AN EVALUATION OF THE HEALTHY BEGINNINGS PILOT PROJECTS IN CENTRAL VANCOUVER ISLAND

by

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Abstract

This project was an evaluation of Healthy Beginnings parent drop-in groups in the Central Vancouver Island Health Region. The groups were funded through the Ministry for Children and Families.

Participants who agreed to take part in the evaluation were contacted by phone to complete a questionnaire. Participants were also invited to take part in focus group discussions in each community. Facilitators reviewed progress through focus group discussions.

Questionnaire data indicated that there were no significant differences between groups. There was a high level of satisfaction with the content presented in drop-in groups. The group process experienced by participants was stated as empowering. Participants were generally satisfied that Healthy Beginnings had met their expectations.

Data from participant focus group discussions identified Health Nurses and Health Units as the primary source of information concerning Healthy Beginnings. Factors which helped them attend were identified. These factors included appreciation of the opportunity for social interaction, learning about child development and the warmth and welcoming nature of the group. Challenges identified

included transportation, employment, family commitments and parking.

Avoiding isolation was the main motivator for attendance. Feelings of increased well being, stress reduction and support from other parents were identified as making a difference to participants and their families.

Participants appreciated interaction with other adults and the warmth and caring expressed by staff. The opportunity to socialize with their peers and learn from other parents with no responsibility for organizing the group was emphasized in focus group discussions.

Group members suggested they need more time for discussion among themselves and that they value the learning that occurs during those informal discussions. Their suggestions for ways that the community could improve support to parents included improved public facilities for feeding and changing babies. They would also like to see sidewalks and "child friendly" grocery checkouts in their communities.

Facilitators were able to identify what had worked well in groups as well as some challenges that had surprised them. They predict a growing demand for this type of program and a continuing need for funding.

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Chapter One: Introduction

In May 1997 Minister Priddy announced $3 million for health promotion and prevention innovations targeted to children pre-birth to five years, including support services for their families.

Ten provincial regions were identified as having indicators of greatest risks to children from birth to five years of age. Risk indicators included: infant mortality, parental substance abuse, teen pregnancy, proportion of children in care and proportion of families on income assistance (BC Ministry for Children and Families, 1998). Central Vancouver Island was one of the regions selected for a pilot program and was requested to develop pilot programs with child care as a focus.

These "Healthy Beginnings" programs were initiated through a collaborative partnership between the Ministry for Children and Families and the Central Vancouver Island Health Region. Four communities within this region developed Healthy Beginnings programs: Port Alberni/West Coast, Parksville-Qualicum, Nanaimo/Ladysmith and Duncan/Cowichan. Provincial criteria required that pilots:

- be creative and innovative

- include members of the community and clients in planning and, where appropriate in delivery of services
- address the needs and resources of aboriginal children and families
- contribute to linking of existing services, especially those provided through public health funding
- build on existing strengths of individuals and communities
- address identified risks for children 0-5 years in each region
- be sustainable over time
- include potential for additional funding from other sources
- ensure a balance of urban and rural planning

Pilot programs in The Central Vancouver Island Region were developed with a commitment to:

- operate from a health promotion/population base (i.e., will offer basic supports for all parents and children)
- will do everything possible to remove or minimize barriers to participation

- begin by focussing on new parents with children from birth to six months
- work to build the resilience of very young children by building the resilience of their parents
- build the resilience of parents by emphasizing self care, promoting peer support, modelling healthy play and behaviour management with their children, developing skills in help seeking and advocacy for their child when needed
- incorporate the expertise of early childhood educators along with health and social service professionals to provide a well-rounded and "normalized" approach to parents' and infants' needs
- contribute to the ongoing improvement of early childhood education and care services through ongoing participant feedback as well as formal evaluation of the pilots (BC Ministry for Children and Families, 1998).

Programs have been developed with a universal focus rather than one of targeting "high risk" parents or infants. The focus is empowering parents to support each other and to build on the capacity of parents to care for and promote the

healthy development of their children (Central Vancouver Island Regional Operating Agency, 1997).

This project evaluated the Healthy Beginnings parent drop-in groups to determine what is working or successful for parents, what is not working, and why. Participant questionnaires and focus group discussions were utilized to understand and document the difference Healthy Beginnings made to children and families in The Central Vancouver Island Health Region. These evaluation findings may be used as a planning tool for future programs. Participant questionnaires were used to collect information on the number of sessions attended, awareness of community resources for parents and children, knowledge of child development and health and safety issues affecting children, infant feeding and nutrition, levels of confidence and support in the parenting role and the level of satisfaction with Healthy Beginnings. Participant focus group discussions collected information on the accessibility of Healthy Beginnings, reasons for attending drop-in groups, what difference attending groups may have made and suggestions for improvements. Facilitator focus group discussions identified successful strategies, parent referral to other community resources, levels of parent competency, parenting skills, parent isolation and level of participant change.

Chapter Two: Literature Review

Resilience

The term resiliency is relatively new; it began appearing about twenty five years ago. Garmezy and Masten (1991) define resilience as "a process of, or capacity for, or the outcome of successful adaptation despite challenging and threatening circumstances". Garmezy (1993) describes resilience as the ability to spring back from adversity. Resilience is not static, when the situation changes so may one's resiliency. Radke-Yarrow and Brown (1993) also focussed on the fluidity of resilience when they described children having setbacks when faced with new stressful situations.

Four characteristics associated with childhood resiliency are, an active approach to problem solving, a tendency to view experiences constructively, the ability to gain positive attention from others and the ability to use faith to maintain a positive outlook on life (Werner, 1984). In order to develop trust, children need to establish a close bond with at least one caregiver. Werner notes that resilient children seem to be able to recruit surrogate parents when required. Werner's research suggested that children exposed to serious challenges or disasters cope

better when they have a belief that they have some control over their fate.

Resilience tends to focus on individual and family strengths rather than deficits, (Barnard, 1994). The meaning attributed to experience and the ability to reframe the conceptual or emotional response a parent has to his/her child may provide a model of effective coping for the child. Barnard suggests that the parents' ability to reframe their child's stubbornness into determination or independence can change their perception of the child as difficult or challenging.

The Rochester Child Resilience Project (Cowen, Wyman, Work, and Parker, 1990, p. 192-212) reported that a cluster of five variables, global self worth, empathy, realistic control, interpersonal problem solving skills and self-esteem, correctly predicted children's stress-resistant or stress-affected status in 84% of cases reviewed. This study found that the quality of the child's environment played an important role in protecting children against the effects of stress. The environment also promoted adaptive behaviours and instilled in the child the belief that he/she could deal with adversity.

Variables identified as risk factors in one situation can become protective factors in another (Rutter, 1987).

Rutter identifies four mediating mechanisms, reduction of risk impact, reduction of negative chain reactions, establishment and maintenance of self-esteem and opening of opportunities. He also suggests that secure attachment relationships between the child and parents provide protection against later risk environments.

Fonagy, Steel, Steele, Higgitt and Target (1993) suggest that the current interest in resilience is part of a shift in focus to prevention, which is driven by economic factors. They also note intergenerational transmission of insecurity; the parents' perception/model of relationships may influence the child's security of attachment. The relationship between infant-caregiver attachment and parental attachment security is powerful. Secure attachment is a goal of intervention because of developmental advantages, but also because it will direct how the children cope with problems through their life span. Reflective self function, the understanding of mental states, and the capacity to contemplate alternative perceptions offer huge benefits to the individual when dealing with adversity (Fonagy et al., 1993).

When children experience extreme stress the quality of the care they receive from adults is most important. Children living through wars and disasters cope much better

if they do not experience separation from parents and if they perceive their parents as coping effectively (Masten et. al., 1990).

