CLIENT, PUBLIC HEALTH NURSE AND FAMILY VISITOR ENGAGEMENT

ENGAGEMENT BETWEEN MOTHERS WITH CHILDREN AT-RISK OF

DEVELOPMENTAL DELAYS, PUBLIC HEALTH NURSES AND FAMILY

VISITORS IN A BLENDED HOME VISITING PROGRAM

By

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Abstract

This sandwich thesis summarizes the findings from two qualitative studies exploring the process of engagement among mothers with children at-risk for developmental delays, public health nurses (PHN) and family visitors (FV) in a blended home visiting program. The purpose of the phenomenological study (study #1) was to identify and describe factors which influence the establishment of a working relationship between FVs and at-risk families. In-depth, semi-structured interviews were conducted with a purposeful sample of six FVs and six PHNs. The analytic process revealed that PHNs have an important role in marketing home visiting programs and facilitating FV access into the home. Family visitor-client engagement occurred through "finding common ground" and "building trust." The purpose of the grounded theory study (study #2) was to explore the process of engagement from the client's perspective. In-depth, semi-structured interviews were conducted with a purposeful sample of 20 mothers who were receiving PHN and FV home visits. Clients engage with home visitors through a basic social psychological process of limiting family vulnerability. This process has three phases: (1) overcoming fear, (2) building trust, and (3) seeking mutuality. The personal characteristics, values, experiences, and actions of the PHN, FV, and mother influence the speed at which each phase is successfully negotiated and the ability to develop a connected relationship. Client characteristics that influence engagement include: preconceptions of PHNs and FVs, past experiences with service providers, motivation to participate, client attachment style, and the identification of specific health related needs. Remaining engaged in home

visiting is influenced by family beliefs about the value of the visits and the client's ability

to identify short-term benefits related to working with either the PHN and/or FV.

Increased understanding of these factors will assist both PHNs and FVs access those

families who are hard-to-reach and resist support and services.

Dauna Crooks took to explain the finer details of grounded theory to me. A special thank you to Rose Vonau for ensuring that all of my forms were completed and delivered.

Most importantly, thank you to my husband Richard. His never-ending supply of love, support, encouragement, technical assistance, and patience kept me focused and enabled me to achieve my goals. The arrival of Benjamin and Ryan this past year has brought me indescribable joy and enhanced my ability to stay organized, complete multiple tasks at once, and to remain focused on the important people in my life. Thank you also to my sister Lesley Moisey. With her help, I had extra time for writing and her incredible sense of humour always brought joy into our home. I am forever grateful to my parents, Bernie and Gail Moisey and my grandmother, Helen Keogh, who have supported my desire to continue my education and who have always believed in my ability to accomplish any goal.

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Chapter 1

Introduction

This doctoral dissertation is a 'sandwich' thesis, a compilation of four articles, one of which has been published and three of which have been prepared for future submission to scholarly nursing journals. The first three articles summarize my qualitative research findings about public health nurses' (PHN), family visitors' (FV), and clients' experiences of engagement in the *Healthy Babies, Healthy Children* program. The fourth article (Appendix A) is an exploration of the nurse-researcher and participant relationship that develops during the conduct of in-depth interviews. The purpose of this chapter is to provide background information on the *Healthy Babies, Healthy Children* program, to identify the clinical issues that led to the development of the research questions, and to describe the process undertaken to address the research questions.

Background Information on the *Healthy Babies, Healthy Children* Early

Intervention Program

There has been a long history of both professionals and lay persons providing care and services to families in the home environment (Kerr, 1991; Swift, 1995). Since the beginning of the 20th century, PHNs have routinely conducted home visits to provide support and information to families, primarily during the childbearing years (Lancaster, 1988). In 1987, the Ontario Public Health Branch was restructured and public health nursing practice experienced a shift from providing client-centered care to delivering

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program-focused services (Rafael, 1999). As a result, postnatal home visiting was severely reduced and even eliminated from some health units.

During the 1990s reports of harm to vulnerable children created a public outcry about the alarming and appalling state of child welfare. At the same time, significant findings about the importance of early childhood development and the benefits of intensive nurse home visitation in preventing child abuse were being disseminated (for example, Kitzman et al., 1997; McCain & Mustard, 1999; Olds et al., 1997).

As a response, in 1998, the Ontario Ministries of Health, and Community and Social Services developed a joint initiative under the auspices of the Office of Integrated Services for Children to implement an early intervention program, *Healthy Babies, Healthy Children*. The goal of the program is to promote optimal growth and development of children. The objectives of this voluntary program are to link families to community services, promote the development of parenting knowledge and skills, and increase the proportion of high-risk children who attain their appropriate developmental milestones on time (Ontario Ministry of Health, 1997). Local public health units are responsible for coordinating all aspects of this program.

The *Healthy Babies, Healthy Children* program offers universal services to all consenting families with newborns and targeted services to consenting high-risk families. Community agencies and physicians are also encouraged to identify and refer pregnant women who are experiencing multiple social problems to the program. Universal services include: postpartum screening, a telephone call and brief postpartum assessment by a PHN within 48 hours of discharge from hospital, and the offer of a home visit. To

determine the presence of family risk factors correlated with difficulties in providing infant care and successfully promoting child development, hospital nurses and midwives screen families using the *Ontario Ministry of Health Postpartum Screening Tool*. This screening instrument is a modified version (14 items vs.18 items) of the *Parkyn Priority Assessment Tool* which is a multifactor, weighted assessment form used to identify infants at-risk for developmental delays, failure to thrive, neglect or abuse, or physical or emotional problems secondary to other disabilities (Hanvey, 1997). The psychometric properties of the Ontario version have not yet been established. However, the original version of the *Parkyn* has been demonstrated to be a reliable tool when used by PHNs of all experience levels. The Pearson correlation coefficient was 0.95 when the tool was independently assessed by two nurses with the same family (inter-rater reliability), which exceeded 0.80, the standard that was set for the study (Parkyn, 1985). The tool development committee established content validity through a comprehensive review of the literature. Then a panel of four experts rated the items on the screen for relevance (Parkyn).

Using data from the provincial evaluation of the *Healthy Babies, Healthy Children* program, during the period from July 2000 to June 2001, 92% of live births in Ontario were screened and referred to public health. Of all families referred, 98% received a PHN telephone call and assessment within two to eight days post hospital discharge. Of the families called, 49% accepted a postpartum home visit from a PHN (ARC, 2002).

Targeted services for high-risk families include: further screening and assessment, referrals to other community supports and services, service coordination, and long-term home visiting by both PHNs and family visitors (FV). A FV is a lay person with training in child development, parenting skills and community resources. The needs of the family, as assessed by the PHN, determine the content, frequency and duration of home visits (ranging from weekly to monthly). In this blended model of home visiting, provincial guidelines recommend that families receive PHN and FV visits at a ratio of 1:3 (Ontario Ministry of Health, 1998). From July 2000 to June 2001, 22% of live births in Ontario were identified through the universal screen as at-risk for developmental delays. As part of the targeted services, 7% of live births received one or more blended home visits (ARC, 2002).

Statement of the Problem

One of the challenges of home visiting, identified both from clinical practice and in the home visiting literature, is the difficulty in consistently accessing and working with some high-risk families (Byrd, 1995; Chalmers, 1994; Luker & Chalmers, 1990). The barriers to entry erected by the family make it difficult for home visitors to address the identified health needs of the family. Many of the families who are enrolled in the *Healthy Babies, Healthy Children* program are socially and economically disadvantaged, young, and facing multiple stressful life events. The *Healthy Babies, Healthy Children* program is a voluntary program in which families are offered a choice to accept or refuse a home visit.

Within the *Healthy Babies, Healthy Children* program, many families identified as having infants at-risk choose not to participate in any or all aspects of the program. In 2001, at the Middlesex-London Health Unit where data for study two were collected, 30% of live births screened and identified as 'at-risk' refused a referral to the program and a further 20% were not assessed by a PHN within 48 hours of hospital discharge. Family refusal and the inability of the PHN to locate the family were the most common reasons provided for not completing the assessment (Middlesex-London Health Unit, 2001).

As a PHN home visiting high-risk families, I often found that families would not be home at our scheduled appointment time or that the family had moved, the phone had been disconnected and I had no method of contacting them. Even more frustrating were those times when I would arrive for a home visit, stand outside the client's house and ring a doorbell that no-one would answer even though I could hear voices and could glimpse movement in the house through curtained windows.

During the spring of 1998 the father of a family that I had been visiting for several months shared his feelings about my visits to their home. He said, "Although you are very nice and helpful, you will never understand the stress we go through before you come here. How will we be judged? Will we have done something wrong in parenting our son?" This took me by surprise. For the first time, I began to reflect on how it must feel for a young, poor family to have a professional, middle-class stranger enter into their home to teach them about their child's health and parenting. Kristjanson and Chalmers (1991) declared that to "assume that nurses enter family systems and effect only

benevolent results is naive and professionally arrogant" (p. 149). Dingwall (as cited in Zerwekh, 1992) explains that PHNs are often viewed as "agent[s] of the state" who are invading the privacy of the family home (p. 104). Public health nurses have a dual, but sometimes-conflicting role, of empowering parents and monitoring the safety and well being of the children (Zerwekh).

In 1999, I was a Program Manager, Family Health at an Ontario public health unit and one of my roles was to supervise PHNs and FVs in the *Healthy Babies, Healthy Children* program. The nurses' experiences working with high-risk families reflected my own clinical experiences. Much of their time was spent trying to locate and negotiate entry into the homes of families of children at-risk. One rationale for hiring lay or paraprofessional home visitors in the program was the assumption that they would share common experiences and values as the families they visited and that these would facilitate access into the home. To my surprise, many FVs also started to express their frustrations and share anecdotal accounts about the number of families they were assigned to work with who cancelled and rescheduled, or consistently missed appointments.

In a review of the home visiting literature, it became evident that the process of accessing and engaging high-risk families was a universal concern for professional and paraprofessional home visitors trying to deliver preventive health care services. The following issues have consistently been identified as research priorities to improve the quality and implementation of home visiting programs:

- To identify factors that facilitate or inhibit family engagement and participation in home visiting programs (Center on Child Abuse Prevention Research, 1996; Gomby, Culross, & Behrman, 1999)

- To identify client needs for health information, referral, frequency of visits, and support from nurses (McNaughton, 2000)

- To describe client experiences of engaging with home visitors and of participating in home visiting programs (American Academy of Arts and Sciences, 1994; McNaughton)

In my review of the literature no studies were located that described the process or experience of home visiting when conducted by paraprofessionals. We therefore do not know if paraprofessionals gain entry into clients' homes and build relationships with at-risk families in the same way as nursing professionals. Also, the role of the PHN and her influence on the development of a relationship between paraprofessionals and at-risk families has not been explored. A need has been identified for research on the interactions between lay home visitors and at-risk families that have a positive impact on family and child health (Center on Child Abuse Prevention Research, 1996; Olds & Kitzman, 1993).

Research Process

Symbolic interactionism is a theoretical perspective in which society is viewed as a dynamic process of ongoing activity and varied, reciprocating interactions based on symbolic communication (Kendall, 1999). By using symbols to represent objects, humans are able to establish shared meanings in their interactions with others (Milliken

& Schreiber, 2001). Therefore, Kendall explains that 'with whom, with what, and how one interacts becomes a major determinant in how one perceives and defines reality." (p. 744). If behaviour is based on constructed meanings, then it is important to identify those meanings in order to understand and explain human actions (Milliken & Schreiber). For this reason, phenomenology was the methodology selected in study one to understand FVs' experiences of working with high-risk families. In study two, the purpose was to not only understand mothers' experiences of being home visited, but to also discover the behaviours and processes used to interact and engage with PHNs and FVs. Therefore, the selection of grounded theory was a more appropriate methodology to meet these objectives.

Study One

In 1997, I was admitted to the Master of Clinical Health Sciences (Nursing) Program at McMaster University. My coursework was completed by December 1998. The title of my research project was "Factors which influence the establishment of a working relationship between lay[1] home visitors and at-risk families." The purpose of this phenomenological, qualitative study was to explore lay home visitors' lived experiences in establishing relationships with at-risk families within the context of the *Healthy Babies, Healthy Children* program. Data for this study were collected in Spring 1999 in a Central West Ontario public health unit.

For this study, the research questions were:

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[1] As the *Healthy Babies, Healthy Children* Program has evolved, the title of the paraprofessional home visitors has switched from 'lay home visitor' to 'family visitor.'

1. What is the experience of establishing a working relationship between lay
   home visitors and at-risk families?

2. What factors influence the establishment of a working relationship between
   lay home visitors and at-risk families?

The specific objectives of the study were to:

1. Explore experiences of lay home visitors when accessing at-risk families and
   to identify factors which facilitate and/or hinder entry into the home

2. Describe lay home visitors' perceptions of what makes a home visit successful
   or unsuccessful and determine which factors are related to the lay home
   visitor, the referred family, the referring PHN, and/or the environment

3. Explore PHNs' views about the roles and value of the *Healthy Babies,
   Healthy Children* lay home visitors

At this point, I made the decision to transfer into the Ph.D Clinical Health Sciences

(Nursing) Program. In July 1999, the study findings and recommendations were

summarized in a final report and successfully defended at an M.Sc to Ph.D transfer

examination.

In Chapter 2 of this thesis, findings from this study are presented in an article

titled *Opening Doors: Factors Influencing the Establishment of a Working Relationship

Between Paraprofessional Home Visitors and At-Risk Families*. This article has been

published in the Canadian Journal of Nursing Research[2]. Permission has been granted by

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[2] Jack, S., DiCenso, A., & Lohfeld, L. (2002). Opening doors: Factors influencing the establishment of a
working relationship between paraprofessional home visitors and at-risk families. Canadian Journal of
Nursing Research, 34(4), 59-69.

the managing editor of the journal to include the article in my thesis. McGill University holds the copyright privileges of the original published article. Dr. A. DiCenso and Dr. L. Lohfeld, the co-authors of this article, have granted their written permission to include the article as part of the thesis. As the principal investigator and lead author, I was responsible for conceiving the study question, designing the study, collecting and analyzing the data, and writing the final report. Dr. DiCenso was my thesis supervisor who provided supervision throughout the process and Dr. Lohfeld is an experienced qualitative researcher who provided expertise related to the design of the study and the data collection, analysis and interpretation.

Study Two

Once admitted to the Doctoral program, I successfully completed my coursework and comprehensive examination by December 2000.

The purpose of my doctoral research was to develop a theory grounded in the data that describes the process of high-risk mothers' engagement with PHNs and FVs within the context of a blended home visiting program. The overarching questions for my grounded theory study were:

1. What is the basic social psychological problem or issue that mothers with children at-risk experience during the engagement phase with public health nurses and family visitors in a blended home visiting program?

2. What social psychological process do mothers with children at-risk use to resolve this problem?

The study objectives were:

1. To describe the key events in the process of maternal engagement.

2. To identify the factors that facilitate and/or inhibit engagement with professional and paraprofessional home visitors.

Participants were recruited from a South-West Ontario public health unit. Data collection and analysis commenced in Spring 2001 and concluded in Winter 2002. From February until September 2002, I took a maternity leave. As the principal investigator for this study, I was responsible for conceiving the research question, study design, and for collecting and analyzing data. In Chapter 3, the process of maternal engagement is described and in Chapter 4, maternal factors that influence this process are identified.

Appendix A

In Appendix A, I have chosen to include an article adapted from a paper submitted for partial fulfillment of the comprehensive examination requirements. In this article the relationship between clinician-researchers and research participants within the context of qualitative interviews is examined. Issues that arise during interviews related to role conflict and the desire to provide clinical interventions are discussed. Questions for consideration are proposed to assist researchers to reflect about the nature of the relationship they establish during an interview so that both the credibility of the data and the participant's integrity can be maintained. This article is important to include as part of the doctoral thesis as it highlights some of the methodological challenges I experienced while collecting data from study participants.

References

American Academy of Arts and Sciences (1994, June). Revisiting the issues: Home
visiting. [Online]. http://amacad.org/revisit.html [1999, April 10].

ARC Applied Research Consultants (2002). Evaluation of the *Healthy Babies, Healthy
Children* program: Middlesex-London Health Unit 2001-2002. Toronto, ON:
Prepared for the Integrated Services for Children Division, Ministry of
Community and Social Services and Ministry of Health and Long-Term Care.

Byrd, M.E. (1995). The home visiting process in the contexts of the voluntary vs.
required visit: Examples from fieldwork. Public Health Nursing, 12, 196-202.

Center on Child Abuse Prevention Research (1996). Intensive home visitation: A
randomized trial, follow-up and risk assessment study of Hawaii's Healthy Start
Program. Final report prepared for the National Center on Child Abuse and
Neglect. Chicago, IL: National Committee to Prevent Child Abuse.

Chalmers, K.I. (1994). Difficult work: Health visitors' work with clients in the
community. International Journal of Nursing Studies, 31, 168-182.

Gomby, D.S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program
evaluations-analysis and recommendations. The Future of Children, 9(1), 4-26.

Hanvey, L. (1997). *Healthy Babies, Healthy Children*: Rationale for screening and
assessment tools. (Unpublished document). Toronto, ON: Ontario Ministry of
Health.

Kendall, J. (1999). Axial coding and the grounded theory controversy. Western Journal of
Nursing Research, 21, 743-757.

Kerr, J.R. (1991). Early nursing in Canada, 1600-1760: A legacy for the future. In J.R.

    Kerr & J. MacPhail (Eds.). Canadian nursing: Issues and perspectives (2nd ed.).

    Toronto: C.V. Mosby.

Kitzman, H., Olds.D.L., Henderson, C.R., Hanks, C., Cole, R., Tatelbaum, R., et al.,

    (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy

    outcomes, childhood injuries, and repeated childbearing: A randomized controlled

    trial. JAMA, 278, 644-652.

Kristjanson, L.J., & Chalmers, K.I. (1991). Preventive work with families: Issues facing

    public health nurses. Journal of Advanced Nursing, 16, 147-153.

Lancaster, J. (1988). History of community health and community health nursing. In M.

    Stanhope & J. Lancaster (Eds.), Community health nursing: Process and practice

    for promoting health (pp. 3-27). Toronto, ON: C.V. Mosby.

Luker, K.A., & Chalmers, K.I. (1990). Gaining access to clients: The case of health

    visiting. Journal of Advanced Nursing, 15, 74-82.

McCain, M.N., & Mustard, J.F. (1999). Reversing the real brain drain: Early years study

    final report. Toronto, ON: Prepared for the Government of Ontario.

McNaughton, D.B. (2000). A synthesis of qualitative home visiting research. Public

    Health Nursing, 17, 405-414.

Middlesex-London Health Unit (2001). Healthy Babies, Healthy Children activity report

    (ISCIS Report). London, ON: Unpublished document.

Milliken, P.J. & Schreiber, R.S. (2001). Can you 'do' grounded theory without symbolic

interactionism? In R.S. Schreiber & P.N. Stern (Eds.), Using grounded theory in nursing (pp. 177-190). New York: Springer

Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H., Powers, J., Cole, R., et al., (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. JAMA, 278, 637-643.

Olds, D.L., & Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. The Future of Children: Home Visiting, 3(3), 53-92.

Ontario Ministry of Health (1997). Implementation guidelines for the *Healthy Babies, Healthy Children* Program. Toronto, ON.

Ontario Ministry of Health (1998). Implementation guidelines for the *Healthy Babies, Healthy Children* Program: Phase 2. Toronto, ON.

Parkyn, J.H. (1985). Testing the reliability and validity of a weighted multifactor assessment form for identification by public health nurses of infants and preschool children at-risk. (Unpublished document). Kamploops, B.C.: Author

Rafael, A.R.F. (1999). From rhetoric to reality: The changing face of public health nursing in southern Ontario. Public Health Nursing, 16, 50-59.

Swift, K.J. (1995). Manufacturing 'bad mothers': A critical perspective on child neglect. Toronto, ON: University of Toronto Press.

Zerwekh, J.V. (1992). The practice of empowerment and coercion by expert public health nurses. Image: Journal of Nursing Scholarship, 24, 101-105.

Chapter 2

Opening Doors: Factors Influencing the Establishment of a Working

Relationship Between Paraprofessional Home Visitors and At-Risk Families

Key Words: home visiting, client-provider relationship, public health nurses, paraprofessionals, trust

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This article has been published.

Abstract

The purpose of this phenomenological study was to identify and describe factors which influence the establishment of a working relationship between paraprofessionals and at-risk families. In-depth, semi-structured interviews were conducted with a purposeful sample of six family visitors and six public health nurses employed to home visit at-risk families. The analytic process revealed that nurses have an important role in marketing home visiting programs and facilitating family visitor access into the home. Factors related to the family visitor, the client and the client's household influenced relationship development. Family visitor-client engagement occurred through "finding common ground" and "building trust." Increased understanding of these factors will assist both nurses and family visitors access those families who are hard-to-reach and resist support and services. Findings also have implications for nurses who are responsible for hiring, training and supervising family visitors.

A family visitor is a paraprofessional from the local community who provides social support and health education, promotes child development and connects families to community resources (Ontario Ministry of Health).

Literature Review

There is an extensive base of home visiting program evaluation literature. Home visiting programs are generally classified as one of three types: professional, paraprofessional or blended, a program that utilizes a mix of both professionals and paraprofessionals. A series of rigorous randomized controlled trials (RCT) evaluating American home visiting programs, that use highly trained nurses, demonstrated multiple positive maternal and child outcomes, especially for those families most at risk (Olds et al., 1999). A subsequent RCT examining the effectiveness of home visiting by nurses and by paraprofessionals, as separate service providers, to improve maternal and child health outcomes concluded that for most outcomes on which the nurses produced beneficial effects, the paraprofessionals' effects were approximately half the size (Olds et al., 2002).

Despite the evidence to support the use of nurse home visitation programs, many governments and agencies have implemented paraprofessional home visiting programs, or as in Ontario, a blended model. It is challenging to synthesize results from evaluations of paraprofessional programs because of the complexity and diversity of programs (which vary in terms of purpose, intended outcomes, and target population); and variation in home visitors (characteristics, education and experience), duration and intensity of the home visiting, and the type of intervention provided during the home visit. However, a recent and thorough systematic review of the effectiveness of paraprofessional home

visits summarized 21 studies, four of which were rated as methodologically strong and 17 as moderate (Wade et al., 1999). The authors concluded that paraprofessional interventions can positively impact child development and parent-child outcomes especially when an intense number of visits are offered (weekly or bi-weekly for a minimum of one year), when started during the prenatal period, and when part of a multifaceted program that offers professional support and links families to other services and resources.

