

***KIDSFIRST* PROGRAM EVALUATION:  
UNDERSTANDING THE RELATIONSHIP BETWEEN  
HOUSING INSECURITY AND PROGRAM EFFECTIVENESS**

by

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# APPROVAL PAGE

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UNDERSTANDING THE RELATIONSHIP  
BETWEEN HOUSING INSECURITY AND  
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## **Abstract**

*KidsFirst*, an targeted early childhood intervention in Saskatchewan, is delivered through home visitation. The *KidsFirst* program evaluation was a multi-phase evaluation aiming to assess the short-term impact of the program on families and on communities. The qualitative component of this evaluation included 84 individual interviews and 27 focus group interviews with 242 participants. Participants in the qualitative component included: parents; staff, program managers and management committee members; and representatives from supporting agencies. Based on findings from a sub-analysis of the qualitative data, this study investigated why the impact of *KidsFirst* was limited in families with complex needs. Principally, participants shared how *KidsFirst* assumed the role of crisis management in the lives of complex-needs families. Housing insecurity in particular led to difficulties retaining these families in the program. Adequate and stable housing may improve program delivery and retention and therefore program impact for some of Saskatchewan's most vulnerable children and families.

**Keywords:** early childhood intervention; at-risk families; housing; program retention; home visiting; evaluation research

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## Table of contents

<b>Approval</b> .....	<b>ii</b>
<b>Abstract</b> .....	<b>iii</b>
<b>Acknowledgements</b> .....	<b>iv</b>
<b>Table of contents</b> .....	<b>v</b>
<b>List of tables</b> .....	<b>vi</b>
<b>1: Introduction and purpose</b> .....	<b>1</b>
<b>2: Background</b> .....	<b>2</b>
2.1 The <i>KidsFirst</i> program.....	2
2.2 Background literature.....	4
<b>3: Methodology</b> .....	<b>7</b>
3.1 Research design.....	7
3.2 Data collection.....	8
3.3 Participants.....	9
3.4 The interview and focus group process.....	9
3.5 Coding and analysis.....	10
3.6 Ethical issues.....	11
<b>4: Findings</b> .....	<b>12</b>
4.1 Summary of findings from the Qualitative Report.....	12
4.2 Families with complex needs.....	12
4.3 Families in crisis.....	14
4.4 Retention of complex-needs families .....	15
4.5 Housing .....	16
<b>5: Discussion</b> .....	<b>18</b>
<b>6: Limitations and strengths</b> .....	<b>22</b>
<b>7: Implications for public health practice, policy and research</b> .....	<b>24</b>
<b>Appendix A: Family descriptions</b> .....	<b>26</b>
<b>References</b> .....	<b>28</b>

## **List of tables**

<b>Table 1: Number of participants by type.....</b>	<b>8</b>
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## 1: Introduction and purpose

Early childhood development (ECD) is a powerful determinant of health. As such, numerous interventions have been developed to ensure that children get a healthy start (Hertzman, 1998; McCain & Mustard, 1999; Olds, Sadler & Kitzman, 2007). *KidsFirst*, a provincial ECD intervention, has been operating in Saskatchewan since 2001. Through a targeted approach, the program aims to support families and young children who are vulnerable due to their social and economic circumstances. *KidsFirst* works to address both the needs of children who may be at risk and the environments (parents, families, service systems, communities) that place children at risk (Muhajarine, Glacken, Cammer & Green, 2007). The program addresses multiple determinants of health: income; education; social support networks; personal health practices and coping skills; social services; and health services. Services are voluntary and are delivered to vulnerable families with young children in nine sites across Saskatchewan. Vulnerable families are identified through in-hospital screening for social and economic factors, referral by other agencies and self-referral. By identifying and providing support to very vulnerable families with young children *KidsFirst* ultimately aims to reduce disparities in maternal and child health outcomes.

This paper presents a subset of data analysis from the *KidsFirst* program evaluation. The *KidsFirst* program evaluation is a three-year multi-phase evaluation, which aims to assess the short-term effectiveness of the *KidsFirst* program in bringing about positive changes within *KidsFirst* families and communities. The evaluation uses a mixed methods approach to appraise whether or not *KidsFirst* is meeting its goals and objectives. Findings from this evaluation have a great potential to inform policies and practices within the *KidsFirst* program. Additionally, the *KidsFirst* evaluation is expected to have a wider impact, informing emerging knowledge on promising or best practices in early childhood interventions among vulnerable families in Canada. Through this program evaluation I therefore hope to inform more effective policy for the reduction of maternal and child health disparities in the Canadian context.

## 2: Background

### 2.1 The *KidsFirst* program

*KidsFirst* was launched in Saskatchewan in 2001 following the Federal-Provincial-Territorial ECD Agreement, which allocated funding to each province in Canada for the purpose of improving ECD (Muhajarine et al., 2007). In 2001, the province of Saskatchewan announced \$15 million of new funding to be spent annually on ECD programming. Although some early childhood supports existed prior to the ECD agreement, this was the first time that Saskatchewan had funding specifically designated for ECD programming. *KidsFirst* was introduced as the conduit for dispensing the funding. At this time the new ECD funding represented 0.5% of provincial healthcare funding totaling over \$3 billion annually (Government of Saskatchewan, 2001). Of note however, *KidsFirst* involved multiple ministries beyond the Ministry of Health. *KidsFirst* in Saskatchewan has therefore involved partnerships between community agencies and the provincial Ministries of Health, Education, Social Services, and Government Relations and Aboriginal Affairs (Muhajarine et al., 2007).