Zimmerman and Arunkumar (1994, p. 7) encourage researchers to identify factors which "innoculate" against the effect of risk factors rather than focussing on negative outcomes. They suggest that prevention strategies build on capacity and should involve social institutions and communities in forming strategies to foster resilience.

Cicchetti and Garmezy (1993, p. 499) emphasize the need for longitudinal studies to enable us to understand more about resilience as a process rather than a product. They also caution against making assumptions that children identified as resilient have actually been exposed to the stressor under investigation.

Reviewing literature on resilience, as it relates to early child development, leads directly to a consideration of the work on attachment.

Attachment

Karen's book, "*Becoming Attached*" reviews a history of the major figures in this research. He begins by outlining Bowlby's research on early separation/deprivation. Bowlby could be considered as the founder of attachment theory. He had a long working relationship with Mary Ainsworth who

developed the Strange Situation laboratory assessment of security of attachment. Both Bowlby and Ainsworth were convinced that the nature of one's earliest relationships determined how one felt about one's self and one's expectations of others. The quality of that early attachment affected how the individual approached human connections at later stages of life and in periods of crisis (Karen, 1998). Main (Karen, 1998, p. 364) developed the Berkeley Adult Attachment Interview which resulted in her identifying three major patterns of adult attachment that paralleled Ainsworth's childhood attachment categories. Main's work supported the assumption that being able to put feelings into words makes them available for review, reworking and access of new information. Unlike Ainworth's categories, which labeled the relationship and not the individual, Main's system identified each adult with a single attachment-style. Main's model neglects the possibility of adults relating differently to different relationships.

Maccoby describes infancy as being characterized as a state of "prepared readiness" on the part of parent and child to develop reciprocal behaviours. Attachment behaviour is very much dependent on the responsiveness of the caregiver (Maccoby, 1992, p. 1009). Responsiveness to

the demands of the infant results in children having the security to explore their environment. The child's social capacity expands when the mother can respond appropriately to his/her demands. As the child internalizes the quality of the parental relationship, future patterns of relationship building are established. Maccoby (1992, p. 1014) suggests that "…any enduring parental influence stems mainly from the nature of the relationships parents have co-constructed and continually reconstructed with their children".

The raising of competent, resilient children is a community responsibility involving the family, government and community health services (Steinhauer, 1996, p. 212). The primary goal of the first year should be to ensure the mother's health, development and delivery of a healthy baby and the availability of a support system that enhances a secure attachment with the mother. Steinhauer suggests that a secure attachment is necessary to provide for the child's physical and emotional needs.

Intervention Outcomes

The child development and long-term outcomes of successful interventions suggests that health, well being and competence are intertwined. Early childhood experiences have a profound impact on brain development. The human

brain may have sensitive developmental periods during which pathways will be established if the child receives stimulation. Hertzman (1996, p. 12) suggests that many of the most effective interventions are modest involving community development, emphasis on population health, recreation programs for children and strong support networks. He also argues that it is important to provide programs to optimize cognitive and social emotional development of children (Hertzman, 1996).

New brain imaging techniques confirm that good prenatal care, warm attachments between children and adults and positive, age-appropriate stimulation affect children's development for a life time (Newberger, 1997, p. 4). Although heredity determines the basic number of brain cells a child starts out with, the child's environment determines how the brain's circuits will develop. During the first three years of life, brain connections develop in response to stimulation, good or bad. High levels of stress can result in the production of cortisol, which causes depletion of brain cells and may interfere with the child's ability to respond to stress in the future.

There is an interplay between genetics and nurturing which influences adult competence and coping. Community initiatives need to build on each other to optimize outcomes

for children and families (Keating and Mustard, 1996, p. 12).

Program Evaluation

What kinds of community programs are effective? Dunlap discovered that membership is an important aspect of empowerment. Parents were motivated to take part in preschool activities because their children would benefit (Dunlap, 1993, p. 508). Parents coming together in the preschool setting developed new and innovative ways to solve problems and were able to transfer their skills to other areas of the community.

Powell (1989, p. 3) emphasizes the importance of programs being a collaborative venture between parents and staff. Programs should empower parents to learn from each other and develop a strong social network so that they are not reliant on professional intervention.

Trivette, Dunst and Deal (1997, p. 75) suggest that early intervention programs will be more effective if a resource-based rather than a service-based approach is taken. A resource-based approach recognizes families as being part of a broader community and that this is their major source of support and resources. Service approaches tend to be deficit-based whereas resource approaches are asset-based with a focus on building competency and

community capacity. Strengthening community support and systems for the needs of children and families ensures accessibility since they are more likely to be stable.

Program evaluation is often utilized to make decisions about service delivery and resource allocation. The Cornell Empowerment Group favours an emphasis on program improvement, process versus product and quality determination. Empowerment-oriented evaluation focuses on the needs and concerns of the least powerful (often intended beneficiaries of programs). This model suggests that evaluation should consider issues of accessibility and the fit with participant needs (Cornell Empowerment Group, 1989).

Barnett reviewed a variety of early childhood programs to determine long-term effects of child care, early intervention, preschool education and Head Start programs (Barnett, 1995). Short-term effects of child care depend on the quality of care provided and the richness of the child's home environment. Earlier entry benefited children from impoverished homes, while children from home environments which were highly supportive of cognitive and social development did not realize similar gains (Barnett, 1995, p. 27). Home-visiting programs appeared to be ineffective in improving children's development, but did improve maternal

and child health and reduced child abuse and neglect. Project CARE, The Infant Health and Development Program, Even Start, and The Comprehensive Child Development Program have produced short-term results with improved IQ scores, language skills and behaviour. Of the 21 large-scale studies reviewed, IQ effects persisted the longest in the two experimental studies that enrolled infants in full-day educational child care programs (Barnett, 1995, p. 35). Across all the studies there was evidence that early childhood care and education programs (ECCE) can improve school success. Teachers and parents reported long-term positive effects on both socialization and delinquency reduction. The Perry Preschool study found that ECCE was associated with increased commitment to school, better relationships, economic success, and for girls, increased marriage and fewer out-of-wedlock births (Barnett, 1995, p. 41). When considering the effect of age of entry into a program, it may be important to look at infants and continue programs to kindergarten age to maximize the effects on brain development.

Benner (1997, p. 7) reviewed nine home visiting programs. They had positive outcomes resulting in improved IQ scores, reduced risk factors, reduced child abuse and neglect and improved home environments. Benner found that

Hawaii's Healthy Start Program and the Florida Longitudinal Home Visitor Program were able to provide substantial benefits to families as a result of early and consistent intervention. The intensive centre-based educational day care program combined with family support offered at Project CARE improved cognitive outcomes, language development, home environments, and parents' attitudes toward their children (Benner, p. 5).

Olds, Hill and Rumsey (1988) reviewed the twenty-year history of the nurse home visitation program in Elmira, New York and determined that the program had reduced anti-social behaviour and delinquency in children. The program also reduced child abuse and neglect.

The Ministry of Community and Social Services in Toronto reviewed ten prenatal/infant development primary prevention programs. A technical advisory group to the ministry found that most programs involved home visits to at-risk families and focussed on issues surrounding diet, family planning, attachment, social isolation of the mother and mental, behavioural and cognitive development of infants (Ministry of Community and Social Services, 1989, p. 9). Five of these programs were identified as models for prenatal/infant development programs and included The Prenatal and Early Infancy Project, The Child Health

Supervision Project, The Yale Child Welfare Research Project, Becoming a Family Project and The Montreal Diet Dispensary Project. These model programs demonstrated short-term positive effects for children in the forms of better physical health, better nutrition, fewer feeding problems, fewer accidents and less abuse by parents. Short-term benefits for parents included improved networks of social support, improved parenting skills and confidence in parenting, better parent-child interactions and less child abuse (Ministry of Community and Social Services, 1989, p. 16). Long-term positive effects for children included better behaviours at school and improved attitudes toward school, less delinquency and a higher rate of pro-social attitudes. Long-term benefits for parents included increased school registration and completion by mothers and higher rates of employment (Ministry of Community and Social Services, 1989, p. 17). This review showed cognitive development effects as being inconsistent. Programs with the greatest impact had multiple components, home visits, parent support groups plus child care and they were of two to five year duration.