Therefore, there is evidence to suggest that participating in a home visiting program can have a positive impact on a high-risk family's overall health and well-being. However, it is estimated that 10-25% of eligible high-risk families choose not to participate and of those who do participate, between 20-67% will eventually leave the program before their goals are met (Gomby, Culross, & Behrman, 1999). Program attrition rates are higher when the home visitor is a paraprofessional instead of a nurse (48% vs. 38%, p= .04) (Korfmacher, O'Brien, Hiatt, & Olds, 1999). Reasons for prematurely leaving a home visiting program may include moving, gaining employment, death or removal of a child or a lack of interest in participating (Gomby et al.). The failure to establish a supportive and empathetic relationship built on a foundation of trust between the home visitor and the mother may also result in premature termination (Gomby et al.; Robinson, Emde, & Korfmacher, 1997).

If lay home visiting is to have a positive impact on the health and well being of at-risk families, it is essential to understand and promote the factors that influence the establishment of a trusting lay visitor-client relationship. Anecdotal evidence suggests

that clients are able to quickly establish rapport with paraprofessional visitors when they share common life experiences and the visitor shares her life history (Hiatt, Sampson & Baird, 1997). In my review of the literature, no qualitative studies were located that described the process of paraprofessional-client engagement or the home visitors' experiences working with at-risk mothers and/or public health nurses. There is also a large gap in the literature describing the work of Canadian paraprofessionals given that most of the lay home visiting program evaluations focus on the delivery of services to urban, high-risk American clients.

Study Purpose and Research Questions

The purpose of this study was to explore family visitors' lived experiences in establishing relationships with at-risk families. The research questions were: 1) what factors facilitate and/or hinder family visitor entry into the home and engagement with the family? and 2) what is the role of the public health nurse in the development of the family visitor-client relationship?

Method

Phenomenology was the qualitative approach selected for this study of family visitors' experiences engaging with at-risk families. The goal of phenomenology is not to develop models or theories but to accurately describe an individual's lived experience of the phenomenon under study (Ploeg, 1999). The study was approved by the Research Ethics Board, McMaster University, Hamilton, Ontario.

Sample

Participants were recruited from a Central West Ontario Health Unit that provides services to clients living in both rural and small, urban communities. All six family visitors employed by the health unit participated in the study. The study also included a purposive sample of six public health nurses, experienced in home visiting at-risk families, who are responsible for making referrals to the family visitor component of the HBHC program. The nurses were included in the study to examine how nurses' perceptions of family visitors influences relationship development with the client.

All of the family visitors interviewed were female with an average age of 41 years. Five were married, one was separated and all but one were mothers. Three of the family visitors had a university degree, two had a college diploma and one had completed some post-secondary education. They had on average 14.5 months experience working as HBHC family visitors. The nurses were all married females with an average age of 45 years. Five of the nurses had a bachelor's degree in nursing, and one nurse had a public health nursing diploma. They had on average 23 years of experience as registered nurses and 16 years in public health nursing.

Data Collection and Analysis

Data were collected during in-depth semi-structured interviews. Each family visitor and public health nurse participated in one 60-90 minute interview about their experiences home visiting at-risk families. The principal investigator also maintained field notes and a reflective journal. All interviews were tape recorded and transcribed verbatim. As is the norm in qualitative research, data analysis occurred concurrently with

data collection. Colaizzi's (1978) framework was used to guide the data analysis. First, transcripts were read in their entirety to make sense of the participants' descriptions of engagement. Significant statements about accessing and engaging with clients were then extracted and the meaning of each statement was formulated. Formulated meanings were then organized into theme clusters and a written description of the participants' experiences was created. Finally, I revisited the participants to validate if the theme clusters and my written interpretation accurately described their lived experience (member checking).

Results

Selling the program

The nurses talked extensively about the frustration they felt because the highest risk clients were least likely to accept a referral to the family visitor component of HBHC:

> Many times families who are at-risk don't see themselves at risk. They don't necessarily want the [family visitor], don't see it as they need it. My overall feeling is that the people who really need it don't always take it. They don't see the potential benefits of having someone involved.

When the nurses assessed that the introduction of a family visitor into the home would be appropriate then they had to convince or "sell" the family on the benefits of the program. Several of the nurses identified that many of the at-risk families they visit have numerous professionals involved in their lives. They expressed concern that the introduction of another individual into the home, the family visitor, might overwhelm families. According to the nurses, families were more receptive to the referral if the nurse was first able to establish rapport and trust with the client and other household members.

Once the decision had been made to seek consent for a referral to a family visitor, the nurses identified two ways they "sell" the program to families. One is by giving the family written information on the HBHC program. The second way was to clearly describe the family visitor's role using non-threatening language. The family visitors also stressed that how well their relationships start with the families depends on how well the nurses "marketed" or "sold" their services:

> The public health nurses are key because they know a lot about [the program]. I'm hoping they sell it very well to parents because they know what it's about. They can give the parents a realistic idea of exactly what's going to happen. I think as long as the parent has a very good understanding of what exactly is going to happen, they feel more comfortable, and that is what creates success.

Getting in the door

The family visitor's physical access to the home was facilitated when the nurse clearly informed the family about her role and purpose prior to the first visit. All the family visitors, and some of the nurses, explained that they had found it beneficial to make the first home visit together. A conjoint visit allows the family to see the family visitor and nurse working together for a common purpose and provides another opportunity for role clarification:

> PHN: I think that there will be times when these families won't be able to tell the difference between a nurse and a family visitor. I want to make [it] very clear to the families that I will still be involved and that I am the nurse and she's more the friendly visitor.

The family visitors also identified several strategies used when they experienced difficulty gaining physical entry into the home. These strategies included leaving notes on the family's door, making unplanned visits, consulting with the nurse to decide the

next steps and connecting with families by telephone to explore their reasons for missing the appointment.

Finding common ground

Once physical entry into the home has been made the family visitor then has to gain emotional entry into the family's life. The family visitors identified several characteristics of both themselves and the clients that influenced this process. During the initial home visits the family visitors explained that they enter into the client's home and present themselves as non-judgmental, supportive, and non-threatening. They then work towards identifying common ground or shared experiences with the client. Most frequently the family visitors shared information about their personal experiences as parents. Also, sharing the same language and culture as the family often made it easier to develop the relationship:

> I talk a little about myself. I find it can be helpful, a small disclosure; not really telling my life story, but a little disclosure like that I have kids. I have two clients that are not Canadian and it was very helpful for me to tell them something about my experiences because I am also a foreigner. It made it easier to work with them when I told them I didn't know any English when I came to Canada, and I know exactly how you feel.

The family visitors explained that it is easier to build relationships with some families than with others. Client characteristics identified by the family visitors that facilitate this process include being 'open' to the home visit, having identified health or parenting concerns, being satisfied in the parent role or having had positive past experiences with other health and/or social service professionals. Clients who were not open to building a relationship with the family visitor frequently cancelled visits, were

not home at the appointment time or were passive during the visit and demonstrated avoidant body language. Clients may also be reluctant to open up if Family and Children Services had requested that the family visitor work with the family.

Building trust

The work of enhancing child and parent development cannot occur until the family trusts the family visitor and feels comfortable with her in their home. To build trust, family visitors tried to keep their appointments with families and arrived on time. They tried not to enter the home with an agenda. Rather discussions were client centred and directed. The family visitors hypothesized that due to negative life experiences, perhaps even difficult relationships with close friends and relatives, some at-risk clients find it hard to initially trust the family visitor, a virtual stranger in their home. In this situation, the family visitors often focused on working with the children while the mother looked on:

> Actually it was easier to get through the children first. The mom chose not to actively participate in the visit but she watched the way I interacted with her children. I think when she saw how much her children trusted me, that's really what built the relationship.

If the client was not ready to focus on the issues of parenting and child development, the family visitor would instead provide support around the mother's personal issues:

> She had too much going on and couldn't focus on the children. I think it's more important for them to really see I'm there for her also, the mother. And it's taken a really long time to build a relationship with her because there are a lot of walls to knock down.

The family visitors said that sometimes the best way to help the family was to provide them with practical assistance or information that made an immediate difference

in their life. The family visitors listed many examples of the practical help they provided including locating food, clothing and transportation; translation; role modelling bedtime and mealtime routines; cooking skills; and attending doctor's appointments, court, case conferences or parenting classes with mothers. As one family visitor explains:

> I picked up clothes for the kids from a clothing drive [for the mother]. And I think just those types of things really help build a relationship. Now every time I go she's much more open with me.

The public health unit supplies family visitors with many resources to use on their home visits including a selection of toys, craft supplies, books (on child rearing and parenting) and videocassettes. Some resources are also supplied as 'gifts' to the parents such as child proofing safety gadgets, breastpumps and children's tape recorders. Providing these gifts helped to gain access to the family and to build the relationship.

Working with others in the home

One challenge for the home visitors was to develop a relationship with both the mother and other people living in the home. Sometimes the family visitor used the presence of a family member to induce the client to work with her:

> I think that because I'm accepted by the family, [the mother] puts a little bit more trust in me. You can see that the grandparents are really the ones that influence her [the client].

More frequently, though, the presence of others in the home during a visit retarded the development of the relationship. The client was either distracted by other activities or withdrew from interacting with the family visitor and allowed others to take over the conversation. When the presence of others in the home negatively affected the development of the relationship, the family visitors worked to clarify their role with

family members, attempted to involve them in the visit, or offered to work with the client in a setting other than the home.

If the father was in the home or involved with the children, the family visitors often encouraged him to participate in the visit. In their experience, though, fathers tended to not participate in the visit or were not supportive of the mother working with the family visitor. In these situations, if the mother wished to continue working with the family visitor, visits would be scheduled at a time and/or location where the father would not be present.

Discussion and Implications for Nursing Practice

The factors that enabled the development of a working relationship involved the nurse marketing the program and clearly defining the family visitor role and the family visitor's ability to establish common ground with the client and identify appropriate trust building strategies. Personal characteristics of the client and the presence of others during the visit were factors that if not recognized, could inhibit relationship development.

In comparison to professional home visiting practice, the family visitors described a similar process of locating clients, gaining physical and emotional entry into their lives, establishing common ground and building trust so that the work of health promotion could begin (Zerwekh, 1991). One notable difference however, is that the entry work for the family visitors was facilitated with assistance from a public health nurse. Both the family visitors and the nurses emphasized the importance of building trust with clients, and as Zerwekh states, trust is the foundation of all interpersonal relationships. Without a trusting relationship, interventions will only be isolated attempts to influence change that

may not have any lasting effects and the home visitor will only be contributing external guidance rather than sincerely supporting the family (Paavilainen & Astedt-Kurki, 1997).

Given these findings, program planners should ensure that in the engagement phase flexibility related to the intensity of home visiting exists and nurses are allocated adequate time to establish rapport and trust with clients prior to involving the family visitor. Nurses must also be permitted designated work time to provide support and assistance to family visitors as they work to problem solve complex issues related to accessing and engaging at-risk families.

Nurse managers should aim to hire family visitors who can be matched to families on the basis of similar cultural background, language or life experiences so that common ground can be established. Training programs developed for family visitors should include sessions on cultural sensitivity, communication skills and the therapeutic use of self. It may also be beneficial to have inservices attended by both nurses and family visitors where issues of relationship development and conjoint visiting are discussed. To the home visiting nurse, these results suggest that she needs to be able to clearly define the family visitor role and have the skills and tools necessary to effectively market the program to target families (i.e. more than leaving a pamphlet). The family visitors have the potential to make a difference in the lives of the families participating in the HBHC program, but first it is essential that they be provided with the knowledge and skills necessary to develop trusting relationships. Awareness of the factors identified in this qualitative study may help facilitate this process.

References

Ciliska, D., Mastrilli, P., Ploeg, J., Hayward, S., Brunton, G., & Underwood, J. (1999).
The effectiveness of home visiting as a delivery strategy for public health nursing interventions to clients in the prenatal and postnatal periods: A systematic review. Hamilton, ON: Ontario Ministry of Health.

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.). Existential phenomenological alternative for psychology (pp. 48-71). New York: Oxford University Press.

Gomby, D.S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations-analysis and recommendations. The Future of Children, 9(1), 4-26.

Hiatt, S., Sampson, D., & Baird, D. (1997). Paraprofessional home visitation: Conceptual and pragmatic considerations. Journal of Community Psychology, 25(1), 77-93.

Korfmacher, J., O'Brien, R., Hiatt, S., & Olds, D. (1999). Differences in program implementation between nurses and paraprofessionals providing home visits during pregnancy and infancy: A randomized trial. American Journal of Public Health, 89(12), 1847-1851.

Olds, D.L., Henderson Jr., C.R., Kitzman, H.J., Eckenrode, J.J., Cole, R.E., & Tatelbaum, R.C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. The Future of Children, 9(1), 44-65.

Olds, D.L., Robinson, J., O'Brien, R., Luckey, D.W., Pettitt, L.M., Henderson, C.R., Ng,

R.K., Sheff, K.L., Korfmacher, J., Hiatt, S., & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. Pediatrics. 110(3), 486-496.

Ontario Ministry of Health (1997). Implementation guidelines for the *Healthy Babies. Healthy Children* Program. Toronto, ON.

Paavilainen, E., & Astedt-Kurki, P. (1997). The client-nurse relationship as experienced by public health nurses:Toward better collaboration. Public Health Nursing. 14(3), 137-142.

Ploeg, J. (1999). Identifying the best research design to fit the question. Part 2: Qualitative designs. Evidence Based Nursing. 2(2) 36-37.

Robinson, J.L., Emde, R.N., & Korfmacher, J. (1997). Integrating an emotional regulation perspective in a program of prenatal and early childhood home visitation. Journal of Community Psychology. 25(1), 59-75.

Wade, K., Cava, M., Douglas, C., Feldman, L., Irving, H., O'Brien, M.A., Sims-Jones, N., & Thomas, H. (1999). A systematic review of the effectiveness of peer/paraprofessional 1:1 interventions targeted towards mothers (parents) of 0-6 year old children in promoting maternal (parental) and/or child health/developmental outcomes. Hamilton, ON: Effective Public Health Practice Project.

Wasik, B.H. (1993) Staffing issues for home visiting programs. The Future of Children. 3(3), 140-157.

Zerwekh, J.V. (1991) A family caregiving model for public health nursing. Nursing

Outlook, 39(5), 213-218.

Chapter 3

Limiting Family Vulnerability: How Mothers with Children At-Risk Engage with Public Health Nurses and Family Visitors in a Blended Home Visiting Program

Introduction

In an effort to enhance child and parent development, the Province of Ontario, Canada implemented the *Healthy Babies, Healthy Children* (HBHC) program. This early intervention program provides support to families through home visiting and service coordination. High-risk pregnant women or families with children identified as being at-risk for developmental delays are eligible to receive home visits from public health nurses (PHN) and family visitors (FV) until the child is six years of age. This program is an example of a blended model of home visiting because both professional and lay home visitors work with families to change parental attitudes, knowledge and behaviours to encourage healthy child growth and development. Families that are invited to participate also tend to be the most difficult to access and engage and commonly drop out of home visiting programs prematurely (Kitzman, Cole, Yoos, & Olds, 1997). The purpose of this article is to describe the process by which mothers of children at-risk engage with PHNs and FVs in a blended home visiting program.

Literature Review

Home visiting programs vary by the nature of the program (universal or targeted), type of home visitor (professional, paraprofessional or lay person), the duration and intensity of home visits, the types of interventions provided during the home visit, and the

anticipated outcomes. In public health, nurses have traditionally conducted home visits that focus on meeting maternal-child health needs during pregnancy, the postpartum period, and the child's early years. A systematic review of 20 moderate to high quality studies that examined the effectiveness of home visiting by PHNs to prenatal and postpartum mothers identified a number of positive outcomes for children and their mothers (Ciliska et al., 1999). Children experienced improvements in mental development, mental health and physical growth and mothers experienced a reduction in maternal depression and improvements in maternal employment, education and nutrition. These outcomes were most likely to occur in home visiting programs that were targeted to families most at-risk, were more intensive with a minimum of weekly home visits during pregnancy or immediately postpartum and linked families to other community supports.

Despite strong evidence to support the use of nurse home visitation programs, many governments and agencies have implemented paraprofessional home visiting programs or a blended model using both nurses and lay home visitors. A recent systematic review of the effectiveness of paraprofessional/peer home visits summarized 21 studies, four of which were rated as methodologically strong and 17 as moderately strong (Wade et al., 1999). The authors concluded that paraprofessional interventions can positively impact child development and parent-child outcomes, especially when home visits are intense (weekly or bi-weekly), are started during the prenatal period and are part of a multifaceted program that also offers families professional support and links them to other community services. However, in a randomized controlled trial examining

the effectiveness of home visiting by nurses and by paraprofessionals as separate service providers working to improve maternal and child health outcomes, it was identified that for most outcomes on which the nurses produced beneficial effects, the paraprofessionals' effects were approximately half the size (Olds et al., 2002).

It has been hypothesized that positive maternal-child outcomes are related to the development of a working relationship or therapeutic alliance between the nurse home visitor and mother (Kitzman et al., 1997; Weiss, 1993). This is the vehicle in which parenting and child information can be shared; emotional, social and instrumental support can be offered; and linkages to community resources can be made (Weiss, 1993). Several rigorous qualitative studies describe the home visiting process and identify factors that most influence the development of the nurse-client relationship from the nurse's perspective (Byrd, 1995a; Chalmers, 1992; De la Cuesta, 1994; Zerwekh, 1991; 1992a). In her synthesis of qualitative home visiting research, McNaughton (2000) identified four phases of the nurse-client relationship: (1) pre-entry, (2) entry, (3) working, and (4) termination. The relationship varies in depth and evolves over time, and is formed during the first two phases.

The pre-entry phase occurs prior to the first nurse-client home visit. Home visiting is unique in comparison to other modes of health care delivery because care is offered in clients' private homes. The client is therefore the gatekeeper and determines who can enter. Potential health risks and needs are identified by the nurse so that care is frequently offered to, rather than sought by families. Learning new health promoting behaviours may be a low priority to parents who are struggling to cope with multiple,

complex stressors in their daily lives (Chalmers, 1992; Kitzman et al., 1997).

Consequently, time is spent during this phase marketing home visiting as a service that is

acceptable, relevant and accessible to clients (De la Cuesta, 1994). Home visitors also

spend considerable time trying to locate families who frequently miss appointments or

cannot be contacted either because of unstable housing arrangements or due to a lack of a

telephone (Zerwekh, 1992a).

There are two steps to the entry phase: first, gaining physical entry into the

client's home and second, gaining interpersonal entry into the private and personal details

of the client's life (Chalmers, 1992; Zerwekh, 1992a). The ease of entry varies depending

on the client's perceived needs and views of visiting nurses (Byrd, 1995a). Physical entry

into the home is facilitated when the nurse does not present herself as an authority figure,

respects the client's need for autonomy and control, presents home visits as a 'routine'

event offered to all families, and identifies the client's priority needs (Chalmers; Luker &

Chalmers, 1990). De la Cuesta (1994) suggests that health visitors also 'bargain their

way' into the home by negotiating the best time and location for the visit.

Interpersonal entry (the second step in the entry phase), defined as the client

opening up to the nurse and sharing personal information, has been identified as a crucial

condition necessary for the work of health promotion (McNaughton, 2000). Establishing

trust between the client and home visitor is essential for ongoing physical entry and to

establish an interpersonal relationship. Zerwekh (1992a) identified eight strategies that

PHNs use to build trust, including: getting through the door, backing off, listening,

finding something to hook them, affirming strength, not judging, persisting, and being

trustworthy. Mothers who do not feel valued by the nurse and who do not perceive that their needs are being met are less likely to actively participate in the home visit or to provide information to the health visitor (Chalmers, 1992; Chalmers & Luker, 1991).

To reduce the social distance between the professional nurse and the client, many home visiting programs employ paraprofessional or lay home visitors who share similar values, beliefs and life experiences with the client (Wasik, 1993). In a phenomenological, qualitative study exploring the experiences of lay home visitors in a blended model of home visiting, Jack, DiCenso, and Lohfeld (2002) found that lay home visitors relied on nurses to effectively 'sell' the program to clients, build a foundation of trust with clients and facilitate lay home visitor entry into the home. Lay home visitor-client engagement then occurred through 'finding common ground' and 'building trust.'

Qualitative studies of the home visiting process have described the strategies nurses use to gain both physical and interpersonal entry into their clients' lives and identified client, visitor and contextual factors that influence the engagement process (Byrd, 1995a; Chalmers, 1992; De la Cuesta, 1994; Zerwekh, 1991; 1992a). However, data for the nurse home visitation programs were collected through in-depth interviews with only public health nurses in the United States, and with health visitors in the United Kingdom. This limits understanding of the fit and relevance of these findings to a Canadian context. More importantly, client experiences and perceptions identified in these studies have been interpreted by and described from the perspective of the service provider. A significant gap in the home visiting literature exists because we have few in-depth descriptions of client experiences in home visiting programs, their perceived need

for health promotion services, and factors that influence their ability to create a therapeutic alliance with a home visitor. There is also a need to describe clients' experiences in receiving services from multiple providers in blended home visiting programs.

Research Purpose and Questions

The purpose of this study was to develop a theory based on or grounded in the data that describes the process of engagement between mothers with children at-risk and PHNs and FVs in a blended home visiting program. The process of engagement will be generally defined as actions and interactions that occur during the pre-entry and entry phases of the home visiting process that facilitate the work of health promotion. The specific research questions were:

(a) What is the basic social psychological problem or issue that mothers with children at-risk experience during the engagement phase with PHNs and FVs in a blended home visiting program?

(b) What social psychological process do mothers with children at-risk use to resolve this problem?

Method

Design

Classic grounded theory (Glaser, 1978; Stern, 1985) was used to systematically guide the collection, recording, organization and analysis of the data. Within qualitative research, grounded theory is an approach derived from symbolic interactionism, a philosophy based on the assumption that individuals apply meaning to phenomena or

objects based on their interactions with them in their social world (Milliken & Schreiber, 2001). The researcher focuses on human interactions in social settings and attempts to understand a phenomenon as it is experienced, perceived, and valued by the research participant (Liehr & Marcus, 1994). The development of a theory based on, or grounded in, the data is the hallmark of grounded theory (Strauss & Corbin, 1994). Through the incorporation of multiple perspectives and interpretations of the phenomena under study it is possible to develop a substantive, mid-range theory that is conceptually dense (Strauss & Corbin). In a substantive, mid-range theory the researcher generally studies and describes one behavioural concept or phenomenon (Morse, 2001). In this study, engagement is the behavioural concept under investigation. This research approach is particularly relevant to developing nursing knowledge because once we understand the processes that surround social interactions, we can develop nursing interventions that are highly responsive to client needs (Wuest, 1995).

Research Setting and Participant Recruitment

Approval to conduct this study was obtained from the McMaster University and Hamilton Health Sciences Corporation Research Ethics Board. Study participants were recruited from the HBHC program offered by a South West Ontario public health unit. In this health unit, a specific team of PHNs and FVs visit all at-risk families. The duration and intensity of home visiting are flexible and determined based on professional nursing judgment, FV input, and identified client needs. Public health nurses briefly described the study to their clients who were eligible to participate in the study and obtained permission

for the principal investigator to contact them in order to explain the study in detail. The principal investigator was responsible for obtaining informed consent from clients.