*KidsFirst* was modeled after a successful and well-developed American national ECD intervention, *Health Families America* (HFA). HFA is a voluntary ECD intervention delivered through home visiting services. Extensively evaluated through both randomized-controlled trials and quasi-experimental studies involving a comparison group (Harding et al., 2007), HFA has been demonstrated to be effective in multiple areas: improving positive parenting practices, improving family health, enhancing school readiness, improving self-sufficiency and reducing child maltreatment. However, these results have yet to be replicated through experimental trials in the Canadian context.

Before *KidsFirst* was implemented, targeted neighbourhoods, in larger urban centres, or smaller rural communities, were identified based on the level of poverty, as indicated by the percentage of individuals receiving social assistance, the rate of babies born with a low birth weight, the rate of hospitalization for children less than one year of

age and the proportion of single-parent families within the community (Nickel, Muhajarine, Program Managers, and the *KidsFirst* Research Team, 2008). The program was implemented in nine communities in Saskatchewan where the greatest concentration of vulnerable families existed in 2001: Meadow Lake, Moose Jaw, Nipawin, Northern Saskatchewan, North Battleford, Prince Albert, Regina, Saskatoon and Yorkton<sup>1</sup>. *KidsFirst* communities vary greatly in size and therefore also in available services. *KidsFirst* works to fill large gaps in health and social services, especially in the rural sites (Muhajarine et al, 2010). Each community is unique and the program has been adapted in each community to best meet the needs of the population.

Program intake was done primarily through in-hospital birth screening and referral (Muhajarine *et al.*, 2007). Although mothers are enrolled primarily through the in-hospital birth questionnaire, increasing proportions of mothers are being enrolled during pregnancy. The eligibility criteria for entry into the program are based on measurements of maternal education levels, maternal mental health, family financial stability, infant birth weight and other risk factors. Following intake, a family is offered weekly home visiting services by a trained para-professional visitor. Upon further assessment, the frequency of regular home visitation may be reduced according to the level of risk at which the family is assessed.

The *KidsFirst* program consists of six components, representing a mix of services and assessments: pre-natal referral and support; universal in-hospital screening; in-depth and on-going assessment; home visiting services; mental health and addiction services; and early learning, care and family support<sup>2</sup>. The *KidsFirst* program is mainly delivered through home visitation. During home visits, a trained para-professional meets with a

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<sup>1</sup> For a detailed overview of the program sites see Community Profiles: Nickel D, Muhajarine N, and *KidsFirst* Program Managers, and *KidsFirst* Research Team. *KidsFirst* Community Profiles. Saskatchewan Population Health and Evaluation Research Unit, 2008.

<sup>2</sup> For a detailed overview of *KidsFirst* program vision, goals and objectives see: 2007-2008 Performance Plan: *KidsFirst* Strategy. Regina: Saskatchewan Learning, Early Learning and Child Care Branch and ECD Unit, 2007. *KidsFirst* Strategy: Performance Plan 2006-2007, Regina: Saskatchewan Government, 2006.

family to assist them in meeting their basic needs, provides information and encourages improvements in parent-child interactions (Muhajarine et al., 2010). Home visitors deliver the ‘Growing Great Kids’ curriculum to parents during their visits. *KidsFirst* was designed as a dyadic model of home visitation in which para-professionals are trained and supervised by professional home visiting supervisors (Gates et al., 2010). The educational background of home visitors is variable, ranging from those who have completed a university degree, to those who have completed some high school. *KidsFirst* focuses on hiring home visitors who have a background similar to the parents they work with. Through the establishment of an ongoing relationship between home visitor and family, *KidsFirst* aims to reduce the social and economic marginalization of vulnerable families and create an environment that promotes the healthy development of children.

## **2.2 Background literature**

The *KidsFirst* program evaluation has included the publication of a number of documents, four of which have particularly informed this study. First, an evaluation framework was developed (Muhajarine et al., 2007). This framework presented a logic model which outlined the causal pathways between the program’s goals and objectives and activities that are undertaken to achieve the outcomes. The *KidsFirst* evaluation framework identified the short-term outcomes that were evaluated as well as the data sources and methods used to evaluate each outcome.

Second, a theory document was published to inform and assist in the evaluation of *KidsFirst* (Terstappen, Muhajarine, Nickel, & Green, 2009). This document identified three theories corresponding to the individual, family and community improvements that the *KidsFirst* program was intended to effect. The three theories — Albert Bandura’s self-efficacy theory, John Bowlby’s attachment theory and Urie Bronfenbrenner’s ecology of human development theory — were identified to provide a systematic theoretical foundation for activities and components of *KidsFirst*. These theories also provide a better understanding of the pathways through which *KidFirst* works to affect positive changes in parents and children.

Third, a document profiling the nine *KidsFirst* communities was produced (Nickel, Muhajarine, *KidsFirst* Program Managers, & *KidsFirst* Research Team, 2008). This Community Profiles document described the program's evolution from implementation through to when the Community Profiles document was written. Additionally, the document describes in detail the social, economic and service characteristics of each of the *KidsFirst* communities. The document also gives an overview of the staff, management, partnerships and number of clients at each site.

