Home Visiting in Alberta: A current state assessment
Final Report

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Executive Summary

A comprehensive review of the current state of Home Visiting (HV) services in Alberta has been undertaken by the Alberta Centre for Child, Family and Community Research (The Centre) on behalf of Alberta Human Services over the past 18 months.

In order to capture a wide range of perspectives and information, the project team used systematic processes to gather and synthesize findings from five components:

- A survey of HV delivery agencies and interviews with home visitors, supervisors/program managers, and Child and Family Services (CFS) regional contract administrators
- Document review of service contract Schedule A's and reporting templates
- State of the science and practice literature review
- Environmental scans on focused topics including national and international HV models, HV staff competencies, and training topics
- Consultations with thought leaders through interviews and an in-person meeting

This review confirmed the overall value of HV as a strategy that is in alignment with the following policy outcome objectives from Human Services' Business Plan for 2016-2019:[1]

- Alberta families and communities thrive through improved supports by strengthening prevention and addressing the root causes of social and economic challenges
- Albertans receive higher quality programs and services that are more coordinated, seamless, and tailored to their needs to maximize their potential
- Greater collaboration between government, communities, and Indigenous partners to strengthen services and achieve shared social outcomes

Key lessons that emerged from analysis across all components, including:

Key Lessons for the Foundations of Home Visiting

- The relationship that develops between the home visitor and the family was consistently identified as the heart of HV. This theme of relationships, and by extension the process of engagement, was particularly prevalent across findings from all sources in the review.
- The rationale for HV is supported and bolstered by significant evidence on the importance of the social environment and parenting on early brain growth and health, as well as evidence on the adverse impact of toxic stress on infants and young children.
- There is considerable consensus on the guiding principles of HV; these guiding principles can serve as an important anchor for HV in Alberta.

- Extensive research has confirmed the effectiveness of HV on a range of child and family outcomes, when there is: adequate capacity for implementation, consideration for context, and guidance by overarching principles.
- There are reliable and credible methods for ongoing learning and continuous improvement. Such methods allow stakeholders to gather the evidence they need, be accountable, and improve outcomes in credible and responsive ways.

Key Lessons for the Practice Level

- Notable variability exists in family eligibility in terms of both demographic and risk factors. There was concern that some referrals are not appropriate for the service scope of HV, with some families needing more intensive services.
- With respect to staffing, there was support for continued use of paraprofessionals as home visitors, provided training is thorough. There was a favourable view of current training content and levels, with some suggestions for improvement.
- There are many HV models available to learn from, and build the understanding about how and why HV works. This reinforces the need for ongoing evaluation, monitoring, learning and improvement.
- Variability exists across many aspects of practice, ranging from the level of use of the S&G, tools and procedures for screening and assessment, use of particular models and/or curricula, to outcomes measurement and reporting. Managing variability within a range is beneficial for allowing HV agencies to respond to community needs, leading to successful programs. There was reasonable consensus on the areas of practice for which greater consistency is desired and the areas of practice where flexibility is needed.

Key Lessons for the System Level

- HV is well established as a cornerstone of PEI for families with infants and young children.
- HV is embedded in a continuum of early childhood services and integrated within a service system that crosses health, social, educational, and human sectors.
- Community connections are essential to successful HV and needs to be adaptive and responsive to family and community needs.
- Leading practices in HV include clarification on shared outcomes, being situated within a continuum of support, and having the capacity to support the programs.
- Adequate and supported capacity is necessary to advance HV in Alberta.

Current state findings reveal the many strengths that can provide a strong foundation upon which to build an enhanced provincial approach, including:

- Passionate and enthusiastic staff and supervisors who believe in the importance of HV and feel that the work they do is making a difference for families
- Commitment to the core principles of HV that are aligned with progressive practice elsewhere
- Positive working relationships amongst home visitors, their supervisors, and teams
- Recognition of the benefits of greater consistency and the areas where flexibility is also important
- Positive receptivity to, and an appreciation of, continuous learning to advance practice
- Strong desire amongst home visitors for increased connectivity and communication with other HV staff and agencies, other service providers, within and between regions, and with Human Services

The review identified variability in operations, service delivery, evaluation, and performance reporting that may be detracting from achieving the collective objectives for positive outcomes for Alberta families. While providers clearly value their work and many examples of positive change for families are being reported, the amount of practice variation across so many parameters can undermine the effectiveness and efficiency of services, and ultimately the achievement of desired outcomes. In addition, it is currently difficult to document the benefits of HV for the whole province. While these challenges are not trivial, there is an encouraging level of existing wisdom and capacity already present, as well as a depth of tools and resources in the scientific and practice literature to support a solid path forward. This report details a number of considerations for moving forward.

A renewed and advanced approach to HV that best serves key policy objectives is one that fits within the array of related services serving Alberta children and families in within the Alberta context.

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Introduction

The purpose of this document is to report on the findings across all components and to recommend next steps considerations for advancing Home Visiting (HV) in Alberta.

HV is a key program element within the continuum of Prevention and Early Intervention (PEI) programs and services for families in Alberta that encourages positive child development and family functioning. HV and other closely related services (e.g. Parent Link Centres) serve families with identified risk factors and are designed to strengthen protective factors and reduce the impact of risk factors. These programs offer families valuable support to help ensure children have stable and healthy living environments in which to grow and develop. Ongoing evaluation of these services is essential to continue to meet short and longer term policy and program-level objectives.

A comprehensive review of HV in Alberta has been undertaken by Human Services in partnership with the Alberta Centre for Child, Family and Community Research (The Centre). The purpose of this review was to assess the current state of HV services in Alberta to inform the updating of the 2004 provincial HV Standards and Guidelines (S&G) and to aid the conceptualization of capacity building approaches to improve PEI services focused on early childhood development (i.e., for children aged 0-6 years).

In order to capture a wide range of perspectives and information, the review of HV current state included systematic research processes to gather and synthesize findings from five research components:

- A survey of HV delivery agencies and interviews with home visitors, supervisors/program managers, and Child and Family Services (CFS) regional contract administrators
- A document review of service contract Schedule A's and reporting templates
- State of the science and practice literature reviews
- Environmental scans on focused topics including national and international program models, HV staff competencies, and training topics
- Consultations with thought leaders through interviews and an in-person meeting

This work has confirmed the value of HV as a high-level approach grounded in a set of core principles. It has also identified areas for further refinement and harmonization of practice across the province. These findings can help contribute to the achievement of desired outcomes that align with Alberta's current policy directions.

A Note on Terminology

This report uses the terms "Aboriginal" and "Indigenous" with the recognition that while the terms are similar, they are not the same. "Aboriginal" is a constitutionally defined term that includes First Nations, Métis, and Inuit people. The authors of this report prefer the term "Indigenous," which is more inclusive

and internationally used, while also recognizing that individuals and communities will self-define their identities.[2] However, because the sources from a number of the components used both terms, both terms appear throughout the report.

Background of Home Visiting in Alberta

HV services were initiated in 2001 as a provincial initiative in response to the Alberta's Children Forum and the Provincial Task Force on Children at Risk. In 2004, the Ministry of Children's Services (currently Human Services), in consultation with the province's Child and Family Services Authorities (currently Child and Family Services (CFS)) and the Alberta Home Visitation Network Association (AHVNA), released *Guidelines for Home Visitation Programs*, frequently referred to as the standards and guidelines (S&G).[3]

The purpose of the S&G was to provide new agencies with direction regarding an overarching HV approach and key operational and quality standards to help ensure consistency of implementation across the province. The aim of HV was stated as assisting families who "may place their children at risk and keep them from developing [to] their full potential." [3(p5)] In keeping with international leading practice, HV was positioned as an early intervention program designed to foster healthy child development in families in their community context.[3] The HV initiative built its foundational objectives, values and principles off the vision and mission of the Ministry of Human Services which are, "working together to enhance the ability of families and communities to develop nurturing and safe environments for children, youth, and individuals" and the vision was "an Alberta where children and youth are valued, nurtured and loved, and develop to their potential, supported by relationships, healthy families, and safe communities." [3(p6)]

When the provincial HV initiative started in 2001, emphasis was placed on the Healthy Families America (HFA) HV model that was created in the United States in 1992 through the Prevent Child Abuse America initiative.[4] HFA is one of over a dozen models currently considered to have sufficient evidence for effectiveness[5,6] and was designed to "promote positive parenting, enhance child health and development and prevent child abuse and neglect,"[4] Several of the twelve critical elements of the HFA model are evident in the S&G.[3] Over the years, several agencies in Alberta, but not all, have used the HFA model as an initial guiding approach for service delivery.

Alberta Human Services currently funds over 30 agencies under a specific funding code (355). Some of the Human Services' code 355 programs are jointly funded through partnerships, for example, with Alberta Health Services. Human Services originally contracted with the ten regional Child and Family Service Authorities (now CFS), which in turn subcontracted local agencies for the delivery HV services while overseeing HV operations. In 2014, the ten CFS regions were merged into seven regions along with one Metis region. Although these boundary changes have shifted contract connections for some HV agencies, the structure of funding and delivery of HV services in Alberta has otherwise remained unchanged over the past decade. CFS in the eight regions work with their service delivery partners to enhance existing HV programs and develop new programs to meet the particular needs of their

communities. Through HV, parents, families, trained home visitors, and community agencies work together to raise healthy, well-adjusted children who can succeed at learning and achieve their full potential.

HV in Alberta is currently positioned in a continuum of services within an overall framework for Prevention and Early Intervention (see Table 1).[7] Alberta's HV programs are part of a continuum of supports to vulnerable Alberta families across the spectrum of promotion, prevention, and early intervention through to direct child intervention.

Table 1: A Model of the Current Prevention to Intervention Continuum in Alberta[7]

Primary Prevention	**Early Intervention**	**Intervention**
Programs and services that provide families with the support that they need to build protective factors and prevent the development of risk factors	Involvement with families when vulnerabilities are first identified in order to strengthen protective factors and reduce the impact of risk factors	Targeted interventions after maltreatment has occurred to reduce the negative consequences and to prevent its re-occurrence.
***Examples* of programs and services:**		
▪ Parent Link Centres ▪ Early Childhood Development Programs ▪ Child Care Programs ▪ Triple P Parenting Programs: Levels 1, 2, & 3 ▪ Fetal Alcohol Spectrum Disorders (FASD) Awareness and Prevention ▪ Youth Mentoring Programs ▪ Taking Action on Bullying ▪ Prevention of Family Violence and Bullying Education and Awareness ▪ FCSS	▪ Home Visitation Programs ▪ Alberta Vulnerable Infant Response Teams (Edmonton and Calgary) ▪ Head Start Programs ▪ Parent Link Centres ▪ Triple P: Levels 4 & 5 ▪ FASD Network Supports ▪ Family Support for Children with Disabilities ▪ Youth Mentoring Programs ▪ Community Programs for Youth at Risk ▪ Prevention of Family Violence Programs ▪ FCSS	▪ In-Home Family Support Programs ▪ Counselling Services ▪ Triple P: Levels 5 – Pathways ▪ Families with Child Intervention involvement may also be referred to, and/or continue to participate in, community-based programs such as Parent Link Centres or Home Visitation for additional and on-going support.

Research activities for the HV current state review were conducted from October 2014 to June 2016. This report will be followed by a HV capacity framework for enhancing current capacity and building new capacity, expecting to be shared in 2017.

Methods of the Current State Review

Brief descriptions of the methods used for each of the five research components (HV agency survey and interviews with stakeholders, document review, state of the science and practice literature, environmental scans, and thought leaders consultations) of this review are provided below. Once findings from all components were summarized and reviewed by team members, key messages were developed into themes by the full project team in the form of themes in a full-team face-to-face nomination, discussion and consensus exercise. See Appendix A for more detail about each of these components.

Home Visiting Agency Survey and Stakeholders Interviews

The purpose of the agency survey and stakeholder interviews was to help develop an understanding of the operational details of HV agencies in Alberta. Informed by initial interviews with Advisory Committee[i] members, the project team surveyed HV agency leads using an online questionnaire. This questionnaire covered topics such as staffing, characteristics of clients served, referral and screening approaches, HV models and/or curricula used, and staff training, amongst others (See Appendix B for the full survey questionnaire). Responses were received from 27 of 36 eligible agencies, resulting in a response rate of 75%.

From participant nominations within the questionnaire, in-depth interviews were conducted with ten home visitors and nine supervisors/program managers (See Appendix C for interview guide). Eight CFS regional contract administrators identified by the Human Services Early Childhood Development Branch were also interviewed. Interviews were conducted over the telephone, were recorded, and transcribed verbatim.

Questionnaire responses and interview transcripts were compiled and analyzed, with summaries validated by at least two team members. These summaries were then cross-mapped against the major content areas of the S&G and findings were synthesized (see Appendix D for details on the approach).

To ensure all perspectives were represented in this review, an additional data collection strategy was conducted focusing on those providing HV services specifically to Indigenous communities. Alongside the specific Aboriginal serving HV agencies included in the previously mentioned questionnaire and interviews, additional interviews were conducted with other Canadian Indigenous HV programs. Analysis is currently underway and the findings from this work will be reported at a later date.

[i] To ensure the inclusion of existing wisdom in the field, The Centre worked with an Advisory Committee consisting of members from Human Services, Child and Family Services, and PLC and HV agencies. The group met intermittently to hear about the work the project team was doing and to provide valuable feedback. At the beginning of the project, the project team interviewed Advisory Committee members to help develop an initial understanding of HV. Their suggestions and information were invaluable in shaping the data collection strategies. The project team used this approach for this project to build on the strong foundation of past research and existing practice-based knowledge.

Document Review

CFS's Schedule A contracts for HV services from six of seven regions were compared and contrasted for content and format. These documents contain details regarding program delivery and operations, including descriptions of clients served, goals, and desired outcomes. Schedule B contracts, containing financial information, were not included in this review. Five of seven regions also provided a copy of their program reporting template. The Schedule As and reporting templates were contrasted and compared for content and format.

State of the Science and Practice Literature Reviews

Reviews of the scientific literature were conducted in three rounds to identify key research to support the project at various stages. Each review built on previous steps, with each round becoming more targeted. The first review was conducted to identify the major concepts and practices of HV historically up to the present. The search strategy for this first review used multiple research databases with no limit on publication date, and summarized foundational concepts of HV from 29 articles published between 1995 and 2016.

A second, rapid literature scan was conducted focusing specifically on literature from the past five years. This search was aimed at the identification of cutting-edge scientific and policy documents on HV such as systematic reviews of effectiveness, major recent policy initiatives, emerging practices and innovation. It yielded 77 abstracts (of which 47 articles were selected and retrieved for information extraction) and 10 grey literature documents. Additional searches for articles by key authors in the HV field and nominated by team members (or experts involved in other components) resulting in a total of 87 documents published between 1998 and the present (with the majority published in 2007 or later).

The initial scan was then repeated across four databases with refined search terms and a more systematic process of article selection.[8] In this final stage, 125 unique articles were found and 99 were selected using explicit criteria (i.e. articles on HV practice that targeted two or more outcomes) and by saturation for inclusion in the write-up. Summary points were compiled from the first two literature reviews separately and then combined by major topic. Summary points from the final review were added and key messages from the literature were incorporated into the major themes that crossed all components. Grey literature was compiled across all steps and a list of key resources including organizations and topical documents was produced (see Appendix E).

The scientific and grey literature on HV policy and practice has grown, particularly in the last decade. While most of the papers found originated in the U.S., a recent major review published by the National Institute for Health and Care Excellent (NICE) in the UK was included as well as individual papers from several countries including Canada. More recently, findings from systematic evaluation and field implementation initiatives have added a richness of information about practice that can inform initiatives more generally than controlled-setting randomized trials that predominate in earlier literature.

Environmental Scans

An environmental scan was conducted online to develop a high level picture of current HV policy and practice in other jurisdictions, both nationally and internationally. Building on this review, a more comprehensive search was done for HV models used worldwide and in other Canadian provinces. Models were included in this cross model scan if families entered the program with infants/children from the prenatal period up to 2.5 years of age and exited the program when the children reached age six years. Thirty-nine models were identified from ten countries and their details were reviewed and compared. Environmental scans for information on HV training programs and HV staff competencies were also conducted to identify key resources for advancing practice in Alberta in the next steps of HV policy and practice development (See Appendices F and G for more details).

Thought Leaders Consultations

National and international thought leaders on HV and related early childhood services were identified through internet searches, team members' networks, and snowball sampling (initial contacts suggesting additional people to contact). Fourteen thought leaders in HV and policy from the US and Canada were approached by telephone and interviewed regarding policy and practice in their jurisdictions and their views on HV. Three of these thought leaders were able to attend a two-day face-to-face workshop held in Edmonton in March 2016. The purpose of the meeting was to allow for an exchange of ideas among the Human Services team overseeing HV in Alberta, and the project team with thought leaders in HV science and practice. The meeting process was designed to focus the knowledge and expertise of thought leaders on the Alberta context to best inform provincial plans for advancing HV.

Findings of the Current State Review across Research Components by Key Themes

In this section, sets of key findings arising from all components of the review are presented. Some findings arose from single sources; others were drawn from multiple components, but all represent consensus of the full research team.

The key findings themes have been organized in three groups:

- The Foundations of Home Visiting,
- Key Lessons for the Practice Level, and
- Key Lessons for the System Level.

A summary is provided at the beginning of each grouping. In addition, an overarching theme – Relationships and Engagement, is presented at the beginning of this section.

Overarching Theme – Relationships and Engagement

The relationship that develops between the home visitor and the family was consistently identified as the heart of HV; indeed, HV is described as a "relationship-based" intervention.[9] This theme of relationships, and by extension the process of engagement, was particularly prevalent across findings from all sources in the review.

Survey and interview participants in Alberta highlighted the importance of positive relationships between the home visitor and the family, commenting that being invited into the clients' homes was "an honour" and that developing a trusting relationship with families, the community, and fellow HV workers was felt to be essential for successful home visiting.

The fundamental nature of this relationship is also underscored by leading authors. Li and Julian, for example, describe developmental relationships as the "active ingredient" of effective interventions serving at-risk children and youth.[10] They define developmental relationships as "reciprocal human interactions that embody an enduring emotional attachment, progressively more complex patterns of joint activity, and a balance of power that gradually shifts from the developed person in favor of the developing person". They further argue that, "the effectiveness of child-serving programs, practices and policies is determined first and foremost by whether they strengthen or weaken developmental relationships." [10(p157)] This understanding emerged from extensive experience in numerous fields and programs serving children and youth as well as the academic literature.

> "the effectiveness of child-serving programs, practices and policies is determined first and foremost by whether they strengthen or weaken developmental relationships."
>
> Li and Julian (2012, p. 157)

This importance of positive relationships between home visitors and families was underscored by interviewees. Putting the time and effort into the emotional work of relationship building was seen as important, as described by one home visitor:

> There needs to be a time where you have that relationship building as well, and we have to form that trust, because you know you're there to help the families meet their needs and you know if you're using a strength-based approach then you're building that family up and you have to have time for that relationship building.

Another home visitor explained that it is through this trusting relationship with the family that she could make the needed referrals and address the real challenges being faced:

> I worked with a family, families which was like successful on surface and good and, and you know and then three years later there is a family violence but like you have to have that comfort of level of personal relationship and trust in order to reveal it.

