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Linking the Academic and Helping Communities into a Best-Practice Community to Improve the Health Outcomes for Isolated Families

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Abstract

A crisis nursery and respite care programme in a large Canadian city began as a grass-roots, helping community of volunteers that addressed the problem of child maltreatment. At the outset, they began with three essential beliefs. One, isolated families can learn to improve their effectiveness in dealing with crises. Two, isolated families learn best when exposed to positive experiences that promote self-learning. Three, every helping community has to verify how it benefits society.

Three years after its inception, the community of volunteers reached out to the academic, nursing community to fashion a mission, philosophy and goals. The combined helping and academic communities developed an ecological, practice model that focused on the role of stress and lack of coping skills in precipitating child maltreatment. This model, with its measureable outcomes, eventually resulted in a best-practice model that now has two decades of research. The model addresses the interplay of stressors, a lack of resources and coping strategies that often overwhelm isolated parents and that place their children at-risk for maltreatment. To ameliorate their conditions, these isolated families require social support, including efforts to improve personal agency, access to community services and clinical interventions, when necessary.

The best-practice model has, over six years, using a single-group, pre- and post- design, collected data from families (n = 3,394). Outcomes include: stress, positive and negative affect, hopefulness and coping. Quantitative and qualitative analyses indicate that parents benefit from their experiences at a crisis nursery. The data generally support the thesis that after parents receive social support their stress and negative feelings decrease, their hopefulness, in terms of all sub-factors (cognitive, affective and situational), as well as their coping skills increase. Furthermore, anecdotal data indicate that the families have increased resourcefulness in meeting the challenges that occur in their everyday lives.

Keywords:

Corresponding Author:

Introduction

This paper reports on a long-term study of a nurse-managed crisis nursery and respite care center, known as the Children's Cottage Society, in Calgary, Canada. The program endeavours to reduce stress, improve coping skills and increase hopefulness for socially isolated families that request support, for upwards of seventy-two hours, because they require safe environments for their infants and children during family crises. Opened in 1986, the idea for the program derived from second generational thinking about the prevention of child maltreatment that had only begun to appear in the academic literature. The thinking centered around preliminary data that suggested a relationship between social support for families in crisis and the reduction of stress, associated with child maltreatment. This knowledge, however, remained largely confined to the research community (Allison, Kilgallon & Reilly, 1989). The transfer of this knowledge and subsequent alliance between the academic researchers as well as the political and practice communities eventually produced an initiative that became the Children's Cottage Society.

Before academics spoke about knowledge translation as means of moving ideas from the laboratory to practice, Etienne Wenger (1998) introduced a similar notion, known as "community of practice" (CoP). A CoP constitutes a group "...of people who share a concern, a set of problems, a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger, McDermott & Snyder, 2002, p.4). The concept of academics joining with the larger community to solve a social health problem certainly describes the collaboration that took place with regards to the development of the Children's Cottage Society. That is, nursing educators as well as clinicians and various stakeholders concerned about child maltreatment joined with the political and philanthropic communities to provide an innovative kind of social support to young families. Together they formed a legal entity, with its own organizational structure, distinct from the university. A collective enterprise, with shared purposes, the CoP developed a set of goals that distinguished it from other resource-based social health organizations. Without any formal mandate, it became a self-organizing system that spanned the institutional structures where the educators, clinicians and other stakeholders were employed. Over time, the CoP reset its terms of reference and its membership as practices evolved so that it adapted to changes in community standards and applied the latest research about best practice to prevent intentional harm to children of isolated families. Notwithstanding these changes, nurse educators remained at the core of the CoP—they assumed responsibility for the construction of outcomes, the selection or design of psychosocial tools and instruments and the evaluation of data. Eventually their participation in the work of the crisis nursery and respite care programs came to define their clinical focus and ultimately their knowledge about best-practices. Although they constituted the core of the organization, the nurse educators and clinicians insured full participation by the larger community so that the CoP more closely resembles all stakeholders and not self-described

experts. In effect, the Children's Cottage Society benefitted from a distributive kind of leadership. Depending on the needs at any one time, different individuals, not always nurses, took on a leadership role. By legitimizing the participation of others in the CoP, the Children's Cottage Society benefitted from the expertise of individuals that brought with them different skills and mind sets.