This report makes the point that research and programs, which dominate the literature, are primarily American programs focussing on ghetto populations. The literature may not reflect Canadian sub-groups of at-risk families, which

would include single mother families, new immigrant, rural, and First Nations families (Ministry of Community and Social Services, 1989, p. 41). The report also makes the point that "universal access to a prevention program is important to encourage broad community participation and ownership." The universal focus of Healthy Beginnings with its focus on capitalizing on the strength, competencies and adaptive skills of people within the community make it an appropriate subject to explore the following research questions.

Research Questions

Question 1: Does attending Healthy Beginnings drop-in groups improve parents' levels of confidence in their parenting skills?

Question 2: Does attending Healthy Beginnings drop-in groups reduce reported isolation for parents of infant children?

Other program components were evaluated and made up the following list of related questions:

Question 1: How many sessions were attended?

Question 2: What were participants' reasons for attending Healthy Beginnings?

Question 3: What was liked least/best about Healthy Beginnings?

Question 4: Did parents' awareness of community resources, knowledge of child development, health and safety issues and infant feeding increase?

Question 5: Did participants feel supported in their parenting role by the group/community?

Question 6: How satisfied were participants with Healthy Beginnings?

Question 7: What strategies did facilitators identify as successful?

Question 8: How successful was referral of participants to other community resources?

Question 9: Did parent competency improve?

Question 10: What was the level of participant change?

Question 11: What was the effect of other events/ circumstances?

Definition of Terms

Health Promotion

Promotion is a process of enabling people to increase control over and improve their health and well being.

Prevention

Prevention is anticipatory action taken to avoid the occurrence of a given problem or to reduce the incidence of that problem in the population.

Early Intervention/Support

Early intervention services provide outreach and additional supports to people recognized to be at risk of experiencing problems, or who are in the early stages of development of problems (Central Vancouver Island Health Agency, 1997).

Rationale

The purpose of this project is to promote the healthy development of children and their families, including support to parents to acquire or improve parenting skills, and to provide enriched developmental experiences for children between birth and six months of age.

Parenting is the most complex and important job in our society according to the 1996/97 Annual Report of the Children's Commission. Often parents do not have the support of extended family members to assist them to fulfill their role. Research on early brain development recognizes the importance of effectively nurturing children's emotional, physical and intellectual functioning. The quality of children's early attachments influences brain development. In order to reduce a child's vulnerability to stress and increase his/her capacity for resilience, we need to do as much as possible to encourage the establishment of

a close bond with a caregiver (hopefully one or both parents) during the first years of life.

Chapter Three: Method

Each of the four service areas, Port Alberni/West Coast (Port Alberni), Parksville-Qualicum (Parksville), Nanaimo/ Ladysmith (Ladysmith) and Duncan/Cowichan (Duncan), offered drop-in groups at one or more community sites. New parents learned about Healthy Beginnings groups from health nurses and prenatal instructors. They saw a variety of advertising materials at community centres and community agencies. New parents were able to self refer to a drop-in group.

The information collection process was broken into three segments: a questionnaire, participant focus groups, and facilitator focus groups. An outline of the information expected to be collected and the source of the information is given in Table 1 (p.24). The source of collection for each data item listed is marked with an "X". Non-applicable sources for each data item have been indicated with a dash ("-").

Facilitators requested that participants complete a registration form, which had a space to indicate whether they were willing to be contacted by a researcher for evaluation purposes. Facilitators passed copies of registration forms to the researcher when the participant's child reached six months of age.

The researcher mailed a consent letter to the participant with a stamped, addressed envelope. When the consent letter was returned to the researcher, the participant was contacted by phone. If the timing was convenient for the telephone interview, the researcher reviewed the issue of consent and completed the questionnaire with the participant. If the time was not convenient, another time for the call was arranged.

Focus groups were conducted with facilitators. Focus groups were conducted with participants in each community.

The researcher created a group environment that nurtured different perceptions and points of view, without pressuring participants to vote, plan or reach consensus (Krueger, 1988, p. 18). Open-ended questions were used to allow respondents to determine the direction of the response. The researcher avoided responding to comments or signaling approval by verbal or non-verbal means to avoid influencing discussion. An assistant recorded the discussion on audiotape and took comprehensive notes on the discussion and interactions among participants. The researcher employed strategies for dealing with challenging participants. During pre-session small talk, seating arrangements were planned to have dominant talkers close to the facilitator and shy participants placed opposite to

allow the use of eye contact and body language to ensure that everyone had a chance to be heard (Krueger, 1988, p. 77). Closing questions brought the discussion to an end and gave the facilitator an opportunity to summarize and check with participants as to accuracy of summary and to ensure that there were no further areas of concern (Ellis, 1998, p. 117).

Data were analyzed from completed questionnaires and themes were identified from participant and facilitator focus groups. Using the information gathered and analyzed, a report was written describing the findings. The report outlined the limitations of the study and listed recommendations arising from the evaluation.

Table 1: Evaluation Plan

Measure	Question-naire	Participant Focus Group	Facilitator Focus Group
No. of sessions attended	X	-	-
Reasons for attending Healthy Beginnings (HB)	-	X	-
What was liked best/least about HB	-	X	-
Successful strategies	-	-	X
Awareness of community services for parents	X	-	-
Parent referral to other community resources	-	-	X
Awareness of community services for children	X	-	-
Parent competency	-	-	X
Knowledge of child development	X	-	-
Effect of other event/ circumstances	-	-	X
Knowledge of health and safety issues concerning children	X	-	-
Knowledge of infant feeding/nutrition	X	-	-
Level of confidence in parenting	X	-	-
Level of support in parenting role	X	-	-
Level of satisfaction with HB	X	-	-
Accessibility of HB location	-	X	-
Level of participant change	-	-	X
Level of parent isolation	-	-	X
Parenting skills	-	-	X

Chapter Four: Results

Questionnaire return rates for each community are summarized in Table 2.

Table 2: Participant Questionnaire Return Rates

Community	Consents Mailed	Consents Returned	% Returned
Duncan	34	14	41%
Ladysmith	7	7	100%
Parksville	14	8	57%
Port Alberni	22	16	73%

Eighteen consent letters were mailed to Duncan participants who had indicated on their registration form that they were willing to be contacted by a researcher. Sixteen consent letters were mailed to participants who began attending before the registration form was developed. Eight registration forms were returned to the facilitator indicating that they did not wish to be contacted by a researcher for purposes of evaluation. In the other three communities all of the participants who completed registration forms indicated their agreement to be contacted by a researcher.

Questionnaire

Question one on the questionnaire was used to measure effects of attendance on levels of satisfaction and will be

reported at the end of the questionnaire results section. The following results describe responses to questions two to eight on a seven part Likert scale with one meaning "strongly disagree" and seven meaning "strongly agree". Results are summarized in Table 3.

