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# Exploring mothers' perspectives of an intensive home visiting program in Australia: A qualitative study.

## *Abstract*

Intensive nurse home visiting programs are an early childhood, population based intervention that target vulnerable families. Programs are dependent on the relationship between home visitor and mother to bring about change. Few studies have focused on investigating parents' perspectives of these programs using qualitative methods and none in the Australian context. The aim of this qualitative study was to explore and describe mothers' perspectives of an intensive nurse home visiting program in South Australia. Eight in-depth interviews were conducted with mothers receiving the program. The findings indicated the role of a trusting relationship between nurse and participant as well as shared decision-making was central to program engagement and led to participant perceptions of increasing control over their role as parents. However, a clear distinction was made by the mothers: that they engaged in a relationship, not a program.



**Keywords:** home visiting; evaluation; qualitative studies; maternal-child health; maternal perspectives/views/attitudes.

## *Introduction*

Young children are particularly vulnerable to the effects of poverty and inequities in early childhood (Hertzman, 2010). Vulnerability can be broadly defined as families or individuals who have one or more of the following characteristics; teenage motherhood, low maternal educational status, low economic status, maternal substance abuse, Aboriginality, refugee status, domestic violence, disability and maternal mental health issues (Karoly et al, 2005, pp 6-14). The effects of being raised in an environment that renders infants vulnerable can translate into negative outcomes, including health outcomes, across the lifespan (Blair et al., 2003, pp 160-164). Negative outcomes include conduct disorders, child abuse, poor educational outcomes, teenage pregnancy, substance abuse, mental health issues and crime (Vimpani, 2005). Early childhood is the most important developmental stage and health interventions targeting this stage offer the greatest potential for long term change (McCain and Mustard, 1999). In recent years, there has been a focus on and investment in early childhood interventions both within Australia and internationally that aim to reduce health inequalities. Intensive home visiting is one approach that has been widely advocated in recent times.

## *Home visiting programs*

Home visiting is one of the most commonly used approaches to early childhood intervention for vulnerable families. In the US, home visiting programs extend to approximately 400,000 children each year (Watson & Tully 2008, p 7). The aim of intensive home visiting programs is to modify preventable risk factors for the health of mothers and children by raising the mother’s awareness of strategies to improve their own and their family’s health, developing responsive and confident care-giving and increasing social networks (Olds et al, 2002). Intensive home visiting programs can include between 30 – 50 home visits by nurses or

paraprofessionals during a client's pregnancy in the first two years of an infant's life. Of critical importance to bringing about change is the relationship between the home visitor and mother. The relationship must be strong enough to reassure and empower the mother to act on the information provided through the program and bring about positive change (Gomby, 2005). Program designs and models vary greatly in terms of home visitors, structure, syllabus and underlying theories. In Australia, intensive home visiting programs are predominantly implemented by nurses.

The Family Home Visiting Program in South Australia is a state wide intensive nurse home visiting program which was introduced in South Australia in 2004 as part of the South Australian Government's *'Every Chance for Every Child*' (DHS, 2003) framework for early childhood services. This program is premised on a universal population based strategy of universal contact home visits. During these visits families appearing most at risk are identified and their case is brought to a multidisciplinary case conference to discuss their eligibility to receive the intensive nurse home visiting program. Program eligibility is based on population and maternal assessment criteria (Family Home Visiting Service Outline, 2005). Population criteria include: mothers less than 20 years; an infant identified as Aboriginal or Torres Strait Islander; mothers who are socially isolated; and mothers expressing negative attribution towards their infant. Maternal assessment criteria includes: mothers who have a mental health issue impacting on parenting; maternal drug and alcohol issues; domestic violence impacting on parenting; a previous intervention from a child protection agency; a child born with congenital abnormalities; and nurse assessment concerns. When a family meets the eligibility criteria, they can be offered the program. The program is underpinned by the principles of the *Family Partnership Model* (Davis, Day & Bidmead, 2002). All program nurses are educated in accordance with this model. The South

Australian Family Home Visiting Program was chosen to explore mothers' perspectives of involvement, as it is uniquely the only state wide program offered in Australia.

