A Short-Term Impact Evaluation

of the

Growing Together Program

A Study Funded by
the Invest in Kids
Foundation

Growing Together, Toronto, Ontario

A collaborative project sponsored by
the Hincks-Dellcrest Centre and
the Toronto Public Health Department

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Growing Together - A collaborative project sponsored by the Hincks-Dellcrest Centre and the Toronto Public Health Department

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Executive Summary

A total of 80 research participants took part in the study: 57 group participants completed pre- and post- data; 12 provided pre-test and follow-up data after a short-term counselling and therapy intervention; 4 families consented to be interviewed for the purpose of developing case studies about Developmental Clinic participation; and 7 completed pre- and post- test interviews after receiving advocacy services. Data was collected between March, 1997 and August, 1998 and consisted of interviews with clients using both standardized measures and specially developed questionnaires and interview protocols. Data collection tools were designed to measure the objectives of each of the interventions being evaluated. Data analysis included descriptive statistics to summarize the responses of participants and paired sample t-tests were used to test for significant differences between pre- and post- test data when it was available for ten or more participants. Content analysis of open-ended interview responses was carried out in order to identify dominant themes.

Results showed that for the six groups evaluated (parenting, therapeutic and skill-based), group objectives were being met and desired improvements in the identified areas were occurring for participants. As well, participants reported satisfaction with their experience and particularly with the support they felt from meeting with other mothers. The Developmental Clinic services were extremely important for each of the families whose case studies were discussed. The cases presented illustrated the importance of the Developmental Clinic resources for children identified with biological difficulties and for parents who are anxious about the feeding and sleeping patterns of a normal infant. Mothers who received counselling/therapy services for four months, during the immediate post-partum period, demonstrated improved psychological functioning, and showed improved capacity to engage in a therapeutic relationship and to begin to be able to process and gain insight from discussion with their workers. In many instances it was possible to link up mothers to necessary services in the community. Perhaps most significant, the level of risk for the compromised development of their children was reduced. A large number of families received advocacy services, and pre- and post- test data indicated that their level of depression was reduced but the services were not able to impact on the difficult life circumstances that the families had to deal with. Again, satisfaction with and appreciation of the service was high. Combining these findings with information obtained through the Process Evaluation study, research from early intervention studies, and the views of the Co-Directors and staff, the following program components were seen as being critical:

- Early screening of mothers and newborns needs to be provided using a risk factor assessment and that immediate nursing and other services should be provided immediately in the neonatal period, as needed.
- Ongoing and regular monitoring and assessment of children and families should be available and referral to intervention services within and outside the program occurs as necessary.
- Services should be provided directly to the child.
- Services need to be provided to enhance the parent-child interaction and relationship.
- Family support programs need to be provided to families.
- A community development component should be provided.

The following recommendations are made:

1. That a budget be put in place to assure the continuity of the essential components of the program.

2. That efforts be made to expand services that are provided directly to children.

3. That the program must continue to develop a number of approaches to meet the needs of the most multi-challenged families.

4. That caution be used around trying 'to be all things to all people' and instead efforts should concentrate on providing services which have proved to be effective or are consistent with the essential components outlined in this study.

5. That additional funds be provided if further research is to take place as the program's current resources cannot be used to carry out research without severely compromising the integrity of service delivery.

Limitations of the research and recommendations for further study are outlined in the report.

Acknowledgements

This project was made possible through the commitment of the program partners, the Hincks-Dellcrest Centre and the Toronto Public Health Department, and the Invest In Kids Foundation who provided funding for both the Process and Short-Term Impact Evaluation studies.

The Growing Together Research team initiated and oversaw the entire project. Members of the Research Team, represented by both the Hincks-Dellcrest Centre and the Toronto Public Health Department, included the following people. Sarah Landy was responsible for the overall supervision of the project. Joyce Radford coordinated the study and report writing. Kwok Kwan Tam oversaw computer programming, data entry and analysis, developed figures and tables, and laid out the reports. Susan Mockler prepared the chapter on Groups. Nikki Martyn helped with the preparation of data collection instruments and research materials in general, and interviewed Growing Together group leaders and clients. Ken Leang interviewed clients. Remaining Growing Together research team members met bi-monthly and, in general, were responsible for providing feedback and assisting with report preparation. Thanks to: Joanne Cooper, Susan Dundas, Corinne Hart, Denise Martyn, Anne-Siri Oyen, Zoe Tate, and Michelle Weiss.

An Advisory Group made up of key stakeholders from the Invest in Kids Foundation, the Hincks-Dellcrest Centre, and the Toronto Public Health Department met every three to four months to advise on report preparation and dissemination. Our appreciation goes out to: Lorraine Bodnaryk, Nancy Cohen, Chaya Kulkarni, Lorraine Loeb, Freda Martin, Sara McColl, and Carol Crill Russell.

Growing Together workers remained highly committed throughout the course of this project and are thanked for their cooperation. Group leaders, counsellors, and therapists were particularly instrumental in providing opportunity for the participation of clients in the study. We are grateful to these clients for their time and feedback about their knowledge and experiences as parents, and for their opinions about the various aspects of the program. Photographs which appear throughout the report were primarily taken by Lennox White of the Hincks-Dellcrest Centre with a few having been provided by G.T. workers. Computer scanning of photos was done by Stacey Baines.

We are grateful to all those involved with the *Short-Term Impact Study* for their efforts and support.

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St.James Town
Rental Office

I Introduction

1.1 Purpose of the Study

The Growing Together (G.T.) Program is a population-based, prevention and early intervention initiative. Located in the neighborhood of St. Jamestown in the City of Toronto, the program offers health promotion, prevention, and early intervention services to families with children under the age of five.

The study of the immediate impact of the program on program participants involved assessing clients' knowledge or skill improvements, attitudinal, and behavioural changes.

Three key reasons for studying the short-term impact of the Growing Together program were:

1. To assess the immediate impact of four of the program's intervention services:
   - Groups
   - Therapy and Counselling
   - Developmental Clinic
   - Advocacy services

2. To suggest program components deemed critical or essential for successful program operation and impact and necessary for effective program replication.

3. To explore the need for further long-term evaluation of the project, as well as the appropriateness of other approaches, in order to examine the impact of different program components on various types of risks and family situations.

1.2 The Community Served

St. Jamestown, Toronto, where Growing Together operates, is a densely populated area of the city in which 22,000 people live and 300-400 babies are born a year. Many families with infants

and young children in the area face multiple risks. The family income of the residents is 41% below the Toronto average and currently more than 50% are unemployed and a high proportion are on social assistance. Poverty in St. James Town is associated with the highest rates of low birth weight infants and hospital admissions for young children in Ontario. As well rates of abuse and neglect are high. The area is extremely culturally diverse with only 35% of families speaking English in the home. Many new immigrant families have to cope with adjusting to unfamiliar surroundings and the loss of extended family and other support systems. These stressful life circumstances and the absence of social supports for many families contribute to a multiplicity of challenges to the physical and mental health of the infants and young children in the area.

1.3 The Growing Together Program

The goal of the Growing Together Program is to optimize the health, wellbeing and development of infants, young children and their families living in St. James Town and the surrounding area. There are a number of important principles, grounded in theory and research that guide the program. The guiding principles and their theoretical foundation are outlined in Table 1 which appears opposite.

1.3.1 Services are universal and open to the whole community

Perhaps one of the more unique aspects of the program is that although the services target families with infants and young children in a high risk area, **within that area many of the services are universal or are open to the whole community** (Gomby, Larson, Lewit & Behrman, 1993). For example, all families with a newborn are phoned, and are offered a home visit, in order to reach out to them, offer information, assistance and to find out about their immediate needs for support and information and ongoing desire for further services. As well, many of the groups (such as parenting and skill development groups), are open to all families with a young child in the area. With this goal of universality and of enhancing health, well-being and development of **all** children in the area, there is recognition of three important facts. By offering services to all families the project avoids stigmatising families who attend its various program components. Secondly, although it is important to assess risk and needs when a baby is born, longitudinal studies have shown that for many aspects of child and maternal health and development, an individual's risk status can be in constant fluctuation as life circumstances change or developmental difficulties become evident. Lastly, although it is critical to work with high risk families to change their risk status, a preventative approach which prevents those at low or moderate risk from becoming high risk by **offering services on a population-wide**

basis will have a long term effect in reducing the number of young children who reach high risk status or develop difficulties. (Chamberlin, 1988). In other words, Growing Together and its services rather than targeting a small group of families are intended to impact on the outcomes of young children in a whole community.

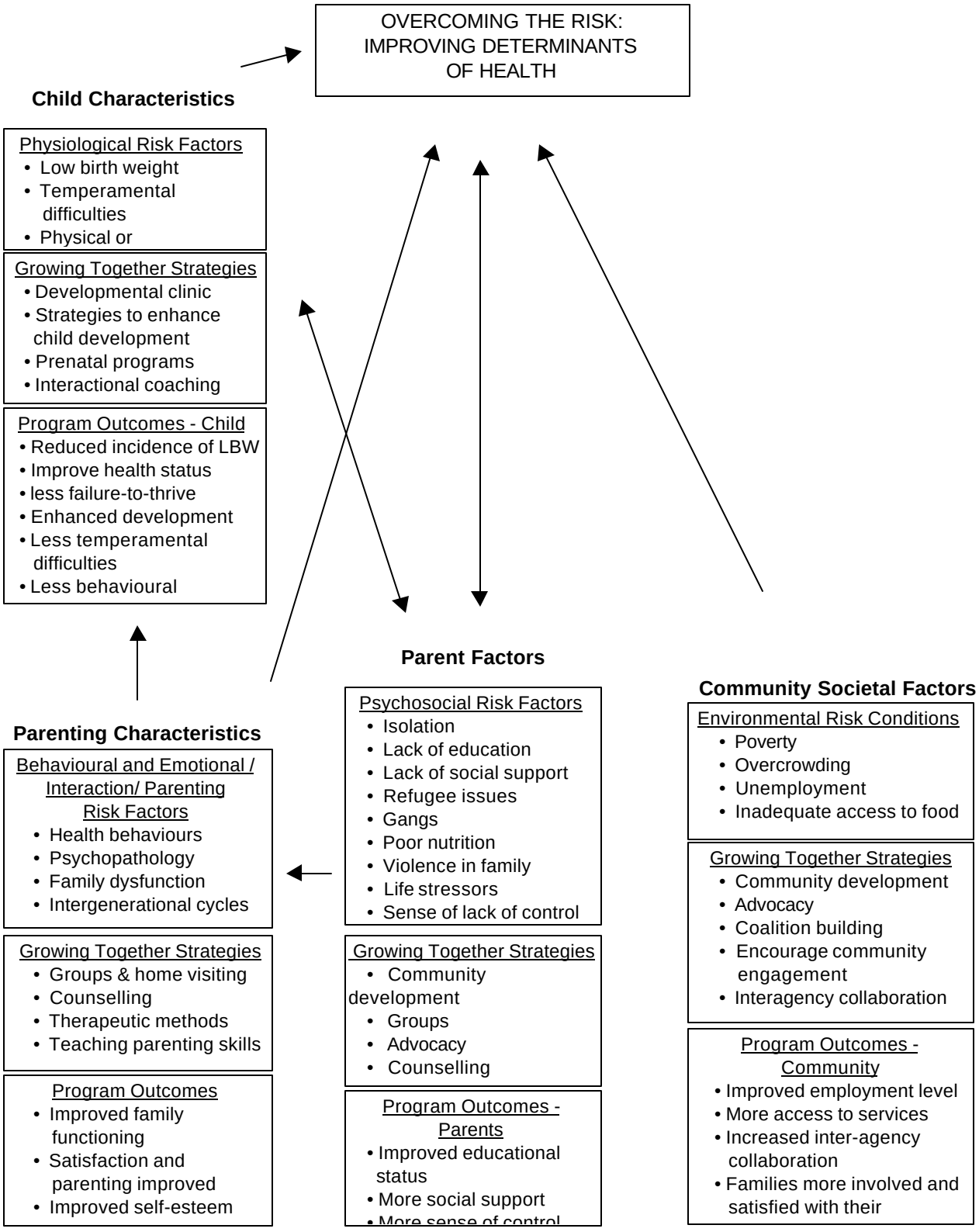
Table 1
Guiding Principles of the Growing Together Program

- Services are **universal** and open to the whole community. Efforts are made to enhance the development of ALL young children in the area.
- Families are **initially screened using an ecological or transactional approach**, which considers risk and protective factors in the child, parent-child interaction, parental characteristics, support systems and sociodemographic variables. Consequently, all these areas are considered when offering services.
- A variety of services are **specifically designed to meet the needs of families identified as being at risk for negative child outcomes**.
- In order to reach its goal to optimize the health well-being and development of infants and young children in the St. Jamestown area prevention strategies and interventions have been developed **that focused on the child, parents and community**.
- **The development of children and the well-being of families are regularly monitored** and services provided as necessary.
- Services are provided **that are accessible** with families passing easily from more intense to less intense or from less intense to more intense services as risks are identified or resolved or as families identify a need for or are willing to accept a particular service.
- Services are provided in **collaboration with other agencies,** with the major partnership being between public health and children's mental health. The program is funded from multiple sources and parent participation in the on-going functioning and planning of the program is seen as critical.

1.3.2 Families are assessed during the postnatal period for level of risk.

In assessing a child's risk for compromised development, the following are considered: child characteristics, interactional or parenting variables, parental history and current functioning and sociodemographic and societal factors (see Figure 1). A variety of variables have been found to be associated with poor outcomes for children (e.g. prematurity, chronic medical conditions of the child or parent, non-nurturing parent-child interactions, abuse and neglect, maternal depression, drug or alcohol abuse, extreme poverty, lack of support systems) but there are multiple pathways and processes that determine the ultimate patterns of adaptation or maladaptation (Cicchetti & Rogosch, 1996; Zeanah, Boris, & Larrieu, 1997). One of the reasons for the diversity in outcomes is the influence of a variety of protective factors which interact complexly with the risk factors. Although predicting a child's potential for difficulties is challenging, there are a number of important and consistent findings from longitudinal studies of development that guide our practice.

Figure 1. Growing Together Strategies in Improving Determinants of Health



The most important and consistent finding has been that one or two risk factors, unless they are extreme, rarely impact on development. As the number of risk factors increases, the negative effect has been found to enlarge disproportionately. For example, having four or more risk factors which relate to the child, parent, and sociodemographic situation can lead to a ten-fold increase in difficulties, a result that has been replicated in a number of studies (Rutter, 1979; Sameroff, Seifer, Baracos, Zax, & Greenspan, 1987; Sanson, Oberklaid, Pedlow, & Prior, 1991). This was recently replicated using Canadian data from the National Longitudinal Study of Children and Youth (NLSCY) (Landy & Tam, 1998). The other finding that is of importance is the need to consider the individual or types of factors that are impacting on the child and their likely effect on eventual outcome. It is clear from a number of studies that in the earliest years, particularly from birth to 3 years of age, proximal variables such as parenting interactions, and parental attributions and knowledge have greater impact than more distal community variables which may have a mediating effect through their influence on parenting interactions (Barnard, Hammond, Booth, Mitchell, & Spieker, 1989; Bee, Barnard, Eyres, Gray, Hammon, Spietz, Snyder, & Clark, 1982; Coates & Lewis, 1984; Sameroff et al, 1987; Werner, 1995). Thus, the number of risk and protective factors and any extreme risks in the parenting interaction are considered in determining the level of risk and services to be offered at Growing Together. By determining the risk for compromised development families who both need and want more intensive services can receive them. In addition, understanding the particular profile of risks and protective factors in a family can allow appropriate services to be designed for individual cases.

1.3.3 Services are specifically designed for at-risk families.

About 40% of Growing Together families are identified as **being at moderate or high risk and are offered services** that are specifically designed to meet their individualized needs. Children at risk can be classified under three main categories.

- A child is born with an established disability or at biological risk, which poses significant challenges, and can disrupt the interaction patterns of the most stable and supportive of families. Individualised services need to be made available directly to the child and support and help in accessing services to the family.

- Families lack a support system which is available, stable or viewed by them as helpful or useful. Numerous studies of children and families both at risk and not have shown that social support can directly influence the health and well-being of children and families. (Crnic & Greenberg,1987; Dunst & Trivette, 1988). Other researchers have noted that

social support may also has an indirect effect on children's development over time (Cochran & Brassard, 1979; Melson, Ladd, & Hsu, 1993). Isolated families who lack sufficient support systems require a full range of services from home visiting, efforts to help them identify and activate support systems, information about community services and assistance in accessing needed services. Home visiting is often carried out by community home visitors from the same culture and ethnic group as the family.

- The parent-infant/child interactions and relationship(s) are problematic and without intervention can place the child at risk. Interactions with caregivers that are non-responsive, lack sensitivity, are dominated by negative affect or lack of emotional availability can place children's development at risk (Barnard, Booth, Mitchell, & Telzrow, 1988; Beckwith & Cohen, 1984; Morisset, Barnard, Greenberg, Booth, & Spieker, 1990). The extremes of abuse and neglect, of course, are the most catastrophic for children's developmental outcomes (Barnett, 1997; Cicchetti, 1989). The reasons for problematic interactions can vary from, for example, lack of parenting information, maternal depression, criminality of either parent, mental illness, distorted parental attributions and parents' unresolved loss and trauma. Consequently, strategies to improve the interactions include interventions directed at the interactions (e.g., interactional guidance, videotape viewing and Watch-Wait-Wonder); provision of parenting information individually or in groups; health promotion activities; supportive services; psychiatric interventions and individual, marital or group therapy.

Because of the range and complexity of the interventions that are necessary to meet the needs of high risk children, a multidisciplinary team is critical with specialisation in children's health and development, advocacy, psychiatric conditions and medication, working with traumatised parents, parenting, and improving parent-infant/child interactions. Staff include: community home visitors, psychiatrist, pediatrician, speech and language pathologist, developmental psychologists, public health nurses, social workers, community development worker, early childhood educators, and child psychotherapists.

1.3.4 Services are designed to meet objectives that focus on the child, parents and community

Based on both research evidence and theory many specialists in early intervention do not believe that a single focus or even a combination of two approaches can be successful. This is because of the multiple stresses that families with young children living in areas such as St. James Town face. As outlined in Section 1.2, these include chronic unemployment and poverty, lack of job skills, strained family relationships, spousal and child abuse (Duncan, 1991). Children living in these difficult life circumstances suffer higher rates of prematurity, and without intervention for their families, typically are more likely to have subsequent developmental delays, behaviour problems and to be less prepared for kindergarten (McLoyd & Wilson, 1991).

At all times, the focus of interventions is on enhancement of the health, well-being and development of infants and children. At the same time, while it is recognised that a child may be at risk because of being born with an established disability or at biological risk, children can also be at risk because of parent difficulties or due to lack of support or a hostile environment in the family or community in which they live. So while certain interventions are child-focussed, or provided directly to the child, others have been developed for parents and community enhancement. See Tables 2 and 3 for a full list objectives and services that are provided.

Table 2
Program Goal and Objectives

GOAL

To optimize the health, well-being and development of infants, young children and their families who live in the St. Jamestown area.

OBJECTIVES

The Child

1. That parents achieve optimal health, before and during pregnancy by maintaining healthy lifestyle practices. In this way the incidence of low birth weight babies can be reduced.

2. That babies are breastfed exclusively from birth until they double their weight at approximately 4 to 6 months of age.

3. That the physical health and development of children living in the St. James Town area is optimized.

4. That children in the St. James Town area have the necessary language and cognitive capacities to assure their readiness for school.

5. That children in the St. James Town area have optimal emotional and social capacities.

6. That children in St. James Town area establish secure attachment with caregivers and supportive social relationships.

7. There are fewer injuries and deaths of children in the St. James Town area as a result of poor safety practices.

Parents/Families

8. All families in St. James Town make a successful adjustment to the new baby in the immediate post-partum period (0-3 months).

9. All parents of young children in the St. James Town area have adequate parenting knowledge and effective parenting skills.

10. That parents in the St. James Town area have the opportunity to resolve parenting issues resulting from unresolved trauma, abuse and loss or being raised in a dysfunctional family during their early development.

11. That parents in the St. James Town area are provided with opportunities to maximize their competencies and potential.

12. That the emotional well-being of parents in the St. James Town area is optimized by meeting the therapeutic needs of parents and families with severe dysfunction, psychiatric disorders, alcohol and/or drug addiction, abuse or violence.

13. All families with young children are free from abuse and violence.

The Community

14. Parents in the St. James Town area develop supportive networks and make optimal use of new and established services.

15. Parents in the St. James Town area develop a sense of belonging within their communities.

16. Efforts are made to mobilize and support parents and families to strive towards change in the community and a sense of ownership, control, and decision-making power in the community and within Growing Together.

17. Programs are developed to assist all families in St. Jamestown to have access to the basic prerequisites for health and safety.

Table 3
A Full Range of Services to Meet Program Objectives

The Child

Services:

- Prenatal Group
- Provision of information to individuals concerning healthy lifestyle practices during pregnancy when groups are not appropriate or available.
- Assessment of breastfeeding of infants immediately after birth to allow early identification of difficulties
- Responding to breastfeeding crisis within same day with individual contact
- Developmental Clinic
- Prenatal program and When Baby Comes Home group.
- Assessment of infants immediately after birth to allow early identification of health and/or developmental difficulties
- Infant Monitoring System.
- Provision of special services when children are identified with delays including specialised preschool program; in-home stimulation, groups for parents, speech and language assessment and consultation and referral to intensive services.
- Childcare services while mothers attend groups.
- Consultation to daycares around children identified with delays.

Parents and Families

Services:

- Early screening and crisis intervention for families in newborn period
- Parent groups such as: Nobody's Perfect, When Baby Comes Home
- Developmental Clinic and counselling and health promotion re. nutrition, healthy lifestyle practices, parenting, etc.
- Provision of printed material to parents and prenatal clients
- Consultation and collaboration with community agencies or groups working with pregnant women with special needs.
- Community kitchen
- Psychiatric assessment, consultation and prescribing of medication as necessary.
- Individual health promotion and counselling regarding feeding and nutrition, development and other parenting issues.
- Family, group and individual therapy.
- Supportive services / enhancing support network.
- Referral to appropriate services in community / advocacy for services.
- Parent activity and stimulation groups, such as Hanen Group, Mother Goose.
- Home visits to help parents stimulate children with delays.
- Interactional coaching approaches e.g., WWW, developmental guidance, videotape viewing.
- Skill based groups for parents, e.g. Computer skills, Arts and Crafts, etc.
- Volunteering of parents in Growing Together program.
- Crisis intervention as necessary
- Specialised groups for parents who experience difficulty with interactions or relationships with their children, e.g. Anger Management, HEAR, Psychotherapy Group
- Prenatal Program
- Respite childcare for parents who need parent relief

The Community

Services:

- Mailing of information about Growing Together services
- Community newsletter
- Parent groups in order to organize around community issues
- Community events and activities such as Art Show, community gardens
- Volunteering on Advisory Committee of program
- Community kitchen
- Safety committee to address safety concerns in the neighbourhood
- Networking with other agencies in the neighbourhood

As a result two-generation, three pronged or multidimensional programs have become popular, which attempt to attack problems from multiple directions (St.Pierre, Layzer, & Barnes, 1995). At Growing Together this three pronged approach provides the following program components:

a. **Child-focused programs** which include assessment and consultation about child development by a pediatrician, psychologist, public health nurse, speech and language pathologist and early childhood educator. Ongoing monitoring of children's development takes place through the Infant Monitoring System (IMS) and Developmental Clinic. When difficulties are identified, children are offered a preschool program, referral and consultation to relevant agencies and regular in-home services. Children with emotional, social or behavioural difficulties may be provided with individual treatment, using play therapy. As well, all children receive childcare services when their parents attend groups which can offer them opportunities to socialize with other children and to learn a number of developmental skills.

b. **Parent-focused programs** aim to have short-term effects on parenting skills which are expected to have indirect effects on children's development. The parent-focused programs emphasise development of healthy life-style practices during pregnancy, provide parenting skills and information, as well as address the improvement of parent-child interactions either directly or by working with parents supportively, therapeutically or through skill-based programs. These are outlined below:

- **Programs that emphasis improvement of the parent-infant/child interaction or relationship.**

  These can involve direct intervention with the caregiver-infant/child dyad, provision of parenting information and health promotion around breast-feeding, nutrition, safety issues and other healthy life style practices. Information is also provided about prevention of illness and care of a sick child. Other efforts to enhance the parent-infant/child interaction or relationship may include interventions which emphasise alleviation of maternal depression or other psychiatric conditions and provide parents with strategies to parent difficult children or manage their own anger. When children are identified with speech and language or cognitive delays parents can receive interactional coaching in the home or in specialized groups such as the Hanen and Mother Goose programs. These interventions may be provided individually or in groups, in the home or at the centre.

- **Programs that offer family support** aim to build a system of natural supports, professional support and links to relevant services in the community. Usually in the initial stage of entry into the program a supportive presence and the building of a nurturing worker-client relationship is crucial. For families, for whom isolation and lack of supports are central issues family support services may continue to be the major focus of intervention. Community home visitors from the same culture as the family, often play a crucial role in providing family support services. Linking to needed services is carried out by individual workers, however, a specialist in locating and advocating for services is also available to help families navigate the maze of services, for example, immigration, welfare, housing and daycare services, and assist families who wish to apply for them. Attendance at centre groups and community events and activities can also alleviate isolation and provide opportunities to meet with others. In high risk, very stressful situations parent relief may be provided whereby children attend respite daycare occasionally or for a short period of time.

- **Programs that concentrate on competence and skill building for parents** are often the programs which are most requested by parents. These programs are expected to have direct effects on parents, increasing their self-esteem and self-confidence and providing them with job-related skills. Programs that are offered include computer skills, English skills, a newsletter and a community-focused parent group. Entrepreneurial activities are supported but are not a part of direct services. As well, a number of parents are involved in various aspects of the program as volunteers and as a consequence gain valuable skills while at the same time contributing to Growing Together and their community.

c. Community-focused programs

Because families in St. James Town contend with adverse circumstances which can place their children's development at risk, services are also directed at enhancing the community in which the families live. These services include networking with other agencies to encourage the development of services to meet the needs of families. Efforts are also made to increase parents' sense of belonging in their community. Activities include formation of community groups and support of community driven and directed initiatives. Various initiatives are begun or supported by Growing Together which improve the neighbourhood, (e.g., community gardens and a safety initiative). In addition, a variety of community events are organised and are attended by parents

which: provide information on crucial topics, such as family violence; allow residents to demonstrate their skills and talents; and provide an opportunity to meet new friends and form new support systems.

1.3.5 The development of children and the well-being of families are regularly monitored.

Because it is clear that the initial estimate of risk status can change over time, ongoing monitoring of the health, well-being and development of the child and their families is crucial. Risk status can quickly change from high risk to low risk or, more importantly from low to moderate or high risk. Ongoing monitoring allows any necessary services to be provided as early as possible in order to prevent further deterioration in health or development. A number of mechanisms are in place to provide this ongoing monitoring. For example, families already involved with a worker or who attend programs are provided with an opportunity to discuss issues and developmental or health problems can be identified early.

In addition, an Infant Monitoring System (IMS) which uses the Ages & Stages Questionnaire (Bricker & Squires, 1989; Squires, Nickel, & Bricker, 1990) is popular with families and currently helps in the monitoring of over 200 children's development. Parents complete developmental screening questionnaires at specific intervals which are then mailed back to Growing Together for scoring. As well as providing a relatively low-cost method for tracking large groups of at-risk infants, parents benefit as a result of completing questionnaires about their children. Completing interviews or questionnaires informs parents about what to expect of their children and can enhance their ability to provide their children with age-appropriate activities (Squires & Bricker, 1991). When delays are identified through the IMS, parents are invited to bring their child for further assessment at the Developmental Clinic.

The Developmental Clinic, staffed by a pediatrician, public health nurse, psychologist and speech and language pathologist, provides an opportunity for assessing the health and development of infants and young children. Infants and children attend the clinic for assessment, for regular monitoring of their health and development or because delays or emotional, behavioural or social problems are suspected. Referrals for assessment are made from within or outside the program. Once developmental delays in cognition or speech and language are identified interventions are provided through staff of the TLC^3 program.

Families who were initially assessed as low to moderate risk and who do not require intensive services or families who initially declined services, are monitored once a year on their child's

birthday. Families are phoned and asked about any concerns and told about Growing Together's current programs. They are also invited to bring their child for a developmental and/or pediatric assessment.

1.3.6 Services are accessible

For disadvantaged, high risk families, particularly those who are resistant to receiving support or intervention, it is essential that services are made inviting and accessible. A number of characteristics of the program are important for increasing availability of the project to families. The Growing Together site is in one of the apartment buildings in St. James Town, consequently it is visible and accessible to families. As well, by showing respect and caring for families a friendly, inviting atmosphere is provided. Services are provided flexibly, at different locations, and when necessary, outside of traditional hours. By having paraprofessional and professional staff from the major ethnic groups and languages in the area (Tamil, Urdu, Filipino, Somali and French) it is possible to provide culturally sensitive services in the languages of the families.

Two other important aspects of the program are the outreach approach and efforts to meet the needs of families in making groups attractive. **Home Visiting** is used by the program in order to outreach to families and to deliver service in the home where family life takes place. This is particularly crucial in the lives of parents with infants and young children who may find it particularly difficult to attend sessions or programs outside the home. However, what is perhaps most critical is that the home visitors demonstrate a willingness to go to the family's turf and to accommodate to the family's needs and schedule. As well, support, crisis intervention and assistance in locating basic needs are provided. Perhaps the most crucial aspect of change begins to develop as the parents begin to trust and to form a meaningful relationship with the home visitor (Olds, & Kitzman, 1990; Osofsky, Culp, & Ware, 1988; Powell, 1990). As stated by Weiss (1993) "home visits are a necessary component of early preventive interventions for families who are highly stressed or are otherwise difficult to reach and service" (p.114).