Table 3: Participant Questionnaire Results

Question / Community		N	Mean	Standard Deviation
Q2	Duncan	14	6.57	0.76
	Ladysmith	7	4.86	2.27
	Parksville	8	5.00	1.41
	Port Alberni	16	5.56	1.36
Q3	Duncan	14	6.29	1.64
	Ladysmith	7	4.86	1.95
	Parksville	8	4.63	1.41
	Port Alberni	16	5.38	1.26
Q4	Duncan	14	6.14	1.10
	Ladysmith	7	4.43	2.23
	Parksville	8	5.50	1.31
	Port Alberni	16	5.94	1.48
Q5	Duncan	14	5.86	1.23
	Ladysmith	7	5.43	1.51
	Parksville	8	4.88	1.36
	Port Alberni	16	5.81	1.22
Q6	Duncan	14	6.29	0.99
	Ladysmith	7	6.43	0.79
	Parksville	8	5.63	1.30
	Port Alberni	16	6.25	1.06
Q7	Duncan	14	6.57	0.65
	Ladysmith	7	6.29	0.76
	Parksville	8	6.56	0.76
	Port Alberni	16	6.69	0.60
Q8	Duncan	14	6.64	0.63
	Ladysmith	7	6.14	1.07
	Parksville	8	6.50	1.07
	Port Alberni	16	6.81	0.40

Figure 1 illustrates questionnaire results for all four communities.

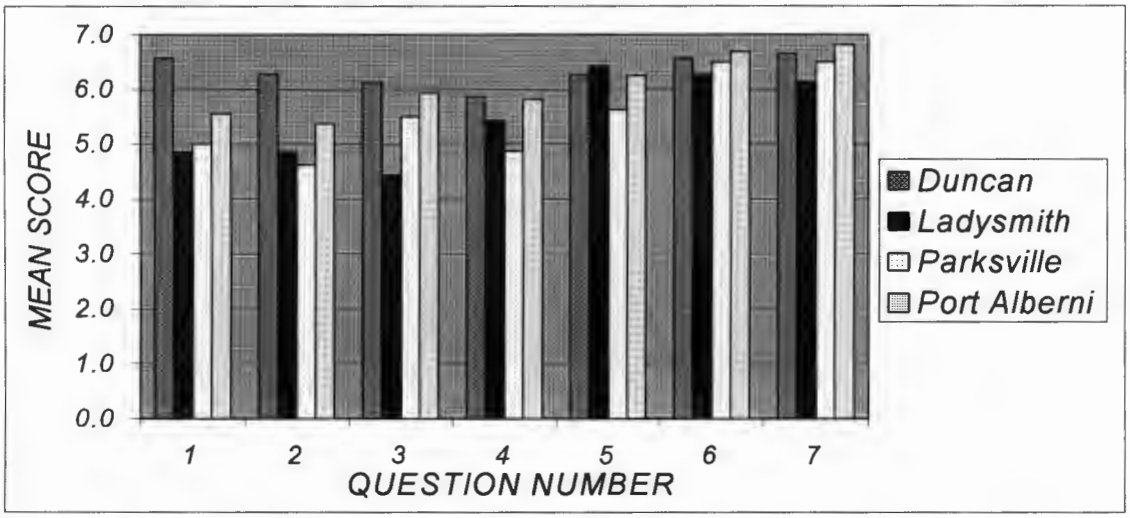

Figure 1: Questionnaire Results for Four Communities

An ANOVA test was performed to determine variation between groups and within groups and is presented in Table 4.

Table 4: Between Groups and Within Groups Variance

SUMMARY

Groups	*Count*	*Sum*	*Average*	*Variance*
q1	45	255	5.67	2.27
q2	45	245	5.44	2.57
q3	45	256	5.69	2.40
q4	45	252	5.6	1.7
q5	45	278	6.18	1.10
q6	45	295	6.55	0.43
q7	45	297	6.6	0.56

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	61.50	6	10.24	6.49	1.82E-06	2.13
Within Groups	486.04	308	1.58		significant p<.000002	
Total	547.55	314				

Attendance information compared to question ratings is presented in Figure 2.

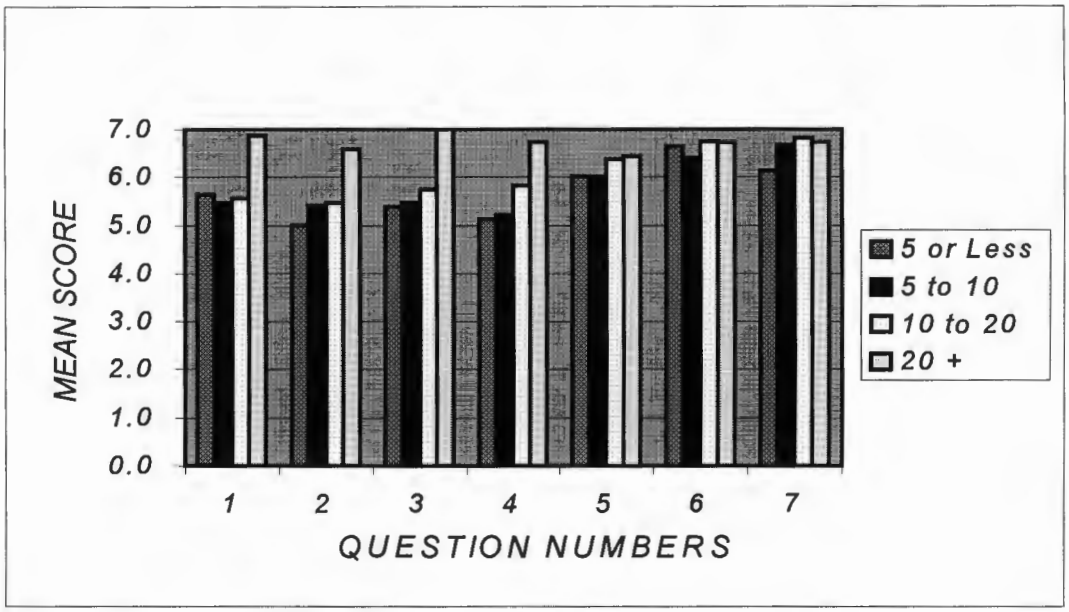

Figure 2: Attendance Information Compared to Question Ratings

Participant Focus Groups

Focus groups were held in Shawnigan Lake (for the Duncan/Cowichan area), Ladysmith, Parksville and Port Alberni. The number of participants in the groups ranged from 4 to 8.

Data were collected by recording on audiotape and by written notes taken by the focus group assistant. Data were transcribed and analyzed, themes were identified and coded by the means of coloured highlighters. The themes were then summarized and interpreted. The following presentation of results is arranged to reflect the questioning route outlined in the Healthy Beginnings Focus Group Questions sheet in Appendix C.

Participant Focus Group Discussion Results

Question 1: How did you hear about the Healthy Beginnings Group?

A major theme for all four communities was that parents heard about Healthy Beginnings from the Health Unit or Health Nurse either at baby clinics or during home visits. Referrals from friends or community agencies were also common to all four communities. Some Parksville participants received information about the group from attending a breastfeeding clinic and some had seen an advertisement in the local newspaper.

Question 2: What helps or makes it hard for you to come to the Healthy Beginnings group?

In all four communities, the major theme for what helped seemed to be the opportunity to get out of the house and meet other young mothers. There was general agreement that the participants felt it was important to attend the group meetings and that it was the main source of adult interaction of the week for them. In all four groups, participants described getting everything done the night before so that they could be ready for the group the next morning. Parksville participants commented on the facilitator being very welcoming as contributing to making it easy to attend. A second theme identified collection and

exchange of information as being an important element in what motivated them to attend the group meetings. A desire to find out about child development and community resources was common to all four communities. Participants seemed to especially value being in a situation where they could observe other mothers and babies in a friendly, relaxed setting where they did not feel their questions would seem stupid. Port Alberni and Parksville participants identified the fact that the program was publicly funded as being important. They suggested that the fact that mothers could attend without becoming involved in planning or organizing the meeting place or session topics made it easier to attend. Ladysmith participants mentioned timing of the group sessions. The participants enjoyed having the group in the morning as it worked well with their babies' schedules. Child minding was identified as a factor that motivated mothers to attend. The mothers found it easier to relax when they knew that their older children were cared for in an adjacent room. The mothers appreciated the opportunity to focus on their babies.