Based on this understanding of the home visitor-family relationship as the core of HV, one thought leader suggested that in order to understand the capacity required for effective HV services, one should begin with this fundamental relationship and then determine all of the supports, at progressively higher levels (agency, community, regions, province) that are necessary to initiate and sustain that relationship. Another suggested that the pivotal question should be "how does a practice, program, system, or policy help strengthen and mobilize the HV relationship?"

Several thought leaders and interview participants used the term "parallel processes" meaning that the fundamental relationship between home visitor and family needs to be paralleled or emulated through every layer of service; that is, such relationships are important not only between home visitor and family, but also amongst home visitors and their peers, between home visitors and supervisors, across agencies and so on.

> "it's funny, when a person takes a step back and actually looks at the work that we do, it's just all about relationships"
>
> HV Supervisor

The Foundations of Home Visiting

Four inter-related themes emerged as foundational to HV. These included: early childhood development, guiding principles, evidence-based approaches and outcomes, and ongoing learning, adaptation and improvement.

Summary

- The rationale for HV is supported and bolstered by significant evidence on the importance of the social environment and parenting on early brain growth and health, as well as evidence on the adverse impact of toxic stress on infants and young children.
- There is considerable consensus on the guiding principles of HV; these guiding principles can serve as an important anchor for HV in Alberta.
- Extensive research has confirmed the effectiveness of HV on a range of child and family outcomes, when there is: adequate capacity for implementation, consideration for context, and guidance by overarching principles.
- There are reliable and credible methods for ongoing learning and continuous improvement. Such methods allow stakeholders to gather the evidence they need, be accountable, and improve outcomes in credible and responsive ways.

HV Rationale: Early Child Development

Rationale for HV is supported by early brain development research[11-14] as well as research examining the inter-generational transmission of social vulnerability.[15,16] Both bodies of research demonstrate the importance of the social environment and underscore that early childhood is the optimal time for changing adverse trajectories and building resilience. Early brain development research, particularly highlights the importance of the family for early brain growth and health, and the serious adverse impact of toxic stress on infants and young children that can have lifelong consequences and costs to families and communities.[12-14,17] Research related to the inter-generational transmission of social vulnerability underscores that the optimal time for changing adverse trajectories and building resiliency is very early in life and requires a focus on early parent-child attachment and parenting behaviour.[15,16] HV is explicitly designed as a prevention and early intervention strategy and is considered by many to be one of the most effective ways to reduce inequities.[6,12]

Guiding Principles

The overarching principles of HV were remarkably consistent in the literature,[6,18-21] with only minor variation. They were:

- Family centred
- Strengths based
- Evidence informed
- Cultural sensitivity
- Relationship focused
- Offered at no cost to parents/families
- Grounded in PEI
- Voluntary
- Intensive, in terms of frequency
- Home based
- Connected to the community
- Oriented to early childhood
- Starting as early as possible in the child's life

These principles were consistent among HV stakeholders in Alberta as well, with a strong shared vision expressed by interviewees, and aligned with the original HV S&G. Thought leaders also stressed the importance of keeping HV true to its core principles and added that the principles are directly applicable in the two critical components of HV delivery: parent support and community connections.

These consistently identified principles can serve as an important anchor, and be the foundation for the revisions to the S&G and Capacity Framework.

Evidence based Approaches and Outcomes

More than two decades of research and evaluation has shown that, when implemented with fidelity[ii] and supportive capacity, HV is effective in achieving a range of important outcomes in the domains of child development, parenting ability, and family well-being.

HV can reduce the risk for adverse events (such as child maltreatment) as well as increase resilience and protective factors for beneficial outcomes (such as parental self-efficacy, social and emotional competence of children, positive parenting and child health) in families with young children, ultimately increasing quality of family and community life.[11-16] Other related outcomes, as found in individual and systematic reviews, include: child development and school readiness; family economic self-sufficiency; linkages and referrals; maternal health; reductions in child maltreatment; reductions in juvenile delinquency; and reductions in family violence and crime (see Appendix H for a list of outcomes found in the cross model scan).[23-33]

[ii] Fidelity is a consideration when the desired outcomes of the HV program have been determined, and the approach to achieve those outcomes is well described and ready to be implemented. *"Fidelity refers to the extent to which an intervention is implemented as intended by the designers of the intervention. Fidelity refers not only to whether or not all the intervention components and activities were actually implemented, but whether they were implemented in the proper manner."*[22(p27)]

As research continues, an evidence-base is accumulating, including insight on specific approaches.[23-29] Evidence needs to be considered in context, as effectiveness or impact is not demonstrated in all studies and lower effects are generally found in the field relative to controlled research settings.[34-38] The degree of effectiveness of HV depends on several variables including:

- which outcomes are targeted[23,39-42]
- the characteristics of the targeted families (e.g., mothers with depression or lone parents)[40,43]
- the way the program is delivered (e.g. intensity)[41,44]
- the maturity of the program[45]
- the quality of staff training[46]
- other parameters[26,47-49]

The Center on the Developing Child at Harvard proposed that the generation, implementation, and evaluation of new ideas in Early Childhood Development is most effective when it results from an "active co-creation process that combines multiple domains of knowledge, expertise and experience."[50(p35)]

These domains include: [50(p35-36)]

Science	Combining contributions from various fields such as developmental psychology, neurobiology, and implementation science
Practice	Using a pragmatic understanding of what it takes to design and implement specific strategies with identified program participants in particular contexts
Community	Bringing expertise, wisdom, goals, and values of local leaders and parents who understand best what kinds of resources and supports are needed
Policy	Ensuring a focus on scalability, sustainability, balancing costs and benefits, and generating system-level support for promising innovations

The literature on cost-effectiveness or cost-benefit is also accumulating but is typically focused on single outcomes or very local, specific interventions.[51] However, enough evidence has accumulated that suggests potential for a positive return on investment for HV if well implemented.[52] Descriptive cost studies across five models in multiple sites were done as part of a major national funding and evaluation initiative in the United States led by the Department of Human and Health Services called the Maternal Infant and Early Childhood Home Visiting Program (MIECHV). Potential savings in relation to reductions in child maltreatment alone were also calculated.[5,53] In a community-wide randomized controlled trial of a universal HV program that examined emergency department service use, for every dollar spent on the HV program, about $3.00 per child was saved.[31] Due to the very high cost of child maltreatment intervention, even small to moderate reductions in those outcomes can generate cost savings.

There are few studies of the perceptions of HV recipient families in the literature. One early publication reported positive and transformative experiences of HV recipients in Alberta.[54] Survey and interview participants from this project indicated that their programs were generally well received by families.

> "I think home visitation programs are awesome and just so helpful for our families and they just make such a difference and we hear that from our families all the time … it's just invaluable."
>
> Home Visitor

Contextualizing and Applying Evidence

While efforts have been made to systematically appraise and report the research evidence for specific HV models,[5] it was consistently noted in the environmental scan that published literature on models is not reflective of HV models across a broader range of countries and contexts. Strong adherence to evidence-based models is increasingly being replaced by an understanding that common outcomes are achievable by adapting practices to context and situation, while staying within broad guidelines.[55] See the *Key Lessons for Practice Level* section for a more detailed description adaptation of the evidence base for the practice context.

Standardization and adaptation to context do not need to be at odds; increasingly in human services and health interventions, approaches to achieving consistency on some aspects while valuing flexibility on others are being developed.[56] The body of evidence about how to deliver HV effectively and flexibly in community contexts rather than as rigidly packaged models is growing.[12,57] The Center for the Study of Social Policy has urged that research and evaluation "must go beyond yes/no judgements about 'what works', to understand why, how and for whom, and under what conditions policies, programs, practices and systems accomplish desired results."[58]

A theory of change can help to guide HV stakeholders in understanding the early steps necessary to achieving the long term goals, recognizing the necessary preconditions to achieving the desire outcomes and impact.

Ongoing Learning, Adaptation and Improvement

Unsurprisingly, findings from each source were unequivocal about the importance of ongoing learning, adaptation and improvement. Research and experience has shown clearly that program monitoring (whether through ongoing quality measurement and/or periodic evaluation) is critical for ensuring investments in HV will produce the intended benefits for families and the broader community.

> "I like my job very much and I think it's meaningful and helpful and it makes sense, and it has to continue – it has to grow."
>
> Home Visitor

The broader literature contains valuable resources to guide a common way forward on continuous improvement and evaluation for HV programs. For example, there are useful common conceptual frameworks for process and outcomes measurement such as one proposed by Avedis Donabedian[59] and new evaluation approaches such as utilization-focused evaluation and developmental evaluation developed by Michael Quinn Patton,[55] which could be used in the field of HV.

The body of reliable and credible methods for ongoing learning and continuous improvement is growing. Increasingly this growing body of literature has argued that stakeholders must be able to gather the evidence they need, be accountable, and improve outcomes in credible, nimble and iterative ways.[38,50] These approaches enable stakeholders to learn. Schorr and Farrow stated that ongoing learning and improvement must, "allow interventions to be adapted to refine strategy and improve implementation over time, reflecting advances in knowledge, changes in context, evaluation findings, and experience."[38(p26)]

Key Lessons for the Practice Level

Five themes relevant to HV practice emerged in the review process: scope (including screening and assessment, and families served); staffing (values, qualifications, training and competencies, and supervision); HV models[iii]; quality improvement, evaluation and reporting; and practice variability.

Summary

- Notable variability exists in family eligibility in terms of both demographic and risk factors. There was concern that some referrals are not appropriate for the service scope of HV, with some families needing more intensive services.
- With respect to staffing, there was support for continued use of paraprofessionals as home visitors, provided training is thorough. There was a favourable view of current training content and levels, with some suggestions for improvement.
- There are many HV models available to learn from, and build the understanding about how and why HV works. This reinforces the need for ongoing evaluation, monitoring, learning and improvement.
- Variability exists across many aspects of practice, ranging from the level of use of the S&G, tools and procedures for screening and assessment, use of particular models and/or curricula, to outcomes measurement and reporting. Managing variability within a range is beneficial for allowing HV agencies to respond to community needs, leading to successful programs. There was reasonable consensus on the areas of practice for which greater consistency is desired and the areas of practice where flexibility is needed.

Scope

There was substantial consensus in the scientific literature that to achieve population-level impact, it is important to target families with the greatest potential to benefit from HV.[11-16] The relative merits of universal versus targeted HV have been debated for some time[12,60,61] and will be discussed in more detail in the *Key Lessons for the System Level* section below.

There was considerable concern expressed by participants that the risk factors and overall complexity of families being referred were beyond what could be appropriately addressed by the current scope of HV services. Thought leaders cautioned against trying to serve families whose needs were beyond the scope of HV for three reasons:

[iii] For the purposes of this paper, models will be understood as the approaches, curricula, components, and criteria followed or replicated in home visiting – the "what". Programs and the associated services, activities, outreach etc. will be understood as the "how" for putting those models into action.

1. it can result in home visitor burnout,
2. it risks failing to meet the family's needs, and
3. it can be unsafe – with the risk of doing more harm than good.

There was confirmation from thought leaders that HV is designed to serve PEI policy objectives but not intervention objectives, and that there may need to be a more intensive version of home-based family intervention in the continuum of early childhood services, situated between HV and child intervention. The need for "HV on steroids" was also described by interview participants. Furthermore, one thought leader explained:

> We have a number of sites where they have partnered clinical staff with their home visitors. For example, a mother might be struggling with maternal depression. The home visitor will remain involved with the family, but simultaneously, they will receive short-term in-home counselling and behavioural therapy for twelve weeks during that time. Instead of home visitors feeling like they somehow lack the necessary skills to support families, we like to bolster them in knowing that they have exactly what a family needs in terms of the relationship piece and around supporting the infant and parent child relationship and things around development.

Screening and Assessment

Rather than basing eligibility on demographics, the literature emphasizes the importance of using evidence-informed, validated screening and assessment tools to identify eligible recipients most likely to benefit.[31,62,63] More recent studies that relate parent characteristics with likelihood of enrolment, engagement and ultimately outcomes are helpful in terms of framing reviews of screening from the perspective of both greatest need and greatest potential to benefit.[33,64] A recent population level study in the US showed that large proportions of children with specific risk factors were not being served, underscoring the importance of considering screening at both total population and local levels.[65] Approaches to determining need for services also include regional or community needs assessments; one such approach is described by.[66]

Survey and interview participants commented that there is no specific uniform approach in Alberta to screen for parent/family eligibility or to assess baseline family risk at intake. Up to a third of agencies surveyed were not using a standardized screening tool. Among the 18 agencies who reported using one, 10 different tools were listed. In terms of assessment, 40% of agencies are not using a standardized tool. Among those reporting using an assessment tool, at least five different tools were listed. Some agencies described the systematic intake processes they had developed, that may merit dissemination.

Families Served

In the cross-model scan, there was consistent focus on parents with characteristics that elevate risk. Nearly all model materials described families targeted or served as "at risk," "disadvantaged," and/or facing multiple challenges that require additional support. The specific groups that require that support differed depending on the local context. In Australia and Europe, young and/or disadvantaged mothers, parents dealing with addiction, "travellers, asylum-seekers, and refugees" were populations of particular interest for some home visiting programs. Canadian models often see Aboriginal families over-represented as service users, whether or not the programs target them specifically. Developing strategies to meaningfully connect with and serve these different groups was consistently described as an "integral part of the work". The literature also speaks to the special needs of families with particular characteristics or circumstances including intellectual disability,[63] multiparous women[65] and women in abusive relationships.[67,68]

The majority of models reviewed in the cross-model scan served children younger than 24 months. Children's age of entry was typically prenatal or at birth. The more recent literature underscored the benefits of starting services prenatally since it is shown to improve both engagement and outcomes.[69]

In terms of children's characteristics in Alberta, survey and interview participants indicated that the usual age span was birth to age 6. There was variability in whether the child had to be the first born, first born in Canada, or any child, to participate in the program. Regarding referral sources, there was also substantial variability across regions in the proportion of referrals from public health, child welfare, CFS, and health services (hospitals/family doctors), as well as self-referral.

> "If there's room on our caseload and there's a high need and this family really needs support, then of course we would support them over that year and take them."
>
> Interview participant

There is an opportunity to build on the current state of HV in Alberta, namely, to reiterate which families HV serves, what intervention(s) families receive, and what outcomes are expected.

Staffing

Across all sources, it was expressed repeatedly that the foundation of HV is the relationship between the home visitor and the family. The importance of home visitor staff having foundational values and personal attributes, strong core training and optimal skills, appropriate caseloads, and quality supervision cannot be overstated if positive outcomes are to be achieved. This point was stressed by thought leaders, interview participants, as well as the scientific literature.[70] Under the staffing theme, four subtopics emerged: home visitor values, qualifications, training and competencies, and supervision processes.

Values

A list of values central to successful home visiting were compiled from the grey literature materials in the focused environmental scan of training and core competencies (see Appendices F and G). It is worth highlighting the similarities between these values and the guiding principles above. They included:

- the value of cultural sensitivity[71-75]
- a relationship-focus[71,72,73,75]
- a family engagement approach (i.e., working *with* the family to achieve the outcomes rather than directing them)[71,73-75]
- viewing families as the experts and acknowledging the critical role that parents play as the child's primary teacher[73,75]
- the use of self-reflection as a home visitor[71-73]
- informing practice with evidence[73-75]

In the cross-model scan, many Aboriginal-serving models in Canada placed particular emphasis on weaving spirituality, caring, creativity, and pride throughout their programming.

The congruence between values and guiding principles bodes well for enacting principles and practice, meaning the S&G and the capacity framework will capture and build on this shared language and understanding (as discussed in the *Guiding Principles* section above).

Qualifications

There is little evidence in the scientific literature on the optimal educational backgrounds and mix of staff to conduct home visiting. A systematic review of 21 rigorous trials of HV published in 2013 has shown that models that predominantly use paraprofessionals[iv] can be as effective as models using only professionals.[41] This review also demonstrated that the level and quality of home visitor training was an important predictor of programs effectiveness; however, a subsequent review contradicted these findings.[77]

> "training, opportunities for professional development, program support, and ongoing supervision that match [home visitors] diverse needs are essential"[78(26)]

Gill et al. emphasized the need for a range of in-service training and supports to accommodate the diversity in qualifications and educational backgrounds of blended professional and paraprofessional staff.[78] Other studies present potential benefit of matching specially trained home visitors (paraprofessionals or peers) for certain recipient families including home visitors from the same

[iv] Harden defines professional home visitors as those with a formal degree in the service professions and paraprofessional home visitors as those without a degree and/or training in the service professions.[76]

community or ethnicity[79,80] or with particular risk factors.[68] This necessary training support in response to the diversity of staff qualifications was also discussed by interview participants.

Valued more highly than specific degrees or diplomas, were the personal characteristics of the home visitors. As one thought leader commented, "[home visitors] have to be relationship builders. That's their characteristic and I think that's more important than the title after their name". Another explained, "it's really more the quality of the staff and the training and the supervision they get than the professional degree they hold".

The cross-model scan revealed wide variation in the qualifications of staff providing home visiting services (see Appendix I). Six models exclusively used licensed nurses and those with human services backgrounds, such as social work, were also common for home visitors. Other backgrounds included training in mental health, education, child development, midwifery, and behavioural science. Some models used trained volunteers. Of the models that described the composition of their home visiting staff, half used a blended approach with professionals and paraprofessionals working alongside each other. Two models paired together a professional and a paraprofessional home visitor to meet with families as a team. One distinct community-based staffing approach in Australia and Europe was that of "mentoring mums" where mothers and grandmothers from the communities were trained to serve as home visitors. In North America, Aboriginal programs were most often delivered by paraprofessionals, while the Australian model serving Aboriginal communities used registered general nurses. The scan demonstrated that a variety of staffing strategies produce effective home visiting services.

Surveys, interviews, and document reviews of HV practice in Alberta all revealed substantial variation in position descriptions and staff qualifications. Participants held the view that the current qualifications for HV staff were adequate and that requiring professional credentials for all home visitors was not necessary if suitable personal characteristics were considered and minimum mandatory training was in place. There was concern expressed about the ability to recruit home visitors if a requirement for professional credentials was instituted. This was especially the case in rural areas where the recruiting participant pool is smaller than urban centres. As well, it is important to note that if higher qualifications were to become a requirement, home visitors would require a corresponding higher wage.

Training and Core Competencies

In interviews with Alberta home visitors, information about current training and training needs was a significant point of discussion. While the S&G provide a foundational list of basic training topics, some participants noted that their agency had additional specific policies on training while others reported no set requirements. Interviewees were generally positive and grateful regarding the amount of training they had received and described supplementary ways they had been prepared for their role, including job shadowing and agency orientation.

Attending training was viewed as beneficial, not just for the content learned, but also for the added opportunities of networking, team building, practice rejuvenation, and strengthening confidence (see Appendix F for a list of training topics reported by interview participants).

