see a lot of my friends…being there for an hour and a half sometimes two hours a week...for two years…you become part of their family.

And then there are crises:

If you just had a major crisis, like your ex came in and took your baby…you really don't want to hear about a nursery rhyme that week…they may need a friend that week…. you have to be very careful that you don't offend them by almost ignoring some of the crises.

When a parent is in obvious need of more intense counseling home visitor's will discuss this their supervisors but ultimately, the parent may need more than what the home visitor and/or public health system can provide. The process of referring for more specialized psychological/psychiatric service is not without problems as exemplified by the following:

Refer-- is what we are told…it could take months to get there and then when they get there and they don't hook up with somebody "good" then its like –"now what am I supposed to do"… I've heard of the reputations of some of the counselors who don't follow up, who don't call them back…and you want me to refer them there ..SURE…No…I am not going to stick my client on the cutting block...I wouldn't say oh yeah, go and see this person when I know they haven't followed through with the last ten people that I suggested 'go see them'.

B. Training and Documentation: Home visitors noted the following issues around training.

For one home visitor the training was problematic:

> *I honestly think they need to revamp the initial core training...they need to give you a strong example base of what a charted document looks like and nowhere is that done…give us the expectations you have for a documented chart.*

Additionally it was noted:

> *…we could do a simulated visit with a client, then discuss as a team and try to get on the same page re expectations for documenting.*

One home visitor noted :

> *…if there was more training say in working with FAS children, Aboriginal families, special needs we could help other families.*

Terminating clients is a difficult area that may need to be addressed in training to facilitate greater consistency and/or reinforce compassion. When resources are limited for clients cutting them out of the program too quickly could be problematic as evidenced by the following home visitor comment:

> *the program guidelines work for some but others it's a problem, sometimes we flex them a bit, give them another chance. I know some will say if they miss a couple of visits in a row and then that's it, their off. I find that a little rigid...there's not a whole lot of other places for them to go.*

Documentation issues were often voiced with varied focus. For instance for one HV:

> *there is a lack of organized flow in the documentation area. The more documentation, the less families we can serve…all the forms I showed you… the daily, weekly, monthly, all of those add up... nobody has spent time on the documentation end of it.*

> *The paperwork is very long and tedious… there has to be some but it could be streamlined.*

Another opinion regarding documentation included the comment that home visitors should be involved in the process of developing survey forms.

I think the surveys, they are very shoddy because the HVs aren't part of the process, which they should be before final approval. We usually get this information one or two months before they finalize it and between our home visits and our schedules and part time work, we don't get a chance to sit down and really take a look at that survey...that could be improved upon.

C. Limiting Areas of the Curriculum: The curriculum was perceived as stringent and delivery uncomfortable at times.

The curriculum is so stringent in a lot of cases, families don't always fit into the sequence, we have to be flexible but it doesn't give us a lot of flexibility.

Some of the modules are difficult, uncomfortable and inappropriate in certain situations.

a bit limited…some of the activities that they have in there, sometimes I don't find appropriate…they tend to be too high a level or too easy.. its up to us to find alternatives which has been a challenge.

Putting the program before the family was viewed as a negative in the words of one home visitor:

…when you do that, people know that and if you do, people aren't going to want to see you.

Another noted the potential for additional service delivery:

...there are people out there that could use the support from birth to six months...if we aren't full why can't we give some support to these other families.

There was some concern that the program was addressing superficial skills and issues while underneath, the reasons why there were parental problems and/or needs were not being addressed.

...the program is good in helping them develop parenting skills but...what is the reason they don't have good parenting skills...they haven't dealt with that yet…we are trying to teach them how to be good parents but they still haven't healed that person inside them…that is a weakness…we have to give them skills or counseling or whatever to be able to go back and deal with those issues.

D. Supervisory/Office Issues: Home visitor's referred to some friction related to staffing and office space, team difficulties, and lack of promotion of the program. These were all noted as problematic to greater or lesser degrees across the four regions.

There is not enough staff … not enough space… space is distanced from the PHNs… not enough money—we are scrounging around for space to hold programs… would be nice to have one space for parenting programs.

Sometimes the consultations and communication is really lacking. You don't feel comfortable in saying that's not right or you don't agree. It builds and festers over. …results in ineffective team meetings.

People don't know this program is available…there has to be some advertising or something.

There was also a perceived need for debriefing by some home visitors:

…you end up taking a lot of it home with you and you are worrying about so and so, its hard…you are so involved in peoples lives, some of them tell you everything…you are traumatized by some of it"

Supervision was problematic for some:

I know a lot of people that get "heck" from the supervisors-I did (with reference to variables contributing to that) which in turn can make for a low quality home visiting program. Supervisors need to look at all the demands on the HV before being too critical.

E. Job Pay and Job Future: This is viewed as very limited both in terms of pay and future advancement.

There are others doing similar work for more pay or as another noted the pay and the job don't even out (considering the traumatization you can experience as noted above)

You can make $18.00 an hour at Safeway compared to $12.00- $13.00 with Families First.

It's a dead end job…you can't advance, once you are a HV you are a HV...it would be nice to advance or do something else in the program but you can't really...so I've started (participant referred to an educational institution & program)

5. Public Health Nurse & Home Visitor Perceptions of Factors Related to the Success of the Program in Improving Parenting Skills

The measurement of success related to improving parenting skills in particular, and/or general functioning of the family in a broader sense, was discussed by participants along the following dimensions:

5(a). Public Health Nurse Perceptions:

Public health nurses were predominantly positive across all regions in the perceived positive impact of the program in improving parenting skills. They fell short of saying 100% improvement across all families though one public health nurse indicated with confidence that there has been improvement in "90% of my families". Overall the impression given by public health nurses is that there is improvement in a substantial number of families. Success was described in terms of (A) parental readiness, (B) parental learning, (C) enhanced parent-child relationships, (D) reduction of parental stress and enhanced coping and (E) feedback for home visitors.

A. Parental Readiness for Involvement: As public health nurse have first contact with most parents this area may have more saliency with them as opposed to home visitors.

For one public health nurse, she described that:

some families are moving to a preparedness to change position which is important.

Another public health nurse viewed success as:

the parents wanting to be involved with us and additionally as the number of parents that are coming out to our literacy programs or our baby steps group-that's a success-they are actually coming out to seek these programs out.

For another public health nurse it was the:

…parents themselves…they have to buy into the program.

B. Parental Learning: In general varied exemplars of successful outcomes were described. These included:

The program has come a long way in terms of meeting the goal for parenting skills…I have had probably at least a half a dozen 17 year olds that have had babies that have become wonderful parents just because they've got the support.

I see the parenting skills have no choice but to improve…just by learning about child development, learning to play with their kids and learning to be empathetic to their children.

Learning was also perceived as being extensive with it being noted that:

Where there is lots of learning it can go from parenting skill improvement to life skills improvement to better self-esteem…. it goes

way beyond the intent of the program…not just being a good mom, but good at everything in your life.

One public health nurse noted that:

they (parents) are trying different things for their parenting skills and that's due to our home visitors, being so diligent….taking the time to explain to people why they need to do what they do because of the child's developmental age or different things.

Another public health nurse notes:

…we are seeing that their parenting skills improve with the use of the four steps to success and the use of all these daily do's, play by play and empathy…its really working.

C. Enhanced parent-child relationships: A number of comments related to the improved quality of relationships as exemplified by the following:

…parents are learning along new techniques on disciplining their children, on talking to children, on just being involved in their lives and they're approaching their children in a different way….

…they are learning baby's cues…they are knowing what are the normal developmental stages of the child…and there is decreasing risk of unacceptable responses as a parent. These families are interacting a lot more with their children because of the FF program.

Another public health nurse notes:

…we've had some families where we've really seen growth…They are having a second or third child and you're seeing how much different they are with that child than they were with the first.

Another notes:

I've seen a lot of changes…a lot of positives… I've seen them becoming more effective even with their older children.

D. Reduction of Stress and Enhanced Coping: This theme emerged in both public health nurse and home visitor responses. For the public health nurses:

…we are heading in the right direction, I think they're (parents) are learning more coping strategies, more problem solving skills, more-other ways to interact with their children.

Where parents have an infant and a toddler:

they are learning how to cope with the behaviors of each, learning how to cope and learning what is normal… families feel more successful and they look more relaxed.

A good example was provided by one public health nurse who described:

…a mom who would always go to the emergency room with every little thing…she didn't know what else to do… we've worked with her and she is almost ready to go off the program…she has been connected to so many other resources…she's doing really well…she has had other children and she's managing much better.

E. Child and Family Services: Public health nurses note examples where in prior times child and family services would have been involved and apprehension of children would have been likely, though with the supports provided by the program, this has been avoided. This is an important area of success exemplified by one public health nurse noting:

…a couple of families I am sure CFS would have had to become involved, however with the HV and FF the parent did ok. Not that we were there to keep an eye on them, but we were there in the sense that we were able to give them support and information regarding parenting.

Another notes:

There are some families that we have worked with that were involved with CFS because of parenting issues and we have seen changes in those families.

Getting in the door is sometimes very hard there is a negative reputation…we are coming in to spy on you...instead of being there to help you.

F. Feedback for Home Visitors: Some public health nurses were sensitive to the fact that sometimes home visitors are too close to the situation and don't always see the positives they are making.

Sometimes the HVs are with these families every week and they are not necessarily seeing those subtle changes but we can see them because we are a step back...we can identify and say look at what you've done with these families, look at what they're doing now.

Public health nurses are also able to observe family follow-through with HV suggestions. One public health nurse noted that a parent:

...had told her how well it was working ... the parent seemed to understand and was demonstrating to the PHN how to model and play with baby.

5(b). Home Visitor Perceptions:

For home visitors improvement in parenting skills were described in relation to: (A) meeting the goals of Families First, (B) 1) short and 2) long term success, (C) reduction of stress and enhancement of coping skills, (D) enhancement of the parent-child relationship, (E) enhancement of parental self-esteem, (F) improved connection to the community and (G) measuring success over time, and (H) success in building trust within the home visitor-parent relationship.

A. Meeting the goals of Families First: Home visitors were enthusiastic in reporting that the goals of the program are being met with recognition that success is sometimes hard to measure. If inroads are established even in a small way it can mean significant change to the dynamics of the family.

Some families will make the connection that the child isn't there to annoy them. They start to see the child as a real person and are able to identify their feelings. "Even if they are just changing one or two things it is making a difference.

There were numerous examples of positive outcomes, most of which encompass both short-term and long term growth. Long term indicators of success incorporated the perception that the "children are better prepared for kindergarten" (comments made by parents/school principal to a public health nurses as noted by a home visitor). Evidence of improved parental attachment behaviors were noted frequently by home visitors. This included "hugging and cuddling" which has both short and long term value for the child. There was a strong representation of comments by home visitors that the strategies are being used and infants are benefiting from this.

1) Short term indicators of success: Home visitors noted a number of areas where short-term success was indicated if you can accomplish the following:

...establish stable feeding pattern...,

...see improvements on the Ages and Stages Questionnaire (ASQ)...

...make changes in parents expectations of child capacities, the child is 2 not 5... and see use of the activities and strategies demonstrated or encouraged.

An additional indicator of success was in the area of disciplining the child. The program was perceived as:

...giving parents more tools and information from which to select options-- in reaction to their child's behavior

Success was also described across the dimensions of skill building related to the parental skills and/or the positive impact of provision of information.

Some parents were noted as:

...just needing the information

Thus there is a fine distinction being drawn between enhancement of parental functioning versus those parents who required the basic building blocks of parenting skills. Some home visitors thus focused their comments at a skill level:

...it has been teaching them the skills

versus other home visitors who saw a facilitating role in the program as providing:

...enhancement of parental functioning.

In smaller communities home visitors are perhaps more likely to see parents in a casual setting, such as grocery shopping, and have the unique opportunity to observe parents using the skills or the information provided them.