Transportation and family commitments were the main inhibiting themes that affected attendance at Healthy Beginnings. Port Alberni and Duncan participants experienced difficulties getting to the group by public

transportation. Bus service was limited and schedules were not convenient. Most of the mothers in Port Alberni (5 of 7) walked to the meetings with their babies in strollers and reported that it was difficult to board a bus with an infant, a stroller and a diaper bag, especially if they were also travelling with a toddler.

Ladysmith and Duncan participants mentioned family commitments as a barrier to attending the group sessions. Participants expressed their frustration at trying to meet the needs of other family members before they could take time for themselves and get to the group. They described finding it difficult to arrive on schedule for any events.

Parksville participants had difficulty finding parking. There is parking attached to the building where they meet, but the building is multi-purpose and very busy. Often participants had to park one or two blocks away and they found it difficult to transport the baby and all their equipment to the site.

Question 3: What were your main reasons for attending Healthy Beginnings?

In all four communities, the main theme was that mothers attended these groups to avoid isolation. They saw the group as an effective way to meet other young mothers and network. Closely related to this theme was the degree

of support that mothers felt from the other group members. They saw each other as a resource for information and encouragement, and that other members reinforced the choices they were making about parenting.

Learning about community resources, being exposed to guest speakers and special topics were mentioned as reasons for attending the group. The issue of guest speakers produced lively debate. Although participants enjoyed being able to request speakers or particular topics, they were clear that they enjoyed their own discussion more. They enjoyed being recognized as the experts on their babies and the source of ideas and problem resolution for each other.

The Parksville participants mentioned that facilitator style was an important factor for them. They found the facilitator was accepting and maintained a neutral position in discussions. They appreciated the fact that she encouraged all points of view and used gentle redirection when required.

Question 4: Please tell us what difference if any coming to the group makes for you and your family?

In all four communities, the two major themes were stress reduction and increased sense of well being. Many of these mothers were experiencing a great deal of stress adapting to the role of parenthood. Often they described

extended family members as exerting pressure on them because they held different values about parenting. Mothers suggested that their parents were out of date, old fashioned and not very patient with having babies around. The mothers found support for their ideas and values around parenting at the Healthy Beginnings group. The mothers reported that coming to the group had allowed them to feel more relaxed and less stressed. Many of the participants had felt frustrated and burnt-out before attending Healthy Beginnings. Several mothers expressed the view that the group was preventative in that it allowed them to cope with stress and had improved their marital and extended family relationships.

A related theme was new ideas about parenting and positive feedback from peers. Participants often took pamphlets home to educate family members, to relay new information on brain research and infant development. There seemed to be a significant difference in the way the past generation and the current generation handled crying babies. The current generation mothers were more likely to pick the baby up when crying, but faced criticism from their mothers, who thought they would spoil the baby. The mothers agreed that being a brand new parent seemed to elicit a great deal

of advice from family members that was often contrary to the new ideas on parenting being discussed in the groups.

Duncan participants thought that the opportunity for the babies to interact with each other was a benefit. They also appreciated the "round robin" part of their meeting and suggested that it gave them a feeling of connection. They not only enjoyed hearing amusing stories from the other mothers, but also thought that the interaction improved conversations with their spouses. There was general agreement that child care was labour intensive and they did not have much opportunity to take part in other activities that they might discuss with their spouses.

Parksville participants appreciated the facilitator's ability to encourage everyone, especially when they made mistakes, and how she reminded them that they did not have to be perfect. This group positively identified the fact that their facilitator was open to learning and how she reflected on how she had parented her children and admitted that she had made mistakes and might do things differently now. The participants saw her attitude as empowering.

Question 5: What do you like most about the Healthy Beginnings drop-in sessions?

The major theme from all four groups was that participants liked getting out and meeting other adults.

They felt welcome and comfortable and enjoyed seeing their babies interact with one another. They also enjoyed having someone else available to hold or amuse their babies. Participants emphasized how valuable they found the support and feedback from other members and facilitators.

Snacks were mentioned as being a favourite part of the group by the Port Alberni and Ladysmith groups. The Duncan group identified the warmth of the staff as a very important aspect of what they liked most about the group.

The Parksville group talked about their ability to direct how the group would develop and function and how much they appreciated that freedom. They were enthusiastic about the facilitator's ability to reinforce discussion and to find additional resources or information to support their interests. They identified her as a very skilled facilitator, someone who could bring the group together, while nurturing their ability to direct the group's development.

Shortly after this discussion, a young mother with a toddler and an infant came into the room. The young woman stated that she could not stay, but would return the next week. The group immediately welcomed her. They offered her coffee and refreshments and invited her to stay and listen to the rest of the discussion. The woman introduced

herself, told us that she was having a hard time coping, because she had two children to care for and that she had a personality disorder. The group was very accepting. One mother offered to give her a ride to the group and another invited her to the church she attended, since the young woman was not finding her own church very accepting. This was a very powerful demonstration of the acceptance level of the group and their ability to be self-directed.

Question 6: What would you like to tell the drop-in staff about the way they treated you, your children and the others who come to the drop-in groups?

The major theme was that participants appreciated the warmth, friendliness and support of the drop-in staff. The Port Alberni group identified the facilitator as a very warm, caring person, who called them at home if she thought they needed it. There was a great deal of enthusiasm about the facilitator's approach and her contribution to the group. One mother suggested, and others agreed, that more personal time with the facilitator would be a benefit. They also enjoyed the child care arrangement and appreciated the quality of the care their toddlers received from the staff. The Ladysmith group expressed its appreciation for the friendliness and warmth the staff provided to the members and wanted to encourage them to keep up the good work. The

Duncan group was very appreciative of having a warm, friendly place to bring their new babies and to be able to maximize their efforts toward successful child development. The Parksville group made similar comments and suggested that the Healthy Beginnings group was the most welcoming place to go with a baby.

The Port Alberni group expressed appreciation of guest speakers and especially valued the advice they received on breastfeeding. There was some disagreement about guest speakers. One mother felt that sometimes guest speakers made assumptions about group members' parenting skills that put the speaker in the position of being an expert. Other mothers did not have that perception. All participants agreed that they needed to be open to all ideas, and that there was no perfect way to be a parent.

Question 7: Do you have any suggestions for improving the Healthy Beginnings group?

The major theme presented was that participants would like more time for individual discussion. Most participants valued the check-in times and would like them to be longer. The Parksville group identified their space a being a major concern; they have out grown their site.

Question 8: In what other ways do you think our community might support parents of babies?

The major theme was that participants would like to see more public facilities providing spaces for families with young children, especially comfortable places to breastfeed and to change infants. Participants would also appreciate work environments that were conducive to breastfeeding. One participant was about to return to work at a university and talked about the difficulty of breastfeeding in an open office area. Her employer did provide breaks for breastfeeding, but the office space has no privacy.

The lack of child care, especially spaces for infants, was another area that participants identified as one where the community needed to support parents. Community activities for mothers and young children was suggested as another form of support that needed to be enhanced. One mother would like to see subsidized fitness programs for mothers and infants.

Participants in the Duncan and Ladysmith groups would like to have sidewalks provided in their communities. Port Alberni and Duncan participants would like to see "child friendly" checkouts provided in grocery stores. A summary of participant focus group discussion themes is provided in Table 5.