Growing Together does not rely on home visiting exclusively. There is also an extensive in-centre component with a variety of groups and activities that parents and their children can attend when they are ready.

In the Growing Together program early postnatal visits and risk screening and many of the parent-focused activities occur during home visits, although they can also take place at the Centre. In other words, parents are provided with parenting information, health promotion,

interactional guidance or coaching, social support, linking to other services and where necessary, with counselling and therapy.

Because of the disadvantaged situations of many Growing Together families, whenever possible group participants are provided with money for transportation, food coupons, a nourishing meal or snack for them and their children, various handouts, and childcare along with other supports to encourage their participation in various program components.

1.3.7 Services are provided in collaboration with other agencies

Because of the complexity of the services that need to be provided, Growing Together is a partnership between the Hincks-Dellcrest Centre (a children's mental health centre) and the Toronto Public Health Unit. This partnership allows for a sharing of expertise and provision of services by a well-trained multidisciplinary team of professionals. As well, the program has funding agreements under the Community Action Program for Children (CAP-C) with the parenting centres of the Toronto Board of Education and a community recreation centre. Provision of respite care is provided for families by Victoria Daycare. In addition funding is provided to the program by the Invest in Kids Foundation, Junior League of Toronto and other smaller grants. As well, the community development component of the project and other networking activities by staff contribute to the development of a collaborative group of agencies who provide early intervention services in the area. The Advisory Committee, consists of representatives from agencies in the area and parents involved in the Growing Together program who contribute to decisions regarding the planning and provision of Growing Together Services.

1.4. Findings from research on the effectiveness of early intervention and their relevance for the Growing Together program.

Evaluating the findings from studies on the effectiveness of early intervention and determining their relevance for the Growing Together project is extremely complicated. There is tremendous diversity in early intervention programs and approaches to improving child outcomes. Early intervention programs vary according to a number of important components (see Figure 2). These include:

- The population targeted (e.g. low birth weight infants, drug addicted parents, families in high risk neighbourhoods). Very few programs have a universal approach to providing services.

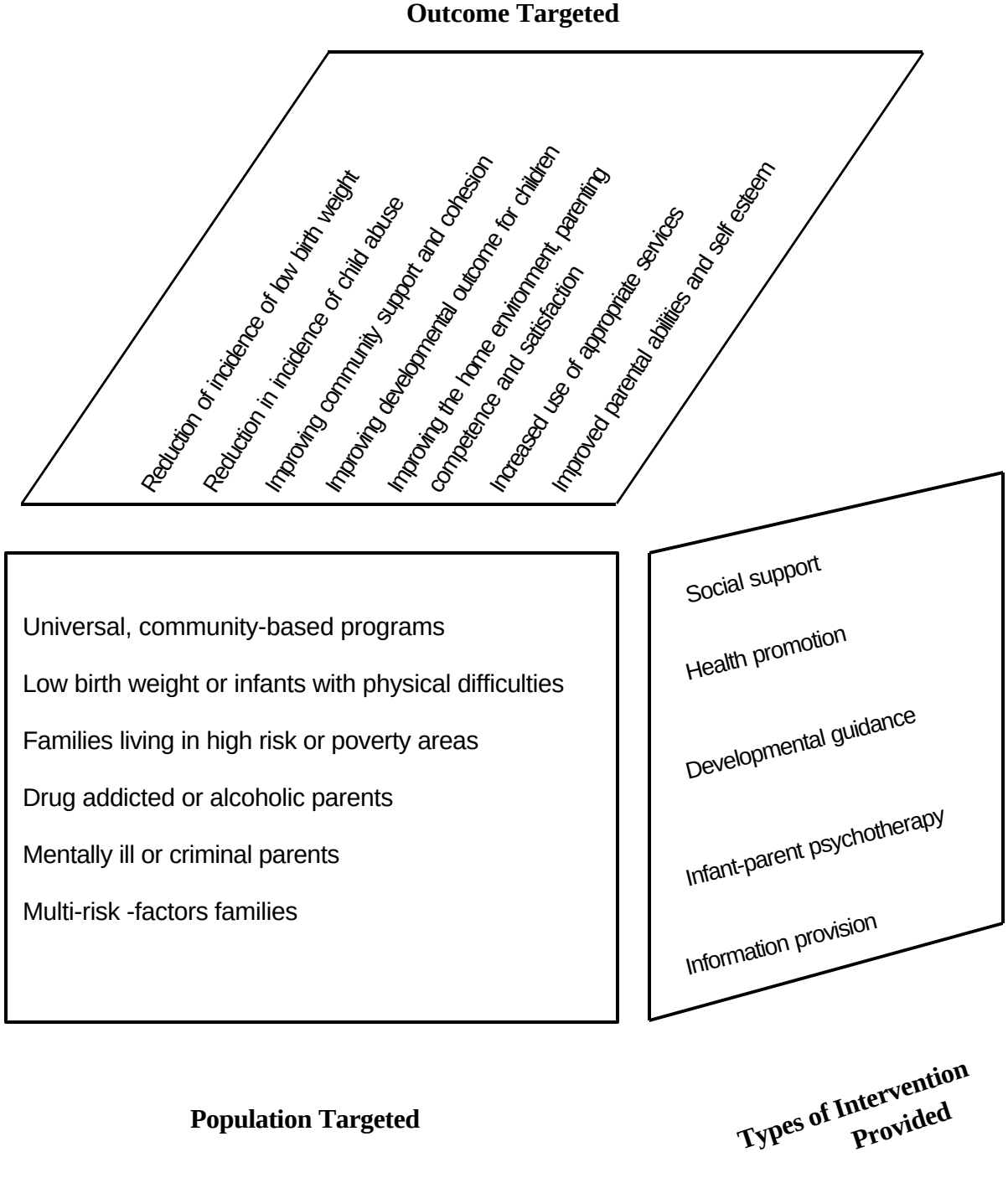
- The outcomes targeted and therefore evaluated (e.g. reduction of the incidence of child abuse; improvement in the developmental status of the child).

- The qualifications, training, and characteristics of the service providers (e.g. community mothers, public health nurses, mental health professionals). In some programs there is a mix of service providers while others rely primarily on, for example, community mothers or public health nurses.

- The duration and intensity of the services (e.g. only during one year post-partum; weekly or monthly, for 6 months or several years).

- The program's philosophy and assumptions and the type of interventions provided (e.g. approaches tend to be more social support, follow an instructional curriculum or to be more psychodynamic).

Figure 2: Some of the Multidimensional Aspects of Early Intervention Programs



Perhaps the last component has proved to be the least clearly articulated in a number of program descriptions and evaluations. Programs vary significantly in terms of the range and extent of programming that is provided. Some evaluations have considered the effectiveness of one particular approach (such as interactional guidance, psychodynamic therapy) while the majority have considered the effect of an entire program on various outcomes. This makes evaluation difficult because many service providers may move between various treatment modalities and approaches adapted to the needs of the family at a particular time and context.

Early intervention programs, particularly ones like Growing Together, present a number of challenges to scientific evaluation of their effectiveness. One of the primary problems has been the need in experimental designs for random assignment of families to different types of intervention and particularly to non-intervention. For many programs which aim to be universal and to have various intervention approaches available to all families, this experimental design has not been possible. As well, not intervening in some families creates an insurmountable ethical dilemma. Moreover, even in >non-treatment= control groups it is not always possible to assure that families are not receiving treatment from other agencies or individuals. In some studies multiple approaches such as the use of comparison groups and comparison of outcomes to community norms or other data sets have been used instead.

Another major problem has been the lack of large sample sizes which could allow for stratification of subjects in order to examine differential effects according to such variables as age, race, gender and the economic condition of the family. Because of this it has often been difficult to take into account the diversity of families which receive services from one program. Other evaluations have suffered from a lack of adequate measures, particularly to measure child outcomes, which are usable with multicultural populations, acceptable to families and can document change. Another major flaw has been the failure to include relevant variables as possible outcomes at the outset, thus losing valuable data and making it difficult to determine the percentage of those variables successfully impacted compared to those not positively affected. Perhaps what has been most lacking and what is now needed as pointed out by Guralnick (1997), “is to identify these specific program features that are associated with optimal outcomes for children and families”, (p.13). As he notes, this kind of “specificity” is rare and research continues to be needed that takes into account which program features are most essential (e.g. the intensity of the relationship, content of intervention), with whom they are effective (e.g. the

influence of child characteristics and the level of risk); and which outcomes they impact and how various outcomes may mediate others (e.g. are there direct or indirect effects on the child, parent-child interactions and/or parental competence, and how do changes happen over time).

1.4.1 Historical Perspectives

The period between the early 1970's to 1995 has shown tremendous growth in understanding of the importance of the early years on child development and the significance of aspects of the environment on child outcomes. Moreover, a number of early intervention programs have been evaluated using adequate experimental designs which have been able to establish the efficacy of certain early intervention approaches. For example, two meta-analyses (Casto & Mastropieri, 1986; Shonkoff & Hauser-Cram, 1987) as well as a review of effectiveness (Guralnick & Bennett, 1987) established that early intervention programs can improve outcomes by one-half to three-quarters of a standard deviation, or by between 8 and 12 IQ points -- not an insignificant amount. It is important to remember that these results were primarily based on the effectiveness of well funded, model programs which compared the outcomes for children and families who received early intervention programs and those receiving no services or supports. It is also significant that since the time that many of these model programs were offered, situations for many children and families have become far grimmer with increasing numbers of children living in poverty (Duncan, 1991). For these reasons the results of these studies are not always relevant to the type of community-based service delivery provided in the Growing Together program. As will be noted later, although it has been possible to establish the efficacy of a number of model programs, it has been far more difficult to establish the effectiveness of community-based programs which have often offered more multidimensional and fragmented services.

1.4.2 Significant Findings from Early Intervention Studies

Since these broad statements made in the 1980's about the effectiveness of early intervention, later researchers have provided findings which, although they leave many questions, have been somewhat helpful in guiding the selection of the principles and components of early intervention programs. These include:

a. Child-focused interventions, typically daycares and preschools, consistently result in improved outcomes for children who attend the programs. These include being less likely to require special education or to be retained in-grade. A number of programs

such as the Perry Preschool Program have shown long-term outcomes with intervention children, as adolescents (compared to controls), being more likely to have graduated, to be employed, to be in stable relationships and not to be in trouble with the law (Beller, 1983; Burchinal, Lee & Ramey, 1989; Lally, Mangione, & Honig, 1988; Schweinhart, Barnes, & Weikart, 1993).

b. Those programs that in addition to child-centred interventions, provide parent education and support, have shown some success in helping mothers interact with their children in a more positive way and to provide more positive learning opportunities for their children. However, the effects on parents have been mixed depending on the complexities of their needs and the quality of the program (Benasich, Brooks-Gunn, & Clewell, 1992; Yoshikawa, 1995). However, child-focussed programs with significant parent intervention produce more substantial long term developmental outcomes for children than child-focused outcomes alone, and, as well, have been most effective in reducing later antisocial behaviour and delinquency (Achenbach, Phares, Howell, Raugh, & Nurcombe, 1990; Johnson, 1988; Lally et al, 1988).

c. Family support programs that only provide home visiting and parent education programs without any interventions provided directly to children or to parents dedicated to improved child development, have inconsistent and only very modest effects on child development (Crnic & Stormshak, 1997). The effects of these programs on parenting behaviour have been somewhat more successful and modest effects have also been found for the likelihood that parents will get more education and delay subsequent births (Melson, Ladd, & Hsu, 1993; Wasik, Ramey, Bryant, & Sparling, 1990). In general, the provision of social support services is most likely to work by providing parents with a more solid parenting foundation which can then mediate more positive development for children.

d. More recently a number of two-generation or multidimensional programs, which provide services for the child, parenting and to enhance the parents' own competencies and employment skills, have produced short-term results of their effectiveness. Unfortunately, to date these programs have produced minimal effects on child outcomes. Effects on parenting behaviours and on parents' income and employment have been scattered. Some improvements have been found in time spent with the child, teaching skills, in attitudes about child rearing and in parent-child interactions. Few effects on the long-term income of parents or employment or in reducing parental depression or improving self-esteem or use of social supports have been found. The

reasons for these outcomes are yet to be determined (Johnson & Walker, 1991; St. Pierre, Swartz & Gamse, 1995; St. Pierre, Layzer, & Barnes, 1995; Travers, Nauta, & Irwin, 1982). It may be that the effectiveness of these kinds of program will only be shown in terms of beneficial long-term effects. It could also be that the magnitude and range of difficulties faced by families today makes effecting change with low intensity interventions not possible. It could also be that the quality of the programs and the tendency to try and be "all things to all people" results in a diffuseness of interventions that undermines their quality, intensity and effectiveness. However, because of their theoretical appeal and their relative newness, continued and more sophisticated evaluations of their effectiveness are justified and necessary.

e. There is some research to suggest that disadvantaged children and parents, especially when there are additional risk factors such as being a teenage or single mother, benefit more from early intervention programs than those children and families with fewer risk factors. This is probably because improvements are more noticeable and more likely to be stable and significant when pre-test levels are low (Halpern, 1986; Olds & Kitzman, 1993). However, it has also been suggested that a curvilinear relationship may exist with families with multiple risk factors or those with very few, less likely to demonstrate improved outcomes.

f. Research has not indicated the intensity or length of intervention that is ideal. However, with families with complex and multiple risks a high level of intensity and continuity over two or three years is probably necessary to yield benefits (Powell & Grantham-McGregor, 1989). Research on the Infant Health and Development Program for premature infants found that the degree of family participation was one of the most important indicators of outcome, indicating the importance of the intensity of the intervention (Brooten, Kumar, & Brown, 1986; Grantham-McGregor, Schofield & Powell, 1987: Osofsky, Culp, & Ware, 1988; Pierson, 1988; Ramey, Bryant, Wasik, Sparling, Fendt, & La Vange, 1992).

g. There is some evidence that beginning intervention prenatally or in infancy generates larger effects than waiting until children reach the preschool years (Larson, 1980). Programs that have been particularly successful in the prenatal period in improving birth outcomes and reducing premature births have: (1) targeted life style behaviours, (2) supported high risk mothers through outreach, (3) included multidimensional approaches (Dunn, 1988).

h. Whether the program is child-focused, works with parents, or both, high-quality services are necessary to generate long-term effects and benefits. Well trained and dedicated staff are crucial and in general are more effective with high risk families than community mothers. Community mothers must receive intensive supervision. However, when programs are intervening with populations with multiple risk factors those which have professionals have better outcomes than those that rely on paraprofessionals and community home visitors only (Hundert & Houghton, 1992; Larner, Halpern, & Harkavy, 1992; Musick, Bernstein, Percansky, & Stott, 1987: Olds & Kitzman, 1993; Osofsky, Culp, & Ware, 1988; van den Boom, 1994). There is also evidence that public health nurses are particularly effective in the neonatal period. Research also suggests that quality often suffers when programs are implemented at multiple sites.

i. Programs that target the following populations have been shown to be particularly effective: low birth weight infants, infants with disabilities and when parents request and indicate a need for particular kinds of information or resources and for parents who already are used to seeking out help and companionship from naturally occurring support systems. However, the results with populations at risk, such as abusing and neglecting parents, substance-abusing and teenage mothers, have been far more equivocal with attrition being a significant problem. In these populations whether the parents see a need for the intervention and are committed to it are important determinants of the success of the intervention.

j. Increasingly, efforts are being directed at enhancing child competencies and social capacities rather than only concentrating on improving IQ as a narrow outcome of cognitive competence. Some of the outcomes considered have included the ability to sustain interactions with others, to resolve conflicts and to strive for goals (Guralnick & Neville, 1997). This trend has influenced the consideration of child outcomes and has resulted in efforts to develop treatment strategies to enhance social competence in children including encouraging peer interactions, parent interactional guidance around these developmental issues and emphasising initiative by the child in interactions.

1.4.3 The Impact of Various Intervention Strategies

Perhaps most useful and informative for the Growing Together program has been research that has explored the effectiveness of particular approaches or intervention strategies. These are summarised below:

- For some populations less intensive interventions such as a single Brazelton examination involving parents and occasional monitoring of children's development by public health nurses and referral to appropriate services may be sufficient to help parents become active agents of change and to produce positive outcomes in children over time (Landy, DeV. Peters, Arnold, Allen, Brooks, & Jewell, 1998; Widmayer & Field, 1981).

- Home visiting studies do not allow definitive conclusions as to its effectiveness primarily because it is often unclear from the studies as to what was done during the home visits. As well, home visits are often done as well as other interventions so it is difficult to determine which is contributing to what effects. Nevertheless, when findings are aggregated home visiting appears to have been successful in improving parent-child interactions, parenting self-confidence and parenting knowledge, increasing support and reducing stress. At the very least, home visiting is a crucial link to ensure parent participation in programs and to increase the use of appropriate community services (Weiss 1993; Ramey & Landesman-Ramey, 1995).

- In an interesting study disadvantaged mothers were given baby carriers to use with their newborns, while controls were given infant seats. At 13 months the infants of mothers who received the baby carriers were more securely attached (Anisfeld, 1990). Field, Grizzle, Scafidi and Abrams (1998) found that massage therapy for infants of depressed mothers significantly improved the development of the infants and White-Traut and Nelson (1988) found that maternally administered tactile stimulation improved the mother child interaction. These three studies suggest that encouraging touch and contact in the postpartum period can be helpful in improving child outcomes.

- That for abusive and neglecting parents, some programs aimed at changing parenting behaviour have been found to be less threatening than more non-directive approaches (Wolfe, Edwards, Marion, & Koverda, 1988) and most effective for certain parents (Brunk, Henggeler, & Whelen, 1987). However, establishing a relationship with parents first may be crucial to assure their participation in the program and to avoid attrition. This relationship may be established by helping families find food, clothing and shelter to meet their basic needs (Barnett, 1997).

- Numerous studies of children and families at risk have shown that social support (especially from intimate relationships and friendships) enhances parenting interactions and is associated with higher cognitive functioning in children (Crnic & Greenberg, 1987; Dunst & Trivette, 1988). It is probable that the effects on children's development when present are indirect associations and mediated by reducing parental stress and improving parent interactions with their infants and children (Nelson, Ladd, & Hsu, 1993). When social support is provided by early intervention programs as a strategy for intervention the results have been somewhat mixed. In one program, the Parent-Infant Project (PIP) (Dawson, Robinson, Butterfield, van Doorninck, Gaensbauer, & Hammon, 1991), support for teen mothers was begun in the third trimester of pregnancy and continued until the baby was 14 months and was provided by community mothers. No significant differences between intervention and controls were found by 12 months. On the other hand in a study by Affleck, Tennen, Rowe, Roscher and Walker (1986) in which nurses provided support to mothers of premature infants in the transition from the NICU to home, with home visiting for 4 months, although the results were mixed it was found that for mothers who reported a need for the intervention, their sense of control, competence and responsiveness was significantly increased. As well, the more severe the medical condition the more positive the effects. When mothers perceived less need the effects became increasingly negative. These three studies show that social support does not always have positive effects and may be seen as burdensome and not useful by some mothers. Moreover, results have tended to be correlational in nature and little research to date has addressed the directionality of effects or has examined possible constraints such as the mother's level of self-esteem and coping as influential.

  In an examination of 105 studies of the effectiveness of social support with children with disabilities, Dunst, Snyder and Mankinen, (1988) found the methodologies to be very disappointing and found only 8 studies which "specifically evaluated the influences of social support as an intervention" p.506. Collectively the evidence shows that informal social supports are related to positive outcomes and that formal support provided by early intervention programs by giving information and advise was modestly related to the child's functioning but bears little relationship to improvements in the parents' personal functioning (Halpern, 1986; Larner & Halpern, 1987; Weiss, 1993). Interestingly, parents with weak social support networks were less likely to engage in community-based parent support programs (Beckman, 1991; Dunst & Trivette, 1988; Rauf & Rimmerman, 1993).

- Although it is very difficult to separate the effects of the various components of two generation programs, when it has been considered as a strategy the provision of adult

education and job training appears to have had very little effect. Long term increases were not found, as a result, for household income or employment. None of the programs had effects on variables such as maternal depression, self-esteem or the use of social supports. As expected these approaches showed very small effects on child development even though with some programs a child-centred approach was included in the intervention (Johnson & Walker, 1991; St. Pierre, Layzer, & Barnes, 1995). In some cases, the early intervention program adopted a case management approach, referring parents for these services to outside agencies. As a consequence, the services have varied considerably in quality and intensity and the program loses control of service provision.

- As well a few studies of psychotherapy or the provision of a range of comprehensive services for depressed mothers have shown mothers improved the quality and quantity of contact with their infants and that services speeded up the remission of depression compared to controls. Infants showed more positive interactive behaviours and better growth and development. This in turn was associated with a reduced rate of insecure attachments. (Cooper & Murray, 1997; Field, 1997). Cooper and Murray (1997) compared the effects of nondirective counselling, cognitive behaviourial therapy and dynamic psychotherapy with depressed mothers and found no differences.

- A number of parenting group interventions have shown promising outcomes in reducing behaviourial difficulties in young children. Various approaches have been used including use of videos, parent-child play sessions, role playing and provision of parenting information (Eyberg, Boggs, & Algina, 1995; Landy, & Menna, 1998; Webster-Stratton, Kolpaceff, & Hollingsworth 1990).

- There are a number of parent-child interaction interventions which used for short periods have shown encouraging results and improvements in parent-child interactions and/or child outcomes A number of these are noted below:

  In a series of studies Barrera and her colleagues (Barrera, Kitching, Cunningham, Doucet, & Rosenbaum, 1991; Barrera, Rosenberg, & Cunningham, 1986) intervened with low-birth weight infants. Two different interventions and a no-treatment control group were studied. In one treatment (parent-infant interaction) mothers received training designed to increase the quality of parent-infant interaction and to enhance parental observational skills. In the other (developmental programming intervention group) the focus was more on the infant and was designed to improve developmental outcomes in various domains of functioning. Visits were weekly for 4 months and monthly for another 3 months. Both interventions were

successful post-treatment and 3 years later in improving parent interactions with their infants and improving developmental outcomes. The parent-infant interaction group had somewhat better home environment scores showing that the mothers were more responsive to their infants.

In a review of 10 studies in which the parent-child interaction of parents with children with disabilities was the focus of the intervention, McCollum and Hemmeter (1997) found that changes in caregiver interaction strategies were reported in all studies. The interaction training strategies used videotapes of parent-child interactions, role playing and modelling. The changes included increases in responsiveness and decreases in controlling behaviour. Two studies reported increases in parental positive affect and playfulness. All studies found improvements in child outcomes including with cognitive and linguistic behaviour and interactional skills. The writers concluded that the interventions which were individualized, emphasized collaboration and shared responsibility with the parent and built on the strengths of the interactions were more likely to be successful.

Barnard and colleagues (1988) evaluated the comparative effectiveness of two interventions against no treatment controls. The mothers were referred as at-risk because of having few supportive networks. They were on welfare and had not completed high school. Two interventions were used:

1. Mental Health Model in which the nurse focused on relationship building and fostering social competence.

2. Information and Resource model which was more of a standard public health approach of providing information and referrals to services.

Overall the Mental Health Model was most effective in improving interactions and child outcomes. This appeared to be particularly true of mothers who improved significantly on social competency scores (Barnard, 1997; Barnard, Morisset, & Spieker, 1993).

A number of other short term interventions of approximately 3 to 10 sessions, targeted at interactional and child outcomes have shown significant improvements following intervention. Some have used control groups while others have instead compared two interventions without a comparison group. Interestingly, in some studies, interventions which were more behaviourial were as successful as those which were more non-directive or psychodynamic (Cramer, Robert-Tissot, Stern, Serpa-Rusconi, Muralt, Palacie-Espasa, Bachmann, Knauer, Berney,

D'Arcis, 1990; Cohen, Muir, Lojkasek, Muir, Parker, Barwick, & Brown, 1997, van den Boom, 1994).

In conclusion, thousands of early intervention research studies ranging from evaluations of the effectiveness of large model programs and community-based programs to comparisons of short focused interventions have been carried out. Because of the complexity of outcomes targeted, interventions provided and populations receiving services, conclusions are difficult. However, it is clear that a number of interventions are effective with certain populations and should be considered for use in community-based programs such as Growing Together.

1.5 The Growing Together Evaluation Plan

This study aimed to examine the effectiveness of certain approaches used in Growing Together in enhancing the development of children as well as parenting capacities and competencies. These results, the results of other early intervention and prevention approaches outlined in this chapter, along with discussions conducted with a variety of staff and funders, will be considered in making recommendations about: essential components of Growing Together; possible strategic directions for future operation of the program; and, suggestions for further research.

Documented in the process evaluation report (Radford, Landy, & Tam, 1998) was the operation and procedures of the G.T. program. The quality of each of the program's components, that is, the program operation and service delivery system, was considered. The short-term impact evaluation study of program services provides opportunity to examine areas of immediate client improvement. In combination, the process and short-term evaluation helped to clarify those components that are critical to the successful operation of the program. One common reason for under use of evaluation research findings is that selected research designs fail to address critical program components and policy issues relevant to the operation of a successful program (Wholey, Scanlon, Duffy, Fukumoto, & Vogt, 1970; cited in Windsor, Baranowski, Clark, & Cutter, 1994, p. 31). This investigation into the program's operation and immediate impact ensures the research addresses the goal of optimizing service delivery system and program efficacy.

The evaluation project was designed to facilitate program decision making and enhance program workers' ability to provide more effective services to clients. Information from the two levels of evaluation will be used to further explore critical program components and required aspects for successful program replication.

1.6 Organization of the Report

The report has seven chapters, three of which describe study findings. The Short-Term Impact Study is introduced and the study design described in Chapters I and II respectively. Study findings are considered in Chapters III, IV, V and VI.

In Chapter III six program groups are described and the pre- and post- scores of program participants are discussed. The short-term impact of counselling and therapy services, provided by PHNs and Infant Mental Health Workers, are examined in Chapter IV. The impact of Developmental Clinic services on families is described in Chapter V through four case studies. Chapter VI covers the impact of Advocacy services on clients. Presented findings are part of the CAP-C (1998) study.

In Chapter VII, the findings are summarized and limitations of the research considered. Program aspects identified as being critical or essential to the effective operation of all G.T. programs are discussed in this final chapter. Recommendations for the program and further research are offered.

As in the Process Evaluation Report, a double-column format is used for the findings chapters. Findings of the study are provided on the inside column, while tables, figures, literature, client quotations, and photos, appear on the outer side of the page. Chapters I and VII appear in full page format.

II Design of the Study

2.1 Research Approach

The Short-Term Impact Evaluation study involved a total of eighty G.T. clients[1] and focused on four important intervention areas: groups; the Developmental Clinic; psychotherapeutic and counselling work, and advocacy work. The immediate impact of having received services in one of these four areas was investigated. The short-term impact of Advocacy services on clients, considered in this report, is based on findings of an earlier study.[2] Summarized in Table 4 is the number of research participants for whom data collection was successfully completed for each of the four service areas. Data was collected over the course of one-and-one-half years, between the months of March, 1997 and August, 1998.

Table 4
Number of Research Participants by Service Intervention Area

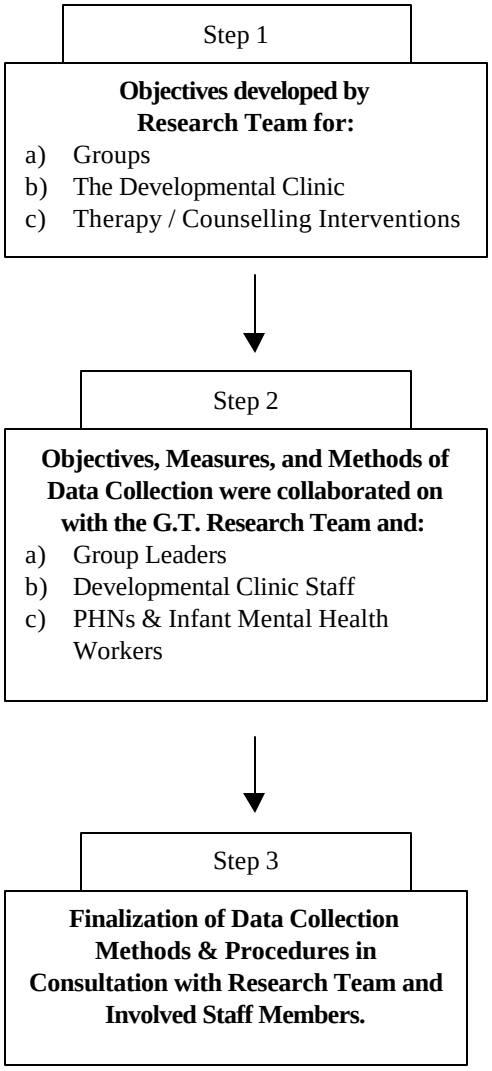
Service Intervention Area	N
Group pre-post testing *	57
Counselling/therapy pre-post (four months Follow-up) testing*	12
Developmental Clinic Case Studies	4
Advocacy Services pre-post testing	7
Total Participants	80

* This number represents the total number of completed pre-post testing interventions.

[1] This number does not include those participants whose pre- post- data was not complete.

[2] Community Action Program for Children (CAP-C) in St. Jamestown: Follow-up Report, 1998.

Figure 3
Short-Term Impact Evaluation: Design Procedure



Measures and data collection strategies were chosen through consultation with the G.T. Research Team and involved workers. The procedure used in selecting measures and methods for data collection are outlined in Figure 3.