The crisis nursery and respite care center are two of nine programs organized by the Children's Cottage Society. They provide a caring and supportive environment where infants and children stay, while their parents receive psychological or informational support and obtain respite. In summary, they employ a social support model and follow a resource-based approach by providing twenty-four hour childcare and parental support during disruptions in family life.

Significance

Trocme, Fallon, MacLaurin, Sinha, Black, Fast &Holyroyd (2010) report that in 2008 Canada recorded 85,440 substantiated child maltreatment investigations. On this same point, measured across a wider spectrum of factors associated with the well-being of children, The United Nations Children's Fund(2007) (as cited in *Innocenti Report Card* 7, 2007) ranked Canada overall in the sixtieth percentile of twenty-one OECD countries. With exception of education (90th percentile) and material well-being (70th percentile) Canada ranks below the median for child well-being along six dimensions. The four include health and safety (40th percentile), subjective well-being (25th percentile), behaviours and risks (15th percentile) as well as family and peer relationships (10th percentile).

Importance

In November, 2012, The Royal Society of Canada & The Canadian Academy of Health Sciences Expert Panel published a white paper about how adversity affects the health of children into adulthood. That is, it asked whether adverse childhood experiences (ACEs) (Anda, 2011), including child abuse and neglect, impair individuals' mental and physical health later in life. Additionally, it asked whether any interventions mitigate these effects and whether they are implemented in Canada.

In answer to the first question, the report maintains that ACEs impair bio-psycho-social development, even if the causal relationships remain elusive. With regards to whether there are suitable interventions, the report insists that social support represents the most effective means available. However, the report points out that sustained and intensive interventions with vulnerable populations have only begun in Canada.

> There is now a limited but promising body of research showing that child maltreatment, perhaps the most serious adversity that children may encounter, and its associated outcomes can be reduced if targeted, intensive and sustained services are deployed. In contrast, there is a paucity of credible research evidence on how broader interventions at the level of the community might influence adverse childhood experiences in ways that, in turn, would influence long-term developmental outcomes (p. iii).

Immediate, short-term interventions are not broached. There is no discussion of the buffering effects of psychological, material and informational assistance during critical life events on the health trajectory of children exposed to ACEs.

Review of the Literature:

Bronfenbrenner (1979) writes that demands and stressors directly effect parents. Crises are especially critical for poor, isolated, lone- parent, families that lack the social support to cope with disruption in their lives.

Dunst's (1994, 2000) research demonstrates that social support, personal well-being, parenting interaction styles and child development are both conceptually and empirically related. Moreover, his findings indicate that social support and parent-well-being are intervening variables, and they account for much of the variation in child development usually attributable to family risk factors such as socioeconomic status. His research delineates differences among kinds of social support and the mechanisms for their delivery.

A variety of research studies have consistently found parenting stress to be a significant precipitating factor in child maltreatment (Thomas, Leicht, Hughes, Madigan &Dowell, 2004). Current theoretical models of child maltreatment, termed transactional models (Belsky, 1993) explain the role of stress in child maltreatment. These models postulate that the development and maintenance of child maltreatment occurs in the context of complex transactions including child and parent characteristics, parent-child interactions, marital and family relationships, and broader ecological or societal variables (Holden &Banez, 1996).