Table 5: Participant Focus Group Discussion Themes

Question	Duncan	Ladysmith	Parksville	Port Alberni
Question 1: How did you hear about Healthy Beginnings?	Health Nurse Friends	Health Nurse Community agency Friends	Health Nurse Breast feeding clinic Community agency Friends Newspaper Ad.	Health Nurse Friends
Question 2: What helps you to come?	Social interaction. Finding out about community resources. Learning about child development. Food.	Interaction with others. Time.	Facilitator welcoming. Getting out, meeting other mothers. Child minding. Program being publicly funded.	Getting out, meeting other mothers. Having questions answered. Program being publicly funded.
Question 3: What makes it hard for you to come?	Transportation Family commitments.	Family commitments.	Parking. Transportation.	Transportation. Employment. Getting to anything on time.
Question 4: What are your main reasons for attending?	Avoid isolation. Speakers &topics.	Avoid isolation. Networking. Group support.	Avoid isolation. Exchange ideas with peers. Facilitator's skill level.	Avoid isolation. Group support. Learning about community resources. To talk to the other mothers.
Question 5: What difference does the group make to you/family?	Support from other parents. New ideas about parenting. Babies interact with each other. Round robin makes a feeling of connection.	Support for new ideas. Dealing with pressure from parents.	Stress relief. Positive feedback from peers. Encouragement from facilitator.	Increased well being. Stress reduction. New ideas about parenting.

Table 5: (continued)

Question	Duncan	Ladysmith	Parksville	Port Alberni
Question 6: What do you like most?	Warmth of staff. Access to resources and advice.	Interaction with other adults. Getting out. Snacks. Facilitator and guests.	Interaction with other adults. Group process - self-directed.	Interaction with other adults. Getting out. Snacks.
Question 7: What would you like to tell the drop-in staff?	Appreciate warm friendly environment.	Appreciate friendly warm staff.	Welcoming place to go with a baby. Appreciate help with baby.	Appreciate the warmth/caring. Enjoy guest speakers. Appreciate child care worker. Advice on breastfeeding was helpful.
Question 8: Suggestions for improvement.	Weekly check in.	Time to talk. Ability to direct group.	Better space.	More time for individual discussion.
Question 9: What could the community do to support parents of babies?	Provide sidewalks. Provide "child friendly" grocery checkouts. Subsidize fitness programs for mums and infants.	Provide suitable breast feeding areas in public places. Provide change tables in washrooms. Provide activities for mums and infants. More child care for infants. Provide sidewalks.	Provide suitable breast feeding areas in public places. Provide change tables in washrooms. Provide "child friendly" grocery checkouts. Maintain child safety seats in grocery carts.	Provide suitable breast feeding areas in public places. Provide change tables in washrooms. Provide "child friendly" grocery checkouts.

Facilitator Focus Group Discussion

A Facilitator Focus Group discussion was held in Nanaimo with six facilitators attending.

Data were collected by recording on audiotape and by written notes taken by the focus group assistant. Data were transcribed and analyzed, themes were identified and coded by the means of coloured highlighters. The themes were then summarized and interpreted. The following presentation of results is arranged to reflect the questioning route outlined in the Healthy Beginnings Facilitator Focus Group Question sheet in Appendix D.

Question 1: What differences did you observe that Healthy Beginnings made to participants?

The major theme was that coming to the group "normalized" the mothers' experiences. The group made the mothers feel that they were not alone, which was especially important for first time mothers. They enjoyed making connections with each other and receiving support for their ideas about parenting.

Two examples were given of the group helping mothers to avoid serious depression. This theme involved the group providing support and helping the depressed mothers to feel more confidant in their parenting role and it reduced their isolation by making connections with other mothers. This

connection and the ability to form friendships in their community was seen as a powerful deterrent to mothers feeling overwhelmed.

A third theme involved the group facilitating the discovery of neighbours with similar interests and children of similar ages. Facilitators from several communities gave examples of mothers reporting they had lived in the area for four or five years but didn't really know anyone. One facilitator mentioned two mothers who lived on the same street, with babies born within days of each other, who didn't know each other.

Another theme dealt with mothers reporting fewer visits to their doctor. The participants were able to get many of their questions answered by the group and by the guest speakers. One facilitator added that there was a reduction in the time required by staff to answer questions because parents were able to access answers from group members. It was suggested that this allowed more time to focus on more high risk families.

The final theme involved mothers being proactive about requesting phone lists of people willing to be contacted by group members and forming a co-op for babysitting.

Question 2: What effect did the Healthy Beginnings groups have on parent isolation?

Since the group felt we had talked about parent isolation in the previous question and there was general agreement that reducing isolation was a primary outcome of Healthy Beginnings we moved on to the next question.

Question 3: In what ways did the Healthy Beginnings group increase participant feelings of parent competency?

A major theme was the acknowledgement from facilitators and other group members that each mother was doing a good job. They felt that parents felt more confident when it was pointed out to them that they were the expert on their babies. The fact that the facilitators stepped back and let the group generate solutions to problems, allowed mothers to air concerns and select strategies from the peer wisdom of the group. There were several examples of difficulties presented by mothers during the round robin component of the group, which resulted in brainstorming of ideas.

A second theme was reinforcement for current thinking, trends and research on parenting. Sometimes mothers ask if facilitators have handouts on issues. The group mothers would like to educate their mothers and other family members on new ways of parenting.

One facilitator remarked that she had really found herself reflecting on her own parenting since observing and interacting with the Healthy Beginnings group. There was general agreement among the facilitators that they were impressed by the efforts these mothers were putting into parenting.

Question 4: In what ways did the Healthy Beginnings group improve participant parenting skills?

A major theme was whether guest speakers contributed to improving parenting skills. Facilitators seemed divided on this issue, some of them had groups that really enjoyed having speakers. Others stated that participants enjoyed having topics raised, but preferred to have their own discussion without a guest speaker. They were in agreement that it was important to draw on the knowledge of the group and to ensure that they felt comfortable enough to give their opinions and perceptions. There was also general agreement that participants did not want to be "talked at" by experts. One facilitator suggested that perhaps speakers needed to be selected that could utilize an adult education perspective rather than one of being an instructor. There was discussion on how important the style of the presenter was when dealing with adults.

There were ongoing requests for presentations from a nutritionist as babies were introduced to solids. One facilitator suggested that speakers be selected based on their ability to work with the group to bring out their discussion and questions, rather than presenting an agenda to them.

Another theme involved the philosophy behind facilitation, in particular, presenting the idea that participants are competent, capable and that every child is unique. The group felt that their facilitation encouraged members not to take a body of knowledge and apply it to all situations, but to see what worked and what fit for their particular situation. One facilitator talked about reinforcing the idea that all kinds of parents are successful and that their kids turn out "o.k." even if they did not do it the same way she did. This facilitator tries to get the message out to parents that there is no one, perfect way to be a parent, but that many approaches work well and produce healthy children.

Question 5: What were the results of the referral process to other community resources?

The major theme was that often facilitators don't know what the results of the referrals are. They mentioned that it was a slow process getting a response from other agencies

and that it required persistence to get results. Since the mothers requiring referrals were often having a difficult time with everyday tasks, it seemed unlikely that they could manage the frustration of finding their way through the system. Referrals covered a wide range of community agencies including respite care, income assistance, housing, transportation, breast feeding, safety, nutrition, motor vehicles, employment standards, occupational therapy, infant development, nurses/doctors and skin specialists.

Question 6: How was the group affected, both in a positive and negative way, by other events and circumstances?

A major theme identified was group dynamics when there was someone in the group whose behaviour or attitudes were challenging or disruptive. Several examples were provided and included a young woman who was mentally challenged and who tended to monopolize the conversation. Others included a couple who had been directed to attend the group by the court, a teenage mother who was a drug abuser and a man who attended who had rigid values around parenting. Each of the groups had appeared to accept these parents, but one facilitator said that she heard feedback in the community that drop-in members didn't want these people in their group. The discussion began to focus on the issue of

economic class distinction and how surprised the facilitators were to encounter this phenomenon in the Healthy Beginnings groups. The facilitator focus group seemed divided on this point; some of the Healthy Beginnings groups seemed to be homogeneous with no issues around membership, while other groups had experienced some challenges. The facilitators of these challenged groups reported that the group members had accepted the "problem" parents and that these parents were still attending. One facilitator reported that she had been told by several parents that they felt their group had "turned yuppie". There was general agreement that teenage mothers would benefit from their own group. The teenage mothers have different needs and are struggling with different family issues. There was also agreement that in most cases the groups seemed to work better if all the participants were mothers. The facilitators were checking into the feasibility of having an evening meeting when fathers could attend also, perhaps once a month with specific topics scheduled.