> "We have so much training, like this agency really focuses a lot on continuous learning and training and we always have tons. I've never worked for another agency that had so much focus on continued learning, so really appreciate that."
>
> Interview participant

Challenges related to training included expenses associated with travel for training (both time and direct costs, especially for rural agencies), the need to tailor training to home visitor needs, and learning through different approaches other than formal training (e.g., less formal opportunities to share experiences with other home visitors). Suggested topics by interview participants for (further) training included addictions and gambling, financial literacy, dealing with war grief, signs of illicit drug use in the home, infant mental health, family violence, working with cognitively delayed parents, and more training on how to actually apply the concepts to situations. Cultural sensitivity and home visitor safety were two training topics mentioned very frequently. Supervisors indicated a desire for more specific training relevant to their role. Many participants felt strongly that (at least) a core amount and content of training should be consistent across Alberta. If this were to move forward, participants argued that considerations would need to be made for sustainability and accessibility.

The focused environmental scan for grey literature on HV training topics in other jurisdictions identified and compiled the top six core competencies for home visitors. They were centred on the following knowledge areas:

- family wellbeing and child development
- community collaboration and resources
- professional practice and well-being
- relationships
- planning and conducting home visits
- cultural sensitivity

(See Appendix G for a tabulation of these key core competencies and detailed sub-areas by source.)

Several sets of core competencies and key knowledge areas for home visitors were also found and are described in detail in Appendix G. One example, from Nova Scotia[81] provided a list of personal attributes for home visitors, predicated on the belief that home visitors (in this case peer home visitors) should be recruited

> "[home visitors] need enough knowledge and skills, and supports, to be autonomous in their practice."
>
> Thought Leader

based on their personality, values, people skills, life experience, connection to the community, and ability to work collaboratively, rather than on their educational achievements.

While the review shows that current approaches to staff orientation and training in Alberta are well-received, the findings described above can provide a starting point for discussion about HV staffing and training.

Supervision

In interviews, the role of the HV supervisor was consistently highlighted as a key contributor to program and practice effectiveness. Home visitors indicated that opportunities to discuss practice challenges contributed to their wellbeing.[78,82] One interview participant elaborated that supervision gives home visitors "a chance to go over a lot of information and to have the discussion reflected back and help […] to overcome some of what we see in the home visits, just basically to collect ourselves and to gain a different perspective on what we could have missed." Supervisory processes were reported by survey and interview participants as very positive experiences and, for the most part, in keeping with the S&G which specify supervision be regular (at least two times per month), reflective, and collaborative, with at least one supervisor for every six home visitors. Some participants indicated a slightly lower frequency of supervisory visits (the range was one to four times per month). A few commented on the value of technology (e.g., teleconferencing) in maintaining supervisory contact, especially in areas where the supervisor and home visitor were geographically separated.

Supervisory competencies were also discussed in three documents found in the grey literature scans. These competencies included communication skills, reflective supervisory processes, knowledge about supervision styles, conflict management, ability to build trust, managing relationships and boundaries, and provision of staff support. Program planning and evaluation-related competencies were also mentioned.

Literature and thought leaders noted that there are three types of supervision: administrative, clinical, and reflective.[83] One paper describes a useful approach to caseload management that allows for adjustment of caseload numbers using considerations of engagement and needs; a necessity alluded to by survey and interview participants.[64]

> "[Supervision] gives us a chance to go over a lot of information and to have the discussion reflected back and help us to overcome some of what we see in the home visits, just basically to collect ourselves and to gain a different perspective on what we could have missed."
>
> Home Visitor

Ongoing supervision and support for home visitors has consistently been described as critically important, conversely ongoing support and training must also be available to supervisors in all three of these areas.

HV Models

As highlighted in the *Foundations* section above, there is a great opportunity to learn from others regarding HV models and approaches. An abundance of HV models have been developed over the past decades.[12] The insights and resources of other HV models and studies can assist in defining scope, understanding and applying evidence and leading practices in Alberta, and creating a performance measurement framework to orient programs to specific policy objectives and outcomes.

Even the most rigorously researched models may not achieve their potential without adequate supports for successful implementation, consideration for context, and being guided by best principles.[38]

HV models typically include a combination of a general approach and specific curricula. Many HV models have been highly formalized and many have been implemented before having adequate evaluation. Models vary widely across a range of attributes from families targeted through the intended outcomes, as well as in effectiveness. The most widely studied (and disseminated) models in North America are the Nurse Family Partnership , Healthy Families America, Parents as Teachers, and Early Head Start – Home Visiting.[5] The U.S. National MIECHV initiative has been compiling research evidence related to the effectiveness of models for several years and currently lists 17 HV models as "evidence-based."[5,84] However, as discussed above, literature is clear that even the most rigorously researched models may not achieve their potential without adequate supports for successful implementation, consideration for context, and being guided by best principles.

In the cross-model scan, the duration, intensity, and scope of programs varied greatly, ranging from a couple of visits within the first few months after birth to frequent visited over multiple years. The majority of the models reviewed determined the frequency of visits and duration of program participation based on each family's needs, similar to what interview participants described as common practice in Alberta. The intensity of these programs ranged from weekly to monthly visits.

All the models in the cross-model scan shared a commitment to relationship- and strength-based approaches that work to increase families' self-efficacy and connect them to community resources. Specific strategies for those approaches included family-led process and the integration of attachment theory. Behavioural approaches were less common in the scan, with only two models from the United States and the United Kingdom describing their key principles in such terms. A distinct approach is offered by one Canadian model that explicitly stated that its programming is based on social justice principles.

A document describing an evaluation of models adapted for Aboriginal peoples in the US was found in the grey literature, which can offer some guidance for developing collaborative approaches to advancing practice in this area.[85] Extensive work has been done in Manitoba on a policy approach and model for First Nation people called "Strengthening Families Maternal Child Health Program". Strengthening Families, developed by and for First Nations, is a home visiting early childhood health promotion

program implemented in 14 First Nations jurisdictions that could inform advancement of HV for Alberta's Aboriginal populations.[86-89]

Recent peer-reviewed literature has revealed further innovations in HV programming. They included findings relevant to structural, relational, delivery and evaluation aspects of HV such as recruitment, screening, assessment, engagement and dis-engagement prevention. Relevant to the service process, there are recent papers on the use of technology[90-92], and descriptions of new assessment tools (including for measuring household chaos[93], internal representation[94], and parents' involvement in early learning)[95]. There is also recent literature on innovation in target population or program content including greater inclusion of fathers and other family members[96,97], those in non-traditional home settings[98], tailoring for specific ethnic or occupational groups[80,92] and inclusion of approaches for specific issues or concerns such as maternal depression[99-110], infant mental health[111-113] and intimate partner violence[68,114], immunization adherence[115], or the integration of brief interventions[105] and adding group well-child visits.[116]

Learning from Others

The insights and resources of other HV programs and studies can assist in defining scope, understanding and applying evidence and leading practices, and creating a performance measurement framework to reinforce or re-orient programs specific to policy objectives and outcomes. However, careful attention needs to be paid to determining where flexibility around program parameters is required, as HV programs can be delivered in diverse contexts. A large body of evidence cautions that when program evaluators ask "does it work?" or "what works best?" it is at the risk of understanding 'how' and 'why'.[37,38,50,55,58] Patton advises not to ask what is best, but rather to ask "what works for whom in what ways, with what results under what circumstances and in what contexts and over what period of time?".[55(p193)] The Center for the Developing Child takes Patton's advice one step further adding the question – "and why?".[50(p37)]

A number of thought leaders cautioned against an exclusive focus on specific evidenced-based models, noting that one of the unintended consequences of aligning funding to standardized curriculum can limit innovation in HV. A further caution is that by limiting implementation to only models that seem worth replicating in their proven form, there can be missed opportunities to expand, improve, and build on effective strategies to achieve greater impact. This reinforces the need for ongoing evaluation, monitoring, learning and improvement in order to better understand the optimal balance between fidelity and flexibility.

Practice Variability

The document review, surveys, and interviews revealed variability in practice across the province on a range of aspects of HV. One type of variability was the use and understanding of the 2004 S&G. Based on survey responses, up to 17% of programs were not using the Guidelines or were not familiar with them. This finding was further confirmed in home visitor, supervisor, and regional contract administrator interviews. Supervisors and regional contract administrators reported using the S&G more than front-line staff, but even among those participants some reported using them directly and extensively, others hardly at all. There was also some lack of clarity on whether the S&G were just guidelines or absolute standards. Several participants suggested or implied a need for the S&G to be updated.

Another area of substantial variability was in screening and assessment processes and tools, as discussed above in the *Scope* section above. There was also notable variability in use of models and/or curricula; more than an estimated 15% of survey participants reported not using a specific model and among those who did, 11 different models were listed. Variability was also noted on several aspects of the home visiting process such as frequency of visits (dependant largely on family's need) and home visitor caseloads. Participant responses for caseloads varied from 12 to 35, with most falling within the range of 15 to 25 (generally in line with the S&G recommended range of 15 to 20). The S&G acknowledge that caseloads will vary according to other parameters like travel time and family need. This recognition of contributing factors for determining caseload amounts was stressed by interview participants. One home visitor explained "I really believe in […] being client led, so the fact that we can move levels [for visit frequency] as it suits the clients' needs really makes a difference to me." The document review revealed variability in what aspects of practice are described and reported on across programs and regions (see details in Appendix J).

A paper by Sawyer et al. examine a range of issues and unique challenges of HV service delivery in rural areas.[117] These included more travel, greater difficulty providing training and supervision to home visitors, and the frequent necessity of home visitors to fulfill multiple roles. These issues were further expressed by survey and interview participants.

When asked about the balance of provincial fidelity and local flexibility, many survey and interview participants acknowledged the importance of both aspects, see Table 2 below. The need for greater consistency across the province was identified in several aspects of service delivery and scope. Interview participants stressed the value of families receiving a similar level and quality of service regardless of where they live, so that they would be able to access an equitable program if they were to move from one location to another across the province. See the following table for a list of commonly described aspects that were considered important to be consistent and those considered important to be flexible.

Table 2: Interview participants' views on consistent and flexible aspects of HV

Practices considered important to be **consistent** by most participants (who commented on the area)	Practice considered important to be **flexible** by most participants (who commented on the area)
• program philosophy and high level parameters (especially centrality of relationship) • use of the S&G • screening and assessment tools • use of evidence-informed and leading practices • use of weekly visits, dependent on family's interest and needs • minimum mandatory training • minimum supervision standards • staff safety protocols • inter-agency protocols • confidentiality and privacy practices • cultural sensitivity and competency • outcomes measurement and reporting	• home visitor's qualifications (i.e., not having specific, narrow requirements) • caseload amounts (need to reflect travel time and frequency of visits) • modalities for supervision (e.g., teleconference or videoconference)

Interviews, literature, and the cross-model scan similarly revealed areas of flexibility and consistency that allow home visiting models to meet the needs of their communities. In particular, the existing wisdom of home visitors provided a starting point for setting priorities for advancing HV practices that are dynamic and consistently benefitting families across Alberta.

HV is delivered in diverse contexts and contextual variables are important in achieving fit with local needs as well as common provincial outcomes. Careful attention needs to be paid to determining where flexibility around program parameters is necessary, to find the optimal balance between consistency and flexibility.

Key Lessons for the System Level

Five themes relevant at a system level were identified in the review, including: 1) positioning of HV within the continuum of PEI services and embedded within an integrated service system, 2) the importance of community connections, 3) considerations for quality improvement, monitoring and accountability, 4) policy objectives as a starting place for improvement, and 5) needed supports for strengthening and mobilizing capacity.

Summary

- HV is well established as a cornerstone of PEI for families with infants and young children.
- HV is embedded in a continuum of early childhood services and integrated within a service system that crosses health, social, educational, and human sectors.
- Community connections are essential to successful HV and needs to be adaptive and responsive to family and community needs.
- Leading practices in HV include clarification on shared outcomes, being situated within a continuum of support, and having the capacity to support the programs.
- Adequate and supported capacity is necessary to advance HV in Alberta.

Positioning Home Visiting within a Prevention and Early Intervention Continuum of Services

> "I really believe in early intervention and that's where we're at."
>
> Interview Participant

HV is recognized as an effective practice that can be directed at several early life outcomes for children and families,[6,12] but caution has been expressed around treating HV as either a panacea or a stand-alone approach.[44] It has been recommended that HV be embedded conceptually within a comprehensive framework and integrated structurally in a service system that includes a range of services based on a life-course approach.[6,12,26,57,118,119] Being situated within a continuum of supports that address varying levels of family needs allows the scope of HV to be contained and focused on the outcomes known to be positively influenced by HV. This can also be beneficial for connecting referrals for related services.

Being integrated structurally in a service system across health, social, educational, and human sectors, has been shown to, together, advance desired outcomes.[6,12,26,57,118,119] While system integration is a complex undertaking, there is useful literature to help guide the process. For example, Stark et al. noted that the "key strategies for integrating home visiting into a comprehensive early childhood system are collaborative planning and systems building, identification, screening, and referral; professional development; and quality improvement and evaluation."[57(p3)] Berger & Font describe complementary programs at individual and community levels that could be considered as part of the continuum[99] and

Storey-Kyl et al. have advanced ideas about models which foster community connections at a higher level within which HV could be embedded.[120] Other authors discuss how connecting HV structurally to a range of health-related services or early education services can increase family engagement.[109,121-123]

Community Connections

Survey results and stakeholder interviews confirmed a strong commitment to the importance of inter-agency connections and referral processes. Participants reported these to be working well overall, but some concerns were expressed about gaps in needed services for some families. Participants strongly valued broader community networks and partnerships with organizations with aims related to child and family health and social well-being. Significant emphasis was placed on the importance of flexibility and responsiveness to community and family needs.

> "it's important to have the people that live in the community service the community"
>
> HV supervisor

Many thought leaders discussed the challenge and importance of integrating HV into the suite of services provided within a community. One thought leader candidly described the importance of community connections in their jurisdiction when they stated, "I think, the home visiting field wasn't humble enough when we started touting all these great results. We didn't say some of our results are a function of our other service partners in the community and we were beneficiaries of those resources." The ability to refer readily to needed services as well as to respond to families' immediate needs (including basic needs) was considered by thought leaders and participants alike as being critical to HV success.

In the cross-model scan, a common priority was to create engaging networks between families and communities, whether that was creating opportunities for parents to connect with each other or with other community services. These strategies contributed to a common goal of reducing the social isolation of children and families who may be marginalized or alienated due to various risk factors and/or barriers related to their socio-economic status.

Policy Objectives as a Starting Place for Improvement

Thought leaders and literature consistently identified policy objectives as an important starting place for advancement of HV practice. They advised that all of the following should flow from the desired outcomes for Alberta families:

- Refinement of S&G
- Development of a common language
- A common understanding of where HV fits in relation to other parts of the child and family service system

- The selection of common evidence-informed core services and curricula
- A common theory of change and/or logic model
- Common outcomes measurement processes

This message was also found in the literature. For example, Jacobs et al. stressed that although many evidence-based programs are available, it is important to select a model based on desired outcomes and resources.[124] The Pew Policy Framework Report recommended an overarching policy and oversight to clearly articulate programs and their objectives as well as establishing data collection and evaluation infrastructure, to not just set standards but also monitor them.[118]

The general question of whether a program "works" has typically guided policy decisions. As has been discussed throughout this paper, HV is an intervention that is complex, interactive, and relationship-based. It can be adapted to a variety of communities and cultures, as well as new and changing contexts.

A valuable understanding exists when asking not just whether or not HV affects outcomes, but *how* it does. With this understanding, policy objectives articulated at the system level can have the potential to support and sustain the foundations of HV.

Quality Improvement, Monitoring, and Accountability

The literature is clear about the need for consistent quality of delivery and monitoring for accountability. There are many tools, processes, and resources for quality improvement and evaluation of HV programs in the recent research literature. In order to best reflect the nature of HV and the diverse contexts within which is it provided, frameworks that guide improvement should.[27,33,112,125-129]

- include multiple levels of measurement from program-level quality improvement through to regional and provincial performance measurement[130],
- be compatible with theories of change and logic models, and
- provide stakeholders with the ability for ongoing learning, adaptation and improvement.

There is a general receptiveness among stakeholders to working towards more consistency across the province in these important aspects of performance measurement and accountability, including identifying the need for common outcomes and outcome measurement processes.

Performance Measurement and Accountability

Survey and interview participants commented on several aspects of system-level reporting, performance measurement, and accountability. The document review identified significant variability in the measurement and reporting of HV programs (see Appendix K), including reporting timelines,

content, and measures. One identified barrier to more coherent and multi-level performance measurement and accountability was the separate reporting lines to the CFS regions and Human Services, see Figure 1 below.

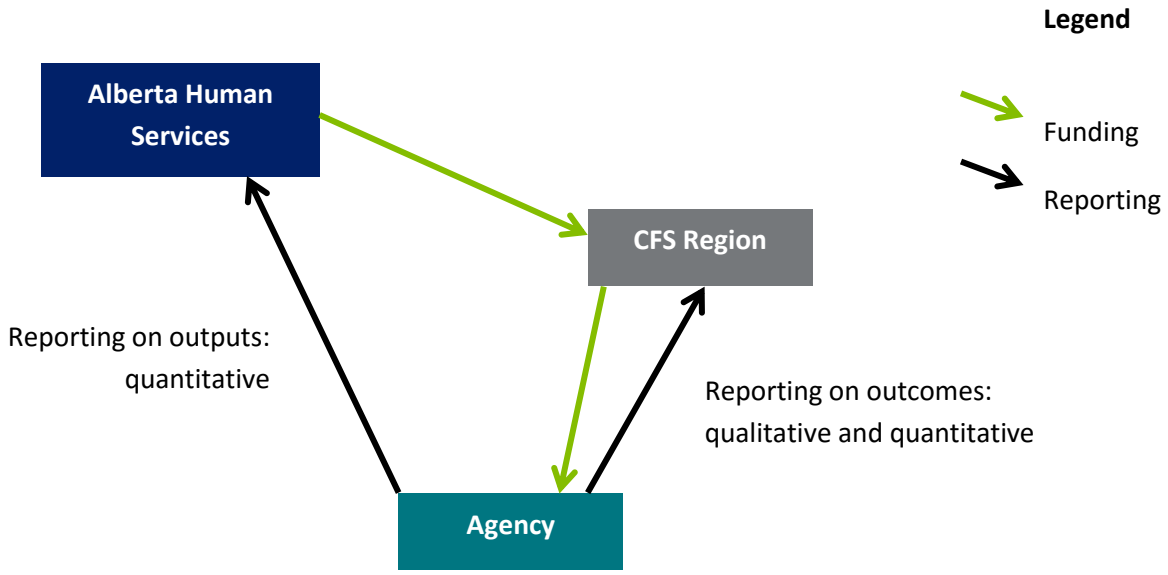

Figure 1: HV funding and reporting pathways

The Schedule A document review identified some variation in expectations for routine reporting of operational details such as critical incidents, clinical records management, and grievance processes. All documents provided had allowance for reporting plans and processes for internal monitoring along with more formal evaluation, but the requested details and frequency of reporting varied across regions.

Processes and content for reporting primary service goals was also variable. Within the agency's reporting to their CFS region, some HV programs reported quantitative information such as numbers of children/parents/families served, referrals made, visits made, and/or demographic characteristics of service recipients. Some provided pre-post data on outcomes such as child development and parenting knowledge data. Also included was qualitative information related to work with clients, such as notable successes, major achievements, and strategies for engaging families. Most reports addressed specific goals, objectives, outcomes, performance measures, and/or progress to date, although these also differed across documents (see Appendix K for a more details about the goals and outcomes from the documents).