The Stress and Coping Model of Child Maltreatment (Hillson& Kuiper, 1994) elaborates upon the mechanisms whereby parental stress, unless modified by cognitive appraisal and coping strategies, along with requisite resources, can lead to child maltreatment, whether as abuse or neglect (Figure 1). As the model states, parents that abuse their children do so because they "focus on venting of [their] emotion[s]". In effect, they react to stress in a manner that gives rise to feelings of "anger, anxiety, fear, guilt, shame, sadness, envy, jealousy or disgust" (p.268). These reactions occur because the parents either appraise their situations as uncontrollable or harmful to themselves. They lack the resources and/or coping dispositions to alleviate

their situations. Unable to reduce their emotional distress or cope with their problems in a constructive manner, they lash out at the most vulnerable members. Whether these events produce a stressful reaction depends on how the parents appraise their situations. That is, a stressful reaction by itself does not necessarily result in child abuse. It only occurs when upon examination of their resources and coping options, highly stressed parents find themselves without social support or the coping disposition to engage in appropriate parental behaviour. Alternatively, in the words of Hillson and Kuiper, "…those caregivers perceiving the availability of more resources and/or options, and hence greater control, may experience lower levels of stress, and thus engage in more desirable caregiver behaviour" (p.273).

Several research studies specifically examine factors of parental stress, sources of stress, levels of stress reduction, and rates of child abuse and neglect in the context of provision of combinations of supportive counselling and respite care (Cowen, 1998; Andrews, Bishop &Sussman, 1999). These studies examine the role of emergency respite centre care as a means of preventing child abuse, and conclude that social support reduces stress. The reduced levels of stress—the researchers believe—results in lowered risk of abuse. In short, the literature supports the belief that targeting parental stress prevents child maltreatment.

Research Design

This study employs multiple measurements in a single mixed method pre-post test design. It collects quantitative and qualitative data on one group of parents prior to and at the end of their children's stay at the crisis nursery. The study examines stress in combination with other aspects of emotionality associated with crises, including hope, and adds a question about the parents' behavior or coping response of parents during their children's stay at the crisis nursery and respite care centre.

The study addresses four research questions. They are:

1. Do parents indicate changes in their levels of hopefulness after receiving support from the crisis nursery?
2. Do parents report differences in their levels of stress after receiving support from the crisis nursery?
3. Do parents report a difference in their positive and negative feelings after receiving support from the crisis nursery?
4. Do parents report facilitative coping strategies after receiving support from the crisis nursery?

In total, four instruments or tools collect data on a single group of families that ask for and receive social support from the nursery. Each answers a different question. First, the Herth Hope Index (HHI) contains several subscales that tap into cognitive, affective and situational aspects of hope. Designed for a sixth-

grade reading level, the HHI is a reliable, 12-item Likert-scale instrument, designed for repeated measurements. Second, the Parental Stress Rating Scale (PSRS) collects data from parents about their levels of stress at two points in time. The first is when they arrive at the crisis nursery, and the other is when they return for their children. The third instrument, the Positive Affect, Negative Affect Scale (PANAS), (Watson, Clark &Tellegen, 1988) examines two broad measures of emotionality, whereby parents select their specific feelings before and after their children's stay. The scales are reliably sensitive to changing internal and external events. Fourth, the study also collects qualitative data. It asks one open-ended question, "All in all, what was the most important thing that you did while your child or children stayed at the Children's Cottage?"

Sample

  Two-thirds of the families are Caucasian; First Nation families and other visible minorities constitute the next largest group. They are female, single, and tend to cluster between 25 and 30 years of age. They are highly mobile; at least one-third of the families report that they moved two or more times in the last year. Some have contact with child welfare, but approximately half have had no involvement whatsoever. The majority have incomes below the poverty line that makes them eligible for social assistance. Most have some kind of childcare available, although the data do not reveal whether it is always accessible. A sizeable number have no regular available childcare. From other data we know that most of these parents lack an important resource for coping with stress. When asked whether they have other options if the Cottage cannot accept their children during a crisis, a majority report that they have no alternatives. In fact, a surprising number, more than half, report that they would consider temporary foster care without the crisis nursery. Regarding how frequently they access the crisis nursery, about half of the families report that they call the crisis nursery one or two times over twelve months; the other half state they come about twice as much.