## *Program evaluation*

Intensive nurse home visiting programs are costly and have been the subject of close scrutiny in terms of their health, social and developmental outcomes. Internationally these programs have been widely evaluated using randomised controlled trials. The most convincing evidence comes from the Nurse Family Partnership, which was evaluated in three sites in the United States of America (Olds et al, 1986, 1997, 2002). Over a 15 year follow up period, it was reported that disadvantaged first time mothers had gained the most from the program (Olds et al, 2002). The intensive nurse home visiting programs have also been evaluated in trials in Canada (MacMillan et al, 2005), the United Kingdom (Barlow et al, 2006), Australia (Armstrong et al, 2000; Kemp et al, 2008) and New Zealand (Fergusson et al, 2005). The measures used within trials assessed the impact interventions had on risk factors for poor child health and development. Examples include assessment of children's cognitive development, immunisation rates, attendance at emergency departments, verified child abuse, quality of home environment and the sensitivity of care-giver-child interaction. Despite having the potential to deliver major benefits to children (Gomby, 2005) many intensive nurse home visiting programs have demonstrated only modest improvements in health outcomes using these measures. Pawson & Tilley (2008, p 2) argue that interventions never work indefinitely in the same way and in all circumstances, and not at all for some groups. Other reasons for varying outcomes include differences in program design, lack of theoretical underpinning, and methodological weaknesses in the conduct of the evaluation (McIntosh and Shute, 2006).

A review of the published and grey literature indicated that while there was a heavy focus on program evaluation, the majority of evaluation reports do not include an investigation of clients' perspectives of intensive home visiting programs. There are five studies that have specifically investigated parents' perspectives of intensive nurse home visiting programs: two of these studies are from the United Kingdom (McIntosh & Shute, 2006; Kirkpatrick et al, 2007), two from Canada (Jack et al, 2005; Heaman et al, 2005) and one from the United States of America (DeMay, 2003). Five major themes were identified during the review of these studies, they included: negative preconceptions, trusting relationships, support, empowerment, and change. This literature suggests that parents valued participating in home visiting programs and as a consequence felt empowered to change.

The aim of this study was to explore mothers' perspectives of an intensive home visiting program in Adelaide, South Australia by exploring their experiences of participation in the program and their experiences of the program as empowering them to change.

## *Methods*

Qualitative methodology involves an interpretive naturalistic approach to the world, and attempts to make sense of phenomena in terms of the meanings people bring to them (Denzin & Lincoln 1994, p.2). These methods can answer the 'how' and 'why' questions and give an in-depth understanding of how complex interventions like intensive nurse home visiting programs work. Liamputtong & Ezzy (2005) argue that qualitative methods are appropriate for researching vulnerable groups. Women who participate in intensive nurse home visiting programs are identified as vulnerable and therefore a qualitative approach was appropriate to researching their experiences. Also, the research question was exploratory in nature and therefore a qualitative methodological approach was deemed appropriate.

This study draws on a poststructural theoretical framework. Poststructuralism is a theory of knowledge and language and is concerned with how discourses of power are constructed (Derrida, 1978; Foucault, 1980). This is achieved through the practice of deconstructing discourses. Deconstruction seeks to expose taken-for- granted assumptions underpinning our concept of reality however deconstruction aims to challenge rather than overturn existing beliefs and enables the unraveling and exposure of invisible assumptions that shape health-care practice (Cheek et al 1996, pp 188-191). In terms of this study, deconstruction enabled the voices and perspectives of mothers receiving the intervention to be heard and validated.

Ethical approval was received from Flinders University Social and Behavioural Research Ethics Committee and the participating organisation's Human Research Ethics Committee before commencing the study. In addition, permission to carry out research was gained from the Director of the targeted health service.