One facilitator mentioned the difficulty of knowing what had not been successful for the participants if they attended only one group. The facilitators acknowledged that their usual procedure was to phone the new person to check

and see how they were doing and to identify what their needs were. Facilitators were in agreement that it was challenging to balance the needs of the group and the needs of individuals who may be coping with different life issues.

Question 7: What worked well in the Healthy Beginnings groups?

The major theme identified was that bringing the mothers together, provided a structure for them to meet, but that it was then necessary to get out of the way and let the mothers direct their group. Facilitators felt that providing child minding, snacks and administration and facilitation of the group allowed the mothers to focus on developing friendships and making connections and to learn from one another.

A second theme involved a lack of partnership in communities. Facilitators had experienced challenges when dealing with community members, community agencies and high profile individuals in the community. Sometimes the perspective was presented that in the past people had gone out for coffee to meet other mothers, why did people need a group to do it now? There was general agreement that everyone is short of funding dollars and new programs are rigorously scrutinized by the community. The challenges of working mothers were also acknowledged. Working mothers

often do not have the same opportunities to form friendships and network with other mothers in their community as stay-at-home-mothers.

Question 8: What would you like to change about the Healthy Beginnings groups?

The general consensus was that more groups were needed and more funding would be required to support them. Most of the groups had outgrown their space and needed to split into two groups. Facilitators wondered how they would manage these extra groups with the resources available. There was a brief discussion about the optimal number of participants for a group. The consensus was that seven to twelve people in a group worked well. When facilitators consider the number of babies born in their communities and the number of mothers attending Healthy Beginnings they are convinced that they will be faced with increased demand for these groups in the future.

Chapter Five: Discussion

This section presents a discussion and analysis of the data from a questionnaire distributed to Healthy Beginnings participants and qualitative data gathered from participant and facilitator focus group discussions. The discussion begins with an analysis of the following two research questions: (1) Does attending Healthy Beginnings drop-in groups improve parents' levels of confidence in their parenting skills; and (2) Does attending Healthy Beginnings drop-in groups reduce reported isolation for parents of infant children? As well, related questions dealing with levels of awareness of community services for parents and children, knowledge of child development and health and safety issues, infant feeding and levels of support in the parenting role will be discussed.

Research Questions Answered

Question 1: Did attending Healthy Beginnings increase parents' levels of confidence in their parenting skills?

Questionnaire data supports the information gathered in the participant focus-group discussions, where mothers identified feeling more confident about parenting after attending Healthy Beginnings. Interactions with participating mothers and other relatives regarding new

ideas about parenting appeared to be a significant pressure on new parents. Related information about the levels of support experienced by group participants seemed to contribute to how confident parents felt. Questionnaire data support the focus-group discussion data, which gathered information about how supported parents felt. Participants emphasized the importance of receiving support and of being able to access information from peers.

Information relating to feelings of parent competency gathered in the facilitator focus-group discussion also supports the finding that Healthy Beginnings seems to help new parents to feel more confident. Reinforcement of current thinking and trends in parenting, as well as an emphasis on the new mother being the "expert" on her baby appear to be powerful strategies for recognizing the efficacy of parenting in these new mothers.

Facilitator focus-group discussion identified that they observed changes in participants which would indicate that parenting skills increased as well as did levels of confidence in parenting. The "softening" or "moderating" of parenting styles seems to have been accomplished by a combination of peer interaction and the presentation of new information. The group dynamic of "normalizing" the new parent's experience with their baby is a powerful outcome of

bringing new parents together. The skill level of facilitators, their ability to provide an environment that recognizes the needs of adult learners, and their commitment to empowering parents, all appear to have made a significant contribution to participants' growth.

Question 2: Did attending Healthy Beginnings drop-in groups reduce reported isolation for parents of infant children?

The focus group discussion information gathered about participants' reasons for attending Healthy Beginnings, suggest that avoiding isolation was the major motivator for attending groups. Participants also identified getting out and meeting other mothers as a major influencing factor for getting mothers to attend group sessions. The focus-group discussion section that dealt with what participants liked most about the group sessions also resulted in interaction with other adults being identified as a powerful motivator. Participant suggestions for program improvement focussed on providing more time for them to interact with each other. The questionnaire information gathered on participant satisfaction with Healthy Beginnings; in particular, their feeling that they got what they came for, suggests the participants are very happy with the program. Since there was an indication that reducing isolation was the main

motivator for attending groups, and that satisfaction was high, Healthy Beginnings participants seemed to experience a change in their level of isolation.

Facilitators identified a reduction of isolation as one of the differences they observed in participants in focus-group discussions. The examples they presented of mothers finding that they did not know their neighbours, and the disclosure by participants that they knew very few people in their community, suggest that isolation is a very real issue for new mothers. Facilitation of referrals to other agencies also suggests that it would reduce isolation for new mothers, while expanding their knowledge of community resources.

Participants indicated that their awareness of community resources for parents and children had increased, when responding to questionnaire items dealing with these two issues. Ladysmith and Parksville had lower rates of agreement for these two items. It is not clear whether the smaller size of the Ladysmith community meant that there were fewer resources for parents to discover, or that because the group had not been running for as long they had less opportunity to be exposed to resources through guest speakers. Parksville is more of a retirement community than any of the other targeted communities. It is not clear

whether there was a lower rating for improved knowledge of resources because the population base is different, with different resources available, or whether participants came to the group with a broad knowledge of resources in place. Participant focus group discussions seem to indicate that while learning about resources was not the most important factor in deciding whether to attend, group members did appreciate improving their knowledge. Information from facilitator focus group discussions suggest that group members improved their knowledge of community resources by sharing information with each other.

Knowledge about health and safety issues concerning children seems to have increased for most participants, based on information gathered on the participant questionnaire. Ladysmith had a lower rate of agreement on this item. It is not clear if this is because the group has had a different focus when choosing topics up to this point, or whether this is a reflection of reduced exposure to guest speakers because the group has not been operating as long as some others.

Questionnaire information seems to suggest that participants did increase their knowledge about infant feeding and nutrition. Participant focus-group discussions identified that helpful advice on breastfeeding had not only

benefited babies, but also had significantly changed mothers levels of confidence about breastfeeding. Suggestions for ways that the community could support parents of infants focussed on the need for improved breastfeeding and change areas for infants in community facilities. Facilitators identified infant feeding and nutrition as topics that participants requested frequently. They also suggested that the introduction of solid foods was an issue that parents sometimes had difficulty understanding. Facilitators often requested handouts to show to participating mothers and other family members.

Questionnaire and focus group discussion information seems to confirm that parents feel supported in their parenting role in association with attending Healthy Beginnings. Increased well being and more relaxed attitudes toward parenting seem to result from the support they experience at Healthy Beginnings. The participants seem to be forming friendships and networks that will expand beyond their group experience. Their suggestions about ways the community could support them further make interesting avenues for further community development.

Questionnaire results for the number of sessions attended seems to suggest that "dosage" has a positive effect. Parents who had frequently attended sessions seemed

to be more satisfied, or more convinced that Healthy Beginnings had met their needs. The first four questions on the participant questionnaire seem to have an overall trend towards greater satisfaction with more sessions attended. This trend is not as noticeable for the last three items, which may suggest that people attend for as long as they need to, to get what they want or to reach a level of awareness that is adequate for them.

Limitations of the Study

The foremost limitation of the study concerns the research design, since the study did not include an experimental design with randomized assignment of the independent variable it is difficult to assert that Healthy Beginnings caused the changes observed in participants. There are many other factors within the individuals, the family and the community, which may have contributed to changes (e.g. maturation). The lack of a comparison group also makes it difficult to attribute causation to the independent variable.