Quality Improvement and Evaluation

As with many other aspects of program delivery, there was variability in quality improvement and evaluation practices as reported by home visitors, supervisors/program managers, and regional administrators across Alberta. Surveys and interviews revealed that there was a lack of capacity and supportive processes for:

- outcomes measurement within the program and across programs for benchmarking and evaluation; and
- for reporting at the system level for accountability purposes.

Ongoing performance monitoring is vital to understanding whether desired family and child outcomes are being realized.[118]

Details on tools and quality improvement processes used for ongoing learning, adaptation, and improvement were also reviewed from models in the literature review (see Appendix E). Approaches ranged from client and/or community surveys, community consultations/evaluations, external reviews (e.g. accreditation), internal reviews (e.g. document reviews, observations of team meetings), and formal government audits.

As discussed in the *Foundations* section there are many outcome domains typically measured in HV, Table 3 illustrates common outcomes across all research components.

Table 3: Mapped Outcomes and Outcome Domains for HV

Alberta HV Logic Model – Outcomes	Cross Model Scan – Outcome Domains	Literature Review – Outcomes Domains
Work in partnership to provide coordinated service delivery so that families can receive coordinated services. Community partnerships are responsive to the needs, values, and cultures of children and their families. Increase parent knowledge of community resources and services. Families are then able to access formal and informal services and supports in their communities, building social support networks and reducing their social isolation.	Linkages and referrals	Improved coordination of, and referrals for, other community resources and supports

Alberta HV Logic Model – Outcomes	Cross Model Scan – Outcome Domains	Literature Review – Outcomes Domains
Families are connected to their communities.		
Identify families' risks, needs, and strengths to be able to provide direction for goal planning and service provision, leading to families' increased awareness and confidence to address risk factors and strengthen protective factors. Families overcome the impact of at-risk circumstances. Parents provide safe and nurturing environments for their children.		
Increase parent knowledge of child development and of positive and effective parenting strategies. Parents' interactions are then positive and responsive, and parents have increased parenting confidence. Families promote children's development. Children are physically, emotionally, socially, intellectually, and spiritually healthy.	Positive parenting practices Child health Child development and school readiness	Improved school readiness and achievement Improved health and development
Reduced child abuse and neglect. Strong children, youth, families, and communities.	Reductions in child maltreatment and family violence	Reduced child abuse, neglect, and maltreatment
	Maternal health	
	Family economic self-sufficiency	Improved family economic self-sufficiency
	Reductions in juvenile delinquency, family violence, and crime	Reduced crime including domestic violence

Alberta HV Logic Model – Outcomes	Cross Model Scan – Outcome Domains	Literature Review – Outcomes Domains
	Children's and parent's increased cultural knowledge and identity	
		Prevention of child injuries Reduced emergency department visits

Supports for Strengthening and Mobilizing Capacity

Capacity, simply defined, is the ability to perform a specific service, produce a product, achieve a desired outcome[131,132] or carry out stated objectives[133]. It can be thought of as the raw materials or the "necessary ingredients" for successful development, implementation, evaluation, adaptation, and sustainability of a program, initiative, or system change. Capacity exists and is required at multiple levels from individuals to organizations and systems.

Capacity is also multi-dimensional. Numerous dimensions of capacity are described in the literature, including, for example:

- Political will, leadership, commitment, and buy-in[131,132,134-142]
- Shared purpose and values[135,139,140,143,144]
- Enabling processes and structures (e.g., planning, decision-making, monitoring, evaluating, communicating, coordinating, policies, roles/responsibilities, job design)[9,131,132,134, 136,140,142,145]
- Resources (e.g., sustainable funding, information, and information systems)[9,131,134,136,137,139]
- Partnerships/collaboration/networks[9,131,134,136,137,141]
- Trusting relationships/sense of community[139,140,143]
- Knowledge development/learning/adapting[9,131,134,136,137,141-143]
- Skilled workforce[9,131,132,134,136,137,140,142,145]
- Supportive external environment[132,134-136,139,140]

Capacity mobilization is about identifying and putting existing capacities into action; capacity building is a deliberate effort to create, support or strengthen capacity.[131] Both are about ensuring that proper conditions and supports are in place to deliver effective services and sustain them over time, independent of external events.[142]

Participants described aspects of Alberta's current capacity, including existing structures for curricula, networks, and training, along with a passionate workforce with receptivity to learning, motivation to make a difference for families, and a strong desire to connect with other HV agencies and regions. Human Services was regarded as ideally serving as a "backbone" of supportive infrastructure for

advancing practice in collaboration with other stakeholders. Widespread commitment to the philosophy of HV, to the children and families served, and to a vision for a positive future for HV represents important existing capacity for advancement of HV practice in Alberta.

Observations of the thought leaders meeting revealed that consideration of existing and required capacities for HV in Alberta is already well underway. For example, there were conversations about core values and principles for HV, political will and commitment, resourcing, clarity of roles and relationships, training, systems/processes for ongoing learning, communication, and strengthening relationships throughout the HV community in Alberta.

The capacity framework is a key priority moving forward, and work on this is currently underway. In ongoing discussions about capacity for HV, it will be important to clearly define "capacity for what?". Once this question is addressed, next steps include building on literature to identify and describe specific dimensions of capacity that are particularly relevant to the Alberta context. Continued engagement with Alberta home visitors, supervisors, regions, and policy makers is essential for developing a relevant and practical framework for mobilizing and developing capacity for HV services in Alberta.

Summary and Recommendations

A thorough review of the current state of HV in Alberta has been undertaken. All components of the review were informative, both in terms of broad findings and specific resources to inform next steps. The most consistent and important messages of the review were that HV is an evidence-based PEI approach that has an important place in both reducing risk for adverse events (such as child maltreatment) and increasing resiliency and protective factors for beneficial outcomes (such as positive parenting and child health). This is possible, not in isolation, but as part of a continuum of related early childhood services across education, social, and health domains, and within a system of related child and family supports. There is a shared vision for HV among stakeholders, but there is also variation in several aspects of practice that would benefit from provincial leadership. The importance of choosing outcomes based on policy objectives before prescribing specific models or curricula, and ensuring appropriateness and adaptability to community contexts were predominant themes.

There is an opportunity to capitalize on the many strengths identified in current practice as well as the resources identified in the literature for articulating the specific policy objectives of HV and its place relative to the continuum of related services. It is also important for all next steps in advancing HV in Alberta to include engagement of stakeholders including provider agencies, staff, recipient families, and in particular, Indigenous peoples of Alberta.

Recommendations

Current state findings reveal the many strengths that can provide a strong foundation upon which to build an enhanced provincial approach, including:

- Passionate and enthusiastic staff and supervisors who believe in the importance of HV and feel that the work they do is making a difference for families
- Commitment to the core principles of HV that are aligned with progressive practice elsewhere
- Positive working relationships amongst home visitors, their supervisors, and teams
- Recognition of the benefits of greater consistency and the areas where flexibility is also important
- Positive receptivity to, and an appreciation of, continuous learning to advance practice
- Strong desire amongst home visitors for increased connectivity and communication with other HV staff and agencies, other service providers, within and between regions, and with Human Services

The review identified variability in operations, service delivery, evaluation, and performance reporting that may be detracting from achieving the collective objectives for positive outcomes for Alberta families. While providers clearly value their work and many examples of positive change for families are being reported, the amount of practice variation across so many parameters can undermine the

effectiveness and efficiency of services, and ultimately the achievement of desired outcomes. In addition, it is currently difficult to document the benefits of HV for the whole province. While these challenges are not trivial, there is an encouraging level of existing wisdom and capacity already present, as well as a depth of tools and resources in the scientific and practice literature to support a solid path forward. The time is right in Alberta for all stakeholders, including families served and Indigenous people, to work together toward a common vision for desired outcomes for HV. A renewed and advanced approach to HV that best serves key policy objectives is one that fits within the array of related services serving Alberta children and families in within the Alberta context. A framework detailing the necessary capacities to achieve articulated goals will be available soon to inform the work going forward.

The following tables highlight key recommendations for moving forward, paired with the corresponding findings from this review.

Overarching Theme – Relationships and Engagement

Recommendations	Related Findings
Build recognition of the central value of relationships in HV, including the updating of the S&G and capacity framework. Ground HV in the foundational home visitor-family relationship.	Relationships are at the heart of HV practice. HV efforts would be best served if a focus on the core home visitor-family relationship was considered at all levels of capacity.
Ensure Indigenous community leaders, new Albertans, and all levels of HV stakeholders are engaged in ongoing planning and implementation of HV.	Stakeholder relationships and engagement (in particular with Indigenous peoples) are essential to advancement of HV in Alberta.

HV Foundations

Recommendations	Related Findings
Reaffirm the role of HV as a valued service for improving the social environment and wellness outcomes for Alberta children and families with elevated risk.	The rationale for HV is supported and bolstered by burgeoning evidence of the importance of the social environment and parenting to early brain growth and health and the serious adverse impact of toxic stress on infants and young children.
Host an initial engagement exercise for HV stakeholders to discuss guiding principles and approaches that could be the foundation for practice in Alberta, including: common policy and practice objectives, the scope of HV, and its desired outcomes. This could help in establishing a	HV principles are well established across jurisdictions which are also shared by a majority of HV stakeholders in Alberta. Extensive research has confirmed the effectiveness of HV, on a range of child and family outcomes,

shared language and understanding across the province. If no adaptations are considered suitable for Indigenous Albertans, extend this work to include program development specifically for those communities.	including outside controlled research settings, when there is adequate capacity for implementation. Policy objectives are a starting place for advancement of HV practice. Recognition that shared language does not necessarily equal shared understanding.
Move from a logic model framework to a theory of change approach.	Recognizing the need for agencies to work flexibly within standards, moving to a theory of change approach could help HV stakeholders to move beyond questions of "did we reach the desired outcome?" to a deeper understanding of why, how, for whom, and under what conditions did the program achieve the desired results. This would guide HV stakeholders in understanding the necessary preconditions to achieve the desired outcomes and impact.

Key Lessons for the Practice Level

Recommendations	Related Findings
Build on the good work already being done in Alberta; decide on whether or not to adopt, adapt, or develop a common screening and assessment tool to be used consistently across the province. Allow for a contextually appropriate degree of flexibility within the referral, screening, and assessment processes. Clearly articulate the boundaries of services and the requirements and processes for appropriate referrals. Review the situations of families that have needs that are beyond the scope of HV. Make recommendations to ensure appropriate availability of services either within existing or enhanced services.	There is a lot of variability in family eligibility (both demographic and risk aspects) and service scope as well as concern that some current referrals are not appropriate for HV as it is currently conceptualized and delivered.
Work with HV stakeholders to determine the potential of a province-wide training program, building on the training that is already being offered in the province. Decide on the central	With respect to staffing, there is support for continued use of paraprofessionals as home visitors, provided that training is thorough. There is a very favorable view of current training content

content elements to be included in core training, the timing of when it would be required for staff, and the accessibility and sustainability of the training. Develop a common core set of desired qualifications for home visitors (valuing personal characteristics and skills alongside experience and education) and a common set of job descriptions.	and levels, but some suggestions for improvement.
Articulate and agree upon policy objectives and desired outcomes. Regularly review how existing and new program models (including those that have been adapted for Aboriginal peoples) fit with the objectives.	Many HV models are available, but literature and thought leaders stressed that models should be chosen only after policy objectives are well defined.
Update the S&G to reflect what has been learned from this current state review. Prepare easy reference versions that can be incorporated into HV orientation and day-to-day operations. Gather feedback from stakeholders on the revised S&G to assess the meaningfulness and usefulness for daily practice. Include Indigenous voices within the S&G.	This review identified variability across many aspects of practice ranging from use of the S&G, screening and assessment, use of particular models and/or curricula, to outcomes measurement and reporting. There was reasonable consensus on the areas of practice for which greater uniformity was desired and the areas of practice where flexibility was needed.

Lessons for the System Level

Recommendations	Related Findings
Affirm the positioning of HV as PEI in the continuum of early childhood services.	HV is well established in the literature and by thought leaders as a cornerstone of promotion, prevention and early intervention for families with infants and young children.
Build upon existing strengths to refine conceptualization of the continuum of early childhood services as well as the positioning of HV within the broader service system. Examine existing referral processes and connections.	HV should be embedded in a continuum of early childhood services that is itself integrated in a service system that crosses health, social, and educational human services. Community connections are essential to successful HV and HV programs need to be adaptive and responsive to their unique community needs.
Work collaboratively with HV stakeholders and evaluators, design a province-wide multi-level	Program stakeholders value quality improvement and evaluation but current approaches vary widely

quality improvement, evaluation, and performance measurement system. Include in the design processes for data collection and reporting, as well as consideration for needed capacity to facilitate this change. Develop reporting processes that allow data to be collected, shared, and used by HV stakeholders. Estimate the capacity needed to support the reporting process on an ongoing basis. Encourage ongoing learning opportunities and improvement by revisiting these processes annually, with an in depth review every 3-5 years.	in Alberta and many participants considered capacity to be lacking in this area Participants identified a need for more consistency in measuring and reporting outcomes.
Use the upcoming capacity framework to allocate the necessary resources to support HV.	Support for the necessary capacity for successful advancement of HV in Alberta will maximize its potential to achieve policy objectives.

Conclusions – A Way Forward

HV has been in service to Alberta children, families and communities for more than a decade. This comprehensive review has identified important areas for service refinement and harmonization which may ultimately optimize outcomes. These proposed advancements have great potential to further policy objectives of the Alberta Government more broadly and the Human Services Department specifically including the following[1]:

> *"Alberta families and communities thrive through improved supports by strengthening prevention and addressing the root causes of social and economic challenges".*
>
> *"Albertans receive higher quality programs and services that are more coordinated, seamless and tailored to their needs to maximize their potential".*
>
> *"Greater collaboration between government, communities and indigenous partners to strengthen services and achieve shared social outcomes"*

The time is right to action the collective wisdom of stakeholders and the knowledge gathered about HV here and elsewhere, to move forward in identifying the specific policy outcomes for HV that are of greatest importance to Alberta's future, to relate those to programs suitable for Alberta children and families, and to move forward on harmonization and optimization of HV practice and systematic measurement of its outcomes.

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Appendices

Appendix A: Research Components and Methods

Current State Analysis

Surveys

The purpose of this component was to get an initial understanding of the operational details of HV agencies. An online survey that covered content including clients served, referral and screening approaches, use of model programs, staff training and supervision and other related details was completed by representatives of 27 of the 36 (75%) of HV agencies approached (see Appendix B). Survey participants were asked to nominate home visitors and their supervisors for more in-depth interviews on their observations and views about service delivery.

HV agencies funded under Human Services' (HS) provincial initiative (code 355) across Alberta were identified by the HS Early Childhood Development Branch. A representative from each agency (CEO, executive director, or program manager) was contacted by the project team via phone, introduced to the project, and invited to participate in an online survey. The purpose of the survey was to gain an initial understanding of the operational details of each community agency, including the profile of the clients served, screening and assessment tools used, and training received, among others. All 36 identified agencies agreed to participate (including two Metis Settlement agencies) and a total of 27 agencies completed the survey (response rate of 75%).

Interviews

The conclusion of the initial survey consisted of asking participants to recommend home visitors and/or supervisors/program managers to contact for a follow up interview (see Appendix C for the interview guide). Out of the 27 agency representatives who completed the survey, 83% recommended potential interview participants. Interviewees were selected based on their geographical location with the goal of collecting perspectives representative of the province. Thematic saturation was reached after 10 home visitors and 9 supervisors/program managers were interviewed.

Interviews were also conducted with contract administrators from the Child and Family Services (CFS) regions. Representatives were selected through recommendations provided by the Early Childhood Development Branch. One interview was completed for each of the seven regions, with two conducted in a recently combined region, for a total of eight interviews. A representative of the Metis Settlement region was interviewed as well, and this has been flagged as an area for further exploration.

Document Review

Document review of CFS contracts, specifically the Schedule A component of their HV contract was completed along with a review of reporting forms (see Appendix K). This includes comparing and contrasting the elements between the regions to better understand the contracting process that occurs in Alberta. The purpose of this component is to better understand the HV contracting content and process.

"Schedule A" is the common term for part of the contract that the CFS region has with each agency offering HV services. The Schedule A section contains details related to the program including goals and outcomes, reporting requirements, and client information. While there are many common sections of the Schedule As between regions, there are also notable differences. The contract with the agency also includes a "Schedule B", which focuses on financial/budget considerations; that was not a focus for this review and therefore they have not been included.

Six of the seven CFS regions provided a template of their contract's Schedule A agreement. Half of these were either partially or fully filled in while the other half contained just the headings. Due to the variety in documents, there were limitations in being able to compare the sections, since there was some uncertainty what would be filled in under the headings.

The main sections of the majority of Schedule As were:

- Agency/program information and details
- Program description; client information
- Program goals, outcomes, and performance measures
- Reporting details
- Issue resolution and decision appeal
- Position qualifications
- Organizational chart
- Monitoring and evaluation
- Other

Five of the seven regions provided a version of their reporting documentation. These documents significantly varied from one another in regards to the period of time the report was for (quarterly, mid-year, and year-end), whether they were blank templates or completed reports, and included a synthesized final report from multiple agencies. These documents also had variety in both length and style, including a 49 page written document with a reference list, combining the year's data with literature, an 8 page document completed with qualitative point form comments, a 9 page document with multiple tables requesting specific dates and numbers, and a 3 and 5 page word document with a mixture of qualitative and quantitative data to be reported. Also to note, the amount of information provided, the type of data (statistics, comments, etc.), and the quality of it (how the information was

collected, etc.) could significantly vary between agencies filling out an identical template within the same region.

Due to the variety of information provided, comparing what was reported across the five regions proved to be challenging.

Core Competencies and Training Review

To explore grey literature pieces on this area, an Internet search was conducted with the search words "home visiting core competencies". Previous discussions with an AHVNA working group on the topic also led to relevant grey literature to include. Works referenced in these documents were also pursued. This review resulted in eleven sources (ten American resources and one Canadian), which are summarized below. The identified sources included:

1. Oregon (2015)
2. Florida (2015)
3. Pennsylvania (2015)
4. Minnesota (n.d.)
5. Michigan (2013)
6. Nebraska (2015)
7. Nova Scotia (2003)
8. Wisconsin (2004)
9. New Hampshire (2011)
10. Vermont (2011)

Environmental Scan

State of the Science and Practice Literature Reviews

The reviews of scientific literature, conducted in three rounds, were based on searches of the research database available at the National Center for Biotechnology Information (NCBI) and Jersey Clicks, specifically Academic Search Premier, PubMed, Medical Subject Headings (MeSH), Health Source, ProQuest, and Education Resources Information Center (ERIC). Some articles of interest were located through University of Calgary library system, Rutgers University library system, National Library of Medicine, as well as Google Scholar engine. Other articles were sourced through references included in prominent articles (ascendancy searches) as well as through articles that have cited them (descendancy searches).

