Towards Flourishing, Mental Health Promotion of Families: Perspectives of Parents and Home Visitors

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Dedication

I dedicate this thesis to my husband James, and my boys Carter and Charlie for their ongoing support. They are my reason why, and I absolutely could not have done this without them.

Abstract

Towards Flourishing (TF) is a mental health promotion strategy offered throughout the well-established Families First Home Visiting program in Manitoba, Canada. Families First provides support in the prenatal and early childhood periods to families experiencing poverty, lack of social supports, unstable housing, unemployment, parenting challenges, and developmental concerns for the newborn. TF aims to promote the mental health and well-being of families, and to decrease mental illness and distress through the implementation of nine everyday strategies. The purpose of this descriptive qualitative study was to explore parents' and home visitors' perspectives of the TF program, and the impact it has on families' mental health and well-being. Ten parents and ten home visitors from a rural health region in Manitoba participated in individual, face-to-face, semi-structured interviews. Data analysis was performed using the Framework Method and revealed three over-arching themes: Social/Structural Determinants of Mental Health Among Parents; Perceived Benefits of TF; Ways to Improve TF. Multiple social/structural determinants of poor mental health were identified, including lack of emotional and practical support, income and housing insecurity, and social isolation. Overall, participants reported that TF is positively impacting families' mental health and well-being, with emotional support from home visitors having the strongest impact. While parents' and home visitors' perspectives were generally aligned, there were subtle differences in their views of social and structural challenges facing families. These findings contribute to further understanding the effectiveness of the TF program, and specific recommendations for how it can be improved to better meet the mental health needs of families, based on suggestions from study participants.

Keywords: community, mental health, families, home visiting, Towards Flourishing, determinants of mental health, children, mental illness prevention, mental health promotion

Table of Contents

Chapter I: Introduction

Mental Health is integral to overall health and may be defined as a state of well-being, where an individual realizes their own abilities, can cope with life stressors, work productively and make contributions to the community (WHO, 2017). The prevention of mental illness and promotion of mental health is of vital concern for individuals, families, communities and society. Unfortunately, the mental health of Canadians is not ideal, with respect to system-wide challenges and access to services, coordination and resources (Mental Health Commissioner of Canada, 2015). In Manitoba, a province with a population over 1.3 million, the mental health needs are costly, evolving, and begin in early childhood (The VIRGO report [VIRGO], 2018). The impact of early childhood mental illness is profound with associated negative health outcomes well into adulthood (DeSocio, 2018). Therefore, programs and policies need to focus on the mental health and well-being of families with young children (Chartier, 2015).

Community-based programs that focus on the prevention of mental illness and promotion of mental health are essential to the integrated health care system, in particular those targeting the most at-risk families with young children (Chartier, 2015). These programs aim to support families and provide the necessary resources for their mental health needs. Yet, there is limited research on the effectiveness of these programs in relation to mental health outcomes, in particular from the perspective of participating parents and program providers.

The Towards Flourishing (TF) program is a community-based mental health promotion strategy offered to vulnerable populations throughout the province of Manitoba, Canada. TF is embedded throughout the existing Families First Home Visiting (FFHV) program, and is overseen by Healthy Child Manitoba (HCM). This program fosters mental wellness of families

and increased mental health services, supports, and collaboration between the delivery of health care services and providers.

This research study aimed to explore the perspectives of parents and home visitors (HVs) participating in a rural health region of Manitoba, regarding the impact of TF on the mental health and well-being of families.