Finally, a literature review on home visitation was published (Gates, Nickel, Muhajarine, and Evaluation Research Team, 2010). This literature review examined the extent to which home-visiting interventions similar to *KidsFirst* produced benefits for parents and children. This and other similar literature reviews have summarized the evidence from both experimental and quasi-experimental evaluations of home visitation based ECD programs in Canada and the United States. These reviews have shown that successful parent and child outcomes have been achieved in ECD intervention programs similar to *KidsFirst* when comparing intervention families to controls (Gomby et al., 1999; Gomby, 2005; Gates et al., 2010). However, results have been inconsistent and variable in magnitude (Sweet & Appelbaum, 2004; Gomby, 2005). Some of the positive outcomes that have been observed in programs similar to *KidsFirst* include: a greater reliance on non-violent discipline (Duggan et al., 1999); benefits in parenting practices, attitudes and knowledge (Gomby et al., 1999); linking of families to medical services (Duggan et al., 1999); improved parental self-efficacy; decreased parental stress; decreased injuries resulting from partner violence in the home; greater knowledge about alternative forms of discipline (Daro & Harding, 1999); greater sensitivity to children's cues, improved maternal life course, increased rates of immunization (Gates et al., 2010); early detection of developmental delays in childhood (Krysiak & LeCroy, 2007); and improved school readiness (Anderson et al., 2003). In a review of 15 studies involving a control or comparison group, Harding and colleagues found that *parental* outcomes, such as improved parenting knowledge and practices, are the outcomes most frequently demonstrated (Harding et al., 2007).

Corroborating the findings from the literature, in the qualitative study of the *KidsFirst* program evaluation, we found that participation in *KidsFirst* resulted in improved parenting skills and increased quality of parent-child interactions in many families (Muhajarine et al., 2010). However, *KidsFirst* benefits were inconsistent and positive outcomes were not reported in all families. In particular, the study by Muhajarine and colleagues reported a notable impact for many parents from low- and intermediate-needs families but limited change in complex-needs families (see Appendix A for a description of low, intermediate and complex-needs families). Consequently, this paper will examine why the impact of the *KidsFirst* program was limited in complex-needs families. It is important to be aware of how the lives and experiences of complex-needs families interact with the *KidsFirst* program. More importantly, it is necessary to understand why the impact of *KidsFirst* is limited within complex-needs families if we are to understand how the program might be improved to better meet their needs. Through this understanding, we hope to better reach some of Saskatchewan's most at-risk young children to ameliorate the environments in which they grow and develop. This information can also help inform early childhood intervention in Canada.

## 3: Methodology

### 3.1 Research design

The *KidsFirst* program evaluation used mixed methods and consists of three phases. In Phase 1, a comprehensive evaluation framework was developed (Muhajarine, Glacken, Cammer, Green, and *KidsFirst* Evaluation Team, 2007). Phase 2 of the evaluation consisted of analysis of existing quantitative data and a qualitative study designed to enrich the understanding of the quantitative findings. Findings from a sub-analysis of the qualitative study are presented here. Phase 3 represented an integration of the evaluation findings and linked them to program goals and objectives and presented a set of recommendations that are consistent with the findings.

I was involved as a full-time researcher for the qualitative component of the *KidsFirst* program evaluation from May 1, 2009 through December 31, 2010. During that time I was involved in planning, data collection, coding, data analysis and writing. I traveled to six of the nine *KidsFirst* sites, conducting the interviews and focus groups with a co-researcher at those sites. After data collection, two other researchers from the *KidsFirst* evaluation team and I were responsible for developing the list of codes. With another researcher I coded all interview and focus group transcripts. Four researchers including myself were responsible for data analysis and writing the qualitative study report for the *KidsFirst* program evaluation. I was solely responsible for the initial data analysis and writing for two evaluation objectives for the qualitative evaluation. These results were discussed with and reviewed by the *KidsFirst* evaluation team. I completed the analysis and writing presented in this paper.

The qualitative study was done to provide more in-depth and complementary information to the quantitative study by presenting findings, in part, illuminating the experiences of parents in the *KidsFirst* program (Muhajarine et al, 2010). In other words, a qualitative approach allows for exploration of why, not just whether, the program does or does not work. In particular, the qualitative study captures the unique and complex experiences and perceptions of those involved in the *KidsFirst* program to a greater

extent than does the quantitative study. A constant comparative method was applied to continuously compare the experiences and views of participants (Glaser, 1965). Data were compared between interviews from the same participant type, between interviews from differing participant types, between sites and between data collection methods to develop themes. Themes and findings were compared continuously between researchers as they emerged until consensus was met amongst the researchers.

### 3.2 Data collection

The *KidsFirst* research team carried out 111 interview and focus groups between May and October 2009 (see Table 1). Interviews and focus groups were conducted in all nine *KidsFirst* communities. Another researcher and I conducted the interview and focus groups at six of these sites. The total number of interview and focus group participants was 242. *KidsFirst* staff members who participated in individual interviews were also invited to participate in the *KidsFirst* staff focus group. All parent participants were required to have been in the *KidsFirst* program for six months or longer and to be willing to sign informed consent agreeing to participate in the study.

**Table 1: Number of participants by type**

Type of interview participant	Number of participants	Type of focus group participant	Number of focus group participants
Program Manager	9	Management committee member	51
Home Visitor	28	Supporting agency representative	34
Home Visiting Supervisor	15	<i>KidsFirst</i> staff member	70
Parent	34		
Aboriginal Elder	1		
<b>Total number of interview participants</b>	87	<b>Total number of focus group participants</b>	155
<b>Total number of interviews</b>	84	<b>Total number of focus groups</b>	27

### **3.3 Participants**

Data were collected from a variety of participants through the interviews and focus groups. We included participants from all levels of the program including parents, home visitors, home visiting supervisors, program managers, supporting agency representatives and management committee members. This diversity in participants provided us with a source of triangulation within our sample as we were able to corroborate of the findings across different participant groups. For the parent interviews, in three cases two parents participated in the interview, while all the remaining were individual interviews. Table 1 outlines the number of interview and focus group participants by type.

### **3.4 The interview and focus group process**

Eight researchers (including the author) were involved in various stages of the qualitative data collection. All female, we nevertheless came with different academic background and life experiences and ranged in age from 20-60 years. These varied ages, academic backgrounds and life experiences enriched the data collection by setting a multi-disciplinary tone and helped enhance the reliability of the data analysis.