Being from a rural area, I hear feedback, or I see them at the grocery store. It's really cool to see them using the things that we've talked about.

1) Long Term Success: As the program has been in place for a number of years the educational system is seeing enhanced school readiness:

...we have heard from parents and from schools that the BF/FF program prepares kids for school

...parents come back and tell me how much it has helped them.

...Principals are seeing an improvement in children entering kindergarten.

C. Reduction of Stress and Enhanced Coping Abilities: Home visitors provided numerous examples of families as less stressed, as coping better and as experiencing improved family functioning:

...families are less stressed and more comfortable with the parental role through the development of skills to better parent their kids.

...parents are benefiting, the program is helping them identify what good parenting is and is not.

Helping parents understand (their children) makes a better family unit. They, (the parents) are easier to get along with and that keeps everybody happy

I have a parent I am working with who has made a lot of changes already and she finds herself way more content.

D. Enhancement of the Parent-Child Relationship: An important outcome that we would hope to see as a result of the program is in the improvement of the basic parent-child relationship. These relationships could improve across attachment, involvement, appropriate interactions, responding to cues, warmth and responsiveness. Home visitors are seeing all of these areas improving as noted by the following comments:

We see a lot more parent/child involvement. I've seen parents playing with their kids, where they never would before.

...Mom's that wouldn't be looking their baby in the eye are now holding them closer and talking to them more. This mom is starting to understand the more subtle cues her baby is giving her.

...parents are not expecting so much of their children i.e. they are 2 not 5....

When I told her (the parent) how to interact with her child she saw his face light up...THEN she realized how important it was.....

One mom told me (HV) that my kids are so different; just talking to them makes a difference. Before I would be yelling more than talking and not recognizing that.

...these families are getting a chance to attach to these babies. It certainly does promote attachment, just talking to the baby more and picking the baby up more.

E. Enhancement of the self-esteem of parents: Comments reflecting success also included perceptions of improved confidence, observations of parental self-praise, decreases in uncertainty, and empowerment.

One father was doing a play by play of his child's play behavior and saying to himself "yah, I'm doing good

One mom has come up with her own conclusions. She is feeling like, I came up with this idea on my own and did it and it worked!!

I have seen a lot of improvement in families since day one. Initially they would ask a lot of questions where now they don't ask so many questions but say they tried this instead of that…what do you think?

…for almost all of my families, I definitely see their confidence build.

…the program is giving parents an empowered feeling.

I thought one parent left the program because she didn't like it...but it was because she felt comfortable to be on her own.

…we are always celebrating something, even if it is small. We find it really builds up their self-esteem and self confidence.

I've had parents that are now teaching their sisters and their friends.

F. Improved family connection to the community: Parents, whether in a rural, remote or urban area can be isolated and lack support networks. Helping them access resources or establish networks thus becomes an important survival tool. Home visitors do see improvements in connectedness to the community.

I have seen how the family is less socially isolated.

Quite a few families are on creative outreach. Some feel more comfortable coming to a group setting.

G. Success is measured over time. Numerous home visitors noted the role of time in determining success as evidenced by these comments:

…you do see growth, but you have to look at it over time.…

…definite improvement in parenting skills but sometimes it's a long, long process…

I think there is success, a great success, but overall I don't know. I think it would be neat to follow a family through for three years, just to see what they have learned…..

…if you have a parent for a year, you will see an improvement. You see a bigger improvement if you keep them for a second or third year. I definitely see parents grow and improve in their parenting skills…..

…the program will prevent problems later on, I see that with the families and the changes they have made…..It's a slow process, but I have seen quite significant changes …

The program is a success definitely. Just from seeing a family that you worked with, that really struggled to start with and now you can see the improvements.….

Some families come on board during the prenatal period and you see so many potential problems, then when the baby is 6 months old or so you can see how far they have come.

H. Success in building rapport and trust. Before you can involve the family in the program the most challenging period is in the establishment of trust and rapport. Achieving this is no small success. Home visitors describe the following:

Some of my visits started off with 5-10 minute level (the family comfort level), now she is phoning me and I'm in the home for an hour…that's success

You will start to see more growth after that trust is built.

6. Parental Experiences with the Families First Program

Parental experience was fairly consistent across regions and thus are presented as a group response. Areas discussed included (A) enrolment, (B) relationship with 1) public health nurses and 2) home visitors, (C) Activities of 1) public health nurses and 2) home visitors, (D) Satisfaction with the program and (E) Overall benefits of the program.

6(a). Enrolment in the program:

Most of the mothers in the program reported being introduced by a public health nurse after the birth of their child, either in the hospital, or during a post natal visit. Other sources of introduction to the Home Visitor included creative outreach contact, participation in a prenatal program, and through another involved family member. A small number of mothers did not mention how they were introduced to their home visitor.

I guess on a visit I was having with the public health nurse, the public health nurse called (HV) in and we had a visit and the (HV) started coming out.

Through the public health nurse. She asked me if I wanted to enter the program.

Other sources of inclusion into the program were prenatal classes, previous enrollment in the program with older children, and by the suggestion of a family member.

I'd say through the prenatal classes. The best thing is to go through prenatal and do it that way.

A family member referred me to it.

My sister was actually involved in it…

As the program is voluntary, it was considered important to probe for why the family became involved in the program. Answers included concern about delayed child development, attempts to obtain extra help around the house with children, to obtain assistance with complications surrounding childbirth, and self-perceived lack of knowledge in child rearing. Only two participants noted they thought they were asked due to CFS being involved in their cases.

Examples of information resources specifically mentioned were lack of experience, suggestions, peace of mind, strategies for dealing with an overactive child, parenting information, and developmental information.

…to put my mind at ease, knowing she had experiences showed me what I could expect.

Raise my son. Parenting issues. Developmental issues.

…by giving me information because I didn't know anything about babies. Up until that point I was scared of babies.

Other reasons for enrolling included observed developmental delays, inadequate preparation for parenting and/or first time motherhood:

I brought (child) in for evaluation and (public health nurse) thought (child) was a little behind so she mentioned that it would be a good idea for her to become involved in the visiting and I said sure."

…to help us to help get prepared because we didn't really know what to do.

…because I am a first time mom and I am a single parent so I thought it would be good to help give me more, better information so I could help my child learn more

Other reasons mentioned for program involvement included someone to talk to, confidentiality, and education about vaccinations.

But mostly just to talk

I didn't know if I could confide in somebody and I know that what ever I talk to (the HV) about is going to stay between me and (the HV).

Education …now-a-days there's new stuff and a long time ago there wasn't all these new vaccines and everything else.

She gives me information and I call her any time.

CFS involvement was directly implicated in at least one case as this participant noted:
He (CFS worker) just told me, because we had an agreement saying that if I participate in the FF program, I would see the worker for six weeks and he said that he wouldn't bother me after that…so I said okay…I'll start the …program so you can stay out of my life because he was harassing me.

This participant joined but indicated she did not think it would help and noted further:
At first I thought it was like-ok, you don't really trust me with my own son--but now I don't mind because it helped out lots.

6 (b). Relationships with Public Health Nurses and Home Visitors:

1) <u>Relationship with Public Health Nurses</u>: According to mothers the most important aspect of the services provided by the public health nurse was information (medically oriented). The relationship focused heavily on the professional role of nurse and parent as client in need of medically based information.

With her resources she knows a lot more than I do…

Just when I have questions I can call her about breast-feeding or about changing over from breastfeeding. Just basically information on the nursing aspect.

She helped me when (child) had thrush, I had been to a doctor and got medication that didn't work, and then she got me information on purple violet… and it was gone right away.

…there are so many things, she weighs him for me so that to make sure he is doing good, and then she gives me information on breast feeding because I had some trouble at first.

She came for an assessment on both of the kids and recommended that they go to a speech therapist, she recommended a Denver.

When I first brought her home she helped with care.

She's helpful by being able to answer questions and stuff like that. When I had concerns about his eating and I'd bring him in she weighed him and see how he was doing.

Other valued characteristics of the public health nurse included accessibility, the ease of the home visits, access to vaccinations without a doctor's visit, and the value of the relationship.

She comes and does home visits so I don't have to come out of the house because sometimes it can be pretty hard.

I like that she gives the vaccinations instead of having to go to the doctor.

She gives the needles.

…she offered me the program. She made the services available for me and asks me how we are doing.

Most mothers could not mention any characteristic they did not like about their contact with the public health nurse. However, one mother did not like the manner in which the Denver (a developmental assessment tool) test was administered, and another mother said it was difficult to see the public health nurse given the nurse's busy schedule.

She came for an assessment on both of the kids and she recommended that they go for an assessment for a Denver screening… It's really discouraging. So she did one and my opinion is still a little like that. It's good to know where they are at, but you don't point out all the wrong things.

She is super busy. It's hard to see her because she is always really busy.

2) <u>Relationship with Home Visitor</u>: All mothers related some characteristic or characteristics that they valued in their home visitor. This list included personal characteristics, the interaction style of the home visitor, and how the program was administered under the home visitor. These characteristics included the tips and resources provided; talking about life's problems; the non-judgmental style; teaching ability; the time spent with the child; help with childcare; information on development; accessibility; focused information on potty training and tantrums; access to community resources provided; confidentiality; activities; flexibility in hours of visits; education on fire safety, baby proofing, toys, foods, how to deal with a crying baby; and the manner in which the curriculum was covered.

Everything. There was tips on teething… Just helpful thing like that, things I would never have thought of.

…to have her come in once a week and share new ideas and new experiences and do different activities with my daughter that I never thought of to do with her is very exciting, I like having her come in.

When she comes in she doesn't judge my home either, whether it's dirty or whatever. It's nice that way, they just come in and they are so relaxed, like you can talk about anything with them. They're just always open and always have suggestions. Never giving you, "you should do this", or "you should do that". They're saying, "this is what I've done", or "What I've heard people do". It's wonderful.

…(child) was eight months and she asked for a towel and she put it on the coffee table and blew bubbles, but I didn't think (child) would care, he was only eight months. But he loved it, just the things you don't think of…

She brings information about any questions I ask. If she doesn't know it right off the top of her head she will look it up and bring it the next day. I can call her at home too.

I think a lot of it is just talking about things with (Home Visitor), with her and I, just having a little visit and talking about life problems.

She always brings me information even on things that don't regard to (child). I was having trouble with banking because I got a loan and I got myself into some trouble with it. So she found the legal aid and got all the numbers for those so I could call them.

The activities that we do, they are helpful.

Talking about things that you can't talk to other people about really.

She talks about things like fire safety. She talks about baby proofing, appropriate toys, foods. Going through different curriculum, those are all a part of that too. Just bringing those things to your attention.

…she lets me know about a lot of programs that happen in town and what's going to be happening, so that me and (child) can join in.

The supportive role of the HV was noted as:

It's someone to talk to too…like when you have problems, just little things that are bugging you, you can tell her and she can't exactly go tell anybody. So it's someone to talk to.

If you do need outside help they can refer you to people.

Almost all mothers said there were no aspects of the home visitors they did not appreciate. However, disliked characteristics that were mentioned included bringing

games that were too simple, parenting magazines that were not useful, not respecting confidentiality, and when the home visitor was not helpful. These were rare comments.

> *She was bringing out the Parents magazine but I didn't need them. Some of the games, I think (child) has gone above some of the stuff that used to be brought out.*

> *Sometimes I find that when my (older daughter) is home from school she'll (HV) have the same kind of conversations in front of (older daughter) that I have with her. Which I find sometimes not appropriate… I don't want (older daughter) to hear that kind of thing, like the problems I am having in my life. That's only happened occasionally.*

> *… one of the (HVs) wasn't really helpful at all and only came once or twice.*

6(c). Parental Perceptions of Public Health Nurse and Home Visitor Activities:

1) <u>Public Health Nurse Activities</u>: Mothers focused on a variety of activities performed by the public health nurses. These included 1) immunizations and developmental progress, and 2) Medical information (i.e., issues such as breastfeeding, rashes, cradle cap and thrush).