Background and Significance of the Research

Manitoba's FFHV program was implemented throughout the province in 1999. The program was amalgamated with Early Start in 2005 and became known as 'Families First' (Government of Manitoba, 2010). The program is overseen by Healthy Child Manitoba (HCM), a cross-sector government office that has shown commitment to families and children with the *Healthy Child Manitoba Act*, which was written into legislation in 2007. This act ensures government funding is provided to support the health and well-being of Manitoba children and families (Government of Manitoba, 2019). HCM collaborates with many partners and has invested in policies and programs aimed towards early childhood interventions. The goal of HCM is to promote the health, safety, and security of Manitoba's families in an effort to raise healthy children through the implementation of healthy child resources, programs, and community supports (Government of Manitoba, 2019). The FFHV program was initially developed to support families and young children under five years of age, experiencing social and emotional challenges. Currently, with emerging evidence suggesting early prenatal care may improve maternal mental health and family outcomes (Stewart & Vigod, 2016), the program aims to reach families prenatally. During the prenatal and postpartum period, Public Health Nurses (PHNs), visit families and assess their need for supports including FFHV. This voluntary program is offered to disadvantaged families with socio-economic challenges such as poverty,

lack of social supports, unstable housing, unemployment, parenting challenges, and developmental concerns for the newborn. Approximately 10% of Manitoba women with newborns are accepted into this intensive home visiting program (Chartier, 2015). The goal of the FFHV program is to provide support to families, resources and enhance the parent-child interaction.

The FFHV program has been evaluated on home visiting's effectiveness in improving the mental well-being of families, and the evaluation found mixed results (Government of Manitoba, 2010). The results showed that there was a significant increase in positive parenting and reduced hostile parenting, increased neighborhood cohesiveness and social supports, as well as some aspects of psychological well-being. However, the program did not show any effects on maternal depression or any other aspects of maternal psychological well-being. This is concerning given the evidence that, during the perinatal period, some women experience psychological distress. Moreover, universal screening suggests that approximately 14% of women experience symptoms of post-natal depression and anxiety, with longitudinal studies showing this can have serious negative effects on families, may compromise the maternal child interaction and child development (Government of Manitoba, 2010; Steward & Vigod, 2016).

In response to the FFHV evaluation and through many partnerships, a mental health promotion strategy known as 'Towards Flourishing'(TF) was embedded throughout the existing FFHV program in Manitoba in 2012. Chartier et al. (2015) looked at the perspectives of parent and home visitor participants of TF in 3 urban areas of Manitoba early on in the program. Based

on that study, some further changes were made to TF. Considering the program is now well-established it would be interesting to explore the perspectives of participants in rural Manitoba.

Towards Flourishing

'Towards Flourishing' (TF) is a mental health promotion strategy for families that focuses on positive mental health, and decreasing mental illness and distress. It does so by embedding a number of mental health promotion strategies into existing home visiting services. These include a mental health promotion curriculum, everyday strategies, mental health screening and increasing access to health care providers such as the Public Health Nurse (PHN), and the Mental Health Promotion Facilitator (MHPF) (Government of Manitoba, 2016). TF is based on Keyes' (2002) 'Mental Health Dual Continuum' (Appendix A), which identifies mental health as either *languishing* or *flourishing*, based on certain characteristics, with *flourishing* being identified as functioning well socially, psychologically and emotionally (see 'Theoretical Framework' for a more detailed discussion). An early evaluation of the TF demonstration project found that almost half (49%) of women on the FFHV program were not flourishing, indicating a need for increased perinatal mental health support (Chartier, 2015).TF recognizes that the maintenance of positive mental health is important to overall well-being, and encourages working towards flourishing daily.

The TF curriculum was developed to assist with increasing parents' understanding of mental health and how this impacts themselves and their children's well-being. The curriculum covers four topics, which the evidence suggests are the most common and of significant concern for parents: changes and expectations, flourishing, coping strategies and reaching out. These

topics cover the normal changes that parents experience with a new infant and common parenting challenges.

TF has implemented nine everyday strategies to promote positive mental health and well-being (the strategies are summarized in Table 1; a more detailed description can be found in Appendix B). These strategies are based on Embry and Biglan's (2008) kernels, which are evidenced based strategies that have shown to effectively change behavior, and significantly improve mental health if used correctly and consistently. These strategies may assist with managing stress more effectively, coping with emotions in healthy ways, building resilience and enhancing mental health. Home Visitors (HVs) are guided by the TF curriculum, providing them with instructions for each strategy explaining how the strategy may be used and its benefits. HVs also provide parents with strategy handouts so they can do them on their own and with their families.