Sample

In qualitative research, purposeful sampling involves selecting specific individuals who will be able to provide detailed information about the phenomenon under study (Patton, 1990). To learn about the process of engagement with home visitors from a client perspective, inclusion criteria for this study included the following: being a mother from a family identified by the PHN as 'high-risk' based on professional judgement and a completed *HBHC Family Assessment Tool* who had received at least one PHN visit and three FV visits, who spoke English and who was assigned a PHN as her service coordinator. While those families who were identified as high risk because of social disadvantage, young maternal age, or financial difficulties were included, those families who were identified as high-risk because their child had a congenital or acquired health challenge were excluded. Maximum variation sampling, or the selection of participants who vary on multiple dimensions, was also used to select a heterogeneous group of women participating in the HBHC program (Patton). The benefit of maximum variation sampling is that "any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program" (p. 172). This sampling technique also enhances the trustworthiness or rigour of the study by ensuring that the emerging theory is generic (Marshall & Rossman, 1995). Variability within the sample was achieved by selecting

mothers who differed on the following dimensions: timing of referral (prenatal or postpartum), parity, age, marital status and household composition.

As data analysis progressed and the core category of 'limiting family vulnerability' emerged, theoretical sampling was used to guide the collection of further data. Theoretical sampling involves identifying individuals who can provide information that develops and conceptually links emerging categories (Glaser, 1978). During analysis, it became evident that client preconceptions and experiences with social and health service providers and the availability and quality of informal and formal supports influenced a mother's ability to engage with home visitors. Therefore, sampling was extended to re-interview or recruit mothers who lived in a rural setting, who had past experiences with a child welfare agency, who were new immigrants to Canada and/or whose husband or partner also participated in the home visits. Negative cases, or those mothers who were perceived by nurses to not have fully engaged in the home visiting process, were also sought in order to raise the level of abstraction of the theory and to understand the limits of the variables (Glaser).

Data Collection

In keeping with the canons of good qualitative research, data collection and analysis occurred simultaneously (Glaser, 1978). Demographic data were collected using a short, written questionnaire administered by the principal investigator. Contextual data about the home visits were gathered through a review of client charts. Each participant's experiences, beliefs, and expectations related to the phase of engagement with their PHN and FV were explored during in-depth, semi-structured interviews that lasted between 60-

90 minutes. As the core category emerged during analysis, interview questions were added that focused on understanding the dimensions and properties of the category. Participants were interviewed between one to three times. A total of 29 interviews were conducted, 18 in-person and 11 by telephone. Permission was granted to tape record 23 of the interviews, which were then transcribed verbatim. Six interviews were not recorded for two reasons. First, four mothers expressed discomfort at having their voice recorded either because of a speech impediment or because they identified English as their second language. Second, the interview conditions were not conducive to using a tape recorder and microphone. For example, one mother requested that the interview be conducted in a shopping mall food court. Extensive notes were made during these six interviews. Field notes recording observations and thoughts around the emerging concepts were documented immediately following each interview. A summary of their individual interview was presented to 15 participants for review. Five mothers could not be located for follow-up. At the end of the first interview, each participant was given a $20 gift certificate as a token of gratitude for participating in the study. A detailed audit trail was maintained that included a description of all study events and decisions regarding study design, sampling techniques, data collection and analysis. An audit trail is a recording of all study activities and decisions that another researcher could follow and is a tool used to establish confirmability in qualitative research projects (Streubert & Carpenter, 1999).

Data Analysis

Data were analyzed using three levels of coding. Open coding involved a line-by-line analysis of the transcripts, interview summaries and field notes to identify substantive, or *in vivo*, codes. These codes often capture the participant's own words and tend to be about the behaviours or processes that explain how the basic social problem is resolved (Glaser, 1978). Once the core category was identified, selective coding of data was completed to uncover the dimensions and properties of this category (Glaser). Theoretical coding was accomplished by grouping substantive codes into categories and identifying theoretical constructs which move the data to a more abstract level (Glaser). Theoretical memos were written at each stage of coding to capture ideas and hypotheses and to explore the relationship among concepts emerging from the data. Through this constant comparison of data in theoretical memos, codes were verified and saturated, while patterns and themes emerged (Stern, 1985). Data continued to be collected until categories were saturated and no new information was emerging. To confirm or disconfirm emerging hypotheses, negative cases were sought out to identify the limits of the variables and to raise the level of theoretical abstraction (Schreiber, 2001). To achieve this goal, families who were perceived by PHNs as passively participating in the program were recruited to partake in the study. Coding of data and the organization of memos were facilitated through the use of NVivo 1.3 software (QSR, 2002).

Grounded theory is situated in a constructivist paradigm of inquiry where the researcher and the participant create knowledge during their interactions (Annells, 1996). For this reason, no attempt was made to separate the researcher from the participant. For

example, during the interviews the researcher was open to discussing her personal

experiences of pregnancy and her parenting knowledge with the participating mothers. To

avoid bias in data analysis, the principal investigator wrote extensive memos describing

her professional experiences as a PHN home visiting at-risk families and her personal

experiences receiving PHN home visits during a high-risk pregnancy with twins and the

subsequent postpartum period. As categories and hypotheses emerged in the theoretical

memos, she returned to the data to confirm that these hypotheses were based on

participant experiences and not her own. Once the data analysis was completed, the

emerging substantive theory of engaging with PHNs and FVs was validated with eight of

the original participants who could be located. They each agreed that it 'fit' their

experiences in the home visiting program. Academic colleagues and practicing PHNs

provided feedback about the emerging concepts and commented on the relevancy of the

model to nursing practice.

Findings

The final sample included 20 mothers who had experienced engagement with

both PHNs and FVs. These women had received an average of 11 PHN home visits

(range 3-25) and 14 FV home visits (range 4-32). The average duration of participation in

the HBHC program at the time of data collection was 10 months. The average age of the

mothers was 26 years (range 17-40) and their average household income was $15,250

CDN. Three of the women's husbands remained in the room during the initial interviews

and consented to having their views and experiences recorded as part of the study. The

information shared by the women during these joint interviews may have been biased due

to the presence of their husbands. For that reason, follow-up phone calls were made to two of the women (the third could not be located) to confirm that the comments they made during the first interview were accurate reflections of their personal beliefs and experiences.

Feeling vulnerable was the basic social psychological problem mothers experienced during the phase of engagement with PHNs and FVs. Mothers felt vulnerable and frequently powerless because they were aware that they were allowing service providers into their homes who had the power to alter family structure and recommend changes to family processes. As one mother explained, "I was nervous when [the PHN] was coming over. I always want to say and do the right things in front of her because I'm not sure what will happen if I don't."

Mothers with children at-risk engage with PHNs and FVs through a basic social process of limiting family vulnerability. A mother's decision to participate in a home visiting program is made by weighing the unknown risks and consequences of participating in the visit with her need for social support, guidance and information. Mothers who take the risk of participating use various strategies to protect the integrity of their family and limit their vulnerability. Limiting family vulnerability has three phases: (1) overcoming fear, (2) building trust, and (3) seeking mutuality. These sub-processes are continually negotiated during home visits as the mother allows first, the PHN, and secondly, the FV physical entry into her home. This is a circular process, with each phase dependent upon the establishment and stability of the other two phases. Fears are overcome once trust has been built and trust exists only when the mother feels that

mutual goals and sharing are occurring in the two different client-provider relationships. At the heart of the process, the personal characteristics, values, experiences and actions of the PHN, FV and mother influence the speed at which each of these sub-processes are successfully negotiated and the success of developing a connected relationship (Figure 1).

Overcoming Fear

Once the client has accepted the referral to public health, she is contacted by a PHN and an initial home visit is arranged. Many mothers are ambivalent about accepting the visit because they perceive that the nurse is coming to visit to 'check up on them' and they fear that they will be judged as inadequate mothers. To overcome this fear, parents used specific strategies, including 'hiding nothing', 'trying to measure up', and 'protecting self.' The strategy of 'hiding nothing' refers to making a choice to allow the PHN entry into the home so that she can see for herself that her original stereotypes or suspicions may be unfounded. As one mother explained, "What I do is invite them over to see how well I am doing and then say, 'Well, there you go."

It is important for these mothers to create a positive first impression when the nurse enters the home. One young mother emphasized that when the nurse came to visit, she wanted her to see that "I really care about my baby and that I am working hard to be a good mom." The majority of the mothers identified that they purposefully clean the house and make the baby presentable (clean diaper, new outfit, etc.) prior to the nurse's arrival. This action may be partially explained by common courtesy, that it is the role of a host to have a clean environment for a visitor. But for these mothers, the data suggest that they are also motivated by 'trying to measure up' to the perceived ideals of being a 'good

mother', with a clean house, all the resources necessary for parenting, and a tidy, calm baby. For these mothers, they perceive that the stakes are higher if a nurse were to enter their home and observe filth and chaos. As one mother explained:

> I do have a thing about that [housecleaning], because being a single mother, you know there is a stereotype of a single mother on welfare and her house is a mess. So I'm really freaky and make sure the house is clean when they come over. Because you never know, they might see something and they might report it, too. Like even me with my cats. [The nurse] might see the baby start crawling, they see an open cat litter box, and [think], 'Well, I better take that kid from her because it might eat cat poop.' You know, like, I'm really scared of that sort of thing.

For those mothers who had support, it was common for a spouse, partner or other family member to be present during the initial postpartum home visit. To accommodate family members' needs and desires to be included, home visits were commonly scheduled at a time amenable to all parties. However, for those mothers and fathers who were hesitant or unsure of the purpose of the nurse's visit, the presence of another individual served the additional purpose of 'protecting self.' Mothers felt safer in the presence of a family member. They anticipated that the presence of the individual would shift the power balance and the nurse would be less likely to judge them or make negative comments. One mother explained, " I had him [my husband] here with me, so for the most part I wasn't too concerned because it was two against one in a sense. But I could understand being nervous if you are, like, a single mom with a baby."

A client's ability to overcome fear is dependent upon the nurse's actions as she enters the house. For most mothers, after implementing these strategies, they were able to redefine the role of the PHN from authority figure or monitor inspecting the home to a genuine, caring individual whose goal was to support the family in meeting their

identified health care and social needs. However, when a nurse entered the house and her initial actions were to inspect the nursery, or ask to watch the mother perform basic tasks such as changing or feeding the baby, mothers felt that their fears were confirmed, that they were being judged, and that their family was increasingly vulnerable.

Families who were eligible for long-term home visiting were encouraged to accept a referral to a FV. In comparison to their preconceived perceptions of PHNs, most mothers were less fearful of engaging with an FV. Mothers who had established trusting, working alliances with their nurses had little hesitation about accepting the PHN's referral to the FV component of the program. Three hypotheses that emerged from the data to explain this situation include the following: (1) over time mothers came to trust the PHN and thus perceived her interventions, including a FV referral, as genuine and helpful; (2) mothers had an accurate understanding about the role and purpose of the FV home visits due to detailed explanations from the PHN; or (3) mothers perceived that a FV is "a mother just like me," had less power than the PHN, and so posed less of a threat to the integrity of their family than the PHN did.

There were several consequences of not being able to overcome fear. These included: hesitancy about accepting ongoing support from the PHN and/or the FV, cancelling or not being present for scheduled home visits, dropping out of the home visiting program without offering an explanation to the PHN, or choosing to not fully disclose information shared during individual and family assessments. When the mother is not fearful or suspicious of the provider's intent, she feels safer in openly sharing

details about her history and her imminent needs, knowing that the goal of the nurse and the family visitor is to support her.

Building Trust

The process of home visiting involves an in-depth examination of many personal aspects of a family's life, including the quality of interpersonal relationships; alcohol, tobacco and drug use; finances; and parenting style. As trust in the home visitor increased, the mother's sense of vulnerability decreased and she was more willing to take a risk and discuss personal, sensitive issues. Mothers referred to this as 'opening up' and being able to 'talk from the heart.' The purpose of sharing this information was to better identify meaningful interventions to meet the client's needs. While participants struggled with defining the term 'trust', it was easier for them to describe when they knew it was finally safe to 'open up.' Being honest and sharing aspects of their lives was easiest when they knew that the home visitor was reliable, would keep information confidential, and would not react negatively to any of the information disclosed by the parent. Mothers also identified that it was easier to trust those PHNs and FVs who were able to accurately identify and address their priority concerns in the first few visits.

The ability to trust or 'open up' occurs at different points of time during the process of engagement. The level of trust that is developed exists on a continuum, from no trust, to tentative trust and then strong trust. The speed with which the mother trusted the home visitor was influenced by maternal characteristics and perceptions of the home visitor's role. Mothers who were open to the relationship, motivated to participate, confident in their parenting ability, and perceived the PHN as a positive source of support

were most likely to immediately trust the PHN or FV. These mothers perceived trust as an entity that automatically exists in the client-provider relationship and is something to be lost or strengthened. Mothers who came across as defensive, who identified that they 'trusted no-one' and who were suspicious of the nurses' motives when visiting did not initially trust them and viewed trust as something to be earned over time.

In deciding to trust the PHN and the FV, some mothers and one father discussed the various ways they 'tested' these service providers. Most commonly, clients would use secondary sources to verify the information provided to them by a home visitor. As one mother explained, "My nurse is full of information. I would always check out the information elsewhere and it's usually true. She's usually right on target." Clients also tested the home visitors to assess how reliable they were. As one father explained, "I asked her very specific questions and she came back with the answer, or she came back with something relatively close. And that was a bonus for me." Home visitors who were reliable (i.e. got back to clients with information, were on time, maintained scheduled visits, and were able to follow through on their promises to the client for example to secure subsidized daycare or to locate extra clothes for the children) were then viewed as more trustworthy than others.

Confidentiality was another important component of trust. Some mothers admitted to testing the boundaries of their relationship with their home visitors, particularly with the FVs, to assess how much information they would share about other clients. One mother described this process of testing and seeing 'how far she could go' with her family visitor:

> I asked a lot of questions about their workplace and my home visitor. You can go actually pretty far. I asked her what's the youngest person [she had ever worked with]. She said, '16.' And, I'm like, 'Oh my gosh.' [The home visitor then continues on to say] 'Yeah, and there's this lady that's got five kids and she's still pregnant' and stuff like that. I don't think I should know that. Now I am afraid that she will go to her next family and talk about me!

Home visitors who were perceived as 'gossipy' or willing to talk openly about other clients were not viewed as trustworthy. As a consequence, clients did not trust these providers and engaged in only superficial discussions rather than disclosing sensitive information.

In comparing the PHNs to the FVs, it was not evident that clients generally trusted one group more than the other. However, when examining the individual triadic relationships, a mother generally placed more trust in either her PHN or her FV because of differences in individual characteristics such as reliability, genuineness, warmth and ability to be caring and empathetic. For mothers who had just recently started working with the FV, they identified that they trusted the PHN more because "I have had a little more time to discuss things with her." This was especially true for mothers who began working with a PHN during the prenatal period and were not referred to a FV until after the baby was born.

One outcome related to the development of trust between the family and the PHN and FV was the establishment of an effective, working alliance. A second outcome was that communication between all individuals improved. Finally, when trust is built, the mother was more willing to examine her current situation, behaviours and parenting practices and then work with the PHN and FV to enhance the home environment, improve child development, and connect the family to community resources. Mothers

who did not trust or who stopped trusting either the PHN and/or FV experienced feelings of frustration, extreme stress and anger. This limited their ability to work effectively with the home visitors, to disclose personal information, and to implement any suggestions or recommendations made by the home visitors. As one mother openly disclosed:

> I am one of those people who doesn't trust anybody. So the way it kind of works is that the nurse will tell me things and I kind of pick and choose what I'm actually going to listen to. So when she is telling me what to do with my baby, I'll tell her, "Yeah, yeah, okay." But then as soon as she is gone, I do what I think is best.

When trust is not established, then the outcomes of developing a working alliance, improving communication and identifying appropriate interventions for change are limited. It is also difficult for mothers to engage in educational sessions focusing on personal, child and family health. Mothers who did not trust the PHN and/or the FV acknowledged that they were considering leaving the program. Other mothers were hesitant to drop out of the program because they were fearful that such action would result in a telephone call to the child welfare agency. So the usual response would be to "play along with them so that they leave me alone."

However, one of the benefits of participating in a blended model of home visiting was that mothers felt that if trust was lost with the FV for example, they could still trust and work effectively with the PHN. Other mothers who were unable to establish trust with the PHN still hesitantly accepted the FV referral, particularly in situations where the mother was isolated and desperately seeking social support and 'someone to talk to.' The need for companionship and support outweighed the distrust of the nurse. These mothers

maintained hope that the next individual they would be referred to would be that special person who could help them.

Seeking Mutuality

Mothers attempting to limit their vulnerability do so by seeking mutuality with either the FV or PHN. Henson (1997) defines mutuality as a feeling of being able to connect with or understand another. This connection facilitates a dynamic, evolving process of social exchange to achieve mutually defined goals. At any one time, the exchange between individuals does not need to be equivalent, however. All the mothers hoped for mutuality with either of their home visitors. They wanted the PHNs and FVs to be people with whom they could openly share their stories, and who in return would share their experiences and some details about their lives outside of nursing and home visiting. They also desired respect and wanted to have meaningful input into the content, structure, and goals of each home visit. The mothers shared stories about their past experiences with health and social service providers. They described how they had been viewed as 'pathetic' and had felt powerless in making decisions regarding the care they or their children received. In an attempt to not have these experiences repeated during the home visits, the mothers subconsciously and consciously altered their behaviours to create mutuality with the home visitor.

One way used by many of the mothers was to create an environment that would be conducive to sharing information and reduce the formality of the home visit. Mothers purposefully scheduled home visits at times when outside distractions would be limited, for example when older children were in school or during a toddler's naptime.

Frequently, refreshments such as coffee or juice were offered to the home visitor and a brief social exchange took place. The majority of the mothers felt that these social exchanges and sharing of refreshments did not overshadow the primary purpose of the visit. Offering food or drink was a common courtesy or a social moré. These same mothers were able to clearly articulate that they viewed the FV as 'friendly' but not as a friend. One mother explained:

> Well she [the FV] is friendly, and I might talk to her about issues that I would talk to about with a friend, such as problems I am having with my boyfriend. But I don't view her as a friend. Just as someone who is very supportive.

Another mother, however, felt that the visits were becoming too social, lacked focus, and that the FV was too informal and acted unprofessionally (i.e. put her feet up on the couch) during the visits. To reduce the social nature of the visits, this mother purposefully decided to not offer the FV any coffee. Another mother, who did not trust either the PHN or FV, and who felt that they were overly judgemental about her parenting abilities, always poured them a cup of coffee. For that mother this was an effective way to 'eat away' at the home visiting time and limit the time available for the FV or PHN to 'criticize' her.

Therapeutic reciprocity, or the "mutual exchange of meaningful thoughts, feelings, and behaviors" is an important property of mutuality (Marck, 1990, p.52). In their interactions with the PHNs and FVs, the mothers desired to know more about the persons they were working with so they asked their home visitors questions about their personal experiences, beliefs and practices, especially related to child rearing. When a mutual exchange of information occurred, mothers felt less vulnerable in answering

personal questions related to such topics as their histories of depression or experiences of domestic abuse. Clients described experiencing a sense of relief when they realized that the PHN or FV struggled with the same issues that they encounter on a daily basis. One mother who needed help with how to effectively discipline her children was terrified to admit that she had spanked her children. In a very candid discussion about disciplinary techniques, her FV admitted that she had in the past spanked her children. This disclosure by the FV enabled the mother to open up and discuss her fears and frustrations. Together, the FV and mother worked to identify more appropriate disciplinary methods.

Reciprocity indicates a mutual, equal exchange of information. However, mutuality is different; it means finding a balance and having one of the individuals provide support or strength when the other individual is weak (Henson, 1997). This level of mutuality was sought by mothers who worked to 'create an alliance' with their PHN or FV. It was common for many of these mothers to be berated by their partners or parents. Often their baby's father would be overly critical of the parenting methods adopted by the mother, especially when these 'new' ways were contradictory to his cultural beliefs or the traditional ways of parenting. These mothers often sought reinforcement from the home visitor. Together they would present a common front, often with the PHN praising the mother's parenting abilities in front of the father. When fathers were present for the home visit, the mother would tend to ask more questions of the PHN or FV, even when she knew the answers. This strategy was used so that the father could hear from someone he respected as knowledgeable that what the mother was doing was appropriate. The home visitor's positive affirmations also contributed to the mother's confidence in her

parenting ability. One mother explains, "My boyfriend and I disagree on a lot of things about raising our daughter and the family visitor gives me a lot of the correct information. So it lets me know that what I am doing to raise her is right."

Mothers also took note of the verbal and non-verbal language that occurred during the visits. When conversations were filled with humour, caring and empathetic responses, respect, and a mutual exchange of ideas, mothers felt that they were able to deepen their connection to their home visitors. They observed mannerisms that indicated that the home visitors respected them and would not judge them or be 'shocked by anything I have to say.' Mothers reported feeling comfortable engaging with home visitors who smiled, nodded their heads in encouragement, and allowed adequate time for the mothers to talk.

Mutuality is also defined by the participation and collaboration of people in defining a common goal. The mother-home visitor relationships that were the most engaged were those where the PHNs or FVs made the mothers feel that their contributions to both the content and process of the home visits were meaningful. It was important for mothers to feel that they had control over identifying what would be addressed during a home visit. One mother was very pleased with this at the first visit with her nurse. In her words, "We just sat down and talked, and I told her what I wanted to start off with. And she started the way I wanted." Mutuality was reduced when home visitors did not identify or ignored the mothers' priority needs and instead established their own agendas of what should be discussed during a visit. It was more common for

FVs than PHNs to not provide this aspect of client centred care or to 'lecture' the mothers. One exasperated mother stated:

> I don't want the family visitor to get in my face about my daughter. Don't tell me to do things that I am already doing! Instead, start by asking questions to find out what I am doing and why I am doing it.

Some mothers felt disconnected from their PHNs and did not perceive the encounter as beneficial, if during the eight week review meeting, the nurse entered the home and mechanically collected family assessment data and did not spend time interacting with the child or engaging in some social conversation. As one mother explained:

> She's just visiting because its part of her job. It's not really a long visit and it's pretty boring. It's kind of like there is no need for her to really come. There's nothing really that we have got to cover except for what's on her papers, so it's not really important to me.... It would be better if she would come in and be interested in asking, 'How are you? How was your day?