Techniques for ensuring rigour in qualitative research include theoretical rigour, methodological rigour, interpretative rigour, triangulation, evaluative rigour and reflexivity (Mays & Pope, 1995). Theoretical rigour was maintained by ensuring that the method and theoretical framework specifically addressed the research question. Methodological rigour was maintained by providing an explicit account of how the study was conducted in terms of sampling, recruitment, data collection and analysis (Silverman 2010, pp.275-288). Data validation was assured by matching the transcriptions against a replay of the audio-recordings for the interviews. Data from the first two interviews were assessed as part of an iterative process that helped shaped the interview schedule as the data were being collected. An audit trail was maintained by keeping meticulous records of meetings, emails, interviews, transcripts, and reflexive diaries throughout the study.

### *Data collection*

Participants were recruited purposively with the aim of selecting information-rich cases for in-depth study to examine meanings, interpretations, processes and theory (Liamputtong & Ezzy 2005, p.46). Study participants were recruited between February 2011 and May 2011. Recruitment of participants was facilitated through nurses working in the program. Nurses were given information on the research study and the importance of information-rich cases at team meetings. They were asked to identify potential participants, explain that there was a study about the *Family Home Visiting Program,* and give the participants the researcher's contact details. Potential participants were required to be over eighteen years of age; proficient in English language and have participated in the program for more than one year. Participants were then able to contact the researcher directly if they wished to participate. This minimised the possibility of coercing participants. A meeting was then arranged to provide the participant with an information package (information sheet, letter of introduction and a consent form). When informed consent was obtained, an interview time was then arranged. The interview schedule was developed from themes in the literature review and the aim and objectives of the research. The schedule was continually reshaped by reading around the themes and redefining concepts such as power and empowerment. The schedule was also reviewed following mock/pilot interviews. Two mock/pilot interviews were carried out to ascertain the relevancy of the interview schedule, to practice interviewing and to identify issues in interviewing style. Some of the main interview questions asked included: 'how did you come to be in the program?', 'how did you feel about being offered the program at that time?', 'can you tell me about your relationship with your nurse home visitor?', 'can you tell me whether the program has helped you or your baby in any way?' and 'can you tell me about any changes you have made as a parent since you've been in the program?' A total of

eight interviews were conducted. While eight interviews may be viewed as a small study, qualitative research is acceptably local, specific and contextual in nature.

Table 1 provides details of the study participants. The criteria column identifies the Family Home Visiting criteria under which the mother was referred to the program. Data were collected using the method of in-depth semi-structured interviews and each interview was audio-taped. Interviews were carried out in the homes of the participants and were arranged at their convenience.

**Table 1**: Study Participants

| Part. | Age | Criteria for referral by nurse to home visiting program | Length in Program |
|---|---|---|---|
| 1 | 20 | Mother < 20years.<br>Mother in domestic violence relationship.<br>Negative maternal attribution. | 22 months |
| 2 | 28 | Maternal mental health issues.<br>Mother in domestic violence relationship | 23 months |
| 3 | 33 | Maternal mental health issues.<br>Mother experienced childhood abuse. | 12 months |
| 4 | 25 | Maternal mental health issues.<br>Mother experienced childhood abuse. | 22 months |
| 5 | 19 | Infant identified as Aboriginal.<br>Mother < 20years.<br>Mother experienced childhood abuse.<br>Infant with disability | 12 months |
| 6 | 32 | Maternal mental health issues.<br>Negative maternal attribution.<br>Mother experienced childhood abuse.<br>Infant with disability | 22 months |
| 7 | 23 | Maternal mental health issues.<br>Mother experienced childhood abuse. | 13 months |
| 8 | 29 | Maternal mental health issues.<br>Mother experienced childhood abuse.<br>Negative maternal attribution. | 12 months |

### *Data Analysis*

The data in this study were analysed using thematic analysis as described in (Braun & Clarke, 2006). Thematic analysis is a method for identifying, analysing and reporting patterns within data and can be applied across a range of theoretical and epistemological approaches. The first step of the process was transcription with all interviews being transcribed verbatim within a week of each interview. The next stage was reading and re-reading the transcripts to identify patterns and open codes. The interpretative stage of analysis began with searching for themes from the codes. This involved sorting the codes into potential themes and collating the relevant coded extracts within the identified themes with codes being compared and contrasted throughout the process.