Lastly, TF also addresses mental illness and distress, including depression and anxiety, trauma and ways of changing behavior(s) using evidenced-based interventions (Towards Flourishing, 2016).

Table 1. *Nine Everyday Strategies*

Strategy	**Description**
Nasal Breathing	Take long deep breaths when feeling stressed, anxious or frustrated. Benefits may include feeling calmer and more relaxed.
Creating a Vision	Identifying and envisioning goals for oneself and family. Benefits may include increasing mindfulness and goal setting.
Belonging	Feeling a sense of belonging, and engaging with others is an important aspect of self-identity. Benefits may include improved self-esteem and confidence.
Three good things	Reflecting on the positive things that happen throughout the day. Benefits may include thinking more positive, and a greater appreciation for life.
Connecting with others	Feeling connected contributes to positive mental health. Benefits may include decreased feelings of loneliness and low self-esteem.

Physical activity	Being active increases energy levels, and decreases anxiety and releases endorphins. Benefits may include decreased stress and likelihood of health related illnesses.
Self-monitoring	Choosing a simple goal, monitoring behavior and keeping track of progress. Benefits may include increased motivation, goal setting and improved self-esteem.
Three-minute breathing break	Taking short breaks assists with managing stress more effectively. Taking a few minutes to be mindful, and present allows us to check in with our emotions. Benefits may include increased mindfulness and better decision making.
Progressive muscle relaxation	This deep relaxation technique aims to relax the entire body. Benefits may include decreased stress and tension.

TF began as a collaboration between the University of Manitoba, HCM, and the Winnipeg Regional Health Authority, with funding provided by the Public Health Agency of Canada. A participatory approach was used early on in the process for knowledge exchange purposes, and to engage decision makers and influence practice. TF was initially implemented at 18 pilot sites and 14 First Nations communities throughout the province using a cultural lens with Manitoba's Indigenous, Francophone, newcomer and immigrant families. This involved partnerships with Manitoba's regional health authorities (RHAs) and the Assembly of Manitoba Chiefs. Over the course of a 1-day workshop, First Nations service providers from different organizations made recommendations to reflect Indigenous culture, and these recommendations were integrated in a new version of the curriculum (Towards Flourishing 2015). Moreover, cultural safety was taken into consideration which included striving to create an environment that is respectful of diverse backgrounds, where power imbalances are minimized and individuals are "empowered and feel safe to communicate their unique realities of life" (Towards Flourishing,

2015, p.9). Furthermore, materials and resources have been translated into multiple languages including French, Punjabi, Cree and Ojibway to name a few.

It is important to evaluate programs such as TF, not only to provide evidence that the program is working and to determine areas of improvement but also to continue to receive future funding and support (Towards Flourishing, 2015). Since the implementation of TF, there has been ongoing rigorous quantitative data collecting to evaluate the program's effectiveness. HCM continues to collect data on the Enhanced Mental Health Screening form, Alcohol Identification Test and the Edinburgh Postpartum Depression Scale among others. This information is collected not only for research purposes, but foremost to assist families with mental health struggles and improving families' access to community mental health resources (Towards Flourishing, 2015).

So far, there is only limited qualitative data about TF. Chartier et al. (2015) explored the implementation of the TF demonstration project from January through June 2012 in urban areas of Manitoba. They found that parents reported the nine everyday strategies fostered relaxation, improved awareness of available resources and increased positive thoughts. HVs reported the training they received increased their capacity, confidence and knowledge of available resources to support the families they work with (Chartier et al., 2015). The purpose of this research study was to explore the perspectives of parents and HVs participating in TF regarding their experience, and the extent to which TF impacts their families' mental health and well-being, more than seven years following the program's implementation. It is anticipated that this study

will provide useful information that may be used in the future to improve TF for families and HVs.