The scientific and grey literature on HV policy and practice has grown, particularly in the last decade, with many findings generated by the US MIECHV. Accordingly, most of the literature found so far has its origin in the United States, but there was also a recent major review generated by the National Institute for Health and Care Excellent (NICE) in the UK as well as individual papers from several countries

including Canada. Information was also collected on related activities in other provinces in the environmental scan. More recently, findings from systematic evaluation and field implementation initiatives have added a richness of information about practice that had built knowledge beyond the randomized trials in more controlled settings that characterizes the earlier literature..

Articles that addressed evidence-based practices for HV and focused on perspectives of HV were considered. HV articles about only preventing child abuse, improving low birth weights, or postnatal depression were excluded.

Thought Leaders Consultations

National and international thought leaders on HV and related early childhood services were identified through internet searches, team members' networks, and snowball sampling (initial contacts suggesting additional people to contact). Fourteen thought leaders in HV and policy from the US and Canada were approached by telephone and interviewed regarding policy and practice in their jurisdictions and their views on HV.

In March 2016, The Centre hosted a thought leaders' discussion which consisted of bringing Human Services, the project team, and external content thought leaders together to build on the understanding of the current state, and to consider the future state of HV. This two day event brought together carefully selected leaders on policy, practice, and research to discuss gaps and considerations for moving HV forward in Alberta.

The purpose of this component was to allow for an exchange of ideas among the Human Services team overseeing HV in Alberta, the project team and consultants, with world leaders on HV science and practice, over two days. This discussion provided an opportunity to ask for direct advice from thought leaders in relation to the context of Alberta HV service delivery, and to get their thoughts on plans for advancing HV and related services in Alberta.

Cross Model Scan

To find models for the scan, general search terms included "home visitation," "family home visiting," "child home visiting service," "home visitation service," "pre- and post-natal home visiting," "pre- and post-natal home visitation services," as well as specific searches with these terms in various countries around the world. Websites and studies on HV services were reviewed based on selection criteria to find those programs that share common ground with current practices in Alberta.

The selected models align with the mission and objectives in Alberta's 2004 HV S&G, sharing characteristics such as community referrals and partnerships, and evidence-based practices. These criteria do not exclude programs where nurses are service providers, as long as the activities in the home address the cognitive and overall well-being of families as well as the physical health of the child. Models were selected for the scan if families entered the program with children prenatally and up to 2.5

years of age and exited the program when children reached the age of 6. The full criteria were met by 40 models from Australia, Canada, Cuba, Ireland, Jamaica, the Netherlands, New Zealand, South Africa, the United Kingdom, and the United States.[v]

The content of analysis for the international scan of HV models included the following: key principles or philosophical constructs; program description; people served; home visitors' characteristics/competencies, HV activities in the home; 'parenting' curriculum used; outcomes; high quality implementation[vi]; quality assurance process; and, impact on MIECHV outcome domains[vii] where applicable. Information on this content was gathered from program websites, HV studies and program evaluations.

[v] These criteria produced a wealth of models to asses, however, it is worth noting that differences in terminology and language may have led to the exclusion of models from countries where English is not the first language. Furthermore, HV models fitting most of the criteria were not included in the analysis if the programs have not been extensively implemented or evaluated. For example, UNICEF has begun working in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) to "strengthen home visiting systems and [build] the capacity of the frontline workers" (Grover, 2015). Another example is the Healthy Start Home Visit Program that was piloted and evaluated in one community in Hong Kong. The project was completed on 22 June 2013 and the evaluation is under consideration for further implementation in other Chinese communities (Leung , Tsang & Heung, 2013; 2015)

[vi] Common features of high quality HV identified through evidence based HV: maintenance of low caseloads for home visitors; strong supervision of home visitors; low staff turnover among home visitors and supervisors, which reduces changes in a participant's home visitor; ability to enroll a high proportion of the families referred for service; ability to maintain consistent contact with enrolled families as prescribed by the home visiting program model

[vii] MIECHV outcome domains: child health; child development and school readiness; family economic self-sufficiency; linkages and referrals; maternal health; positive parenting practices; reductions in child maltreatment; reductions in juvenile delinquency, family violence, and crime.

Appendix B: Current State Survey Questions

Survey with Community Agencies

Thank you for agreeing to participate in the project "The Continuum of Prevention and Early Intervention Programs in Early Childhood Development: An Evaluation of the Current State and Capacity Building Framework Development" (The Home Visitation Early Childhood Development Prevention Early Intervention Project). We greatly value your time and feedback.

The purpose of this survey is to gain an understanding of the profile of the different community agencies providing HV under the Alberta Human Services' provincial home visitation (HV) initiative.

Your participation in this survey is voluntary. If there are any questions you do not want to answer, you can skip them.

The information you provide will be used only for the indicated purpose in conformity with the Alberta Freedom of Information and Protection of Privacy Act (FOIPP). Your answers are confidential and will be used only for project purposes. Following ethical standards, the information you provide will be stored in a secure database for five years and then destroyed. The results of this project will be analyzed and reported only in group format. No single person or agency will be identifiable.

This survey will take approximately 20 minutes to complete.

Please complete this survey by Monday, March 16th, 2015[viii]. You are able to return to previous pages as you move through the survey. Also, once you have started the survey you can return at a later time to your saved answers (as long as you are on the same computer) until the date deadline.

If you have questions about the survey, please let us know at any time. You can reach the Alberta Centre of Child, Family, and Community Research office by calling the coordinator of this project, Anna Pujadas Botey at (403) 955-7616.

Please check the box below if you would like to continue this survey

- ○ I willingly consent to talking this survey.

To clarify, this survey is specifically in regards to the Alberta Human Services' provincial Home Visitation (HV) initiative (i.e., programs funded under Code 355).

Each question will have a comment section by the answer. Please feel free to comment if you wish to expand on a question. We appreciate your feedback.

[viii] Please note that this date was extended.

1. Would you consider the area your agency serves to be rural or urban?
   - Rural (including small town)
   - Urban
   - Both rural and urban

   Optional comment: _____
   _____

   Definition of rural/small town: Population under 10,000 living outside the commuting zone of a centre with a population of 10,000 or more.

   Definition of urban: Population of 10,000 or more or smaller population living within the commuting zone of a centre of 10,000 or more.

2. What is the approximate number of years your agency has been providing HV services? _____
   Optional comment: _____
   _____

3. How many home visitors does your agency currently have? (Number of full time equivalents (FTEs)) _____
   Optional comment: _____
   _____

4. How many supervisors (or program managers or coordinators or similar) does your agency currently have? (Number of full time equivalents (FTEs)) _____
   Optional comment: _____
   _____

5. How many total employees does your agency have? (Number of full time equivalents (FTEs)) _____
   Optional comment: _____
   _____

For questions 6 and 7, please use as many rows as needed.

6. What mandatory/core training do home visitors in your agency receive (e.g., 5 day mandatory training by Early Childhood Development Support Services (ECDSS) in Edmonton)?	7. What are the corresponding topics covered in the mandatory/core training that home visitors in your agency receive (e.g., early childhood growth and development, child abuse and neglect)?
a) Training 1:	a) Topics covered in training 1:

b) Training 2:	b) Topics covered in training 2:
c) Training 3:	c) Topics covered in training 3:
d) Training 4:	d) Topics covered in training 4:
e) Training 5:	e) Topics covered in training 5:

Optional comment: _____

_____

8. Other than the mandatory/core training, is there any other training that home visitors in your agency receive?
   - Yes
   - No. If so, please provide further comments
   - Not sure. If so, please provide further comments

   Optional comment: _____

   _____

[Skip 9 if 'no' or 'not sure' in question 8]

9. Please list what training (other than the mandatory/core training) the home visitors in your agency receive. (If not sure, please provide further comments)

   _____

   _____

10. For your HV program does your agency use a particular HV model and/or curriculum (e.g., Healthy Families America, Growing Great Kids, Invest in Kids)?
    - Yes
    - No. If so, please provide further comments
    - Not sure. If so, please provide further comments

    Optional comment: _____

    _____

    Definition of model (or framework or approach): Philosophy of a HV program (i.e., way of thinking about HV). An example is Healthy Families America.

    Definition of curriculum: A specific program manual that focuses on the key content to be covered in home visits. It is a resource for those working in HV and provides practical guidance and structure to home visits. An example is Growing Great Kids.

[Skip 11 if 'no' or 'not sure' in question 10]

11. Please list what particular model(s) and/or curriculum(curricula) your agency uses (e.g., Healthy Families America, Growing Great Kids, Invest in Kids). (If not sure, please provide further comments)

    _____

    _____

12. What is the typical caseload for each home visitor? (Overall average number of families per home visitor) _____
    Optional comment: _____
    _____

13. Does your HV program maintain a waitlist?
    - Yes
    - No. If so, please provide further comments
    - Not sure. If so, please provide further comments

    Optional comment: _____

    _____

    Definition of waitlist: Families who are eligible and are waiting for HV services but are not able to be accommodated currently.

[Skip 14 if 'no' or 'not sure' in question 13]

14. How many families are on the waitlist of your HV program? (Overall average is fine) _____
    Optional comment: _____

    _____

15. What are the age range criteria for children entering your agency's HV program?
    _____
    Optional comment: _____

    _____

16. Out of the families that you typically work with, what are some of the major challenges that they are experiencing? (Please select all that apply)
    - Poverty
    - Unemployment/work conditions
    - Homelessness/living conditions
    - Food insecurity
    - Health condition, including mental health and disability
    - Domestic violence
    - History of abuse or neglect
    - Substance use
    - Social isolation/lack of social support
    - Limited access to health and/or support services
    - Low education level
    - Young age of parent(s)
    - Cultural/language barriers
    - Other(s). If so, please provide further comments.
    - Not sure. If so, please provide further comments

Optional comment: _____

_____

17. Please list the main referral sources to the HV services offered by your agency (e.g., Public health nurses, Child Welfare, self-referral). (If not sure, please provide further comments)
    _____
    _____

18. Please list the screening tools (for eligibility) that your agency uses (e.g., Parkyn Screen, the Calgary Postpartum Screening Tool). (If not sure, please provide further comments)
    _____
    _____

19. Please list the assessment tools (for eligibility) that your agency uses (e.g., Edinburgh Postnatal Depression Scale, the Kempe Family Stress Checklist). (If not sure, please provide further comments)
    _____
    _____

20. Please list what HV outcomes your agency measures (e.g., child development, positive parenting skills). (If not sure, please provide further comments)
    _____
    _____

21. Please list what tools your agency uses to measure the outcomes identified above (e.g., parent interviews, client satisfaction surveys). (If not sure, please provide further comments)
    _____
    _____

22. To whom do you report the outcomes identified above? (If not sure, please provide further comments)
    _____
    _____

23. Are there other services that your agency provides that are related to HV (e.g., Parent Link Centres, family literacy programs)?
    - Yes
    - No. If so, please provide further comments
    - Not sure. If so, please provide further comments

    Optional comment: _____

    _____

[Skip 24 if 'no' or 'not sure' in question 23]

24. Please list what other services related to HV your agency provides (e.g., Parent Link Centres, family literacy programs). (If not sure, please provide further comments)

    _____

    _____

25. Are there other services available in your community that complement the HV services your agency provides? (e.g., Family and Community Support Services, Parent Link Centres)
    - Yes
    - No. If so, please provide further comments
    - Not sure. If so, please provide further comments

    Optional comment: _____

    _____

[Skip 26 if 'no' or 'not sure' in question 25]

26. Please list the other services available in your community that complement the HV services your agency provides (e.g., Parent Link Centres, family literacy programs). (If not sure, please provide further comments)

    _____

    _____

27. Does your agency link with other community agencies (or organizations) to meet client needs?
    - Yes
    - No. If so, please provide further comments
    - Not sure. If so, please provide further comments

    Optional comment: _____

    _____

[Skip 28, 29, and 30 if 'no' or 'not sure' in question 27]

Please use as many lines as needed. If you need more space, please use the comment area below.

28. What agency(ies) or organization(s) does your agency link with (e.g., YWCA of Calgary)?	29. What service(s) is/are provided by the agency/ organization your agency links with (e.g., housing assistance)?	30. What type of linkage is there between your agency and the agency/organization you link with (e.g., information sharing, referrals, making appointments, client follow-up)?
Agency/Organization 1:	Services provided:	Type of link:
Agency/Organization 2:	Services provided:	Type of link:

Agency/Organization 3:	Services provided:	Type of link:
Agency/Organization 4:	Services provided:	Type of link:
Agency/Organization 5:	Services provided:	Type of link:
Agency/Organization 6:	Services provided:	Type of link:
Agency/Organization 7:	Services provided:	Type of link:
Agency/Organization 8:	Services provided:	Type of link:
Agency/Organization 9:	Services provided:	Type of link:
Agency/Organization 10:	Services provided:	Type of link:

Optional comment: _____

_____

_____

_____

31. The "Guidelines for Home Visitation Programs" provide the province-wide standards and guidelines against which all home visitation programs are held accountable. The Guidelines outline the four main components of the Home Visitation program: community partnerships, information and referrals, screening and assessment, and home visits.

    If you would like to reference the guidelines, copy and paste the following URL into your internet browser:
    http://www.ahvna.org/pdfs/home_visiting_guidelines_final_november-2004.pdf

    To what extent do the HV Standards and Guidelines act as a reflective tool in creating a dialogue of understanding of HV practices in your agency? (Select all that apply)

    - ○ Review the Standards and Guidelines with all new HV staff
    - ○ Reflect on and review Standards and Guidelines on an ongoing basis with all agency staff
    - ○ Use as a document for review with CFS contract specialists
    - ○ Other. Please describe in the comment section below

    Optional comment: _____

_____

32. Is there anything else that you would like to add with regards to elements that can help us understand the profile of your agency as a service provider related to the Alberta Human Services' provincial HV initiative?
    - No.
    - Yes. If so, please specify in the comment section below.

    Optional comment: _____

    _____

33. The next step of our project involves interviewing frontline HV workers and their supervisors/mangers/coordinators. This part would consist of a phone interview that would last between 30 and 60 minutes. The questions asked would expand on the ones from this survey and help us to further understand what HV looks like in practice.

    Would you be able to recommend one (or more, if possible) home visitor and one (or more, if possible) supervisor (or coordinator or program manager) who might be interested in taking part in a phone interview?
    - Yes
    - No

    Optional comment:

    _____

    _____

[Skip 34 - 37 if 'no' to question 33]

34. What is your agency's name? _____

35. What location (city/town) does your agency operate out of? _____

36. Who are the home visitors you recommend to take part in a phone interview?
    a) Name: _____
       Phone number or email: _____
    b) Name: _____
       Phone number or email: _____
    c) Name: _____
       Phone number or email: _____

    Optional comment: _____

    _____

37. Who are the supervisors (or coordinators or program managers) you recommend to take part in a phone interview?

a) Name: _____
   Phone number or email: _____
b) Name: _____
   Phone number or email: _____
c) Name: _____
   Phone number or email: _____

Optional comment: _____

_____

Thank you very much for participating in this survey.

38. Are you interested in learning more about this project? If so, we would be happy to arrange a conversation for further discussion.
    - Yes. If so, we will contact you to schedule a time to talk. Please provide your email address and name in the area below.
    - No

    Email address and name/optional comment: _____
    _____

The information you provide will be used only for the indicated purpose in conformity with the Alberta Freedom of Information and Protection of Privacy Act (FOIPP). Your answers are confidential and will be used only for project purposes. Following ethical standards, the information you provide will be stored in a secure database for five years and then destroyed. The results of this project will be analyzed and reported only in group format. No single person or agency will be identifiable.

39. Are you are interested in receiving project updates?
    - Yes. If so, please provide the best email account for us to send updates to in the area below (if not already provided in the question above)
    - No

    Email address/optional comment: _____
    _____

40. Can we contact you again in relation to this project in the future, for reasons such as following up about any questions that arise or to access the home visitors working in your agency?
    - Yes. If so, please provide your email address and name in the comment area below (if not already provided in the two questions above)
    - No

    Email address and name/optional comment: _____
    _____

Thank you again for participating in this survey.

Appendix C: Current State Interview Guides

Interview Template for Home Visitors

Introduction and consent

Thank you for agreeing to participate in "The Home Visitation Early Childhood Development Prevention Early Intervention Project". We greatly value your time and feedback.

The purpose of this interview is to gain a better understanding of the HV practices and perspectives of home visitors from different community agencies providing HV under the Alberta Human Services' provincial home visitation (HV) initiative.

This interview will take approximately one hour. To clarify, this interview is specifically in regards to the Alberta Human Services' provincial Home Visitation (HV) initiative (i.e., programs funded under Code 355).

Participation in this interview is voluntary and you can choose to end the conversation at any time or chose not to answer certain questions. Your answers are confidential and will be used only for project purposes. The results of this project will be analyzed and reported only in group format. No single person or agency will be identifiable.

Also, the interview will be tape recorded (with your permission) and transcribed verbatim. The recording of our conversation will be kept on a secured, locked and protected site, and nobody outside the project will have access to it.

Continuing with this interview indicates your consent. Do you want to continue?

Context

- Can you please describe your role/position in your HV program?
- How long have you be involved in HV?
    - What roles have you been involved in for HV?
    - What parts of your experience and roles have been under the Alberta Human Services' provincial HV initiative? [If they have been involved in HV outside of the initiative: What aspects are different?]
- What is your background before HV (i.e., education, accreditation, certification, other experience)? What background is required by your agency to be a home visitor?
- In your agency, do you have other job expectations/duties outside of your HV role? If so, do they impact your ability to perform in your role in HV? If so, how?

Training

- What training did you receive when you first entered the HV program (core training)? Is that the core training currently required in your agency?
- What training have you had since (additional/wraparound training)? Is that additional training currently required in your agency or is it an optional choice? What training do you have access to?
- Is this training (core and/or additional) something you are trained on once during your career, or multiple times? Do particular training topics have follow-ups (e.g., refresher sessions)? What topics are covered by your training? (Just those that come to mind)

    - Who decides what topics are taught?
    - Do you think the topics covered by training in your agency appropriately prepare you for your home visitation practice? In what ways?

        - Are there some areas of training that you feel like you have received too much training on? What are they?
        - Are there some areas of training that you feel like you have received not enough training on? What are the gaps?
- Have you received any other training that is useful for your home visitation work?
- How does the training you have impact the way you perform in your work (as a home visitor)? In what ways?
- What is the usual format of your training (e.g., workshops, reading, time to practice applying new skills)? Does this format(s) work well for you?
- Alternative options to ask:

    - Regarding training overall, according to your experience, what would you say could be improved? What would you say are the strengths?
    - If you could change anything about your training, what would it be?
    - What advice would you have for a HV program just starting up to have successful training?

Supervision

- What is the objective/purpose of the supervision you receive in your agency?
- Can you describe your supervision process (e.g., are meetings scheduled ahead of time, do you meet with your supervisor as frequently as needed, what is your relationship with your supervisor like)?
- Is it reflective supervision what you receive?
- Does this method of supervision work for you? Do you see any areas that could be improved?

Operations

- Could you explain the process of how families go through your HV program?