1) Immunizations:

> *I see her every two months for immunizations.*

> *Just for immunizations and evaluations. (Child) is classified as special needs child and there is nothing special needs about it. But who knows that in the future, it could be not necessarily a learning disability, but emotional disabilities that could show up. So that's fine, I don't mind her being evaluated. She goes to Winnipeg and gets evaluated also.*

> *She's helpful by being able to answer questions and stuff like that. When I had concerns about his eating and I'd bring him in and she would weigh him in and see how he was doing. That little chart thing to see if he's 50%, that's helpful.*

> *Oh gosh, there is so many things, she weighs him for me so that to make sure he is doing good, and then she gives me information on breastfeeding because I had some trouble at first. I didn't know if it was supposed to hurt, and I got an infection and she got me all the information for all that.*

2) Medical Information:

She helped me when (child) had thrush. I had been to the doctor and got medication that didn't work and then she got me information on purple violet… She said that the doctors won't recommend it, but just to go ask the pharmacist for it, and it was gone right away. That was a big help. She helped with information on breastfeeding as well.

2) <u>Home Visitor Activities</u>: This theme examined the mothers' perceptions of the roles carried out by the home visitors with Families First. Most of the mothers agreed there was a strong (A) teaching or informational component and (B) advocacy and supportive aspects to the program.

A) Teaching and Information:

We make crafts for my daughter, she brings motivation skills that help me to enrich my daughter with her learning. She brings paperwork that she thinks I might be interested in reading.

We read and do activities and play with (child) and sing to her.

Each week we go over something- like how he's developing and how his brain… those little pathways and how his brain develops and everything. Each week is something new like that.

All the information and learning.

Another category that was often discussed was the role of play as a learning activity. About one-third of mothers discussed some aspect of the program involving some form of play.

She sits (child) down and they play, but in the playing the child is learning.

To develop the child's mind better, they give you ideas that can help develop their eyesight and their hearing, and their speech.

She has all these things, like if you take a toy and move it around it helps with his brain growth and you can see how he's developing.

B) Supportive and Advocacy Experiences: A few mothers gave examples that explained the home visitors informal role as both an advocate in assisting in the procurement of resources and services, and as a counselor, offering to listen to them weigh out problems and offering referrals to assistance when necessary.

They did help with getting funding for preschool for (child).

She has gotten us food hampers when we really needed it and we were kind of too embarrassed to go and get them and wouldn't get them. So she went and got them for us."

and I like that (HV) is a really good person to talk to about things that aren't necessarily involving the baby but relate to things about the father, money and stuff like that.

I think a lot of it is just talking about things with (HV), with her and I, just having a little visit and talking about life problems.

6(d). Satisfaction with the Program:

All mothers expressed satisfaction with the program. Mothers focused on a variety of areas that included the information, activities, their relationship with the home visitor, and the structure of the program that allows access to services and resources. The most frequently mentioned of these categories were the information provided and the relationship with the home visitor.

It helps you to raise happier kids. You are more able to cope with what they are feeling. (HV) taught me to identify the feelings.

She brings motivation skills that help me to enrich my daughter with learning.

She sits down and they play, but in the play the child is learning.

To me it's been great. I have learned a lot that I never knew existed with my daughter. The simple toys that you can make that she plays with. Just the overall knowledge that I never knew. I have books on babies and what to expect and stuff, but when they tell their own stories on what happened with their kids and how they treated it. It just makes you feel that much more at calm, I guess easy. They are very helpful, both the PHN and the HV ... It's a great way to learn new things to do with your daughter, or with your kids, period.

Oh yeah, that's the best, just the support. Just telling me, you know you are doing such a good job and what I see is just great, it's reassuring.

The resources and just all that stuff is very important I think.

Somebody to be able to talk to too, and the games and stuff that we can do with (child) even though he's just little. She has all these things, like if you take a toy and move it around it helps with his brain growth and see how he's developing. So I am aware of it and not reading five-

million books and getting five different answers on how to do this or that. I can just deal with one person, and say this is a good thing. We both interact with him. She shows me or explains to me how to do it and I do it with him.

It has helped some get more involved with the community:

It gets me into the community more… keeps me updated…teaches me…gives me company.

About half of the parents could not mention any aspect of the program they did not like. Among the other half of parents, concerns mainly focused on things they thought were missing from the program. These concerns included the length of visits, lack of transportation to play groups, lack of a parent support group, HV not covering enough material from booklets, not enough HV's to go around, lack of advertising, and that the program should be available to every one.

Maybe if it was half-hour visits twice a week… for some parents if they are having problems with their child it might be better having it broken up.

I'm not going to bundle these two up just to go. I don't have my driver's license so I don't bundle them up just to go to a playgroup in the winter.

Not enough volunteers. When they tried to get a parenting group together. I don't think there is enough people that are willing to participate.

(HV) needs to be more informed about the information in her booklet, sometimes she will bring it in and we won't even open it but I would prefer if we could go through it once every time she comes."

They don't have enough workers. They don't do very much advertising because I had a friend who just had a baby two months ago. She didn't even know that they even had this at all and I was telling her about it so she's interested in it.

I think it (program) should be available to more people.

6(e). Overall Benefits of the Families First Program for Families:

Almost all parents stated they had learned effective parenting as a result of the program. Mothers reported other benefits of the program that fell into the categories of increased parenting skills, increased self-esteem, practical benefits in the form of the books, games and toys in the program, reduced anxiety, and child improvement. Results are organized

across (A) General Positive Comments, (B) Provision of Resources and Information, (C) Child Development, (D) Safety Issues, (E) Specific Skill Building & Support 1) Strategies and 2) Disciplining, (3) Parent Groups and 4) Companionship.

A) General Positive Comments:

Being a new mom I always am open to suggestions and opinions. With the HV coming, because she has older children, she would share stories with me and not necessarily give advice. But suggest things on how I could do things or make it easier for me, being a new mom I flip on everything. It was a little easier for her to put my mind at ease.

It's really, really good because my HV helped me keep everything grounded. She was really positive about everything. Even when I was feeling down she was like tomorrow will be a better day than today was, and next week will be better than last week.

To me it has been great. I have learned a lot that I never knew existed with my daughter. The simple toys that you can make that she plays with, just the overall knowledge that I never knew.

that's helping, just to have reassurance that (child) can do the things she is supposed to be doing.

She has helped (child) with learning different things and learning to wait to be patient. And to be able to sit longer than a few seconds.

It's really, really good…however I would have liked them to have been around five years ago when my five yr. old was born. … I think it's a really successful program…

I would definitely say it has succeeded… I am lucky I qualified-my cousin didn't and they needed it really badly-I think they did end up getting it…

…my youngest son is a lot different than my oldest..(improvement attributed to program)…

It's succeeded greatly. I think this program is very helpful in ways if you don't know what you are doing...they help you and they show you not how things should be done but give you some insight into what you should be doing. They help you along the way to make right choices and decisions for your child-that's the strong points

B) Provision of Resources and Information:

One parent noted that

with the resources the HV left with me, I can always refer back to these if I have any questions… she always supplies you with information"… I had no clue of what to do with the baby until I started going..

If it wasn't for this program I probably would have stopped breastfeeding two days after he was born. If I didn't know things about breastfeeding I would have stopped a long time ago. I thought it was embarrassing. I didn't want to tell her. But she gave me information and it is like everyone has gone through it, and I thought oh, okay I won't mind then.

C) Child Development (physical, social and emotional):

The information given to me on development skills of the baby--I know what to look for and what levels of development she should be at. And how to help her with different things that she needs to do.

Things like getting him to follow something with his eyes, It's encouraging…

It's helping with development, helping her to associate things" …even her saying she's doing this at this level, she's doing well-helps me to think if she's doing all this right then I must be doing something right….

Having the reassurance she is doing the things she is supposed to be doing… "I didn't know what to do as a parent and I learned about brain stimulation and everything….its just been a blessing….

It enhanced what I was capable of doing--my parenting skills I had with my first two children are different from what I am doing now, for my part its better and its benefiting my children--gives me pointers on what would be helpful…

I find it more centered on how they are developing socially, mentally and physically than it is on anything else.

D) Safety Issues:

Oh yeah, safety issues…he's rolling around on the floor now so I have to baby proof, you get on the floor and see what he sees…

She talks about things like fire safety. She talks about baby proofing, appropriate toys, foods.

E) Specific skill building:

1) Strategies:

While I think I had parenting skills...it helped in learning and developing
strategies"…"its helped in learning how to fit and develop strategies for my child (ADD-special needs)

the more they help the parents being involved with their children, that's success...it's not just straight by the book i.e. 'this is how you do it and that is all there is to it-it's helping mothers learn to interact and do things with their children.

2) Disciplining, dealing with anger and temper tantrums:

…its helped develop strategies regarding temper … It's given me different approaches –how to approach my child under different situations and it did work… it makes a difference if you follow the literature or if you go by the HVs …

I feel I have been able to handle the frustrations better-when it comes to disciplining. … It's sure different disciplining since my parents were around-very different…

…it helped me deal with the older siblings anger.

… the times I want to freak out on my kid-I go to the bathroom-- part of my brain keeps clicking baby first, ok what should I be doing right now-- its like a dictionary in my head."

3) Parent Groups:

These were viewed positively, with a number of parents noting:
You go to the parent group and there are other mom's going through the same thing.

I love those groups…you learn a lot… more parent groups-it's a small group and you learn, at home you feel that you're the only one in the world and you go to a parent group and you are not.

4) Companionship:

It's much easier to make decisions when I have someone else to talk to and see what they are doing…I feel I am a better parent because of it.

It gives me companionship as well which is what I need at this time because I am going through a separation… having a baby by myself and raising children alone, it would have been a very difficult time for me if I didn't have somebody there.

7. Recommendations from PHN's, HV's and Families for Program Improvement

7(a). Recommendations from Public Health Nurses:

Public health nurses made a number of recommendations which were subsumed under two major themes of (A) training and (B) administration. Training recommendations addressed both public health nurse and home visitor roles. Administration included five sub themes with recommendations which related to 1) staffing and resources, 2) standardization of the program, 3) focus of the program, 4) documentation and demands on the home visitors.

A. Training: Training suggestions pertained to both public health nurses and home visitors. It was noted by public health nurses that home visitors needed additional core training, though the areas that this would focus on were less clear. One public health nurse noted:

they should be looking at some type of entrance level of education for HVs--I am not sure what it should be, maybe child development-- but then that would alter how it was run, because you could not pay educated people to do what they are doing at the same salary

More training for both public health nurses and home visitors was perceived as necessary:

…continued training for them as well as us (PHN)…maybe looking at those screening forms

…the whole process of setting up a chart...or where to send the paperwork… yes you got training on how to interview the client but then that was it…

PHNs need more orientation…as a PHN there needs to be a more thorough orientation.

…more training for the PHNs for dealing with the HVs would be a good thing--I didn't get any

I have an idea of what they go through…it would be nice to know what they know…I think the ones that do lead-role have that training but not the rest of us.

More training needs may be indicated by the following comments:

…more time for us to be able to figure out how to do our parents survey…

…the consent form is confusing…we have a lot of forms here to consent to the evaluation portion and it doesn't seem that we're consenting to the program…we are doing a lot more consenting to the evaluation…but it is the program...it's both right?

I was still under the perception that they had to score a certain number to qualify…really, I was just told that if you really think a person needs it, regardless of what they score, you could recommend that…I was hesitant and waited until the parents survey was done …but I almost think that maybe I could offer the program sooner…it's still a little confusing. (PHN).

Give me the book and you can go home now…that's exactly how I felt about the parent survey training.

…the whole process of setting up a chart…you got the training on how to interview the client, but then that was it…they didn't tell you the rest of the program…the way MB runs it.