Seeking and finding mutuality in a relationship with either the PHN or the FV was an essential condition to remaining engaged with the home visitor and motivated to continue working on strategies to enhance maternal-child health. Of the mothers interviewed, eight identified that they had established a mutual connection with both the PHN and FV, eight had connected with the PHN only, three with the FV only and only one mother felt that she had not been able to establish a mutual connection with either visitor. Mothers who were able to create a connection with only one of the home visitors were partially engaged in the home visiting process. The eight mothers who felt connected only to the PHN identified a desire to discontinue working with the FV. Many of these mothers, however, were unsure of how to approach this topic with the PHN as

they didn't want to 'get the family visitor in trouble.' Many felt that the only way to

express their dissatisfaction would be to make it difficult for the FV to reach or access

them. One mother explained:

> Don't actually just barge in and tell us what we should be doing. Because it won't
> make your job any easier because it's just going to be like I don't want you to
> come back to my house. When you call my house, I'll block your number out.
> Simple things like that.

The three mothers who had developed a connection only with the FV were satisfied to

continue working in the blended home visiting program. As the mothers explained, the

FVs were meeting their needs and the PHN only visited every eight weeks for a joint

review of goals and progress to date.

Discussion

The use of home visits in early intervention programs is a key strategy to promote

optimal child and parent development. Public health nurses and FVs seek entry into

private homes to provide support and information to parents (predominantly mothers) of

infants and young children at-risk. Mothers attempted to cope with feeling vulnerable and

powerless through a circular process of engagement identified as 'limiting family

vulnerability.' Successful engagement with home visitors was evidenced by creating a

connected relationship built on a foundation of overcoming fear, building trust and

seeking mutuality. This grounded theory provides new insight into the experiences and

thoughts of mothers who accept home visits. It moves us towards a more holistic

understanding of the home visiting process, which, in the literature, has been

predominantly described from the nursing perspective only. The findings are clinically

relevant because they provide insight into the reasons why mothers decide to continue or withdraw from home visiting programs.

Engagement with home visitors can be inhibited if a mother feels vulnerable and hesitant about allowing the visitor access into her home and interpersonal entry into the details of her life. The fears that mothers expressed in this study about being judged and monitored are not unfounded. Peckover (2002) confirms that some mothers perceive home visits as form of surveillance. Nurses recognize and struggle with balancing their role of providing support with that of policing families (Peckover; Zerwekh, 1992b). It has been suggested that home visiting vulnerable families is a source of social control, or a form of cultural imperialism, whereby a nurse, typically representing dominant middle-class values and beliefs, works to change the behaviour of the mother who has less social capital (Gomby et al., 1999; Hodnett & Roberts, 2002; Kearney, York & Deatrick, 2000). When nurses identify a parental attitude or behaviour that they believe is detrimental to the well-being of a child, they work to change prevailing family processes. Nurses do this by reasoning with or confronting clients, and when change is not occurring and the nature of the risk is serious, by threatening to contact other authorities (Zerwekh). They do this believing that change will occur with external coercion (Zerwekh). As a consequence, mothers who feel threatened may choose to avoid or resist the home visitors' attempts to contact them (Peckover).

Despite feeling vulnerable and powerless, many mothers in this study assumed control and made choices regarding the level to which they would engage in the home visiting program. Mothers made the decision to participate by weighing their needs for

support, information, and acceptance with the potential risk of allowing the PHN or FV into their home. For the mothers, their needs outweighed perceived risks. Vulnerable mothers who agreed to home visits protected their families and limited their vulnerability by constructing an image of the 'good' mother so that the home visitors would not judge them. Peckover (2002) refers to this as the 'discursive production of herself as a good mother' and explains that mothers understand the disciplinary power of home visiting nurses, so they actively conceal negative aspects of their lives such as domestic violence (p. 373). The compelling need the majority of the mothers had to clean their houses prior to a visit indicates that they instinctually understand the societal view that a dirty, disorderly house is associated with neglect and is seen as a preliminary condition for agency involvement to protect the children (Swift, 1995). Mothers also work to alter the balance of power by choosing to have family members present during a home visit.

The most important home visiting outcome to mothers was the development of a connected relationship with one or both home visitors. Establishing an interpersonal nurse-client relationship is the foundation of nursing practice (Peplau, 1992). In order to access and offer health promotion services to families with young children, home visiting nurses have consistently identified the importance of developing nurse-client relationships built on trust and collaboration (Byrd, 1995b; Chalmers, 1992; De La Cuesta, 1994; Paavilainen & Astedt-Kurki, 1997). There is some evidence that if a therapeutic relationship is not established during the engagement phase, it may result in clients prematurely withdrawing from the service (Bachelor & Horvath, 1999). In this study, vulnerable mothers who did not feel that their needs were being met or who judged

the quality of the client-home visitor relationship as poor were most likely to resist help or withdraw from the home visits. In this study, examples of disconnected relationships were exemplified by PHNs acting in a bureaucratic manner during home visits and family visitors 'lecturing' or being paternalistic towards clients.

In their interactions with home visitors, mothers wanted to feel respected, have opportunities for input and to feel that they were making meaningful contributions to the relationship. Most important, they felt less vulnerable when PHNs and FVs treated them first as persons and second, as clients. Morse labels this as a connected nurse-patient relationship (1991). Mothers felt that the power differential decreased when the PHN or FV partook in a reciprocal exchange of information and was willing to disclose personal information about her life and parenting experiences as they related to client issues. Chalmers (1992) discusses the process of 'giving and receiving' that occurs in home visiting and identifies that clients give personal information in exchange for professional nursing services, such as education, advocacy or referrals. The findings from this study indicate that nurses should also consider different ways of relating to their clients such as 'giving' out some information about themselves.

Mothers' descriptions of trusting, mutual interpersonal relationships also provide insight into their preferences for either a professional PHN or a lay FV. Recognizing that most PHNs represent dominant, middle class values, many home visiting programs instead hire paraprofessionals or lay persons who share similar experiences, values and beliefs with the families they visit. This 'shared culture' is believed to facilitate entry into the home and promote the development of a trusting relationship (Wasik, 1993). Findings

from this study indicate that shared experiences do facilitate the process of trust building. However, analysis of the mothers' data suggests that the variable most likely to influence successful engagement is not the provider's demographic background but rather her skill and ability to develop rapport and mutuality. A majority of the mothers in this study identified that they had a connected relationship with their nurse. Eight of the mothers expressed a preference for working with the PHN only because the FV was unable to meet her needs. Kearney, York and Deatrick (2000) suggest that the skills necessary for working with complex, multi-problem families, such as relationship building and the therapeutic use of self, are professional nursing skills that are underdeveloped in paraprofessional or lay home visitors.

Implications for Home Visiting Practice and Research

Once they have access to clients, PHNs work to market their services and encourage families to accept home visits (De la Cuesta, 1994). However, there is also a responsibility for public health administrators, provincial nursing organizations and individuals responsible for implementing early intervention programs to develop additional marketing strategies to educate the general public about the role of the PHN and FV, the importance of early intervention programs for all children and the benefits of participating in a home visiting program. It is important to change vulnerable families' perceptions of long-term home visiting programs from something that inadequate families require to a strategy that promotes child development for all.

Public health nurses, and to some extent FVs, balance providing support to families while also performing a surveillance function to ensure that children are not

being neglected or abused (Peckover, 2002). Knowing that mothers were hesitant to

initially open up to nurses and fearful of full involvement in the program, it is imperative

that nurses identify client fears during the initial visits. To reduce client fears, PHNs and

FVs have a responsibility to clearly define their role for the family and honestly identify

those conditions under which child welfare involvement may be necessary. They can

reassure the family that child apprehension is a rare event and that their goal is to work

with the family to prevent this situation from occurring (personal communication, HBHC

High Risk Home Visiting Team, December 2, 2002).

Most important, mothers who remained engaged in the home visiting program did

so because they trust and feel that they have established a connected relationship with the

PHN and/or FV. Creating mutuality may be difficult for some PHNs or FVs who choose

to focus exclusively on the client during a visit and decide not to disclose any information

regarding their personal experiences. Mothers noted the power differential between

provider and client was reduced when PHNs or FVs made appropriate personal

disclosures while maintaining professional boundaries. This served to reduce the

mothers' feelings of vulnerability. Given the importance that mothers place on the

development of an interpersonal relationship, it is important for PHNs and FVs to take

time to assess the quality of their relationships with clients. Time spent in home visits is

generally spent focusing on content. However, to maintain families in the program, it is

important to spend time identifying barriers or relationship influences that may inhibit the

family from making the transition from the engagement phase to the phase of doing

health promotion work.

The primary limitation of this study is that only mothers who agreed to participate in the home visiting program were interviewed. Also, it may be that only those mothers most engaged with their PHNs consented to be contacted by the principal investigator. Therefore, future researchers should identify strategies to locate and interview families who have refused a referral to public health or who have refused to allow a PHN to visit so that their perceptions of health promotion programs can also be identified. Given the importance of developing and maintaining the connected relationship, there is a need to develop and test tools that measure the quality of this relationship and that can be used by a PHN or FV during a home visit.

Conclusion

After considering potential risks, many vulnerable mothers are willing to participate in home visiting programs with PHNs and FVs. To establish a connected relationship with their health care providers, they must first overcome their fears, build trust and seek mutuality with the home visitor. Therefore, it is imperative that public health administrators recognize the importance of allowing home visitors flexibility in deciding how many visits are required during the early phase of engagement. It is difficult to predict in advance how much time is needed to develop a good working relationship with mothers of children at-risk. To increase client use of and satisfaction with home visiting programs, and to develop appropriate home visiting outcome indicators, it is vital to understand and incorporate the mother's perspective.

References

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. Qualitative Health Research, 6, 379-393.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), The heart and soul of change: What works in therapy (pp. 133-178). Washington, D.C.: American Psychological Association.

Byrd, M.E. (1995a). A concept analysis of home visiting. Public Health Nursing, 12, 83-89.

Byrd, M.E. (1995b). The home visiting process in the contexts of the voluntary vs. required visit: Examples from fieldwork. Public Health Nursing, 12, 196-202.

Chalmers, K.I. (1992). Giving and receiving: An empirically derived theory on health visiting practice. Journal of Advanced Nursing, 17, 1317-1325.

Chalmers, K.I., & Luker, K.A. (1991). The development of the health visitor-client relationship. Scandinavian Journal of Caring Sciences, 5, 33-41.

Ciliska, D., Mastrilli, P., Ploeg, J., Hayward, S., Brunton, G., & Underwood, J. (1999). The effectiveness of home visiting as a delivery strategy for public health nursing interventions to clients in the prenatal and postnatal period: A systematic review. Hamilton, ON: Effective Public Health Practice Project.

De la Cuesta, C. (1994). Marketing: A process in health visiting. Journal of Advanced Nursing, 19, 347-353.

Glaser, B. (1978). Theoretical sensitivity. Mill Valley, CA: Sociology Press.

Gomby, D.S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations-analysis and recommendations. The Future of Children, 9(1), 4-26.

Henson, R.H. (1997). Analysis of the concept of mutuality. Image: Journal of Nursing Scholarship, 29, 77-81.

Hodnett, E.D., & Roberts, I. (2002). Home-based social support for socially disadvantaged mothers (Cochrane Review). The Cochrane Library, Issue 4, Oxford: Update Software.

Jack, S., DiCenso, A., & Lohfeld, L. (2002). Opening doors: Factors influencing the establishment of a working relationship between paraprofessional home visitors and at-risk families. Canadian Journal of Nursing Research, 34(4), 59-69.

Kearney, M.H., York, R., & Deatrick, J.A. (2000). Effects of home visits to vulnerable young families. Journal of Nursing Scholarship, 32, 369-376.

Kitzman, H.J., Cole, R., Yoos, H.L., & Olds, D. (1997). Challenges experienced by home visitors: A qualitative study of program implementation. Journal of Community Psychology, 25, 95-109.

Liehr, P.R., & Marcus, M.T., (1994). Qualitative approaches to research. In G. LoBiondo-Wood & J. Haber (Eds.), Nursing research: Methods, critical appraisal and utilization (3rd ed., pp. 253-285). St. Louis: Mosby.

Luker, K.A., & Chalmers, K.I. (1990). Gaining access to clients: The case of health visiting. Journal of Advanced Nursing, 15, 74-82.

Marck, P. (1990). Therapeutic reciprocity: A caring phenomenon. Advances in Nursing Science, 13(1), 49-59.

Marshall, C., & Rossman, G.B. Designing qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

McNaughton, D.B. (2000). A synthesis of qualitative home visiting research. Public Health Nursing, 17, 405-414.

Milliken, P.J., & Schreiber, R.S. (2001). Can you 'do' grounded theory without symbolic interactionism? In R.S. Schreiber & P.N. Stern (Eds.), Using grounded theory in nursing (pp.177-190). New York: Springer.

Morse, J.M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 16, 455-468.

Olds, D.L., Robinson, J., O'Brien, R., Luckey, D.W., Pettitt, L.M., Henderson, C.R. et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. Pediatrics, 110, 486-496.

Paavilainen, E., & Astedt-Kurki, P. (1997). The client-nurse relationship as experienced by public health nurses: Toward better collaboration. Public Health Nursing, 14, 137-142.

Peckover, S. (2002). Supporting and policing mothers: An analysis of the disciplinary practices of health visiting. Journal of Advanced Nursing, 38, 369-377.

Peplau, H.E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. Nursing Science Quarterly, 5, 13-18.

Schreiber, R.S. (2001). The 'how to' of grounded theory: Avoiding the pitfalls. In R.S. Schreiber & P.N. Stern (Eds.), Using grounded theory in nursing (pp.55-83). New York: Springer.

Stern, P.N. (1985). Using grounded theory method in nursing research. In M.M.

    Leininger (Ed.), Qualitative research methods in nursing (pp. 149-160). Orlando,

    FL: Grune & Stratton.

Strauss, A. & Corbin. J. (1994). Grounded theory methodology: An overview. In N.K.

    Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (pp. 273-285).

    Thousand Oaks, CA: Sage.

Streubert, H.J., & Carpenter, D.R. (1999). Qualitative research in nursing: Advancing the

    humanistic imperative (2nd ed.). New York: Lippincott.

Swift, K.J. (1995). Manufacturing 'bad mothers': A critical perspective on child neglect.

    Toronto, ON: University of Toronto Press.

Wade, K., Cava, M., Douglas, C., Feldman, L., Irving, H., O'Brien, M.A., et al. (1999). A

    systematic review of the effectiveness of peer/paraprofessional 1:1 interventions

    targeted towards mothers (parents) of 0-6 year old children in promoting maternal

    (parental) and/or child health/developmental outcomes. Hamilton, ON: Effective

    Public Health Practice Project.

Wasik, B.H. (1993) Staffing issues for home visiting programs. The Future of Children,

    3(3), 140-157.

Weiss, H.B. (1993). Home visits: Necessary but not sufficient. The Future of Children:

    Home Visiting, 3(3), 113-128.

Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and

    tensions between the two traditions in knowledge discovery. Qualitative Health

    Research, 5, 125-137.

Zerwekh, J.V. (1991). A family caregiving model for public health nursing. <u>Nursing Outlook, 39</u>, 213-217.

Zerwekh, J.V. (1992a). Laying the groundwork for family self-help: Locating families, building trust, and building strength. <u>Public Health Nursing, 9</u>, 15-21.

Zerwekh, J.V. (1992b). The practice of empowerment and coercion by expert public health nurses. <u>Image: Journal of Nursing Scholarship, 24</u>, 101-105.

Figure 1. Theoretical Model of Maternal Engagement with Public Health Nurses and Family Visitors
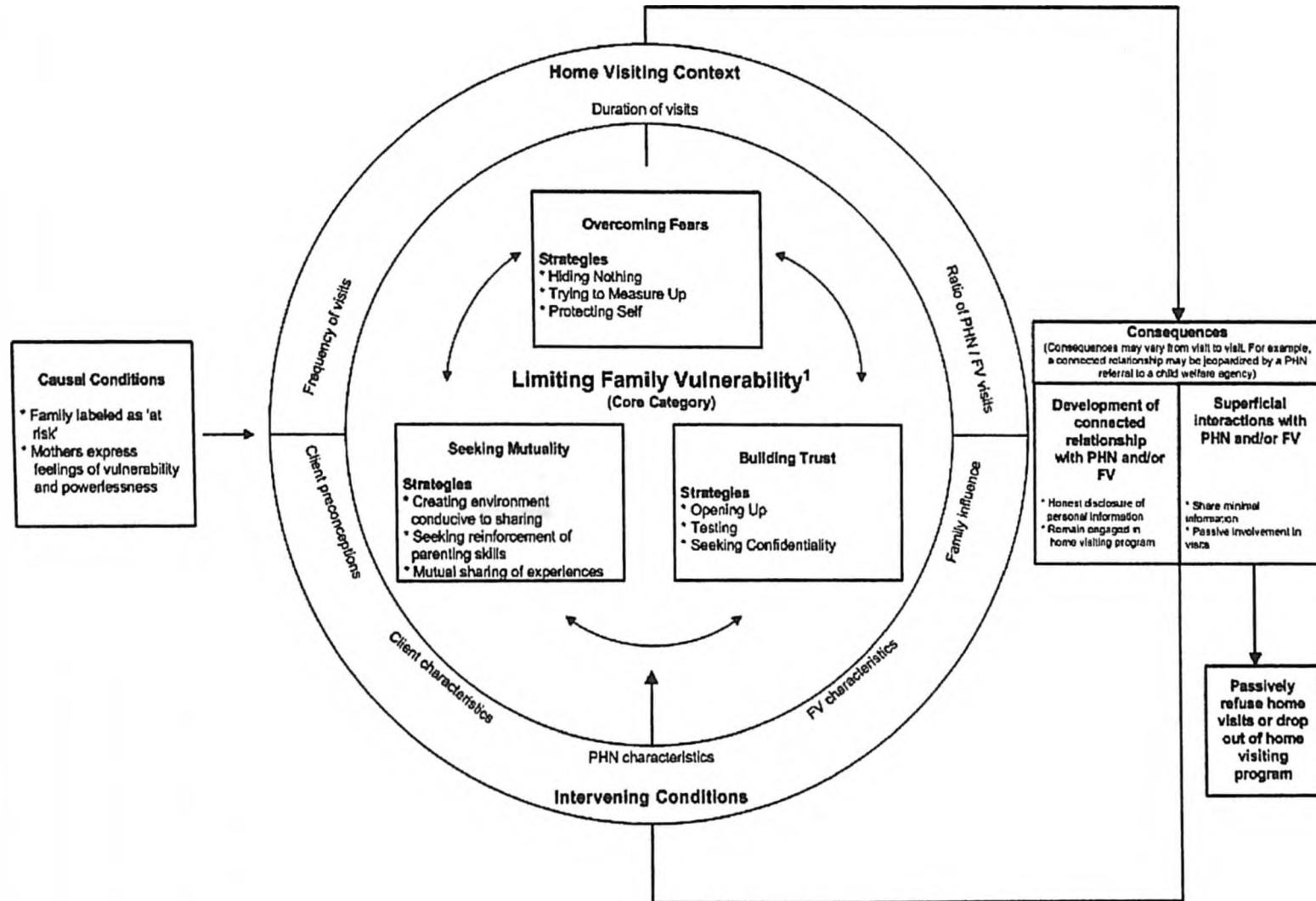
1 Dynamic process that is negotiated during each visit

Chapter 4

Client Factors that Influence Engagement: Descriptive Data from a Grounded Theory Study of Engagement Among Mothers with Children At-Risk, Public Health Nurses and Family Visitors

Mothers, with children at-risk of developmental delays, who participate in home visits engage with public health nurses (PHN) and family visitors (FV) through a basic social psychological process of limiting family vulnerability. The three phases of this process include: (1) overcoming fear, (2) building trust, and (3) seeking mutuality. Successful negotiation of these phases results in the development of a connected relationship, which facilitates the delivery of health promotion services. The development of this interpersonal relationship is influenced by the individual experiences, values, beliefs, and skills of each participant, as well as the relationships that develop between client-nurse, client-family visitor and family visitor-nurse. The purpose of this article is to identify client specific factors that influence a mother's decision to accept PHN and FV services and then continue to participate in a blended home visiting program.

Literature Review

Prior to a home visit, it is common practice for a PHN to schedule an appointment time with the client. However, some clients cancel their appointments or, upon arriving at the house, the PHN finds that the client is not at home. In a prospective study of 232 low-income, high-risk pregnant women who had received at least one PHN home visit, the following client characteristics were associated with not keeping appointments:

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younger age, more stressful life events, receipt of medical assistance, inadequacy of prenatal care, non-compliance with health recommendations, and longer gestational time (Josten, Mullett, Savik, Campbell & Vincent, 1995). Another prospective study examined the relationship between nurse and client characteristics and client termination from a home visiting program in rural Minnesota, U.S.A. (Josten et al., 2002). Mothers who were most likely to continue with the home visits until the care plan goals were met were: married, not mentally ill, and had higher incomes and more children than mothers who dropped out of the program. Conversely, clients who received social assistance, were enrolled in a special, supplemental nutrition program for women, infants and children (WIC), and received food stamps were more likely to drop out of the program before service goals were met.

Both quantitative and qualitative studies have been conducted to understand client preconceptions of and satisfaction with home visiting programs. In England, a sample of 302 low-risk mothers who received visits from nurse health visitors during the first 9 to 12 months of their child's life completed a postal questionnaire to assess their level of satisfaction with the health visiting service (Bowns et al., 2000). The majority of the mothers (86%) were 'fairly' or 'very' satisfied with care provided to their infant, and 72.5% were similarly satisfied with the support and services they received for maternal health issues.

Rovers and Isenor (1988) conducted an exploratory study that examined the perceptions and use of PHN postpartum home visits by rural Canadian mothers who had vaginally delivered a healthy, full-term infant. Two groups of mothers were randomly

selected one year apart. Each group was stratified to include 30 primiparas and 20

multiparas. Prior to hospital discharge, the majority of the mothers (64% and 70%

respectively) identified that they wanted a PHN home visit and perceived that the PHN's

role would be to assess the newborn, and provide the mother information and general

reassurance. After the initial PHN visit, 82% and 76% of mothers respectively perceived

the PHN to be somewhat helpful or very helpful and reassuring. For these mothers, the

most important aspects of the visit included: weighing the baby; a newborn physical

assessment and, the information, support, and reassurance provided by the PHN. Mothers

who perceived the visits as not helpful or of limited help indicated that the visits were

poorly timed, that information provided by the PHN was not compatible with their

personal parenting practices and beliefs, or that there was a poor interpersonal fit between

the nurse and client.

Vehviläinen-Julkunen (1994) administered a postal questionnaire to a random

sample of 263 home visiting PHNs and 323 mothers receiving maternal-child home visits

in Finland to evaluate the function and meaning of home visits for each group. The

results indicated that PHNs and clients have different perceptions about the most

important aspects of the visit. More clients than PHNs identified weighing the baby (81%

of clients vs. 62% of PHNs) and having the baby physically examined by the PHN (76%

of clients vs. 55% of PHNs) as the most important features. Compared to the PHNs,

fewer mothers identified the provision of support and encouragement as the primary

function of home visits (25% of clients vs. 82% of PHNs). Both clients and PHNs

perceived the ability to avoid travelling to a clinic, enjoying a relaxed visit in the home,

and the opportunity for the nurse to meet the father as advantages of home based service delivery.