    - How are families referred to the program?
    - What is the eligibility criteria of families included in your program?
    - How are families screened and assessed? What areas are screened for? What is assessed?
    - Typically how frequent are home visits? What is your typical caseload? What factors influence your caseload amount? Does your HV program have a waitlist?
    - How long do you typically help a family in HV for?
    - How do you use goal setting?
    - What happens when the families conclude the HV program? What criteria are used to determine when a family exits the program (e.g. goals are met, family moves, age of the child, been in the program for a certain time)? Who has established the criteria and who makes the decision for each case?
    - How are families referred to other agencies or programs?

- Overall, does this process work well? What ways could this process improve?

Service provision

- Out of the families that you typically work with, what are some of the major challenges that they are experiencing? What are their main needs? How have their needs changed over the time you've been a home visitor?
- Approximately what proportion of your visits focus directly on parent education, parent-child interaction, and child development compared to time spent addressing other concerns (i.e., financial problems, mental health illness, homelessness, etc.)? Is there an ideal proportion?
- In your experience, have you found that the HV services your agency provides and the needs in your community are well matched?
- How would you define a HV model? How would you define a HV curriculum? How are the two concepts different? (Other words used: guide, manual)
- [Depending how they answer the above question:] For your HV program, does your agency use a particular HV model (e.g., Healthy Families America) and/or a particular curriculum (e.g., Growing Great Kids, Invest in Kids)? If so, which?

Opinions

- As a home visitor, what would you say are your major challenges?
- Do you think the way your program works is different from the way other agencies (perhaps in other contexts) provide HV? In what ways?

- Could you speculate how these aspects discussed would be different and/or similar between urban/rural, northern AB/southern AB, physically isolated populations/denser populations?
- What do you think are the most important strengths within your program?
- Do you think there are particular barriers or challenges to the success of your program? If so, what are they and how do you (or how could you) overcome them?
- What do you think could be improved in your program?
- So far we have been discussing your HV program, in regards to HV at the broader level:
    - Can you comment on any local and/or regional home visitation connections or networks?
        - What is your position or responsibility (if any) in these connections?
        - What kind of support are you able to receive or offer through these connections?
        - Does your connection in any way impact the way your agency's HV program is delivered?
        - Do you think there is a general feeling of being connected and/or supported at this level?
        - Do you have any comments related to what is working well, what is not working well, and what could be improved?

    - Can you comment on the provincial connections or networks of home visitors or agencies?
        - What is your position or responsibility (if any) in these provincial connections?
        - What kind of support are you able to receive or offer through these connections?
        - Does your connection in any way impact the way your agency's HV program is delivered?
        - Do you think there is a general feeling of being connected and/or supported at the provincial level?
        - Do you have any comments related to what is working well, what is not working well, and what could be improved?
        - What does "the home visitation provincial initiative" mean to you, if anything?
            - Do you feel part of the "HV provincial initiative"? In what ways?
            - Does the "HV provincial initiative" influence the HV work you do (e.g., training, tools used, selection of models, process of working with families)?

    - [As a follow up to any of the above two sections, if they don't identify any connections/networks] Do you think this would be important? How would you remedy this?

- Can you also comment on the provincial standards and guidelines for home visitation?
    - Are the standards and guidelines something that informs your HV delivery?
        - If yes: In what ways? How do the standards and guidelines affect the way HV is delivered?
        - If no: Why do you think there is a disconnection between the standards and guidelines of HV and HV delivery?

    - Some people think that HV practice should be uniform across the province. Some think that HV practice should be flexible. Others are in the middle. What are your thoughts on this?
        1. What aspects of HV do you think are the best to have uniformed across the province?
        2. What aspects of HV do you think are best to be flexible?

Thank you again for your time and insights. We are happy to share a summary of our findings from these interviews. Would you be interested in receiving a follow up about what we found? What would be the best email address to send that to?

Interview Guide for Supervisors, Managers, and Coordinators

Introduction and consent

Thank you for agreeing to participate in "The Home Visitation Early Childhood Development Prevention Early Intervention Project". We greatly value your time and feedback.

The purpose of this interview is to gain a better understanding of the HV practices and perspectives of home visitors from different community agencies providing HV under the Alberta Human Services' provincial home visitation (HV) initiative.

This interview will take approximately one hour. Participation in this interview is voluntary and you can end the conversation at any time or chose not to answer certain questions. Your answers are confidential and will be used only for project purposes. The results of this project will be analyzed and reported only in group format. No single person or agency will be identifiable.

Also, the interview will be tape recorded (with your permission) and transcribed verbatim. The recording of our conversation will be kept on a secured, locked and protected site, and nobody outside the project will have access to it.

Continuing with this interview indicates your consent. Do you want to continue?

Context

- Can you please describe your role/position in your HV program?
- How long have you be involved in HV?
    - What roles have you been involved in for HV?
- What is your background before HV (i.e., education, accreditation/certification, other experience)?
- What background is required by your agency to be a home visitation supervisor/manager? [*Alternative way of asking this*: If there was a new home visitation supervisor/manager hired for your agency, what background would be required or preferred?]
- In your agency, do you have other job expectations/duties outside of your HV supervisor role? If so, how do they impact your ability to perform your supervision role?

Training

- What training did you receive when you first entered the HV program?
    - Is that initial training still currently required in your agency?
- What training have you had since your initial training?

  - Is that required in your agency or is it optional?

- [*If not already mentioned*] Generally speaking, what topics are covered by your training? How have they influenced your HV practice?
- Who decides which trainings you attend?
- What training did you receive for the role of supervisor? Is it different from the training home visitors receive? How so?
- In regards to your training that we have just discussed, are those one time trainings or do some trainings have follow-ups/refresher sessions?
- What is the usual format of your trainings (e.g., workshops, reading, webinars)? Does this format(s) work well for you?
- Do you think your training has well prepared you for your home visitation supervisor role?

  - Are there some areas of training that you feel like you have received too much training on or areas you feel you have not received enough training on? What are they?
  - Are there certain trainings that you'd like to attend but that you do not have access to?

- Have you received any other training that is useful for your home visitation work (e.g., offered for another program you work with or for your agency)?

- Do you think that the home visitors you supervise should have different training than they currently do (either more, less, or on different topics)?
- Regarding training overall, are there any areas that you think could be improved? What would you say are the strengths? [*Alternatively*: If you could change anything about your training or the training your home visitors receive, what would it be?]

Supervision

- What is the goal of the supervision role you provide?
- Can you describe your process of providing supervision to home visitors?

  - How frequent? Pre-scheduled and/or as needed?
  - What is your relationship with your home visitors like?
  - What do you expect from your home visitors?
  - Is it reflective supervision what you provide?

- How many home visitors do you supervise?
- Does this method of supervision work for you and/or your home visitors? Are there any areas that you think could be improved?
- What type of supervision do you receive?

- Who provides your supervision? Do you receive supervision or support from others beyond a direct supervisor?
- How frequent? Pre-scheduled and/or as needed?
- What do you expect from your supervisor?
- Is it reflective supervision that you receive?

Operations

In regards to the process of how families go through your HV program:

- How are families referred to the program?
- Is there usually a waitlist? If so, approximately how long is it? What factors influence whether or not there is a waitlist? When/if there is one, what happens to the families on the waitlist?
- What is the eligibility criteria of families included in your program (e.g., certain risk factors, age of child, etc.)?
- How are families screened and assessed? What areas are screened for? What is assessed? Who does the screening/assessment?
- Typically how frequent are home visits? What factors influence this?
- What is the typical caseload for your home visitors? What factors influence the caseload amounts?
- How long does a family typically stay in the HV program?
- What is the process when a family concludes the program? What criteria are used to determine when a family exits the program (e.g. goals are met, family moves, age of the child, been in the program for a certain time)? Who makes the decision?
- How are families referred to other agencies or programs?
- In regards to the overall process of your HV program, <u>who makes the decisions</u> on these aspects?
- Overall, do you think that this process works well? Can you think of any ways that could this process could be improved?

Service provision

- Out of the families that your home visitors typically work with, what are some of the major challenges that they are experiencing? What are their main needs?
    - Over the time since you have been involved in HV, would you say that the families' main needs/challenges have changed?

- Do you know what proportion of your home visitors' visits focus more <u>directly</u> on parenting (such as parent education, parent-child interaction and attachment, and child development) compared to time spent addressing other concerns (such as financial problems, mental health, homelessness)? Is there an ideal proportion of time?
- Would you say that the HV services your agency provides and the needs in your community are well matched?

- How would you define a HV model? How would you define a HV curriculum? How are the two concepts different?
- [*Depending on the answer to the above question*] For your HV program, does your agency use a particular HV model and/or a particular curriculum? If so, which? How was this model/curriculum selected and why?

Opinions

- What would you say are the main challenges that your home visitors face?
- What would you say are the main challenges that you, as a supervisor, face?
- Do you think the way your program works is different from the way other agencies provide HV (maybe in other contexts, such as rural vs urban locations)? In what ways?
- So far we have been discussing your HV program. In regards to HV at the broader level:
    - Are you a part of any regional home visitation connections or networks?
        - What does your involvement entail?
        - What kind of support are you able to receive or offer through these connections?
        - Do you think there is a general feeling of being connected and/or supported at this level?
    - Are you a part of any provincial home visitation connections or networks?
        - What does your involvement entail?
        - What kind of support are you able to receive or offer through these connections?
        - Do you think there is a general feeling of being connected and/or supported at the provincial level?
- In regards to the regional and/or provincial networks/connections discussed, do you have any comments related to what is working well and/or what is not working well? What could be improved? Is there anything you would like to see differently?
- What does "the home visitation provincial initiative" mean to you, if anything?
    - Do you feel part of the "HV provincial initiative"? In what ways?
    - Does the "HV provincial initiative" influence the HV work you do (e.g., training, tools used, selection of models, process of working with families)?
- In regards to the provincial standards and guidelines for home visitation, would you say that they directly inform your HV delivery?
    - If so, how do the standards and guidelines influence the way your agency delivers your HV program?
    - If not, are there others in your agency that deal with the standards and guidelines? Or is this addressed more at a regional level with Child and Family Services?
- Some people think that certain aspects of HV should be consistent across the province. Some think that certain HV aspects should be flexible. Others are in the middle. What are your thoughts on this? What aspects of HV do you think would be best to have the same across the province? What aspects of HV do you think are important to be flexible?

Thank you again for your time and insights!

We are happy to share a summary of our findings from these interviews. Would you be interested in receiving a follow-up about what we found? What would be the best email address to send this to?

Interview Guide for Child and Family Services

Introduction and consent

Thank you for agreeing to participate in "The Home Visitation Early Childhood Development Prevention Early Intervention Project". We greatly value your time and feedback.

The purpose of this interview is to gain a better understanding of the HV practices and perspectives of home visitors from different community agencies providing HV under the Alberta Human Services' provincial home visitation (HV) initiative.

This interview will take approximately one hour. Participation in this interview is voluntary and you can end the conversation at any time or chose not to answer certain questions. Your answers are confidential and will be used only for project purposes. The results of this project will be analyzed and reported only in group format. No single person or agency will be identifiable.

Also, the interview will be tape recorded (with your permission) and transcribed verbatim. The recording of our conversation will be kept on a secured, locked and protected site, and nobody outside the project will have access to it.

Continuing with this interview indicates your consent. Do you want to continue?

Context Questions

- Can you please describe your role/position in Child and Family Services (CFS) and how it relates to HV?
- How long have you been involved with HV?
- Can you describe the organizational structure of your CFS region (e.g., program specialists, resource specialists)?
- According to our information, _____ are the HV agencies in your CFS region. Is this accurate?

HV Agency Contract Questions

- Can you please describe what the contracts with the HV agencies are like? What elements do they include?
    - Mandatory training for home visitors?
    - Background of home visitors?
    - HV model or curriculum used?
    - Eligibility of families?
    - Referral process?
    - Supervision requirements?

    - Others?
- Is there a standard template for Schedule A's that you use across agencies in your region?
- Are we able to see a "Schedule A" agreement? (Template or actual contract?)
- How often are the Schedule A's revisited?
- How often do you re-contract the agencies? (Re-negotiate contract? Re-tender?)
- In regards to HV contracts, how does CFS interact with:
    - Public health? What does this look like? Are they involved in any contract decisions?
    - Other regional groups related to HV (such as ECDSS, CHFC)?
- How frequently do you connect/visit with each agency?
- In our interviews with HV supervisors, we have heard about agencies being accredited. Is this a requirement for agencies to receive the HV contract?
    - What is involved in this process? (CACOHS – Canadian Accreditation Council?)
    - If an agency is accredited, how does that influence the HV program, if at all?
- In what ways do you think the contracts are similar or different from those in other CFS regions (e.g., rural vs urban locations)?
- Do the CFS regions ever connect with each other to discuss the HV contracts/programs? Do you think this would be beneficial to do?
- How are agencies' contracts monitored? How does CFS ensure that the Schedule A's are being upheld?

Data Collecting/Reporting Questions

- What data is collected? What are the reporting requirements?
    - What does the agency have to report to CFS?
    - What does CFS have to report to Human Services?
    - What does the agency have to report to Human Services?
- Who decides what to collect?
- Is it the same across all of the regions?
- How does the data inform decisions (e.g., re-contracting, future funding)?
- Is there a database used?
- How often is reporting done (e.g., annually)?
- How is reporting done (e.g., electronically)?
- What works well with the way this is currently done? Is there anything you think could be improved?

Funding Questions

- How does funding for HV overlap with other sources of funding (e.g., from Alberta Health, funding for PLCs)?
    - Is funding for HV (code 355) kept separate, or are funding sources combined?

Standards and Guidelines Questions

- How do you use the provincial Standards and Guidelines with the HV programs?
- In the HV Standards and Guidelines, there is a statement about how they contain the minimum requirements for HV and that the regions may have additional requirements that are established in the service contracts. Does your region have additional requirements for HV beyond the provincial Standards and Guidelines? If so, what are they?
    - How are decisions around these additional requirements made?
- In terms of the provincial Standards and Guidelines, what aspects of HV do you think should be consistent across province? What elements should be enforced in the Standards and Guidelines?
- What degree of flexibility should there be around these aspects to account for the different contexts?

Appendix D: Cross-Mapping Approach to Synthesis across Data Sources for the HV Project

Step One

1. The objective overall was to generate recommendations for revising the S&G from all information at hand, so it was made to use the S&G as the conceptual frame for a comparative content analysis.

2. It was difficult to see patterns across what is mostly textual information working through one source at a time. So instead sources were worked across for each major topic of the S&G by using a cross-map table.

3. The Key content of the S&G was laid out as the first column in the cross-map table.

4. Each row (representing a major topic) was then populated with text that best fit that topic category from the S&G – with each source represented as a column.

5. The text from each source was shortened and paraphrased as needed for brevity and where there was repetition, generalizations were made (e.g. if there were multiple comments in the survey about the need for safety training – then that 'theme' was summarized in the row for that source with a comment such as 'several calls for safety training').

6. Note that the process was not completely clean – sometimes content from a source didn't map perfectly across the topics of the guidelines – this works better when the topic areas are systematically built into the data collection from each source – but the upside of not being so rigid was that more spontaneous content could emerge. Through this experience the important stuff 'rose to the top' with each stage, but there are always a few loose ends that are not critical or central.

7. It's helpful also to note some key characteristics of the samples for each source – to be mindful of how bias might be playing a role at each step.

Step Two

8. At this point, the key findings were collapsed across the three sources and then 'draft' recommendations were formulated for each section of the S&G– with the collapsed information provided as the rationale for the recommendations. This required pulling out common concepts across the three sources but noting where a recommendation came from only one source if that was the case.

9. When collapsing across sources, points of 'agreement' or points in common across sources and points of disagreement were sought.

Step Three

10. Next, a column was added to map the content from the Thought Leader's meeting notes. After adding that content the recommendations were revisited and tweaked where needed in order to be in alignment with what were now four sources.

11. Abstracts and papers from a rapid literature review were included where relevant.

12. At this point, content from all sources had been entered. A high level summary was generated after reviewing the Tables a few times.

Appendix E: Key Resources

Domain/ Area	Title	Source	Location
General Overview	Home Visiting: Supporting Parents and Child Development Resources and Planning Tools	Zero to Three	https://www.zerotothree.org/resources/series/home-visiting-supporting-parents-and-child-development
	Maternal, Infant, and Early Childhood Home Visiting	US Department of Health and Human Services, HRSA Maternal and Child Health	http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting
	Home Visiting Programs: An Early Test for the 114th Congress	The Brookings Institution	http://www.brookings.edu/blogs/social-mobility-memos/posts/2015/02/05-home-visiting-funding-reeves
	Home Visiting	Encyclopedia on Early Childhood Development	www.child-encyclopedia.com/home-visiting
	Early Childhood Home Visiting Programs	Centres of Excellence for Children's Well-Being	http://cwrp.ca/sites/default/files/publications/en/HomeVisiting73E.pdf
	Home Visiting: Supporting Parents and Child Development Infographic	Zero to Three	https://www.zerotothree.org/resources/455-home-visiting-infographic
	Home Visiting Programs for Child Well-Being	The California Evidence-Based Clearhouse for Child Welfare	http://www.cebc4cw.org/topic/home-visiting/
	About HV COINN	Home Visiting Collaborative Improvement and Innovation Network	http://hv-coiin.edc.org
Program Examples	Healthy Beginnings: Enhanced Home Visiting	Nova Scotia Department of Health and Wellness	http://novascotia.ca/dhw/healthy-development/enhanced-home-visiting.asp
	Home Visiting: Mentoring Parents to Give Young Children a Healthy start	The Ounce	www.theounce.org/what-we-do/home-visiting
	What is Home Visiting?	Texas Home Visiting	http://www.texashomevisiting.org/is-home-visiting-for-me/

Domain/ Area	Title	Source	Location
Program Examples Continued	Family Home Visiting Program	Regent Park Community Health Centre	http://www.regentparkchc.org/infant-child-development/family-home-visiting-program
	Prenatal and Early Years Home Visiting Program	Yellowhead Community Services Society	http://www.yellowheadcs.ca/programs-and-services/early-childhood-0---5-years/prenatal-and-early-years-home-visiting-program
	Healthy Babies Health Children Home Visiting Program	North Bay Parry Sound District Health Unit	http://www.myhealthunit.ca/en/childandfamilyhealth/healthybabieshealthychildrenhomevisitingprogram.asp
	Instructions Not Included	Oxford County	http://www.oxfordcounty.ca/homevisit
	Family Home Visiting Program	Minnesota Department of Health	www.health.state.mn.us/fhv/
	Home Visiting in Washington State	Washington State Department of Early Learning	https://www.del.wa.gov/helpful-resources/home-visiting
	Making High-Quality Home Visiting Accessible with the Home Visiting Services Account	Thrive Washington	http://thrivewa.org/work/family-engagement-2/
	Strengthening Families Background Document	Strengthening Families, Maternal Child Health Program in Manitoba First Nation Communities	Personal communication
	Sacred Babies Infant Survival Curriculum	Strengthening Families, Maternal Child Health Program in Manitoba First Nation Communities	Personal communication
	Home Visiting Evidence of Effectiveness	US Department of Health & Human Services	http://homvee.acf.hhs.gov/default.aspx
Training	Home Visitor	BC Council for Families	https://www.bccf.ca/program/program-2/
Training Continued	Connecting Science, Policy, and Practice: Zero to Three's National Training Institute, 2015	Zero to Three	https://www.zerotothree.org/resources/717-vol-36-no-3-connecting-science-policy-and-practice-nti-2015