…once I was doing a supervision role...it was huge, the amount of knowledge I found out that I didn't know as a PHN…you need a really good handle on what the HV's do…

In terms of training refresher courses on Families First were suggested for both public health nurses and home visitors involved in the program:

I think it should be mandated that we have a refresher once a year, like CPR—take a BF refresher as well.

I think it would be real good to have all the nurses have a refresher course-one day a year-just to review the program, to get some ideas from other nurses on what has worked for them, the difficult situations in the home…it's just nice to feed off of one another-because everyone is different.

B. Administration: Clearly across the four regions there are struggles with sufficient 1) staffing and resources. There were concerns also regarding 2) standardization, 3) focus of the

program, 4) documentation and 5) the home visitors themselves, in terms of demands on them.

1) Staffing and Resources:

...the recommendation from the US was a supervisor shouldn't supervise more than five people…at one point I was at nine--a full-time supervisor though, this is not a supervisor with other responsibilities like coordinating.

...we are still not funded as handsomely as they are in the States to provide the program. It may be a thought to look at some of the funding…supervision time, coordination time…really looking at what does that entail and how much is needed for a program.

...hiring a nurse to do the surveys would be nice but I know that's not in the future…they could use a lot more PHN time for doing surveys and less general duty.

...one recommendation would be having more resources to put into the program...more HVs, more PHNs that are trained.

Either getting more bodies in here so the work can spread out with public health or giving us more time, like each of us being allocated three hours a day ....for this

...our region split the lead nurse role into four districts…before it was just two, probably too much for them…I think that's why our communication doesn't always happen…more staffing would be good, not more lead nurses but maybe more time for the lead nurses.

2) Standardization: A number of public health nurses raised standardized delivery of the program as a concern with the following recommendations and/or comments made:

there needs to be an acknowledgement from the provincial office that the standards are not being met…they have so nicely put on paper the 12 or 14 standards…sent them out to the RHAs but the directors haven't done anything with them…they need to acknowledge a way to move forward and fulfill these standards, have consistency across the province as far as all the forms that are used and how much time the PHN's need to do the program.

...we finally got a standard document for documentation of visits, but we don't have anything standard for how supervisors provide feedback to the home visitors,

...I would like to see a little more consistency so that if someone moved (from one RHA to another) or a PHN moved there would be ...similarities. (This same PHN noted) things are so different from region to region and I know I can't tell them how to spend their dollars but at least if we had some standardized charting...more standardization from a provincial level... I think we are moving towards that...so let's keep striving towards it.

...the program is as if it is an add on to public health, it has provided some challenges to get people to buy into it...if it were phrased as a normal part of public health...just a more focused piece of what you should be doing or normally do...keep it under the umbrella of public health but let it stand alone.

Regions which are rural and remote appear to want more connection between regions, more information, more involvement, for instance as one PHN noted:

...communication of findings, information regarding what it is like in other regions, I need more involvement...I'd like to know how many charts are open, who has the case, who is being seen and whether staff are culturally competent.

3) Focus of Program: Comments in this area included both offering the program to more parents, extending the years of coverage, and building in more liaison with other services i.e. social work, mental health. Comments included:

...making it universal...(this comment was made from a PHN in a remote location who noted further)...there are not a lot of resources/services available in these communities... with the implication being the program may be the only program available for support.

...expanding it to include more people or have it accessible to more people...the community groups...some areas have had the community programs longer

...make the areas smaller so HVs are traveling less and they can be more focused in one or two communities so they become more visible and get more involved with community outreach kinds of things...that might be a way to broaden the program.

...some families have certain risks that are worth letting other organizations, whether it be CFS or mental health, or any one from these other programs...so we can gain some support from them...even if it is to call the mobile crisis unit...we have a situation on our hands that we are not sure how to deal with it

...working with more groups….an HV could start or initiate a Mom and Tot group that families in the neighborhood have in common...that may be a way to look at doing things in the future.

...encouraging parents… do you (Healthy Child MB) have parents on your board? I think it's a good idea to have…maybe a family that have been good clients for the last four years…instead of just people hired by the government…it lends itself to being more of a community program when families are in on the decision making.

With hesitancy, one public health nurse noted:

PHNs across the province would probably cringe if they heard me saying this…but I would say that the parent surveys should become a part of the normal post-partum assessment…I think they should just be done…sometimes despite the outward appearance of the family ...you come up with some pretty startling answers…we are doing a disservice by not asking those questions of everybody…if we eliminated that screening part and incorporated the survey more into public health practice I think we would provide a better service.

4) Documentation: Documentation was clearly an issue for a number of public health nurses and for home visitors as will be covered below. For public health nurses concerns were expressed in relation to the administration of the parent survey, the survey itself and their awareness of the documentation demands on home visitors as being excessive. Comments were fairly direct at times as noted by one public health nurse:

...get rid of the parent survey…or make it a check boxy form and have the computer default to 'no' unless yes is indicated…it's time consuming to fill in 39 no's.

...do something about the charting

...improve the scoring system

...did two days of training ..it was somebody from the U.S…they should have had somebody from BF say this is the way we do the paperwork in MB because I came back and didn't really understand…they didn't go through any of the paperwork in training...a lot of what they had shown we didn't use…the majority of it.

...cutting it back somehow, or more effective paperwork use, I don't know but it's a huge issue

The survey was uncomfortable for some public health nurses to administer potentially due to being in a smaller community where you know everyone. As one public health nurse noted:

> *...just to become more comfortable with the survey and the interview is taking me a long time…maybe some of that has to do with working in a small community where you know people a bit more...and the personal questions…*

5) Demands on Home Visitors: Some public health nurses were concerned for home visitors regarding the documentation demands but as well were concerned regarding being in high risk environments either within the home or in dire winter driving conditions without access to cell phones. While documentation issues may be similar across urban, rural and remote regions of the province the latter concern is specific to rural and remote regions.

> *...we really need to identify risk situations in the homes so it's identified for HVs for PHNs and as well for families.*

> *...you've probably heard this from the HVs…the amount of driving, the miles they put on their vehicles each week…even the safety...if you are twenty miles north of (town) in the middle of winter-they need cell phones…just the safety issues.*

7 (b). Recommendations from Home Visitors:

Recommendations were directed at the (A) program curriculum, (B) documentation, and (C) job satisfaction.

A) Program/Curriculum: Home visitors had a number of recommendations and/or comments to make regarding this area which focused on the inclusion of fathers, community programming, curriculum updates, groups and recruitment of families to the program.

> *...we are excluding Dads and they are part of the family…so we've changed the name, we need to include Dads but we need to have stuff for Dad's…the resources across the board are very much slanted for women and children…*

> *...nowadays there's a lot more Dads that have custody of their kids-it's the Moms that are taking off…so we need to let Dad's know they are important and encourage them*

> *I'd like to see more time for community programming because in so many cases that is where you are encouraging parents and getting them out, that is one of the biggest things we can do...get the families out into the community ...to work with other families*

...the curriculum is very basic...it doesn't have a lot of extra 'meat' to it…more variety is needed…

...finish modules contents…revamp all of it…I have gone up to the twelve months…just so there is more stuff to do.

...recognition that the group setting is a valid technique to use with families versus just the one on one

...it would be nice to get the families a little sooner…the PHNs are overwhelmed and we may not meet a family till baby is almost three months old…I think the more families we can get prenatal the better-I think it is much easier than doing it when the baby comes.

B) Documentation: This is a major issue for both public health nurses and home visitors. From the home visitor perspective the following comments were obtained:

No more paperwork! We do have a lot of paperwork ...summaries and charting is very long…if you have forty families that is forty hours of charting

...the paperwork is always changing

The evaluation survey was very frustrating for one home visitor who had serious concerns about some of the questions. As she notes:

Some of these questions are very ambiguous. One question is 'my HV and I feel that we are working on the changes that are appropriate for me'...a lot of my families don't like that question and I don't like it either because to me that insinuates to them that we are going in there to change them…

And then they have silly questions like, 'I believe my HV likes me' what are you really going to get out of a question like that…people look at me and say 'what is this –you are having me spend my time on a form that asks me if I think you like me??'

The parent survey was also criticized:

I put myself in those parents' shoes…there's a lot of personal questions in there and no wonder out of those 26 families we got 4 or 5 and then the majority of them said no ...you 'know' why they don't want the program.

(C) Job Satisfaction: Recommendations in this area related to remuneration, future career development, the home visitor role, peer networking and promotion of the program. Work environment and safety were also areas discussed by home visitors.

...pay us more…I think the whole thing about counseling, there is a fine line…they don't want us coming in as professionals, ...its important we come in as peers…but you are not counselors…its an ongoing tension how much is too much

...the pay is small…I honestly don't think we are paid enough for what we do…we have a big responsibility…we have an enormous role to play and I really don't think they pay you enough.

...the program wants to keep HVs once they are here because they are putting a lot of time, money and effort and these HVs have some pretty good skills after a few years

...its an incredibly challenging job--we do social work--we venture into those areas in a gray scale- we move into a lot of different areas that are very challenging…they take different abilities and they affect you outside of work…they should pay for what the job is…

In terms of the roles and career development some HVs note:

...have more counseling or give more responsibility in that way to the HVs…our supervisor, case manager and program manager freak out as soon as they hear the word counseling…but technically that's what we are doing...no one wants to admit that but we are doing those things that need to be done to get them to a place in order to be a better parent…they are building trust with us…they are fragile personalities and we have to be careful how we address it…I think they feel like I am handing them off like a football if I refer them to someone else.

I have to think is this (referring out) really going to help them or is the (referral) going to hurt our relationship and I am going to have to start all over with them again. This sometimes prevents me from making a referral.

The work environment is sometimes stressful and discouraging with home visitors noting:

...it's sometimes discouraging to have to get a letter approved ..because they have a degree

...sometimes hear complaints about nurses acting like they are our bosses too

...if supervisors were more acceptable and more approachable it might cut down on some of the tension

Building in connections between home visitors across regions would potentially create or contribute to enhancement of job satisfaction as one home visitor noted:

...to be able to build a bond with your other workers...so you know each other more...

...we should get together more as home visitors...just to discuss things, brainstorming

While training issues were not brought up frequently by home visitors one did note a reasonable recommendation:

...in core training... they didn't cover a lot of things that they should have...disability for one thing...when I asked about it I was sloughed off about it...they give you examples of all these perfect little families...there needs to be a reality...

Further to this the program 'Blueprint for Change' was noted which is a curriculum for dealing with more serious issues, as one home visitor notes:

...when we run into families that are having problems with addictions or depression they (FF program) talk about switching and using that curriculum (Blueprint for Change) but we don't have it and we don't have any training in that curriculum...

Also related to job satisfaction was the connection between program promotion to aid in clarifying their role as separate, distinct and indeed, far removed from Child and Family Services workers. As one home visitor noted:

Maybe some way to promote it (the program) in the community...have a little workshop...get us recognized...HVs tend to be thought of as child and family workers...the spy bit...getting the whole stigma of watchdog off of it (the program)

7 (c). Recommendations from Parents:

Parents' recommendations for the program were divided into four basic categories: (A) the home visit, (B) the curriculum, (C) administering the program, and (D) promotion of the program and program inclusiveness.

A) The Home Visit: Recommendations for the home visit included aspects of the Home Visitors and length of visits.

It just seems to me like the older ones are more experienced than the younger ones. I am not saying that the younger ones don't deserve to be working at Families First. It's just that they maybe haven't experienced quite as much as the older ones have. So they can't necessarily say, "oh I have experienced this or this is how I handled this" because it's just not the same.

I am just thinking (Home Visitor) never lets me know about the programs. The public health nurse lets me know about ...the programs. She'll say, "did you hear about this one or did (Home Visitor) let you know about this one-- like things in the community.

More home workers.

Longer visits, an hour to an hour and a half.