The initial step required the development of objectives for each of the three intervention areas. Objectives were drafted for each selected group, the Developmental Clinic, and counselling/therapy services. Subsequently, eleven group leaders, four Clinic staff, and four workers providing counselling services met to review the objectives and make appropriate revisions. The final step involved revising objectives in consultation with the G.T. Research Team, identifying constructs related to each agreed upon objective, and proposing possible measures for capturing the construct area. Standardized measures were selected when possible and questionnaires or interview protocols developed when standardized measures were inappropriate or unavailable[3]. Objective pages were expanded to include constructs and data collection strategies and workers were given the opportunity to examine and select from a collection of possible measures or other data collection approaches. When necessary, group leaders assisted in the revision or development of questionnaires and interview protocols. For example, an English language skills questionnaire, was developed for use with English Club Members. Methods for capturing the short-term impact of the three service areas included the following.

[3] Details about the psychometric properties of all measures used in the *Short-Term Impact Evaluation Study* can be found in Appendix A where measures are listed alphabetically.

Group participants were compared on a number of measures administered at the start and end of each selected group intervention. Much effort was expended by the Researchers in developing a collaborative relationship with group leaders, in order to guarantee the success of this research project. Their contribution to the research approach ensured their co-operation and enthusiasm throughout the data collection phase. This was a critical consideration since their commitment to the study was instrumental to the participation of group participants who were initially introduced to the evaluation plan by group leaders.

Clients receiving counselling/therapy services were recruited into the study and were interviewed at the start and end of a four month period or within a week of service termination, depending on which occurred first. Therapy/counselling interviews primarily consisted of standardized questionnaires, however, a few questionnaires were slightly revised or developed by the Team.

The impact of Developmental Clinic services was captured through four case studies for which Clinic case files were examined, and interviews conducted with workers and parents. Case studies offered descriptive accounts about the impact the Clinic services had on the lives of children and their families.

Details about the selection criteria and data collection strategies used in studying the three service areas are further explained below. Also discussed is the examination of the program's *Critical Components*, defined as aspects of the

program identified as essential to all G.T. program sites.

As previously mentioned, included in the report are findings of the *Community Action Program For Children (CAP-C) in St. Jamestown: Follow-up Report* (1998). Specifically, data collected on the Advocacy component of the program is presented in Chapter VI.

2.1.1 Group Testing

Information from group participants was collected between March, 1997 and August, 1998. A total of one hundred and six Growing Together group participants, representing a range of cultural backgrounds and risk levels[4], participated in this aspect of the study. Fifty-seven clients (56%) provided complete pre- post- group information.

Loss of participants over the course of the study was largely attributable to group attrition (N=31; 30%), leading to a failure to obtain post- group interviews. The remaining participants (14%) whose data was incomplete had: completed only post- interviews (N=3); provided incomplete information (N=4); or had too many language difficulties to complete the questionnaires (N=7).

Originally, ten groups were approached for the study. For five of the groups, insufficient data was obtained. Not included in the report is data

[4] Growing Together clients are typically assessed upon joining the program through a Risk Factor Assessment (RFA) interview and categorized as being a low, moderate, or high risk for negative child outcome.

collected from the: Young Mother's, Beginner's English Club, Mother's Club, H.E.A.R., and Women's Community Group. In two instances, groups were either ending or being newly established and group leaders were in the process of recruiting new participants. Another group had a number of high-risk clients in attendence and while some were willing to take part in the research others were hesitant and mistrustful. Furthermore, group turn-over rate was a problem in this group in that those few who had completed pre-interviews had all terminated their attendance prior to group completion and new members had joined. The third difficulty encountered was in collecting data in a group that was open-ended and unstructured so as to encourage mothers to drop-in rather than to feel obligated to attend. In this instance group member's attendance was sporadic, making it difficult to determine when interviewers could meet with participants. In the final situation, group members were unable to complete English interviews and therefore post- group follow-up was abandoned. All of these circumstance made pre- and post- follow-up challenging. In the end, too few interviews were completed in these groups for inclusion in this report.

Table 5
Group Participation:
Measures and Number of Participants*

Measures used in each group:	Number of complete and incomplete interviews
Anger Management: • State Trait Anger Inventory (STAXI) • Rosenberg Self-Esteem Questionnaire • Pearline Mastery Scale • Toronto Alexithymic Scale (TAS) • Social Support Provision Scale	Complete interviews: N = 13 Incomplete interviews: N = 5
When Baby Comes Home: • Knowledge of Infant Development Inventory (KIDI) (Revised) • Social Support Provisions Scale • Maternal Self-Report Inventory	Complete interviews: N = 21 Incomplete interviews: N = 15
Advanced English Club: • Use of English Questionnaire • Rosenberg Self-Esteem • Pearline Mastery Scale • Social Support Provisions Scale • Community Invovement Inventory (Revised)	Complete interviews: N = 4 Incomplete interviews: N = 3
Computer Club: • Computer Skills Test • Rosenberg Self-Esteem • Pearline Mastery • Social Support Provisions Scale • Community Involvement Inventory	Complete interviews: N = 13 Incomplete interviews: N = 4
Preschool Group • Preschool Behavior Questionnaire • Child Development Inventory (CDI) • Kohn Social Competence Scale	Complete interviews: N = 6 Incomplete interviews: N = 4
	Total = 57

Five groups[5] are discussed in the study report, for which there were a total of 57 complete interviews. Unfortunately, a few of these groups, for example the Advanced English Club, still had a small number of interviews successfully completed.

The parenting, therapeutic, and support/ skills groups discussed in this report are*: When Baby Comes Home*, *Anger Management*, *Preschool Club*, *Computer Skills Training (Advanced and Beginners)*, and *Advanced English Club*. As well, the *Prenatal Group*, lead by PHNs at the project, took part in a National Evaluation Study over the past year and findings of this study are reported here.

As explained above, group leaders were consulted about the appropriateness of measures according to their group objectives. Measures used in each of the five groups are outlined in Table 5. Also appearing in this Table is the total number of completed pre- post- interviews for each of the five groups as well as incomplete interviews. Incomplete interviews resulted when: 1) group participants completed pre- interviews but did not remain in the group or failed to attend the last session and could not be further contacted, and 2) new members joined the group after pre-interviews had been completed[6] but later provided post- group information. Incomplete pre- post-

[5] A sixth group, the Prenatal group is also discussed in Chapter III. Results discussed are those from the Canada Prenatal Nutrition Program: National Evaluation, 1998.

[6] During the process of pre-data collection it was discovered that new group members often joined after week one. Therefore, in some instances pre- data was collected on members who joined a group during week two.

data was not used in the data analyses presented in Chapter III with the exception of participants' responses to group satisfaction questions which were collected during post-interviews.

Group participants were given the option of completing the questionnaire on their own or being interviewed by a member of the Research Team. Members generally completed questionnaires on their own and asked for assistance from administrators as needed. Those who requested interviews did so due to language difficulties, literacy issues or because they preferred to discuss their opinions and experiences with an interviewer. All group participants were interviewed about their satisfaction with their group experience since the verbatim comments of clients were documented.

2.1.2 Counselling and therapy interviews

Between the months of October, 1997 and June 1998, sixteen Growing Together participants in the initial phase of receiving counselling[7] from a Public Health Nurse or therapy from a Mental Health Worker were asked to take part in the study. Names of potential interviewees were solicited from workers during weekly team meetings. Upon approaching prospective clients about the study, the names of interested clients were passed on to a Research Team member.

[7] As it was difficult to encourage the participation of clients for this aspect of the study, women who had been receiving counselling/therapy services for as long as four months were included in the study.

A total of 12 women completed both pre- and post- interview data. Two women approached chose not to participate due to other demands in their lives, and two women who participated in the pre- interviews moved from the community during the course of the study, resulting in a loss of contact. In the end, seven of the women who completed the interviews were receiving health counselling from a PHN while the remaining five were receiving therapeutic treatment from an Infant Mental Health Worker.

Mothers were interviewed using a variety of measures which examined the following areas: parenting and child development knowledge, mother's breast feeding history, child and maternal health, sense of competence, self esteem, family functioning, maternal mental health, social support, and involvement in the community. Additionally, workers completed the Dimension of the Therapeutic Relationship measure, which documents a client's progress in counselling/therapy work. During post-interviews women were asked about their satisfaction with the G.T. program and which aspects of the program had been most useful. A summary of the measures used in the counselling/therapy interviews appears in Table 6.

Table 6
Measures Used in the Counselling/Therapy Study

- Risk Factor Assessment (briefer termination RFA used at post-)
- Health Status Measure
- Rosenberg Self Esteem Measure
- Pearline Mastery Scale
- CES-Depression Scale
- Personal Assessment Screener
- Family Assessment Measure
- Social Support Provision Scale
- Knowledge of Infant/Child Development Scale
- Community Involvement Checklist (revised version)
- Use and Satisfaction with Services (Community and G.T. specifically)

Each interview took one to two hours to complete and was sometimes done over the course of two home visits. Women were paid ten dollars for the completion of each interview. Follow-up interviews were conducted either within one week of the end of the intervention or after four months had passed.

2.1.3 Developmental Clinic Case Studies

During G.T.Team and Research Team meetings the variety of families seen by Clinic staff were explored. It was determined that four general experiences were representative of families seen by Clinic staff. The first involved the parent using the Clinic as a means of monitoring a healthy, well baby. At times these parents may be anxious about their child's development or health. The second identified type of family seen were those in which an infant is identified early on as being delayed and requiring intervention. Third, there are families in which a genetic or medical problem leads to the need for infant stimulation. And fourth are families in which an older child is in need of developmental assessment. While the specific circumstances surrounding each of these families varies considerably, case studies offered opportunity to explore the impact of the work done by Clinic staff.

Program workers were asked to suggest cases that demonstrated these four general experiences. As a result, four families who had previously attended the Developmental Clinic at Growing Together were selected and approached about participating in a brief telephone interview about their experience with the Clinic. Additional information was obtained through the review of their Developmental Clinic case files, and through interviews with family workers.

Case studies of selected families were developed to provide vivid portrayals of some of the risk-related factors faced by parents in this community as well as to demonstrate the impact that the Developmental Clinic services have on infants and young children.

2.1.4 Advocacy Services: Data Collection

An evaluation of the advocacy component was undertaken using a combination of quantitative and qualitative measures. Two measures were used to assess the impact of Advocacy Services on client's: The Centre for Epidemological Studies Depression Scale (CES-D) and the Difficult Life Circumstances Scale, were given to clients near the beginning of service, and again a few months later. Three parents were given the CAP-C Parent Satisfaction Scale, a qualitative measure designed for evaluating client's satisfaction. On this scale, the program participants were asked how satisfied they were with the service they received from the program, which aspects of the program they liked the best, and which aspects they would rank as the top three. In addition, they were asked for their ideas on what they would like to see added or changed to the program, and to tell in their own words how the program worked for them and what it had meant to them. Further details about the methods used in collecting this information can be found in the CAP-C report.

2.1.5 Critical Components

Critical Components of the G.T. program are defined as those program aspects identified as being essential to G.T. Programs. Information about what is essential to the program was examined on the basis of research findings of the Process and Short-Term Impact Studies, on the early intervention and prevention literature, as well as on interviews with workers. Sixteen workers were asked during

interviews, as part of the Process Evaluation, to generate a list of critical program components and about those program aspects required for successful program replication.

This information combined with the findings of the Process Evaluation and Short-Term Impact studies provided a beginning point from which to discuss critical components of the G.T. model. The opinions of the program's Co-directors, regarding the program's critical components, were explored through discussion and incorporated during the report preparation phase.

2.2 Data Analysis

Pre- and post- questionnaires explored the experiences and related knowledge, attitudes, skills and behaviours of Growing Together group participants and counselling/therapy clients. Descriptive statistics were used to summarize the pre- and post- questionnaire responses of all participants.

In the Short-Term Impact Study, participant numbers were not sufficiently large to allow for statistical analyses to be applied in all cases.
Pre- post- participation comparisons were analysed with paired sample *t*-tests for significant differences when data was complete for ten or more participants. In instances where information was collected from fewer than ten clients, a direct comparison of each participant pre- and post- data are presented.

Content analysis of open ended interview responses was carried out with attention being directed at the identification of dominant themes.

III Groups

3.1 Introduction

Group programs are an important component of Growing Together's early intervention and prevention activities. In general, three types of group programs are offered to clients intended to meet a range of educational, social support, and counselling needs: parenting groups, therapeutic groups, and support and skill-based groups.

This chapter examines the short-term impact of client participation in groups by reviewing the results of pre- and post-test questionnaires and/or interviews completed by group members. Results are summarized below and organized by type of client group (parenting, therapeutic, and support and skill-based). For each of the groups reviewed, a description of the nature of the group is provided, followed by characteristics of group members, along with a discussion of the short-term impact of group participation on clients. At the beginning of the Study, objectives were identified for each of the groups in consultation with group leaders. Underlying constructs and appropriate measures[8] were then selected to assess effects. Results relevant to group impact on clients are discussed in terms of the extent to which these objectives were achieved.

[8] A full description of all measures (standardized and those specially designed for the Study) is provided in Appendix A.

Table 7
Parenting Group Attendance*

G.T. Parenting Groups	Total 1996 Attendance
Prenatal Women meet once a week and prepare a healthy meal while talking about different issues such as healthy eating, fetal development, pregnancy changes, infant care and other topics of interest. Food coupons are given out to promote a balanced diet.	61
Helping Encourage Affect Regulation (H.E.A.R.) This group program for parents of young children helps them avoid or deal with behaviour problems and enhance their child's development. Weekly topics include: the development of self-esteem; attachment; compliance; caring and communication. Parents are provided with useful parenting techniques and a supportive environment in which to learn about parenting young children.	22
When Baby Comes Home (English and Tamil) A support group offered by PHNs and assisted by the Tamil home visitor to assist parents in adjusting to a new baby. Parents meet weekly for 6 weeks. Some of the topics covered: What to do when your baby cries; breast feeding; nutrition for you and your baby; safety; things to do to help your baby learn; growth and development; taking care of a sick baby; learning about resources in your community; developing your child's self-esteem; exercise for you and your baby ; getting your life back after the baby comes; establishing routines.	44 English = 25 Tamil = 19
Nobody's Perfect A program for parents of children from birth to 5 years provided by PHNs. Parents meet weekly for 6-8 weeks. Topics discussed include: normal growth and development; maintaining your child's health; recognizing illness; accident prevention and safety; handling common behaviour problems; meeting your own needs as parents.	10
Mother's Club A club for mothers of children between 6 months and 2 years. As babies grow and start to be able to move around on their own, they keep their mothers busy, trying to make sure they are safe and secure and that they have a chance to see what it's like to explore the world for themselves. On one afternoon a week mothers can come and bring their children to share with other moms how they are helping their growing babies and toddlers to become independent and caring.	8
Young Mothers Group The group is geared to young women with children in the St. Jamestown area. The group provides knowledge, information and support for its members. Each group will vary, to focus on the needs and desires of the specific group members. Topics may include: child development information; dealing with health, welfare and housing issues; as well as relationships and stress management. Mothers involved in the group will meet other young mothers, make new friends and go on outings.	10
Parenting Group Attendance	**Total = 155**

3.2 Parenting Groups

Parenting groups at Growing Together offer parents the opportunity to learn about effective parenting practices and child development. Growing Together's parenting groups include: *When Baby Comes Home, Nobody's Perfect, the Prenatal Group, the Helping Encourage Affect Regulation (H.E.A.R.) Group, the Mothers' Club,* and the *Young Mothers' Group*. Table 7 provides summary descriptions and number of attendants for each of these groups. In total, 155[9] participants attended these six Growing Together parenting groups over a one-year period (1996).

Data to assess the impact of group participation on clients are available for two of these parenting groups: *When Baby Comes Home* and the *Prenatal Group*[10].

3.2.1 *When Baby Comes Home (W.B.C.H)*

When Baby Comes Home is a parent education group for new mothers facilitated by Public Health Nurses. The group runs for six weeks and typically between 10 and 20 women participate in each group. Group participants are often new immigrants for whom English is their second language. Groups are conducted in both English and Tamil. Three sessions of the English *When Baby Comes Home* ran over the year period during

[9] This number may include repeat attendance by individual clients.

[10] Please refer to Chapter II of this Report for further discussion concerning which groups participated in the study.

which data was collected for the evaluation Study. A total of twenty-one English-speaking mothers who attended this group completed all measures in the pre- and post-test interviews. Pre-interviews were typically conducted at the first or second session and post-interviews at or shortly following the final group meeting.

The objectives of the group are to educate parents on child health and development; to reduce women's and their families' social isolation; to promote healthy parenting practices and positive adjustment to parenthood; and to encourage clients' use of other groups and services. Table 8 summarizes the group objectives, constructs, and measures used to assess whether these group objectives were being met.

Table 8
***When Baby Comes Home*:**
Objectives and Measures

Group Objectives	**Constructs**	**Selected Measures**
1. To provide education about child health and development (i.e., infant feeding, safety).	Child developmental knowledge	Knowledge about Infant Development Inventory (MacPhee, 1981) (revised to include only items about very young infants)
2. To reduce women's and family's isolation (i.e., peer support).	Social support	Social Support Provision Scale (Cutrona & Russell, 1989)
3. To promote healthy parenting practices and positive adjustment to parenthood.	Positive adjustment of mother	Maternal Self Report Inventory (Shea & Tronick, 1988)
4. To encourage client's use of other groups and services.	Use of resources	Post-interview Questionnaire (Developed for the Study).

Women[11] who attend *When Baby Comes Home* tend to be relatively recent immigrants, most commonly originating from Sri Lanka or the Philippines. Almost half (45%) of these women reported being in Canada for three years or less and 95% came to Canada within the last ten years. Just over half (56%) were between 25 and 34 years of age, 10% were under 25, 24% between 35 and 39, and 10%, 40 years of age or older. Eighty-six percent of the women were married or living in common-law relationships, the remainder being single, separated, divorced, or widowed. Most women (86%) attending the group had only one child, 10% had two children, and 5% had three or more children. In terms of educational

[11] As all measures were available only in English, these characteristics may not be representative of clients who participated in the Tamil *When Baby Comes Home* group who were not English-speaking.

Parents learn about child development

[I would like] to be able to learn how to raise a healthy and good baby and to become a good parent.
26 year old Filipino Mother of 4 month old.

These are new things for me because it is my first baby. The safety and knowledge about infant growth and development [were the most important things I learned].
33 old Filipino Mother of 6 month old

background, 13% of the women reported having less than a high school education, 33% had graduated from high school, and 40% had some post-secondary training or had graduated from college or university.

The short-term impact on clients of participating in *When Baby Comes Home* was assessed in terms of the group objectives (see Table 8). Each objective is discussed in turn below.

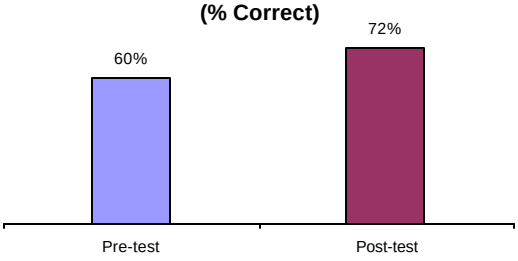
W.B.C.H Objective 1: To provide education on child development and health.

Most mothers attending W*hen Baby Comes Home* indicated at the beginning of the group that one of their main reasons for participation was to learn more about their children's health and development. Once the group had finished, all mothers reported that the information provided by group leaders and the opportunity to learn from other mothers were important aspects of their experience.

The extent to which mothers had acquired greater knowledge about their children's development was further indicated by their responses to a modified version of the Knowledge about Infant Development Inventory (MacPhee, 1981), a measure which examines parents' understanding of their children's development across a number of domains (such as feeding, infant care, physical, cognitive, social, and emotional development).

At the beginning of the group, on average, mothers correctly responded to 60% of the items. By the

Figure 4
***When Baby Comes Home*:**
Overall Knowledge of Infant Development* (N=21)
(% Correct)



*Average scores assessed through Knowledge of Infant Development Inventory

end of the group, on average, mothers correctly answered 72% of the items. This increase was statistically significant (t_{20}= 3.40, $p \leq .01$) suggesting that group participation was associated with an improved understanding of child development issues for these mothers (see Figure 4). Figure 5 provides further detail of some of the knowledge items and the women's responses. Women demonstrated improved understanding on items addressing child feeding, care, and safety.

W.B.C.H Objective 2: To reduce social isolation.

Over 90% of mothers interviewed following their participation in *When Baby Comes Home* reported that meeting other new mothers, the opportunity to get out of the house once a week, and the support of the group were all important components of their group experience.

While this suggests that certain aspects of social support from the group were important to mothers and that mothers appeared to value this supportive experience, their perceptions of social support from their existing social networks did not change from pre- to post-group participation as indicated by scores on the Social Support Provision Scale. This finding could reflect the fact that mothers' perceptions of support from family and friends was high even on the pre-test measure, suggesting that their needs in this area may have already been met prior to group participation, making it unlikely that attending *When Baby Comes Home* would alter their experience of social support.

Mothers value the social experience of the group

I enjoyed meeting everybody in the group. It's a chance to meet other people. And it gives my son a chance to meet other people too.
33 old Filipino Mother of 6 month old.

W.B.C.H Objective 3: To promote healthy parenting practices and positive adjustment to parenthood.

Mothers who attended *When Baby Comes Home* reported increased general confidence in the parenting role from pre- to post-group participation as measured by the Maternal Self-Report Inventory (t_{20}=4.45, p£.001). This improvement in maternal self-confidence was reflected in two of the subscales of the Maternal Self-Report Inventory. Mothers' reported level of confidence in caretaking ability (e.g., feeding, holding, bathing diapering, calming baby) was significantly higher in the post-test than in the pre-test scores (t_{20}=3.40, p≤.01). Mothers' reported overall ability and preparedness to care for their infant (e.g., being there when needed; ability to teach their child, being a loving and caring parent) also increased significantly from pre- to post-test (t_{20}=2.65, p£.05). These findings suggest that participation in *When Baby Comes Home* was significantly associated with mothers' increased confidence in the parenting role.[12] It may be that the increased knowledge mothers gain about infant health and development helps facilitate their greater confidence as parents.

W.B.C.H Objective 4: To promote the use of other services and groups.

[12] Without the benefit of a comparison sample of mothers who did not attend a similar parenting group, the full effect of group participation cannot be determined. For example, by the time of the post-test, mothers in the W.B.C.H group had more time and experience as parents which may also have contributed to their increased confidence.

All mothers who attended *When Baby Comes Home* reported that they had been told about other groups and services at Growing Together by group leaders and had plans to participate in these in the future. Program promotion is particularly important in parenting groups, as it is a common entry point into the program for many mothers. Mothers were less aware of other services in the community outside of Growing Together.

3.2.2 *Prenatal Group*

Since group impact information was collected for the St. Jamestown Prenatal Group as part of the *Canada Prenatal Nutrition Program: National Evaluation* (April 1, 1997 - March 31, 1998)[13], it was agreed that these data would be reported here rather than further disturb group process with additional assessment.

The *Prenatal Group* provides support, health education, and referral to community agencies for prenatal and postnatal women. Facilitated by Public Health Nurses, women meet on a weekly basis for sessions and prepare a healthy meal while discussing a range of issues, such as nutrition, fetal development, infant care, pregnancy changes, breastfeeding, and other topics of interest. Food vouchers are provided to participants to promote a balanced diet as well as encourage attendance. Women may remain as group members until they are three months post-delivery. The objectives of the group are to promote the birth of healthy infants,

[13] Further information on the Prenatal Group will become available in October 1998 with the release of the *Individual Client Questionnaire Local Report*.

reduce the incidence of low birth weight, and promote breast feeding.

Information collected for the St. Jamestown Prenatal Group as part of the *Canada Prenatal Nutrition Program: National Evaluation* shows that almost all infants born to women who attended the group were, in fact, healthy and had birth weights in the normal range. Between April 1, 1997 and March 31, 1998, 87 prenatal and postnatal women participated in the *Prenatal Group*. Thirty-seven infants were born to these women over this time period. Of the 34 infants for whom information is available, 32 were healthy, 28 of whom had birth weights exceeding 2500 grams. Complications were experienced for two (6%) of the infants born.

Other benefits to infants and families associated with the *Prenatal Group* were the encouragement of breastfeeding practices and referrals to other groups and services. A large number of mothers who attended the group both initiated and maintained breastfeeding of their infants. Thirty-four of the mothers initiated breastfeeding with their infants, 32 of whom were still breastfeeding to some extent when their children were six months of age.

Women who attended the *Prenatal Group* were referred by group leaders to other groups, services and supports, both within Growing Together and to outside agencies. The most common referrals were to early childhood intervention programs, community kitchen, and parenting groups.

A Prenatal Case Study

One client was very isolated, had no extended family and very few friends. She attended the group regularly and dressed in her finest clothes. The program provided her with support and counselling related to various issues such as pregnancy, labour and delivery, infant care, infant feeding, child care relief, OHIP and immigration. She stated that the staff from the program were like her family. She found the program enabled her to maintain effective parenting and coping. She was linked to the Growing Together program for ongoing support.
Canada Prenatal Nutrition Program: National Evaluation, 1998, p.12

One client's experience of the program and the impact of the services received is clearly illustrated in the brief case study appearing opposite.

3.3 Therapeutic Groups

Therapeutic groups at Growing Together are both parent- and child-focused. Parent-based groups provide support to parents to promote and maximize their level of functioning. Many of the parenting groups described above also contain therapeutic and counselling components. Child-based group interventions are available to encourage optimal child development.

Data to assess the impact of group participation on clients are available for two therapeutic groups offered at Growing Together: the *Anger Management Group* and the *Preschool Group*.

3.3.1 *Anger Management Group*

The *Anger Management Group* is a therapeutic group for mothers who would like to develop skills with managing their anger. The group runs for 10 weeks, is led by an Infant Mental Health Worker and Psychiatrist, and focuses on identifying triggers, emotions, and behaviours related to anger. Sessions also target skills for managing anger in parents and their children. Three sessions of the *Anger Management Group* ran over the year of data collection and thirteen women who attended this group completed all measures in the pre- and post-test interviews. In this group pre-interviews were typically conducted at the first session and post-interviews at or shortly following the final group meeting.

The objectives of the group are to help clients identify their feelings and accept their affect; to help

clients contain their anger; to promote self-esteem and a greater sense of personal control/mastery over life events; to provide social support; and to encourage client's use of other groups and services. Table 9 summarizes the group's objectives and the measures used in the study.

Clients who attend the *Anger Management Group* tend to be Canadian-born women in their 20's or 30's. Over two-thirds of the women (69%) were between 25 and 34 years of age, 15% were between 35 and 39, and 15% were 40 years of age or older. Almost half of the women were single (39%) or separated (8%), the remainder were in common-law relationships (31%), or dating relationships (23%). On average, women in the group had two children: 46% had one child, 31% had three children, and 23% had four children. In terms of educational background, 46% of the women reported having less than a high school education, 23% had graduated from high school, and 31% had some post-secondary training or had graduated from college or university.

The short-term impact on clients of participating in the *Anger Management Group* was assessed in terms of the group objectives (see Table 9). Each of these issues is discussed in turn below.

Table 9
Anger Management Group:
Objectives and Measures

Group Objectives	**Constructs**	**Selected Measures**
1. To help clients identify their feelings and accept their affect.	Identify feelings and accept affect	Toronto Alexithymic Scale (TAS-20) (Bagby, Taylor, & Parker, 1994)
2. To help clients contain their anger by developing strategies to solve problems.	Contain affect	State-Trait Anger Expression Inventory (STAXI) (Spielberger, 1979)
3. To promote self-esteem and a greater sense of personal control over life events.	Self-esteem and personal control/sense of mastery	Rosenberg Self-Esteem Measure (Rosenberg, 1965) Pearline Mastery Scale (Pearline & Schooler, 1978)
4. To provide social support and reduce social isolation.	Social Support	Social Support Provision Scale (Cutrona & Russell, 1989)
5. To encourage client's use of other groups and services.	Use of resources	Post-Interview Questionnaire (Developed for Study)

Anger Management Objective 1: To help clients identify their feelings and accept their affect.

Most mothers attending the *Anger Management Group* indicated in pre-group interviews that one of their main reasons for participation was to

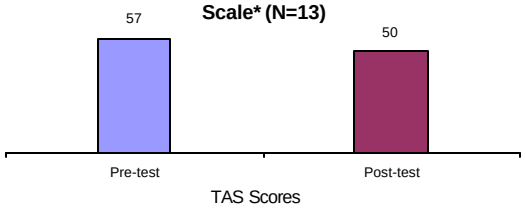
Women learn to identify their feelings

[I enjoyed] coming every week and listening and speaking [about] what I felt.
32 year old Canadian Mother of 9 month & four year old.

[In the group] we share our feelings and I realize other women have similar feelings.
32 old Guyanese Mother of 7 month old.

understand themselves better. At the beginning of the group, women's scores on the Toronto Alexithymic Scale (TAS-20) indicated that these women had significant difficulty processing emotional states, reporting a mean score of 57, compared to a Canadian average of 45 (Bagby & Taylor, 1994). Over two-thirds (69%) of group members had scores in the clinical range for this measure. These scores suggest the women have a tendency to become overwhelmed with emotions and cannot cognitively work through the issues. Because they cannot think about their feelings, they often act impulsively which may include behaving violently towards others as well as themselves through physical means or substance abuse.

Figure 6
***Anger Management Group*:**
Ovearall Score of the Toronto Alexithymic Scale* (N=13)



* The TAS scale ranged from 20-100. The lower the score, the better the ability to handle emotional issues.

Post-test results indicated a significant increase in the group's overall ability to identify, express, and process emotional states, showing a mean post-test score of 50 (t_{12}=2.41, p£.01) (see Figure 6). These scores indicate women showed an increased ability to problem solve emotional issues and explore their emotional states. For example, women were more able to make subtle distinctions between various emotional states, such as distinguishing between being hurt versus being angry and hostile. One of the group leaders further explains the effect of such changes on women's parenting abilities. Her comments appear opposite.

