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Parent-provider relationship in home visiting interventions

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ABSTRACT

Home visiting, while a very popular method of early childhood intervention, is not effective for all eligible at-risk families. The relationship between the home visitor and the family is central to the success of this type of intervention. This study aims to investigate, through 1024 home visit case notes from a French home visiting program, the ways in which the home visitor-family relationship develops, and identify the obstacles to and facilitators of a good quality relationship from the provider's point of vue. Results from a qualitative analysis suggest that the factors associated to the quality of relationship are present within the very first moments of the intervention. Poor relationship quality was found to be significantly associated with the family's mistrust towards the home visitor and with poor social conditions that make the supporting relationship difficult to develop. Good relationship quality was found to be facilitated by the parents' high involvement in the intervention and associated with a feeling of isolation and an ability to form social bonds. The necessitation for home visitor training is discussed, together with a reflection on the risk of home visiting programs to increase social inequalities, when they are not flexible enough to meet families' needs.

1. Introduction

Home visiting (HV) has become one of the leading prevention strategies in North America since the late 1970s and is now of growing interest in Western Europe, where several studies have demonstrated the impact of these programs on a variety of maternal health and child development indicators (Doyle, 2014; Mejdoubi et al., 2015; Sierau et al., 2016; Tubach et al., 2012). Recent reviews, however, have indicated that only half of these programs actually had a significant impact on the children involved (Kahn & Moore, 2010). Research on the obstacles impeding the success of early intervention has increased in order to explain the discrepancies between the expected impact of the intervention and the actual results.

HV preventive strategies often target "at-risk" families (young mothers, parents in poor socio-economic conditions, socially isolated, etc.), and aim to reduce the impact of exposure to poor environments on children's physical and mental health and, for some programs, on parents' health (Bilukha et al., 2005; Geeraert, Van den Noortgate, Grietens, & Onghena, 2004; Howard & Brooks-Gunn, 2009; Sweet & Applebaum, 2004). Among the long-term intervention objectives, reducing risk for maltreatment, promoting attachment, reducing behavioral disorders or enhancing school readiness are the most common outcomes targeted. While one can find that interventions use various mean to attain their objectives (teaching skills, giving information, offering emotional support…), implementing the intervention remains highly dependent on the relationship between the providers and the families (Riley, Brady, Goldberg, Jacobs, & Easterbrooks, 2008).

These interventions often use nursing services to support families from late pregnancy up to the child's second or third birthday (Stevens, Ammerman, Putnam, Gannon, & Van Ginkel, 2005), and they draw upon attachment theory (Bowlby, 1969), self-efficacy theory (Bandura, 1977) and human ecological systems theory (Bronfenbrenner, 1979) as their basis (Olds, Kitzman, Cole, & Robinson, 1997).

Poor socio-economic conditions can be considered both a risk factor for the quality of parenting and child health and an obstacle to the implementation of HV interventions themselves if they are too challenging. Program implementation, a newly developed research area in HV evaluation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005), is a key issue: recruiting the appropriate families (Spoth, Clair, Greenberg,

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Redmond, & Shin, 2007), maintaining families' participation in the program (Brand & Jungmann, 2012; Foulon et al., 2015; Gross, Julion, & Fogg, 2001; Sierau, Brand, & Jungmann, 2012) and applying a protocol with appropriate fidelity (Saïas et al., 2012) and dosage (Lyons-Ruth & Melnick, 2004), are essential for the overall effectiveness of the intervention (Durlak & DuPre, 2008). Low income, parental mental health issues, unstable housing and poor social integration have been identified as the main factors contributing to the risk of families dropping out of the intervention.

Challenging socio-economic conditions as well as social isolation can also affect the delivery of the home visits. Tandon, Mercer, Saylor, and Duggan (2008) found, through a series of focus groups with paraprofessional home visitors (HVr), that HVrs working with vulnerable populations experienced conflict between responding to the families' urgent needs and strictly adhering to the program protocol. For Hebbeler and Gerlach-Downie (2002), the *Parents as Teachers* program failed to achieve its initial goals as the professionals prioritized providing social support to parents over adhering to the program protocol, which emphasized behavioral change. Adverse social conditions can have a significant effect on the relationship between the HVr and the family, as the program may not address the needs of all families. While the HV paradigm relies on the quality of the helping relationship, the families may well be concentrating on meeting basic social needs.

For Paton, Grant, and Tsourtos (2013), understanding the nature of the intervention and its benefits is essential for gaining the trust of the families. Participants who took part in a qualitative research survey in their Australian HV program, reported that their engagement in the intervention was determined by their willingness to engage in a relationship, not a program. Similarly, a Canadian qualitative study showed that the relationship between the professional and the family was developed in three phases: overcoming fear of being judged; building trust and seeking mutuality (Jack, DiCenso, & Lohfeld, 2005). This supports McCurdy and Daro (2001) assertion that taking parents' needs into account is one of the most important tasks of a home visitor.