Data were collected using semi-structured interviews and focus group interviews. An interview/focus group guide was developed by the *KidsFirst* evaluation team in consultation with the program managers. There was a different guide for each respondent type. All interviews and focus groups, apart from parent interviews, were held in private meeting rooms in a neutral location where participants were comfortable. Parents chose the site for their interview. Almost all parents chose to hold the interview in their home where they stated they felt most comfortable. The interviews and focus groups took 60 minutes on average (ranging from 30 to 120 minutes). Two members of the research team were present at each interview or focus group. One member was a responsible for asking the questions while the other took notes, observed and was responsible for recording.

Compensation was provided to parent participants in recognition of their time (typically a \$25 gift certificate to a supermarket).

All interviews and focus group sessions were recorded and transcribed. Member-checks were conducted to ensure the credibility of the data in the eyes of the participants. All study participants were given the option of receiving a copy of their transcript for review. Where requested, a copy of the transcript was mailed to the participant. At that time, participants were free to add or remove any information from their transcript. We found that very few parents requested to review their transcript. This may be because process is cumbersome for busy parents. Additionally, there may be additional challenges for parents with limited literacy. In the future, this process could also be improved by giving parents the option of reviewing their transcript with a member of the research team or by offering the parents a recording of their interview for review. The finalized transcripts were then entered into a database for coding using ATLAS.ti software.

### **3.5 Coding and analysis**

Two researchers and I developed the coding list that was applied to all transcripts. To develop this list, we read through transcripts from each type of study participant and looked for recurring common topics and emergent themes. We first went through the transcripts independently to identify new codes, then we collectively compared codes and negotiated clear definitions of each code. When disagreements arose, they were resolved by discussion amongst the research team until clarity and consensus was reached. This process allowed us to compare emerging codes and settle on a clear descriptor and definition for each code so that we could then subsequently apply the codes to the data consistently. Codes were continually added to the list until new codes stopped emerging and code saturation was reached.

Once the master list of codes was complete, we worked independently to code transcripts and then compared coded transcripts to identify any differences in how and where we were applying the codes. This process was done repeatedly until we were

applying codes consistently. Then the remaining transcripts were coded independently. Throughout the coding process there were ongoing discussions and consultation between the researchers to ensure that coding was consistent.

After all transcripts were coded, we merged coded transcripts into a single comprehensive database. We then drafted a report outline, which linked specific codes to the evaluation objectives. Set evaluation objectives were allocated to different researchers for analysis. As findings emerged, we discussed them as a research team to ensure the consistency and accuracy of the results. When differences in interpretation arose, they were discussed until we reached consensus. For the sub-analysis presented in this paper, codes and themes relating to my research question were reviewed, and transcripts from all sites and all participant types were analysed.

### **3.6 Ethical issues**

Before data collection we received approval for the project from the University of Saskatchewan Research Ethics Board. As well, ethics authorization was provided by either the health region or education board at each site. Secondary approval was granted from the Research Ethics Board at Simon Fraser University.

## 4: Findings

### 4.1 Summary of findings from the Qualitative Report

In the initial qualitative component of the *KidsFirst* evaluation, Muhajarine and colleagues (2010) found that the *KidsFirst* program was effective at improving parenting skills and knowledge as well as parent-child interaction. However, parents with more complex needs did not often show improved confidence or improved knowledge of good parenting practices. Improvements were seen most often in *KidsFirst* parents who were not complex-needs families and in families where the basic needs of the family, such as stable housing, basic security and food security were met. Additionally, the summary of findings from the *KidsFirst* evaluation described how some families, particularly those with complex needs, have not benefitted as quickly or to the same extent as families with less complex needs (Muhajarine, Nickel, Shan & the *KidsFirst* Evaluation Research Team, 2010). Retention of families, especially families with complex needs, was identified as an issues across all sites.

In this paper I will examine why the impact of the *KidsFirst* program is limited in complex-needs families. Findings from the interviews and focus groups are presented here. All the data gathered regarding complex-needs families represented the perspectives of *KidsFirst* program managers, home visiting supervisors, home visitors, and management committee members. Transcripts from all participant types were reviewed in the analysis. However, in reviewing the themes and codes related to families with complex needs I found that parent perspectives on themes presented in this paper were absent from the data set. Therefore, parent quotes were also absent. When attributing a quotation, '*KidsFirst* staff member' refers to any person working for *KidsFirst* apart from the home visitors (including home-visiting supervisors, program managers and mental health and addictions staff). This more general term, as opposed to using the type of staff member, was done to protect anonymity of participants. Because we had a larger group of home-visitor participants, they could be separately identified without compromising anonymity.

## 4.2 Families with complex needs

Study participants described complex-needs parents as those typically with low socioeconomic status and low self-esteem who were also dealing with a combination and accumulation of conditions such as family violence, transiency, social isolation, developmental delays, health problems and mental health issues including addictions. According to participants, some Aboriginal parents are additionally challenged due to the impact of experiences in residential schools and/or foster homes. Respondents reported that when a family was facing multiple complex issues, they were burdened by and preoccupied with demanding life issues and therefore had difficulty focusing on the curriculum, learning parenting skills and receiving information about childhood development. *KidsFirst* staff explained the unique difficulties they experienced when working with complex-needs families.

“With families that have addictions or are in abusive situations, when you walk into a home they’re not thinking about ‘oh, let’s talk about, you know, how great it is to have your child learn to walk without shoes on, because it’s better for the muscles in their feet’ you know? They don’t want to hear that when they just got beat up the night before.” (Home visitor)

Participants spoke of how building relationships between the parent and the home visitor and delivering the curriculum were limited in some families because of the challenging circumstances and environments they were experiencing when they entered the program. *KidsFirst* staff found it difficult to achieve positive outcomes with complex-needs families, and the definition of what is understood as ‘success’ between the family and home visitor would depend therefore on the family’s circumstances. *KidsFirst* staff explained that for some complex-needs families, success might be simply preventing a child’s home environment from declining further.