Anger management skills help to improve parenting

Group members increased ability to process emotional states was reflected in the mothers' experiences with their children. They seemed to show a greater ability to recognize and tolerate their children's emotional states - especially negative ones. Personal stories and examples indicated that mothers were more interested in their children's feelings and that they increasingly tried to label and determine what provoked them rather than impulsively reacting or arbitrarily using punishment as an attempt at control. This increases caregiving sensitivity and encourages affect regulation in parents who are at-risk for emotional abuse and neglect.
Anger Management Group Leader

Anger Management Objective 2: To help clients contain their anger by developing strategies to solve their problems.

Almost all mothers coming to the *Anger Management Group* indicated that managing their anger more effectively was one of their main goals in attending the group. At the beginning of the group, women displayed high levels of overall anger and limited ability to monitor and control their anger states as indicated by their group's average score on the State-Trait Anger Expression Inventory (STAXI).

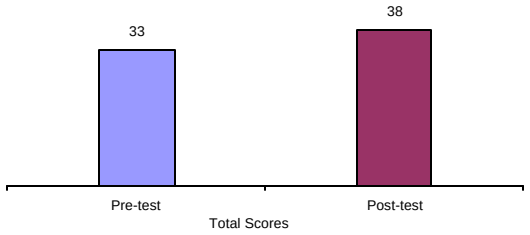
Group members were only at the sixteenth percentile in their ability to monitor and control anger states and at the ninety-fifth percentile in their overall experience of anger. These scores suggested that this group was at high-risk both medically due to stress and in their relationships. After completing the group, women's overall experience of anger scores were less (at the eighty-sixth percentile) and their mean score for monitoring and controlling their anger improved (to the thirty-seventh percentile). These differences from pre-to post-test, while not statistically significant (t_{12}=1.17, p>.10 for anger control; t_{12}=1.10, p>.10, for overall anger), suggest improvements in the experience and control of anger for these women.

Women learn to manage their anger

I felt it [the group] helped me a lot. It helped me deal with anger and how to control it. Overall it was very productive.
27 year old Canadian Mother of 11 month, 6 & 7 year olds.

[The group] was useful. It taught me to be assertive, not aggressive.
33 year old Canadian Mother of 1, 3 & 9 year olds.

Figure 7
***Anger Management Group*:**
Overall Self-Esteem* (N=13)



*Self-esteem was assesed by the Rosenberg Self-esteem Measure, scores ranged between 0 and 40.

Anger Management Objective 3: To promote self-esteem and mastery.

In general, women attending the Anger Management Group had low self-esteem and a limited sense of personal control or mastery over life events at the beginning of the group, as indicated by their scores on the self-esteem and mastery measures. At the end of the group, women showed significant gains in their levels of self-esteem (t_{12}=3.17, p≤.01) (see Figure 7). While not statistically significant, women also reported a greater sense of control or mastery over life events at the end of the group when their pre- and post-test mastery scores were compared (t_{12}=1.65, p=.12).

Anger Management Objective 4: To provide social support.

All women interviewed following their participation in the *Anger Management Group* indicated that being with other women, the opportunity to get out of the house once a week, making friends, and the support of the group were all important components of their group experience. Women's perceptions of social support from their existing social networks also increased significantly from pre- to post-group participation as indicated by scores on the Social Support Provision Scale (t_{12} =2.96, p£.01).

Women gain social support from the group

Before I came [to the group] I was isolated. Listening to the other people made me realize I wasn't alone in my frustration.
29 year old First Nation Mother of 1 month old.

I enjoyed the closeness of the women. I found our group close and comforting. The most important thing I learned was that I wasn't the only one who needed help. There were other women out there in the same boat.
33 year old Canadian Mother of 1, 3, & 9 year olds.

[I liked] the idea of a bunch of single or not single moms -- getting together and talking about similar problems, then laughing about it after. The most important thing is that I am not alone.
27 year old Canadian Mother of 7 month old.

Anger Management Objective 5: To encourage client's use of other groups and services.

Most women who participated in the Anger Management Group had plans to attend other groups and services either at Growing Together or in the community following group participation. Just over three-quarters (77%) of the women planned to attend other groups and services at Growing Together, most commonly parenting or additional therapeutic groups. About half of the women (54%) planned to use other community services and resources, such as parent drop-in centres or daycare services.

Table 10
***Preschool Group:* Objectives and Measures**

Group Objectives	Constructs	Selected Measures
1. To enhance children's social functioning (i.e., cooperation with peers; interest; adapting to preschool structure).	Social functioning	Kohn Social Competence Scale (Kohn & Rosman, 1972) (teacher-completed)
2. To reduce behavioural/ emotional problems (such as aggression, anxiety).	Behavioural/ emotional functioning	Preschool Behaviour Questionnaire (Behar & Stringfield, 1974) (parent-completed)
3. To enhance general child development (particularly in the areas of social, expressive language, and language comprehension).	Child development	Child Development Inventory (Ireton, 1992) (parent-completed)

3.3.2 *Preschool Group*

The *Preschool Group* is offered to children between the ages of 3 and 5 years who have been identified as having a cognitive or language delay. The group focuses on enhancing children's physical, social, emotional, cognitive, and language development. It is an ongoing group facilitated by an early childhood educator. Five sessions are offered every week and most children attend once or twice a week, with six to seven children usually participating in each session. During sessions children are encouraged to take part in unstructured, free-play as well as circle time. Workers focus on facilitating activities that target each child's needs and skill areas requiring attention.

Pre- and post-test measures were completed for six children participating in the group. The objectives of the group are to enhance children's social functioning; to reduce behavioural and emotional problems; and to enhance general child development. Table 10 provides a summary of the group objectives.

Families with children in the *Preschool Group* who participated in the study tended to be immigrant families, most commonly from Sri Lanka who had been in Canada an average of six years. Four of the six families spoke some English at home and in five of the families another language was spoken at home, most commonly Tamil. The average age of children in the group was 3 years and there were 4 boys and 3 girls in the study group.

At the time of the pre-test interviews, most of the children were new to the group. Five of the

children had just started the group and one child had attended three sessions. Post-test interviews were conducted three months later. One third of the mothers whose children were in the group were between 20 and 29 years of age, the remaining mothers were between 30 and 39 years of age. All of the mothers were married (83%) except one who was single. Just over two-thirds (67%) of the families had two children, 17% had one child, and 17% had three children. In terms of educational background of the mothers, one-third of the women reported having less than a high school education, 17% had graduated from high school, and half of the mothers had some post-secondary training or had graduated from college or university.

The short-term impact on children of participating in the *Preschool Group* were assessed in terms of the group objectives (see Table 10).

Preschool Objective 1: To enhance children's social functioning.

All mothers whose children were attending the *Preschool Group* indicated in pre-test interviews that one of their main reasons for participation was to provide their children with the opportunity to play and socialize with other children. In post-test interviews, all mothers reported that the opportunity to play with other children was an important aspect of the group and many of the mothers identified improved social skills as one of the benefits their children derived from the group.

A standardized measure of social competence (the Kohn Social Competence Scale, 1988) was

completed for all children by one of the group's leader at pre- and post-test as another assessment of children's social skill development. At the beginning of the group, children's scores on the Apathy-Withdrawal Scale which measures shyness, isolation from classroom activities, and passivity indicated that these children were just at the cut-off score indicating risk for social dysfunction in a classroom setting (group mean score was 71; cut-off score is 70).[14] There were no difficulties evident, however, on children's scores on the Anger-Defiance subscale which measures defiance, classroom disruptiveness, and hostile peer interactions. The group's mean score was 50 on this subscale which is within the normal range and suggests co-operative functioning and compliance to teachers in a classroom setting.

Post-test results indicated a notable improvement in the children's overall ability to be less socially isolated, shy, and withdrawn (mean post-test score = 63; see Figure 8). Post-test results on the Anger-Defiance subscale were relatively unchanged, remaining within the normal range (mean post-test score = 48).

[14] Descriptive results are presented for all *Preschool Group* measures as tests of significance could not be conducted given the small sample size (N=6).

Preschool Objective 2: To reduce behavioural and emotional problems.

At the beginning of the group, mothers perceived their children as having high levels of behavioural problems as indicated by their average scores on the Preschool Behavior Questionnaire. On average, mothers rated their children at the 92 percentile for total behaviour problems, at the 83 percentile for a subscale measuring hostile-aggressive behaviour, at the 95 percentile on the anxiety subscale, and at the 86 percentile for the hyperactive-distractible subscale. These scores suggested that the children in the group were at high-risk for a range of behaviour problems.

At the post-test, mothers' perceptions of their children's behaviour problems were consistent with pre-test ratings in all areas except the hyperactivity subscale. Mothers' post-test ratings of their children's behaviour was at the 92 percentile for total behaviour problems, at the 88 percentile for the hostile-aggressive behaviour subscale, at the 93 percentile on the anxiety subscale.

Group mean scores on the hyperactive-distractible subscale decreased over time with children being rated at the 86 percentile at pre-test and 74 percentile at post-test. This change suggests a possible association between group participation and a reduction in hyperactive-distractible behaviour.

Preschool Objective 3: To enhance general child development.

Mothers note gains in their preschool children's development

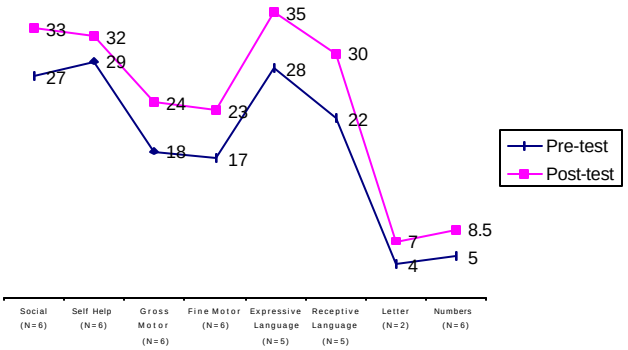
Now she has more vocabulary than before.
31 year old East Indian Mother of 3 year old.

Before he could not speak a lot. Now he is speaking more.
26 year old Tamil Mother of 4 year old.

All mothers of children in the *Preschool Group* reported improvements in their children's development associated with their participation in the group. In post-test interviews, mothers particularly noted gains in children's language and physical development.

These improvements were also reflected in mothers' responses to the Child Development Inventory, a standardized parent-report measure of children's development. At the beginning of the group, all mothers rated their children as being delayed compared to other children their age in one or more of the following areas: gross and fine motor skills, self-help skills, social development, language expression and comprehension, and pre-academic skills (letters and numbers). After at least three months participation in the group, mothers' ratings of their preschool children's development were notably higher across all developmental domains. Particular gains were evident in children's social and self-help skills, fine motor skills, and understanding of numerical concepts (see Figure 9). For four of the six children, their developmental functioning was rated from below age levels at the beginning of the group to within age-appropriated functioning after at least three months group participation. The other two children's developmental functioning showed notable improvements in all areas from pre- to post-test and approached age-appropriate levels when rated by mothers in the post-test.

Figure 9
***Preschool Group*:**
Children's Overall Development*



*Number of items scored on Child Development Inventory

3.4 Skill-Based Groups

Skill-based groups at Growing Together provide the opportunity for parents of young children to learn or enhance a skill in a supportive atmosphere. These groups are offered at no cost to parents and childcare is usually provided. The short-term impacts on clients of participating in two of these groups: the *Computer Skills Training Course* and the *English Club* are reviewed below.

3.4.1 *Computer Skills Training Course*

The *Computer Skills Training Course* is an educational group offered for beginners and advanced beginners. The beginners course is an 8-week program designed to introduce basic software and typing skills to increase the comfort level of first-time computer users. The advanced beginners course runs for 10 weeks. It is a continuation of the beginners course and is designed to introduce participants to more advanced features of word processing and spreadsheet programs. One session of each of the *Computer Skills Training Courses* ran during the data collection phase. Six women who attended the beginners course and seven women from the advanced beginners course completed all measures in the pre- and post-test interviews. Only measures assessing participants' computer knowledge differed between the two groups. Pre-interviews were typically conducted at the first session and post-interviews at or shortly following the final group meeting.

Objectives of the *Computer Skills Training Course* are to increase basic and advanced

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computer skills among participants; to promote self-esteem and a greater sense of personal control/mastery over life events; to increase social support; and to encourage client's use of other groups and services. Table 11 summarizes the group objectives, constructs, and measures.

Clients who attended the *Computer Skills Training Course* were largely immigrant women, most commonly originating from Sri Lanka or the Philippines. The groups consist of both recent immigrants and women who have lived in Canada for a longer period of time. About one-quarter (23%) of the women who participated in the study reported being in Canada for three years or less, 23% came within the last 10 years, and the remaining 54% of women had lived in Canada for ten years or more. Most of the women attending the *Computer Skills Training Courses* were older than participants in other Growing Together groups. Almost all clients (93%) were between 30 and 45 years of age, with only one woman being younger than 30. Most were married (88%) and the remaining women were single or separated. On average, women in the group had two children: 39% had one child, 46% had two children, and 15% had three children. In terms of educational background, 23% of the women reported having less than a high school education, 30% had graduated from high school, and 46% had some post-secondary training or had graduated from college or university.

The short-term impact on clients of participating in the *Computer Skills Training Course* is discussed below.

Computer Skills Objective 1: To increase basic and advanced computer skills among clients.

Most mothers attending the *Computer Skills Training Course* indicated in pre-group interviews that one of their main reasons for participation was to develop basic computer skills or to enhance existing skills. Many women also indicated that their desire to learn or increase their computer skills was motivated by wanting to gain employment.

After the course was finished, all participants reported that they had increased their computer knowledge and felt that these skills would help them in the future. Many participants were still hoping that these skills would assist them in finding employment.

Participants' experience in the group also facilitated their further acquisition of computer skills. Most of the women in the beginners' group (86%) planned to enroll in the advanced beginners course. Many of these women (70%) also planned to attend other computer classes in the community. Fewer of the advanced beginners group participants (33%) planned to take other computer classes outside Growing Together in the future. For many of these women, the advanced beginners class taught them the skills they felt they needed to meet their computer skills goals at this time.

Participants in both the beginners and advanced beginners group also demonstrated their increased computer skill level by their performance on a Computer Skills Test administered at the beginning

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and end of the course. For the beginners group, participant's showed significant gains in skills including learning the basic components of a computer, typing skills, using a mouse, accessing menu items, developing a fundamental understanding of word processing concepts, and performing basic functions using a word processing package (t_{12}=26.57, p£.001) (see Figure 10). Women in the advanced beginners group also made significant gains in their computer skills including learning more advanced word processing features and the basic elements of a spreadsheet program (t_{12}=6.51, p≤.001) (see Figure 10).

Computer Skills Objective 2: To promote self-esteem and mastery.

Some women who attended the *Computer Skills Training Course* identified feeling enhanced self-esteem and greater personal mastery associated with gaining computer skills. These greater feelings of competence did not appear, however, to generalize to statistically significant increases in more global feelings of self-esteem and mastery as indicated by group mean scores on the self-esteem and mastery measures from pre- to post-group participation (t_{12}=0.76, p=.15, for self-esteem; t_{12}=1.31, p=.15, for mastery). However, there is a trend for scores to improve.

Women feel good about learning computer skills

[Being in the group] made me feel good about myself, to know that I am trainable.
40 year old Filipino Mother of 5 year old.

Computer Skills Objective 3: To provide social support.

Most women interviewed following their participation in the *Computer Skills Training Course* indicated that being with other women (85%), the opportunity to get out of the house once a week (92%), and the friendly feeling of the group (100%) were all important components of their group experience. While this suggests that certain aspects of social support from the group were important to group participants and that they appeared to value this supportive experience in a learning environment, their perceptions of social support from their existing social networks did not change from pre- to post-group participation nor did their reported levels of community involvement (including volunteering, community participation, involvement in agencies or organizations) as indicated by the social support (t_{12}=0.62, p=.15) and community involvement measures (t_{12}=0.91, p=.15). It may be that while women found the computer group a supportive environment for gaining computer skills, this was a fairly specific experience and had less impact on their overall sense of natural support systems or general levels of community involvement at that time.

Women value the social experience of the group

I studied a lot. I learned a lot. I made a lot of friends.
32 year old Tamil Mother of 1 year old.

The group was very friendly and the teacher was very good.
38 year old Bangladesh Mother of 6 month, 10 & 16 year olds.

Computer Skills Objective 4: To encourage client's use of other groups and services.

Most women who participated in the *Computer Skills Training Course* planned to attend other groups and services at Growing Together, most commonly the advanced beginners computer course, parenting groups, or community kitchen. Many of the women also indicated that they planned to use other community services and

resources, most frequently other computer courses, parent drop-in centres, or daycare services.

3.4.2 *English Club*

The *English Club* provides an opportunity for women for whom English is their second language to further develop their conversational English skills. The group is open-ended and meets on a weekly basis. Separate groups are offered to women with both beginning and more advanced English skills. Typically 3 to 4 women attend each group every week. In addition to focusing on conversational English, the group also covers topics related to cultural adjustment and learning Canadian cultural practices. Participants are encouraged to attend other English as a Second Language classes in the community. Four women who attended the *English Club* over the data collection phase completed all measures in the pre- and post-test interviews. These women were all members of the advanced group as those in the beginners group were not yet at a point in their English language skills where they could complete the study measures in English. The advanced group women had been coming off and on to the group for about one year when pre-interviews were conducted. Post-interviews were collected four months later just prior to the group stopping for a break because of holidays.

The objectives of the *English Club* are to encourage clients' fluency in English; to encourage clients' community involvement and increase their sense of social support; to promote self-esteem and a greater sense of personal control/mastery over life events; and to encourage client's use of other groups and services (see Table 12).

Table 12
***English Club, Advanced Level*:**
Objectives and Measures

Group Objectives	**Constructs**	**Selected Measures**
1. To encourage clients' fluency in English to help them achieve their education/career plans (e.g., prepare for TOEFL exam).	English proficiency and sense of competence in speaking English in areas with increasing difficulty	Use of English Questionnaire (developed for the study)
2. To encourage clients' community involvement (e.g., participation as volunteers) and increase their sense of social support.	Social support Community involvement	Social Support Provision Scale (Cutrona & Russell, 1989) Community Involvement Checklist (Developed for Better Beginning, Better Future Project)
3. To promote self-esteem and a greater sense of personal control over life events.	Self-esteem and personal control/sense of mastery	Rosenberg Self-Esteem Measure (Rosenberg, 1965) Pearline Mastery Scale (Pearline & Schooler, 1978)
4. To encourage client's use of other groups and services.	Use of resources.	Post-Interview Questionnaire

Clients who attend the *English Club* tend be immigrant women, most commonly originating from Sri Lanka, where Tamil is their first language. Two of the women had been in Canada for 1-2 years, the other two women had been in Canada 5-6 years. All of the women were between 30 and 39 years of age. All were married, one of the women had one child, two had two children, and one had three children. In terms of educational background, group members were well educated. All had graduated from high school, three of the women had some post-secondary training or had graduated from college or university.

The short-term impact of participating in the *English Club* on parents is discussed below.

Women improve their English language skills

I got confidence that I could speak English. Before (the group) I didn't know how to start phone conversations. Now I know how to call 911. We cleared our doubts about English idioms. Now I can ask questions anywhere I go.
35 year old Tamil Mother of 1 year old.

We don't have a chance to speak English other places. Here we can and the teacher corrects us.
37 year old Tamil Mother of 1 & 4 year old.

English Club Objective 1: To encourage clients' fluency in English.

All women attending the *English Club* indicated in pre-group interviews that their main reasons for participation were related to improving their English. Specifically, they were interested in practicing their English and increasing their knowledge of English vocabulary and grammar.

In post-test interviews all women reported that their English had improved and that they enjoyed the experience of the group very much. Several women also indicated that they valued the opportunity to develop a better understanding of Canadian customs and cultural practices.

Participants also demonstrated their increased English language skills by their performance on the

Use of English test, a measure developed for the study where clients rated their degree of comfort in using English in a variety of formal and informal situations. Overall, the group's average score improved[15] (see Figure 11) when their pre- and post-test scores were compared. In post-test interviews, women reported a greater degree of comfort in using English in a variety of settings, such as, reading package labels, English books and newspapers, watching English television, volunteering in English, applying for a job and being interviewed in English, and helping children with their homework in English.

English Club Objective 2: To encourage clients' community involvement and increase their sense of social support.

Women who attended the *English Club* showed greater community involvement (such as volunteering, participating in community events) as indicated by the group's average scores from pre-test (15) to post-test (20) on the Community Involvement Checklist measure (with scores ranging from 0-44). While the number of women completing the pre- and post-test measures was small, it can be speculated that the women's improved English may have given them greater confidence and skills to more fully participate in a range of community activities.

In contrast, women's perceptions of social support from their existing social networks did not change

[15]Descriptive results only are presented for this test and other measures administered to members of the *English Club*. Tests of significance could not be conducted given the small sample size (N=4).

from pre- to post-group participation (group average was 15 in both the pre- and post-test) as indicated by their responses to the social support measure. The women who participated in the pre- and post-test measures were all Tamil women who appeared to already be well integrated in their families and community at pre-test. This may account for the lack of change in this measure associated with their participation in the *English Club.*

English Club Objective 3: To promote self-esteem and mastery.

Women's feelings of self-esteem and mastery did not appear to be associated with participation in the *English Club* as indicated by the lack of change in group mean scores on the self-esteem and mastery measures from pre- to post-test (for self-esteem, group average was 15 in both the pre- and post-test; for mastery, group average was 18.5 in the pre-test and 17 in the post-test).

English Club Objective 4: To encourage client's use of other groups and services.

Most women who participated in the *English Club* planned to attend other groups and services at Growing Together, most commonly the computer course, the developmental clinic, and the community kitchen. Many of the women also indicated that they planned to use other community services and resources, most frequently parent drop-in centres or daycare services.

3.5 Summary

The short-term impact of three types of Growing Together groups were considered in this Chapter: parenting groups, therapeutic groups, and skill-based groups. The range of groups offered meet a variety of client needs and each group appears to be utilized by a specific client group living in the St. Jamestown community. For example, the parent education groups *(When Baby Comes Home; Prenatal Group)* tend to be attended by younger immigrant mothers from Sri Lanka or the Philippines who are first time mothers. Whereas, the *Anger Management Group* participants are Canadian-born women in their 20's and 30's who are typically single and who have more than one child.

Parent-education groups appear to increase parents' knowledge about child development, improve mothers' sense of competence in the parenting role, and provide mothers with a sense of support. The *Prenatal* Group is highly successful in promoting Growing Together families to have healthy infants with normal birth weights and to breast feed their infants.

Both therapeutic groups, the *Anger Management Group* and the child-focused *Preschool Group*, had important benefits to clients. Women in the *Anger Management Group* were better able to identify their feelings and emotions and control their anger after group participation. More generalized benefits were also experienced by clients, particularly in the areas of increased feelings of

self-esteem and social support. It is likely that improvements in understanding feelings, emotional regulation, self-esteem, and greater social support could also contribute to increasing women's functioning in other areas of their lives (e.g., employment) as well as possibly enhancing their parenting behaviour and relationships with their children.

Attendance at the *Preschool Group was also* associated with important gains for child participants in various areas of development. Children were rated by the group leader as less shy and withdrawn after three months participation in the group. Mothers perceived their children as less hyperactive and distractible and noted gains in their cognitive and language development, particular improvements were noted in children's social and self-help skills, fine motor development, and understanding of numerical concepts after attending the group for three months.

The third type of group offered at Growing Together focuses on teaching clients a specific skill or enhancing their existing abilities in a given area. Examined was the impact on clients of participating in the skill-based groups, the *Computer Skills Training Course* and the *English Club.* Women in the Computer group acquired new computer skills in a supportive learning environment which they found personally rewarding and felt would help them secure employment in the future. *English Club* participants improved their English language skills and developed a better understanding of Canadian culture and customs. Many of the women also increased their involvement in the community following group participation.

Group programs are an integral part of Growing Together's early intervention and prevention activities. This Study verifies that these groups have had a significant short-term impact on the clients who use them. Furthermore, clients expressed a high degree of satisfaction with the groups they participated in, noting groups were convenient to attend and delivered in a culturally sensitive manner.

While this study focused on the short-term or immediate impact of group participation, it is possible that there are further benefits for these families which will be evident over the longer term. Group involvement facilitates clients' use of other groups and services as almost all participants planned to use other parent and child resources either at Growing Together or in the larger community following group participation. Linking clients with ongoing services and resources can have important short- and long-term benefits for G.T. parents and their children.

IV Therapy and Counselling Intervention

4.1 Introduction

Counselling and therapy interventions are provided by PHNs and Infant Mental Health workers who are a part of the G.T. project. Services help to promote the health and development of both babies and their mothers. PHN counselling with regard to baby's health and development is most commonly directed toward teaching and support in the areas of breast feeding, nutrition, immunization, the establishment of routines, and the overall healthy development of baby. While the majority of their counselling involves assisting new mothers struggling with typical concerns and difficulties, nurses also play a vital role in those families in which an infant or child is identified as having a physical abnormality or is developmentally at-risk. Nurses may also provide brief counselling to mothers in need of additional support due to coping difficulties, health issues, and life crises immediately after baby is born. On average, nurses remain involved with families for 27 days of services although cases are seen for longer periods.

The Project's Infant Mental Health Workers see families who are in need of more in-depth, long-term counselling and therapeutic services. Isolation, family conflict, early trauma, and mental health problems are areas that are frequently addressed with individual parents. Parents may also receive couple counselling and most high-risk families require workers' support in times of crisis.

Table 13
***Counselling/Therapy Services*:**
Objectives and Measures

Counselling/ Therapy Objectives	Constructs	Measures
1. To begin to establish the capacity for secure relationships by creating a therapeutic and working alliance.	Relationship building (Trust) /capacity for reflection and insight	Dimensions of the Therapeutic Relationship (Greenspan & Wieder, 1987)
2. To assess a family's physical and mental health needs and intervene so as to reduce the family's level of risk and improve functioning.	Family's physical and mental health and overall functioning	Full Risk Factor Assessment interview and for the Post- RFA short version (Landy, 1985) Family Assessment Measure (Byles, et.al, 1988)
3. To teach and promote health and parenting through demonstration and instruction.	Positive behaviours in relation to: feeding nutrition child development parenting	Feeding Measure (Growing Together) Health Status Questionnaire (Growing Together) Knowledge of Infant Development Inventory (McPhee, 1981)
4. To increase clients self-esteem and sense of mastery, decrease depression, and promote general mental health.	Sense of mastery, self-esteem and psychological functioning	Rosenberg Self-Esteem (Rosenberg, 1965) Pearline Mastery Scale (Pearline & Schooler, 1978) CES-D Personality Assessment Screener (Morey, 1991)
5. To support clients around issues of isolation and link people with community resources and encourage their use of services.	Social support Knowledge and use of community services	Social Support Provisions Scale (Cutrona & Russell, 1989) Community Involvement Checklist (Better Beginning

Workers also spend considerable time providing parenting support, education, and modelling appropriate parent-child interactions so as to encourage the optimal development of children. Direct intervention with children may also occur through play therapy or interactional work with parents and children.

Outlined in Table 13 are six short-term objectives of the Program's counselling/therapy services which can be summarized as follows: trust building with clients and the establishment of a therapeutic relationship to enhance the capacity for reflection and insight, assessing and promoting health, enhancing parenting, increasing self-esteem, mastery, and the mental health of parents, improving families' social support and community involvement, and encouraging a connection to the G.T. program. These objectives were developed in collaboration with two PHNs, two Mental Health Workers, the G.T. Research Team, and the program's Co-Directors. The naming of these objectives facilitated the identification of constructs and measures for the Study (see Table 13). For a complete description of the method and measures used for data collection in this aspect of the Study, refer to Chapter II and Appendix A.

The short-term impact of counselling and therapy services are addressed in this Chapter which is arranged according to four general areas: 1) parents' and children's development and health, 2) parents' personal functioning and parenting capacity, 3) parents' sense of support and use of social services, and 4) clients' satisfaction with the G.T. program and the perceived impact of the program on their lives.

Study into the short-term impact of the program's counselling/therapy services involved tracking twelve mothers[16] who were receiving counselling and who agreed to participate in the Study. Interviews were conducted with women early on in the course of their counselling/therapy work and again at the end of a four month period or, if terminated prior to four months, one week after counselling/therapy services had ended.

Seven of the interviewed women were receiving education and counselling services from PHNs at the time of the study. All but two of these mothers received services for four months; one required intervention for only one month and the other for three months. Therapeutic services were provided by Infant Mental Health Workers to the five remaining women. One of these cases was able to be terminated at three months with the remaining being carried beyond the four months Study period. Women's initial interview responses in comparison to those provided at the end of the Study period, are examined throughout this Chapter. Significant differences between pre- and post- interview responses are specifically noted, when not mentioned the reader can assume no significant differences were found.

Three quarters of the twelve women were between 25 and 34 years of age. Only one was younger than 25 years. Most, with the exception of four mothers, had only one child at the time of the interview. At the start of the study, children were

[16] There were originally sixteen women involved in the study, of which twelve provided complete pre- and post- intervention data.

between one month and four years of age. Ten of the children were one year of age or younger. The remaining two children were two and four years old. Typically, PHN cases involve young newborn babies whereas Infant Mental Health Workers see families where there are difficulties in relation to children who are as old as five years of age.

One-half of the women in the Study had partners and were married or living common-law. Their living situations varied from living alone or with extended family, living with a spouse, or living with a spouse and extended family.

Only one of the women had not graduated from high school. Women were found to have average to high intellectual functioning. During initial interviews one-half of the mothers indicated they were either working or on maternity leave from a job. Women were employed as teachers, bank tellers, and hairstylists. At the time of the follow-up interview, only three women reported being employed.