Qualitative studies provide a more in-depth examination of client perceptions and experiences with home visiting. In a qualitative study Machen (1996) interviewed 20 first time mothers from the United Kingdom about their perceptions of health visiting services. Client responses indicated very high levels of satisfaction with the service. Clients said they valued and needed the visits. None of the mothers personally viewed the visits as intrusive. Five mothers perceived it was the health visitor's role to assess the suitability of the home and monitor the mother's parenting and coping abilities. In another qualitative study Bowes and Meehan Domokos (1998) interviewed 68 Caucasian women and 62 women of Pakistani descent living in Glasgow, Scotland. Mothers with positive experiences in the home visiting program valued the health visitor's role in providing social support and acting as a client advocate. Caucasian women were more likely than women of Pakistani descent to identify health visiting as a controlling and policing profession.

The studies described above use samples of clients recruited from a broad spectrum of mothers eligible to receive maternal-child home visiting services. Positive maternal child outcomes are greatest when home visiting interventions are targeted to mothers at highest risk because of low psychological resources, social circumstances, age, income, or education (Ciliska et al., 1999; Kitzman et al., 1997). Examination of high-risk clients' perceptions of home visiting may provide more insight into the challenge of engaging clients in the program under study in this paper.

Knott and Latter (1999) interviewed 12 single, unsupported mothers with children between the ages of 9 and 21 months receiving services from health visitors in the United Kingdom. This group of high-risk mothers perceived that health visitors were more interested in infant, rather than maternal, health issues. They felt that stigma was attached to receiving home visits, and perceived health visitors as judging them because of their single status. Peckover (2002) interviewed 24 health visitors and 16 women who had experienced domestic violence to understand the differences between professional and lay perspectives of the disciplinary practices of health visitors. Health visitors identified their role as providing both support for mothers and assessing and protecting the welfare of children. Participants perceived that home visiting was a form of surveillance and that nurses were primarily concerned with the mothers' abilities to parent their children. Under these conditions, mothers developed strategies to resist actively participating in visits, such as concealing incidents of domestic violence and avoiding contact with the health visitor.

The Hawaii Healthy Start Program provides weekly paraprofessional home visits to families experiencing high levels of stress or with children at-risk for abuse (Duggan et al., 1999). As part of a randomized controlled trial evaluating the program, parents were asked to discuss their experiences with the program. These parents indicated that the development of a client-provider relationship was the most critical element that contributed to the program's success. Parents had positive perceptions of their home visitors and characterized them as a being like a friend or family member. Families identified the following benefits of participating in the visits: receiving emotional or

social support from the home visitor (44%), being linked to community services (29%), and receiving information about child development and parenting issues (26%). Similar to other home based early intervention programs, client attrition was a significant problem, with 30% of referred families no longer participating by the time the infant was six months and 51% by 12 months (Duggan et al.). In the program evaluation, only 70% of the families assigned to receive home visiting and 50% assigned to the control group remained in the study at 18 months (Center on Child Abuse Prevention Research, 1996). A significant limitation therefore of this study is that outcome data were not collected from families the authors identified as being at highest risk.

In summary, findings reported in the literature identify high levels of satisfaction with both professional and paraprofessional home visiting services. Studies that specifically sample high-risk families are more likely to identify those factors which may influence a client's decision to withdraw from the program before service goals are met. This review also highlights that parents and home visitors have different expectations about the purpose of the home visits. Parents primarily expect the home visitor, particularly during the postpartum period, to focus on the physical health of the newborn. Nurses view their role as being more supportive, rather than delivering physical nursing care only. Parents with children at-risk of developmental delays are also more likely to perceive the role of the home visitor as monitoring living conditions and parenting skills.

All of the studies reviewed were primarily descriptive in nature and provide little insight into the explanation for the high levels of attrition experienced by most home visiting programs. No studies were located that describe clients' experiences of receiving

intensive home visitation from both a nurse and lay home visitor. Recommended priorities for future research included the need to examine client perspectives of home visiting programs and in particular to identify factors which influence family participation in home visits (Center on Child Abuse Prevention Research, 1996; Daro & Harding, 1999; Gomby, Culross, & Behrman, 1999; McNaughton, 2000).

The findings and analysis presented in this article are part of a grounded theory study on engagement among mothers, PHNs and FVs participating in a home visiting program to support early childhood development. The overall purpose of the study is to describe the process of engagement from the client's perspective, and to identify factors that influence the clients' decisions to engage with service providers and to remain in the home visiting program.

Methods

Design

Classic grounded theory techniques (Glaser, 1978; Stern, 1985) were used to guide data collection and analysis. Qualitative research is well suited for providing new perspectives on research questions, filling gaps in the current state of knowledge, and increasing our understanding of clinical problems, particularly how clients create and react to experiences (Schreiber, 2001). A grounded theory approach was used in this study because there is no theoretical model that explains the process of engagement from the client's perspective and that identifies specific personal, social and contextual factors that influence the mother's decision to continue to participate in a home visiting early

intervention program. Ethical approval to conduct this study was granted by the McMaster University and Hamilton Health Sciences Corporation Research Ethics Board.

Sample

Data were collected in South West Ontario, Canada. Participants were recruited through the local public health unit's *Healthy Babies, Healthy Children* program. A purposeful sample of parents participating in the blended home visiting program was identified to provide data about the engagement process among clients, PHNs and FVs. Study inclusion criteria included: being a mother of a child, newborn to six years of age, at-risk for developmental delays related to social, environmental or economic factors; having received at least one PHN and three FV home visits; and the ability to give informed consent and converse in English. In order to identify central themes related to engagement, a heterogeneous sample was recruited using maximum variation sampling. Participants who varied on the following dimensions were included in the study: age, parity, marital status, household composition, and timing of referral (prenatal or postpartum).

As is expected in a grounded theory study, as data analysis progressed and the core category of 'limiting family vulnerability' emerged, theoretical sampling was used to guide the collection of further data. Theoretical sampling involves identifying individuals who can provide information that develops and conceptually links emerging categories (Glaser, 1978). During analysis, it became evident that client preconceptions and prior experiences with social and health service providers and the availability and quality of informal and formal supports influenced a mother's ability and willingness to

engage with home visitors. Therefore, sampling was extended to include mothers who lived in a rural area, who had past experiences with a child welfare agency, who were new immigrants to Canada, and/or whose husband or partner also participated in the home visits. Mothers who were perceived by nurses to not have fully engaged in the home visiting process were also sought in order to raise the level of abstraction of the theory and to better understand the limits of the variables (Glaser).

In total, twenty mothers were interviewed about their early experiences in the home visiting program. During three of the interviews, the participant's husband chose to remain in the room. Both the male and female participants consented to having the father's views and experiences recorded as study data. A follow-up phone call was made to two of these females (the third could not be located) to ensure that the information they shared in the presence of their partner was an accurate reflection of their true feelings and experiences.

Data Collection

As is standard practice in qualitative research, data collection and analysis occurred simultaneously. Demographic data were collected using a short, written questionnaire administered by the principal investigator at the end of the interview. Contextual data about the home visits were gathered through a review of client charts. Each participant's experiences, beliefs, and expectations related to engagement with their PHN and FV were explored during in-depth, semi-structured interviews that lasted between 60-90 minutes. As the core category emerged during analysis, interview questions were added that focused on understanding the dimensions and properties of the

category. Participants were interviewed between one to three times to identify and saturate categories. A total of 29 interviews were conducted, 18 in-person and 11 by telephone. Permission was granted to tape record 23 of the interviews, which were then transcribed verbatim. Extensive notes were made during the other six interviews. Field notes, which contained observations and thoughts around the emerging concepts were recorded immediately following each interview. A summary of their individual interview was presented to 15 participants for review. Five mothers could not be located for follow-up. At the end of the first interview, each participant was given a $20 gift certificate as a token of appreciation for participating in the study. A detailed audit trail was maintained that included a description of all study events and decisions regarding study design, sampling techniques, data collection and analysis.

Data Analysis

Data were analyzed using three levels of coding. First, open coding involved a line-by-line analysis of the transcripts, interview summaries and field notes to identify substantive, or *in vivo*, codes. These codes often capture the participant's own words and tend to be about the behaviours or processes that explain how the basic social problem is resolved (Glaser, 1978). After the core category was identified, selective coding of data was completed to uncover the dimensions and properties of this category (Glaser). Finally, theoretical coding was accomplished by grouping substantive codes into categories and identifying theoretical constructs, which brings the data to a more abstract level (Glaser). Theoretical memos were written at each stage of coding to capture ideas and hypotheses, and to explore the relationship among concepts emerging from the data.

Through this constant comparison of data in theoretical memos, codes were verified and

saturated, while patterns and themes emerged (Stern, 1985). Data continued to be

collected until categories were saturated and no new information was emerging. Coding

of data and the organization of memos were facilitated through the use of NVivo 1.3

software (QSR, 2002).

External checks into the process of inquiry are used to increase data credibility

(Krefting, 1991). Once data analysis was completed, the substantive theory of 'limiting

family vulnerability' was validated in a one-time individual conversation with eight of

the original participants who could be located (member checking). They each agreed that

it 'fit' their experiences in the home visiting program. Academic colleagues and

practicing PHNs provided feedback about the emerging concepts and commented on the

relevancy of the model to nursing practice (peer debriefing).

Findings

Data were collected from 20 women. During the interviews, three men chose to

share their beliefs about and experiences with the *Healthy Babies, Healthy Children*

program. The average age of the female participants was 26 years. The majority of the

mothers had high school education or less and the average household income was

$15,250 CDN. Most of the female participants were Canadian born and first time

mothers. Half of the female sample lived alone with their children and described their

status as either single or separated. Summaries of individual and family demographic

characteristics are presented in Tables 1 and 2. The majority of females were identified

by a health care provider as being at-risk either during pregnancy (n=6) or during the

postpartum period (n=13). Families had participated in an average of 11 PHN and 14 FV home visits. Further program participation data are identified in Table 3.

Client Factors That Influence Engagement

Specific client characteristics that facilitate or inhibit engagement with PHNs and FVs include the mothers' preconceptions about the home visitors' roles, their ability to identify and their motivation to address unmet emotional, instrumental and informational support needs, and their style of attachment with other individuals.

Client preconceptions.

Community and hospital-based health care providers were responsible for identifying 19 of the participants who could potentially benefit from home visiting services and were instrumental in seeking client consent to make the referral to public health (Table 3). Only one mother independently contacted public health and asked to participate in the home visiting program. Preconceptions about the role of the PHN and the purpose of a home visit were variables that influenced the degree of hesitancy to which the client consented to the referral and agreed to the initial home visit. Preconceptions were developed based on past personal experiences, knowledge of others' experiences with PHNs and beliefs about the purpose of home visiting.

Of the 20 mothers interviewed, seven expressed positive preconceptions about PHNs and home visiting. They did not hesitate to consent to the referral and accepted the visit. These mothers had either positive or no past experience working with a PHN. Mothers who had previously received care from a PHN described positive experiences related to home visits for an earlier child, contact in a community prenatal program or

services provided in a sexual health clinic. Some mothers had no previous experience

working with a PHN but were influenced by their friends' positive interactions with

PHNs following the birth of their babies. As one mother recounted when she was

discharged home from the hospital:

> I was so excited [to be in the home visiting program] because I had seen a nurse visit my friends. Also, when I was pregnant my friends told me that a nurse would come visit. I was also happy that she was coming to visit because I wanted lots of information about babies and parenting.

Mothers with positive preconceptions described the role of the PHN as being one of

'helper' or 'lifesaver.' One mother who had a difficult pregnancy and was struggling to

cope with her new baby exclaimed, "I just thought it was so great that somebody could

come see me because I really was having a hard time." They perceived that home visits

were a universal service offered to all new mothers.

The remaining 13 mothers had negative preconceptions of public health services

and were ambivalent about their decision to allow the PHN to visit them. Only one of

these mothers identified a negative past experience with a PHN. She explained that the

negative interaction was because she was a teenager when a PHN visited her following

the birth of her first child. At that time she felt very nervous and self-conscious openly

discussing personal issues such as breastfeeding and contraception. Five of these mothers

had previous experience working with child welfare workers and viewed these

interactions as negative. These mothers also explained that they felt there was a stigma

attached to having a nurse visit, and that only marginalized mothers were targeted to

receive home visits.

Influenced by their personal preconceptions, these mothers feared that the PHN's role was to monitor and check up on them to ensure that they were 'doing everything right.' As one mother explains, "When I first heard about the program, I'm thinking, 'Okay, so somebody is going to come in here and judge me and tell me everything that I am doing is wrong." The greatest fear was that they would be judged as incompetent mothers and reported to the local child welfare agency.

Two of the fathers were concerned about letting a nurse into the house because they didn't want "someone to come and tell me how to raise my kids." The fathers were also apprehensive that the PHNs would challenge their traditional beliefs about parenting and would not be sensitive to cultural differences related to child rearing. After meeting the PHN for the first time, however, the majority of these parents altered their beliefs about the PHN role and were more likely to identify her role as providing support and information instead of monitoring the home situation.

Friends' perceptions about home visiting programs also shaped mothers' negative beliefs about the purpose of home visits. One mother said, "I hear by word of mouth from other people, they say, 'Oh my gosh, she's going to come here and check your house!' or 'She's going to take your kids away,' and stuff like that." Some mothers explained that their extended family members also believed that PHNs were 'nosy' and perceived that their families were sceptical about the benefits of participating in a home visiting program.

Preconceptions about the role of the FV were generally more positive. Mothers indicated that the majority of the PHNs they met had thoroughly and clearly described the

purpose of the FV's work. Common perceptions about FVs were that they would be someone with a similar background to the mother and therefore someone the mother could talk to about personal problems and stressors. They perceived that the FV would discuss infant development, model appropriate parent-child interactions, and help link them with community programs. Only one mother was hesitant about accepting the FV referral because that mother did not perceive herself to be a mother with a child at-risk. She believed that the program was only intended for 'families in need' and that there would be a stigma associated with participating in the program.

Motivation to participate.

As current users of the home visiting services, the mothers all expressed a desire to learn more about parenting and childcare practices. Most of the mothers acknowledged that they had done some reading about infant-child care issues prior to accepting the PHN and FV visits. Mothers identified that they were specifically motivated to accept the PHN home visit because of a need for more information about such topics as pregnancy, labour and delivery, newborn care and breastfeeding; for assistance with breastfeeding problems; and for social support. Mothers were motivated to continue working with their PHNs so they could address such unmet needs as inadequate social support, an inability to manage crises, a lack or potential loss of basic resources for parenting (i.e. food, shelter and clothing), and/or knowledge or skill deficits.

Most mothers were motivated to continue to accept long-term lay home visits because they wanted to learn new ways of interacting with their children and understood that the FV would be able to provide them with information on common parenting

concerns such as playing with children, safety and nutrition. First time mothers identified the need to learn how to care for a newborn. Mothers with more than one child were more likely to identify needs related to caring for older children in the house. Mothers liked the idea of being able to access one person for information. As one mother stated, "I felt a little bit more secure about being a mom knowing that there is someone who is going to come over and answer my questions." One of the most common selling features of the program was that they would learn to make inexpensive toys and baby food for their children.

All of the mothers reported that they lacked an extensive, informal support network. Many of them were physically isolated because they lacked access to transportation and/or lived in a rural setting. Most of the mothers also indicated feeling socially isolated from the broader community because they were recent immigrants to Canada, had little contact with their extended family, or had few friends with whom they could confide in. Therefore, they expected that the FV would become an important source of social support. As one mother admitted:

> I just more or less don't have anybody to talk to. I found that the people in this complex aren't very friendly, so I don't have a lot of friends around here. I looked at the family visitor as somebody who would come out and talk to me about the problems that I am having.

Other mothers were motivated to accept the referral because they understood that the FV would assist them to identify and connect with local community resources, especially camps, daycares or playgroups for their children. They also liked the idea that the FV would accompany them to an agency or appointment that they would have felt insecure about accessing alone.

Mothers were also more likely to accept the FV referral when the PHN clearly explained that participation was voluntary and that they could discontinue the visits at anytime. If the mothers' expectations of the FV were not realized, they were more likely to consider discontinuing the visits. One mother who did ask to return to 'PHN only' visits explained:

> I've heard stories from other mothers that their lay home visitor was bringing games over and if there was something the mother was in the process of doing, she'd get her elbows in there and throw in an extra pair of hands to get the dishes done up or help make baby food. I wasn't finding that with my home visitor. She was more standoffish. I was expecting her to be a little more outgoing and wanting to get her hands in there and work, not basically sitting and discussing stuff.

Mothers who were initially hesitant about accepting PHN visits had the strongest need be perceived by society as a 'good mother.' They were aware of and sensitive to their marginalized status and stereotypes associated with such states as being a 'single mother on welfare.' Taking the personal initiative to voluntarily accept a formal support, such as public health visits, was one way to prove to society that they are making an effort to be what the dominant cultures perceives as a 'good mother'. Asked to describe a 'good mother', one participant explained that it is someone "who is always happy, never tired, and who always has the house clean and kept nice." Those mothers with past experiences with child welfare also reported that voluntarily accepting public health home visitors would be viewed favourably in future interactions with social service or legal systems.

Client interaction style.

The way that mothers characterize their style of interacting and their ability to trust others also influences engagement with the PHN and FV. When asked to describe the ease with which they engage with strangers or professionals, 15 of the mothers identified themselves as open participators, eager to work with others, or very trusting. These mothers were quick to disclose needs and concerns to the PHN and FV, and to begin addressing those issues. The other five mothers stated that they were hesitant to disclose personal information and not likely to immediately trust a professional coming into their home. As one of these mothers said, "I'm one of those people who doesn't trust anybody [other than a few people].... My children I trust, my husband, and my grandmother. That's it. Everybody else, usually they back stab you in some way." These mothers had greater difficulty expressing specific goals to the PHN or FV than more open mothers. They were also less inclined to openly share personal background information with the PHN or discuss their feelings or personal situation. In contrasting information obtained through the interviews with data in the client's chart, it was evident that the needs and issues identified by the nurse and client differed. These mothers stated that they had greater difficulties trusting either the PHN or the FV and were less likely to develop a connected relationship.

Factors That Influence the Maintenance of Engagement

An important variable that increases the likelihood that mothers will remain enrolled in a home visiting program is the development of a "connected relationship" built on trust and mutuality. In these cases, mothers were not fearful of opening up to the PHN or FV and therefore felt less vulnerable. In addition, the extended family's beliefs

about home visiting and the mother's recognition of the short term benefits of participating will also influence her decision to remain engaged in the home visits until her identified goals are met.

Family beliefs about home visiting.

The partner or husband's beliefs about the value and purpose of home visits often influence a mother's decision to continue working with home visitors. The majority of the mothers expressed the view that their partner/husband was very supportive of their work with the PHN and FV. Often he had actively participated in the early postpartum visits and recognized the PHN as a credible source of health information and an important provider of support for the mothers. After meeting and working with the PHN, one father who was not initially receptive to the visits was later quite pleased that his family was connected to a public health program because of all the support they had received. As the mothers transitioned into the phase of receiving intensive, long term FV visits, these fathers remained supportive but generally did not participate in the visits.

If the male partner was not supportive of the mother's continued involvement in the program and if he questioned the value of the home visits, the woman was more likely to consider dropping out of the program than mothers with active partner support. Similarly, if a mother lived with members of her extended family who were not supportive of the PHN and/or FV home visits, this impacted the mother's ability to consistently participate. As one frustrated mother said:

> My mother was asking me, 'Why are they coming? Do you have a problem? Why do they both have to come?' At that time, when my mom was asking all the questions, I ended up cancelling all of my visits and trying to reschedule them for later.

Some mothers expressed the thought that family members who did not support the involvement of the PHN and FV in their lives did so because they felt threatened and afraid that the home visitor, instead of the family, would teach the mother how to look after the baby.

Mothers were less likely to contemplate discontinuing home visits if they did not live with either a partner or family member who was unsupportive of their participation in the program. In describing her boyfriend's perceptions of the PHN and FV, one mother stated:

> He thinks that I shouldn't be having them over. He thinks it's just time wasted and stuff like that. He thinks still that she's checking up on [the baby] and to see if she's getting abused or stuff like that...He also doesn't want his family to know...he's embarrassed that I am having a nurse come here, you know, saying that I don't know what I am doing.

This mother, and others in similar situations, were eager to participate in the home visits and arranged visits at a time when the partner or family members would not be visiting.

Recognizing the short-term benefits of participating.

During the interviews, mothers were asked to discuss their reasons for continuing to work with both the PHN and FV. For the majority of the mothers, the primary benefit was to develop a connected relationship with the PHN and/or FV. However, I also learned that mothers who were also able to identify concrete, short-term benefits that were directly related to their participation were more likely to remain engaged in the program.

The PHN was identified as a credible source of health information who was able to answer a broad range of health related questions. Almost all of the mothers commented

that they felt reassured when the PHN conducted a physical assessment of the newborn during the postpartum period. Mothers consistently commented on how important it was to them that the PHN was able to visit and weigh their babies during the first few weeks of life. As one mother explained, "My baby was very tiny. I was concerned because I was breastfeeding and I was also concerned if she was getting enough. So the weight was important to monitor, just to see how she was doing." The PHNs were also identified as being very skilled at reassuring mothers about their babies' growth and development, and complimenting them on their parenting skills, thereby boosting mothers' confidence in their parenting abilities. Nurses were also an important source of information on community resources and programs that mothers could access.

The mothers indicated that PHN home visits were a convenient way to access health care services. Most of the mothers lacked reliable transportation and felt it would have been very difficult and overwhelming to try to take their newborns to several clinic appointments using public transportation. Mothers discussed the challenges of accessing primary care physicians. Several of them did not have a physician they could contact and others felt that it was 'too much of a hassle' to make an appointment or to travel to a clinic to ask general questions about infant and child care. They greatly appreciated being able to call the PHN anytime they had a question or concern. Mothers were continually amazed by the positive and receptive responses they received from their PHNs. Mothers had many stories of PHNs responding to their needs with a return call or home visit, most often within a day. As one mother explained:

> There was one time I was really concerned about my baby. I called [my PHN] and she stopped in that day, out of the blue, just to see me. She always tells me that

she is up and down [the street I live on] all the time during the day. So she said if you need anything, give me a call anytime. So I've had to do it once and she was here!

When mothers were referred to the home visiting program, many of them were experiencing multiple stressors related to unstable housing, and reduced access to food, baby formula and clothes. One of the immediate benefits for the mothers was the nurse's ability to address their basic needs and provide material support by locating and accessing sources of baby supplies, providing mothers with donated materials, and in some cases assisting mothers in filling out forms to access appropriate financial aid. One father, overwhelmed by the amount of support and assistance a PHN provided to his family, said: "She helped me find a doctor and got me a referral for my surgery. She also helped us find subsidized daycare for our older children, and now she is helping us to find a bigger townhouse."