## *Findings*

### *Program engagement*

Program engagement emerged as the first major theme and consists of the following interrelated sub-themes; apprehension, trust, respect, social support and challenges. The sub-themes represent the stages of program engagement but these stages do not occur in sequence but are constantly intertwined throughout the engagement process.

The decision to participate in a home visiting program was made by weighing the unknown risks and consequences of participating with the need for support and information. Six of the participants wanted support in their role as a new parent but were also apprehensive about accepting help. Participant 2 (P2) describes her feelings:

> *"I was getting anxious that I'd be in a program for 2 years and wouldn't be able to get out as I can't say no. I needed that help but was worried in case I*

*didn't like it or didn't like the nurse you know…I changed my mind when I met the nurse. She was so nice and made it easy for me."*

When the nurse supported participants with their issues, it not only eased their apprehension but also helped to build the relationship as stated by P3:

> *"I tried it and her ideas, they worked and next time she gave me some more ideas about something else and more questions and we started to build the relationship."*

Despite initial reservations participants felt reassured by their nurse which helped in the process of engagement.

Participants felt trust was a very important factor in engaging with their nurse and the program. Participants had issues with trust in that some had experienced childhood abuse, grief, mental health issues, abusive relationships and abandonment. Trust had to be built-up and maintained before participants felt comfortable and safe enough to disclose their issues to the nurse without feeling judged, as described by P5:

> *"It's just like having an old friend come round and sit around and talk about my stuff. I feel really supported by her. I trust her and I trust her judgement too. I know that when I tell her anything, she's not going to go off and tell other people. She doesn't judge me and I feel comfortable telling her things."*

P3 describes how she felt she could be open and show her 'real' self to the nurse:

> *"This is somebody I can actually trust and say how I'm really feeling. Not to pretend to somebody that things are all nice and have my house all clean when she comes over."*

When a certain level of trust was established, participants were able to disclose and discuss their problems more openly. The development of trust was ongoing throughout the process of engaging with the program and nurse.

Trust was an essential platform for the development of respect and in turn respect was an essential platform for the development of trust. Participants felt that they had to respect their nurse and her knowledge before they could accept any information and listen to her suggestions as expressed by P1:

> *"We gotta respect each other. Like her job is to help me be a good parent and I've gotta try and do that. I'm not going to listen to someone I don't respect."*

Participants respect for their nurse was often gained where the nurse demonstrated professional knowledge about parenting. The nurse also had to demonstrate respect for the participant before respect was reciprocated. For example, P4 reported how her nurse exhibited respect for her by not imposing her professional ideas:

> *"She is a very calm person and I feel she really cares about us. She is very respectful and professional. But she's not bossy or strict. I could never cope with someone like that. It just wouldn't work for me."*

Participants felt that giving and receiving respect was important to the engagement process but respect was dependent on the existence of trust.