Domain/ Area	Title	Source	Location
Policies and Protocols	Home Visit Policy	Medicare Local, Western NSW	http://bit.ly/2arUIMp
	Family Home Visiting – Service Outline	Women's and Children's Health Network, Parenting and Child Health	http://www.cyh.com/library/CYWHS_FHV_Service_Outline.pdf
	Sample Policy 2: Safe Practice Procedure—Home Visits	Mental Health Coordinating Council	http://www.mhcc.org.au/media/5889/sample-policy-2-safe-practice-home-visiting.pdf
	Safe Home Visiting Policy	Mercy Services Work Health and Safety Policy	http://mercyservices.org.au/download/Policies/7-Work-Health-Saftey-Policies/G.06_Safe_Home_Visiting.pdf
	Home Visiting Policy	Neighbourhood Houses Tasmania	http://nht.org.au/wp-content/uploads/2014/08/Home-Visiting-Policy.pdf
	Regional Program Standards	Strengthening Families, Maternal Child Health Program in Manitoba First Nation Communities	Personal communication
Research Overview	Research on Home Visiting: Implications for Early Childhood Development Policy and Practice across Canada	Encyclopedia on Early Childhood Development	http://www.research4children.com/data/documents/VoicesfromtheFieldResearchonhomevisitingImplicationsforEarlyChildhoodDevelopmentECDpolicyandpracticepdf.pdf
	Home Visitation: Assessing Progress, Managing Expectations	Ounce of Prevention Fund and Chapin Hall Center for Children	http://www.chapinhall.org/sites/default/files/old_reports/323.pdf
	Concurrent Substance Use and Mental Disorders in Adolescents: A Review of the Literature on Current Science and Practice	Alberta Centre for Child, Family, & Community Research	http://www.research4children.com/data/documents/ConcurrentSubstanceUseandMentalDisordersinAdolescentsAReviewoftheLiteratureonCurrentScienceandPracticepdf.pdf
Research Overview Continued	The Research Case for Home Visiting	Zero to Three	https://www.zerotothree.org/resources/144-the-research-case-for-home-visiting

Domain/ Area	Title	Source	Location
	Home Visiting: Looking Back and Moving Forward	Zero to Three	https://www.zerotothree.org/resources/1031-home-visiting-looking-back-and-moving-forward
Policy Brief	Early Childhood Home Visiting in California: The Right Place at the Right Time	Children Now	https://www.childrennow.org/files/9314/1762/6445/CN-HomeVisiting-PolicyBrief.pdf
	Strengthening Home-Visiting Intervention Policy: Expanding Reach, Building Knowledge	The Brookings Institution	http://www.brookings.edu/~/media/Research/Files/Reports/2010/10/13-investing-in-young-children-haskins/1013_investing_in_young_children_haskins_ch7.PDF
	Policy Framework to Strengthen Home Visiting Programs	The Pew Center on The States	http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2011/homevisitingmodelpolicyframeworkpdf.pdf?la=en
	Social and Emotional Wellbeing: Early Years	National Institute for Health and Care Excellence (NICE)	https://www.nice.org.uk/guidance/ph40
Government	Human Services Business Plan 2015-18	Government of Alberta	http://www.finance.alberta.ca/publications/budget/budget2015-october/human-services.pdf
	Alberta's Occupational Health and Safety Code: An Explanation of the "Working Alone" Requirements	Government of Alberta	https://work.alberta.ca/documents/WHS-PUB_wa002.pdf
	Previous Consultations	Alberta Human Services	http://www.humanservices.alberta.ca/department/previous-consultations.html
	A Guide to the Law in Alberta Regarding Child, Youth and Family Enhancement Act	Student Legal Services of Edmonton	http://www.slsedmonton.com/userfiles/file/Child%20&%20Youth.pdf
Program Evaluation	Families First Program Evaluation	Healthy Child Manitoba	http://www.gov.mb.ca/healthychild/familiesfirst/evaluation.html

Domain/ Area	Title	Source	Location
	2011-2012 Regional Research and Evaluation of the Strengthening Families Maternal Child Health Program	Strengthening Families, Maternal Child Health Program in Manitoba First Nation Communities	Personal communication
	Evaluation of Maternal and Child Home Visitation Programs: Lessons from Pennsylvania	PolicyLab, The Children's Hospital of Philadelphia	http://policylab.chop.edu/sites/default/files/pdf/publications/POLICYLAB_ETOA_HOME_VISITING_EVALUATION_FALL_2013_REPRINT.pdf
Measurement	Replicating Evidence-Based Home Visiting Models: A Framework for Assessing Fidelity	Mathematica Policy Research	https://www.mathematica-mpr.com/our-publications-and-findings/publications/replicating-evidencebased-home-visiting-models-a-framework-for-assessing-fidelity
	Development of the Calgary Regional Home Visitation Collaborative Postpartum Screening Tool (The Calgary Postpartum Screen)	Calgary Regional Home Visitation Collaborative	http://www.ahvna.org/tiny_uploads/forms/measurementtoolkit/CalgaryPostpartumScreenFinalReport.pdf
	Vulnerable Children: Can administrative data be used to identify children at risk of adverse outcomes?	University of Auckland	http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/vulnerable-children/
Costs	Costs of Early Childhood Home Visiting: An Analysis of Programs Implemented in the Supporting Evidence-Based Home visiting to Prevent Child Maltreatment Initiative	Mathematica Policy Research	https://www.mathematica-mpr.com/our-publications-and-findings/publications/costs-of-early-childhood-home-visiting-an-analysis-of-programs-implemented-in-the-supporting
	The Potential for Cost Savings from Home Visiting Due to Reductions in Child Maltreatment	Chapin Hall, Doris Duke Foundation, Mathematica Policy Research, Casey Family Programs	http://www.chapinhall.org/sites/default/files/documents/EBHV%20Cost%20Savings%20Brief.pdf
Implementation	Engaging Families in Home Visiting	The Institute for Child and Family Well-Being	http://uwm.edu/icfw/engaging/

Domain/ Area	Title	Source	Location
	Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity	Mathematica Policy Research Children's Bureau Chapin Hall	http://www.chapinhall.org/sites/default/files/documents/EBHV_MakingReplication_Final.pdf
	Implementation Fidelity in Early Childhood Home Visiting: Successes Meeting Staffing Standards, Challenges Hitting Dosage and Duration Targets	Mathematica Policy Research	https://www.mathematica-mpr.com/our-publications-and-findings/publications/implementation-fidelity-in-early-childhood-home-visiting-successes-meeting-staffing-standards
	Prediction of Early Engagement and Completion of a Home Visitation Parenting Intervention for Preventing Child Maltreatment	NHSA Dialog: The Research-to-Practice Journal for the Early Childhood Field	https://journals.uncc.edu/dialog/article/view/40/78
Effectiveness	Assessing the Evidence of Effectiveness of Home Visiting Program Models Implemented in Tribal Communities, Final Report	OPRE Mathematica Policy Research	https://www.mathematica-mpr.com/our-publications-and-findings/publications/assessing-the-evidence-of-effectiveness-of-home-visiting-program-models-implemented-in-tribal-communities
	Using Data to Measure Performance: A New Framework for Assessing the Effectiveness of Home Visiting	The Pew Charitable Trusts	https://ncwwi.org/files/Data-Driven_Decision_Making__CQI/Using_Data_to_Measure_Performance.pdf

Appendix F: Home Visitor Training in Alberta

In regards to their training, some home visitors listed specific requirements set out by their agency and others said that there were no set requirements in their policy. Interviewees spoke about the abundance of training they had received and the various ways they had been prepared for their role, including not only core and additional training, but job shadowing and agency orientations. Attending training was seen as beneficial beyond the content learned, but also for networking opportunities, the potential for team building with coworkers, the "rejuvenating" effect of refresher courses, and the confidence in one's practice that can also be strengthened.

Agency orientations included introductions to policies and procedures as well as acquainting staff with the mission and vision of the agency and their role. Job shadowing of other home visitors included not only going to visit families, but shadowing all aspects of the job (paperwork, phone calls, etc.).

It was reported that typically the home visitor and her/his supervisor make decisions around what training to attend collaboratively. Learning opportunities were described as self-directed, depending on what the home visitor's focus is. Other influences of what training is attended included the background and current knowledge of the home visitor, the identified needs of the families on a home visitor's caseload[ix], what training is available, and ultimately, if there is funding to be able to attend (including the training fee, transportation, accommodation, etc.).

Training topics that were described in interviews with home visitors (in alphabetical order):

- Aboriginal training
- Abuse reporting
- Addictions
- Agency policies
- Anger in families and children
- Anti-bullying
- Assessment tool training
- Brain development
- Communication
- Confidentiality with clients
- Conflict resolution
- Cultural competence
- Early childhood education
- Emotional intelligence
- Family and domestic violence
- FASD
- Financial literacy

[ix] For example, a home visitor with many culturally diverse clients explained how she seeks out multicultural training.

- First Aid and CPR
- Grief and loss
- Home safety for preventing child injuries (including fire safety)
- Homelessness
- Infant massage
- Infant Mental Health
- Leadership
- Mental Health and Mental Health First Aid
- Non-restraint training
- Non-violent crisis intervention
- Nutritional
- Perinatal outreach
- Postpartum depression (and depression in general)
- Public health information (e.g., immunizations)
- Questions to use with families
- Resiliency skills for children and adults
- Safety
- Self-care
- Strategies for working with hard to reach families
- Stress and crises
- Suicide prevention (ASIST)
- "Women's issues"

Areas for improvement around training included the recognition of how expensive training can be, especially for those who have to travel to attend it (more commonly identified for rural agencies). One home visitor suggested that the topics of training required and their timing should be based on the individual's background knowledge. For example, training on relationship-based practice would be less urgent for a social worker to receive and more of a priority for someone without related experience. Another suggestion for improvement related to developing competencies of home visitors involved identifying learning opportunities from sources other than formal training sessions: "You can learn a lot of information from a workshop, but sometimes you learn practice from each other".

When asked what topics they wanted more training on, responses included training on addictions and gambling, financial literacy, dealing with war grief, what to look for in the home in terms of drug paraphernalia, ongoing training on infant mental health and family violence, more advanced training (i.e., beyond the basics), training that specifically addressing helping cognitively delayed parents, to have a more directive tool to use, less about identifying certain problems and more about how to deal with them, and safety for the home visitor. Although many home visitors and individuals have some knowledge and a common understanding in these topic areas, receiving formal training would allow home visitors to feel more confident and comfortable addressing these issues.

Appendix G: Core Competencies and Key Knowledge Areas for Home Visitors

The first knowledge area that was addressed consistently within all ten of the grey literature sources was around family growth, development, health, and well-being. This included a range of subtopics, including but not limited to recognizing, supporting, developing, and understanding areas around school readiness, child development (social, emotional, physical, cognitive, brain), family and infant health and nutrition, dynamics and diversity of families, language and literacy, and adaptations for special needs. Also under this broad category included healthy infant-caregiver attachment, family influences on development, specialized knowledge for working with vulnerable populations, separation and loss, supporting families through transitions, and understanding resiliency.

The second most common theme across the documents was around community collaborations and resources. Included in this competency area was the value of partnerships and working with one's community, identifying current resources and finding new ones, working with others, service system coordination, and the value of interdisciplinary work in serving families.

Professional practices and well-being was a third key area included in the grey literature sources. Adhering to ethical standards, laws and regulations pertaining to HV work, and agency policies were important elements of this area. Along with consideration of professional behaviour, being reflective and self-aware, setting boundaries, following confidentiality rules, and understanding one's role, responsibilities, and limits. Attributes such as having curiosity, empathy, and compassion were part of this knowledge area, as well as ongoing learning and professional/personal development. Self-care and seeking support for one's self was also an important piece of this section.

A fourth knowledge area from these documents was centred on relationships. Broadly speaking, this focus included relationships on many different levels (between parent and child, family and home visitor, home visitor and supervisor, and relationships to the community and other service providers). Within this category was knowledge around building and maintaining relationships, being family-centred and strengths-based, having effective communication skills, and recognizing the family as the expert. Other important concepts included adult learning, developing trust, encouraging engagement, and recognizing the role of relationships in development.

Planning and conducting effective home visits was the fifth knowledge area that dealt with direct service delivery skills. Included in this area were skills such as observation and listening, screening and assessing (and the use of appropriate tools and how their results can inform practice), motivational interviewing, documentation, and learning styles. Integration of current research into practice, outcomes-based philosophy, and the development of family goals were also key pieces of this knowledge area. Linked to this area was the topic of safety, including safety for the family and child as well as for the home visitor. This area incorporated a range of topics such as environmental safety and safe sleep, recognizing and reporting child abuse, neglect, and maltreatment, knowing the signs and impact of domestic violence, and reducing emergency department visits.

Cultural responsiveness and competence was highlighted in about half of the grey literature sources. This included the commitment to understanding within cultural context, providing appropriate supports, and recognizing and respecting the diversity and uniqueness around culture, practices, traditions, and beliefs – as well as their impact on families.

Core competencies and knowledge areas with examples

Core competencies and knowledge areas	Examples within each knowledge area	Supporting grey literature
Family growth, development, health, and well-being	- Dynamics, diversity, and complexity of family relationships - School readiness (approaches to learning, supporting development, language and literacy) - Child's social, emotional, physical, cognitive, brain development (typical ranges of growth, awareness of behaviours, adaptations for special needs) - To recognize, support, develop, and understand these areas - Family and infant health and nutrition - Healthy infant-caregiver attachment - Family influences on development - Specialized knowledge for working with vulnerable populations, including living with poverty - Separation and loss - Mental health - Supporting the family in navigating through transitions - Valuing each family member's unique biology, needs, interests, and potential - Understanding resiliency and the impact of risk factors on development - Value of play, language, and literacy in learning and development - Family self-sufficiency (economic, employment, education) as defined by the family	1-10
Community collaborations/ resources	- Value of partnerships and collaborations - Identifying current resources and finding new ones - Referrals – identifying and accessing - Working with others, supporting others, mentoring - Value of interdisciplinary work in serving families - Service system coordination	1-5, 7-10

Core competencies and knowledge areas	Examples within each knowledge area	Supporting grey literature
Professional practices and well-being	- Ethical standards - Adhering to laws and regulations pertaining to HV work and agency policies - Professional manner, reflective, self-awareness - Self-care, seeking support for self - Setting boundaries - Curiosity, empathy, compassion - Confidentiality - Emotional response - Professional/personal development - Ongoing learning - Thinking from the child's perspective - Understanding one's role, responsibilities, and limits	1, 3-6, 8-10
Relationships (on many levels)	- Building and maintaining relationships with families and communities - Family-centred, strengths-based practice - Communication skills - Family systems theory - Adult learning - Recognizing the family as the experts - Supporting and mentoring others - Developing trust - Engagement - Role of relationships in development	3-6, 8-10
Planning and conducting effective home visits (direct service skills)	- Observation and listening - Screening and assessment – using appropriate tools - Advocacy - Life skills - Motivational interviewing - Documentation - Learning styles - Integration of current research into practice - Outcomes-based philosophy - Developing family goals	1, 3-6, 9, 10

Core competencies and knowledge areas	Examples within each knowledge area	Supporting grey literature
Safety	- Safety for the individual, the family, and the community - Environmental safety, safe sleep - Recognizing and reporting child abuse/neglect/maltreatment - Signs and impact of domestic violence - Reduction of emergency department visits	2-5, 8
Cultural responsiveness/ competence	- Commitment to understanding within cultural context - Providing appropriate supports - Recognize diversity and uniqueness around culture, practices, traditions and beliefs, and their impact	1, 3, 5, 6
Supervision	- Communication skills - Reflective supervision - Supervision styles/skills - Conflict management - Relationships and boundaries, trust - Staff support and retention - Program planning and evaluation - Parallel process	4, 6, 8

Appendix H: Home Visiting Outcomes/Domains

MODEL	TARGET POPULATION	TARGET OUTCOMES
AUSTRALIA		
Maternal Early Childhood Sustained Home Visiting Program (MESCH)	Pregnant women, Birth-11 months, 12-23 months	Maternal health, Child health, Positive parenting practices
Mentoring Mums	Pregnant women, Birth-12 months	Positive parenting practices, linkages and referrals, Child development and school readiness
Women's and Children's Health Network: Family Home Visiting	Pregnant women, Birth-24 months	Child development and school readiness, positive parenting practices, reductions in child maltreatment and family violence
CANADA		
Aboriginal Head Start in Urban and Northern Communities And Aboriginal Head Start on Reserve	Children 0-6 years old	Child development and school readiness, linkages and referrals, child health, positive parenting practices, children's and parent's increased cultural knowledge and identity
BC Healthy Connections Project	Pregnant women, 0-24 months	Reduction in child maltreatment, child health, family economic self-sufficiency, child development and school readiness, maternal health
Best Start (PEI)	Families, 0-3 months	Child health, child development and school readiness, positive parenting practices
Families First (Manitoba)	Families, 0-5 years old	Positive parenting practices, linkages and referrals, reductions in child maltreatment

MODEL	TARGET POPULATION	TARGET OUTCOMES
Healthy Babies Healthy Children (Ontario)	Families, 0-6 years old	Child development and school readiness, positive parenting practices, linkages and referrals
Aboriginal Healthy Babies Healthy Children (Ontario)	Families, 0-6 years old.	Child development and school readiness, positive parenting practices, linkages and referrals
Healthy Beginnings: Enhanced Home Visiting (Nova Scotia)	Families, 0-3 years old	Positive parenting practices, linkages and referrals, reductions in child maltreatment and family violence
Healthy Family Program (Northwest Territories)	Families, 0-5 years old	Child development and school readiness, positive parenting practices
Healthy Families Yukon	Families, 0-6 years old	Positive parenting practices, child development and school readiness, linkages and referrals
KidsFirst (Saskatchewan)	Families, 0-5	Positive parenting practices, linkages and referrals, family economic self-sufficiency, child development and school readiness
SIPPE (Quebec)	Pregnant women, families, 0 to 5 years old	Child development and school-readiness, positive parenting practices, linkages and referrals
Healthy Babies Healthy Families (New Brunswick)	Pregnant women, 0-24 months	Child health, child development and school readiness, positive parenting practices, linkages and referrals
Direct Home Services Program (DHSP) (Newfoundland)	Families, 0-5 years old	Child development and school readiness, positive parenting practices

MODEL	TARGET POPULATION	TARGET OUTCOMES
Maternal and Child Health (MCH) Program (First Nations of Quebec and Labrador)	0-6 years old	Child health, child development and school readiness
CUBA		
Educa a tu hijo	0-6 years old	Child development and school readiness, linkages and referrals
EUROPE		
Baby Steps (UK)	0-6 months	Positive parenting practices, linkages and referrals, child development and school readiness, maternal health
Community Mothers Programme (Ireland)	Families, 0-5 years old	Positive parenting practices, child development and school readiness, child health, maternal health
Home-Start (based in UK, implemented in: Belarus, Czech Republic, Denmark, France, Greece, Hungary, Ireland, Latvia, Malta Netherlands, Norway, Poland, Sweden; South Africa, Tanzania, Uganda, Zambia, Australia, Japan. Sri Lanka, Calgary, Québec)	0-5 years old	Positive parenting practices, child development and school readiness
Parents Under Pressure (PuP) (UK)	0-5 years old	Positive parenting practices, reductions in child maltreatment
Preparing for Life (Ireland)	Pregnant women, 0-5 years old	Positive parenting practices, child development and school readiness, child health.
Sure Start (UK)	0-48 months	Child development and school readiness, positive parenting practices, linkages and referrals