Emotional support from PHNs was also important to many mothers. Many of these mothers lacked positive, informal social networks. Therefore, many of the PHNs filled the role of listening to the mother, talking to her in a comforting manner, and providing positive feedback about parent-child interactions. Mothers enjoyed the visits and a common sentiment was that when the nurse visits, "I have someone to talk to, someone who will listen to what is going on in my life."

Once a client's immediate health needs are met, the program goal is to slowly decrease the number of PHN visits and increase the number of FV visits. Some of the mothers had reached the stage in the program where the PHN would visit once every eight weeks to review their progress and to identify new goals and the FV would continue

to visit once every week or two. Mothers who were working more intensively with their FV identified several short-term benefits that motivated them to continue accepting this blended model of home visiting. Family visitors were seen as an important source of information, particularly around infant and toddler development, safety and nutrition. They were also able to provide anticipatory guidance to mothers around infant development. Mothers identified the FV as instrumental in their development of new skills such as baby massage, budgeting, making toys and baby food. For recent immigrants to Canada, working with the FV provided them with the opportunity to improve their skill in speaking English. Mothers who were working more intensely with FVs also consistently identified them as an important source of emotional support; many even referred to the FV as a friend who they could confide in. Family visitors were also able to link mothers to local community resources. One mother summed up many of the benefits of working with a FV:

> My new visitor is very motivating and I really look forward to our visits. We talk about issues that are really important to me right now, such as discipline. We also do a lot of different things when she is here, she shows me how to make inexpensive toys, she shows me different things to do with my daughter. The visits are very interactive, she also helps me budget, plan out my time, set goals. She also really cares. When we were short of food around Christmas, she made some calls and made sure that we got some food and a hamper. She has also worked to get me involved in some programs in the community for moms and children.

Other mothers confided that they were contemplating dropping entirely out of the home visiting program or at least requesting only PHN visits because their time was not effectively used during FV visits. As one mother expressed, "[The FV] was repeating everything we had learned before. I felt I was wasting her time and sort of wasting mine."

In other situations, mothers felt that the FV was not consistent in her ability to focus on the issues they had identified as a priority. Some mothers expressed the view that the FV was often more comfortable focusing on her own 'agenda' (generally issues related to child development) rather than on issues the mother wanted to address (e.g., self-esteem, weight control, depression or her relationship with her partner).

Discussion

Client specific characteristics that influence the ability to engage in a connected relationship with PHNs and FVs include preconceptions about the home visitor's role, a motivation to participate, and attachment style.

Parents who had positive preconceptions about PHNs and FVs, who were able to identify specific needs that could be addressed by the home visitor, and who self-identified as being 'open' or 'trusting' individuals had fewer difficulties engaging and developing an interpersonal relationship with a PHN or FV. The decision to remain engaged in the home visiting program was, in contrast, influenced by family beliefs about the value of home visits and the ability of a home visitor to identify and address needs identified as a priority by the mother.

In the home visiting literature, client characteristics that influence the development of a client-provider interpersonal relationship have been identified through interviews with service providers only. Findings from this study of client experiences confirm many of the providers perceptions that there are fewer barriers to entry when clients: have had positive past experiences with other service providers, who have a clear understanding of the home visitor role, who value preventive health services and perceive

a need for the service, who have positive interpersonal relationships with significant others, and whose families support maternal participation in a home visiting program (Byrd, 1999; Luker & Chalmers, 1990; McNaughton, 2000; Zerwekh, 1992).

The mothers' past experiences with PHNs influenced their decision to accept home visits. Findings from this study support the community development work of PHNs. Mothers who had worked with PHNs in a community setting, either a well-child clinic, parenting group, or prenatal program, understood the role of the nurse and did not hesitate to accept the PHN home visit.

The majority of the parents had negative preconceptions about home visiting programs and were hesitant to accept the PHN visit. Preconceptions were based, in part, on past negative experiences with health and social service providers. These mothers also perceived that the role of the PHN was to monitor the home and family situation. They feared being judged as incompetent mothers and having their children apprehended. This supports past findings that mothers with children at-risk perceive the role of the PHN is to monitor and police the family (Peckover, 2002), particularly in North America where home visiting has traditionally been offered to poor, high-risk families (Gomby et al., 1999; Kearney, York & Deatrick, 2000; Swift, 1995). However, after meeting and working with the PHN, the majority of mothers and fathers stated that they were pleased with their decision to participate in the home visiting program. In a study to test the orientation phase of Peplau's theory of interpersonal relations, Forchuk (1994) confirmed that client preconceptions are related to and influence the length of the orientation phase between client and nurse and have an impact on the development of the therapeutic

particularly home visiting programs, must focus on providing informational, instrumental and emotional support rather than emphasize service delivery. To maintain mothers in the home visiting program, it is very important that home visitors, particularly FVs, continue to identify and address the needs that mothers identify as important priorities. Home visitors and clients frequently do not agree on which topics should be given priority during a visit and consequently have differing perceptions regarding the success of the interaction (Pearson, 1991; Vehviläinen-Julkunen, 1994). As soon as mothers feel that the information is redundant or not relevant to their current situation, they are more likely to miss scheduled appointments or withdraw from the program. This supports findings from the provincial HBHC evaluation where it is identified that the most common reasons clients refuse or end home visits are that they did not want help anymore or had no further need for the visits (62%) and that they found the visits not useful (19%) (ARC, 2001).

Identifying key personal characteristics of mothers who participate in home visiting programs can help explain why some mothers fully engage in programs and others only partially engage in them. In counselling, an individual's attachment style is considered a key variable that determines how well a client will relate to his or her therapist (Dolan, Arnkoff, & Glass, 1993). These authors define attachment as the development of a strong, affective union with another individual perceived to be stronger or wiser. Three categories of attachment behaviour have evolved from Attachment Theory: anxious/ambivalent, avoidant or securely attached (Bowlby, 1978; Dolan et al.). Anxious/ambivalent individuals are described as over dependent and immature. They

desire closeness but often perceive others' support for them as temporary and superficial. Avoidantly attached individuals are self-reliant, deny a desire for support, and fear becoming overdependent on others or having others become too dependent on them. In contrast, securely attached individuals trust others, accept support, and are comfortable developing interpersonal relationships (Dolan et al.). Bowlby (1978) has written about the therapeutic implications related to attachment style: securely attached individuals are open to new information whereas those who are insecurely attached are more likely to resist information and care proffered by the therapist.

Family beliefs and perceptions about home visiting also influence clients' decisions to participate or remain in home visiting programs. When family members, particularly husbands or boyfriends, are supportive of the visits, mothers are likely to continue in the program. If a male resides with the mother and begins to question the value of the home visits or perceives the visits as an intrusion into their private lives, the mother is more likely to consider dropping out of the program. When the male is unsupportive, but does not co-reside with the mother and child, then mothers tend to continue participating in the program. In a randomized controlled trial of nurse home visitation in Memphis, Tennessee, mothers who lived with a male partner had better childrearing environments than mothers who lived alone; however mothers who lived alone made the greatest improvements related to maternal and child well-being (Cole, Kitzman, Olds & Sidora, 1998). The authors hypothesized that mothers who lived alone decided what services and supports the family would access in comparison to households where a male partner resided and usually assumed the role of family decision maker.

Implications for Nursing Practice and Research

Public health nurses should continue to be involved in and facilitate community-based programs, such as prenatal nutrition programs or parenting classes. This provides high-risk mothers the opportunity to learn about the PHN role prior to accepting home visits. Given the importance of client preconceptions during the engagement phase, it is important that PHNs and FVs address any misperceptions clients may have during the first visit. At that time, they should also clearly explain the scope of the PHN and FV's respective roles. A significant limitation of this study was that only mothers who agreed to participate in the home visiting program were interviewed. Future studies should identify strategies to recruit mothers who have negative preconceptions of home visiting programs and choose not to participate.

Clients generally decided to participate in home visits because they believed that the PHN or FV would be able to address specific identified needs. Often client and home visitor perceptions of priority needs vary. To keep clients in the program, it is essential that mutual goal setting and collaboration in deciding on interventions to address those goals occur. Both the PHN and FV should be responsible for ongoing evaluation to ensure that client needs are being met. To ensure that FVs are comfortable in addressing a wide range of topics, health units could offer them continuing education workshops to develop their knowledge base.

Public health nurses and FVs should not stereotype all mothers of at-risk children as difficult to engage. Clients have different ways of interacting and inherently different attachment styles influence their ability to develop connected relationships. Future

research on home visiting programs should focus on identifying nursing strategies that are most effective in eliciting positive maternal-child outcomes in mothers of different attachment styles, particularly those who exhibit avoidant attachment behaviours.

Many mothers do not live alone or make decisions in isolation. When possible, and if the mother desires, it may be beneficial for the PHN and FV to encourage other household members to participate in the home visits. When fathers do participate, home visitors should be skilled and knowledgeable enough to present information that is relevant and of interest to him. This may require PHN and FV education around father-infant interactions and male health issues. Due to time constraints and the initial scope of this study, the views of only three fathers were recorded. Given that fathers can influence a mother's decision to participate in a home visiting program, future research with fathers should be conducted that focuses on their preconceptions, experiences and needs related to home visiting programs.

Conclusion

The home visiting literature has been dominated by research obtained from the perspective of the service providers and by descriptive studies of client experiences. The present findings provide new information that explains from a mother's perspective which factors influence engagement among clients, PHNs and FVs. Given the potential of home visiting programs to enhance maternal and child well-being, it is essential that home visitors focus on delivering care that is tailored to the needs and characteristics of each mother.

References

ARC Applied Research Consultants (2001). Evaluation of the *Healthy Babies, Healthy Children* program: The *Healthy Babies, Healthy* Children program in the Middlesex-London Health Unit. Toronto, ON: Prepared for the Integrated Services for Children Division, Ministry of Community and Social Services and Ministry of Health and Long-Term Care.

Bowes, A.M., & Meehan Domokos, T. (1998). Health visitors' work in a multi-ethnic society: A qualitative study of social exclusion. Journal of Social Policy, 27, 489-506.

Bowlby, J. (1978). Attachment theory and its therapeutic implications. In S.C. Feinstein & P.Z. Giovachini (Eds.), Adolescent psychiatry. Vol VI: Development and clinical studies (pp. 5-33). Chicago: University of Chicago Press.

Bowns, I.R., Crofts, D.J., Williams, T.S., Rigby, A.S., Hall, D.M.B., & Haining, R.P. (2000). Levels of satisfaction of 'low-risk' mothers with their current health visiting service. Journal of Advanced Nursing, 31, 805-811.

Byrd, M.E. (1999). Questioning the quality of maternal caregiving during home visiting. Image: Journal of Nursing Scholarship, 31, 27-32.

Center on Child Abuse Prevention Research (1996). Intensive home visitation: A randomized trial, follow-up and risk assessment study of Hawaii's Healthy Start Program. Final report prepared for the National Center on Child Abuse and Neglect. Chicago, IL: National Committee to Prevent Child Abuse.

Chalmers, K.I. (1992). Giving and receiving: An empirically derived theory on health

visiting practice. Journal of Advanced Nursing, 17, 1317-1325.

Ciliska, D., Mastrilli, P., Ploeg, J., Hayward, S., Brunton, G., & Underwood, J. (1999). The effectiveness of home visiting as a delivery strategy for public health nursing interventions to clients in the prenatal and postnatal period: A systematic review. Hamilton, ON: Effective Public Health Practice Project.

Cole, R., Kitzman, H., Olds, D., & Sidora, K. (1998). Family context as a moderator of program effects in prenatal and early childhood home visitation. Journal of Community Psychology, 26(1), 37-48.

Daro, D.A., & Harding, K.A. (1999). Healthy Families America: Using research to enhance practice. Future of Children, 9(1), 152-176.

Dolan, R.T., Arnkoff, D.B., & Glass, C.R. (1993). Client attachment style and the psychotherapist's interpersonal stance. Psychotherapy, 30, 408-412.

Duggan, A.K., McFarlane, E.C., Windham, A.M., Rohde, C.A., Salkever, D.S., Fuddy, L., et al. (1999). Evaluation of Hawaii's Healthy Start Program. Future of Children, 9(1), 66-90.

Forchuk, C. (1994). The orientation phase of the nurse-client relationship: Testing Peplau's theory. Journal of Advanced Nursing, 20, 532-537.

Glaser, B. (1978). Theoretical sensitivity. Mill Valley, CA: Sociology Press.

Gomby, D.S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations-analysis and recommendations. The Future of Children, 9(1), 4-26.

Jack, S., DiCenso, A., & Lohfeld, L. (2002). Opening doors: Factors influencing the

establishment of a working relationship between paraprofessional home visitors

and at-risk families. Canadian Journal of Nursing Research, 34(4), 59-69.

Josten, L.E., Mullett, S.E., Savik, K., Campbell, R., & Vincent, P. (1995). Client

characteristics associated with not keeping appointments for public health nursing

home visits. Public Health Nursing, 12, 305-311.

Josten, L.E, Savik, K., Anderson, M.R., Benedetto, L.L., Chabot, C.R., Gifford, M.J., et

al. (2002). Dropping out of maternal and child home visits. Public Health

Nursing, 19, 3-10.

Kearney, M.H., York, R., & Deatrick, J.A. (2000). Effects of home visits to vulnerable

young families. Journal of Nursing Scholarship, 32, 369-376.

Kitzman, H.J., Olds, D.L., Henderson, C.R., Hanks, C., Cole, R., Tatelbaum, R. et al.

(1997). Effect of prenatal and infancy home visitation by nurses on pregnancy

outcomes, childhood injuries, and repeated childbearing: A randomized controlled

trial. JAMA, 278, 644-652.

Knott, M., & Latter, S. (1999). Help or hindrance? Single, unsupported mothers'

perceptions of health visiting. Journal of Advanced Nursing, 30, 580-588.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness.

American Journal of Occupational Therapy, 45, 214-222.

Luker, K.A., & Chalmers, K.I. (1990). Gaining access to clients: The case of health

visiting. Journal of Advanced Nursing, 15, 74-82.

Machen, I. (1996). The relevance of health visiting policy to contemporary mothers.

Journal of Advanced Nursing, 24, 350-356.

McNaughton, D.B. (2000). A synthesis of qualitative home visiting research. Public Health Nursing, 17, 405-414.

McWilliam, R.A., & Scott, S. (2001). A support approach to early intervention: A three-part framework. Infants and Young Children, 13(4), 55-66.

Pearson, P. (1991). Client perceptions: The use of case studies in developing theory. Journal of Advanced Nursing, 16, 521-528.

Peckover, S. (2002). Supporting and policing mothers: An analysis of the disciplinary practices of health visiting. Journal of Advanced Nursing, 38, 369-377.

Rovers, R., & Isenor, L. (1988). Mothers' perceptions and use of community health services during the postpartum. Public Health Nursing, 5, 193-200.

Schreiber, R.S. (2001). The 'how to' of grounded theory: Avoiding the pitfalls. In R.S. Schreiber & P.N. Stern (Eds.), Using grounded theory in nursing (pp. 55-83). New York: Springer.

Stern, P.N. (1985). Using grounded theory method in nursing research. In M.M. Leininger (Ed.), Qualitative research methods in nursing (pp. 149-160). Orlando, FL: Grune & Stratton.

Swift, K.J. (1995). Manufacturing 'bad mothers': A critical perspective on child neglect. Toronto, ON: University of Toronto Press.

Vehviläinen-Julkunen, K. (1994). The function of home visits in maternal and child welfare as evaluated by service providers and users. Journal of Advanced Nursing, 20, 672-678.

Zerwekh, J.V. (1992). Laying the groundwork for family self-help: Locating families,

building trust, and building strength. <u>Public Health Nursing, 9</u>, 15-21.

Table 1

Demographic Characteristics of Study Participants

Individual demographic variables	Females (n=20)	Males (n=3)
Education		
Less than high school	2	0
Some high school	5	0
Completed high school	8	1
Some college/university	3	0
Completed college university	2	2
Marital Status		
Married	7	2
Common-law	3	1
Single	7	0
Separated	3	0
Parity		
Primiparous	13	N/A
Multiparous	7	
Average Age	26 years (Range 17-40)	30
Immigrant Status		
Canadian citizen	17	2
Recent immigrant to Canada	3	1

Table 2

Family Characteristics

Family Demographic Variables	Families (n=20)
Average Yearly Household Income	$15,250 CDN (Range <10,000-40,000)
Average Number of Children	1.7 (Range 1-4 children)
Household Location	
Rural setting	4
Urban setting	16
Household Composition	
Mother and children only	8
Mother, father, children	10
Mother, children, extended family	2
Past Experience with Child Welfare Agency	
No previous contact with CAS	15
Previous contact with CAS	5

Table 3

Maternal Activity in the Healthy Babies, Healthy Children Program

Program activity	
Timing of referral	
Prenatal	6
Postpartum	13
>6 weeks postpartum	1
Source of referral	
Community Agency or Physician	6
Hospital	13
Client Self-Referral	1
Maternal participation in home visits	
Number of PHN home visits	11 (range 3-25)
Number of FV home visits	14 (range 4-32)
# Months in HBHC Program	
Length of time receiving PHN visits	10 months (range 4-21)
Length of time receiving FV visits	8 months (range 3-19)

Chapter 5

Thesis Conclusion

This sandwich thesis consists of articles accepted or prepared for publication that summarize findings from two original qualitative studies exploring the process of engagement between clients, public health nurses (PHN) and family visitors (FV) in a blended model of home visiting. I have appended an additional article that provides suggestions to assist clinician-researchers to resolve issues that relate to role conflict and the dilemma of intervening clinically within the context of an in-depth interview. The purpose of this concluding chapter is to briefly summarize the contents of each chapter, highlight overall conclusions and clinical implications, detail the strengths and limitations of each study, summarize my role as a nurse-researcher, and present suggestions for future research.

In Chapter 2, findings from a phenomenological study (study #1) of FVs and PHNs suggest that nurses have an important role in marketing home visiting programs and facilitating FV access into the home. Factors related to the FV, the client, and the client's household influence relationship development. Family visitor-client engagement occurs through finding common ground and building trust.

Findings from a grounded theory study (study #2) exploring the phenomenon of client-home visitor engagement from the perspective of the client are presented in Chapters 3 and 4. The basic social psychological process of limiting family vulnerability

is presented in Chapter 3. This process has three phases: (1) overcoming fear, (2) building trust, and (3) seeking mutuality. The personal characteristics, values, experiences and

actions of the nurse, FV, and mother influence the speed at which each phase is successfully negotiated and the ability of the practitioners and clients to develop a connected relationship. In Chapter 4, the client characteristics that influence engagement are examined in further detail. These characteristics include: preconceptions of PHNs and FVs, past experiences with service providers, motivation to participate, client attachment style and the identification of specific health related needs. Remaining engaged in home visiting is influenced by family beliefs about the value of the visits and the client's ability to identify short-term benefits related to working with either the PHN and/or FV.

Overall Conclusions

Preconceptions about the role of the PHN influence a client's decision to accept a home visit. The majority of mothers held negative preconceptions about the program and felt vulnerable when allowing the nurse entry into the home. Despite these feelings, all the mothers agreed to participate in the program because they identified needs they felt the nurse could fulfill. Mothers and FVs concur that PHNs play a vital role in facilitating FV entry into the home. After meeting and working with their PHN, a majority of the mothers described the interactions with her as positive and beneficial to maternal and infant well-being.

All of the mothers expended tremendous energy preparing for their home visits and experienced varying degrees of anxiety prior to meeting the nurse. Clients were very

fearful that the nurse would judge them. Mothers of at-risk children engage with PHNs and FVs through a process of limiting family vulnerability. Throughout the home visiting process, mothers work to overcome their fears of participating, build trust with the home visitors, and most importantly seek to establish mutuality. Successful negotiation of this process results in engagement and the development of a connected relationship. According to the mothers, the development and maintenance of this relationship is, in itself, a primary benefit of home visits by the PHNs and FVs. Findings from both studies support the hypothesis that failure of the home visitor (nurse or FV) to establish an interpersonal relationship with the mother will result in poor engagement and may lead to the mothers withdrawing partially or fully from the program.

Maternal, PHN and FV characteristics also influence the engagement process. Home visitors said that some clients are open to the process whereas others are more reserved and often stay on the periphery, watching the FV interact with the child. The mothers concurred, identifying themselves as either trusting or guarded individuals. To build trust, FVs establish common ground with the mother.

In discussions about FVs, mothers explained that it was easier to work with someone who spoke her language, had similar cultural values, and life events. This shared culture is the rationale often cited for using paraprofessional home visitors instead of professional home visitors, who tend to represent middle class, majority values. This hypothesis was explored in the second study and clients clearly identified that they were able to engage with professional PHNs despite their differences in age, level of education and socioeconomic status. The determining factor appears to be the home visitor's ability

to connect with clients on a personal level and their willingness to share stories of

personal parenting experiences within accepted client-provider boundaries and not their

status as either professional or paraprofessional home visitor. One benefit of

implementing a blended model of home visiting, is that it increases the likelihood that the

client will be able to develop a connected relationship with at least the PHN or FV.

The provincial implementation guidelines for the *Healthy Babies, Healthy*

Children program recommend a visiting ratio of one PHN visit for every three FV home

visits (Ontario Ministry of Health, 1998). Findings from this study suggest that intensive

nurse home visitation or an increase in the number of PHN home visits compared to FV

visits is justified when clients are in crisis. Clients experiencing acute social, medical or

economic crises explained that the nurses were best able to support them in meeting their

basic needs. Once the situation has stabilized, mothers are better able to work with the

FV and focus their attention on the more abstract issues of parenting and child

development.

Mutual goal-setting by the PHN, client and FV is an essential step if families are

to remain engaged in the home visiting program. Research on client-home visitor

interactions has repeatedly demonstrated that there often is disagreement between nurses

and mothers on the priorities for discussion during the home visit (McNaughton, 2000).

The goals of the public health home visiting program include providing support and

linking families to community resources to promote long-term healthy child growth and

development. In my studies, clients perceived the PHN visits that addressed their

immediate needs as the most beneficial. Securing access to food or clothing, obtaining

subsidized childcare, addressing emotional or physical health concerns, or supporting the family to locate new housing are examples of interventions that the clients appreciated.

Public health nurses were viewed as credible sources of health information. Some families discussed the difficulties they experienced in accessing a local family physician. These difficulties included not having a family physician or finding it too difficult to make and travel to an appointment to have the newborn weighed, breastfeeding issues addressed, or questions around newborn care answered. For these families, the PHN was able to address all of their questions and concerns in a timely and convenient fashion.