Findings

Data collected during five years (n= 2466) support the intended outcomes (Table 1). That is, data indicate that the levels of hopefulness become more positively skewed after the children's stay. An examination of the scores shows an increase in the number of parents that had higher levels of hopefulness in the post-test. In effect, parent's level of hopefulness increased significantly ($\alpha= .01$) after their children's stay. Similar findings are reported for the second factor, stress. That is, data analysis confirms that parents had significantly ($\alpha= .01$) lower levels of stress as measured between the arrival and at the end of their children's stay at the crisis nursery. Analysis of positive

and negative affects shows significant (α= .01) differences between the arrival and the end of their children's stay. Parents reported less negative feelings, They seemed less likely to describe themselves as "distressed", "scared", "irritable", "hostile", "ashamed", "jittery", "nervous", "afraid", "guilty" and "upset". Parents, in effect, reported more positive feelings. They seemed more likely to describe themselves as "interested", "excited", "strong", "enthusiastic", "proud", "alert", "determined", "attentive" and "active". The fourth and last research question examines coping behavior in qualitative terms. It asks parents to describe how they utilized the time and resources, during the time, about seventy-two hours, their children stayed at the crisis nursery. Derived from Hillson & Kuiper (1994), the analysis classified the different behaviours, during the children's stay, according to four kinds of facilitative coping responses (Table 2).They are: Active Planning and Coping, Restraint Coping, Use of Functional Social Support, and Positive Reinterpretation. The tool does not collect data about abusive or neglectful caregiver behaviour because the children are in temporary care with the staff of the crisis nursery and respite care center. Consequently, abusive and neglectful behaviour cannot occur during the children's stay. With the freedom to focus on their needs and problems, the parents report that they use their time and resources to lend structure and organization to their lives. About 80% of parents generally report behaviors corresponding to "active planning and coping". The next category, "restraint coping", accounts for about 10%. The remaining two categories, *viz.* "functional social support seeking" and "positive reinterpretation", account for roughly 05% respectively. The candor of their comments display an openness that implies a willingness to develop appropriate coping responses to the stressors and adversities in their lives. There is an evident readiness to accept responsibility for the management of their lives.

Conclusion

After five years of study, we can offer the following conclusions:
One, early, discrete interventions significantly mitigate stressful factors that produce a climate of toxic stress for infants and children;
Two, social support significantly replaces the negative feelings of distress and disagreeable engagement with positive feelings of high energy and enjoyable engagement so important to families in adversity;
Three, although in times of adversity and exhaustion, hope appears low, it can significantly improve with social support;
Four, support and respite, in combination with a resource-based approach to early intervention, enhances positive parental agency so important to mitigating the toxic stressful responses of infants and children.

