

Opening Doors: Factors Influencing the Establishment of a Working Relationship Between Paraprofessional Home Visitors and At-Risk Families

Susan Jack, Alba DiCenso, and Lynne Lohfeld

Cette étude à caractère phénoménologique avait pour objectif de cerner et décrire les facteurs influençant le développement d'une relation de travail entre les intervenants sociaux et les familles à risque. On a mené des entrevues en profondeur et semi-structurées auprès d'un échantillon au jugé constitué de six intervenants et de six infirmières de la santé publique embauchés pour faire des visites à domicile auprès de familles à risque. L'analyse révèle que les infirmières jouent un rôle important dans la tâche de promouvoir les programmes de visites à domicile et faciliter l'accueil des intervenants au sein de ces familles. On a établi que certains facteurs relatifs à l'intervenant, au client et au ménage avaient une influence sur le développement de la relation. Un lien s'établit à mesure que se définit « un terrain d'entente » et que « la confiance s'installe ». Une compréhension accrue de ces facteurs permettra tant aux infirmières qu'aux intervenants sociaux d'atteindre les familles réticentes qui repoussent les offres de soutien et de services. Ces résultats ont des implications pour les infirmières responsables de l'embauche, de la formation et de la supervision des intervenants sociaux.

Mots-clés : visites à domicile, infirmières de la santé publique, intervenants sociaux, relation de confiance

The purpose of this phenomenological study was to identify and describe factors that influence the establishment of a working relationship between paraprofessionals and at-risk families. In-depth, semi-structured interviews were conducted with a purposive sample of 6 family visitors and 6 public health nurses hired to visit at-risk families in their homes. Analysis revealed that nurses have an important role to play in marketing home visiting programs and facilitating family visitor access to 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 help both nurses and

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family visitors to access those families who are hard to reach and resist support and the provision of services. The findings have implications for nurses who are responsible for hiring, training, and supervising family visitors.

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

Home visiting by public health nurses has had a demonstrated positive effect on maternal well-being, child development, and awareness and use of health services, particularly for high-risk families (Ciliska et al., 1999; Olds et al., 1999). With some at-risk families, nurses may experience difficulty locating, accessing, and engaging the family in the home visit (Zerwekh, 1991). To ameliorate this problem, some early-intervention programs employ paraprofessionals or lay persons to act as a link between families and formal support systems. The rationale for hiring these visitors is that their life experiences, values, and beliefs may be similar to those of the families they visit and that this "shared culture" will facilitate the development of a trusting relationship (Wasik, 1993).

In this article, we will identify and describe factors that influence the establishment of a working relationship between family visitors and at-risk families. An enhanced understanding of these factors will help both professional and paraprofessional home visitors to access families who are hard to reach and who resist support and the provision of services.

Background

In 1998 the Province of Ontario implemented a universal early-intervention program called Healthy Babies, Healthy Children (HBHC). The objectives of this voluntary program include linking at-risk families to community services, supporting the development of parenting knowledge and skills, and enhancing child development (Ontario Ministry of Health, 1997). Universal postpartum screening is conducted to identify families whose children are at risk of developmental delays. At-risk families are then eligible to receive home visits from both a public health nurse and a family visitor. 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 literature on the evaluation of home visiting programs. These programs are generally classified as one of three types: professional, paraprofessional, or blended — a program that uses

a mix of professionals and paraprofessionals. A series of rigorous randomized controlled trials (RCTs) evaluating American home visiting programs that used highly trained nurses demonstrated multiple positive maternal and child outcomes, especially for those families most at risk (Olds et al., 1999). A subsequent RCT examined the effectiveness of home visiting by nurses and by paraprofessionals, as separate service providers, in improving maternal and child health outcomes. It found that for most outcomes on which the nurses produced beneficial effects, the effects produced by the paraprofessionals were approximately half the size (Olds et al., 2002).

Despite evidence supporting the use of nurse home visiting programs, many governments and agencies have implemented paraprofessional home visiting programs, or, as in Ontario, a blended model. It is difficult 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 because of variation in the characteristics, education, and experience of home visitors, in the duration and intensity of home visiting, and in the type of intervention provided during the home visit. However, a recent thorough systematic review of the effectiveness of paraprofessional home visits summarized 21 studies and rated four as methodologically strong and 17 as moderate (Wade et al., 1999). The authors conclude that paraprofessional interventions can positively impact child-development and parent-child outcomes, especially when the visiting is intense (weekly or bi-weekly for a minimum of 1 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 participation in a home-visiting program can have a positive impact on the overall health and well-being of high-risk families. However, it is estimated that 10–25% of eligible high-risk families choose not to participate in such programs and that 20–67% of those who do participate will leave the program before their goals are met (Gomby, Culross, & Behrman, 1999). 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 (Gomby et al.). Premature termination may also result from failure on the part of the home visitor to establish a supportive and empathetic relationship with the mother built on a foundation of trust (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 that the factors that influence the establishment of a trusting lay visitor-client relationship be understood and promoted. Anecdotal evidence suggests that rapport is more quickly established between clients and paraprofessional visitors when they share common life experiences and life history (Hiatt, Sampson, & Baird, 1997). In reviewing the literature, we located no qualitative studies that described the process of paraprofessional-client engagement or home visitors' experiences working with at-risk mothers and/or public health nurses. Also, there is a dearth of literature describing the work of Canadian paraprofessionals; most of the evaluations of lay home visiting programs focus on the delivery of services to urban, high-risk American clients.

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 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 of McMaster University in Hamilton, Ontario.

Sample

Participants were recruited from a health unit in central-west Ontario 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 were responsible for making referrals to the family visitor component of the HBHC program. We included the nurses in the study in order to examine how a nurse's perception of a family visitor might influence the development of the family visitor's relationship with the client.