Language spoken at home was most commonly English, along with two Tamil, one Filipino, and one Spanish speaking family. This distribution is not representative of the G.T. population since participants were selected on the basis of their being able to communicate comfortably in English. Those who were not originally from Canada (N=7) had generally been in the country for longer than six years.

4.2 Mother's and Baby's Health

Considered in this first section is the health of mothers and their infants/children. Reported here are women's responses to the Feeding Measure, Health Status Questionnaire, and health related aspects of the Risk Factor Assessment (RFA)[17] interview.

4.2.1 Mother's Health

One-half of the women reported having had an abnormal pregnancy, due to anaemia, excessive nausea and vomiting, and/or bleeding. Three of the women felt their labour and delivery experience had been negative due to long labour, infant distress, an emergency cesarian section, and/or premature labour. Four women were kept in hospital longer than usual after the birth of their babies largely due to their needing time to recover from Caesarean Sections. One mother remained in hospital because of breast feeding problems and postnatal complications.

All but three of the twelve women reported having no health concerns at the time of the Study. During pre-interviews only one mother reported having a health concern which was related to her suffering from excessive pain in her body. She along with another mother reported bodily pain at post-interviews. The two were seeing doctors about these concerns.

Some mothers have personal health concerns

I have a lot of pain, throughout my body, the doctors says because I'm depressed, but I'm depressed because of pain, I have Epstein-Barr disease. ... I have back and arm pain from lifting my son.
35 year old Canadian Mother of 2 year old.

I'm taking medication for sleep deprivation because I've been having nightmares. My family doctor prescribed these.
28 year old Canadian Mother of 9 month old.

[17] During post-interviews women responded to abbreviated versions of the Feeding Measure and the RFA.

Most felt they were currently taking good care of their health by having a good diet, getting ample rest, and by exercising. However, three of the women said they did not have a healthy lifestyle or that they took risks with their health because of not eating sufficient amounts due to being anorexic, not eating healthy foods, getting no exercise, and/or because they smoked.

Overall, six of the women reported some health risk. One mother indicated she was engaging in excessive drug and alcohol use at the time of the pre-interview, which was no longer apparent at the time of the second interview. At post-interviews, four mothers reported being social drinkers on special occasions. Four of the women smoked. Only one woman had cut down on the number of cigarettes consumed per day at the time of the post-interview follow-up. Three of the women were taking prescription drugs for depression, asthma, or to help with sleep.

Although the majority of the group felt positively about their diet, at post-test, four mothers said they had run out of food, baby formula, or other staples over the course of the study. While this occurred rarely for most, it happened more than once a month for one mother. Women resorted to the assistance of family, churches, and food banks during these times.

In general, medical services were well used by mothers themselves as well as by their babies. However, two mothers indicated that they had wanted to access dental services for themselves and their children during the past twelve months but the expense of such services had prevented their

addressing these health care needs. One of these same mothers along with another also wanted to access specialized medical services for their children but had failed to do so as of yet.

4.2.2 Children's Health

***Birth and Feeding*.** Three of the babies were born early. Two were premature at 30 weeks and one was pre-term (33-37 weeks). These mothers knew their babies may be delivered early because they had had difficulties with the pregnancy or because they were carrying twins. Two infants were kept in hospital because of complications associated with being premature and having a low birth weight.

All twelve women had breast fed their babies at the time of their children's birth. However, at the start of the Study, most of the mothers were bottle feeding their babies (N=7). Two mother's, were exclusively breast feeding, and one was combining breast and bottle feedings. As well, two children, who were older, were drinking cow's milk from cups. By the end of the four month study period, only one child was being exclusively breast fed.

These results are unusual as anecdotal information suggests that early PHN intervention with mothers who are having difficulty breast feeding encourages the continuation of breast feeding in more than 90% of cases seen. Many of the mothers who agreed to participate in this Study were women who were receiving longer-term interventions from PHNs and Mental Health Workers. Therefore, these families may not be representative of typical breast feeding

Reasons why women stopped breastfeeding

My milk just stopped, like I couldn't get it back no more. No matter what I did, eating properly, pumping [milk]... I was pumping until I got to London, where they [my twins] were transferred a few hours after they were born [prematurely at 30 weeks]. My milk stopped shortly after I got to London.
28 year old Canadian Mother of 9 month old.

My milk dried up when I was under a lot of stress due to problems in [my] relationship with the baby's father. I stopped breastfeeding and gave my son formula for 5 days. When my breast milk restarted my child wouldn't take breast milk [any more]... I figured I'd formula feed so the father could help also.
35 year old Canadian Mother of 2 year old.

I was on [an] antibiotic and my doctor told me not to breast feed and when I stopped my milk was totally gone.
37 year old Canadian Mother of 3 month old.

interventions. These families may over represent cases in which infants have special medical and health issues, resulting in breast feeding not having been feasible or desirable.

Assistance from PHNs was found to be most helpful

I guess the health nurse [has been most helpful with feeding concerns], she seems to answer the questions better than the doctor does. The PHN talks about what I should try. I was glad she talked to the doctor about putting her on homogenized milk, it saves me money.
28 year old Canadian Mother of 9 month old.

First [most helpful with feeding concerns] I would say has been the PHN, secondly my paediatrician. Also I got very good help from a mothers' group, and I read a lot of books on breast feeding and pamphlets which was given to me by the PHN, group leader and the Doctor.
35 year old Canadian Mother of 2 year old.

The PHN was most helpful with my feeding concerns. [She visited] twice a week, we talked about breast milk and bottle milk and formula and all that nice stuff.
32 year old Canadian Mother of 1, 2, 7 & 14 year olds.

Well the public health nurse helped me a lot, she gave me some pamphlets. We talked about different kinds of food. ... She told me where to go to get utensils to make my own baby food. She told me what to give her every week and to wait a few days in between. Then she told me to start cereal.
35 year old Chilean Mother of one month old.

Those who were bottle feeding said they had got information about the kinds of milk to feed their children primarily from Doctors and PHNs. In addition, mothers read literature on the topic, and consulted Clinic's and other health specialists.

Three of the mothers reported during initial interviews to having feeding problems with their children. Problems were related to: a mother's mastitis, a child's poor feeding routine, and a child having medical problems. For two of the children, feeding difficulties had resulted in their failing to gain weight. Both mothers had spoken with their Doctor and/or PHN about their concerns. At the time of follow-up interviews, no mothers reported feeding problems and all reported their children had normal weight gain patterns.

Women were asked, during both initial and follow-up interviews, about those who have been of greatest assistance with feeding problems or concerns. At the time of the initial interview, mothers' said their feeding questions and concerns were most frequently addressed by PHNs (N=10), followed by doctors (N=9), breast feeding clinics (N=7), family and friends (N=6), and mother's groups (N=1). At the end of the counselling/therapy intervention period, all twelve of the women noted PHNs as having provided the most assistance with feeding questions and concerns, their comments appear opposite. As

well, mother's use of all other sources of assistance had increased.

Health, development and safety. Six of the babies and young children included in the Study had some form of health difficulty identified early on. Three had major problems in multiple areas, such as serious medical problems, physical abnormalities, and/or developmental delays. The three other children had more minor difficulties such as a low birth weight (>2500 grams), feeding difficulties, ear infections and allergies. At post-interview, fewer problem areas were identified for these babies and young children however their difficulties did continue. One additional child was identified at follow-up as having persistent allergies and ear infections.

Four mothers, two of whom had babies with difficulties, had other children as well with developmental challenges or medical problems, such as epilepsy, Attention Deficit Disorder, allergies, and asthma.

Five of the mothers said they had felt worried when they first brought their babies home, mostly because of excessive crying and feeding problems. One mother knew her daughter had had a brain haemorrhage shortly after birth and was frightened for her child. At post-interview time all five mothers said their concerns had largely been resolved through continued medical intervention, PHN and Infant Mental Health Worker visits, and through the child's own maturation.

Some mothers have children with serious medical concerns

He had two infections, one at six weeks, one at eleven weeks. He had a high fever and wasn't eating. I was force feeding him. It went on for two days and we brought him to Emergency and they admitted [him]. ... Doctors thought he had Meningitis but tests showed he had a urinary tract infection. Happened again at eleven weeks, they checked his kidney and everything else, but it was a repeat episode of the urinary tract infection.
32 year old Guyanese Mother of 11 month old.

[I was worried about] the thing in her head that made her haemorrhage ...it made her bleed in her head. It made her throw-up. It's gotten smaller both the spot and my concern. The doctor says it will probably go away.
28 year old Canadian Mother of 9 month old.

He has a very complicated heart, he had only two chambers [at birth] and he didn't have any valves, when he was one month he got a heart [transplant]. The doctors say he is doing well now.
27 year old Tamil Mother of 5 month old.

Three mothers at pre-interview said their baby had been so sick that they thought he/she might die. In one case a twin boy was lost, leaving mother feeling anxious about the health of her remaining twin. In another case a young six week old baby suffered high fevers which were the result of urinary tract infections. In the third case, a baby's persistent crying lead to the discovery of heart abnormalities which necessitated a heart transplant. PHN counselling on medical issues and Mental Health Worker support has been critical for these families.

During pre-interviews, nine mothers reported bringing their children to Hospital Emergency services a total of 13 times. Reasons for going to Hospital included: excessive crying, infections, flu and cold symptoms, and accidents resulting in minor injuries. At post-interviews six women had used Emergency services once each for reasons related to flu symptoms, infection, accidents, and breathing difficulties.

Mothers at first described their babies' health as being excellent (n=7), good (n=4), and fair (n=1). At follow-up the opinions of mothers about their children's health dropped; excellent (n=4), good (n=6), and fair (n=2). Two women reported health concerns at pre-interview with regard to their children eating well, and returning to health after surgery. At post-interview mothers reported continued concerns related to their children's lack of weight gain and strength. These mothers were receiving advice and support from PHN workers and their family doctors in relation to these concerns.

Mothers' worries lead them to emergency services

She was crying so much and I didn't know what was the matter so I took her to the emergency. There was nothing wrong she was just crying
28 year old Canadian Mother of 9 month old.

I took her only once [to emergency services] because she was non-stop crying and the doctor said she must be having colic. She was about two months then. The baby calmed down and I was told what was wrong with the baby, so everything was clear.
27 year old Tamil Mother of 3 month old.

The last time [I went to emergency services] was when he put his two front teeth through his tongue, he hit his mouth on the bed post.
32 year old Canadian Mother of 4 year old.

Mothers had also discussed the importance of immunization with PHNs and Family Doctors.
Only two of the children were not yet immunized, one due to being too young the other because of medical complications.

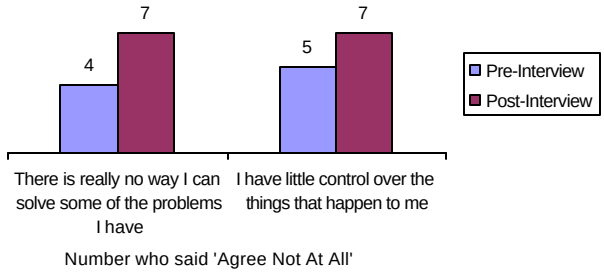
All of the mothers felt they knew how to keep their baby safe from harm as he/she grew older. All were dedicated to the consistent use of seat belts for children, whereas three mothers did not personally always use seat belts.

4.3 Parent Functioning and Capacity

In this section women's responses to the Personality Assessment Screener, Family Assessment Measure, CES-D, Pearline Mastery & Rosenberg Self-esteem Scales, and parts of the RFA are used to describe the personal functioning of mothers. Women's answers to the Knowledge of Infant Development Inventory and aspects of the RFA are discussed in relation to women's parenting capacity.

4.3.1 Parent Functioning

Figure 12
Sense of Mastery*: Number of Women Who Said 'Agree Not at All' with Selected Items (N=12)



*Selected items of Pearline Mastery Scale. Items are on a 5 point Likert Scale ranging from 'Agree Not At All' to 'Agree Completely'.

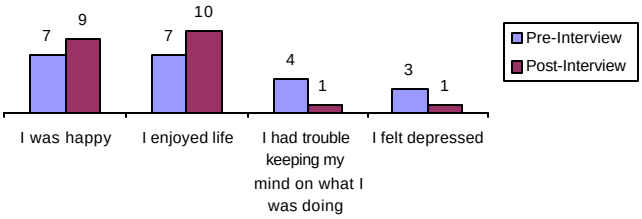
In general, women's psychological functioning improved over the course of the Study. In particular, mothers' sense of mastery, as measured by the Pearline Mastery Scale, was high and significantly improved during the course of the study (pre=20; post=22; t_{12}=2, $p \leq .05$). Figure 12 provides two sample items from the Mastery Scale, showing a greater number of women reported at post-interviews having a sense of control and problem solving ability. Women's self-esteem also increased slightly during the course of the Study (pre=33; post=34).

Women's overall psychological functioning was found to improve over time as well, although the change was not significant. The Personality Assessment Screener (PAS) total score provides an assessment of the individual's potential for emotional and behavioural problems of clinical significance (Morey, 1991). The average score of the women at pre-interview was 17, indicating a

mild risk for problems with potential for emotional and or behavioural problems being greater than typical for community adults. At the time of post-interviews the group's mean score had dropped to 14 indicating their potential for clinical problems had been reduced to being less than typical.

Signs of depression amongst the women were likewise reduced over the given time period.
Women's mean score on the CES-D measures of depression, while mild, showed a downward trend and dropped from a score of 13 to 9. While this change was not significant, interviewers noted on the RFA that women's feelings of depression had been reduced. Figure 13 offers examples of women's changes on four of the measure's items. As demonstrated through this figure, a greater number of women indicated they felt happy and enjoyed life while fewer said they felt depressed and had trouble concentrating.

Figure 13
Number of Women Who Felt Happy or Depressed 'A Moderate Amount' or More* (N=12)



Number of women who felt this way 'A Moderate Amount (3-4 days during the past week)'

*Selected items from CES-D. Items are on a 4 point Likert scale ranging from 'Rarely or none' to 'Most or All'.

The Family Assessment Measure provides an assessment of family dysfunction with higher scores indicating greater difficulties. Overall, group scores indicated the presence of a low level of family dysfunction and there was no change in women's scores over the study time period (pre=13; post=13).

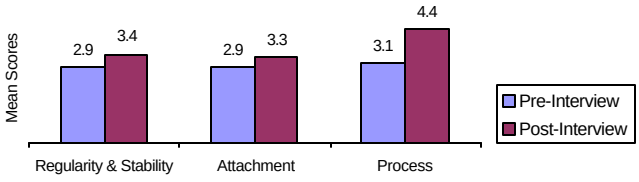
Risk Factor Assessment data provided further and, in some instances, more detailed information about these families and their functioning.

Conflict or violence in the home was reported by five of the women at the time of the initial interview. Only two women indicated they were experiencing conflict and/or violence at the time of the post-

interview. Four women were noted by interviewers as being conflicted with regard to separation or divorce at the start of the study, this was no longer apparent at the time of follow-up.

Women's family histories were often fraught with traumatic experiences. All of the women had experienced some degree of violence, family dysfunction, and/or loss during their young lives. Five of the women had experienced violence in their background and seven had experienced major separations in their early lives. Two had parents who had suffered from major physical illnesses and four had lost a caregiver figure when young. Four reported parents had used drugs and alcohol excessively and three had parents who engaged in criminal activities. Four women had moved frequently during their childhood. Traumatic family histories such as these can often make it difficult for adults to parent effectively since they themselves were without positive parent role models. Providing individual therapeutic services is key to helping parents learn new ways of interacting with their own children.

Figure 14
Women's Ability to Form a Relationship and Gain Insight With a Therapist/Counsellor*



Therapeutic Relationship Subscale Scores

*Regularity & Stability, and Attachment subscales range between 1-5, Process subscale ranges between 1-10.

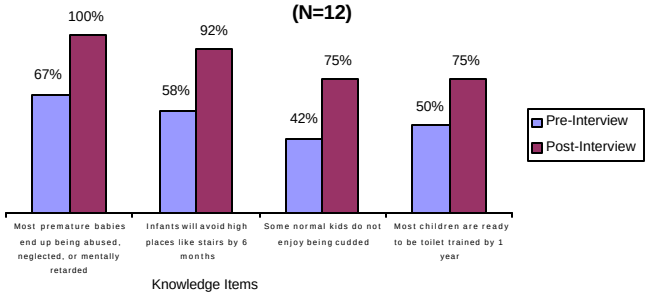
The ability of mothers to form a meaningful and useful relationship with a therapist/counsellor was assessed through use of the Dimensions of the Therapeutic Relationship Scale. Workers completed the scale at the start of the study and again at the end. No significant differences were found between administrations, however, women tended to show improvement in their ability to engage with workers in a meaningful and constructive manner. There was a demonstrated trend in which women showed an improved ability to regularly meet with workers, demonstrate

attachment to workers, and process material (see Figure 14). Surprisingly, the greatest change came in the ability of parents to be able to begin to talk about feelings and begin to explore connections between patterns of behaviour and relationships. The process dimension can be seen as the outcome of the regularity and attachment which mediate the working through needed for emotional growth.

4.3.2 Parenting Capacity

Pre-interview data showed mother's correctly answered 68% of questions about infant and child development, as measured by the Knowledge of Infant Development Inventory (KIDI). At Study's end, women's knowledge had increased with an average score of 73% correct. Figures 15 offers more detail on women's responses to specific knowledge items. As demonstrated in these figures, mothers showed improved knowledge about children's developmental milestones, child care practices, appropriate discipline, and safety.

Figure 15
Knowledge of Child Care, Discipline, and Safety: Percent Correct on Selected Items (N=12)



*Selected items from Knowledge of Infant Development Inventory. The 1st, 2nd and 4th items are incorrect and the 3rd item is correct.

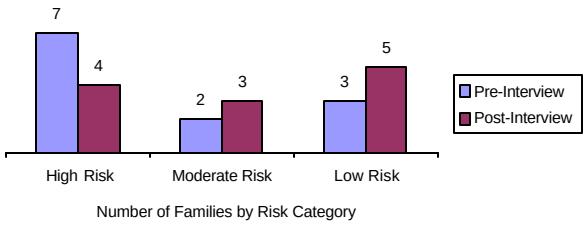
All of the women felt their babies were attractive. At pre-interviews, however, three women sometimes described their babies in negative terms whereas this was not noted for any mothers at follow-up.

All of the children were considered by interviewers, who completed the RFA, as receiving adequate care. Interviewers also observed two homes in which structure and routine was slightly disorganized and two of the parents had previous children taken into CAS care.

At the time of the pre-interview, two mothers stated they felt 'overwhelmed' caring for their children and three felt a little nervous. At follow-up interview time, only two mothers reported feeling 'slightly nervous' caring for their children.

Over time, the women experienced their children and their care taking roles in more positive terms. One-half of the women during initial interviews reported their children cried a moderate to excessive amount. Only two women indicated at follow-up that their babies cried moderately, with the remainder saying they cried very little. One-half of the mothers initially reported they frequently or sometimes saw their baby as a burden. At post-interviews, all of the women said they rarely found this to be true.

Figure 16
Families' Clinical Estimation of Risk*
(N=12)



*Determined by Interview rating on the Risk Factor Assessment (RFA) Protocol

The overall estimated risk to the children, as determined according to Risk Factor Assessment ratings, was found to decrease during the course of the intervention. Based on RFA interview information, interviewers determined each families' risk level as being high, moderate, or low. At pre-interviews the majority of the group fell into the high risk group (n=7), with two being rated as moderate and three low risk families. This pattern changed over the course of the four months. At Study's end, four families were rated as being high risk, three moderate and five low risk (see Figure 16).

For seven of the families there was no change in their estimated risk; four remained high risk, one moderate risk, and two low risk. Four cases did however show marked improvement and a substantial reduction in risk. Of these, two families moved from a high to a low estimate of risk, one

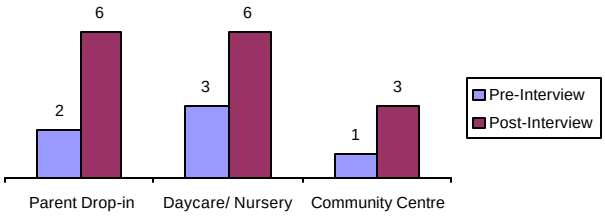
from high to moderate, and one from moderate to low risk. Only one case was found to increase in risk status from a low to a moderate level over the course of the Study.

4.4 Social Support and Use of Services

Described in this section are women's service use patterns and social support networks. This information was obtained from the Social Support Provisions Scale, Community Involvement Checklist, relevant sections of the RFA, and the Health Status Questionnaire.

Data obtained from the Social Support Provision Scale indicated that on average, the women's sense of support was determined as being high at both interview times (pre=16; post=16). However, as noted by interviewers while completing the RFA pre-interview, three mothers had a limited support system, this remained true for two of the women during the course of the Study.

Figure 17
Women's Community Service Use Patterns*
(N=12)



*Service use based on RFA data

According to RFA interview information, all twelve women said they used the community programs and social services available to them. As shown in Figure 17, service use patterns increased during the course of the study. Women's greater use of parent drop-in centres, community centres, and child day cares indicate mothers were encouraged about using appropriate, child focused services as their children grew older. Over time, more women reported using free stores (pre=1; post=2), YMCA (pre=0; post=2). Six women used Welfare services.

The Community Involvement Checklist showed women's involvement in community activities, such as committee participation, volunteering, and events planning, declined between pre- (n=11) and post-

(n=9) interviews. Perhaps this is because these new mothers were less able to participate in activities outside those that involved their children.

During pre-interviews two mothers said at times they felt the services they received from medical and social service providers were not as good as those given to others. None of the women reported feeling this way at post-interviews.

4.5 Client Satisfaction and Use of Services

Mothers feel very satisfied with G.T. services

I learnt a lot about my baby, [like how] to take care of my baby and those things.
37 year old Canadian Mother of 3 month old.

[It has been] really helpful, [I] don't know what [I] would do without my worker [and] going to [the] group [for] support. [They are] sympathetic but not overly so. [They provide me with] practical solutions [and they are] extremely resourceful, [and] connect you with the help you need. [My worker is a] great listener, you feel better talking about it.
35 year old Canadian Mother of 2 year old.

To me everybody that I've worked with has been very supportive and helpful and there whenever I've needed them. I like the whole surrounding everyone seems friendly and stuff. The Anger Management Program is helpful in teaching me not to jump at stuff right away - like work it out. Its helped me control my anger. I don't usually go there people come here [to my home], its more convenient for me, cause then there's more time to spend with that person. I don't like to be rushed.
28 year old Canadian Mother of 9 month old.

I can count on her [my worker]. I can call her and I can keep in touch with her all the time. And she gave me all the information I need.
27 year old Filipino Mother of two month & 2 year old.

Study participants were asked at the end of the post-interview to respond to questions about their use of Growing Together's services as well as their satisfaction with these services. Women also provided personal accounts about how the program had effected their lives. Finally, women spoke about services they would like to have delivered by G.T. in the future.

All of the women were multiple service users, with the most accessed services being: PHN counselling, Infant Mental Health Worker visits, parenting group and other group participation, use of the Developmental Clinic and Infant Monitoring System, Advocacy services, and attending G.T. organized events.

Overall satisfaction with the services they received from Growing Together was rated on a one-to-ten point scale, with ten being 'extremely satisfied'. Women's satisfaction with the program ranged between scores of 7 and 10. Seven of the mothers gave the program a rating of 10. Women's quotes, appearing opposite, illustrate their sense of being supported and assisted by program workers. The fact services are readily available both on site and through convenient home visiting was seen as most helpful. Being provided with practical answers and solutions to child care questions and life circumstances was also noted as important.

A more specific assessment of the assistance received by the mothers through G.T. worker visits

was considered. Women were asked to complete the Parent Satisfaction Scale which lists 35 statements about various forms of assistance which may or may not have been received by clients. Statements that did not apply were eliminated and those that did apply were placed in order of importance by the mothers.

While almost all of the 35 assistance statements applied to the women, there were 18 which stood out as being most often noted. These 18 assistance statements are listed in Table 14 according to the number of women who mentioned receiving such assistance as well as to the importance rating attributed to each form of assistance.

Considered by mothers to have been of greatest importance were those services which provided them with the skills and knowledge needed for helping them to care for their babies and young children.

A second area of identified importance involved the provision of services that allowed parents to share their feelings, gain confidence, examine their needs in relationships, and feel happier in their lives.

A third area of importance was providing mothers with ongoing, and immediate support around every day child care questions, breast feeding problems, and medical concerns. Mothers felt a sense of belonging and friendship through the assistance they received. Finally, the women received instrumental assistance with child care and housing needs.

Overall, the women in the Study felt very positively about the services they received through the G.T.

e me a wide was scared idence in

. I felt totally nnected with and I felt I is not the only y really ould escalate

Table 14
Assistance Received and Its Importance

	Importance Rating
1. Helped you learn more about how children develop and what they need to grow up healthy and happy.	N=9 (Rated between 1-10)
2. Taught you how to take care of your health and your baby's health.	N=9 (Rated between 1-10)
3. Gave you things to read when there was something you wanted to know more about.	N=8 (Rated between 3-12)
4. Helped you give your child(ren) a better start then you had.	N=8 (Rated between 4-19)
5. Helped you give your child(ren) a better start then you had.	N=7 (Rated between 1-5)
6. Helped you have more confidence in yourself.	N=7 (Rated between 2-18)
7. Helped you understand other people better.	N=7 (Rated between 2-23)
8. Helped you have a happier life.	N=7 (Rated between 3-22)
9. Gave you a person to talk to who really cared about you.	N=6 (Rated between 1-18)
10. Gave you a place where you could let your feelings out.	N=6 (Rated between 1-14)
11. Helped you understand yourself better.	N=6 (Rated between 1-19)
12. Assisted you with your baby's feeding problem (i.e., breastfeeding or bottle feeding, questions or concerns).	N=6 (Rated between 2-10)
13. Gave you someone to call to answer your medical and health questions.	N=6 (Rated between 4-15)
14. Gave you a place where you could make some new friends.	N=6 (Rated between 4-21)
15. Arranged for care for one or more of your children.	N=4 (Rated between 1-8)
16. Gave you a place where you felt you belonged.	N=4 (Rated between 2-17)
17. Gave you some help in finding a new place to live.	N=3 (Rated between 3-6)

program. Women were asked to comment about what the program has meant to them and about the changes that have occurred in their lives as a result. Their responses which appear opposite can be summarized as follows. The program assisted women by: helping them cope with stresses in their lives, providing ongoing support with breastfeeding, health concerns and developmental problems, increasing their sense of confidence, offering critical child care information and assistance, listening to women and helping them deal with anger and other issues, providing concrete assistance with everyday needs, and encouraging a caring and supportive relationship to help women build trust and overcome their feelings of isolation and loneliness.

When asked what services the program does not provide that they would like, most had not experienced any gaps in services. Mentioned by a few were: more children's groups, written material on how to work and deal with children, and a group focused on partners and adult relationships.

4.6 Summary

Mothers receiving counselling/therapy services from G.T. PHNs or Infant Mental Health Workers were followed over a brief four month period to determine the short-term effect of these services. Findings suggest the women benefited greatly from the provided services and were highly satisfied with the G.T. program.

Contributing to the health of mothers and their babies was the assistance and support provided by PHNs to mothers who were: having personal health problems, dealing with infant and child feeding questions and concerns, or trying to address the multiple needs of infants and children with serious health difficulties. Mothers identified the assistance received by PHNs with the program as a significant source of information and reassurance.

Women also demonstrated improved psychological functioning over the four month period. As a group, their potential for psychological problems decreased as did signs of depression. As well, fewer women reported being in a conflictual and/or violent home situation at the end of the Study period. Women showed a significant increase in their sense of mastery, expressing a greater sense of control and problem solving skills.

The women's ability to work in a meaningful way with workers also improved over time with mothers being more regular in their appointments, demonstrating a greater degree of trust and attachment to workers, and having an improved ability to process issues.

According to mothers, an essential aspect of the services they received through the program was the child development information and caretaking skills imparted by G.T. workers. Mothers' knowledge of infant development milestones, child care practices, discipline techniques, and safety concerns improved over the four month period. Negative feelings about their babies expressed at the beginning of the Study decreased over time.

Many high-risk families, because of traumatic early backgrounds, are likely to need longer-term, ongoing intervention. Most encouraging was the fact that the overall risk to children's outcome, as measured by the RFA interview, decreased during the course of the four month Study, with fewer families being identified at Study's end as being at 'high risk' for a negative child outcome. Clients' demonstrated a trend toward improved functioning within this short four month period which is both important and encouraging.

V The Developmental Clinic

5.1 Introduction

Discussed in this chapter is the role played by the Developmental Clinic in the early identification of children's developmental delays and medical problems and in facilitating the child obtaining necessary services.

Children who have attended the Clinic represent a substantial portion of the program's total population (359 of 961 children; 37%). Figures on the number of children seen by Clinic staff and identified as needing follow-up due to developmental and/or health concerns were documented as part of the *Process Evaluation Study*. Relevant statistics are reiterated here to provide the reader with an overview of the Clinic's operation and contribution to early intervention work. Further information can be found in the Process Evaluation of the G.T. Program report.

In an effort to further explore the question of how Clinic services effect St. Jamestown families, four case studies were developed. The presented case studies were selected to depict a variety of developmental circumstances and issues faced by children and their parents who are seen at the Clinic. Each family's story was developed through review of their Developmental Clinic case file, and through interviews with involved workers and the parents themselves. Their experiences vividly capture the nature and importance of the services

Operation of the Developmental Clinic

The Developmental Clinic operates one-half day per week at the St. Jamestown project site. Team members include two Public Health Nurses, as well as a Pediatrician, and Developmental Psychologist. A Speech Pathologist, employed one day per week through the TLC[3] program is available for those Developmental Clinic cases where follow-up is requested. Developmental and speech assessments are provided at times outside Clinic hours in order to accommodate the schedules of parents.
Radford, Landy & Tam, 1998, p. 69.

provided by the Developmental Clinic Team and G.T. workers in general.