...to have more classes and opportunities that they do in the more urban places because I think in our rural areas we don't get as many opportunities for classes and stuff. Like, I went to Nobody's Perfect and it was excellent.

Having more time with the Home Visitors to talk with them.

B) The Curriculum: Recommendations for the curriculum included extension of the program to add more support to fathers, and more funding to support additional curriculum options such as groups.

I know that in the city there are fathers groups, there's a lot more. Even those baby clinics they get them once every how often, and it would be nice to have those more often too.

...I mentioned funding. I think (Home Visitor) has basically done a great job. I know she's tried to put together a few things, like she wanted to make a park for younger children, toddlers, because there is really no place for them to play and I think the town basically shrugged it off. So maybe more support from the town, maybe more support from other people.

...in the summer, maybe more group activities, outings, whatever.

C) Administration of the Program: Recommendations for administering the program focused on adding a daycare option to the program, more integration between agencies, and providing transport at certain times for certain services.

Recommend daycare every day... Get other people involved, like I've got my Families First person coming and I am with CFS. Say have a

group meeting with the social worker and (Home Visitor) and just see how things are going along. Because I have to tell the whole story 500 times.

Maybe a transit thing that goes to the hospital every once in a while for doctor appointments.

Here is just a thought. For those people who can't, like for me, I don't have a license, ...the FF program should have like a taxi thing to pick up parents and stuff...I miss a lot of the FF and Mother Goose stuff because my fiancée works and I don't have a license and that's hard.

D) Program Promotion: Parents' recommendations for program promotion and inclusiveness involved more advertising for the program, more targeting of fathers to enroll in the program, offering the program to more people, and adding workshops during evening hours to allow more people to become involved.

Much more advertising. I think it should be available to more people.

there is becoming more and more fathers having custody of their kids, they need help. Fathers were not brought up to look after children.

And now that I'm working I don't get to go to any of them. So maybe if there was an evening class. That would be a good idea too, for people that work.

Conclusions

1. General Conclusions:

1 (a). Participants:

Participants were drawn from four Regional Health Authorities three of which were rural and one was from remote Northern Manitoba. A respectable sample size for PHNs, HVs and parent participants was obtained. Unfortunately, no fathers were interviewed. Interviews with Aboriginal parents ranged from a low of 13% in Assiniboine RHA to 90% in the Burntwood RHA. The parents volunteered to participate in the study. Dissatisfied parents may not have been aware of the study and/or may have declined participation even if asked.

1 (b). Goals and Objectives of the Families First Program:

Most public health nurses and home visitors attributed multiple goals and objectives to the program. As described above, these goals related to a range of program components. This included program processes, outputs and outcomes. Goals and objectives focusing on how the program processes were implemented included: (1) the requirement that the program be individualized and tailored to the needs and circumstances of each family, (2) the necessity of an active outreach capacity and that the program be delivered in a manner which accommodates ethno-cultural and socio-

economic variation, and (3) the orientation of program activities toward enhancing the strengths of parents. These goals and objectives were not universally endorsed and some home visitors even expressed deficit and pathology oriented rather than strength-based process goals. Similarly, some public health nurses raised questions about accommodation of ethno-cultural variation.

Goals and objectives related to program outputs included both the direct provision of social support and the facilitation of formal and informal community support. This facilitation sometimes included active referral by the home visitor, sometimes enablement of the parents to connect to community support, sometimes reporting the need to public health nurses and supervisors (who in turn made the referral), and sometimes arranging activities which could provide a locus for the development of peer support. Direct provision included affective, cognitive and instrumental support functions.

Goals and objectives related to program outcomes included effects upon family relationships, parental capacity, child development, and reduction of child maltreatment. Healthy child development leading to success in adult roles was seen as the ultimate goal of the program. The more proximate milestone of school readiness and success was also mentioned by home visitors. Relationship enhancement goals related largely to the parent-child dyads and occasionally to the integrity of the family as a unit. The enhancement of parental capacity included both developmental knowledge and parenting and problem-solving skill components. Reduction of child maltreatment was mentioned only by public health nurses.

Finally, only one unintended negative effect was mentioned. That related to the development of dependence upon home visitor support. This might limit both the development of communal support and autonomous family problem solving capacities.

1(c). Public Health Nurse & Home Visitor Activities in the Families First Program:

Nurses and home visitors are involved in a complex range of direct service and program support functions. Two areas emerge from the program providers' perspectives which should be subject to more comprehensive review. One is the high level of documentation effort, especially by home visitors, for establishment of client eligibility, supervision, administration and evaluation. This may well be justified, but should be examined in cost-benefit terms, especially in locales where resources are insufficient to provide the desired level of service.

The other area which should be examined is the complex program staffing model for public health nurses. This has to do with distribution of supervisor, lead role and case management roles. Minimally, this requires significant communication costs. It may also create an arena for role conflict and tension for public health nurses, and of competing direction for home visitors.

1(d). Strengths & Limitations:

For both public health nurses and home visitors the program has a strong strengths-based focus which is viewed as the primary strength of the program. However there is variation here as some home visitors had more of a deficit-based view of the program as described above. Public health nurses also endorse the home visitors themselves as being essential to the strength of the program. In general training and orientation were viewed positively. From the home visitors perspective strengths were additionally defined as the program's curriculum, especially noting Growing Great Kids and Small Steps, Big Futures, the fact that the program is relationship oriented, that the program focuses on linking families to the community the service delivery team. That home visitors perceive as a strong back-up was viewed as a program strength.

Limitations of the program were noted as being its voluntary nature and the belief that some parents should be mandated to attend. Rural and remote areas were challenged by seasonal variants (weather) and difficulties connecting with families (no phones, moves dependant on season in part). Screening had numerous negative evaluations (too personal and intrusive, scares people away, inconsistently administered etc). The multiple roles public health nurses create stress regarding meeting all demands. Both public health nurses and home visitors were concerned about the documentation as has been described in many sections of this report. For home visitors there were some limits with regards to curriculum (resource material gaps), sufficient office space and the limitations they perceive within the job itself. They perceive lack of job future and limited pay as important issues.

1 (e). Impact on Parenting Skills:

In articulating how the program has been observed to improve parenting skills public health nurses and home visitors both described the decrease in stress and increase in coping strategies of parents. As well both groups focused on the improvements observed in parent-child relationships (increased bonding and attachment behaviors). Both groups also described many positive outcomes of parental learning whether it was in terms of activities with the child or behaviors for self-improvement (decision-making, problem solving). Where public health nurses describe a parent's readiness for change as key to improving parental response to the program home visitors suggest building contact time from 10 minutes to a full hour as a measure of success of the program. Home visitors further describe how the program is meeting the goals of Families First and of the increased self-esteem in the parents they see. The increase in trust and rapport, is seen by them, as being significant measures of success of the program. Home visitors further note that to truly measure success one needs to measure over time. They view success from minutes, through to one year of retaining a parent on the program, through to two years of retention. With each extension of time improvement can be seen.

1 (f). Parental Experience:

Most mothers were introduced to the program through the public health nurse shortly after the birth of their child or through prenatal classes. They were less sure about why they thought they were offered the program but joined for information, assistance and companionship. Notably one mother did indicate that her Child and Family Services

worker had said that if she participated she would be left alone, but ultimately, she found the program very positive and helpful and was glad to be involved.

Mothers valued their relationship with both public health nurses and home visitors and stressed accessibility, the non-judgmental style and information provided by each type of service provider. Descriptions were articulated of public health nurse activities being of a medical nature (immunizations, tests etc.) and home visitor activities being more broadly defined within information, play activities and advocacy. This is similar to distinctions made by program providers.

Mothers expressed satisfaction with the program focusing on the information provided, the activities, their relationship with the home visitor and the program's facilitation of access to resources. Negatives were minimal and usually focused on parents wanting more HV time or more visits or the program not having enough home visitors.

Mothers cited numerous benefits of the program noting the wealth of information received but qualifying that with the program they are raising their children differently, more positively. They note enhanced development of their baby and were well aware of the role of activities promoting brain stimulation. On a very personal level they identified changes in strategies utilized in parenting, in disciplining and in dealing with a child's anger and frustration. Some were very positive about parent groups and others appreciated the companionship with the home visitor that made them feel less alone in making decisions (especially for single mothers).

1(g). Recommendations from Public Health Nurses, Home Visitors & Families:

Public health nurse recommendations focused on training needs for both nurses and home visitors. There was lack of confidence in the public health nurse's ability to do the survey and concerns about its reliability in gaining accurate information. If parents did not trust them, (the nurses) they would not provide the necessary intimate knowledge of their life situation and hence would not be screened as eligible for the program. A similar lack of confidence was evident when it came to supervising the home visitors, in part due to not being totally familiar with the program curriculum. Refresher courses were recommended.

For public health nurses, administration of the program was very challenging with issues related to staffing and resources to supervise home visitors and to administer the survey. Examination of the roles of lead nurses, supervisors, case managers and coordinators that are set up differently across regions need to be conducted.

Standardization was an important issue for a number of public health nurses with some noting that standards expected are not being met, standards regarding supervision and providing feedback to home visitors were viewed as inconsistent and as such very problematic in that "things are so different region to region".

Conflict was evident in the desire to provide the program to everyone. Some felt that all parents could benefit and targeting only families at risk was frustrating for them. Ideas were generated regarding expanding the program through use of groups and more community outreach activities and provision of short-term support to mothers in lesser need. While the survey may create some stress there are some that would give it as part of the normal post-partum assessment. Public health nurses were also concerned with the demands on home visitors and about issues related to their safety (domestic situations as well as bad weather conditions in rural and remote areas).

For the home visitors concerns focused on three primary areas: the curriculum, documentation and job satisfaction. Numerous positive suggestions were put forth by home visitors including more father friendly information, starting the program earlier or as early as possible, streamline the documentation and improve some of the questions on both the parent survey and the survey utilized to evaluate the home visitors. Job satisfaction has some significant challenges (i.e. the pay is low, demands high and there is little room for advancement). The work environment can also be stressful (crowded office conditions, confidentiality issues and some stress related to tensions between people and process). Home visitors would like greater connection across regions such that they can feel connected and supported by each other. From a home visitor point of view, program promotion was desired as it related to differentiation of their service from child and family services and would help counter the idea or notion that they were "the spies" of the system.

From parents there is a desire for longer visits, more visits, more home visitors. There were curriculum recommendations (father groups and funding to support options such as groups targeting varied topics). Transportation was an issue for a substantial number of parents leading to the recommendation for some kind of transportation consideration. Parents also thought that there should be more promotion of the program as they knew many parents who could have benefited from the program but who were not aware of it. As there are more and more fathers raising their children, program promotion may help them as well.

2. Relationship of Findings to Child Maltreatment

2 (a). Reduction of Risk:

Reducing the risk for child maltreatment may come in the form of reducing parental stress, improving parental self-efficacy, enhancing parental empowerment and through the provision of nonjudgmental parental support. Enhancing community connectedness and/or reducing isolation may also be significant contributors to reducing a parents' risk for abusive behavior towards a child. These are clearly within the scope of services provided by home visitors and positive outcomes are being achieved through the Families First Program.

2 (b). Reducing Stress:

Public health nurses and home visitors both indicated that parents appeared more relaxed, had a calmer outlook, were more directed and generally less stressed. This is an important outcome. Cadzow, Armstrong and Fraser (1999), for instance have found perceived stresses related to finances, accommodation and relationships in the immediate postpartum period are associated with heightened child physical abuse potential at 7 months. Efforts to reduce stress and their success would be an important indicator of improving outcomes for children. Again, positive outcomes in this area are being observed and attributed to the impact of the program.