All of the family visitors interviewed were female with an average age of 41 years. Five were married and one was separated. 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 female with an average age of 45 years. All were married. Five of the nurses had a bachelor's degree in nursing and one had a public health nursing diploma. They had on average 23 years' experience as registered nurses and 16 years' experience 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 visiting at-risk families. The principal investigator also maintained field notes and a reflective journal. All interviews were audiotaped and transcribed verbatim. As is the norm in qualitative research, data analysis took place 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 extracted and the meaning of each statement was formulated. Formulated meanings were then organized into theme clusters and the participants' experiences were described in writing. Finally, the principal investigator revisited the participants to determine whether the theme clusters and her written interpretation accurately described their lived experience (member checking).

Results

Selling the Program

The nurses spoke extensively about the frustration they felt because the clients at greatest risk were the 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]... 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 a nurse determined that it would be appropriate to introduce a family visitor into the home, she had to convince the family of the program's benefits. Several of the nurses said that many of the at-risk families they visited had numerous professionals involved in their lives. They expressed concern that such families would be overwhelmed by the introduction of another individual into the home. Families were more receptive to the referral, they said, if the nurse had been able to establish rapport and trust with the client and other members of the household.

Once the decision had been made to seek consent for a referral to a family visitor, the nurses had to "sell" the program to families in two ways: by giving the family written information on the HBHC program, and by clearly describing the family visitor's role using non-threatening language. The family visitors also stressed that their relationships with the families depended 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 allowed the family to see the family visitor and nurse working together towards a common purpose and provided an opportunity for role clarification:

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 they used when they were experiencing difficulty gaining physical entry to the home. These included leaving notes on the door, making unscheduled visits, consulting with the nurse to decide on the next step, and connecting with the family by telephone to explore their reason for missing the appointment.

Finding Common Ground

Once she had gained physical entry into the home, the family visitor had to gain emotional entry into the family's life. The family visitors identified several characteristics — both their own and the clients' — that influenced this process. They explained that during the initial home visit they presented themselves as non-judgemental, supportive, and non-threatening. They then sought to identify common ground or shared experiences. Most frequently they shared information about their personal experiences as parents. 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 was easier to build relationships with some families than with others. Client characteristics they identified as facilitating this process included openness to the home visit, admission of health or parenting concerns, satisfaction with the parenting role, and positive experiences with other health 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 appointed time, or were passive and used avoidance body language during the visit. Clients could also be reluctant to open up if Family and Children Services had referred the family to the family visitor program.

Building Trust

The process of enhanced 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 arrive on time. They tried to enter the home without an agenda and to make the discussions client-centred and client-directed. The family visitors hypothesized that due to negative life experiences, perhaps even difficult relationships with close friends and relatives, some at-risk clients found it hard to initially trust the family visitor, a virtual stranger in their home. In such a situation, the family visitor often focused on working with the children while the mother looked on:

Actually it was easier to get through [to] 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 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 lives. They listed many examples of the practical help they provided: locating food, clothing, and transportation; translating; role modelling bedtime and mealtime routines; teaching cooking skills; and accompanying mothers to doctors' appointments, court hearings, case conferences, or parenting classes. One family visitor explained:

I picked up clothes for the kids from a clothing drive, 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 supplied family visitors with many resources for their visits, including a selection of toys, craft supplies, videocassettes, and books on childrearing and parenting. Other resources were offered as gifts. These included child-proof safety gadgets, breastpumps, and children's tape recorders. Such gifts helped the home visitor gain access to the family and build the relationship.

Working With Others in the Home

One challenge for the home visitors was developing a relationship with both the mother and other members of the household. 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.

More frequently, though, the presence of others in the home during a visit hindered the development of the relationship. The client was either distracted by other activities or withdrew from her interaction 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 sought to clarify their role with family members, attempted to involve them in the visit, or offered to meet with the client in a setting other than the home.

If the father was in the home or involved with the children, the family visitor would often encourage him to participate in the visit. In the experience of the family visitors, however, fathers tended to not participate in the visit or to be unsupportive of the mother's participation. In such a situation, if the mother wished to continue seeing the family visitor, meetings would be scheduled at a time (or location) when the father would not be present.

Discussion and Implications for Nursing Practice

Factors found to enable the development of a working relationship were the nurse's role in promoting 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.

The family visitors described a process similar to that of professional home visiting: locating clients, gaining physical and emotional entry into their lives, establishing common ground, and building the trust necessary for health promotion (Zerwekh, 1991). One notable difference, however, is that the family visitor's entry into the family was facilitated by a public health nurse. Both the family visitors and the nurses emphasized the importance of establishing trust. Zerwekh also states that 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 be providing external guidance rather than truly supporting the family (Paavilainen & Astedt-Kurki, 1997).

Given these findings, program planners should ensure that, in the engagement phase, there is room for flexibility in the intensity of home visiting and that nurses are given adequate time to establish rapport and trust with clients prior to involving the family visitor. Nurses must also be allowed sufficient time to support and assist family visitors as they deal with complex issues related to accessing and engaging at-risk families.

Nurse managers should endeavour to hire family visitors who can be matched to families on the basis of 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, communications skills, and the therapeutic use of self. It may also be beneficial to have both nurses and family visitors attend inservices for the discussion of issues surrounding relationship development and conjoint visiting.

The results suggest that the home visiting nurse should possess both an ability to clearly define the family visitor role and the skills and tools necessary to effectively market the program to target families (i.e., more than leaving a pamphlet). Family visitors have the potential to make a difference in the lives of the families participating in the HBHC program, but 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.

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