One-hundred and twenty-eight children were seen by Developmental Clinic staff over a one year period. The specific experiences of David, Anna, Siva, and Susan[18] are each recounted through one page case studies. Discussed throughout the chapter are both the common and unique experiences of the four families as well as those elements identified as being crucial in the tracking of children's development and in assisting those facing health concerns and/or developmental delays.

[18] The anonymity of clients has been protected through the use of pseudonyms.

5.2 The Impact of Early Identification and Intervention: Four Case Studies

5.2.1 David

The first presented case study is that of David. David was two-and-one-half-years-old when he first visited the Growing Together program's Developmental Clinic. The majority of children who come to the Clinic are under 12 months of age at the time of their first visit.

David's parents were highly anxious about their son's development due to his recently having been diagnosed as language delayed and autistic or as having Pervasive Developmental Disorder (PDD). The family was having a hard time accepting the latter diagnosis and were desperately in need of support and clarification as to David's actual limitations and abilities. Referral to the program occurred through a local community worker. Entering a G.T. group initially to receive treatment for herself and her son, mother was quickly referred on to the services of the Developmental Clinic for further assessment of David.

The importance of developmental assessments in early intervention

What is needed is well-designed and implemented interventions…… in tandem with early screening and the identification of children in need of early intervention/special education services—our commitment is to identifying developmental problems and including more subtle problems in the realm of socioemotional development.
Musick, Bernstein, Percansky, & Stott, 1987, p.5

DAVID

David is the only child of Julie and Steven. Julie is a 41 year old woman from Argentina who came to Canada seven years ago. She met her husband Steven (48 years old) after one year, the couple married within a few months, and David was born a few years later. An apparent problem surfaced when David was 18 months old and he started to lose some of the vocabulary he had previously acquired. David wanted to communicate but uttered no real words, instead he babbled. He made sounds consisted of unintelligible rather hoarse vocalizations and he made the occasional attempt to imitate words. David's parents became concerned and sought out assistance at a children's hospital when David was two years old. During this time David was seen by a hospital psychiatrist and diagnosed as having a language delay. Still worried about David's limited language abilities, and on the advice of their pediatrician, David's parents pursued further assessment with another psychiatrist. This time it was suggested that David showed signs of having a language delay as well as features of Pervasive Developmental Delay (PDD) or, what David's parents understood to be, autism. His parents were advised to seek out a speech and language consultation and a group program for their son. David's mother recalls hearing about the Growing Together program from a community worker shortly after receiving this news: "David was found to be autistic and we couldn't accept the diagnosis. I talked to someone at the Welfare office [about our needs] and they told me about Growing Together. [When I called the G.T. office] I was told about the Mother's Club and I left a message for the group leader [to call me back]." Soon after mother and son attended the group and the group leader quickly became aware of the problems faced by the family and became involved. She explained: "In the first [group] meeting the mother mentioned her concern over David's not talking. Soon after she also expressed worries about the diagnosis of what she referred to as autism. Her anxiety was really high around wanting to understand if her child was normal. By playing, observing, and talking about mother's concerns the worker suspected the diagnosis of PDD was incorrect and the family was referred to the Developmental Clinic for assessment by the Clinic's Developmental Psychologist.

Initial attempts to assess David using the Developmental Inventory for Screening Children (DISC), failed because David was very distractible and uncooperative. Formal assessment testing was put on hold and his behaviours in relation to his environment and others was assessed through observation. On this basis it was concluded that David did not appear to be PDD, which greatly relieved his parents. It was recommended that parent counselling take place immediately in order to focus on discipline techniques and the relationship between mother and child. Subsequently, mother became involved in interactional exploration and observational work with her G.T. worker. The family worker remembered this time as very difficult for mother: "Anxieties about David's development would bubble up [for mother] and we would talk about his development as it was unfolding. I was always pointing out things that autistic children cannot do and alerting mother to what David could do." This work occurred over the course of the next six months, until couple counselling was identified as a need and another G.T. worker became involved with the family for a short time. Speech therapy was provided by the G.T. speech pathologist at the same time the family received parent and couple counselling. Over a ten month period, speech therapy services focused on increasing the complexity of David's sentence structures. In addition to this work, mother was referred to the Hanen Program to facilitate David's learning and set limits around his behaviours. The outcome was that David made great gains in language development, he began to form simple two word sentences. Mother was using the techniques she had been taught through the Hanen Program, like amplifying his attempts to communicate. In addition, parents found it helpful to be instructed by the G.T. Speech Therapist about ways to work with David. Mother commented: "I saw the way the therapist was working with David and I tried to do the same thing when I got home. She also suggested some exercises I could do with him and my husband also came and learned how to work with David." One year after the initial developmental assessment attempt, David was seen again at the Clinic. This time the DISC was successfully used to assess David's developmental abilities. David's development was found to be delayed in two areas: auditory attention and memory, and fine motor skills. At the same time David was assessed by the program's Speech Pathologist. In summary, David presented with delayed receptive and expressive language skills. Areas that were delayed included his vocabulary and inconsistent errors that occurred in grammatical structures. As well, his attention was short. It was recommended that the family be referred to the G.T. TLC^3 program for remedial help in these identified areas. Language therapy was provided once a week to increase his vocabulary. David became enrolled in the TLC^3 preschool group to focus on play skills and maintaining attention and language needs within a social context. The program's Resource Consultant would provide consultation to the family and the child's daycare with regard to David's ability to focus and follow directions. The program's Speech Therapist consulted with day care providers as needed to provide strategies for them to improve David's vocabulary and grammar use.

This thorough developmental assessment was most important to David's parents, providing them with reassurance about David's delays and methods for his improvement. Mother commented: "We think everything is fine now. We're working on behavioural issues with him now .. getting him use to routines. ... He's at Day Care now and starting kindergarten in September. His daycare workers are very optimistic that he will adjust well."

Today, David is four and a half years old. David's mother, commenting on the services provided by the Clinic and program staff, expressed her gratitude: "I am very thankful for G.T. Everybody was really helpful. ... My experience with all the people at G.T has been very good. I think it is a very valuable service. ... For most immigrants, it's hard to find a place where it is comfortable and you can get help with all kinds of issues. To find a place where I feel so supported has been great."

Children seen at the Clinic visit with the PHN, Paediatrician and Developmental Psychologist. In this case, the role of the Developmental Psychologist was paramount due to the question of David's previous diagnosis. Children (48%) are most often assessed using the Developmental Inventory for Screening Children (DISC), a standardized measure which assesses young children in a broad range of developmental areas including fine and gross motor skills, receptive and expressive language, auditory and visual attention and self-help and social skills. In 1996, 71 children were assessed by a G.T. Developmental Psychologist. Other assessment measures used are the Brazelton Neonatal Assessment Scale, Rorshach, WPPSI-R and the Bayley Scales of Infant Development. In order to complete an assessment, two to three appointments are generally required.

Description of the DISC

The DISC identifies delays in the age range from birth to five years. The justification for the specific scales chosen for inclusion of the DISC rests on two major goals: to uphold precedent established regarding content areas assessed by other assessment tools deemed formidable in the field of testing; to address and incorporate current research in the field of child development addressing the issue of "early identification" and the areas of development delay felt to be predictive of future developmental difficulties.
Amdur, Mainland, & Parker, 1994, p.10.

In the case of David, it was not possible the first time to properly administer the DISC measure due to his being highly distractable. As an alternative approach, a Developmental Psychologist with the project observed the child as a means of assessing his developmental status. The program Psychologist, Speech Pathologist, and family worker all concurred that David's symptoms did not appear to fit the diagnosis of PDD. Having highly skilled workers who are flexible enough in their schedules to conduct observational sessions with children in their home and day care environments is essential when working with attention challenged children and anxious parents.

Speech and language services for preschoolers

It has been well established that language-impaired children are at risk for developing a psychiatric disorder. ... Attention needs to be paid to screening children for language impairments and to helping adults understand how language disabilities impact on communication and behaviour.
Cohen, Davine, Horodezky, Lipsett, & Isaacson, 1993, p. 595.

Over the course of one year the family received a variety of supportive and therapeutic services from the G.T. program. Interventions provided to this family included: supportive home visiting, mother-child interactional counselling and guidance, speech and language therapy, couple counselling, and a therapeutic preschool group. The program's TLC[3] Resource Consultant and Speech Pathologist provided consultation to the family as well as to the child's daycare around facilitating David's language and attention skills. Additionally, mother was referred to a specialized outside program in order to further her training in the area of stimulation of his speech.

During her interview mother noted the importance of David's work with the Speech Therapist at G.T. Watching this therapist work with David and being explicitly instructed on helpful exercises to promote David's language skills, demonstrated to these parents how they themselves could assist David in his learning. Also seen as important for this family was the follow-up assessment David received one year after first attending the Clinic. This time David was able to complete the DISC assessment and two areas of language development were found to be delayed. David's parents were reassured by the follow-up testing and felt gratified to hear of his progress. Areas of continued delay were less anxiety provoking for his parents, because David's needs were readily addressed by G.T. services in an immediate and comprehensive manner.

5.2.2 Anna

The case of Anna represents another type of situation seen by Clinic workers. Anna's mother Linda, learned about G.T. services when a program PHN visited her at her home soon after Anna was born. During initial visits it is standard procedure to promote with parents the value of visiting the Developmental Clinic to ensure children are healthy and developmentally on-track. Services of the Clinic are also offered to parents at the time of earlier telephone contacts by PHNs and the G.T. Intake Worker. All contacted parents are encouraged to make use of the Developmental Clinic's services through regular appointments. According to the findings of the Process Evaluation, the objective of contacting all new mothers residing in St. Jamestown, in order to promote G.T. services, is being successfully accomplished. During a one year period, 87% of 359 families with new born babies, received a telephone contact from a PHN. This community-based approach is a most effective means for establishing a prevention and early intervention initiative.

Tracking the development of children reassures parents

Although the standard interventions were not intensive parents knew that they would be visited at preassigned times. As well the assessments provided over time, answering questions and providing information about child development was identified by parents as most helpful.
Landy, DeV, Peters, Arnold, Allen, Brookes, & Jewell, 1998, p.53

ANNA

Linda was without the support of her husband when her first child, Anna was born. Gordon was still living in the Filipines and arrived six months after Linda. Feeling alone and uncertain of herself as a new mother, she was very receptive to the idea of attending G.T. services for support and reassurance. Mother remembered hearing about the program: "My first baby was a month old when the PHN told me about the clinic. I didn't have any friends who had children and she told me there was also a class for new moms."

Shortly after the PHN visit, mother was visited by an Infant Mental Health Worker for assessment of risk. Baby was determined to be in good health and thriving and a lot of protective factors were noted. Mother demonstrated good interaction and bonding with the baby, was supported by her friends, was an intelligent mother, spoke English well, and made good use of community services. It was also evident, however, that mother was concerned that the baby was not sleeping and, because they were living with friends at the time, this resulted in considerable distress for mother. Linda remembers feeling alone and worried during that time in her life: "It was important to have a place to bring my baby to be checked and have my questions answered."

At one month of age Anna attended the Clinic. Linda continued to be concerned about the sleeping as well as the feeding patterns of her baby. She was reassured by the Doctor that her child was developing normally and was referred to the PHN for further assessment and counselling around these issues. The Clinic PHN assessed infant feeding, advised mother on formula use and discussed different strategies to promote sleep. One month later Anna returned for a developmental assessment with the Brazelton Neonatal Behavioural Scale. Again mother was reassured that her child's development was proceeding normally.

Regular appointments at the Clinic, attended by mother and baby, provided assurance that Anna was healthy and well. Mother felt it was important that the Clinic provided her with a second opinion about her child's development: "I would go to my family doctor and he would tell me everything is ok but doctors don't tell you everything. I was still worried about her crying a lot and not sleeping. ...People at the Clinic said she was normal, and told me to cuddle her and stuff. ...The advice [they gave me] and getting a second opinion was important to me, it was helpful. I would get a little peace of mind when I went to the Clinic." When her second daughter, Emily, was born two and one-half years after Anna, she too attended the Clinic and minor concerns around crying and feeding were again addressed.

The family has since moved from the neighborhood, but the children return for regular follow-up appointments. Linda feels satisfied with the assistance she has received from the Developmental Clinic and the program in general, she commented, "At G.T. they are always ready to help you."

In the case of Anna, little encouragement to join the program was needed. The baby's health was positively assessed by the nurse at the time of the initial home visit, and the completion of the RFA by an Infant Mental Health Worker confirmed mother was at low risk for a negative child outcome. Still, Linda was a first time mother and was feeling alone and uncertain of herself as a caregiver. The program's *When Baby Comes Home Group* and *Developmental Clinic* services offered opportunity to relieve mother of her many doubts and concerns. Both services are readily available to all G.T. clients, regardless of risk status.

During her visits to the Clinic Anna was assessed by the PHN, Pediatrician and Developmental Psychologist. These professionals confirmed Anna was a normal, healthy baby. Still, mother's concerns about Anna's feeding, and sleeping patterns persisted and it became important for Clinic staff to continue to reassure mother of her child's well-being during her early years. In visiting the Clinic mother felt relieved to hear from sources, outside of her family doctor, that all was fine. The parent counselling and care-taking advice provided by PHNs allowed mother to feel more sure of herself and gave her a sense of being supported as a parent.

A large proportion of children seen at the Clinic have no identified health concerns or developmental delays (45%). For these families the Clinic is a preventative developmental-tracking service whereby bi-yearly or yearly appointments ensure children's continued good health and development. For children identified early on as having possible

delays or medical concerns (55%), the Clinic has the resources to effectively assess children and intervene.

In the case of Anna, mother's anxieties about her baby's health were appropriately dealt with through regular Clinic appointments every six months. Parents interviewed as part of the Process Evaluation said the Clinic provided reassurance about their child's developmental progress. Encouraging all interested parents to attend the Clinic both ensures the prevention of future problems and the early identification of existing difficulties in as many community children as possible. Regular follow-up appointments at the Clinic ensure unfolding development difficulties are identified early and parents whose children have already been identified as having probable or actual delays can receive up-dates about their children's progress and on going needs.

Operating since 1993, the G.T. Developmental Clinic has seen 332 children, with only 66 cases having been closed. Process evaluation findings show 63% of the Clinic's cases have attended follow-up appointments.

5.2.3 Siva

Siva's story is representative of those cases in which an infant is identified early on as being in need of stimulation to ensure optimal development. Siva was born with physical abnormalities due to a genetic disorder.

Similar to Anna's family, Siva's family entered the G.T. program through the Birth Registration Referral route[19], which involved a home visit by a PHN early after Siva's birth. Findings from the Process Evaluation Study showed an average period of ten days between the time a child is born in St. Jamestown and a PHNs initial contact. The Birth Registration Notice route of referral, provides an efficient and thorough means for ensuring early contact with new mothers.

Since mother was Sri Lankan, the program's Tamil Home Visitor was quickly brought in to meet with the family, offer support, and promote the services of the Developmental Clinic.

[19] The Birth Registration Referral form is completed by hospital staff at the time of a child's birth and forwarded to Toronto Public Health Department staff. St. Jamestown families are flagged and contacted by telephone by a G.T. affiliated PHN.

SIVA

Siva is the first and only child of Rani and Rajah. His parents arrived from Sri Lanka as refugee. Shortly after their arrival Rani became pregnant. During her second trimester, Rani was referred by her family doctor to a gynecolgist for follow-up. It was at this point that abnormalities in the baby were identified through an ultrasound. Mother was referred to a hospital specialist for further blood work, x-rays, and ultrasounds. It was confirmed that the baby was developing abnormally, the extent of his problems would only become clear after birth. Siva was born at 38 weeks gestation with a low weight and identified abnormalities. Later, Doctors discovered Siva also has physical difficulty and a hormone deficiency.

Shortly after the baby's birth, G.T. became involved with the family through the usual Birth Registration Notice route. A Growing Together PHN visited the new mother at home and learned of her concerns about Siva's development and functioning. At that time the PHN observed he was not responsive to noises or his environment in general. The need for a developmental assessment was clear and the PHN asked the program's Tamil speaking Home Visitor to meet with the family to discuss the Clinic's services. During her first visit the Tamil Home Visitor learned more about the difficulties experienced throughout the pregnancy. Mother was worried about her baby's development and his appearance, as he was small and different looking. An immediate appointment was scheduled for the Developmental Clinic, but was later cancelled by mother because of the demands of other hospital appointments. In retrospect, mother admits to having been fearful about further testing: "At first, I was reluctant to go to the Developmental Clinic. Just in general, [I was anxious to go outside with him], to dress up my and son and go out. I was [also] afraid of his delays." The Tamil Home Visitor continued to visit with mother and promote the benefits of the Developmental Clinic.

Mother was more receptive to the idea of completing the Infant Monitoring System Questionnaire, which offered a means of following her son's development without immediately bringing him to the Clinic. Mother found the IMS questionnaires to be very helpful in identifying those areas where Siva was delayed and in need of more stimulation. This information encouraged mother to take the next step and make an appointment at the Clinic for Siva who was now two months old. After her first appointment with the Clinic's PHNs, and Developmental Psychologist, it became painfully obvious that Siva was delayed in a number of areas. Mother felt anxious about hearing her son could not do certain things. After a few months, she was able to return for two appointments in order to complete the DISC assessment. At 9 months of age Siva's development was found to be proceeding unevenly. Average scores on the fine motor, auditory and visual attention and memory and social skills suggest that his development in these areas was within the norms for his age. However, low scores in the gross motor and in the self help skills pointed to delays in these domains. Sub-average scores in the receptive and expressive language subtests pointed to possible delays in these areas. Rani recalls learning about how to help stimulate her son: [when I first came to the Developmental Clinic] my son was not active for his age. I asked the doctor [Developmental Psychologist] for activities to do and he also arranged for an occupational therapist to come to my home. The Occupational Therapist provided and demonstrated stimulation activities for a brief time.

At 14 months of age Siva returned to the Clinic for a follow-up appointment with the Clinic's PHNs, Pediatricitan, and Developmental Psychologist. Siva was again assessed using the DISC and results suggested his development was proceeding generally well and that he had made significant gains since his last testing. Progress was particularly noticeable in the areas of Siva's receptive and expressive language, where he was now scoring in the average range. Siva's self help skills were still, however, in the subaverage range, although he had made significant gains in this area since his last testing. Progress was also noticeable in his fine motor, auditory attention and memory and social development. In one area, gross motor development, Siva had made only moderate gains and his score remained in the delayed range. It was recommended that a G.T. Tamil Home Visitor with the TLC^3 program, continue to help Siva and his mother with some of the activities and strategies used by the Occupational Therapist to enhance Siva's gross motor and self help skills. Additional activities for supporting Siva's development were provided. Mother has found it helpful to have workers come to her home since Siva is more apt to demonstrate his skills in his familiar environment.

Siva continues to regularly attend follow-up appointments at the Clinic every six months while his development is also monitoried through mother's completion of the Infant Monitoring System Questionnaires. The family continues to receive services from the TLC^3 program. Mother feels very good about her son's development now, she comments: "I am satisfied because he's doing the [appropriate] activities for his age now. ... The most helpful thing [about the Developmental Clinic] was that they helped me stimulate Siva more. They helped me to develop my son. Otherwise I couldn't know which areas he was delayed in. They helped me develop him in those areas. I found there's a big difference between my family pediatrician and the Developmental Clinic services. When my son gets sick I go to my family pediatrician, but I go to the Clinic for developmental reasons. I don't believe in my pediatrician for my son's developmental concerns. At first they just tested, tested and tested him, we never heard how to help develop his abilities [until we came to the Clinic]. ... When I have difficulties I can reach them [easily]. I feel supported. I am very glad to have the Developmental Clinic in our area [neighborhood]. I gained a lot from the service.

Outside service providers, interviewed as part of the Process Evaluation Study, indicated that having staff who are themselves members of the St. Jamestown community's cultural groups, is an important aspect of the program. David's mother also commented on her appreciation in locating a program where new immigrant families feel supported and welcome.

While worried about Siva's development, mother was equally distressed by the fact that his physical difficulty made him stand out as different. As a new mother she felt overwhelmed by the many demands placed on her because of having a special needs child. Considerable hospital testing was being done in an effort to identify and diagnose Siva's condition. According to mother, providing support services directly in the home was critical during this early time. Workers and parents who took part in the Process Evaluation, felt positive about home visiting. Parents who are isolated, lack English speaking skills, or have disorganized or chaotic lives, benefit greatly from having workers come to their homes.

Making Clinic services convenient for families is key to the success of the program. The inclusion of worker home visits in addition to Clinic visits is an important service for families dealing with a number of demands and anxieties. The Clinic's Developmental Psychologist and Speech Pathologist meet with clients outside of Clinic hours, making services even more accessible. As well, the Developmental Psychologist conducts assessments at homes and daycare facilities where children can be observed more naturally. Outside service providers, interviewed for the Process Evaluation

Parents who learn about their children's developmental delays are often anxious

It's so hard for parents to acknowledge that their baby is not the perfect baby they dreamed about and waited for. But it is really important for the baby that parents begin to understand and respond to her needs and difficulties, without giving up hope, because the baby might need specialized care to grow to her potential. And if parents are able to relate to their baby as the whole person she is, she will grow up with a firm sense of her identity and the self-esteem we know is so important.
G.T. Infant Mental Health Worker

One of the major psychological adjustments after birth is the necessity for the parents to reconcile themselves with the actual baby and mourn the perfect imaginary one. ... The reaction of disappointment and grief is particularly pronounced if the child carries a visible defect. ... Repeated observations shared with parents are a powerful kind of intervention. They fuel the parents' perceptions of the infant as competent and developing individual, even through all the complications of prematurity.
Brazelton & Cramer, 1990, p. 203

Study, commented on the value of having Clinic services which are readily available to families, without the usual long waiting period.

Overwhelmed and exhausted by hospital appointments and fearful of taking her son outside her home, Siva's mother was reluctant to attend scheduled appointments at the Clinic. Additionally, the thought of what she might hear from Clinic staff, with regard to her son's development, was frightening. While she attended one appointment when Siva was just a few months old, she did not return again until he was nearly 9 months old.

Infant Monitoring System

The Infant Monitoring System uses parents to monitor the development of their at-risk infants by completing developmental screening questionnaires at specific interval…… It can be educational for parents by directing their attention to not only what their infants are doing, but also to what they should be doing…… ability to provide their children with age-appropriate activities may be improved.
Squires & Brickers, 1991, p.163-164.

In the meantime, and through the continued support of the Tamil Home Visitor, mother did agree to take part in the Infant Monitoring System (IMS) which is designed to identify infants and young children who show potential for developmental problems. This mail-out tracking system, consists of the *Ages and Stages Questionnaire* which is completed and returned by parents every four to six months until the child is three. A final questionnaire is completed at four years. In all there are 11 questionnaires, with each requiring 10-30 minutes to complete. The questionnaires have been translated into Tamil and 35% of those completing the package request the Tamil version. An important outcome of the IMS is that it engages parents in the monitoring of their children's developmental progress. Parents acquire critical information about their children's development. Over 200 families currently use the System, with approximately one-third being identified as having a possible developmental or health difficulty. Those cases where identified problems are suspected are contacted and encouraged to attend an appointment at the

Developmental Clinic for further screening. Feedback is otherwise provided in the form of a letter which explains to parents their child's development is proceeding as expected.

Completing the IMS packages helped Siva's mother begin to see, in her own time, the delays Siva was experiencing while also beginning to introduce her to ways to stimulate Siva's development. Subsequently, mother became able to make and keep appointments with the Clinic in order that a full Developmental Assessment could be completed.

Siva's initial assessment showed his development to be proceeding unevenly. Low scores in gross motor and self-help skills suggested delays in these areas with possible delays in the areas of expressive and receptive language. Stimulation activities to facilitate Siva's development were taught to mother and arrangements were made for the outside services of an Occupational Therapist. Re-tested five months later, Siva was found to be making significant gains although gross motor skills were still falling within the delayed range. A Tamil speaking home visitor from the program began to work with Siva and mother during home visits on stimulation activities. The comfort and convenience afforded by having workers come to the home to work with Siva, continues to be identified by mother as an important aspect of the provided services.

SUSAN

Susan was six months old when she first came to the Developmental Clinic. Her parents, Joanne 35 and Steven 37, were both born in Poland. They met in Canada approximately 10 years ago, soon after immigrating here. Susan is their first and only child. In the first few months of pregnancy, Joanne suffered bleeding and later developed an amniotic leak at 32 weeks, at which point she was admitted to hospital for bed rest. Onset of labour developed early and a vaginal delivery occurred, seven weeks prematurely. Susan could not breath on her own and was ventilated for two days. As well, she was jaundice for two weeks and had difficulty feeding. The baby was discharged from the hospital's Intensive Care Unit after four weeks.

Initial contact with the Growing Together program occurred through a Public Health Nurse home visit. The case was presented to the Growing Together team by the PHN once the family consented to the program. It was noted by the nurse that the baby cried in an unusually loud and persistent manner and was having considerable problems breast feeding. Team members agreed this baby's health and development needed further evaluation. The team psychiatrist was asked to visit in order to assess mother's apparent depression. At the same time, a G.T. Infant Mental Health Worker visited with the family in order to promote the program's services and complete the Risk Factor Assessment interview. Joanne, who seemed overwhelmed, expressed worry immediately upon meeting the worker and asked for ideas on how to stimulate her daughter. Recalling this period in her life, Joanne comments, "After 3 months [of age] I was worried [about Susan], she didn't do this and that, and everyone kept saying don't worry, it's because she's premature." Although mother had voiced her concerns with her family doctor during regular appointments, no further explanation for her daughter's behaviour was offered. During her first visit to the home, the Infant Mental Health Worker identified the baby as having an odd gaze, she looked everywhere but nowhere. Susan was awkward to hold and could not be soothed by her mother. There was no apparent attempt on the baby's part to reach out or hold things and she generally showed no interest in objects. Referral to the Developmental Clinic for further assessment was happily received by mother, "I was keen to go [for a Developmental Assessment] because it was the only thing at that time that was going to help me understand what was going on [with Susan]."

Once at the Developmental Clinic Susan was seen by the PHN, Pediatrician, and Developmental Psychologist. The baby was not sociable or engaging, but appeared anxious and cried throughout the examination. Through observation of her functioning, their general impression was that Susan was significantly delayed in all aspects of development, with visual and auditory deficits as well as possible cognitive delay. On this basis, further pediatric, neurological and physiotherapy assessments were recommended. The family's worker contacted the Community Occupational Therapy Association (COTA) to come to the home and initiate a physiotherapy program. As well, referral for follow-up with an outside Developmental Pediatrician was made. Hearing such grave concerns and speculations was, at first, very difficult for the family. At the time, mother remembers feeling both satisfied and dissatisfied with her experience at the Clinic, "I was disappointed at what I heard. The good part was that Susan was young enough and interventions could begin quickly, when she most needed it." Nevertheless, it took a month before the family's worker could get Susan's parents to take the next step. Gradually, by helping them see the developmental milestones Susan was failing to reach, they were able to agree to an appointment with an outside Pediatrician. Mother and baby were accompanied by the worker for support. At seven months of age, Susan was found to be functioning with gross motor skills at about a three month level, and with even lower level social and adaptive skills. A full investigative study and developmental delay work up was arranged, as was physiotherapy and occupational therapy. Infant stimulation exercises provided in the home began to address Susan's physical and cognitive delays. The Growing Together worker referred the family to Community and Social Services for Handicapped Children's Benefits and helped with the completion of the necessary application forms. Mother recalls, "The Clinic staff were really helpful at that time [in our lives]. I was very overwhelmed. I could not have done everything that was [needing to be] done at that time [without their assistance]. It was hard, but the support of everyone there [at the Clinic] was very good".

Follow-up developmental assessments were conducted at the Clinic with Susan at 11 months and again at one and a half years. Susan showed gains in her ability to react to stimulation and maintain auditory attention. Improved responsiveness was occurring between Susan and her mother, with Susan being more interested in social interactions in general. She was also starting to babble, making 'ma' and 'ba' sounds. Visual attention and memory skills, however, remained problem areas for Susan. A current diagnosis suggests this child is seriously developmentally delayed and suffering from Cerebral Palsy.

Susan, who is now three years old, recently completed a special needs nursery school and is preparing for a special needs kindergarten classroom. Her home environment is optimal as she continues to receive physiotherapy and occupational therapy services required for supporting her self-help skills and overall development. Her family is receiving the funding for their special needs child that was arranged for with the assistance of the G.T. worker. Over the years, Joanne has received regular supportive psychotherapy from her G.T. worker during home visits. While mother has tried to attend other services at Growing Together, she has found it too difficult to be amongst other children. Instead, she has become involved with families who have children with similar delays. According to mother, "Susan is doing better and better."

5.2.4 Susan

The final case study is of Susan, who was first seen at the Clinic when she was only 6 months old. Susan was born seven weeks premature and although mother consulted her family physician early on about concerns with regard to her baby's functioning, Susan's difficulties were largely attributed to her prematurity.

The G.T. PHN who initially visited the family found Susan had a persistent and loud cry and was having difficulty breastfeeding. A visiting Infant Mental Health Worker identified the further concerns of a baby who could not be soothed and who showed little interest in her environment. Mother, feeling no one was addressing her concerns, was immediately receptive to the notion of attending the Developmental Clinic.

Assessment by the Clinic's Pediatrician, Developmental Psychologist and PHNs led to the conclusion that the baby was delayed in all aspects of development. The family was referred for outside pediatric, neurological and physiotherapy assessments. Furthermore, it was arranged that a Physiotherapist visit the home to help stimulate Susan. Later assessments diagnosed Susan as developmentally delayed and as having Cerebral Palsy.