Participants identified themselves as requiring social support for their parenting and had agreed to participate in the program on that basis. All participants reported feeling supported by their nurse and the program. Participants identified support in both practical and emotional terms. Practical support for participants related specifically to child health information, settling, feeding, safety, child development, housing, welfare, advocacy and navigating health

systems. Emotional support for participants related to empathy, listening, exploring, acknowledging and addressing emotional issues. P4 describes how she was unprepared for parenting:

> *"I didn't have a clue about being a parent. I prepared and read everything but when we came home we had no idea really. Nurse has helped with lots of things. Early on it was his sleep and settling. His weight has always been an issue as he is small and thin ."*

P2 describes how she was supported emotionally and practically to deal with her mental health issues:

> *"She helped me to see that if I got help I could enjoy life more and not be so unhappy. At that time I felt helpless but she explained it was the depression and the relationship and not me. She was just there for me. You know when you're in an abusive relationship; you feel such shame and want to hide it. She knew everything and I didn't feel like that with her. So yea I went and got help for my depression."*

P3 describes the practical support she received:

> *"It's helped really practically with ideas especially for my toddler and his eating and that has been very good. He's a fussy eater and he's very skinny. The nurse weighs both children regularly so that helps to know how he's doing. Just lots of practical ideas, all the booklets that the nurse gives me."*

Another participant (P6) describes how her nurse supported her with her son who has developmental delay:

*"Probably the most helpful has been that she has referred me on to the physio, podiatrist and speech pathologist. My nurse picked up things early on that he couldn't walk and like he was late doing that. I wouldn't have known that and wouldn't have noticed till too late. She got me referred on to the paediatrician so they can test him. She knows all these services that can help me."*

Support on a practical and emotional level helped participants to learn about parenting and understand more about themselves and their children.

Three participants found some aspects of the program challenging. These comprised two main areas – disliking aspects of the program itself and feeling uncomfortable with being challenged by the nurse regarding their parenting.  P1 found it difficult when her nurse challenged her on aspects of her parenting:

*"Sometimes I'll like do something and think I'm doing something right and I'll tell my nurse and it's like not right….As an example when she had a tantrum…….and we were alright with that but then the nurse said that you can't leave her when she's upset… You can't walk off and leave her there cos you need to reassure her. She taught me to like make her come to me."*

While these experiences presented a challenge to these participants at the time, they also felt the experiences helped them to overcome difficulties and further engage in the program.

## *Control*

Control is the second major theme and consists of the following sub-themes; shared decision making and feeling empowered. Control in the context of this study is about power; whether it is power over one's personal choices or one's behaviour or power over relationships and resources. Given that participants had personal experiences of childhood sexual abuse, grief, domestic violence, mental health issues and abandonment, they have also experienced powerlessness and lack of control in all or some of their relationships.

Shared decision making relates to the process of decision making in the program between the nurse and participant. Participants often felt that decision making was shared with their nurse when a flexible and timely approach was adopted. For example P2 felt it was important that the nurse responded to her needs at the time as she was in a controlling relationship and needed support, not control:

> *"It wasn't like we were following a roster or anything. Yes it was relaxed as I wouldn't have been able to cope with anything else. When I'd been through a rough time with my ex, she knew something was wrong and we'd just talk about that and that helped me….. I needed to be able to talk about stuff that was going on in my life."*

P4 describes what happens for her:

> *"We don't have a plan as such. Sometimes the nurse plans to talk about a topic but then when she gets here, something might have cropped up and we talk about that instead. Sometimes she talks about her topics and gives me all the information but it's*

*very relaxed and flows really. When I have an urgent problem I might ring her and we talk about it on the phone but we might spend the whole visit on that topic."*

Participants used words like 'relaxed' and 'flowing' to describe how decisions were made. Both participants and nurses appeared to address their issues and cover program content in a shared decision making process.