“Some of the families in the Kids First program are so high risk, or may have mental health and addictions issues, that maybe instead of them progressing, maybe they’re not sliding. And those things are very, very hard to measure. Maybe they don’t become a Child Protection family. But I don’t know how you would measure that. Many of these families are very complex, complex needs.” (Home visitor)

Participants recognized that some parents showed no clear improvement from participation in *KidsFirst*. Parents who did not benefit from the program were mostly complex-needs parents. Respondents reported that confidence and knowledge were not improving (or improved to a lesser extent) among these families. Home visitors shared often poignant stories about numerous families that experienced multiple complex-needs and who were unable to extricate themselves from dire social and physical environments. These complex-needs families often had shorter stays in the program compounding the problem of not being able to achieve success through participation in the program.

“She had been back on the streets. It’s been a continual cycle for her and it’s one of those ones where you think you’re not doing your job right. It’s been five years. You’ve seen nothing change. They’re into horrible things for themselves. Their children are removed several times. The last time she went out of the program was because of all children had been finally removed for good.” (*KidsFirst* staff member)

*KidsFirst* staff shared their concerns for high-risk families and noted that a higher level of intervention (ie., more intense, specifically tailored) may be required to see changes in complex-needs families.

“I can think of another family that we helped to flee a domestic violence situation. She’s since moved back and she’s back in the same relationship. Was there progress or not? We have some families where it works and we have some where it doesn’t. I’m not sure of the level of intervention that’s required with some families. Like this particular family probably needs a much higher level of intervention or intent.” (Home visitor)

### **4.3 Families in crisis**

Many respondents shared how families with complex needs are dealing with a steady stream of crises. Crisis situations are urgent situations where the issue at hand becomes *the* priority for the family. Respondents identified food insecurity, family violence, substance abuse and other mental health issues and housing insecurity among the most common crisis situations facing families on a regular basis. *KidsFirst* staff noted that home visitors often enter a situation of crisis during home visits with complex-needs families and how these crises often detract from curriculum delivery.

“A lot of times the home visitors go out and they’re already faced with: this mom has addictions issues, housing issues, they’re overwhelmed, they have four children, often, the parents have cognitive delays themselves. So, you’re faced right away with four or five issues and a parent doesn’t read or has a grade three reading level. So you’re bringing out your curriculum to read through with them and they’re not comprehending it. And they’re so crisis focused that they can’t focus on the important thing about their parenting relationship.” (*KidsFirst* staff member)

Many home visitors reported that the most salient issues hindering program delivery and effectiveness were all sources of instability for families: transience, addictions and family violence. These issues often meant that the parent’s focus, energy, and attention were centered on crises, leaving little attention and energy for the parent to engage with the home visitor.

“It [positive change] so depends on where the parent is at, if they’re ready for it [change]. A lot of it comes down to addictions and abuse. Depending on where they are in those two things that changes everything too. It pulls everything, even what they want to do just doesn’t happen because they’re so pulled in by those.” (Home visitor)

The *KidsFirst* program plays a different role when it serves complex-needs families compared to other families. During home visits with complex-needs families, the home visitor often enters a volatile situation and supports the family through crisis rather than delivering curriculum and focusing on parenting, parent-child interactions and child development. For complex-needs families, the *KidsFirst* program and its staff fulfilled the role providing support, emergency counseling and crisis management rather than directly targeting early child development. Participants noted however that providing families with support and helping them through a crisis may set the conditions necessary for improvement of child development eventually. By reducing the frequency and severity of the crises, *KidsFirst* staff attempted to create safer, more supportive and stable environments for children.

“When you start prenatally with the child, it still is early in terms of the child’s life but not so for the parent. Many parents are already far into crisis and it [*KidsFirst*] becomes a program that must do crisis intervention before it can do early childhood intervention.” (*KidsFirst* staff member)

## 4.4 Retention of complex-needs families

*KidsFirst* staff shared how complex-needs families were hard to reach and often dropped out of the program after a short period of time. Home visitors noted that these families were difficult to contact or meet with. They frequently did not have phones, and they had difficulty scheduling and keeping appointments. Complex-needs families were also often highly transient making contacting and following these families even more challenging.

“You know because of the challenges that a lot of the parents face coming into our program because of the transience, because of addictions issues, all those issues we have a very high turnover of families. So some families maybe all we do is plant some seeds before they leave our program either due to moving or not engaging in the program because they have too many other issues in their lives maybe due to child protection issues.” (*KidsFirst* staff member)

Home visitors shared how the families who might benefit most from *KidsFirst* services are the most difficult to reach and they often drop out. Participants suggested that many families leave the program due to their “transient lifestyle”. Many participants shared how high risk families are very mobile and therefore very hard to reach.

“Really high risk families you want to see them maybe twice a week maybe six times a month, but they are the hardest ones to reach sometimes. You know what I mean? Like they’ve got the highest risk. There’s lots of movement on their part and their priority isn’t you [the home visitor]. Even though they may have a good connection with you, you’re still not their priority.” (Home visitor)

## 4.5 Housing

Respondents noted that many *KidsFirst* families experience housing instability and relative homelessness. The lack of stable housing contributes largely to the high degree of transience seen among complex-needs families. Study participants shared how a lack of stable housing undermines effective program delivery, program outcomes and parenting.