Similar to the sense of feeling overwhelmed expressed by Siva's mother, Joanne was not immediately able to act on the recommendations given by Clinic staff. The family's G.T. worker was instrumental in helping the parents take notice of their daughter's developmental delays and needs.

Importance of Early Identification of Delays

The first experience of a family with a child who may need early intervention services typically involves a process of identification, evaluation and assessment, in which the need for services is established and defined.….. Depending on the program and the degree of the child's disability, the initial evaluation to determine whether a child qualifies for services and subsequent re-evaluations for that purpose can be seen as rites of passage into early intervention.
Berman & Shaw, 1996, p.362.

G.T. PHNs and Infant Mental Health Workers provide much needed support to families experiencing distress due to illness and/or children's delays.

Once able to attend outside pediatric appointments, Susan was identified as seriously delayed in gross motor, social and adaptive skills. Infant stimulation exercises were implemented to target the identified delays. Follow-up assessments were provided at the Clinic three months after the initial assessment and again six months later and improved social interactions were noted.

Outside referral for specialized services

"The process of providing regular assessment allowed at-risk families to be identified early and to be referred to other agencies if necessary…… combining early identification through regular assessments and referral was effective in improving outcomes for children."
Landy, DeV. Peters, Arnold, Allen, Brookes, & Sewell, 1998, p.54.

Most important for this family was the early identification of Susan's delays, support in dealing with Susan's needs which included the family's financial needs, and the co-ordination of outside service referrals.

The referral of families to outside services was found, in the Process Evaluation Study, to occur most frequently through the Developmental Clinic where children, such as Susan, are identified with multiple assessment, intervention and instrumental needs.

5.3 Summary

Clinic services are provided in a convenient, friendly environment, in a culturally sensitive manner. The speed with which parents can access Clinic services offers additional assurance that children's development will be monitored as early as possible.

In three of the presented case studies it was evident that the specialized skills of the Developmental Clinic's multidisciplinary team, offered opportunity for the early assessment of delays and the implementation of intervention approaches.

Siva's mother commented that she depends upon the Clinic for the continued monitoring of her son's development. Most importantly, Clinic services, were unique in that they provided parents with the opportunity to help Siva develop his existing skills. David's family benefited from a thorough assessment of their son which re-directed their attention to working with David's skills and away from the mis-diagnosis of PDD. Finally, Susan's mother's attempt to have her early concerns addressed by a family practitioner failed. In the opinion of this mother, the early identification of Susan's extensive delays, provided by the Clinic, has been instrumental to Susan's optimal functioning.

All children and their families were perceived by workers as doing well at this time. Each of the four parents reported feeling satisfied with the progress their children have shown and the role the Developmental Clinic has played in ensuring proper

assessment and intervention services continue to be received by their children.

VI Advocacy Services

6.1 Introduction

An Advocacy Worker who specializes in providing Advocacy services provides clients living in St. Jamestown with assistance in accessing other community services such as social, health, or legal services, housing, child care subsidies, education, and immigration. Promoting programs with clients and helping them link up with these programs is a major component of this work. Home visits provide an additional means for assessing needs around financial, immigration, or other problems. Support is at times instrumental, such as: helping clients fill out applications for subsidies, writing letters to immigration, apartment management, or welfare, obtaining emergency shelter, money, food, or furniture for needy clients, translating or interpreting from the Filipino language into English. At other times more emotional support is offered: helping an isolated and stressed parent, or visiting new immigrants and refugees in the community and teaching them how to cope with their new environment.

The worker also advocates on behalf of clients by researching particular legislation in order to better protect clients' rights. The worker subsequently accompanies and represents clients at various agencies where they go for assessments or interviews.

Table 15
Community Home Visitor Activities

Types of Service Provided	N
Subsidized child care obtained	40
Emotional support/counselling	30
Referrals to other social services	60
Subsidized housing application	46
Welfare/financial assistance	26
Supportive groups	18
Accompanying to meetings, visits	45
Immigration and other legal services	15
Translating, interpreting, and filling out forms	53
Employment and educational assistance	24
Emergency food or shelter	26
Drop-in	26

Between September, 1994 and April, 1997, the Community Home Visitor saw 148 clients and currently has 147 active clients. Table 15 is a list of the types of services provided and the number of clients for whom services were provided.

6.2 Impact of Advocacy Services

Advocacy services were evaluated on the basis of results obtained from two measures administered to seven clients as well as parent satisfaction scale administered to three clients.

Measures were selected because they best reflected client needs. The following two scales were administered: Centre for Epidemiologic Studies Depression Scale (CES-D), and the Difficult Life Circumstances scale. These measures were given to clients near the beginning of the service, and again several months later.

A perusal of the Depression Scale revealed that the total depression score went from a mean score of 15 to a mean score of 10.9. Of the individual clients' scores, 40% remained the same, 20% dropped by 4 points, 20% dropped by 7 points, and 20% dropped by a total of 10 points.

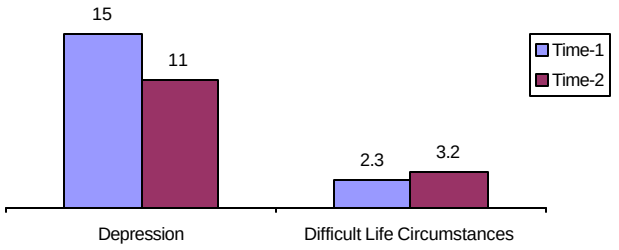
Scores on the Difficult Life Circumstances scale indicated very little change between the two time points that were sampled. At time 1, the mean score was 2.3, and at time two, the mean score was 3.2, with very little variation among individual clients' scores from one time to another. It appears that although the Advocacy Worker may be able to influence the internal states of people, the external

life circumstances measured by the later scale are more difficult to change. The scores for these two scales are listed in Figure 18.

A Parent Satisfaction Scale was administered to three of the clients of the Community Home Visitor. All three indicated that they were very satisfied with the service they received from this program. When they were asked which aspects of the program they liked the best, at least two mentioned the following:

- Went along with you when you went to some other agency. *
- Helped you learn more about how children develop and what they need to grow up healthy and happy. *
- Gave you a place where you could make some new friends. *
- Helped you make positive lifestyle changes such as making more nutritious food for yourself and your family.
- Gave you ideas for enjoyable activities to do with your children. *
- Helped you plan your future.
- Gave you a place where you could let your feelings out.
- Helped you get along better with your family.
- Gave you a place where you felt you belonged.
- Helped you have more confidence in yourself. *
- Gave you things to read when there was something you wanted to know more about.
- Helped you give your child(ren) a better start than you had. *
- Acted as your advocate when you needed services from an agency.
- Helped you understand yourself better.

Figure 18
Mean Scores on Depression* and Difficult Life Circumstances Scales (N=7)**



*Depression was assessed by CES-D which ranges from 0 to 40.
**Difficult Life Circumstances Scale is a count of various negative life events as perceived by the respondents

- Helped you plan a better schedule.
- Gave you a person to talk to who really cared about you.
- Increased your skills and confidence as a parent.
- Increased your English language skills.
- Enhanced your child's development (social, language, physical, cognitive, and/or confidence).

** These items were ranked among the top three best liked aspects of the program.*

Women appreciate advocacy services

All the information was given clearly. Her information was very helpful.

I feel really grateful and thankful for the help she has given me. She gave me information about other community services.

She helped me with Metro Housing. She helped me with my child by giving me ideas for activities, and by giving me toys that I could borrow.

No changes or additions to the program were recommended by any of the clients of the Community Home Visitor. Women's comments illustrate their sense of gratitude for the advocacy services received.

6.3 Summary

For parents living in high-risk neighbourhood, such as St. Jamestown, assistance in accessing services and resources are crucial. Although all G.T. workers assist families in this way, having someone who specializes in this type of service and can advocate for services as necessary, reduces stress of staff and allows them more time to meet the other needs of families. With 147 families receiving these types of services in one year the need is obvious. This service is well received by parents and has been shown by these results to reduce the level of depression experienced by mothers and consequently is likely to enhance their interactions with their infants and young children. Although these services cannot eliminate the difficult life

circumstances faced by many families, knowing that there is a service that can support them in accessing the basic prerequisites for adequate food, shelter, medical care and some security in immigration status is crucial in order to reduce their stress and to help them make life better for their infants and young children.

VII Essential Program Components and Recommendations

7.1 Introduction

Presented first in this final Chapter is a summation of the findings of the *Growing Together Short-Term Impact Study*.

The objective of determining which aspects or components of the Toronto based G.T. program are critical or essential to include in all G.T. program sites appears as a central discussion point of this Chapter. Information obtained through the study of the program's immediate impact, combined with the findings of the Process Evaluation Study (1998), provided the foundation for such a discussion. A third source of information used in developing the program's essential components was the vast body of literature on early intervention programs, both theoretical and evaluative, which was reviewed in the Introduction Chapter of this report.

Principles of practice, or the principles which guide those in the field who are conducting the work, are also presented in this Chapter. A third area consider here are those operational features of the program identified as necessary for the G.T. model.

Global programmatic recommendations, and suggestions for future research are also considered in this Chapter.

7.2 Short-Term Impact Evaluation: Summary of the Findings

Consideration of the short-term impact of a total of six Growing Together parenting, therapeutic, and skill-based groups showed group objectives were, overall, being met and that desired improvements in the identified areas were indeed occurring for participants. Furthermore, clients expressed a high degree of satisfaction with the groups they participated in, noting groups were convenient to attend and delivered in a culturally sensitive manner. In general, women who attended the groups said that meeting other mothers, having opportunity to get out of the house once a week, and receiving support from other group members resulted in a positive group experience.

When Baby Comes Home, a PHN led parenting group, was shown to increase parents' knowledge about infant development, improve mothers' sense of competence in the parenting role, and provide mothers with a sense of support. Perhaps because of women's increased knowledge about infant development, their level of confidence and preparedness to care for their baby significantly improved as well. All mothers felt they had benefited from the information provided by leaders as well as other mothers.

The *Prenatal* Group, also led by PHNs, was shown to be highly successful in meeting the objective of promoting the birth of healthy infants. Of 34 infants born to women who attended the group between April, 1997 and March 1998, 32 were healthy and had birth weights in the normal range with complications having been experienced by only two infants. All thirty-four of the mothers initiated breast feeding, and 32 were found to still be breastfeeding six months later.

Both therapeutic groups included in the Study, the *Anger Management Group* and the child-focused *Preschool Group*, resulted in important benefits for parents and children. Women in the *Anger Management Group* were better able to identify their feelings and emotions and control their anger after group participation. Over two-thirds (69%) of the group members had difficulty processing emotional states which may lead to impulsivity and aggression. At post-test women's ability to identify, express, and process emotional states significantly improved. Women also showed an improved ability to problem solve and explore their own emotional states as well as those of their children. At group termination mothers were found by group leaders to be more interested in their children's feelings. At the beginning of the group, women also displayed high levels of overall anger and a limited ability to monitor and control their anger states resulting in their being at high-risk medically and in their interpersonal relationships. While scores did not show significant change at group's end, scores did indicate women had a greater ability to monitor and control their anger at group termination. More generalized benefits were also experienced by clients, who showed significant increases in self-esteem and social support.

Attendance at the *Preschool Group was* associated with important gains for child participants who were three to five years of age. Children were rated by the group leader as being significantly less shy and withdrawn after three months participation in the group. Mothers rated their children as being significantly less hyperactive and distractible and noted gains in their physical and language development after attending the group for three months. Opportunity to play with others their age was viewed by mothers as key to resulting in their children's improved skills.

The impact on clients of participating in the skill-based groups, the *Computer Skills Training Course* and the *English Club* was also found to be positive. The objective of increasing the computer skills of participants was most clearly accomplished in both the beginners and advanced beginners groups. All participants reported they had increased their computer knowledge. Participants of both groups showed significant gains in their computer skills on an established program test. The group, while experienced as supportive, did not effect women's overall social support scores or did their level of community involvement change after group participation. Similarly, while participants reported feeling more competent their scores on measures of self esteem and mastery did not significantly increase after group participation. Women in the *Computer* group acquired new computer skills in a supportive learning environment which they found personally rewarding as they felt these skills would help them secure employment in the future.

English Club participants improved their English language skills and developed a better understanding of Canadian culture and customs. Women all reported that their English had improved and that they enjoyed the experience of the group. At post-interviews women reported a greater degree of comfort in using English in a variety of settings, such as reading package labels, English books and newspapers, applying for a job and being interviewed in English, and helping their children with their homework in English. Many of the women also showed greater community involvement, such as volunteering, and participating in community events, possibly because of their improved English skills and greater confidence. Surprisingly, women's feelings of self-esteem and sense of mastery did not change over the course of the Study. These measures were perhaps too brief to capture subtle changes. Women's social networks did not change. All of the group participants were Tamil women who already had strong community ties.

Women who participated in the assessed G.T. groups all reported they had been told about other groups and services at G.T. Generally, women planned to take part in other G.T. services as well as outside community services. Linking clients with ongoing services and resources can have important short- and long-term benefits for G.T. parents and their children.

In addition to assessing the short-term impact of G.T. group programs, the short-term impact of counselling/therapy services was considered. Twelve women who were receiving services from G.T. PHNs or Infant Mental Health Workers were interviewed at the start of service provision and again at the end of a four month period or when their services terminated. Findings of this Study suggest the services helped to promote the health and well-being of both mothers and

their babies. While pre- post- change were generally not found to be significant, results consistently indicated a trend toward mothers' improved skill and functioning.

Contributing to the health of mothers and their babies was the assistance and support provided by PHNs to mothers who were: having personal health problems, dealing with infant and child feeding questions and concerns, or trying to address the multiple needs of infants and children with serious health difficulties. Mothers identified the assistance received by PHNs as a significant source of information and reassurance.

Six of the children had some form of health difficulty early on in their lives. Three had major problems such as physical abnormalities or developmental delays. Three mothers had babies who were so sick they thought they might die. Medical conditions included, a baby who had a brain haemorrhage, an infant with multiple urinary tract infections, and a child who required a heart transplant. PHN medical assistance and worker support was critical for these families.

At the time of the study, most mothers were bottle feeding, only three were breastfeeding. Those who were bottle feeding said they had got information about the kinds of milk to feed their children primarily from Doctors and PHNs. Three mothers initially reported having feeding difficulties. For two of the children this had led to poor weight gains. All twelve mothers said that PHNs had provided the most assistance with feeding questions and concerns. Mothers also received immunization information from PHNs and Doctors.

Women demonstrated improved psychological functioning over the four month period. As a group, their potential for psychological problems decreased as did signs of depression. At pre-interview women showed a mild risk for emotional and or behavioural problems. At post-interview time, the groups' potential for clinical problems had reduced to being less than typical for community adults and more women indicated they felt happy and enjoyed life. As well, women showed a significant increase in their sense of mastery, expressing a greater sense of control and problem solving ability. (This was the only significant change in functioning detected in this aspect of the short-term Study.)

All the women had experienced some form of family dysfunction when young. Traumatic family histories make if difficult for adults to parent effectively. Helping parents learn new ways to interact with children is critical. There was an important trend toward an improved capacity to parent as indicated by women's increased knowledge about infant and child development and their greater tolerance and enjoyment of their children and their own caretaking roles. For example, at the time of the pre-interview, two mothers stated they felt overwhelmed caring for

their children and three felt a little nervous, after intervention, two mothers said they felt only slightly nervous. As well, at post-interview fewer mothers reported seeing their children as a burden. Over the course of the study, mothers' showed an improved ability to regularly meet with workers, demonstrate attachment to their worker, and process personal material. Most encouraging was the fact that the overall risk to children's outcome, as measured by the RFA interview, decreased during the course of the four month Study, with fewer families being identified at Study's end as being a 'High risk' for a negative child outcome.

Mothers experienced a strong sense of belonging and friendship through the G.T. program. Program services were well used by the women and their overall satisfaction with the program was very high. The fact services are readily available both on site and through convenient home visiting was seen as most helpful. Considered by mothers to have been of greatest importance were those services which provided them with the skills and knowledge needed for helping them care for their babies and children. Also important was the provision of services that allowed parents to share their feelings, gain confidence and lead happier lives. Thirdly, parents felt it important they were provided with ongoing and immediate support around every day child care questions and medical concerns. Over the course of the study women also reported a greater use of parent drop-in centres, child day care centres, and community centres as their children increased in age. Their involvement in other community activities, such as volunteering, decreased over time, perhaps because of the demands of caring for young children. Such changes over this brief intervention period suggest positive long-term outcomes would be likely to take place for families receiving longer-term counselling/therapy services through the program.

The short-term impact on families of Advocacy services provided through the program was assessed as part of the Community Action Project for Children (CAP-C) evaluation initiative. Findings were briefly discussed in Chapter VI of the *Short-term Impact Study* report. It was shown that post- provision of Advocacy services, women's depression scores, measured by the CES-D, dropped. However, women's scores on the Difficult Life Circumstances Scale changed very little between pre- and post- intervention times. It was concluded that while the internal states of people assisted by the program's Advocacy worker do seem to shift as a result of intervention, the external life circumstances of families are more difficult to change. All three women who completed the Parent Satisfaction Scale indicated they were very satisfied with the services they received from the program's Advocacy Worker.

The short-term impact of the services provided by the Developmental Clinic were examined through four case studies. The stories of David, Anna, Siva, and Susan, helped to depict the

variety of developmental circumstances and issues that bring children and their parents to the Developmental Clinic, the assistance they receive, and the impact clinic services have on families of young children.

Clinic services were provided in a convenient, friendly environment, and in a culturally sensitive manner. The speed with which parents were able to access Clinic services offers additional assurance that children's development will be monitored as early as possible. As well, having highly skilled workers who are flexible enough in their schedules to conduct observational sessions with children in their home and day care environments is essential when working with attention challenged children and anxious parents. In the cases of Siva, David and Susan, the specialized skills of the Developmental Clinic's multidisciplinary team, offered opportunity for the early assessment of delays and the implementation of intervention approaches. A brief review of their experiences is provided below.

Siva had been born with significant physical abnormalities and a hormone deficiency. Like other parents whose children have physical problem, Siva's parents were hesitant to bring their son to the clinic for assessment because of what they might hear about his development. Having a Tamil Home Visitor was of great assistance in getting the parents to join the Infant Monitoring System and ultimately to attend the clinic. According to this mother, providing support services directly in the home was critical during this early time. Making Clinic services convenient for families is key to the success of the program. Siva's mother commented that she depends upon the Clinic for the continued monitoring of her son's development. Clinic services, were unique in that they provided parents with the opportunity to help Siva develop his existing skills.

David's family benefited from a thorough assessment of their son which re-directed their attention to working with David's skills and away from the mis-diagnosis of Pervasive Developmental Delay. David's family received a variety of supportive and therapeutic services from the program. Follow-up assessments helped David's parents see the progress he was making and areas still requiring intervention. His daycare workers are optimistic he will make a successful adjustment to junior kindergarten.

Susan's mother's had attempted to have her concerns about her infant's persistent crying addressed by a family practitioner early on, but was told her difficulties were due to her having been born prematurely. Persistent crying, breast feeding difficulties, and the baby's disinterest in the environment led to recommending a developmental assessment for Susan soon after the initial G.T. home visit occurred. Most important for this family was the early identification of Susan's delays, support in dealing with Susan's needs which included the family's financial needs,

and the co-ordination of outside service referrals. In the opinion of this mother, the early identification of Susan's extensive delays, provided by the Clinic, has been instrumental to Susan's optimal functioning.

In the fourth case, the case of Anna, no developmental or physical problems were noted but mother remained anxious about her baby's crying and feeding patterns. A large proportion of children seen at the clinic have no identified health concern or developmental delays (45%). Visits to the clinic for these families are preventative. Anna came to the Clinic through the usual worker route of referral and continued to come to the clinic every six months. Visits have now been extended to yearly appointments.

All four children and their families were perceived by workers as doing well at this time. Each of the four parents reported feeling satisfied with the progress their children have shown and the role the Developmental Clinic has played in ensuring proper assessment and in helping them access needed services. Clinic services continue to be received by their children.

While the following Study focused on the short-term or immediate impact of group participation, counselling/therapy, advocacy, and Developmental Clinic services, the demonstrated change in the knowledge, skills, and health of parents and children suggest it is probable that there are further benefits for these families which will be evident over the longer term.

7.3 The Growing Together Program: Essential Program Components, Principles of Practice, and Features of Program Operation

An important objective in conducting both the Process and Short-Term Impact Studies was the goal of identifying aspects or components of the program that are critical to both the Toronto G.T. site and other replication sites. As noted above, information obtained through these two evaluation studies, provided a means of considering the essential components of this program. Combined with literature from the field and the experience and expertise of the program's Co-Directors, a list of essential components has been developed (see Table 16). Interviews with workers at the project provided an additional source of information about the essential program components.

Table 16
Growing Together: Essential Program Components

The Early Screening of Mothers and Newborns	Each demonstration of the model will phone all mothers with a new baby, answer questions, provide information, and offer to conduct a home visit. For those who agree, a risk factor assessment will be conducted and used to determine the nature of the services to be offered to the family.
Ongoing and Regular Monitoring, Assessment, and When Necessary, Referral to Intervention Services	Each demonstration of the model will have in place a system for regular monitoring of child development and family well being, for all children and families who participate in the program.
Child Intervention Programs	Each model will have a set of programs that are provided directly to the child. These may include play groups, treatment of developmental delays, assessments, child care, and so on.
Programs that Emphasize Enhancement of the Parent-Child Interaction and Relationship	Each model will provide services which can include direct intervention with the caregiver-infant/child dyad, provision of parenting information and health promotion. In certain situations parents may receive counselling, therapy or crisis intervention. These interventions may be provided to individuals, dyads, families, or groups and can be provided in the home or at the centre.
Programs that Offer Family Support	Each model will provide services aimed at building a support network for families and links to relevant services in the community.
Community Development	Each model must establish a community development component, to enhance the living conditions of families. These may include a community safety program, neighbourhood enhancement initiatives, community advocacy activities, community events and so on.

Appearing below are six identified Essential Program Components. Along with each of the six statements is a brief review of evaluation findings and literature, which assists in illustrating further the importance of each of these program component areas.

7.3.1 Essential Program Components

A. The Early Screening of Mothers and Newborns:

Each demonstration project of the model will phone all mothers with a new baby, answer questions and provide information and offer to conduct a home visit. For those who agree, a risk factor assessment will be conducted and used to determine the nature of the services to be offered to the family. Risk factor assessments will also be completed if mothers with young children join the program.

Information obtained through the *Process Evaluation Study* clearly demonstrated the effectiveness of having PHNs make initial telephone contact with all new mothers in the community. In the year 1996, PHNs successfully contacted 315 of the 361 St. Jamestown families in which a new baby had been born. This population based approach to initial telephone contact, or more specifically the Birth Registration Notice route of referral, accounted for 45% of program referrals during the year 1996. Beyond the fact that PHN contact provided an effective means for encouraging participation in the G.T. program, those mothers who were not interested in participating in the program were provided with immediate nursing services. Almost one-half of the 124 families who refused Growing Together services, received an initial assessment of infant and maternal health as well as any required interventions.

Names of families who agree to be referred to the G.T. program are passed on to the program's Intake Worker. Contact by a G.T. Intake worker was found to be an effective method for further encouraging program participation as well as facilitating the successful completion of the Risk Factor Assessment Interview. Of the 153 clients contacted by the G.T. Intake Worker in 1996, 41% joined the program.

Both PHNs and Infant Mental Health Workers complete Risk Factor Assessment Interviews with families once they agree to the program. In 1996, 106 Risk Factor Assessments were successfully completed. Workers identified the Risk Factor Assessment interview as a critical tool in the assessment of a family's risk and in the assignment of an appropriate service plan. As research has shown, considering both the number of risk factors and those immediately

impacting on the child, as well as any protective factors, is crucial in order to be able to offer the most appropriate treatment strategies. Team meetings provide a critical forum for discussing collected information and risk assignment.

In considering the short-term impact of counselling/therapy services on families, the RFA proved to be a useful instrument for demonstrating change in the overall functioning of families and their related risks. Still, there are groups within the program for whom RFA data may fail to be collected or be incomplete. Families who enter the program through routes other than the usual Birth Registration Route, for example, may not complete an RFA interview. Mothers referred to the program through a community agency may directly join a group and therefore not complete the RFA interview. As well, mothers with older children may not be asked to complete the interview since items are directed primarily toward infants. The usefulness of the RFA information for both clinical and research purposes suggests the need to promote the completion of interviews with all willing parents.

B. Ongoing and Regular Monitoring, Assessment, and When Necessary, Referral to Intervention Services:

Each demonstration of the model will have in place a system for regular monitoring of child development and family well being, for all children of families who participate in the program. Children will be developmentally assessed when appropriate and when necessary consultation and/or referrals will be made to relevant services within the program or to outside agencies. In order to monitor the development of children an Infant Monitoring System will be put in place consisting of questionnaires mailed to parents at regular intervals after the birth of the child. Each program will include a Developmental Clinic for testing and consultation by a Paediatrician, Public Health Nurse, Psychologist, and a Speech and Language Pathologist.

Currently there are over 200 G.T. children who are being monitored through the Infant Monitoring System. The majority of families who have enrolled in the System have continued to complete packages over time, with very few drop-outs. Clients are receptive to this approach to service, in particular, it is an important method for ensuring families who are disinterested in program participation have opportunity to have their child's development monitored and tracked. Mothers completing the System felt the questionnaires provide important educational information about child development. In cases where parents feel anxious about suspected delays, the IMS may help to facilitate greater attunement to children's capabilities as well as their

delays. Such was the case for Siva's mother whose story appears in the form of a case study in Chapter V of the *Short-term Impact Study* report. By answering IMS questions and talking with a project Infant Mental Health Worker, this mother was able to move toward bringing her developmental delayed child to the Clinic for further assessment and receiving intervention through other aspects of the program. It has been clearly demonstrated in research studies that completing interviews and questionnaires and observing developmental assessments can inform parents about what to expect of their children, can enhance their ability to provide their children with age appropriate activities and improve the developmental outcomes of children (Squires & Bricker, 1991; Landy, DeV. Peters, Arnold, Allen, Bookes, & Jewell, 1998).

Four case studies appear in the *Short-Term Impact Study* report, illustrating the variety of families who use the clinic. Presented cases included: 1) a two year old child who was misdiagnosed as PDD but who was language and speech delayed; 2) a baby who had been born with physical abnormalities and a hormone deficiency; 3) a multiply developmentally delayed infant whose difficulties had previously been attributed to her prematurity, and 4) an infant with no developmental or physical problems, whose mother remained anxious about her baby's crying and feeding patterns. In review of these four cases, Clinic services were found to have been provided in a convenient, friendly environment, and in a culturally sensitive manner. The specialized skills of the Developmental Clinic's multidisciplinary team, offered opportunity for the early assessment of delays, the implementation of intervention approaches, and the tracking of children's development over time. The speed with which parents were able to access Clinic services provided assurance that children's development was assessed as early as possible. As well, having highly skilled workers who are flexible enough in their schedules to conduct observational sessions with children in a variety of settings, including their homes, is seen as essential when working with attention challenged children and anxious parents.

Children who attend the Clinic represent a substantial portion of the program's total population (37%). At the Developmental Clinic parents receive assessment services from two PHNs, a Paediatrician, Developmental Psychologist and Speech Therapist. One-hundred and twenty-eight children were seen by Developmental Clinic staff during the year 1996, over half were under one year of age. Review of clinic files showed that 55% of the children seen at the Clinic in a one year period were identified as having a health and/or developmental problem.

Consistently mentioned by program workers as a critical component of the program were the services provided through the Developmental Clinic. Workers noted that these services act as both an easy and convenient point of entry for families while also providing an assurance that children's health and development is proceeding on course. In those cases where workers have

concerns about children's development and/or health, Clinic services offer critical support and guidance in terms of how best to facilitate children's progress. Likewise, local community service providers identified the Developmental Clinic as a valuable service to which they often referred families in need of assessment.

Children being monitored through the IMS, those who are seen by G.T. workers, and families working with outside agencies all benefit from G.T. Developmental Clinic services. The fact that services are readily available without a long waiting period and conveniently located within the neighbourhood has made these assessment services extremely user friendly and popular.

C. Child Intervention Programs:

Each model will have a set of programs that are provided directly to the child. These may include play groups, treatment of developmental delays, child care, and so on.

Currently there are over five hundred children and their families enrolled in the Growing Together program. Programs directed toward servicing the specific needs of infants and young children are continually developing as more resources become available.

The funding through the TLC^3 program now allows children identified with delays to access needed services as soon as their problems are identified. As of 1997, the G.T. program has been augmented by the TLC^3 program. TLC^3 provides the services of a Speech Pathologist one day per week, a Tamil Home Visitor one day per week, a part-time Co-ordinator of the Preschool Program, and a full-time Resource Consultant. This program has been an important addition to the program as it provides greater opportunity to ensure recommendations made by Clinic staff can be implemented as soon as possible. Chapter V of the *Short-Term Impact* report contains case studies on Developmental Clinic cases. In the three cases for when delays were identified, all clearly benefited from the services of the TLC^3 program. Currently over thirty children are receiving TLC^3 services for the treatment of their developmental delays. Research on the success of early intervention clearly demonstrates that programs that impact directly on children (e.g., therapeutic preschool program, daycares) are most likely to enhance the development of children (Barnett, 1995). When programs for parents are also included their effectiveness is enhanced (Achenbach, Phares, Howell, Raugh, & Nurcombe, 1990; Johnson, 1988; Lally, Mangione, & Honig, 1988).