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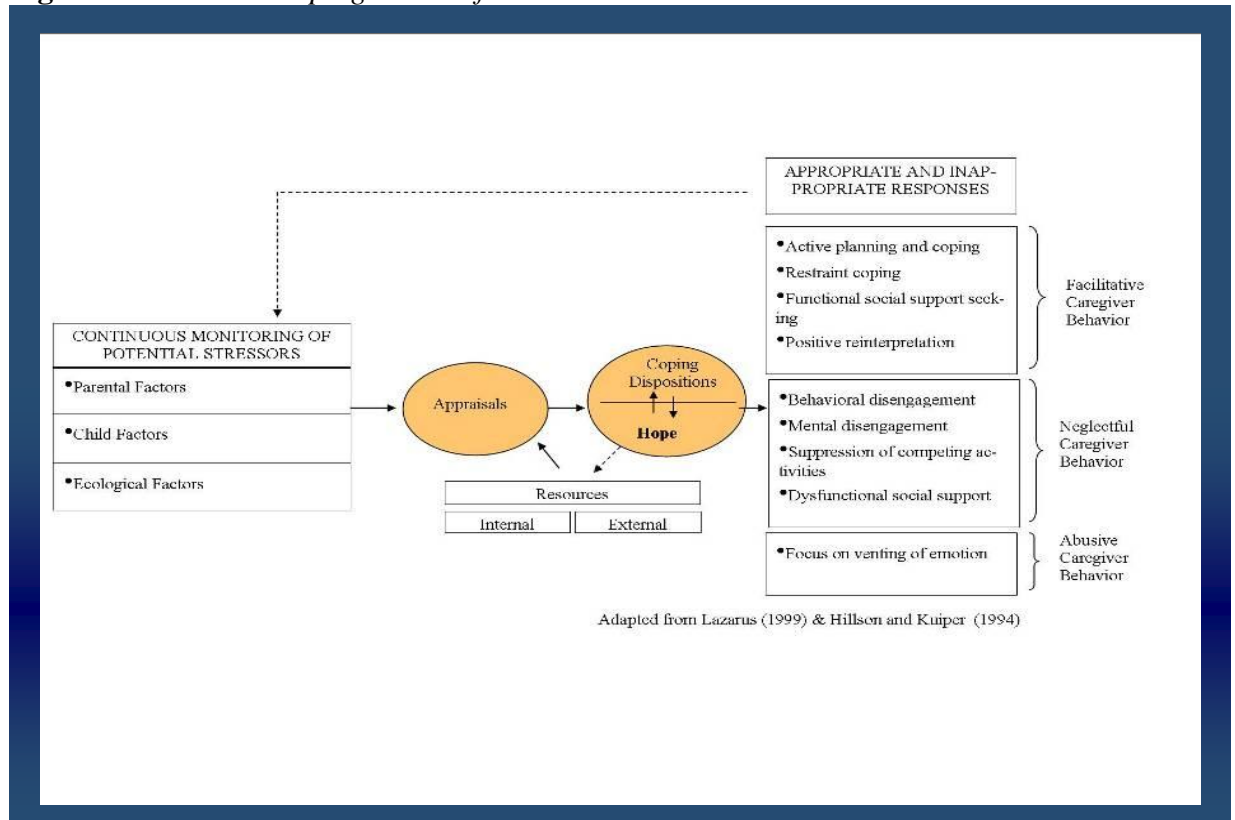**Figure 1.** *Stress and coping model of child maltreatment*

Table 1. *Summary of research design and outcomes*

	Instruments/Tools	Protocol for Administration		Indicators of Success	Outcomes
		Upon Arrival	End of Stay		
1	Socio-Demographic Questionnaire	√		Completed questionnaire	Socio-demographic characteristics of families
2	Herth Hope Index (HHI)	√	√	Increased hopefulness	Significant increase in hopefulness
3	Parental Stress Rating Scale (PSRS)	√	√	Decreased stress	Significant decrease in stress
4	Positive Affect, Negative Affect Scale (PANAS)	√	√	Increased positive affect / Decreased negative affect	Significant increase in positive affect / Significant decrease in negative affect
5	Parental Coping Inventory (PCI)		√	Decision to employ positive coping responses	Demonstration of facilitative coping responses

Table 2. *Representative parental responses corresponding to four facilitative coping categories*

	Representative Coping Responses	Representative Coping Responses
Active Planning & Coping	1. "I got to have a long conversation with my husband to talk about the problems we're having. We wrote down the changes that have to be made. Then went out to buy things that will help with the changes (ie: timer, storage boxes). Now we just have to make changes to our attitudes towards each other."	2. "Spend time with my grandmother, who is dying." 3. "Rest and preparing for the next plan. Find childcare. Take an exam. I thank the Children's Cottage deeply for being there for me. With the Children's Cottage there exists possibilities."
Restraint Coping	1. "Got time to defuse my stress." 2. " i found myself again, regain control ."	3. "I was so stressed with everything going on at the Shelter we needed a break, and I didn't want to take it out on my child. That was really important to us."
Functional Social Support Seeking	1. "I signed up for counselling and was accepted into Discovery House 2nd stage housing."	2. "To be able to see a councilor and talk about my problems. I appreciate everything the Cottage has done.
Positive Reinterpretation	1. "Got time to reflect and found the positive in my current situation."	2. "Reconnect with my spouse. Time for me. Be a better mom - clear up my mind."