“I would think that not knowing, it is one thing if you go on a holiday and you’re sleeping in different places but if that’s your life in the suitcase is how you live it makes you think - I wonder how you’re going to parent a child if you don’t have a home?” (Home visitor)

“Even with all the success we have and all the things we’ve done in *KidsFirst*, when you look at all the crises around housing in this last year; it didn’t matter what was going on, if this family doesn’t have a place to sleep in a few nights, then anything else doesn’t matter; whatever we do, you know?” (*KidsFirst* staff member)

Respondents shared how many *KidsFirst* families were living in substandard housing even when they did have housing. Many stories were told about families who were living in run-down housing, infested with mice or cockroaches. Participants noted that often housing was not secure and not maintained by the landlord. Respondents noted that many families are also living in overcrowded housing situations. The *KidsFirst* staff shared how poor housing negatively affected parenting.

“The housing outlook for lots of our families is often very problematic and I think it can contribute to some of the challenges in parenting and even in relationships and the way we problem solve. It is amazing what having one location that you call home and a fridge that you call yours can do to your security.” (*KidsFirst* staff member)

When asked how the program could be improved, many *KidsFirst* staff noted that housing is greatly needed for *KidsFirst* families. Study participants believe that poor housing impedes program outcomes and that the program could be more effective if families were living in adequate housing.

“When families are in good housing they do better, when they are in substandard housing, overcrowded housing there is always more problems. Hardly ever do families do well when the housing is really substandard so housing would be one area for improvement.” (*KidsFirst* staff member)

## 5: Discussion

Findings in this study showed that when working with complex-needs families, home visiting was more focused on crisis management than on parent-child interactions or on child development. In situations where family support is emphasized over changing parenting behaviour and parent-child interactions, programs such as *KidsFirst* tend to be less effective in achieving the program outcomes (Hebbeler & Gerlach-Downie; 2002, Raikes et al., 2006). It needs to be noted however that in families with complex-needs, the *KidsFirst* program may still be serving a critical function for the family as they are supported through times of crisis. Home visiting programs often initially target parents to have long-term positive effects on children (Raikes et al., 2006). By providing crisis support to families, and the stabilization that results in their immediate environment, children have greater opportunity to develop in a safer and more stable environment.

The findings show that change in families is a process of ‘moving forward and moving backward,’ meaning that change is fluid and is not always in a positive direction. Many of the issues that families are dealing with are complex. As such, families often cycle through highs and lows as they face many different difficulties simultaneously. Relapse is common. Because families cycle through periods of crisis and periods of relative stability, and some drop out of and later return to the program, it is difficult to measure the extent of change and even the impact of *KidsFirst* with these families. Many of the issues that *KidsFirst* families face (poverty, unemployment, housing insecurity, domestic violence, mental health problems and addictions and developmental disabilities) are deep rooted, multifaceted and reoccurring issues which are known to hinder program delivery (Gomby, 2005). Additionally, in Saskatchewan many of the issues that Aboriginal families are facing are related to intergenerational trauma and the lasting effects of the residential school system. Although these issues are prevalent and of great significance, I found I was unable to address these deep and complex topics in a way that would due them justice in the scope of this project.

Not all families experienced positive outcomes from involvement in *KidsFirst*. Level of client risk is known to differentially affect both service delivery and program

outcomes (Russell, Britner & Woolard, 2007). Often, even when *KidsFirst* families with complex needs were successfully retained, there were less reported positive outcomes. HFA found that mothers with fewer risk factors were retained longer (Harding et al., 2007). Additionally, lower rates of involvement in ECD interventions have been seen with parents experiencing family conflict, abusing substances or anticipating a change in residence (Raikes et al., 2006).

In a meta-analysis of 56 home-visitation interventions aimed at improving parent-child interactions, Bakermans-Kranenburg *et al* (2005) note that families who have more relative material wealth and stability gain more from ECD programs; whereas families who are disadvantaged do *not* greatly benefit (2005). In my research, housing as an indicator of stability was related to program outcomes. Housing is a particularly important measure of stability as it is a determining factor for success in the context of a program delivered through home visitation. I found that families with poor housing rarely showed positive outcomes. Additionally, home visitors struggle to retain these families and even to connect them, as a first step, to the scarce housing resources available.

Vulnerable families in Saskatchewan are increasingly facing housing shortages. In Saskatchewan, income inequity continues to increase and the price of houses has almost doubled in the last 2-3 years (Gingrich, 2009). The vacancy rates for rental housing in both Saskatoon and Regina have been below 1%. Families are increasingly unable to keep up with the rising cost of housing due to inflation in housing costs and the concurrent cutbacks to Social Assistance (Muhajarine et al., 2010). Families on social assistance with one or two children receive only \$470 per month for housing (Merriman & Pringle, 2008). They can also apply for an additional supplement of \$134 per month if their accommodations are deemed safe and healthy. However, this additional supplement is largely unavailable to vulnerable families because they are often financially restricted to living in run-down and unsafe housing. Therefore, while \$604 is the maximum housing support a family could receive, many receive just \$470. Both of these amounts are less than the amount needed to rent a two-bedroom unit in any of the urban centers in Saskatchewan (Merriman & Pringle, 2008). Saskatchewan families are facing increases

in their rental costs, poor housing conditions, low vacancy rates and a lack of rent controls. This current housing crisis is forcing families into poor housing, over-crowded living and transiency.