Clients expressed that it was important for FVs to identify and focus on the mother's priority concerns. To 'get something out of' the FV visits, the clients expressed preferred visits that were highly interactive and involved 'hands-on' activities such as practicing baby massage, making home made baby food or creating a family budget. It is interesting to note that the tools family visitors and nurses use mainly as 'hooks' to gain entry into the home such as baby scales, parenting videos or toys, represent the activities that clients identify as the most important aspects of a home visit. Mothers who were dissatisfied with the content of their interactions with family visitors contemplated passively refusing the visits or asking to work with the PHN only.

It is evident from both studies that family members, particularly those living with the mother-child dyad, influence a mother's decision to accept or remain in the home visiting program. When the father or grandparents perceive home visits as a threat or 'not of use', the home visit may become a source of conflict within the household. This means that home visitors must identify successful strategies for engaging both the mother and

the family subsystem. As a minimum, all home visitors should clarify their role and the purpose of the visits to all household members. Home visitors should also give mothers the opportunity to decide where the home visit occurs, and who should participate. Kitzman and colleagues (1997) identify that home visiting programs have the potential to alter family dynamics and therefore it is the responsibility of the nurse to predict, plan for and evaluate any of these changes that occur in order that the program be effective and that maternal safety and well-being is secured.

Clinical Implications

Given the importance that mothers place on developing a connected relationship with at least one of their home visitors (either the PHN or FV), an evaluation of the client-provider relationship should be integrated into the formal client review process. Continuing education opportunities should be provided for both PHNs and family visitors to facilitate the development of communication and relationship building skills. If PHNs and FVs are to develop relationships with high-risk clients based on trust and mutuality, then I support the provincial recommendation for providing opportunities for reflective practice, for identifying appropriate boundaries between clients and home visitors, and clarifying the limits of both professional and paraprofessional roles (Registered Nurses Association of Ontario, 2002).

To promote a successful blended model of home visiting, several other strategies should be taken into consideration. First, the goals and objectives of the program should be marketed and promoted both provincially and locally. Second, health units should support the development of strong partnerships between FVs and PHNs. Third, schedules

of visiting and the provider ratio of home visits should be flexible in order to meet the changing demands of families. Intensive nurse home visitation should be supported during the early phases of the relationship or whenever clients experience acute episodes of stress or multiple crises. As families move into periods of relative stability, then FV visits can be increased and nurse visits decreased.

Suggestions for Future Research

These two studies specifically focused on the entry phase in home visiting and the process of client-provider engagement. Future qualitative research is also needed on the working and termination phases of the home visiting process from the client perspective. I recommend that future studies use a study design that recruits client-FV-PHN triads, so that preconceptions, experiences, and home visiting events can be explained, understood, and verified from multiple perspectives. Then the hypotheses that comprise the grounded theory of limiting family vulnerability can be tested in other studies.

Given that clients have different attachment styles and vary in their ability to engage with home visitors, an investigation of nursing strategies that are effective in engaging those who are hardest to reach should also be conducted. A tool to assess the quality of the client-provider relationship within the context of a home visit should be developed and tested.

Strengths and Limitations

Study One

In 1999, when the first study was conducted, the *Healthy Babies, Healthy Children* program had been running for only 16 months. Several limitations were

imposed on this study because of the program was new. Although, this was a study of the lived experiences of FVs and PHNs working in the program, the PHNs had limited experiences working with FVs. Family visitors were also new to this role. I expect that as the program becomes more established, future discussions with the participants about their roles will be richer and more detailed. A deficit related to program implementation at that time was that comprehensive data were not collected about the families. For example, the health unit did not collect statistics on the number of families who refused a referral from the nurse to the *Healthy Babies, Healthy Children* program. Therefore, during the course of the study I could not accurately determine the scope of this problem. Recent findings from a provincial evaluation of the *Healthy Babies, Healthy Children* program indicate that 4% of eligible Ontario families refused the referral to the blended home visiting program (ARC, 2002).

Using Lincoln and Guba's (1985) framework for evaluating qualitative data, several strategies were incorporated into the study design to enhance rigour. Credibility, or confidence in the accuracy of the data, was strengthened by purposeful sampling, peer debriefing, member checks, and the triangulation of investigators, data collection techniques and sources. Accuracy in coding was reached by having an experienced researcher validate the coding on one transcript.

Confirmability, or the neutrality of the data, was supported by maintaining a detailed audit trail consisting of raw data, field notes, process and reflexive journals, bracketing essays and the coding schema. The research assistant trained by me, conducted a pilot interview of a PHN. This familiarized her with the study aims and

methods. Frequent meetings and discussions took place between the us to discuss emerging concepts and any issues that arose during the data collection and analysis process.

Study Two

The findings from this study describe the experiences of mothers who agreed to participate in the *Healthy Babies, Healthy Children* program. Due to the limitations of time, budget, and the scope of this study, no effort was made to recruit high-risk mothers who refused the initial referral to public health or to extend sampling to include a larger number of males. Inclusion of these populations in future studies may provide further insight into public preconceptions about public health and identify those factors that influence the decision to participate in an early intervention program.

While conducting this study, unexpected complications during my pregnancy and my subsequent maternity leave resulted in an extended period of time between the start and end points of data collection and analysis. As a result, I was able to confirm the accuracy of my interpretations of the interview data with only 15 of the 20 participants (member checking). Once data analysis was completed, I was only able to locate eight of the original participants to assess if the grounded theory of 'limiting family vulnerability' explained their experiences of engagement with PHNs and FVs. Nonetheless, these eight participants confirmed that the theory accurately described their experiences, particularly the descriptions of their preconceptions and their desire to develop connected relationships with the home visitors.

Peer debriefing, another strategy to increase credibility, involves presenting emerging hypotheses to colleagues knowledgeable about qualitative research or the substantive topic of inquiry but who are not directly involved in the study (Krefting, 1991). My insights into the emerging categories and identification of problems I was experiencing with data analysis were discussed and challenged by a group of nursing graduate students. Emerging theory and working hypotheses were examined by a group of seven PHNs. Feedback was also obtained from an experienced public health program manager.

Triangulation, or the use of multiple perspectives to confirm data and minimize bias, is another strategy to enhance credibility (Krefting, 1991). In this study, triangulation of methods (interviews and chart reviews) and of data sources occurred. I actively recruited a heterogeneous sample of mothers that represented the diversity of program participants. Negative cases, or those mothers who were perceived by nurses to not have fully engaged in the home visiting process, were also sought in order to raise the level of abstraction of the theory, to understand the limits of the variables, and to disconfirm earlier hypotheses (Glaser, 1978; Lincoln & Guba, 1985).

Krefting (1991) suggests that knowledge of the researcher's investigative skills, expertise in qualitative research methods, and degree of familiarity with the substantive area of inquiry can impact the credibility of the study. Recognizing my status as a novice grounded theorist, I actively sought out many resources to enhance my knowledge of the methodology and to improve my skills in data collection and analysis. These included: completing a graduate level qualitative research methodology course, attending a data

analysis workshop conducted by Dr. Juliet Corbin (an internationally renowned expert in grounded theory), seeking out and communicating via e-mail and telephone with experienced grounded theorist mentors, reading primary grounded theory texts (i.e. Glaser, 1978; Glaser, 1992; Schreiber & Stern, 2001; Strauss & Corbin, 1998) and reviewing multiple examples of grounded theories. During the data collection portion of the study I relied on my communication and relationship building skills developed over 10 years of nursing experience. Because of my experience as a community health nurse, and my comfort and familiarity working with marginalized populations, I was able to quickly develop rapport with the majority of study participants.

During this study, I worked to balance many different roles including student, researcher, nurse, and client. When I was placed on bedrest during my pregnancy, I was referred to the local *Healthy Babies, Healthy Children* program (this was at a geographic location different from the data collection site). As a client, I gained insider status and developed new insight into the process of home visiting. In qualitative studies, the researcher/interviewer is the research instrument through which data are collected, filtered, processed and analyzed. It is his or her values and beliefs that influence which concepts are further explored (Lipson, 1991; Rew, Bechtel, & Sapp, 1993). Acutely aware that my personal experiences had the potential to bias data analysis, I took steps to ensure that hypotheses emerging during analysis were grounded in the data and not solely representative of my experience. These steps included writing extensive memos describing my thoughts and reactions to the home visits, discussing my personal experiences with my thesis committee members, and seeking guidance from my

grounded theory mentors. Fortunately, 20 of the 29 interviews were conducted prior to my referral to the program, thus ensuring that interview questions were not limited to ones that would only confirm or negate my experiences.

In comparison to the study participants, I had positive preconceptions of the program, clearly understood the role of the PHN, and was motivated to participate. As a former colleague of the visiting nurse, trust and mutuality had been established prior to the first visit and therefore we were able to move immediately into the work of health promotion. However, working with the PHN in the privacy of my home increased my sensitivity to two important concepts. First, during the prenatal period, I worried that the PHN would judge me because the house was not immaculate and I did not have baking or coffee ready to offer her. Second, I realized the implications of being labelled 'at-risk'. Once the twins were born, the PHN started to pressure me into accepting a FV and made referrals for infant development and speech assessments. At the time I felt powerless and hesitant to refuse the FV and developmental assessments, both of which I felt were unnecessary. Upon returning to the data analysis process, I was surprised to see how frequently the themes of "fear of being judged" and "feelings of vulnerability" were emerging from the data. This is not surprising, given the fact that the study participants faced greater risks and consequences related to being judged as incompetent mothers or being labelled 'high risk' by the health and social service systems than I did.

To increase the dependability, or consistency of findings over time, I employed a code-recode strategy during data analysis (Krefting, 1991). Each transcript or interview note was initially coded. After two to four weeks, I recoded the same data and compared

the results to ensure that all essential codes had been captured. As data analysis progressed and new codes were identified, I returned to previous transcripts to identify situations where these new codes could be applied.

Confirmability, or auditability, implies that another researcher would obtain similar conclusions, given the same data and research conditions (Lincoln & Guba, 1985). To increase confirmability I kept a detailed audit trail, which included raw data (field notes, interview summaries, interview transcripts, and chart review summaries), data reduction and analysis products (coding schema, theoretical memos), process notes (descriptions of study events, decisions regarding participant recruitment, data collection and analysis) and reflective memos (notes summarizing my personal experiences, biases and reflections on the process).

Balancing Nurse and Researcher Roles

As both a researcher and nurse, I was aware that my professional nursing knowledge and experiences could affect relationship development with the participant. To reduce potential role conflict, I followed several of the suggestions outlined in Appendix A. To reduce participant confusion regarding my presence in her home, I clearly informed each mother that I was a graduate student from McMaster University conducting a research study on mothers' experiences of engagement. I explained that the primary purpose of my visit was to ask questions about her personal experiences. In addition, I honestly informed them that I was a nurse and had previous experience home visiting families, but that I did not have any professional affiliation with the health unit providing their services.

I assured the mothers that I would protect their anonymity and that all of the information they shared with me would be kept confidential, with one exception. I explained that if I observed any evidence of child abuse or neglect in the home, then I had a professional and legal responsibility as a nurse to report it to the local child welfare agency. This clause was clearly outlined in the study information letter (Appendix B) and verbally discussed with each participant.

Given that I was studying a population that is typically 'hard to reach' or 'difficult to engage', I recognized that as a stranger entering the home I may experience some difficulty in establishing rapport. Strategies used to build trust with the family included accepting their offers of refreshments, bringing toys for the children to play with during the interview, complimenting the mother on some aspect of her parenting and providing assistance when required (for example, to change a baby's diaper or to teach a mother how to cook chicken). When appropriate, I also made personal disclosures about my own pregnancy and parenting experiences as they related to the conversation. It was my experience that these disclosures were most helpful in building trust and encouraging the client to openly share her experiences.

Prior to the interviews, I contracted with the health unit that I would not provide nursing care during any of my interactions with their clients. It was agreed however, that I could answer general parenting or health questions that would not require further follow-up or evaluation by a nurse. If nursing concerns arose during the interview, I was prepared to provide the client with the health unit phone number and encourage her to contact her PHN as soon as possible.

Conclusion

Parenting can be a difficult, stressful, and isolating experience for many new mothers. As a resource for families, PHNs and FVs make home visits to support positive parenting practices, promote healthy child growth and development, and connect socially and physically isolated mothers to community resources. Mothers who have been labelled as high-risk are often perceived by public health staff to be the hardest-to-reach and the most difficult to engage in the home visiting process. Mothers have indicated that it can be difficult to engage with home visitors because of their feelings of vulnerability and powerlessness. An in-depth examination of the mothers' experiences revealed that they are able to overcome their fears when PHNs and FVs are willing and able to develop relationships built on trust and mutuality. When visiting families at-risk, PHNs and FVs have a responsibility to acknowledge the anxiety parents experience and to focus on relationship development in addition to the delivery of program content. Taking these steps may lead to improving the engagement process in the *Healthy Babies, Healthy Children* program which may increase the likelihood of an effective working relationship among clients, PHNs and FVS and ultimately contribute to the support of families with children at-risk.

References

ARC Applied Research Consultants (2002). Project report: Evaluation of the Healthy Babies, Healthy Children Program-Middlesex London Health Unit 2001-2002. Toronto, ON: Prepared for Early Years and Healthy Child Development Branch, Integrated Services for Children, Ministry of Health and Long-Term Care and Ministry of Community, Family and Children's Services.

Glaser, B.G. (1978). Theoretical sensitivity. Mill Valley, CA: Sociology Press.

Glaser, B.G. (1992). Basics of grounded theory analysis: Emergence vs. forcing. Mill Valley, CA: Sociology Press.

Kitzman, H.J., Cole, R., Yoos, H.L., & Olds, D. (1997). Challenges experienced by home visitors: A qualitative study of program implementation. Journal of Community Psychology, 25(1), 95-109.

Krefting, L. Rigor in qualitative research: The assessment of trustworthiness. American Journal of Occupational Therapy, 45, 214-222.

Lincoln, Y.S., & Guba, E.A. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Lipson, J.G. (1991). The use of self in ethnographic research. In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (Rev. ed.), (pp. 73-89). Newbury Park, CA: Sage.

McNaughton, D.B. (2000). A synthesis of qualitative home visiting research. Public Health Nursing, 6, 405-414.

Ontario Ministry of Health (1998). Implementation guidelines for the *Healthy Babies, Healthy Children* Program: Phase 2. Toronto, ON.

Registered Nurses Association of Ontario (2002). <u>Establishing therapeutic relationships:</u>

   <u>Best practice guidelines</u>. Toronto, ON: Prepared for the RNAO Best Practice

   Guidelines Project.

Rew, L., Bechtel, D., & Sapp, A. (1993). Self-as-instrument in qualitative research.

   <u>Nursing Research, 42</u>, 300-301.

Schreiber, R.S., & Stern, P.N. (2001). <u>Using grounded theory in nursing</u>. New York:

   Springer.

Strauss, A., & Corbin, J. (1998). <u>Basics of qualitative research: Techniques and</u>

   <u>procedures for developing grounded theory</u> (2nd ed.). Thousand Oaks, CA: Sage

Appendix A

Clinician-Researcher Role Conflict in Conducting In-depth Interviews

Conducting an interview in qualitative research is a complex social interaction that both the researcher and the respondent have the capacity to influence or be influenced by (Hutchinson & Wilson, 1994; May, 1991). The quality of the data that are shared and collected is influenced by multiple factors including the context of the interview, the meaning(s) attributed to being interviewed, and the values, beliefs and experiences of both the researcher and the participant (May). Another layer of complexity is added when the researcher is a clinician and therefore brings professional knowledge and skills based on established standards of practice and an ethical code of conduct to the interaction (Moch, 2000; Wilde, 1992). In this article, I will examine the relationship between clinician-researchers and research participants within the context of qualitative interviews. Issues that arise during interviews related to role conflict and the desire to provide clinical interventions are discussed. Questions for consideration are proposed to assist researchers reflect about the nature of the relationship they establish during an interview so that both the credibility of the data and the participant's integrity can be maintained.

The Dilemma for Clinician-Researchers

In quantitative research, interviews are conducted to complete structured questionnaires. Here the role of the researcher is clear: to remain neutral and objective and to limit researcher influence over the study subject. In contrast to survey research,

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qualitative interviews are conversational in nature and the goal is to discover how the phenomenon under study is perceived and described by the participant in his or her own words. However, because the qualitative interviewer is the research instrument through which data are collected, filtered and processed, it is his/her values and beliefs that influence what concepts should be further explored (Lipson, 1991; Rew, Bechtel, & Sapp, 1993). Despite the reliance on in-depth interviewing in qualitative research, few clinician-researchers include a detailed discussion in published works about the nature of the relationship with research participants or particular challenges encountered during interviewing (May, 1991). There are some anecdotal examples though of qualitative researchers who describe the struggles they experienced in balancing their dual roles as both researcher and clinician (i.e. Bourdeau, 2000; Hamberg & Johansson, 1999; Krefting, 1991; Sword, 1999).

Philosophical Assumptions

It is generally accepted that effective qualitative researchers require strong interviewing skills including the ability to quickly establish rapport during the initial contact (Field & Morse, 1985; Hutchinson & Wilson, 1994). Good rapport is essential to building trust, which is necessary if participants are to share intimate details about private, and often sensitive or controversial, aspects of their lives (Acker, Barry & Esseveld, 1983; Field & Morse). Where trust does not exist, participants are more likely to provide information based on what they perceive the researcher wants to learn (Lipson, 1991).

Some authors state that while this trust is necessary to enhance the depth of the information collected, it must be balanced with a certain level of detachment so that partial objectivity can be achieved (Hutchinson & Wilson, 1994; Smith, 1992). This requires that the researcher refrain from offering opinions or information during the course of the interview, so as to not introduce bias. Others assert that meaningful data can only be obtained when the researcher and participant establish an authentic relationship built on closeness, engagement, reciprocity and mutual self-disclosure (Cartwright & Limandri, 1997; Connors, 1988; Oakley, 1993; Schutz, 1994; Wilde, 1992).

This debate is important because at the foundation of qualitative research there is a continuum of philosophical beliefs, each based on different assumptions. Prior to commencing qualitative interviewing, it is important that clinician-researchers are familiar with the philosophical assumptions underlying qualitative research. Different epistemological assumptions about the nature of the researcher-participant relationship in qualitative interviewing exist. While there is general acknowledgement that qualitative research cannot be purely objective because the research question, design, and analysis are all influenced by the researcher's experiences, strategies to minimize the influence of the researcher on the interaction have been emphasized (Archbold, 1986; Field & Morse, 1985; Hutchinson & Wilson, 1994; Swanson, 1986). Debate regarding the dominance of this approach has resulted in the "relative neglect of the impact of the person of the researcher on data gathering and analysis" (Lipson, 1991, p. 73).

Proponents of interpretive and critical paradigms reject the possibility that value-free, objective and neutral researcher-participant relationships can be developed within

the context of a qualitative interview. They suggest that an openly subjective approach be adopted in qualitative research wherein the researcher participates in the interview as a whole person and strives to develop authenticity through forming a relationship with the participant built on openness, respect and reciprocity (Connors, 1988; Porter, 1993; Schutz, 1994; Wilde, 1992). It is thus openly acknowledged that the interviewer is part of the research process and that his/her values and beliefs will influence the information that is shared and collected. This approach has been strongly advocated by feminist researchers who believe that if meaningful information is to be shared, then personal involvement "is the condition under which people come to know each other and to admit others into their lives" (Oakley, 1993, p. 242).

Issues in Qualitative Interviewing

Role Conflict

The role of a qualitative researcher is to collect, analyze and interpret data, and report findings for the purpose of increasing understanding about the phenomenon under study (Hutchinson & Wilson, 1994). However, within the context of an interview, it may become difficult to assume the sole role of researcher. In a study of family caregiving conducted by nurses, multiple roles and relationships between the researchers and the participants emerged, including: stranger-stranger, researcher-participant, friend-friend, nurse-client, and guest-host (Cartwright & Limandri, 1997).

Clinician-researchers may experience role conflict when deciding how to introduce themselves to participants. Interviewers are aware that the initial introduction will influence the participant's perception of them (Schutz, 1994). For example, if they

identify themselves as 'nurse-researchers', then participants with positive past experiences with nurses may feel comfortable sharing intimate information to which others may not have been privy (Chenitz, 1986). Conversely, if participants' experiences have been negative then they may purposefully omit information, especially if they are aware that the nurse has a professional responsibility to act on any disclosed information. If participants are unfamiliar with the process of research, then they may view the interviewer in the more familiar role of 'nurse' and attempt to focus the interaction towards their clinical concerns (Archbold, 1986; Moch, 2000). On the other hand, concealing one's role as a clinician may create both personal and ethical concerns for the researcher (Lipson, 1991; Sword, 1999).

An extra layer of complexity exists if the researcher conducts research interviews with his/her own patients. Hamberg and Johansson (1999), family physicians who interviewed their patients about long-term musculoskeletal pain, found that interview situations were filled with tension and that power asymmetry with participants was extreme. Both Britten (1995) and Archbold (1986) advise that clinicians should not interview their own patients because they may feel compelled to participate, fearing that refusal might jeopardize the care or treatment they are receiving.

Desire to Provide Clinical Interventions

The ability to effectively communicate and interpret data on multiple levels is a skill that contributes to both effective in-depth interviewing and the delivery of professional health care (Lipson, 1991; Swanson, 1986). However, even though the goal of a research interview is to generate knowledge, the act of participating in this process

may have therapeutic benefits for the interviewee. For some people, especially those who are vulnerable and marginalized, the experience of telling their story has been described as empowering, cathartic, healing and an opportunity for self-reflection (Lipson; Smith, 2000; Hutchinson, Wilson & Wilson, 1994).

A different situation exists when a clinician-researcher decides to intervene or is asked to provide health information during an interview. In a study about the transition to motherhood, Oakley (1993) identified that over the course of 178 interviews, she was asked 878 questions and that 76% of these questions were requests for health information. Several authors argue that while health care providers are socialized to care and provide service, the primary objective of a research interview is to collect data and not to offer intervention (Chenitz, 1986; Field & Morse, 1985; Swanson, 1986).

The impact of providing clinical interventions during in-depth interviewing can be interpreted differently depending upon the researcher's philosophical assumptions about the nature of the researcher-participant relationship. From a post-positivist perspective, Hutchinson and Wilson (1992) caution that interventions made during an interview threaten the validity or objectivity of the data. Information provided by the clinician-researcher may influence the participant's responses, change the focus of the interview, discourage the participant from openly sharing more information or prematurely terminate the interview (Field & Morse, 1985; Lipson, 1991). In spite of this, refusing to answer clinical questions or concerns may negatively affect the interview (Britten, 1995). One strategy to deal with these issues is to defer requests for information until the end of the interview (Britten; Swanson, 1986). When a need for further intervention is

identified, then the clinician-researcher should refer the participant to another health care professional (Field & Morse; Swanson).