There are internal validity issues when a program has a universal focus. The issues of class differences, which was identified in facilitator focus-group discussions about the effects of other events and circumstances, might suggest that it would have strengthened the study to have known more

about socioeconomic factors associated with the mothers' families.

The validity of the questionnaire is a further limitation. The questionnaire was developed for this study and has not been used in other studies, therefore, its' content validity is questionable. The questionnaire appears to have face validity from the participants' responses to questions. The fact that the questionnaire utilized a retrospective analysis of the experience of being a new parent is problematic. It is difficult to know if participants' view the first six months of being a parent with "rose coloured glasses" when they reflect back on it, or if they remember it as being worse than it was.

Ideas for Future Research

Further investigation is necessary to explore long-term effects of this type of early intervention. Community initiatives, which seek to build on the strengths of individuals and communities by focussing on providing support to parents of infants, need to capitalize on the successful strategies identified as programs are evaluated. Longitudinal study of the effects of successful attachment, enhanced infant stimulation and quality nurturing of the type promoted in the Healthy Beginnings groups will hopefully improve outcomes for families and children.

Concluding Comments

The major findings of this study are that:

Attending Healthy Beginnings drop-in groups improved parents' levels of confidence in their parenting skills and reduced reported isolation for parents of infant children.

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APPENDIX

Appendix A: Healthy Beginnings Participant Questionnaire

Client I.D. Number: _____ HB Site: _____ Date Completed: _____

HEALTHY BEGINNINGS PARTICIPANT QUESTIONNAIRE

In order to plan our program needs and to clearly describe to our funders the value of groups for parents of infants, we would like to have some feedback from you about how we are doing. Participation is voluntary and you are free to refuse or stop the interview at anytime. Your privacy will be protected by not revealing participant names, not associating participants' names with the results of individual surveys or patterns of survey results.

1) Approximate Number of Sessions Attended?
Check (✓) the box opposite the answer you choose.

- ❑ Under 5
- ❑ Between 5 and 10
- ❑ Between 10 and 20
- ❑ More than 20

The following list has examples of some of the ways Healthy Beginnings (HB) may have helped parents. Please tell us how helpful you found the sessions for each of these purposes, using a 7 point scale, ranging from 1 meaning "strongly disagree" to 7 meaning "strongly agree".

		Strongly disagree						Strongly agree
2)	HB improved my awareness of community services for parents	1	2	3	4	5	6	7
3)	HB improved my awareness of community services for children	1	2	3	4	5	6	7
4)	HB improved my knowledge about health and safety issues concerning children	1	2	3	4	5	6	7
5)	HB improved my knowledge about infant feeding and nutrition	1	2	3	4	5	6	7
6)	HB increased my feelings of confidence in parenting	1	2	3	4	5	6	7
7)	HB increased my feelings of support in my parenting role	1	2	3	4	5	6	7
8)	I got what I came for from HB	1	2	3	4	5	6	7

Appendix B: Letter of Consent

HEALTHY BEGINNINGS

NANAMIO HEALTH UNIT

1665 GRANT AVENUE
NANAIMO BC

Dear _____

My name is Vivien Millin and I am conducting an evaluation of Healthy Beginnings drop-in groups to complete an M.Ed. (Counselling) at the University of Northern British Columbia. Your registration form indicated that you would be contacted by a researcher and I would like to explain what this involves.

The purpose of the study is to find out if the program is meeting your needs and what kinds of things you look for in a drop-in group and what things about the group are most helpful. If you agree to my contacting you by phone I will complete a list of questions with you that will take approximately fifteen minutes. Your participation is completely voluntary and you are free to refuse or stop the phone interview at any time. All information will be number coded and strictly confidential. Your identity will not be revealed without your written consent. This study does not involve deception, discomfort or danger.

Please read the following paragraph and if you agree to participate, please sign below:

I understand that any information about me obtained from this research will be kept strictly confidential and that my identity will not be revealed without my written consent.

Signature _____ Date _____

Researcher _____ Date _____

If you have any questions please contact Vivien Millin at (250) 741-5463.

For further information about this research please contact:

Dr. Bryan Hartman
University of Northern British Columbia (250) 960-5555

Please return this form in the enclosed stamped, addressed envelope.

Appendix C: Participant Focus Group Questions

HEALTHY BEGINNINGS - FOCUS GROUP QUESTIONS

Introductions: Name, babies' name and ages.

1) How did you hear about the Healthy Beginnings Group?

2) What helps or makes it hard for you to come to the Healthy Beginnings Group?

Prompts:

- accessibility, location, transportation, time
- baby's response, family's encouragement
- other commitments

3) What were your main reasons for attending Healthy Beginnings?

Prompts:

- information about community services
- specific speakers
- to meet other parents
- to make friends

4) Please tell us what difference if any coming to the Group makes to you and your family?

Prompts:

- feelings about self as parent
- feeling relaxed/competent/skilled
- taking care of own needs (emotional, physical, etc.)

5) What do you like most about the Healthy Beginnings drop-in sessions?

Prompts:

- talking with facilitators
- space, location, facility
- information sharing

6) What would you like to tell the drop-in staff about the way they are with you, your children, and the others who come to the drop-in?

7) Do you have any suggestions for improving the Healthy Beginnings Group?

8) In what other ways do you think our community might support parents of babies?

Summarize ...and closing.

Appendix D: Facilitator Focus Group

HEALTHY BEGINNINGS

Facilitator Focus Group Questions

1) What differences did you observe that Healthy Beginnings made to participants?

   Prompts:
   - why they occurred
   - participant feedback form information
   - networking

2) What effect did the Healthy Beginnings groups have on parent isolation?

   Prompts:
   - friendships formed
   - knowledge of community resources
   - willingness to seek help

3) In what ways did the Healthy Beginnings group increase participant feelings of parent competency?

   Prompts:
   - participants helping each other
   - networking
   - interest in becoming co-facilitators

4) In what ways did the Healthy Beginnings group improve participant parenting skills?

   Prompts:
   - knowledge of community resources
   - knowledge of child development
   - managing health and behaviour challenges

5) What were the results of the referral process to other community resources?

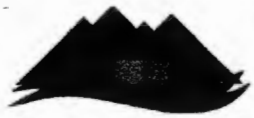
6) How was the group affected, both in a positive and negative way, by other events and circumstances?

   Prompts:
   - weather
   - health
   - children
   - time of year
   - transportation
   - child care

7) What worked well in the Healthy Beginnings groups?

8) What would you like to change about the Healthy Beginnings groups?

Appendix E: Letter of Permission from Allison Cutler



CENTRAL VANCOUVER ISLAND HEALTH REGION

February 17, 1999

Ethics Review Committee,
Office of Research and Graduate Studies,
University of Northern British Columbia,
3333 University Way,
Prince George, BC
V2N4Z9

To Whom It May Concern:

Re: Permission for Research Project

The Central Vancouver Island Health Region (CVIHR) is pleased to grant permission to Vivian Millin to conduct research within our agency as part of the requirements of her graduate program.

It is our understanding that Ms. Millin will be conducting phone interviews with Healthy Beginnings group participants as well as conducting focus groups with group participants and facilitators,

We also understand that participation in this research is voluntary. Verbal and written permission will be sought from all research participants and participants may chose to withdraw from the study at any time without penalty. We understand that the data will be coded and reported without identifiers. Ms. Millin will produce a report of her findings and provide the CVIHR with a copy.

Sincerely,

A Cutler

Allison Cutler
Regional Coordinator, Child Youth Family Health

610-495 Dunsmuir Street,
Nanaimo, British Columbia
V9R 6B9

'Healthy People and Healthy Communities'

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