Many families who may be eligible for the *KidsFirst* program are very transient and difficult to contact. We found that often *KidsFirst* families with complex-needs were highly mobile and were not retained in the program for this reason. Findings suggest that this is linked to housing instability. The proportion of families who do not complete the *KidsFirst* program is high; reportedly 40% of families drop out of the program and 26% of families move out of the program's target area (Gates et al., 2010). The average attrition rate for home visiting interventions similar to *KidsFirst* is about 50% (Gomby, 2005). In a review of home visiting interventions, Gomby (2005) also found that the families who drop out are often the families who are most in need of services. Minimal research has been done regarding the reasons for which families drop out of the program or the reasons that these families are highly mobile. The relationship between housing and program retention has yet to be explored. However, the first step in understanding this relationship is to understand young mothers' experiences of homelessness.

Young mothers in Canada have been shown to have an "invisible" experience of poverty and homelessness (Townson, 2005). Women with young children who are experiencing homelessness often go unnoticed by service providers, policy-makers and the public because they are rarely out on the streets. Rather than experiencing absolute homelessness, women and children are often found moving between situations of overcrowded and temporary housing. Research participants referred to the mobility experienced by families as a "transient lifestyle". This term implies that families are making a choice to be mobile. However, the larger context of housing in Saskatchewan currently suggests that low-income families are experiencing relative homelessness which is not a lifestyle choice for most, if any.

Young mothers' experiences of relative homelessness have important consequences for *KidsFirst* program intake and delivery. The point of contact with services is often in

the hospital at the time of birth. Here women are screened and, if eligible, are invited to join the *KidsFirst* program. Women who are interested in participating in the program but do not have a stable home to return to after leaving the hospital will often be untraceable and the delivery of services will never begin. Additionally, families who are recruited and begin to receive services may be quickly lost as they move between temporary living spaces. Additional studies have found that mobile families were difficult to retain (Raikes et al., 2006; Daro & Harding, 1999).

It is a conundrum to be delivering a program to vulnerable families through home visitation, when some of these vulnerable families in Saskatchewan are in fact homeless or facing housing crises. How would the home visitors find their clients if the clients do not have a home? When families experience housing shortages, sudden and steep increase in rental fees, poverty and other factors these inexorably lead to instability and in turn causes families to leave the program prematurely. Moreover, the issue of housing has endless negative health implications for families. For example, women are more likely to stay in situations of domestic violence to maintain financial support and stable housing. Studies have found that the presence of domestic violence in the home also impedes program benefits (Gomby, 2007). Additionally, at one *KidsFirst* site, staff reported that mothers are entering into the sex-trade to attempt to pay for housing. Both of these examples are amplified in circumstances where the women are single mothers caring for their children.

*KidsFirst* has been successful at effectively supporting families through assistance provided in meeting many of their basic needs such as transportation, childcare and food security. However, for a home visiting program to be effectively delivered, families must be living in secure housing. For families who were retained in the program, home visitors were able to help the families apply for housing and housing supplements but many families without adequate housing have remained out of reach. Families need a stable home to receive home visiting services. Additional research is needed regarding the impact of housing stability on program enrolment and retention.

## 6: Limitations and strengths

Complex-needs families were underrepresented in the sample of client interviews as they are characteristically difficult to contact or meet with; meeting with these families can be a challenge even for home visitors. Many of these families do not have phones, are highly transient and find it difficult to keep to a schedule or remember appointments. Typically the clients who were willing and able to do interviews represented the relatively higher-functioning and more stable parents in the program. All the data gathered regarding complex-needs families represented the perspectives of *KidsFirst* program managers, home visiting supervisors, home visitors, or management committee members. Parent perspectives on the themes presented in the paper were absent from the data set. Additional research is needed to capture the voices and experiences of complex-needs families.

Another limitation was that we were unable to interview parents who dropped out of the program, or gather data from a comparison group of at-risk families not enrolled in the program. Furthermore, because the data collection represented a “snapshot” in time, it did not capture responses that reflected multiple and on-going contact with the clients. For this reason, this study may not adequately present the longer, changing or enduring impacts or effects of *KidsFirst*. Also, with qualitative work that incorporates quotes, there is a natural bias towards quoting study participants who are more eloquent and who speak clearly and directly to the issue of interest.

A methodological strength was that the study was a large mixed methods evaluation where the qualitative and quantitative findings can be compared. The qualitative data can help explain and provide a context for quantitative findings. The qualitative data provides rich descriptions from those who are the most closely involved in the program. The strengths of this report include the large amount of data that were collected and analyzed and the number of different types of respondents involved at all levels of the program. Because we collected data from different sites and respondent types, we were able to compare findings across sites and across participant type, ensuring the reliability and accuracy of our findings.

Our study also benefitted from having a diverse multi-disciplinary research team. The diversity of backgrounds among researchers added depth and understanding to the analysis and findings. Our unique backgrounds allowed us to challenge each other's assumptions as we worked together to form consensus. The continuity of the research team further contributed to the strength to the study. One other researcher and I were involved from the planning stages, through data collection, coding, and data analysis to the writing of the qualitative report.

## **7: Implications for public health practice, policy and research**

The findings of this study inform not only further development and modification of the *KidsFirst* program but also contribute to the larger body of knowledge on early childhood interventions in Canada. Through this study, I was able to provide some insights about why *KidsFirst* has been less successful in retaining and affecting complex-needs families. I found that with these families the focus of the program often shifts from supporting good parenting practices to crisis management. I found that families who are experiencing housing instability are difficult to retain and often do not show positive program outcomes. Greater understanding of how the *KidsFirst* program may help with complex-needs families can improve program delivery by enhancing retention and providing stability to some of Saskatchewan's most vulnerable children and families who are currently not being reached.

As reported in the Qualitative Evaluation Report, to better meet the needs of families with complex needs, specialized case-workers (trained in social work, nursing, psychology or mental health) should be employed (Muhajarine et al., 2010). Extremely well-trained or professional home visitors are needed to serve families who are facing multiple complex issues (Gomby, 2005). Additionally, the intensity of services provided in the initial period (example, up to one year after enrolment) should be increased to multiple visits per week. These two recommendations can help with the retention of complex-needs families and may increase effectiveness of the program for very vulnerable families.