MODEL	TARGET POPULATION	TARGET OUTCOMES
VoorZorg (Netherlands)	Pregnant women, 0-24 months	Positive parenting practices, maternal health, child development and school readiness, family economic self-sufficiency, linkages and referrals
JAMAICA		
Roving Caregivers Programme (adopted in Belize, Grenada, St Lucia, Dominica and St Vincent)	0-36 months	Child development and school readiness, positive parenting practices, linkages and referrals
NEW ZEALAND		
Early Start	Birth-11 months, 12-23 months, 24-35 months, 36-47 months, 48+ months	Child health, Child development and school readiness, Reductions in child maltreatment, Positive parenting practices
SOUTH AFRICA		
Isibindi	Child-headed households	Child development and school readiness, child health, linkages and referrals, family economic self-sufficiency
UNITED STATES		
Child FIRST	Birth-11 months, 12-23 months, 24-35 months, 36-47 months, 48+ months	Maternal health, Child health, Child development and school readiness, Reductions in child maltreatment, Linkages and referrals

MODEL	TARGET POPULATION	TARGET OUTCOMES
Durham Connects/ Family Connects	Birth-11 months	Maternal health, Child health, Positive parenting practices, Linkages and referrals
Early Head Start Home Visiting	Pregnant women, Birth-11 months, 12-23 months, 24-35 months, 36-47 months	Child development and school readiness, Positive parenting practices, Family economic self-sufficiency, Linkages and referrals.
Early Intervention Program for Adolescent Mothers	Pregnant women, Birth-11 months	Child health, Family economic self-sufficiency
Family Check-Up For Children	24-35 months, 36-47 months, 48+ months	Maternal health, Child development and school readiness, Positive parenting practices
Family Spirit	Birth-11 months, 12-23 months, 24-35 months	Maternal health, Child development and school readiness, Positive parenting practices
Health Access Nurturing Development Services (HANDS) Program	Pregnant women, Birth-11 months, 12-23 months	Maternal health, Child health, Reductions in child maltreatment, Family economic self-sufficiency
Healthy Beginnings	Pregnant women, Birth-11 months, 12-23 months	Maternal health, Child health, Child development and school readiness, Positive parenting practices
Healthy Families America (HFA)	Pregnant women, Birth-11 months, 12-23 months, 24-35 months, 36-47 months, 48+ months	Maternal health, Child health, Child development and school readiness, Reductions in child maltreatment, Reductions in juvenile delinquency, family violence, and Crime, Positive parenting practices, Family economic self-sufficiency, Linkages and referrals
Home Instruction for Parents of Preschool Youngsters (HIPPY)	36-47 months, 48+ months	Child development and school readiness, Positive parenting practices

MODEL	TARGET POPULATION	TARGET OUTCOMES
Minding the Baby	Pregnant women, Birth-11 months, 12-23 months	Maternal health, Child health
Nurse Family Partnership (NFP)	Pregnant women, Birth-11 months, 12-23 months	Maternal health, Child health, Child development and school readiness, Reductions in child maltreatment, Reductions in juvenile delinquency, family violence, and Crime, Positive parenting practices, Family economic self-sufficiency
Parents as Teachers (PAT)	Pregnant women, Birth-11 months, 12-23 months, 24-35 months, 36-47 months, 48+ months	Child development and school readiness, Reductions in child maltreatment, Positive parenting practices, Family economic self-sufficiency
Play and Learning Strategies (PALS)	Birth-11 months, 12-23 months, 24-35 months, 36-47 months, 48+ months	Child development and school readiness, Positive parenting practices
SafeCare	0-48+ months	Maternal health, Child development and school readiness, Reductions in child maltreatment, Positive parenting practices, Linkages and referrals

Appendix I: Cross-Model Scan Home Visiting Staff Qualifications

Program Model	Home Visitors' Qualifications
Australia	
Maternal Early Childhood Sustained Home Visiting Program (MESCH)	> Registered nurses with a bachelor's degree (or equivalent) and postgraduate training and experience in child and family health nursing (or equivalent).
Women's and Children's Health Network: Family Home Visiting	> All Family Home Visiting nurses are registered general nurses with a post basic qualification in community child health nursing and skills in managing complex clinical situations often presented by high risk families.
Mentoring Mums	> Volunteer Mentors (mothers and grandmothers from the community) are recruited and undergo induction and comprehensive training that covers topics such as; child development, attachment and bonding, child abuse and reporting, communication, family violence, post-natal depression and child vehicle safety.
Canada	
Aboriginal Head Start in Urban and Northern Communities (national)	> Emphasize local, aboriginal hires
Aboriginal Head Start on Reserve (national)	> No information found
BC Healthy Connections Project (BCHCP)	> Home visitors are public health nurses
Best Start (PEI)	> Home visitors are public health nurses
Families First (Manitoba)	> Public health nurses and paraprofessionals who may have training in health, education or child development and others who may have personal experience with parenting under difficult circumstances.
Healthy Babies Healthy Children (Ontario)	> Home visitors are public health nurses and "lay home visitors"
Aboriginal Healthy Babies Healthy Children (Ontario)	> No information found
Healthy Beginnings: Enhanced Home Visiting (Nova Scotia)	> A combination of community home visitors and other public health staff
Healthy Family Program (Northwest Territories)	> No information found

Healthy Families Yukon	> No information found
KidsFirst (Saskatchewan)	> Paraprofessionals are trained and supervised by professionals (usually with a background in social work).
SIPPE (Quebec)	> Interprofessional Team: nurses, social workers, doctors, nutritionists, community workers.
Healthy Babies Healthy Families (New Brunswick)	> Home visitors are public health nurses
Direct Home Services Program (DHSP) (Newfoundland)	> Home visitors are child management specialists
Best Start (PEI)	> No information found
Maternal and Child Health (MCH) Program (First Nations of Quebec and Labrador)	> Home visitors are community health nurses
Europe	
Parents Under Pressure (PuP) (UK)	> Formal qualifications i.e., psychology or social work, are not required to become a PuP Therapist.
Sure Start (UK)	> No information found
Baby Steps (UK)	> Jointly ointly delivered by a health practitioner (a midwife or health visitor) and a children's services practitioner (family support worker or social worker).
VoorZorg (Netherlands)	> Home visitors are nurses
Community Mothers Programme (Ireland)	> After being identified as suitable candidates by local public health nurses, community mothers undergo training before starting to work under the guidance of a family development nurse.
Preparing for Life (Ireland)	> No information found
Home-Start (based in UK, implemented in: Belarus, Czech Republic, Denmark, France, Greece, Hungary, Ireland, Latvia, Malta Netherlands, Norway, Poland, Sweden; South Africa, Tanzania, Uganda, Zambia, Australia, Japan. Sri Lanka, Calgary, Québec)	> Home-Start professionals and volunteers train and prepare volunteers, usually parents themselves, to work alongside other parents.
New Zealand	

Early Start	> Early Start employs home visitors with educational backgrounds in nursing, social work, early childhood education, teaching, or related fields.
United States	
Child FIRST	> Child FIRST requires that mental health or developmental clinicians have a Master's-level or higher degree, be licensed or license-eligible in a mental health specialty, and have three to five years of experience providing relationship-based psychotherapy with very young children.
Early Head Start - Home-Based Option	> Home visitors working with infants and toddlers are required to have knowledge and experience in (1) child development and early childhood education; (2) principles of child health, safety, and nutrition; (3) adult learning principles; and (4) family dynamics.
Early Intervention Program for Adolescent Mothers (EIP)	> No information found
Family Spirit	> Encourage the use of paraprofessionals for program delivery > familiar with the tribal culture, traditions, and language > All staff have to complete initial training before working with families
Health Access Nurturing Development Services (HANDS) Program	> Professionals and paraprofessionals with experience/degree in social work, public health nursing, social or behavioural science.
Healthy Families America	> Varied workforce with lots of flexibility allowed in educational and professional backgrounds
Minding the Baby (MTB)	> A pediatric nurse practitioner is paired with a licensed clinical social worker to conduct home visits and meet with families separately on an alternating schedule
Nurse-Family Partnership	> 90% of home visitors are nurses
Parents as Teachers	> Home visitors have varied backgrounds.
Global South	
Educa a tu hijo (Cuba)	> Families receive guidance counsellors (often family doctors and nurses, teachers and volunteers), who are selected by the agencies and organizations participating in the programme and include members of the families

	themselves.
Roving Caregivers Programme (originated in Jamaica, adpoted in Belize, Grenada, St Lucia, Dominica and St Vincent)	> The Rovers are secondary school graduates trained in child development and child rearing practices, and are assigned to work as caregivers in their communities.
Isibindi (South Africa)	> The Isibindi model trains unemployed people selected by their communities in accredited child and youth care training

Appendix J: Detailed Findings of Schedule A Document Review

"Schedule A" is the common term for part of the contract that the CFS region has with each agency offering HV services. The Schedule A section contains details related to the program including goals and outcomes, reporting requirements, and client information. While there are many common sections of the Schedule As between regions, there are also notable differences. The contract with the agency also includes a "Schedule B", which focuses on financial/budget considerations; that was not a focus for this review and therefore they have not been included.

Six of the seven CFS regions provided a template of their contract's Schedule A agreement. Half of these were either partially or fully filled in while the other half contained just the headings. Due to the variety in documents, there were limitations in being able to compare the sections, since there was some uncertainty what would be filled in under the headings.

What follows is a description of the main sections of the contract documents and a discussion highlighting the main differences between documents.

Main Sections of Schedule As

The main sections of the majority of Schedule As were:

- Agency/program information and details
- Program description; client information
- Program goals, outcomes, and performance measures
- Reporting details
- Issue resolution and decision appeal
- Position qualifications
- Organizational chart
- Monitoring and evaluation
- Other

Agency/program information and details

The documents began with general information and program details, including:

- Program name
- Term of the agreement (length of time)
- Contract number
- Vender number
- Agency's legal name
- Whether or not they were a profit or a not-for-profit organization
- Agency's address, phone number, fax number, and email address
- The name of the agency's CEO, ED, Board President, or other title

After these pieces of information were requested, there were more questions about the program details. This included some of the same information as the previous section (name of program, address, numbers) but also the program manager's name, the "type of service"[x], geographic area served, client capacity (information about the number of clients to be served in the program or how a full caseload will be determined), and hours of operation. Three regions also enquired about accreditation (if it was required) and its expiration date. These three regions also asked for names, addresses, and phone number of facilities (marked as optional). Two also had headings for professional association membership and the date of expiry (marked as optional).

Program description

All six documents had a space for a program description. Half of the Schedule As also had prompts to include further describe the service being provided, asking the agency to provide details about each component and how each component is delivered. One completed Schedule A included their agency's mission and vision statements, philosophy, and guiding principles in this section. Two of the Schedule As also included "additional contractor responsibility" and "additional ministry/authority responsibility" (marked as optional for one region). Following this section, these two Schedule As contained a section on remuneration, asking the agencies to detail the "negotiated rates for fee for service contracts". One other also had a remuneration section, which referred to the Schedule B.

Client information

Five of the regions included a section on client information. Included in this section were headings about client characteristics (describing individuals served in terms of Children and Youth Services status, age, gender, etc.), describing the referral process, entrance criteria, and exit criteria. One region also had a section after these titled "transition planning". This completed template described developing a unique plan for each family in order to help them to access other supports as/when they are leaving the HV program.

Program goals, outcomes, and performance measures

All of the provided Schedule As included a section about program goals, commonly in a table format. Three of them had a table with columns describing goals, outcomes, performance measures, and the target corresponding to these (sometimes measured in time and sometimes percentage). One region had a table with goals, related objectives, program activities, one-year success indicators (outcomes), measures, and relevant standard data collection measures. Another region had a table with columns titled "short, medium, and long term" (not distinguishing between goals, outcomes, or performance measures). One region had a list of specific outcomes and their corresponding indicators. Since the documents that were sent included some that were filled in, some partially filled in, and some not at all,

[x] The two completed Schedule A's where this was required had filled this in with "home visitation"

it was unclear if these tables were fully or partially completed by the region before they were sent to the agency or if the agency competed the table on their own.

Reporting details

All six of the Schedule As contained a table detailing the reporting requirements. In this table, common columns were: report name, due date, recipient, and description of content. Two had a column for whether the report was mandatory or optional and one had a delivery address (email) column. All but one region had a section about "critical incident reporting expectations". One region had a section that included "retention and disposition", "records series", and "minimum retention required by minister". Another region had a section about "information privacy and security" that discussed the policy around notifying the Ministry about discovery of "any unauthorized access, collection, use, disclosure or disposal of any Record, or of any theft, loss of, or damage to a record" and taking all reasonable steps to prevent a reoccurrence.

Issue resolution and decision appeal

All six Schedule As had a section regarding issue resolution, grievance process, and decision appeal. Three regions included headings such as: "contractor grievance process", "contractor decision appeal process", and "documentation for grievance and appeals". Two of these three also included a section for "issue resolution (consultants)". Another region's Schedule A asked the agency to describe their process and documentation for "concerns resolution, grievances, and appeals".

Position qualifications

Five of the six Schedule As had a section dedicated to describing position qualifications. Headings in this section included a description of the minimum qualifications of the various positions associated with the program. One region asked for a description of the positions, qualifications, and full time equivalents (FTEs). Another had a separate question about the number of FTEs in each role, and then asked about staff responsibilities and qualifications for program managers and parent educators. A third included a list of positions, including director, program manager, team leader/supervisor, family support workers, youth workers, diversion workers, community workers, treatment workers, clinicians, facilitators, overnight staff, and consultants. Four of the regions also asked their agencies to describe the responsibilities of "client development staff".

Organizational chart

Four of the regions had sections requesting information about the agency's organizational chart. One specifically requested showing the administrative, client care, supervisory, clinical, and support positions, as well as their reporting lines.

Monitoring and evaluation

All six Schedule As included details about monitoring and evaluation, asking the agencies to summarize their plans for accomplishing these aspects. One region also included areas for agency visits, submitting reports, and internal monitoring.

Other

Other sections included were notably varied between the Schedule As, and included headings regarding payment terms, insurance required, smoking policy, funding acknowledgement, and an addendum of common terms and definitions.

- Sharing successes and major achievements
- Strategies for engaging with hard-to-reach clients
- Current involvement in partnerships or community meetings
- Challenges/changes/barriers faced and strategies to address them
- Supports that would assist the agency in meeting the program's goals
- Trends or other impressions

Additionally, two of the documents had questions specifically about staffing and the number of FTEs working in the program. Three reporting documents included details around home visitor training and/or professional development. One reporting document included questions such as: How do you evaluate the effectiveness of the program; How do you use this information to improve your services; How are the programs within your agency integrated for the betterment of your clientele; How is the program managing with the current funding allocations; and to note anything you would like to discuss at the upcoming site visit.

Appendix K: Reporting Document Outcomes and Goals

Note: this is a collection of the outcomes/goals that were listed. Not all documents provided a listing of outcomes/goals. Not all reports include all of these points.

- Parents have the capacity to provide positive parenting to their families
    - Parents have increased knowledge of positive parenting strategies (Parents self-report through the use of surveys or home visit assessments)
    - Parents have an improved level of functioning in managing their parental role (Home visitors track and report on goal progress and achievement as part of an Individualized Service Plan)

- Parents have community and social connections to support child development and wellbeing
    - Parents have increased knowledge of community resources (Parents self-report through the use of surveys or home visit assessments)
    - Parents have increased social and community connections through involvement in the programs (Parents self-report through the use of surveys or home visit assessments)

- Families experience positive change or benefit from participating in this program
    - Families experience a benefit from participating in the program (Parents self-report through the use of surveys or home visit assessments)

- To increase accessibility to services for children, families, and/or their communities who are members of an at-risk or otherwise marginalized population
    - To ensure that program participants include members of an at-risk population
    - To reach more Aboriginal families

- To enhance parenting skills and supports by providing direct services to pre-school children, their families, and/or their communities
    - To increase family satisfaction with the services they receive; and their confidence that they have skills, abilities and capacity to make changes
    - To improve parents' parenting knowledge, skills and behaviours
    - To improve children's age-appropriate development
    - To expand families' formal and informal support networks (i.e., helps families connect with other helping resources, families, friends, etc.)

- To promote cultural inclusiveness within the program, by implementing culturally sensitive practices, policies, procedures, forms, etc.
    - To ensure that cultural diversity is reflected in program participation (as appropriate to program design & intent)

  - To develop and sustain local/regional partnerships that reflect cultural diversity (i.e., membership of partnership is culturally diverse)
  - To design and implement standard practices, policies & procedures, forms, etc. that are culturally sensitive
  - To engage in meaningful consultation and collaboration with the aboriginal community (i.e., the program ensures that input from the Aboriginal community is seriously listened to and considered in decision-making related to the program)

- To promote inter-sectoral collaboration at the policy-making and/or direct services level by engaging local and/or regional partners in the planning and ongoing operation of the program; and by working towards the integration of community services for pre-school children and their families
  - To improve the awareness that other service providers have about the range of services and resources that are available in the community
  - To promote the coordination and collaboration of service delivery among agencies (i.e. promoting connections between and among agencies)

- To practice quality assurance, by monitoring and evaluating the program, and by considering the results in program planning
  - To design and implement monitoring and evaluation processes
  - To fulfill contract reporting requirements
  - To consider key learnings from evaluations in subsequent program planning

- Parents develop positive relationships with their children
  - Parents play with their children
  - Parents comfort their children
  - Parents teach and set limits for their children

- Parents are knowledgeable & skillful in meeting changing needs of growing children
  - Parents provide basic care for children
  - Parents provide a safe home environment
  - Parents access community resources and services for parents

- Parents promote healthy child growth & development
  - Parents provide safe, stimulating home environment
  - Parents monitor child's development
  - Parents access child developmental services & resources

- Parents promote family wellness
    - Family basic needs are met
    - Family's health needs are met
    - Parents have a support network

Synthesis of goals and outcomes in reporting documentation

Synthesis of goals and outcomes in reporting documentation	
Parenting capacity and family wellbeing	Parents provide positive parenting, have improved knowledge around parenting, and are able to support child development and wellbeing. They have enhanced parenting skills and a corresponding increase in confidence. Parents develop positive relationships with their children. Families experience positive change and satisfaction from participating in the program. Family wellness is promoted, including meeting basic health needs.
Connections with resources	Parents have community and social connections, as well as expanded formal and informal support networks. Families have increased accessibility to services, especially those who are members of an at-risk population. Other service providers have improved awareness of the program in order to promote coordination and collaboration of service delivery.
Culturally inclusive	The program promotes cultural inclusivity by implementing culturally sensitive practices and policies. It reaches Aboriginal families and ensures that cultural diversity is reflected in program participation.