2 (c). Improving Parenting Self-Efficacy:

Many of the areas of improvement (improved child development knowledge, improved parenting skills including strategies and problem solving around child management issues) have implications for improvements in parents' beliefs about their abilities to successfully raise their children. The improvements noted in parent-child relationships as voiced by all three types of participants in this study (public health nurses home visitors and parents,) address the construct of parenting self-efficacy. Research into the construct of parenting self-efficacy is described as in its infancy (Clement, Wilkinson, Vimpani & Reynolds, 2003). However it would appear reasonable to suggest that the improvements noted in parental functioning as a result of the Families First intensive home visiting program are consistent with a parental self-efficacy construct. Self-efficacy theory incorporates not only parental self-confidence but also knowledge about behavior required to provide good care giving, including interpretation of baby's cues, knowledge of development and developmental milestones and knowledge of factors influencing development as noted by Hess, Teti and Hussey-Gardner (2004).

It would be fruitful to frame outcome measures for home visiting along these dimensions. Future evaluative studies with programs such as Families First would be advised to incorporate parenting self-efficacy measures as dependant variables. The improvements noted in parental functioning as a result of the program are encouraging.

2 (d). Empowering and Supporting Parents:

Home visitors and public health nurses repeatedly noted the strengths-based focus of the Families First program as a strength of the program. Within this framework home visitors worked towards not solving problems for their parents, but rather empowerment of parents such that they can resolve situations for themselves. This finding is consistent with the use of an empowerment approach as a key philosophy to health visiting (Houston & Cowley, 2002). This was repeatedly referred to in home visitor comments within a strengths-based framework.

Repeatedly parents described the relationship with home visitors as being very supportive from an emotional and educational perspective. This perception of the need of and satisfaction with social support, as well as size of networks were investigated by Diver (2003) to determine the role of support in predicting child abuse potential. Demographic variables were the least predictive, accounting for 28% of the variance in

abuse potential scores whereas social support accounted for 40% of the variance in these scores. Seven variables emerged as the most important in predicting abuse potential (self-esteem, self-differentiation, perception of stress, indirect coping strategies, age, education level and being married). In many interviews these issues were raised i.e. improved self-esteem, empowerment, reduced stress, enhanced coping in particular.
Notably age, education level and being married, were rarely mentioned as risk factors by public health nurses and/or home visitors.

2 (e). Increased Community Connectedness and Group Opportunities:

Within parent and home visitor suggestions there were positive comments made regarding the group focus for particular topics. Parents experienced some reassurance that they were not the only ones with the "problem" and home visitors felt that more topics could be delivered on a "group basis". In terms of the literature there is positive evidence for the use of group meetings for parents as a supplement to the home visiting process. Constantino (2001) found increased participation in the group process was associated with a trend towards improvement in parental capacity to interpret infant emotional cues and found that group meetings were an effective means of engaging stressed families in home visitation within an urban population.

2 (f). Relationship with Child and Family Services:

As Child Welfare goes through many changes on the Prairies, so too will the relationships with agencies providing supportive programs to parents. The results within this study point to an uneasy relationship currently. Indeed, home visitors want to put a lot of distance between themselves and child and family services and work hard to counter perceptions of being a "spy" for them. Another disconcerting view becoming increasingly visible is that Child Welfare apprehensions are increasing, not because of child maltreatment but to ensure the child has access to medical and/or other resources. This is based on personal communication with front line workers in child and family service agencies (2006). This trend if it exists, needs to be addressed from a statistical perspective as increasing rates of apprehension will not support the viability of a family support program through its apparent, though false, failure to reduce apprehensions.

Another source of stress, in particular for home visitors who are striving to develop trust with the families, is the ever present knowledge that they are required to report child abuse. In an analysis of the challenges of home visiting Ware, Osofsky, Eberhart-Wright & Leichtman (1987) found that with trust came previously hidden behavioral information (the slaps, name calling, strong feelings of rejection and anger toward baby) in adolescent parents. In a different approach to what is often used, in this case the home visitor increased attendance at the home, was vigilant regarding baby safety, worked towards enhancing mother's awareness of self and baby's needs and worked towards reporting but maintaining the relationship with mother. Ultimately a day treatment program was provided. This is raised as an example, albeit somewhat dated, of creative ways in which home visitors and public health could work together towards prevention of abuse.

3. Factors Limiting Program Impact/Program Improvement Focus

Several factors were found to limit impact and these need to be the focus of program improvement efforts.

3 (a). Counseling Needs of Parents:

It was clear from the interviews with the home visitors that there were ongoing struggles with defining what is and what is not counseling. In addition the referral resources available to the home visitors were often problematic (either not available and/or not effective). The degree to which the family unit continues to be highly stressed impacts not only the Home Visitors' capacity to deliver the program curriculum but the capacity of caregivers to apply the program effectively. Research documents, for instance, the decrease of treatment effects as domestic violence increases, which then limits the effectiveness of interventions to reduce the incidence of child abuse and neglect (Eckenrode, 2000). As research continues, the areas in which home visitors (lay) can improve family situations and which they cannot becomes clearer (Gray et al. 2001). The discomfort of the home visitor in dealing with some of the crises that parents find themselves dealing with combined with the lack of options for referring individuals within smaller and more remote communities may compromise program effectiveness and/or impact through difficulties in retention of parents in the program. Home visitors are also not necessarily comfortable with the resources available and sometimes feel if they do refer the client is not going to necessarily get the services they need.

3 (b). When to Start Involvement: Recruiting and Retaining Parents

It has been noted in the literature that early childhood prevention programs, aimed at decreasing the incidence of problems with children are more successful over the long term if they involve the parents, begin early in the child's life and address multiple risk factors (Normand, Vitaro & Charlesbois, 2000). In keeping with this approach, there was a fairly strong voice from both public health nurses and home visitors that there are benefits to starting involvement during the prenatal period. These were associated with enhanced parental involvement and retention according to both public health nurses and home visitors in this study. Additionally, effort directed at completing surveys in the prenatal period as opposed to leaving it until the baby was born would potentially help with the organization and flow of service delivery and the reduction of time delays.

As engaging families is a complex process fraught with difficulties in connecting due to distance, no telephones and other factors, it is important perhaps to use the prenatal period to build the relationship between parent and home visitor under conditions of less stress (before baby arrives). Olds (2003) has found retaining parents in home visiting programs has more to do with program characteristics than parent characteristics. Level of supervision for home visitors was an essential factor. If home visitors received more supervision they were more likely to make the extra effort required to track down parents who had moved within communities which were disorganized, high-risk and crime ridden.

3 (c). Documentation Overload:

It was fairly clear from public health nurses and home visitors that there is a serious overload occurring within the documentation area of the program. This is an area that is recommended for review at the earliest point possible. Hours demanded by documentation are hours extracted from program delivery. While needed for program evaluation the question of whether the data are an accurate reflection of program activities and impact becomes suspect when a recording system becomes cumbersome.

3 (d). Resources:

There are three areas in need of review which include: program resources within the curriculum; resources to the program in the form of counselor accessibility; and resources to deliver universal versus targeted program elements.

Resources within some regions are limited and home visitors would like access to a computer and the internet to supplement materials provided within the curriculum. In some areas while there may be a computer it is not accessible if the public health nurse is not there. Additionally, given that the program has been extended to include a more family focus as opposed to the focus on mother and baby there is a resource gap related to father friendly materials and home visitors are attempting on their own to fill this gap.

In addition to these areas, referral resources appears limited in some areas with an apparent disconnect between clients and referral agencies. This is not an unexpected outcome with counselors who are themselves likely overstretched, may lack cultural sensitivity and/or training to deal with highly complex family issues which in all likelihood have high rates of trauma and co-occurrence of substance abuse disorders.

The desire of public health nurses, home visitors and parents to see the program available to all would increase resource needs. However there are good suggestions made by the participants of the study regarding delivering some of the components of the program in a universal manner while maintaining a focus on a more targeted population. This is in keeping with MacMillan (2000b) who has noted that it is likely that a combination of universal and targeted approaches will be required in the attempt to decrease child maltreatment.

3 (e). Parent Experience:

Parents once involved, are very positive about the program and from their own report and reports of public health nurses, evidence significant improvement in parenting skills, strategies, confidence and self-esteem is present. The program thus receives a very positive evaluation overall.

Parents were unaware, for the most part regarding why they were selected for the program. This suggests a need for more transparency from the outset. The parent survey is by necessity intrusive in its questions, however the degree to which rapport is built and trust established with the parent influences survey outcome. Currently the program is risking excluding those that would otherwise be considered in need of the program by

virtue of the parent being uncomfortable with the interview process and choosing to avoid answering certain questions, or minimizing the degree of difficulty in certain areas. This becomes a limiting factor as the program is thus not reaching some of the intended target population.

4. Is the Families First Program Meeting its Goals?

The program's goals are to (1) facilitate families' abilities to ensure the physical health and safety of their children, (2) enable parents to build on their strengths and to foster the development of secure attachment with their child/children, (3) support parents in their role of nurturing their children and providing appropriate social, physical and cognitive stimulation for their children and (4) to facilitate a families' connections with community resources and build a sense of belonging in their communities (Healthy Child Manitoba, 2003).

This study has demonstrated through the voices of public health nurses, home visitors and parents positive results in all areas and provides a rich source for examining experiences of all participants. There are a number of areas of concerns. Participants had a number of viable suggestions for improvement that deserve consideration.

While some research has examined the impact of nurse home visitors as better than lay home visitors at reducing child maltreatment, this study demonstrates that from the perception of all of the participants and most notably the parents, both are valued and needed. Parents can clearly differentiate the type of service and activities public health nurses and home visitors provide within the Families First program and experience their relationship with each differently. Many of the positive benefits of the program depend on both public health nurses and home visitors for joint service provision and one of the keys to its success is the foundational relationship between the family and the home visitor, for without that relationship there is no program. This study also documents the complexity of delivering services to families at risk in rural and remote areas of the Province and the need for ongoing training, review and support.

As noted above, a number of recommendations were suggested and areas for potential future projects are emerging. The next phase for this project is to communicate results to Healthy Child Manitoba and the Regional Health Authorities involved to begin discussions of where we could best direct our efforts in response to the findings, recommendations and challenges documented within the study. Future research directions will not be formulated at this time as the above noted discussions need to occur.

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Appendix A: Tables

Group	Public Health Nurses	Home Visitors	Parents
Assiniboine RHA	8	13	16
Brandon RHA	5	6	11
BurntWood RHA	7	5	20
Parkland RHA	13	8	12
Winnipeg Inner-City	12	7	10
Winnipeg - Suburban	12	7	10

Table 1: Number of Interviews Conducted (Shaded area represents the study conducted by Chalmers et al. 2004)

Table 2. Characteristics of Public Health Nurse Participants by Regional Health Authority (RHA)

Characteristic	Assiniboine RHA n = 8	Brandon RHA n = 5	Burntwood RHA n = 7	Parkland RHA n = 13		Winnipeg RHA	
						Inner City n = 12	Suburban n = 12
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)
Age	46.00 (8.67)	39.80 (6.83)	40.29 (9.96)	45.54 (8.57)		49.75 (8.43)	42.00 (7.11)
Years of nursing experience	22.18 (11.18)	13.40 (10.69)	15.29 (11.01)	19.96 (10.00)		21.83 (10.44)	18.54 (10.52)
Years of public health nursing experience	14.63 (8.28)	11.15 (10.54)	6.71 (7.74)	9.73 (10.25)		14.67 (6.56)	13.33 (9.93)
Months of experience with Baby First Program	53.57 (22.74)	42.80 (32.17)	40.67 (23.27)	41.65 (26.21)		60.08 (18.71)	51.33 (16.23)
Number of home visitors worked with	5.88 (6.27)	6.80 (0.84)	5.00 (2.16)	4.77 (2.55)		5.25 (1.98)	4.83 (1.40)
Education in years	14.79 (6.32)	17.60 (1.34)	15.29 (4.68)	16.69 (2.36)		20.73 (3.58)	18.83 (2.66)

Winnipeg RHA figures (Chalmers et al., 2004)