Child based group interventions, such as the *Preschool Group* and the *Saturday Morning Club*, are available at the program site to encourage optimal child development. The Preschool Program specifically aims to enhance the development of children with cognitive or language delays. Consequently, the program used specific strategies to enhance these delays. Considered within the *Short-Term Impact Study* was the effect of children's participation in the *Preschool* program. Attendance at the *Preschool Group was* associated with important gains for the three to five year olds participating in the group. Children were rated by the group leader as being significantly less shy and withdrawn after three months participation in the group. Mothers rated their children as being significantly less hyperactive and distractible and noted gains in their physical and language development after attending the group for three months.

Providing children with opportunities to socialize and join in activities with others their age was noted by mothers as a primary motivation for attending the *Preschool Group*. The *Saturday Morning Club*, which is operated by Junior League volunteers, provides an additional time when parents can bring their children for crafts and play. Currently the program has 25 children enrolled.

Another important child focused program has been the child care services offered to mothers who are attending groups at the project site. Child care services provide children with a safe and healthy environment where they have opportunity to learn about co-operation and play in a structured setting, while also learning to adjust to separating from their parents. Over the course of a one year period, 166 children participated in the child care program which is largely staffed by volunteer workers.

The impact and popularity of these child focused services demonstrates their continued importance.

D. Programs that Emphasize Enhancement of the Parent-Child Interaction and Relationship:

Each model will provide services which can include direct intervention with the caregiver-infant/child dyad, provision of parenting information and health promotion. In certain situations parents may receive counselling, therapy or crisis intervention if, for example, a mother is depressed, a parent has an emotional or psychiatric condition, parents are abusive or violence is present in the home. These interventions may be

provided to individuals, dyads, families, or groups and can be provided in the home or at the centre.

Therapy/counselling services for parents and their children are provided by PHNs and Infant Mental Health Workers during home visits, office visits, and in groups. Counselling and therapy activities provided by PHNs, Infant Mental Health Workers, and the program's staff psychiatrist include: giving parents an opportunity to build a caring relationship with a worker and move toward resolving early life trauma, offering psychiatric services to parents displaying psychiatric problems, providing crisis intervention services, and providing infant/child focused interventions to encourage optimal child development.

Based on information obtained through the 1996 DPH file review, it was concluded that 219 clients received counselling from PHNs during that year. Infant focused interventions are commonly provided by PHNs when infants are between two weeks and two months of age. In 1996, nurses provided infant focused interventions to 176 St. Jamestown families. Interventions typically included guidance around feeding, nutrition, and general health.

The promotion of breastfeeding and proper nutrition pre- and post- natal occurs through PHN home visiting as well as through group programs such as the *Prenatal group* and *When Baby Comes Home.* In a one year period, 61 women attended the *Prenatal group* and 44 attended *When Baby Comes Home.* As evidenced by the Short-Term Impact Study findings, both groups are meeting their objectives of promoting the birth of health babies and encouraging positive parenting practices. *When Baby Comes Home,* was shown to increase parents' knowledge about infant development, improve mothers' sense of competence in the parenting role, and provide mothers with a sense of support. The *Prenatal Group*, was shown to be highly successful in meeting the objective of promoting the birth of healthy infants. Of 34 infants born to women who attended the group between April, 1997 and March 1998, 32 were healthy and had birth weights in the normal range with complications having been experienced by only two infants. In the year 1996, 155 parents took part in G.T. offered parenting group programs.

Assistance received from G.T. workers by those interviewed for the counselling/therapy component of the *Short-term Impact Study* was found to be extensive and vital to women's sense of well-being. Counselling/therapy interventions provided by PHNs and Infant Mental Health Workers encouraged the expansion of women's parenting skills and knowledge. Receiving needed information and assistance in a respectful, convenient and immediate manner was most supportive for women faced with health concerns and at times medical issues. In all

likelihood, these elements of service delivery facilitated women's improved ability to build a meaningful relationship with their workers over the Study's brief four month period.

Infant Mental Health workers, according to monthly statistics, provided 69 clients with 1275 therapy sessions during the year 1996. These interventions generally occur after PHN involvement has ended. Infant focused interventions include play therapy, parent-child interactional work, and interventions focused on children's developmental delays. Crisis intervention efforts, directed toward alleviating the immediate stressors in the lives of families, is undertaken by all staff.

Demonstrated in the *Short-term Impact Study* was the fact that the women who received counselling/therapy services showed improved psychological functioning over the four month period. As a group, their potential for psychological problems decreased as did signs of depression. As well, women showed a significant increase in their sense of mastery, expressing a greater sense of control and problem solving ability. Most encouraging was the fact that the overall risk to children's outcome, as measured by the RFA interview, decreased during the course of the four month Study, with fewer families being identified at Study's end as being a 'high risk' for a negative child outcome.

In addition to individual therapeutic services, therapeutic groups, like the *Anger Management Group* and the *HEAR* parenting group serve to help parents cope and function better as parents. The *Anger Management Group* was found to have facilitated women being better able to identify their feelings and emotions and control their anger. Anecdotally it was noted by leaders that the women, whose ability to identify, express, and process emotional states had improved, also showed an improved ability to problem solve as well as explore and show interest in their children's feelings. At the end of the group women showed significant gains in their levels of self-esteem and in their sense of support. Although the *HEAR* was not evaluated for this report, it has been shown to be highly effective in enhancing parenting interactions and reducing problems in a recent long term study.

Services that enhance the parent-child relationship are a central focus of the program. Research clearly shows that a variety of approaches to improving the mother-infant/child interaction can be effective. Some more short-term approaches hold considerable promise for community-based programs but also need to take into account, that particularly with high-risk, complex situations, it may take some time in order to build a relationship and the necessary trust before these approaches are seen as acceptable and can be provided.

E. Programs that Offer Family Support:

Each model will provide services aimed at building a support network for families and links to relevant services in the community. The building of a nurturing worker-client relationship is seen as crucial and attendance at groups may occur as a way to reduce isolation, to learn new skills, and to enhance parent competencies (e.g., computer skills, conversational English, community kitchens).

A global objective of the G.T. program is to increase families' support networks and use of community services as well as to decrease isolation.

Through group participation it is expected that a greater sense of support and community will develop among families living in St. Jamestown. Findings of the *Short-Term Impact Study* demonstrated that group involvement did indeed encourage a sense of belonging and sharing amongst mothers. Their comments which appear in Chapter III of the *Short-Term Impact Study* report, illustrate mothers' appreciation in feeling accepted by others. Also, women enjoyed opportunity to learn from other mothers. In the case of the *English Club*, women's level of community involvement was found to increase as their English skill levels also increased.

Another important supportive program component is the provision of Advocacy services for clients who are living in a high-risk neighbourhood. A Community Home Visitor with the project specializes in helping clients meet their daily life needs. One hundred and forty-eight families were referred to this worker (CAP-C, 1998). Additionally, workers, in general, often assist individual clients as needs arise. By offering parents practical assistance with needs around housing and food, parents are better able to focus on the demanding task of parenting. The short-term impact of Advocacy services on families was assessed as part of the CAP-C evaluation initiative. Findings were briefly discussed in Chapter VI of the *Short-Term Impact Study*. It was shown that after provision of Advocacy services, women's depression scores dropped but women's experiences of difficult life circumstances changed very little over time. While the internal states of people assisted by the program's Advocacy worker do seem to shift when assistance is provided, the external life circumstances of families are more difficult to change.

Referral of G.T. clients to other services within and external to the program encourages the appropriate use of services by families and further increases their support. In the *Process Evaluation Study* it was noted that the G.T. program successfully receives the referral of

community families to the program as well as referring clients to external services. Case consultation is also provided by staff to child protection agencies, schools, and day care centres. Throughout the *Short-Term Impact Study* it was evident that clients are very satisfied with the services received at the G.T. program. Through affiliation with the G.T. program hard-to-service clients have opportunity to develop a caring and trusting relationship with a worker. In turn, these clients may be more willing in the future to utilize additional community services.

Research would suggest that while helpful these supportive services are likely to have their impact on children by mediating the improvement of parent-infant/child interaction. The finding that these approaches are most likely to be effectiveness when mothers report a need for them and may in fact be negative if less need is perceived by the parent, should be carefully considered in offering this kind of intervention to families (Affleck, Tennen, Rowe, Rescher, & Walker, 1988; Dunst, Snyder, & MacKinnen, 1988). Caution is also necessary in including interventions to provide employment skills, educational classes and so on, as research suggests that these types of initiatives have few direct effects on children and over time appear to have few effects on parents' income or employment, or on maternal variables such as depression, self-esteem or use of supports.

F. Community Development:

Each model must establish a community development component, to enhance the living conditions of families. These may include a community safety program, neighbourhood enhancement initiatives, community advocacy activities, community events and so on.

Community Development activities of the G.T. program have served to: encourage a sense of belonging amongst community members, facilitate community organizing, encourage parents' use of current capacities and further learning, and support parents' business activities. This work has been accomplished by facilitating support groups, community organizing, networking with community service providers and becoming involved with local planning committees, and by organizing and planning large community events.

During 1996, six community events resulted in the participation of over 1000 community members. Activities helped to encourage community involvement as well as educate adults about parenting and the G.T. program and provide opportunity for celebration. Program workers felt community events play a critical role in making the program visible in the community, bringing both residents and local service providers together. Community members

were shown to have an increasingly important role in planning the content and implementation of many of these G.T. events.

In partnership with community members, G.T. workers facilitate and participate in community groups and committees that focus on identifying community needs, organizing for social action, and implementing improvement projects. Since the start of the G.T. project, eleven such initiatives have been undertaken, some of which include a St. Jamestown Safety Committee, a Community Garden, and a Community Art Show and Safety Fair.

Skills training groups at the project enhance parents' sense of self-confidence and competence, help them to be more employable, and encourage their seeking and advocating for needed services. Examples of such initiatives include: the *English Club*, the *Community Kitchen*, and the *Computer Skills Training Project*.

Critical to Community Development activities is a commitment to determining and responding to the needs of community members. The establishment of services which facilitate business skills and help families reach their capacities are often needs expressed by clients. The *Computer Skills Training Club* has been a successful initiative targeting the employment skill needs of local residents. Currently the program has trained forty-seven clients and there are over seventy individuals still on the waiting list.

With more children in areas such as St. Jamestown living in poverty, community development initiatives become particularly crucial. To date, although there is a significant amount of research on community development, there is no research that has shown it to have had significant effects on early child development. However, the idea of improving the environment in order to reduce risks and enhance health and development has appeal and theoretically, is consistent with the ecological and transactional approach to intervention adopted by Growing Together.

7.3.2 Principles of Practice and Operational Features of the Program

Although determining the essential components of the program is important, some of the principles of practice and operational features of the program are also critical for the Growing Together model to be effective. These are outlined fully in Tables 17 and 18. Aspects of these tables are briefly discussed below and are also examined in Chapter I of this report.

Table 17
Growing Together: Principles of Practice

(Principles That Guides All Program Provision)

Child Development is the Focus	Although many of the programs are provided directly to parents and caregivers, the focus and goal of Growing Together is the healthy development of the children.
Ecological or Transactional	The Growing Together model views child development as unfolding in the context of multiple interdependent systems of influence of the child, parent-child interaction, family, community and society. This perspective guides the assessment and intervention strategies of the program.
Respect, Trust and Caring	All relationships at Growing Together must reflect respect, trust and caring for all involved – program participants, staff and community members.
Flexible, Culturally Sensitive Services	Growing Together programs provide services that are flexible and culturally sensitive in order to reach immigrant and non-French or English speaking families.
Accessible	Growing Together programs will operate in convenient locations and during non-traditional hours to reach out to families. When necessary, Growing Together will provide childcare and other supports to encourage active participation in the programs.
Adaptation to Reach the Most At-Risk Families	Certain programs will be developed in each Growing Together site to reach the most at-risk families.
Consideration of Strengths and Protective Factors	All Growing Together program will build on participants' assets and strengths, while at the same time developing interventions to alleviate risks.
Seamless Services	Families involved in the Growing Together model can pass easily from one service to another as needs are identified, risks are alleviated or the family becomes willing to accept a particular services.

Eight Principles of Practice are noted in Table 17, considered to be amongst the most important are the following: having an ecological or transactional model; promoting respect, trust and

caring relationships; providing flexible and culturally sensitive services; and adapting program services to meet the most at-risk families.

An ecological model, in which the child's development is seen as unfolding in the context of multiple systems, guides the assessment of families and the development of a diverse array of services for all those dealing with the demands of parenting.

The respect, trust and caring demonstrated by workers was a critical theme mentioned by mothers who were interviewed as part of the *Short-Term Impact Study*. Participation in groups as well as individual counselling/therapy services led to women feeling socially supported by workers and other mothers. Mothers receiving counselling/therapy services in particular noted a strong sense of belonging had resulted for them during the course of receiving brief intervention services. Offering on-going support in a caring and sensitive manner, having easy access to workers through convenient home visits, and the provision of instrumental assistance by workers, were positive elements identified in the service experiences of clients who were interviewed about their participation in the project.

Giving workers flexibility to address the full range of a family's needs was highly important to clients as well as workers. Providing crisis intervention services, assisting with instrumental needs, and taking part in every day events, such as birthday celebrations, is essential to establishing caring relationships with families. Program workers need to be available to accommodate the multiple needs of families as they arise.

Providing services in a culturally sensitive manner was also noted by clients as a very important program consideration. Making Infant Monitoring System questionnaires available in Tamil for those in the community who do not speak English has proved very important for encouraging the use of this system. Likewise, having workers on staff who represent the various dominant cultural groups found in the community was noted as very important by outside community service providers as well as program staff. Responding to the needs of the most high risk families by providing transportation, child care, and snacks to encourage their attending groups and having available a variety of approaches that can enhance their sensitivity to their children's needs, is also critical.

Key Operational Features are identified in Table 18, noted as being particularly important are: providing home visiting during the postnatal period and on an on-going basis for those identified as in need of further intervention, and offering a full range of services to address the needs of all families.

An operational feature noted as most essential by both program workers as well as clients was the use of home visiting as an outreach strategy and as a method for the continued delivery of services. Mothers felt services provided in their homes were convenient and appealing since they were afforded one-on-one time with workers who could address their questions, concerns, and issues as needed. Going into people's homes and seeing their daily life circumstances provided workers with additional insight. Interventions, whether addressing breast feeding difficulties or parent-child interaction patterns, are often more effective when parents are in a comfortable and familiar surrounding, such as their own homes. Family interactions, structural safety concerns, and environmental conditions are more easily understood and responded to by workers doing home visits. Research suggests that home visiting is a necessary but not sufficient characteristic of effective service delivery. However, having one-on-one time with workers may be essential to building a trusting and caring relationship for parents.

A full range of services, one in which services and approaches vary, was frequently mentioned by program workers as a critical aspect of a community-based program. The variety of program services available at the program were considered to be comprehensive and able to meet the needs of families representing a wide array of risk-levels as well as cultural backgrounds. The inclusion of services to address the various needs and interests of parents encourages community wide participation. Having interest groups, for example, such as craft groups, not only allows low-risk mothers to explore personal interest areas, but also provides opportunity for more high-risk mothers to have normative social experiences and an opportunity to develop supportive relationships. Specially designed interventions to meet the needs of the most high risk families is also important. Having these programs available in the home and at the centre has proved effective for meeting the needs of a variety of families.

Table 18
Growing Together: Operational Features of the Program

High Risk Area	Each demonstration of the model operates in a high risk geographic area.
Families with Pregnant Mothers, Infants and Young Children	Programs are offered for families from conception and with infants and young children up to the age of six.
Universal Access	Within the area some of the programs are offered to all parents with young children. Growing Together does not have further eligibility requirements in order to join the program.
Partnership and Collaboration	The model may be provided by a variety of partners who co-operate to provide the essential program components. As well the program networks with other agencies in the area who provide early intervention services.
Multiple Funders	The model is not funded by only one organization but is funded by a variety of public and private sector funders.
Location	Each Growing Together model must have a location within the geographic area it services. The location should be accessible to families who use the services and should house some of the programming and administration of the program. It needs to be identified as the nerve centre of the program within the area. It is not enough to have a virtual network of services without a physical centre, and the physical identity.
Outreach Through Home Visiting	Each model must provide home visiting for all families in the immediate postnatal period. Home visits will be provided on an on-going basis to families who are isolated, cannot attend the centre-based programs or whose children are believed to be at-risk for compromised development. The content of the home visits will be determined by the needs of the family and will vary in duration in function of the difficulties the family is dealing with.

Table 18 (Cont.)
Growing Together: Operational Features of the Program

Services are Provided by a Multidisciplinary Team	The various interventions and programs are provided by a multidisciplinary team consisting of professionals from public health, mental health, and social services. In addition, community home visitors from various ethnic groups represented in the are may be represented on the team.
There will be a Range of Services Provided at the Centre	The program will provide a range of services at the centre including parenting groups, skill-based programs, and interventions directly for children. These will provide parents with opportunities to meet other parents and thus to reduce isolation and will reduce the number of families who need on-going home visiting.
Full Range of Services	Each Growing Together model must provide a full range of services appropriate for families who face significant challenges and for those families whose needs are for information on child development and parenting.
Training and Mentoring	Growing Together staff will provide on-going training and support to a variety of students and volunteers.
Parent Participation in the Design and Provision of the Model	Parents have meaningful and significant roles in the design and implementation of the Growing Together model.
High Quality	Growing Together staff have a high level of professional training and/or supervision, and programs are of high quality through adequate resourcing, support and planning.
Continuous Monitoring of the Quality of the Services	Staff regularly review risk assessments, case formulations and case reviews in order to evaluate the progress of families. Other program components are monitored by the collection of regular statistics.
Evaluation	Each site will establish and maintain an Information Management System (IMS) in order to provide information on an on-going basis on client characteristics and participation and the number and type of programs being offered. Each demonstration of the model will agree to participate in and collaborate in the design and implementation of a cross-site evaluation framework.

7.4 Recommendations, Suggestions for Future Research

7.4.1 Program Recommendations

Based on the findings of the *Short-term Impact Study*, *Process Evaluation Study*, and the surrounding literature, the following recommendations are proposed:

1. It is absolutely critical that a budget be put in place that can assure the continuity of the essential components of the program. The current practices of periodically cutting staff days and providing no security in positions is not acceptable nor productive.

2. Efforts should be made to expand services that are provided directly to children especially for those children who are at significant risk.

3. The program must continue to research and develop a number of individual, mother-child, and group approaches to meet the needs of the most multi-challenged families and to develop clear models that can be shared and made available to other agencies.

4. Caution should be used when developing programs and services. In particular, any tendency toward trying to 'do it all' should be avoided. Such a tendency can result in spreading staff and resources so thin that a little is accomplished in many areas but not enough to be significant and to affect child development.

5. Additional funds will need to be provided if further research is to take place. The program's current resources cannot be used to carry out research without severely compromising the integrity of service delivery.

7.4.2 Limitations of the Research and Suggestions for Future Research

A fundamental limitation of the following research was the small number of participants included in the assessment of certain groups as well as the counselling/therapy services.

It was extremely difficult throughout the project to maintain the involvement of group participants. As was noted in Chapter II, 44% of group data was incomplete. In a community-based parenting project, clients attend groups as they are able and when young children are involved, sessions are inevitably missed due to illness, bad weather, and schedules. In addition

to this difficulty, open-ended groups made attempts to collect pre- and post- group data problematic and in most instances efforts were abandoned. It remains unclear whether those whose data were not completed were significantly different from those clients who completed the Study.

There is further concern over the validity of the findings when consideration is given to the multi-ethnic population of the program. Questions of whether particular measures, such as measures of self-esteem, are culture fair is a concern of this. The omission of clients whose language skills were not sufficient to include in the Study further raises the question as to whether these clients are benefiting from services in the same way as those for whom data was collected.

Particular measures were found to be less informative than others. The social support measure, for example, was perhaps too brief to capture changes except when used with mothers from very high risk situations who had very few supports. It was noted that certain segments within the community, such as Tamil families, already have well established networks of support. Reduction in families' social isolation was more accurately captured through women's self reports than by this brief standardized measure. In order to assess more subtle changes in women's sense of support other more sophisticated measures of social support may need to be implemented.

The essential components of the Growing Together Program have been confirmed by a variety of data. These data are limited, however, in that there were no comparison samples included in the study design. Therefore, client changes between pre- and post- test periods cannot be confirmed as the absolute result of program participation. Also, there was no follow-up of clients following post-testing making predictions about the long-term effects of the interventions impossible.

Further research would be required to answer more complex questions about the program's long-term impact on children. Assessment of the short-term impact of services largely focused on service components directed toward the parents, since tracking infants over a short-term period, such as a few months, would likely not be a sufficient time frame to demonstrate change. Only one child focused intervention, the Preschool group, was included in this Study. In order to determine the long-term impact of the program on children, a longitudinal path analytic design, using multiple comparison samples will be necessary. As well, in order to fully evaluate child outcomes, interactional measures and assessment of child competencies will be necessary.

Contributing toward a second generation of early intervention research should be considered as a possible direction for future research proposals. In this approach, smaller studies would compare various program strategies and determine, for example, how can services best be provided, for whom do various strategies work best, and for how long do services need to be provided?

7.5 Conclusion

Although this short-term impact study has a number of methodological limitations, the very positive outcomes following participation in all the aspects of the program examined, (i.e., groups, counselling/therapy, Developmental Clinic, and advocacy services), suggest that they are reaching many of their objectives and meeting the multiple needs of clients. A continuing theme throughout the findings has been the significant satisfaction that parents report about the way in which the services were provided, noting them to be convenient and flexible and delivered in a friendly, respectful and culturally sensitive manner. This style of service delivery and the in-centre component of the program enables mothers to experience a strong sense of belonging and friendship as the interventions, individual or group, allowed parents to share their feelings and gain confidence.

As a result of various aspects of these services, parents showed gains in parenting knowledge, sense of parenting competence, ability to manage their anger, self-esteem, various skills such as computer and English language skills, and reduction in psychological problems and depression and in risk for children's development. Infants were more likely to be born full-term and healthy and to be breast fed and children showed a number of developmental gains as a result of receiving direct services.

On the basis of these results, as well as those of the *Process Evaluation* and findings from early intervention research, a list of essential components, principles for service delivery and operational features of the program were developed and are listed and discussed. These listings are supported by various findings but it will require further research before their effectiveness and the program model can be completely verified. In order for the question of the model and effectiveness of the model and its components is answered, a long-term outcome study of the program's effect on young children's development will need to be completed. As well, research on the effectiveness of various intervention strategies with waiting list controls, comparison of different interventions and longer-term outcomes will need to be conducted. This 'second generation' of research will gradually allow the program to determine what aspects of the total

program are effective, with whom, and at what level. With this kind of research the important data provided in this short-term impact study can be built upon and the effectiveness of the program more clearly determined.

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Appendix A: Measures Used in the Study

Measures	**Purpose**	**Items/Time**	**Reliability**		**Validity**	
			Test-retest	**Internal Consistency**	**Concurrent**	**Construct**
Centre for Epidemiological Studies-Depression Scale (CES-D) (Myers & Weissman, 1980)	Access depressive symptoms in the past week. Is a screen only to identify subjects for further assessment.	4-point scale, 20 questions to access frequency/ intensity of the symptom. 5 minutes.	*r* varies from .48 to .50 after 3 months	--	Correlates between .8 and .3 with other depression scales.	Has been used in large epidemiological studies to estimate levels of depression in the population.
Child Development Inventory (CDI) (Ireton, 1992)	Provides profile of a child's development in areas of gross and find motor, expressive language, language comprehension, self-help, social, letters and numbers.	Questions under each domain. One half hour to complete.	Varies from .53 to .86	Various scales range from .42 to .95	CDI scores correlate significantly with all scores except social and gross motor	Identified all of 26 children who later needed early intervention.
Community Involvement Checklist. Developed for PFBB	Designed to assess both the individual's sense of community and cohesion of neighbourhood as-a-whole	39 item self report scale. 5 minutes	r=.95	r=.95, coefficient alpha reliability	Correlates with level of social support	Discriminated well amongst 3 neighbourhoods selected as differing in cohesion
Dimensions of the Therapeutic Relationship (Greenspan & Wieder, 1987)	To measure progress in therapy in three areas: regularity, relationship, and process.	Three likert sckales, 10 minutes f or therapist to complete	N/A	N/A	Correlates with other measures of care-giving functioning	Discriminates between high and low risk groups over time

Appendix A: Measures Used in the Study (Cont.)

Measures	**Purpose**	**Items/Time**	**Reliability**		**Validity**	
			Test-retest	**Internal Consistency**	**Concurrent**	**Construct**
Difficult Life Circumstance (Barnard, Booth, Mitchell, & Telzrow, 1983)	Assesses degree of difficulty parents are facing.	28 items and parent is asked to check which one applies				
Early Child Care Questionnaire (Gross & Rocissano, 1988)	Measures the degree of confidence mothers have about caring for their children.	38 items rated on a Likert Scale of 1-5, 5-10 minutes.	.87 over a 4 week period	.91 to .95	Positive relationship between maternal confidence and parents knowledge of child development and parenting	High correlations with child outcomes and parent-child interactions
Family Assessment Measure (Byles, Byrne, Boyle, & Offord, 1988)	Assess level of family dysfunction	12 Questions, 4-point scale., 5 minutes	Ranges from .66 to .76 for various scales	Cronbachs alpha reached .86	In OCHS showed high relationship to mental disorder than any other measures	--
Feeding Measure (Developed for Growing Together)	Assess feeding patterns of infant/child	12 questions	N/A	N/A	N/A	N/A
Health Status Questionnaire for Child (Growing Together)	To assess any past and present health problems	9-item scale takes about 5 minutes.	N/A	N/A	N/A	N/A

Appendix A: Measures Used in the Study (Cont.)

Measures	**Purpose**	**Items/Time**	**Reliability**		**Validity**	
			Test-retest	**Internal Consistency**	**Concurrent**	**Construct**
Knowledge of Infant/Child Development Inventory (KIDI) (MacPhee, 1981)	Measures parents' knowledge of child Development and parenting	58 statements which parent agrees or disagrees with.	N/A	N/A	N/A	N/A
Kohn Social Competence Scale (Kohn & Rosman, 1972)	Used to assess cooperation and interest and participation	Takes about 10 minutes to complete by observer and child	Inter-rater reliability *r*=.77 - .80		Scores can distinguish children with behavioural disturbances in daycare and school	Moderately predictive over time of behaviour problems
Maternal Self Report Inventory (Shea & Tronick, 1988)	Measures maternal self confidence in the post-partum period	26 items rated on a Likert Scale of 1-5, 10-15 minutes.	*r* = .85		Correlation of total scale with another self-esteem measure of .75	High correlations with 16 important independent variables
Parenting Practices Scale (Strayhorn, 1987)	Measures parents disciplin practices and affective tone.	34 items rated on a 6-point scale. 15 minutes. Shorter version used in NLSCY	*r* = .79 for six months	*r* = .78	*r* =.33 with parent videotaped behaviour	Distinguishes between children with and without behaviour problems
Parent Satisfaction Scale (Developed for G.T.)	To assess parents' satisfaction with various program components they have used.	35 questions yes, no and ranked as most important	N/A	N/A	N/A	N/A

Appendix A: Measures Used in the Study (Cont.)

Measures	**Purpose**	**Items/Time**	**Reliability**		**Validity**	
			Test-retest	**Internal Consistency**	**Concurrent**	**Construct**
Pearline Mastery Scale (Pearline & Schooler, 1978)	Measures perceived control of life events	7 items using a Likert Scale 1 to 5. 5 minutes.	Correlations of .44 reported	Range from .73 to .80 for each item	Stressful events such as job loss reduce sense of personal efficacy	Predicts depression when scores are very low
Personality Assessment Screener (Morey, 1991)	Provides rapid screen of broad range of different clinical issues.	22 questions 4 point scale	Correlation of .88 reported	.71 to .77	Every clinical scale on both the PAI and the MMPI correlates postiviely with the PAS Total Score.	All groups with a diagnosable mental disorder display an elevated score on the PAS Total Score.
Preschool Behaviour Questionnaire (Behar & Stringfield, 1974)	To screen 3 to 6 year old children for emotional problems (parent report)	30 items rated on 3-point scale	*r* = .87	N/A	Correlates with teacher reports	Distinguishes between preschoolers with behaviour problems and without
Risk Factor Assessment (Landy, 1995)	Assesses the level of risk for a child for compromised development	Short and Long Version (58Q)	N/A	N/A	Correlates with degree of distress reported by families	
Self Esteem Measure (Rosenberg, 1965)	Measures perceived acceptance and self worth	10 items using a Likert Scale 1 to 5, 5 minutes.	*r* = .85 over 2 weeks	*r* = .92	*r* =.56 -.83 with other similar clinical measures	Related to other measures such as those of shyness

Appendix A: Measures Used in the Study (Cont.)

Measures	**Purpose**	**Items/Time**	**Reliability**		**Validity**	
			Test-retest	**Internal Consistency**	**Concurrent**	**Construct**
Social Support Provision Scale (Cutrona & Russell, 1989)	Measures social support from family and friends	6 items rated on a 4-point scale. 5 minutes.	*r* = .92	*r* = .85	Correlations with other social support measures are high	Correlates with a number of measures of the individuals interpersonal relationships.
State and Trait Anger Expression Inventory (Spielberger, 1979)	Measures the experience and expression of anger	44 items, 4-point scale Almost never to Almost always			For the anger scale .66 to .73 and for Anger expression scale .05 to .47	
Toronto Alexithymic Scale (Bagby, Taylor, & Parker, 1994)	Assesses ability to differentiate and identify feelings, express feelings, and reflect .	20 items scored on 5-point score Time 10 min. Strongly disagree to Strongly agree.	--	Mean alpha .79	TAS was signficantly correlated with external observer rating with clinical population p<.01	TAS is signifcantly correlated with psychological mindedness p<.01
Use of English Questionnaire (Developed for G.T.)	Developed for Growing Together, assesses use of English in a variety of everyday settings.	28 items - 3-point scale	NA	NA	NA	NA