Participants who felt in control of their decision making felt empowered. In this example, P2 who had been disempowered by a violent and abusive relationship describes her journey in terms of parental decision making:

> *"Certainly when she was born, I didn't feel in control of anything myself included. I worry that I'm doing the best for her and that she will be fine. Being in the program reassured me about that. I suppose having her gave me a reason to leave the relationship. Now he's gone, I think I have taken control."*

P4 describes how having a mental health issue has influenced her decision making:

> *"I think because of my mental health issues, I'm very conscious about making decisions and having some control over my life. I think this is more of a life approach I now have because of things that have happened in the past".*

P3 talked about how she was gaining confidence in her decision making and she recognised this as an important goal:

> *"I think the confidence helps.....It's fine to be flexible and it's fine to make decisions as long as they suit our family. Doesn't matter what others do or what the*

*grandparents think, it's about us…I think the decisions I make I'm a lot firmer with….So I definitely feel more empowered now."*

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According to Labonte (1997) gaining control is dependent on greater access to information, supportive relationships, decision-making processes and resources. By engaging in a trusting supportive relationship with their nurse, participants felt that they were able to gain some control over their parental decision making and make positive changes that improved the health outcomes for their families.

## *Discussion*

For participants, engaging in the program was an ongoing cyclical process that included apprehension, trust, respect, support and challenging experiences. Apprehension for participants could be about fear of the potential risks of accepting help and anxiety over trusting health professionals and leaving themselves open to the unknown. It could also be related to feeling powerless or having little control over one's life. Yet, apprehension was eased by the development of the relationship with the nurse home visitor but trust, respect and social support were identified by all participants as essential building blocks in the relationship and program engagement. For some participants, their relationship with their home visitor was their first experience of a trusting relationship in that they talked about not having a 'mother figure' themselves and that the relationship filled that gap. Participant 5 (P5) felt "it's about the connection with the worker. If you don't have that, there's no point really". Feeling connected is really about trust as this participant felt connected to someone she trusted. A trusting relationship with the home visitor opened up the opportunities for referrals to other services and increased participation and connection to wider supportive networks as described by participants 2 and 3. This corresponds with Giddens (1994) theory

of trust in that interpersonal trust with the healthcare professional must be established before the individual can trust institutions and systems. The development of trust can be interpreted as an outcome of its own. The development of trust is a continuum and occurred at different points in time during the process of engagement. Trust is also dependent on factors such as respect and social support. While it could be interpreted that respect comes before trust, the perspective of participants was that trust was an essential platform for the development of respect and in turn respect facilitated the development of trust.

The concept of respect has its origins embedded in moral philosophy and the work of Immanuel Kant (1724-1804). Respect is shown by listening, acknowledging, validating and being aware. Respect is shown in body language and in how messages are communicated. When difficult messages are communicated with respect, they are likely to be accepted with respect (Kirkpatrick et al, 2007). Lack of respect and adversity especially in early childhood can result is low self-esteem or not valuing one's self, depression and abusive relationships in adulthood (Saunders, 2002). Participants talked about how respect was shown to them in that their nurse listened, demonstrated empathy and did not impose professional ideas on them as described by participant 4. It was important that the nurse was flexible and respected their needs when urgent issues came up. At the same time participants respected the nurse's knowledge and information and accepted it when it was given in a respectful way. Participants were clear they would not listen to someone they didn't respect. Being honest was interpreted as being respectful especially when it came to clarifying the nurse's role and outlining rights and responsibilities. For example, participant 1 was clear that she would not listen to someone she didn't respect. Respect seemed to be intertwined with the participants feeling valued and when they felt valued, trust was established and they engaged more with the program as described by participants 3 and 5. Respect like trust helped to build self-esteem but in this context was also linked to social support.

Social support has been defined as 'the perceived availability of people whom the individual trusts and who makes one feel cared for and valued as a person' (Mindful Project, 2008). Theoretical approaches to social support identify two ways that it is beneficial to health and wellbeing; the direct or main effect and the buffer effect (Cohen & Willis, 1985). The direct effect implies that social support has a positive effect on health, irrespective of life situation. The buffer effect is viewed as significant in sustaining or improving outcomes for individuals when they are faced with a stressor such as ill health, having a baby and financial or housing stress. Lack of social support is associated with poorer physical and mental health as well as increased mortality and low levels of social support are associated with lower socioeconomic status and poverty (Marmot, 2003). The findings from the study indicated that enhanced social support in the form of intensive nurse home visiting seemed to have helped participants to make positive changes and acted as a buffer against stressors such as post-natal depression and having a disabled child. Participants were clear that social support helped them: to address practical issues, increase their knowledge, grow in confidence, and feel valued and acknowledged. This echoes the findings from other studies (Heaman et al, 2005; Kirkpatrick et al, 2007; McIntosh et al, 2006). However, participant 1 also indicated that unless the social support was within the context of a trusting and respectful relationship, it was unlikely to have much impact or add to the process of program engagement.