Table 3. Characteristics of Home Visitors by Regional Health Authority (RHA)

Characteristic	Assiniboine RHA n = 13	Brandon RHA n = 6	Burntwood RHA n = 5	Parkland RHA n = 8		Winnipeg RHA	
						Inner City n = 7	Suburban n = 7
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)
Age	37.15 (11.05)	32.60 (9.81)	35.80 (9.15)	37.29 (6.32)		43.43 (8.64)	34.57 (10.95)
Education in years	14.92 (1.32)	14.67 (1.37)	11.80 (1.10)	14.81 (1.36)		15.64 (1.75)	14.21 (1.52)
Months of experience with Baby First Program	38.77 (18.80)	34.00 (31.18)	34.60 (24.33)	27.00 (25.37)		42.86 (21.93)	28.00 (13.66)
	n (%)	n (%)	n (%)	n (%)		n (%)	n (%)
Ethnic background Caucasian Aboriginal Other	 12 (92.3%) 1 (7.7%)	 3 (60.0%) 2 (40.0%)	 1 (20%) 4 (80%)	 5 (62.5%) 3 (37.5%)			
Marital Status Single/never married Married/common law Divorced/separated Widowed	 10 (76.9%) 2 (15.4%) 1 (7.7%)	 4 (100%)	 4 (80%) 1 (20%)	 6 (75%) 2 (25%)			

Winnipeg RHA figures (Chalmers et al., 2004; some Winnipeg stats unavailable)

Table 4. Characteristics of Parent Participants by Regional Health Authority (RHA)

Characteristic	Assiniboine RHA n = 16	Brandon RHA n = 11	Burntwood RHA n = 20	Parkland RHA n = 12		Winnipeg RHA	
						Inner City n = 10	Suburban n = 10
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)
Age of mother	26.5 (7.10)	23.73 (5.26)	22.12 (3.84)	26.42 (8.90)		25 (5.6)	24.3 (6.3)
Mothers' education in years	11.5 (1.59)	11.64 (1.57)	10.05 (1.73)	10.45 (1.70)		15.64 (1.75)	14.21 (1.52)
Months enrolled in Baby First Program	20.28 (13.83)	16.73 (17.97)	12.20 (9.46)	26.08 (20.90)		19.2 (12.65)	17.6 (13.17)
Amount of home visitors	1.63 (0.96)	1.46 (0.82)	1.32 (0.58)	1.67 (1.07)			
Amount of public health nurses	1.69 (2.85)	1.00 (0.45)	1.22 (0.65)	1.75 (1.22)			
Age of client child in months	16.09 (14.04)	13.68 (7.70)	9.60 (8.51)	17.13 (14.26)		17.05 (14.3)	12.3 (4.52)
Average number of siblings	0.60 (0.91)	0.73 (0.91)	1.60 (8.51)	1.67 (1.30)			

Winnipeg RHA figures (Chalmers et al., 2004; some Winnipeg stats unavailable)

Table 4 (continued) Characteristics of Parent Participants by Regional Health Authority (RHA)
Winnipeg RHA figures (Chalmers et al., 2004; some Winnipeg stats unavailable)

Characteristic	Assiniboine RHA n = 16	Brandon RHA n = 11	Burntwood RHA n = 20	Parkland RHA n = 12	Winnipeg RHA	
					Inner City n = 10	Inner City n = 10
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Enrolled in program						
Before birth of child	4 (25%)	1 (14.3%)	7 (35%)	2 (16.7%)		
After birth of child	12 (75%)	10 (90.9%)	13 (65%)	10 (83.3%)		
Ethnic background						
Caucasian	12 (80%)	7 (70.0%)	2 (10%)	2 (16.7%)	7 (70%)	9 (90%)
Aboriginal	2 (13.3%)	3 (30.0%)	18 (90%)	10 (83.3%)	3 (30%)	1 (10%)
Other	1 (6.7%)					
Marital Status						
Single/never married	5 (31.3%)	4 (36.4%)	8 (40%)	6 (50.0%)	4 (40%)	5 (50%)
Married/common law	10 (62.5%)	6 (54.5%)	12 (60%)	5 (41.7%)	5 (50%)	5 (50%)
Divorced/separated	1 (6.3%)	1 (9.1%)		1 (8.3%)	1 (10%)	
Widowed						
Occupational Status						
Working full-time	1 (6.3%)	2 (20.0%)		1 (8.3%)		
Working part-time	2 (12.5%)			1 (8.3%)		
Unemployed	2 (12.5%)	1 (10.0%)	6 (30%)	2 (16.7%)		
Maternity leave (full-time)	4 (25%)			1 (8.3%)		
Maternity leave (part-time)	4 (25%)	1 (10.0%)				
Full-time homemaker	3 (18.8%)	4 (40.0%)	14 (70%)	5 (41.7%)	9 (90%)	4 (40%)
Other		2 (20.0%)		2 (16.6%)		

Table 5: PHN Activities

Direct Service	Program Support
1. Screening and Eligibility 2. Response to Program Family Problems 3. Referral and Liaison 4. Provision of Primary Care through Other Roles	1. Supervision and Consultation to Home Visitors 2. Consultation to Other Public Health Nurses 3. Program Management Activities 4. Training of Home Visitors and Public Health Nurses

Table 6: HV Activities

Direct Service	Program Support
1. Home Visits 2. Educational and Networking Activities 3. Arranging Referrals	1. Participation in Supervision 2. Case Conferencing 3. Staff Meetings 4. Peer Consultation and Support 5. Development and Maintenance of Community Contacts 6. Assisting with Administration Tasks

Appendix B

Ethics Approvals, Forms, Questions and Participant Letters

Ethical Approval Process:

Ethical approval was received from the Brandon University Ethics Committee in November 2005. The proposal was reviewed in its entirety by each region from an ethical perspective before authorization to interview in the region was received. Following the procedure outlined in the Winnipeg evaluation (Chalmers et al., 2004) ethical issues of recruitment, consent, confidentiality, potential vulnerability and sensitivity were carefully considered. All participation in the study was strictly voluntary for this reason. All interviews and demographic forms were identified by code and maintained under lock and key. Names of participants in the evaluation were kept confidential and were not shared with other participants, agency personal, nor other members of the investigation. All findings and excerpts of interviews have been written in such a way as to avoid identification of participants. However, we acknowledge that it may not have been possible to maintain absolute confidentiality since agency staff may have prior knowledge of health providers' work and family cases.

Note: all forms, demographic questions, interview questions followed that developed by Chalmers et al. 2004 such that eventual comparisons between urban, rural and remote locations could be conducted.

Interview Guide

Public Health Nurses

1. Tell me about your involvement with the BabyFirst Program.

   Probe for length of involvement, process of orientation to the program, numbers of clients, time in the week, experience as a lead role nurse, etc.

2. What is your understanding of the goals and objectives of the BabyFirst Program?

3. What are the program components and how do these relate to the overall goals and objectives of the program?

   Probe: extent to which the program is implemented appropriately

4. In the course of a week, describe your activities related to the BabyFirst Program.

   Probe for role with home visitor, family documentation of program activities, etc.

5. Tell me about your experience in working with the home visitors.

   Probe: What works well and why? What does not work so well and why? How well were you prepared to work with/supervise the home visitor?

6. Tell me about your experience in working with the client families.

   Probe: What works well and why? What does not work so well and why? How did you attempt to create a positive environment for change?

7. In your view, what are the strengths of the BabyFirst Program?

8. In your view, what are the limitations of the BabyFirst Program?

9. What is the overall effectiveness of the Program?

10. a) Tell me about the impact of the BabyFirst on the rest of your workload.

    Probe: effect on other public health programs and priorities, etc.

    b) What is the impact of the rest of your workload upon your ability to meet BabyFirst expectations?

11. If you play a lead role with BabyFirst, are there any other issues you would like to discuss?

12. One of the goals of BabyFirst is to reduce potential for child maltreatment. What perception do you have of the success or failure in meeting this goal?

13. What recommendations (if any) do you have for improving the BabyFirst Program?

Interview Guide

Home Visitors

1. Tell me about your involvement with the BabyFirst Program.

   Probe for length of involvement, process of orientation to the program, numbers of clients, time in the week, etc.

2. What is your understanding of the goals and objectives of the BabyFirst Program?

3. In the course of a week, describe your activities related the BabyFirst Program.

   Probe for role with the family, interactions with lead role and case manager public health nurses, time spent making referrals to other resources, etc.

4. Tell me about your experience in working with the client families?

   Probe: What works well and why. What does not work so well and why? How well were you prepared to be a BabyFirst home visitor? How do you attempt to create a positive relationship with the family?

5. Tell me about your experience in working with the public health nurses?

   Probe: What do the lead role and case manager public health nurses do that helps you in your work as a home visitor? What do you not find helpful?

6. In your view, what are the strengths of the BabyFirst Program?

7. In your view, what are the weaknesses of the BabyFirst Program?

8. One of the goals of BabyFirst is to reduce potential for child maltreatment. What perception do you have of the success or failure in meeting this goal?

9. What recommendations (if any) do you have for improving the BabyFirst Program?

Interview Guide

Parents

1. Tell me about how you became involved with the BabyFirst Program.

   Probe: how did they become enrolled; process of orientation to the program; perception of choice; length of involvement with the Program

2. How did you think the BabyFirst Program would help you?

3. In the course of a week, describe the services you receive in the BabyFirst Program.

   Probe: numbers of home visitors, time in the week spent with home visitor/public health nurses, etc.

4. What do you like most about being involved in the BabyFirst Program?

5. What do you like least about being involved in the BabyFirst Program?

6. What does the home visitor do which you find helpful?

7. What does the home visitor do which you do not find helpful?

8. What does the public health nurse do which you find helpful?

9. What does the public health nurse do which you do not find helpful?

10. In your opinion, what are the overall benefits of the BabyFirst Program?

11. In your opinion, what are the weaknesses of the BabyFirst Program?

12. One of the goals of BabyFirst is to reduce potential for child maltreatment. What perception do you have of the success or failure in meeting this goal?

13. What suggestions (if any) do you have for improving the BabyFirst Program?

Please note that while the following information would be useful to the project, participants need not answer questions with which they are uncomfortable.

Data Collection Form
Public Health Nurse

Participant Number_____

1) Total number of years practicing in nursing _____

2) Total number of years practicing in Public Health Nursing _____

3) Total number of years practicing in Public Health Nursing in this city/town _____

4) Are you currently working full-time or part-time? (Please check)
   Full-time _____
   Part-time _____ If part-time, indicate number of hours per week ____

5) In total, how many years of education do you have? This includes total of grade school, high school, vocational, technical, community college, and university.
   _____ years

6) What diplomas or degrees do you have? (please check)
   Diploma in nursing _____
   Public health certificate _____
   Bachelors degree in nursing _____
   Bachelors degree (other) _____
   Masters degree in nursing _____
   Masters degree (other) _____
   Other (Specify _____) _____

7) What is your age in years? _____

8) What is your gender?
   Female _____
   Male _____

9) What is your current marital status? (please check)
   Single, never married _____
   Married/common-law _____
   Separated/divorced _____
   Widowed _____

10) Do you have children of your own?

Yes_____
No _____

If yes, how many children do you have and what are their ages?

Number of children _____
Ages of children _____

11) Which of the following best describes your racial/ethnic background?

White (Caucasian) _____
Aboriginal (First Nations, Metis, Inuit) _____
Other (specify_____) _____

12) Number of months involved with BabyFirst Program _____

13) Do you currently function as the *lead role* public health nurse for the BabyFirst Program in your community area?

Yes_____ No_____

14) Number of families you have worked with (both past and present) who have received BabyFirst home visitor services _____

15) Number of BabyFirst Home Visitors you have worked with _____

Thank you very much for participating in this project.

Please note that while the following information would be useful to the project, participants need not answer questions with which they are uncomfortable.