Brookes, Summers, Thornburg, Ispa, and Lane (2006) argued that studies on psychotherapist-client relationships provide a framework for understanding a parent's engagement in HV programs. They use Bordin's concept of the counselor-client "working alliance" (Bordin, 1979) to describe what a quality relationship should include: (a) therapist-client agreement concerning desired outcomes, (b) agreement and acceptance of responsibility regarding the steps required to reach those outcomes, and (c) mutual trust and acceptance. The author's emphasis on the latter point, which impacts the quality of the intervention, has been supported by several studies that use the personal characteristics and perceived relationship styles of both parties in their models (Brookes et al., 2006). Relationship and working alliance remain dependent of numerous moderating variables such as the therapist characteristics, the client characteristics (attachment style, mental health specifically) and the context in which the relationship takes place (e.g. Ross, Polaschek, & Ward, 2008).

Although the use of the working alliance model has widely been used in psychotherapy research (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), it has been more confidential in the field of prevention. A few researches have been conducted in order to estimate the weight of the parent-provider relationship in the success of preventive interventions (Korfmacher, Green, Spellmann, & Thornburg, 2007; O'Brien & Baca, 1997; Riley et al., 2008; Rossiter, Fowler, Hopwood, Lee, & Dunston, 2011). These studies often used a single informant (provider or families) to describe the quality of working alliance or of the relationship between families and home visitor. While they conclude that the parents-provider relationship is essential to the implementation and success of home visitation, they haven't been able to describe the relationships themselves. A few studies have tried to develop in vivo assessment by videotaping the home visits (McBride & Peterson, 1996; Riley et al., 2008; Wasik & Sparling, 1995), offering new technological opportunities in the home visiting evaluation field, without concluding on the core characteristics of a "good quality" vs. "poor quality" relationship.

The importance of the quality of the relationship in a HV intervention aiming to support families facing multiple challenges has been acknowledged, and identifies the need for a better understanding of how high quality relationships develop. However, as Brookes et al. (2006) have pointed out, most of the studies have focused on the HVrs or participants' individual attributes and on retrospective appreciation of the characteristics of the relationship (through post-intervention interviews or focus groups).

The present study seeks to evaluate, within a population of first-time parents living in very poor social conditions in the Paris area, France, the extent to which the CAPEDP (*Compétences Parentales et Attachement dans la Petite Enfance*: *Diminution des Risques liés aux Troubles de Santé Mentale et Promotion de la Résilience*) intervention could accurately deliver its content. Using home visit case notes, as a proxy for a naturalistic description of home visits, we have estimated the quality of parental investment and HVr-family relationship. These case notes have been collected by the care providers at the same time as the home visits were conducted.

To evaluate to what extent HVrs and families managed to engage in a positive relationship allowing the program's content to be delivered, and to identify possible obstacles compromising the efficacy of intervention, we qualitatively analyzed the HVr case notes which were written by the HVrs themselves.

2. Material and methods

2.1. The CAPEDP study

The CAPEDP Project took place in greater Paris area (*Ile-de-France*), France, from 2006 to 2011. The project provided home visit support to families with characteristics associated with a higher incidence of maternal postpartum depression and infant mental health problems. In this randomized controlled trial (Tubach et al., 2012), primiparous future mothers under 26 years of age had to present one or more of the following inclusion criteria to participate in the program were recruited: (1) have received <12 years of schooling; (2) intending to raise the child without the father; and/or (3) being eligible for free health care. After completing baseline screening and informed consent procedures, participants were randomly assigned in a 1:1 ratio to either the CAPEDP intervention or the usual care group using a computer-generated randomization sequence, stratified by recruitment center, with random block sizes of 2, 4 or 6 participants. The program aimed to reduce the incidence of maternal postpartum depression and infant mental health problems, as well as to promote parenting skills, infant-mother attachment security, and mothers' knowledge and use of social, medical and educational support services (Tubach et al., 2012). A total of 440 pregnant, primiparous women under the age of 26, were recruited in maternity wards between June 2006 and March 2009. The intervention and control group did not differ in any socio-demographic characteristic. As stated in Dugravier et al. (2013), and as reported in Table 1, the demographic characteristics of the intervention group (on which this study focuses) were the following: participants' mean age was just above 22; 29.5% intended to raise their child without his/her father; 83.6% had <12 years' education; 45.4% were eligible for free health care and 51.6% were born outside of France and 63.5% of them had

Table 1
Main demographic characteristics of participants in the intervention group.

Inclusion criteria	Intervention group (N = 184)
Age	22.5 (2.4)
Plans to raise her child without the father	29.5%
Low educational level (<12 years)	83.6%
Eligible for free health care	45.4%
First generation immigrant	51.6%
Planned pregnancy	63.5%