Challenges can have an adverse impact on program engagement but are likely to strengthen program engagement if addressed appropriately. Resolving challenges involved respectful negotiation, communication and flexibility within the context of a trusting relationship between participant and home visitor. Again the findings are supported by the literature (McIntosh et al, 2006). Identifying and addressing challenges is part of the experience of participating and engaging in the program.

Program engagement is a complex process that described the steps of relationship building within the program. This refers to the relationship between the mother and nurse that leads to engagement and trust in health services. For participants the relationship was central to the program. Without a strong and trusting relationship there was no motivation for them to engage. Several of the participants had not experienced a trusting relationship with a health professional beforehand and in some cases not even with a parent or family member before, so the experience was potentially life changing for them. Where the participants reported a positive relationship with their nurse, that was built over a period of time, they felt valued, respected and supported.

Engaging in the program was essential before participants could develop some degree of control over their decision making. Labonte (1997) argues that central to public health is the idea that if people are to gain more control over their lives and make good choices, they need greater access to information, supportive relationships, decision-making processes and resources. Given that participants had personal experiences of childhood sexual abuse, grief, domestic violence, mental health issues and abandonment, they have also experienced powerlessness and lack of control in all or some of their relationships. Adverse experiences appear to have eroded the participant's sense or perception of control and power. Again, the participants felt that it was the supportive relationship with power sharing that helped them to learn how to make decisions and take control. Just as the relationship helped them to engage in the program, the relationship also supported them towards empowerment and taking control. Participants saw empowerment as being able to have control over their decisions and their lives but they preferred to use the word 'control'. Empowerment had different meanings for each participant depending on their circumstances. For example, Participant 2 who had low self-esteem and depression as a result of domestic violence felt her confidence in her decision making was growing and was able to leave her partner as a result of the support and

therapy she had received in the program. Participant 5 felt she always had control of her decision making despite being vulnerable but that participating in the program strengthened her confidence and sense of control as a parent because of the additional information she had been given. Other participants also felt that participating in the program and being in a trusting, respectful relationship with shared-decision making increased their self-esteem.

### *Implications for research and practice*

The aim of health promoting interventions such as intensive nurse home visiting programs is to improve health outcomes for vulnerable children and their families. Program effectiveness relates to the ability to engage families and bring about change (Gomby, 2005). The most vulnerable families are likely to refuse to engage or drop out early - Watson & Tully (2008, page14) but there is currently an increased interest in strategies which help to recruit and engage vulnerable families.  Vulnerable mothers can engage in relationship based programs with the findings from this small group suggesting that they see the relationship as paramount to their engagement in the program. This has implications for program development. Policy makers and practitioners need to consult with and seek the views of vulnerable women so that they can develop appropriate strategies to engage them. Interventions can then be refined according to need. . This may enable vulnerable families to engage with services that they perceive as powerful and start to build trust. It is important for policy makers and practitioners to recognise that developing trusting relationships takes time and programs must be lengthy enough and have skilled and consistent staff to ensure that this happens.

It is also important to incorporate mothers' perspectives into future evaluations of programs and to be open to using multiple research approaches and methods in evaluating complex interventions. It is not only empowering for participants but will provide further insights into

retaining and engaging mothers in programs and help to further understand aspects of the relationship, and its impact on health outcomes.

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