Even the best-trained home visitors struggle to engage, retain and deliver the required number of visits to families. Without homes of their own, families often move unnoticed between homes of friends, relatives and shelters making them highly difficult to track and contact. Additional housing services and supports are needed for *KidsFirst* families in to see improvements. There is a pronounced need for secure and affordable housing among low-income families in Saskatchewan. As such, the *KidsFirst* should consider incorporating a housing component into the program. Homeless women who

desire to be in *KidsFirst* should be moved from the hospital into *KidsFirst* housing to allow for program delivery. Housing supports could increase program recruitment, retention, and effectiveness. With secure housing, families may be retained long enough such that the program may begin to achieve positive outcomes as seen in other families.

*KidsFirst* staff and management committees *have* been successful at changing municipal housing policy at one *KidsFirst* site (Muhajarine et al, 2010). *KidsFirst* staff, who are well aware of families' needs and challenges, should continue to advocate for changes in housing policy and for additional housing support for families (ie., rent controls, increase social assistance, safe and secure social housing). The structure of the *KidsFirst* program brings community agencies and government ministries together providing *KidsFirst* staff with a forum to whom they can present the needs of vulnerable families.

For the most part, the *KidsFirst* program works well for families who are retained in the program. Many positive outcomes were reported in the areas of parenting knowledge, confidence and self-efficacy as well as improved parent-child interactions. In this report I have uncovered the specific difficulties of working with families with complex needs. More research is needed to understand the relationship between housing and retention. Additionally, research is needed to gather the perspectives of families with complex-needs as well as families who are not retained in the *KidsFirst* program. It is important to understand why families leave the *KidsFirst* program and how they could have been better supported. There are a number of families whose voices have yet to be heard. These include families who have dropped out of the program and families who are not participating in the program. Perhaps these families could be reached through snowball sampling friends of families who are participating in *KidsFirst*. Their stories may be more accurately obtained through training parent with similar life experiences to collect the data. This information will help improve the delivery of *KidsFirst* services and extend the reach of the program to vulnerable families who are not currently receiving services.

## **Appendix A: Family descriptions**

**Excerpted from “A qualitative description of high/complex, medium/intermediate and low complex needs families in the *KidsFirst* program” (Muhajarine et al., 2010, pg 11-12).**

### **Profile of a Typical High/Complex-needs Family**

Sarah is an unemployed 19-year-old mother of two children, aged two and-a-half years and 13 months. She suffers from Fetal Alcohol Spectrum Disorder (FASD), and both children also have FASD and exhibit many developmental delays. Sarah joined *KidsFirst* when her second baby was born. She has a low level of literacy and has trouble remembering information and completing tasks. This has made parenting difficult for her and she often neglects her children’s needs. Sarah’s current boyfriend, Dave, is occasionally abusive towards both her and her children. She has a history of drug addiction and since getting involved with Dave, has had occasional relapses when he uses drugs. Social Services has apprehended her children once in the past, and a social worker continues to work with the family.

Sarah often leaves town to visit friends and family without telling her home visitor and can be difficult to track down. The family home is a two-bedroom rental property, and the landlord has threatened to evict the family because rent is often paid late. Sarah has difficulty managing her budget. Money runs out by the middle of the month and the family relies on food banks and *KidsFirst* vouchers to get groceries and diapers. The family does not own a vehicle and relies on *KidsFirst* for rides and taxi coupons. Their home visitor comes to the home once a week, but the family often asks for additional support and Sarah calls her home visitor throughout the week for advice or transportation.

### **Profile of a Typical Medium/Intermediate Needs Family**

Patricia is a 30-year-old single mother of three children. She has completed high school and works part-time as an administrative assistant in a dental office. Her two older children are in school and her youngest child is in daycare during the day. Patricia joined *KidsFirst* six years ago when her middle child was a baby because she wanted help managing her post-partum depression. Since that time she has continued to struggle with depression and anxiety and finds it stressful to leave her home or to socialize with strangers. *KidsFirst* arranged counselling sessions for Patricia after she joined the program, and she attends them regularly and finds them helpful. Patricia’s home visitor comes to her home twice a month. Patricia enjoys these visits because she often feels socially isolated and likes to have someone to talk to that she can trust. Because it takes

Patricia a long time to open up to people, having this stable relationship has been very important to her. The constant support from her home visitor has enabled Patricia to become more confident in herself. She now finds it easier to leave her house and she has now begun taking her children on outings to the swimming pool and library. For years, Patricia’s home visitor has been encouraging her to attend *KidsFirst* social gatherings, such as community barbeques and cooking workshops, so that she can meet

and make friends with other single mothers. Although she has not participated in these activities yet, she has decided that she is now ready to attend one. Patricia's home visitor has helped her arrange transportation and childcare so that she can attend an upcoming event, and is very proud of the progress that she is making in working through her social anxiety.

### **Profile of a Typical Low Needs Family**

Cecelia is a 26-year-old mother of a one-year-old baby. She is unemployed, but is in the process of upgrading her high school diploma because she would like to apply to nursing school. Cecelia and her baby's father, Kurt, live together and are in a stable relationship. Kurt works full time, and although the family sometimes struggles with money, they are always able to pay their bills and buy groceries. The couple has the support of many friends and family members who live close by. They also have a car and therefore do not have trouble accessing transportation. They decided to join *KidsFirst* when Cecelia was pregnant because it was their first child and they wanted reliable information and guidance on how to care for their new baby. Both parents enjoy the information provided by their home visitor when she makes her monthly visit to their home.

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