In interpretative or critical paradigms the subjective nature of the researcher-participant relationship is highlighted. Therefore, intervening during an interview is seen as enhancing rather than threatening the validity of the data (Hall & Stevens, 1991; Oakley, 1993). Rather, it is this reciprocal exchange of information that builds rapport and trust so that more meaningful information is ultimately shared (Acker et al., 1983; Connors, 1988). Offering of health-related information is also seen as a positive reward that offsets the burden of participating in long interviews that are often physically and emotionally exhausting (Demi & Warren, 1995; Oakley). Wilde (1992) hypothesizes that intervening may even open up new areas for inquiry and exploration.

Regardless of the researcher's paradigmatic stance, there are certain circumstances when the clinician has a legal and ethical responsibility to intervene and perhaps even to stop an interview. If a serious conflict should develop, then the need to provide a therapeutic intervention should take precedence over the need to collect data (Munhall, 1988). For example, if during the course of an interview, the researcher learns or suspects that a child may be in need of protection, the interviewer must report this information to a local children's aid society. The clinician-researcher also has a professional responsibility to intervene if there is an immediate threat to an individual's health and safety, such as respiratory distress or cardiac arrest and she/he has the professional skills to cope with such a threat. The clinician-researcher may also feel a professional responsibility to intervene if she is interviewing an individual in the

community who has limited access to health and social services, or who may not have the skills to follow through with a referral to another health care professional.

Questions for Personal Reflection to Aid Decision-Making

No absolute answers can be given to resolve many of the challenges that clinician-researchers experience while conducting qualitative interviews. Instead, researchers need to reflect upon, rather than ignore, the effect of their involvement on the data (Porter, 1993). Reflexivity, or reflexive analysis, is the process whereby the researcher evaluates the self as the data collection instrument and analyzes the influence of personal and professional values, beliefs and experiences that impinge on the research (Demi & Warren, 1995; Krefting, 1991; Lipson, 1991).

There is a considerable amount of literature highlighting the value of and describing reflexivity, but there is little to guide clinicians who struggle with balancing a dual role while conducting qualitative interviews. What follows is a list of questions and suggestions to assist clinician-researchers reflect on and resolve some of the issues that arise around role conflict and the dilemma of intervening within the context of an in-depth interview.

1. What is the paradigmatic approach in which the research design is situated?

In qualitative research it is imperative that the researcher explicitly identifies the paradigmatic approach in which the research design is situated. The assumptions associated with a particular paradigm will define how a researcher interacts with participants. Related questions that need to be raised include: What is the form and

nature of reality? What is the nature of the relationship between the clinician-researcher and the participant?

2. What have been participants' past experiences with research and the researcher's profession?

It is important to explore with the participant their perceptions and experiences with past care from health and social service providers. The participant's perception of the agency sponsoring the research should also be examined. The nature and quality of their previous experiences with staff from that agency also needs to be understood. Particularly in program evaluation studies, if the clinician-researcher is a part of the institution where the participant is receiving care then honest opinions may be suppressed (Ramhøj & de Oliveira, 1991).

3. What kind of boundaries should be established between the clinician-researcher and the participant?

It is impossible to reduce all inequalities of power, but researchers must protect participants' rights to anonymity, confidentiality and reduce any psychological, physical or social risks associated with participating in an interview (Hutchinson et al., 1994). To decrease the imbalance of power, some authors advocate for mutual self-disclosure, or the sharing of personal values, beliefs or opinions to emphasize shared experiences and minimize differences (Oakley, 1993; Wilde, 1992). When the researcher expresses opinions there is a risk that the participant will choose to agree with the researcher's conclusions, but Hamberg and Johansson (1999) suggest that sharing opinions and interpretations actually opens up opportunities for the participants to react, protest or

modify their responses. If the researcher chooses to disclose personal information, how much is appropriate? Self-disclosure and the intimate content of many interviews may turn the researcher-participant relationship into a friend-friend relationship (i.e. Moch, 2000; Oakley, 1993). Does this enhance the quality of the data or does it create an increased risk of exploitation (Acker et al., 1983)? How does the development of a friendship affect the reporting of research findings?

4. How should a clinician-researcher present his/her role to a participant?

To minimize role conflict, researchers need to be able to clearly define and articulate their roles to participants. Careful consideration must be given to how one presents him or herself to the participant: is it as a graduate student, researcher or clinician-researcher (i.e. nurse-researcher)? The participant's beliefs about the role will influence what information is disclosed (Schutz, 1994). For example, if identified as a nurse researcher, what is the participant's perception of a researcher and of a nurse? Different factors may influence an individual's decision to interact with a nurse versus a researcher. If the participant perceives the nurse researcher in the more familiar role of 'nurse', May (1979) argues that this is an obstacle in obtaining informed consent.

5. Should a clinician-researcher deliver health care interventions during an interview?

The decision to intervene will be determined by the underlying assumptions of the research design and by who identifies the need for intervention and the immediacy of the need. If a life-threatening situation arises, then the clinician researcher must intervene immediately; other interventions could probably be left until the end of the interview. Sponsoring agencies should be aware that clinician-researchers might provide clinical

interventions during an interview. If this is the situation, it is the researcher's responsibility to be aware of the agency's policies and procedures, have a method of reporting interventions if necessary and ensure that they have adequate insurance coverage for their professional interventions.

If the decision has been made that interventions will not be offered within the interview, then the researcher should be knowledgeable of community resources to which to refer the participant or be able to leave a package of pertinent information with the participant. If there is the potential that the content of the interview will trigger a negative emotional response from the participant, then the researcher has an ethical duty to have a counsellor or other services available for follow-up. It would be important to identify if the sponsoring agency has the resources available to respond to an increase in workload in such situations.

6. What impact did the intervention have on the nature of the relationship?

Any decisions to intervene should be documented in the researcher's field notes and described in research publications (Connors, 1988). Additional questions for reflection could include: Did the intervention open up alternate areas for inquiry (Wilde, 1992)? What effect will intervening have on the researcher's relationship with other clinicians or the participant's relationship with his/her primary health care provider? Does the researcher have an obligation to follow-up and evaluate the effectiveness of the intervention?

Conclusion

One of the hallmarks of qualitative interviews is that the interviewer is the research instrument through which data are filtered and processed. This means that it is not only inadvisable but also impossible to have a value-free, impersonal researcher-participant interaction during a research interview. There is a need for continued open and honest discussion about the realities of conducting qualitative interviews by clinician-researchers. Anecdotes in the literature reveal that experienced researchers do struggle with balancing data collection with their role of health care provider and that some do clinically intervene within the context of an interview. Many clinicians, as part of their educational preparation, develop skills in communication, teaching and counselling and therefore find themselves providing health care to study participants, particularly if the intervention involves health education. In addition, when these skills are appropriately incorporated into a qualitative interview the result is the development of a more meaningful relationship with the participant.

The reflexive questions suggested in this article provide both novice and expert clinician researchers with starting points so that they can openly examine and reflect upon the effects of their interventions rather than ignore them. This will enable researchers to evaluate how their actions, skills and knowledge impact their research findings. Clinician-researchers have an obligation therefore to reflect upon and report on relationships they develop with participants. The experiences of each individual, as well as the participant's feelings about being interviewed, how the researcher-participant

relationship developed, and the quality of the interview are examples to help illuminate

understanding of how data are created and used in a qualitative study.

References

Acker, J., Barry, K., & Esseveld, J. (1983). Objectivity and truth: Problems in doing feminist research. Women's Studies International Forum, 6, 423-435.

Archbold, P. (1986). Ethical issues in qualitative research. In W.C. Chenitz & J.M. Swanson (Eds.), From practice to grounded theory: Qualitative research in nursing (pp. 155-163). Don Mills, ON: Addison-Wesley.

Bourdeau, B. (2000). Dual relationships in qualitative research. The Qualitative Report [on-line serial], 4(3/4). Available: http://www.nova.edu.ssss/QR/QR4-3/bourdeau.html

Britten, N. (1995). Qualitative interviews in medical research. BMJ, 311, 251-253.

Cartwright, J., & Limandri, B. (1997). The challenge of multiple roles in the qualitative clinician researcher-participant client relationship. Qualitative Health Research, 7, 223-235.

Chenitz, W.C. (1986).The informal interview. In W.C. Chenitz & J.M. Swanson (Eds.), From practice to grounded theory: Qualitative research in Nursing (pp. 79-90). Menlo Park, CA: Addison-Wesley.

Connors, D.D. (1988). A continuum of researcher-participant relationships: An analysis and critique. Advances in Nursing Science, 10(4), 32-42.

Demi, A.S., & Warren, N.A. (1995). Issues in conducting research with vulnerable families. Western Journal of Nursing Research, 17, 188-202.

Field, P.A., & Morse, J.M. (1985). Nursing research: The application of qualitative approaches. Beckenham, UK: Croom Helm.

Hall, J.M., & Stevens, P.E. (1991). Rigor in feminist research. Advances in Nursing Science, 13(3), 16-29.

Hamberg, K., & Johansson, E.E. (1999). Practitioner, researcher, and gender conflict in a qualitative study. Qualitative Health Research, 9, 455-467.

Hutchinson, S., & Wilson, H.S. (1992). Validity threats in scheduled semistructured research interviews. Nursing Research, 41, 117-119.

Hutchinson, S. & Wilson, H. (1994). Research and therapeutic interviews: A poststructuralist perspective. In J.M. Morse (Ed.), Critical issues in qualitative research methods (pp. 300-315). Thousand Oaks, CA: Sage.

Hutchinson, S.A., Wilson, M.E., & Wilson, H.S. (1994). Benefits of participating in research interviews. Image: Journal of Nursing Scholarship, 26, 161-164.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. American Journal of Occupational Therapy, 45, 214-222.

Lipson, J.G. (1991). The use of self in ethnographic research. In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (Rev. ed.), (pp. 73-89). Newbury Park, CA: Sage.

May, K.A. (1979). The nurse as researcher: Impediment to informed consent. Nursing Outlook, 27, 36-39.

May, K.A. (1991). Interview techniques in qualitative research: Concerns and challenges. In J.M. Morse (Ed), Qualitative nursing research: A contemporary dialogue (Rev. ed.), (pp. 188-201). Newbury Park, CA: Sage.

Moch, S.D. (2000). The researcher experience in health care research. In S.D. Moch &

M.F. Gates (Eds.), The researcher experience in qualitative research (pp. 7-12). Thousand Oaks, CA: Sage.

Munhall, P.L. (1988). Ethical considerations in qualitative research. Western Journal of Nursing Research, 10, 150-162.

Oakley, A. (1993). Essays on women, medicine and health. Oxford: Blackwell.

Porter, S. (1993). Nursing research conventions: Objectivity or obfuscation? Journal of Advanced Nursing, 18, 137-143.

Ramhøj, P., & de Oliveira, E. (1991). A phenomenological hermeneutic access to research of the old age area: Experience with application of the qualitative research interview. Scandinavian Journal of Caring Sciences, 5(3), 121-127.

Rew, L., Bechtel, D., & Sapp, A. (1993). Self-as-instrument in qualitative research. Nursing Research, 42, 300-301.

Schutz, S.E. (1994). Exploring the benefits of a subjective approach in qualitative nursing research. Journal of Advanced Nursing, 20, 412-417.

Smith, L. (1992). Ethical issues in interviewing. Journal of Advanced Nursing, 17, 98-103.

Smith, S.K. (2000). Sensitive issues in life story research. In S.D. Moch & M.F. Gates (Eds.), The researcher experience in qualitative research (pp. 13-21). Thousand Oaks, CA: Sage.

Swanson, J.M. (1986). The formal qualitative interview for grounded theory. In W.C. Chenitz & J.M. Swanson (Eds.), From practice to grounded theory (pp. 66-78). Menlo Park, CA: Addison-Wesley.

Sword, W. (1999). Accounting for presence of self: Reflections on doing qualitative

research. Qualitative Health Research, 9, 270-278.

Wilde, V. (1992). Controversial hypotheses on the relationship between researcher and

informant in qualitative research. Journal of Advanced Nursing, 17, 234-242.

Appendix B

Participant Information Letters and Consent Forms for Study One and Study Two

March 16, 1999

Dear Lay Home Visitor,

I am a graduate student in the Faculty of Health Sciences at McMaster University. I am conducting a research project about the factors that influence the establishment of working relationships between lay home visitors and at-risk families. The purpose of the study is to identify and explore how lay home visitors build relationships with families in the *Healthy Babies, Healthy Children* program. I will also be examining the role of the public health nurse as a case manager in the program.

Information for this study will be gathered through an informal interview that will last approximately 1-1 ½ hours in length at a location of your choice. I will be conducting the interview with you. The interview will focus on your experiences, perceptions and thoughts about the lay home visiting component of the program. I am interested in your personal experiences so there are no right or wrong answers to the interview questions. I will also ask you to make copies of your home visiting documents, with all of the families' names and identifying data marked out.

I also hope that you will permit me to tape record the conversations so that accurate information can be collected. The tapes will be transcribed into a written document. I will review this written document and identify the key themes you have described. I will then schedule another meeting with you to go over my interpretation of your comments. This will give you an opportunity to approve or correct my understanding, or add new information.

The tape recordings, typed transcripts and any notes I take will be kept in a locked filing cabinet in my office. The tape recordings and transcripts will be coded so that your name does not appear, and the key to the code will be kept in a locked drawer in my office. Only I will have access to the documents. None of your individual comments will be shared with your clients, colleagues, or employers at the Wellington-Dufferin-Guelph Health Unit. In the final report your anonymity will be preserved by omitting or disguising all identifying information. At the end of the study, the tape recordings, transcripts and notes will be kept in locked filing cabinet for no less than seven years. If you wish, you may request a summary of the study results.

Your participation in this study is completely voluntary. If you agree to participate in this study, the Wellington-Dufferin-Guelph Health Unit will reimburse you for your time at your regular rate of pay. You may withdraw from the study at any time without any consequence to your employment at the Wellington-Dufferin-Guelph Health Unit.

Your help with this study will be greatly appreciated. The study will help others to better understand the role and experiences of lay home visitors. It will also assist program planners develop strategies to help lay home visitors provide health information and social support to at-risk families. I also hope that this study will provide you with the opportunity to reflect on your experiences. Please feel free to ask questions, make comments and offer suggestions at any point during the study.

If you have any further questions you can contact me at (999)-999-9999. If you agree to participate in this study please read and sign the attached consent form.

Thanking you in advance,

Susan Jack

March 16, 1999

Dear Public Health Nurse,

I am a graduate student in the Faculty of Health Sciences at McMaster University. I am conducting a research project about the factors that influence the establishment of working relationships between lay home visitors and at-risk families. The purpose of the study is to identify and explore how lay home visitors build relationships with families in the *Healthy Babies, Healthy Children* program. I will also be examining the role of the public health nurse as a case manager in the program.

Information for this study will be gathered through an informal interview that will last approximately 1-1 ½ hours at a location of your choice. Wendy Peterson-Rudnicki, a registered nurse with experience in qualitative health research methods, will interview you. She will do this to ensure the confidentiality of your comments. The interview will focus on your experiences, perceptions and thoughts about the lay home visiting component of the *Healthy Babies, Healthy Children* Program. I am interested in your personal experiences so there are no right or wrong answers to the interview questions.

I also hope that you will permit her to tape record the conversations so that accurate information can be collected. The tapes will be transcribed into a written document. To protect your confidentiality on the tape, I will ask Wendy to refer to you by a pseudonym. An independent typist will transcribe the tapes so that I cannot identify you by your voice on the tape. I will review this written document and identify the key themes you have described. Wendy may then schedule a second meeting with you to go over my interpretation of your comments. This will give you an opportunity to approve or correct my understanding, or to add new information.

The typed transcripts and any notes taken will be kept in a locked filing cabinet in my office. Only I will have access to the documents. The tape recordings and transcripts will be coded so that your name does not appear. Wendy Peterson-Rudnicki will keep the key to the code. None of your individual comments will be shared with your clients, colleagues, or employers at the Wellington-Dufferin-Guelph Health Unit. In the final report your anonymity will be preserved by omitting or disguising all identifying information. At the end of the study, the tape recordings, transcripts and notes will be kept in locked filing cabinet for no less than seven years. If you wish, you may request a summary of the study results.

Your participation in this study is completely voluntary. You will be permitted by the Wellington-Dufferin-Guelph Health Unit to participate in these interviews during your regular hours of work. You may withdraw from the study at any time without any consequence to your employment at the Wellington-Dufferin-Guelph Health Unit. If you agree to participate in this study please read and sign the attached consent form.

Your help with this study will be greatly appreciated. The study will help others to better understand the role and experiences of lay home visitors. It will also assist program planners develop strategies to help lay home visitors provide health information and social support to at-risk families. I also hope that this study will provide you the opportunity to reflect on your experiences. Please feel free to ask questions, make comments and offer suggestions at any point during the study.

If you have any further questions you can contact me at (999)-999-9999. If you agree to participate in this study please read and sign the attached consent form.

Thanking you in advance,

Susan Jack

Consent to Participate

Research Title: Factors which influence the establishment of a working relationship between lay home visitors and at-risk families.
Principal Investigator: Susan Jack, B.Sc.N.

- I have read and understood the study information letter. The purpose of the study is to examine the beliefs and experiences of lay home visitors and public health nurses about the lay home visiting role in the *Healthy Babies, Healthy Children* program.
- There is no potential harm to me in participating in this study.
- There is no direct benefit to me for participating in this study. The indirect benefit of participating is that it will help others to understand the role of lay home visitors and strategies for improving service delivery to at-risk families will be identified.
- Any records of our conversations will be kept confidential. My anonymity will be preserved. At no time will our private conversations be shared with my clients, colleagues or employers at the Wellington-Dufferin-Guelph Health Unit.
- I have the right to withdraw from the study at any time without any consequence to my employment.
- If I wish, I can ask to be sent a final copy of the study report.
- Findings from this research may be published in professional journals or used for teaching purposes.
- I will confirm that a signed copy of this consent form has been given to me.
- If I have questions about this research study, I am free to contact either: Susan Jack, Principal Investigator, (999)-999-9999 or Dr. Alba DiCenso, Thesis Supervisor, (905)-525-9140 ext. 22408.
- I have read and understood each item in this consent form.

I (am / am not) willing to participate in this study as it has been explained to me.

_____   _____
Name of Participant (Please print)   Name of Witness (Please print)

_____   _____
Signature of Participant   Signature of Witness

_____   _____
Date   **Date**

Home Visiting Study Information Letter for Study Participants

Research Title
Development of a theory to describe early interactions between mothers and public health nurses and family visitors in a blended home visiting program.

Who is doing the research?
The researcher is Susan Jack. I am a graduate student at McMaster University in Hamilton. I am also a nurse who has experience working with families and children.

Why is this study being done?
The Middlesex-London Health Unit provides supports and services to families with children. I am interested in learning about what it is like to have both a public health nurse and family visitor visit you in your home. The information you will provide will help me learn about the relationship you have with these service providers.

What will I be asked to do if I take part in this study?
You will be asked for your consent for two separate activities.

1. I would like to ask you questions about your experiences in the home-visiting program, and about yourself. I am interested in your personal experiences so there are no right or wrong answers to the interview questions. These questions will be asked during an interview that will last approximately one hour. The interview will be arranged for a date, time and location that is mutually convenient for you and me. The interview will be tape-recorded with your permission.

   Within one or two months I will contact you by telephone to go over my interpretation of your comments. This will give you an opportunity to approve or correct my understanding, or add new information. As I review your comments, I may contact you again to ask you a few more questions.

   You will receive a $20.00 gift certificate in appreciation for your help.

2. Your permission to look at the health records of you and your child pertaining to your involvement with the *Healthy Babies, Healthy Children* program. In particular, I am interested in knowing the total number of home visits you have received, as well as what type of activities the nurse or family visitor did while in your home.

Can I change my mind even if I say yes now?
Yes, you can change your mind at any time, even if you sign the consent form. You can withdraw from the entire study or decide to not answer specific questions. If you decide to withdraw from the study, this in no way will affect the services you receive from the Middlesex-London Health Unit

Your participation in this study is completely voluntary.

Will my information be kept private?
Yes, all of the information that you share with me about your experiences will be kept private. Your name will not appear on any forms. The information you share and the tapes of the conversations will be kept in a locked cabinet. Only I will have access to this information. The only exception is:

*   If during the interview, I become concerned about the safety of your children, then I have a legal obligation to report this information.

What happens if I have questions about my health or the health of my child?
Sometimes during the interview, you might have questions about your health or the health of your child. If it is appropriate, I will answer the question, but will also encourage you to contact your public health nurse for more information. If the nature of the question is serious and requires intensive support from a public health nurse, then at the end of the interview I will ensure that you have the Health Unit phone number so that you can contact your public health nurse.

What do I do if I have questions about the study?
If you have general questions about the study or need to change the time of your interview please call me, **Susan Jack at (999) 999-9999.** If this is long-distance for you, you can place a collect call.

If you have questions about the research protocol, please call Dr. Alba DiCenso, my thesis supervisor at McMaster University, at (905)-525-9140, 22245.

If you have questions or concerns about the services that you are receiving from the Middlesex-London Health Unit, you can call one of the program managers:

Susan Ralyea
Manager, Family Health Services
50 King Street
London, Ontario N6A 5L7

(519) 663-5317 ext. 2250

Consent to Participate

Research Title: Development of a theory to describe early interactions between mothers and public health nurses and family home visitors in a blended home visiting program.

Principal Investigator: Susan Jack, R.N., B.Sc.N., Ph.D Student

- I have read and understood the information letter. The purpose of the study is to learn about my thoughts and feelings about home visiting and the public health nurse and family visitor who work with me from the Middlesex-London Health Unit's *Healthy Babies, Healthy Children* program.
- I understand that my participation in this study is voluntary.
- I have the right to withdraw from the study at any time
- My decision to participate or withdraw from the study will not impact the services I receive from the Health Unit.
- There is no potential harm to me in participating in this study.
- I will receive a $20.00 gift certificate as compensation for participating in this study.
- Any records of our conversations will be kept confidential. My anonymity will be preserved. At no time will our private conversations be shared with my public health nurse or family home visitor.
- If a health concern arises during the interview, it will be recommended that I contact my nurse.
- If I wish, I can ask to be sent a final copy of the study summary.
- Findings from this research may be published in professional journals or used for teaching purposes. If the study results are published, I will in no way be identified.
- I will confirm that a signed copy of this consent form has been given to me.
- If I have questions about this research study, I am free to contact either:
  Susan Jack, Principal Investigator, (519)-766-1915 or
  Dr. Alba DiCenso, Thesis Supervisor, (905)-525-9140 ext. 22445.
- I have read and understood each item in this consent form, and agree:

To participate in a minimum of 2 interviews	Yes ❑	No ❑
To permit the Health Unit, to allow the principal investigator to review information from all of my health records about services I received as part of the *Healthy Babies, Healthy Children* program as described in the Information letter. This information will only be accessible to the researcher until December 31, 2001.	Yes ❑	No ❑

_____   _____
Name of Participant (Please print)   Name of Witness (Please print)

_____   _____
Signature of Participant   Signature of Witness

_____   _____
Date   Date