Data Collection Form
Home Visitors

Participant Number_____

1. Number of months employed as a home visitor with BabyFirst Program _____

2. Are you currently working part-time or full-time as a Home Visitor?
   Part-time _____ (If part-time, indicate number of hours per week _____)
   Full-time _____

3. Total number of families you have worked with as a BabyFirst home visitor _____

4. What is your age in years? _____

5. What is your gender?
   Female _____
   Male _____

6. What is your current marital status? (please check)
   Single, never married _____
   Married/common-law _____
   Separated/divorced _____
   Widowed _____

7. Do you have children of your own?
   Yes_____
   No _____
   If yes, how many children do you have and what are their ages?
   Number of children _____
   Ages of children _____

8. Which of the following best describes your racial/ethnic background?
   White (Caucasian) _____
   Aboriginal (First Nations, Metis, Inuit) _____
   Other (specify_____) _____
9. In total, how many years of education do you have? This includes total of grade school, high school, vocational, technical, community college, and university.
   _____ years

10. What certificates do you hold, if any?

11. Please describe your previous work and volunteer experience:

Thank you very much for participating in this project.

Data Collection Form
Parents in BabyFirst Program

Participant Number_____

1. For how many months have you been enroled in the BabyFirst home visiting program? _____ months.

2. During this time, approximately how many visits have you received from your home visitor? _____ visits

3. Did you start receiving the BabyFirst Program services before or after your baby was born? (Please check)
   Before my baby was born _____
   After my baby was born _____

4. How many BabyFirst home visitors have you had? _____

5. How many public health nurses have visited you while you have been enrolled in the BabyFirst Program? _____

6. What is the age of your youngest child? _____ months

7. What is your relationship to your child?
   Birth parent _____
   Stepparent _____
   Adoptive parent _____
   Legal guardian _____

8. How many other children are in your home, and what are their ages?
   Number of other children _____
   Ages of children _____

9. What is your age in years? _____

10. What is your gender?
    Female _____
    Male _____

11. What is your current marital status? (please check)
    Single, never married _____
    Married/common-law _____
    Separated/divorced _____
    Widowed _____

12. In total, how many years of education do you have? This includes total of grade school, high school, vocational, technical, community college, and university.

_____ years

13. What is your employment status?

Employed full-time and currently working	_____
Employed part-time and currently working	_____
Unemployed (out of work and looking for work)	_____
On maternity leave from a full-time job	_____
On maternity leave from a part-time job	_____
Full-time homemaker (not looking for work)	_____
Other (specify _____)	_____

14. Which of the following best describes your racial/ethnic background?

White (Caucasian)	_____
Aboriginal (First Nations, Metis, Inuit)	_____
Other (specify_____)	_____

15. Are you participating in the provincial evaluation of the BabyFirst Program?

yes _____

no _____

Thank you very much for participating in this evaluation project.

Invitation to Participate Letters*
and
Consent Forms *

*modeled after Chalmers et al. 2004

Note also: BabyFirst changed names to Families First (March 2005)

Invitation to Participate
Public Health Nurses and Home Visitors

We are conducting an evaluation of the BabyFirst Home Visiting Program from the perspective of the providers and recipients of the program. Public Health Nurses, Home Visitors, and clients receiving the BabyFirst Program are being asked to participate. This evaluation study will help us answer the following questions:

1) What are the perceptions of public health nurses involved with the *Baby First Home Visiting Program* regarding :
    - the training they received regarding delivery of the program
    - the implementation of the program
    - their experience in working with the home visitors and clients
    - strengths and limitations of the program and overall effectiveness
    - impact of program on other workload and program priorities
    - recommendations (if any) for change

2) What are the perceptions of home visitors involved with the *Baby First Home Visiting Program* regarding :
    - the training they received and ongoing supervision in the delivery of the program
    - their experience in working with clients and the public health nurses
    - strengths and limitations of the program and overall effectiveness
    - recommendations (if any) for change

3) What are the perceptions of parents involved with the *Baby First Home Visiting Program* regarding :
    - their experience in becoming involved with the program
    - their experience with their home visitor(s) and the public health nurse(s)
    - helpful and not helpful aspects of the program
    - recommendations (if any) for change.

If you agree to participate, either myself or my research assistant would interview you about your views on the BabyFirst Program and collect some demographic data (such as your age, education, gender, number of years work experience, etc.). The interview would take approximately one to one and a half hours (during work time), and would be done at a time and location convenient for you. The interview will be tape-recorded. At a later date, the tapes will be transcribed and the data analyzed. The audiotapes and transcripts of the interviews will be stored in a locked filing cabinet accessible only to the investigators, and destroyed 7 years following completion of the study. All information gathered in the interview will be kept strictly confidential. I will keep a list of participant names and code numbers that will be destroyed as soon as the study is completed, and this list will be stored separately from the interview data. The final results of the study will be based on group data, not individual responses. Your identity will

not be revealed, and your name will not appear anywhere. In this way no one will ever know how you, as an individual, answered the questions.

This evaluation has received funding from the Centre of Excellence for Child Welfare and Healthy Child Manitoba is a participant. It has been approved by the Brandon University Research Ethics Committee. A report will be prepared for the Centre of Excellence for Child Welfare and Healthy Child Manitoba, at the conclusion of the project. The results also may be presented at a conference or published in the form of a journal article.

Your participation in this study is completely voluntary and your decision about whether or not to participate will not influence your employment in any way. You are free to refuse to answer any of the questions you are asked. You are also free to withdraw from the study at any time, without any prejudice or consequence. There is no immediate benefit to you from participating in the study, although the information you provide may help improve the BabyFirst Program.

We hope you will consider participating in this project. If you are interested in participating, please complete the response sheet (attached) and mail it to the research coordinator, Noreen Ek, or leave a message for her at 727-7432. I or my research assistant will then contact you to arrange a time and place for the interview. If you would like any additional information before deciding whether to participate, please contact:

Dr. Noreen Ek, School of Health Studies, Ph. 727-7432

Thank you for your interest in this project.

Dr. Noreen Ek, R.P.N., B.A (Spec.), M.A., Ph.D.
Assistant Professor
School of Health Studies
Brandon University

Response sheet: If you are interested in participating in the evaluation of the BabyFirst Home Visiting Program, please complete this form and either give it or mail it to Noreen Ek, Research Coordinator, BabyFirst Evaluation, School of Health Studies, Brandon University, 270 18th St., Brandon, R7A 6A9 (or leave a phone message at 727-7432).

Name:_____

Phone no. _____

I am a: (please check)
Public Health Nurse (in a lead role for BabyFirst) _____
Public Health Nurse (a case manager for BabyFirst) _____
BabyFirst Home Visitor _____

I work in the following Community Area: _____

This is a : Suburban area _____
Inner-city area _____
Rural area _____
Northern/Remote area _____

Consent Form
Public Health Nurses and Home Visitors

I, _____, agree to participate in an evaluation of the BabyFirst Program being conducted by Dr. Noreen Ek. I understand that my participation will involve participating in an interview of approximately one and one half hours (during work hours) and completing a demographic data form. During the interview, the research nurse will ask me my views on various aspects of the BabyFirst Program. The interview will be tape recorded and the information recorded will later be transcribed. The audiotapes and transcripts of the interviews will be stored in a locked filing cabinet accessible only to the investigators and destroyed 7 years following completion of the study. All information gathered in the interview will be kept strictly confidential, except for a situation in which there is a legal requirement to disclose identity (e.g. child abuse situation). My name will not appear on any written documents. The final results of the study will be based on group data, not individual responses.

I understand that my participation in this study is entirely voluntary, and my decision about whether or not to participate will not influence my employment in any way. I am free to refuse to answer any of the questions, and to withdraw from the study at any time without consequence.

This research has been approved by the Brandon University Research Ethics Committee. I have had all my questions answered to my satisfaction and freely agree to participate in the study. I have been offered a summary of the project. I understand that I may contact Dr. Noreen Ek (Ph. 727-7432, if I have concerns, questions, or need additional information).

_____ _____
Signature of Participant Date

_____ _____
Signature of Research Coordinator Date

Invitation to Participate

Parents in BabyFirst Program

We are conducting an evaluation of the BabyFirst Home Visiting Program from the perspective of those who deliver the program, and those (like yourself) who receive the program. Public Health Nurses, Home Visitors, and parents receiving the BabyFirst Program are being asked to participate. This evaluation study will help us answer the following questions:

What are the perceptions of parents involved with the Baby First Program regarding :

- their experience in becoming involved with the program
- their experience with their home visitor(s) and the public health nurse(s)
- helpful and not helpful aspects of the program
- suggestions (if any) for change.

If you agree to participate, a research nurse would interview you about your views on the BabyFirst Program and collect some demographic data (such as your age, marital status, number of children, etc.). The interview would take approximately one to one and a half hours, and would be done at a time and location convenient for you. The interview will be tape-recorded. At a later date, the tapes will be transcribed and the data analyzed. The audiotapes and transcripts of the interviews will be stored in a locked filing cabinet accessible only to the investigators, and destroyed 7 years following completion of the study. All information gathered in the interview will be kept strictly confidential. The study nurse will keep a list of participant names and code numbers that will be destroyed as soon as the study is completed, and this list will be stored separately from the interview data. The final results of the study will be based on group data, not individual responses. Your identity will not be revealed, and your name will not appear anywhere. In this way no one will ever know how you, as an individual, answered the questions.

This evaluation has been contracted by the Centre of Excellence for Child Welfare and Healthy Child Manitoba and has been approved by the Brandon University Research Ethics Committee. A report will be prepared for the Centre of Excellence for Child Welfare and Healthy Child Manitoba, at the conclusion of the project, and the results also may be presented at a conference or published in the form of a journal article. A summary of the results will be provided to you if you would like one.

Your participation in this study is completely voluntary and your decision about whether or not to participate will not affect the care you receive in any way. You are free to refuse to answer any of the questions you are asked. You are also free to withdraw from the study at any time, without any prejudice or consequence. In order to compensate you for your time, you will be provided with a $20.00 honorarium for participating in the study. There is no other immediate benefit to you from participating, although the information you provide may help RHA's revise and improve the BabyFirst Program.

We hope you will consider participating in this project. If you are interested in participating, please let your BabyFirst home visitor know, and she will notify the research coordinator. Or you can contact the research coordinator directly by leaving a message at 727-7432. The research coordinator will then contact you to arrange a time and place for the interview. If you would like any additional information before deciding whether to participate, please contact:

Thank you for your interest in this project.

Dr. D. Noreen Ek
Assistant Professor
School of Health Studies
Brandon University

Consent Form
Parents in BabyFirst Program

I, _____, agree to participate in an evaluation of the BabyFirst Program being conducted by Dr. Noreen Ek. I understand that my participation will involve participating in an interview of approximately one and one half hours and completing a demographic data form. I will receive $20.00 to compensate me for my time. During the interview, the research nurse will ask me my views on various aspects of the BabyFirst Program. The interview will be tape recorded and the information recorded will later be transcribed. The audiotapes and transcripts of the interviews will be stored in a locked filing cabinet accessible only to the investigators and destroyed 7 years following completion of the study. All information gathered in the interview will be kept strictly confidential, except for a situation in which there is a legal requirement to disclose identity (e.g. child abuse situation). My name will not appear on any written documents. The final results of the study will be based on group data, not individual responses.

I understand that my participation in this study is entirely voluntary, and my decision about whether or not to participate will not affect the care I receive in any way. I am free to refuse to answer any of the questions, and to withdraw from the study at any time without consequence.

This research has been approved by the Brandon University Research Ethics Committee. I have had all my questions answered to my satisfaction and freely agree to participate in the study. I have been offered a summary of the project. I understand that I may contact Dr. Noreen Ek (Ph. 727-7432) if I have concerns, questions, or need additional information.

_____ _____
Signature of Participant Date

_____ _____
Signature of Research Coordinator Date