Theoretical Framework

This study was guided by the 'Mental Health Dual Continuum' conceptualized by Keyes (2002), which describes mental health and mental illness as two distinct concepts with differences characterized by both affect and functioning. Within this model, (Appendix A) there are three groups of individuals who may or may not exhibit mental illness symptoms, people who are moderately healthy, people who are *flourishing* and people who are *languishing.* Individuals who are *flourishing* have an enthusiasm for life, high levels of subjective well-being, and actively and productively engage with others. By contrast, *languishing* individuals have low levels of subjective well-being, and an absence of purpose in life. Moderately healthy individuals are somewhere in-between and are neither languishing or flourishing. According to Keyes, an individual may have a mental illness and be highly functioning and flourishing, and conversely an individual without a mental illness may be languishing. Keyes argues that society views mental health as being positive when in fact, "mental health remains the antonym of mental illness and a catchphrase of inert good intentions" (Keyes, 2002, p.208). Keyes' work empirically describes mental health not on opposite ends of the spectrum as initially thought, but rather on a dual continuum that fluctuates with subjective well-being.

Keyes (2002) work is based on data from a 1995 study conducted in the United States with adults between the ages of 25-74. The results showed the risk of major depressive disorder was two times more likely among languishing individuals than moderately healthy adults, and six times greater among languishing than flourishing adults. These results indicate a positive correlation between those individual that are languishing and major depressive disorder (Keyes,

2002). The data also found a strong association between languishing and significant psychosocial impairment in activities of daily living and functioning at work. The study showed that mental health greatly affects work absenteeism. For example, none of the flourishing adults had missed as many workdays due to mental illness as languishing adults, who were 4.5 times more likely to miss work and 3.5 times more likely to report poorer emotional health than adults who were flourishing.

It is well known that mental illness impairs social and emotional functioning. Factor analysis of the above study showed three distinct dimensions: emotional, psychological and social well-being. Therefore, Keyes has operationalized mental health as a syndrome of symptoms including positive feelings and functioning in life based on these domains. The following is a brief description of these domains.

Emotional Well-Being

Keyes (2002) describes emotional well-being as a cluster of symptoms including the presence or absence of positive feelings of well-being, and perceived satisfaction in life. It may be thought of as an individual's personal view of their life, and how one feels about themselves. The term well-being is a broad concept and may be measured based on positive affect such as if the individual is in good spirits, and has a perceived satisfaction in life, or negative affect like hopelessness. Keyes argues that mental health is the presence or absence of an emotional state of well-being. Emotionally healthy individuals are more confident and are able to recover more effectively from change in their lives. Furthermore, emotional well-being includes the subjective well-being of how an individual views their presence or absence of positive functioning.

TF builds on this by developing strategies specifically to promote the emotional well-being of families. Some of the strategies aim towards emotional health and include encouraging

positive self-talk through difficult emotions, stay with the experience rather than escape, engage in pleasurable activities, journaling, practice acceptance, and use diversion activities such as art and music.

Psychological Well-Being

Psychological well-being involves the private lives of how individuals view themselves. Keyes (2002) identifies six domains for psychological well-being which includes: self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy. In other words:

> Individuals are functioning well when they like most parts of themselves, have warm and trusting relationships, see themselves developing into better people, have a direction in life, are able to shape their environments to satisfy their needs, and have a degree of self-determination (p.209).

Social Well-Being

According to Keyes (2002) there is more to mental health than just the emotional and psychological aspects. Keyes proposes dimensions of social well-being which includes social actualization, social integration, social acceptance and social contribution. This involves the public aspect of individuals, where people evaluate their own social functioning in life. Socially, individuals are functioning well when they view society as meaningful, they feel a sense of belonging in the community, they accept most parts of society, and see themselves as a contributing member of society.

Languishing versus Flourishing

According to the ‘Mental Health Dual Continuum’ (Appendix A), individuals with high levels of subjective well-being and functioning, both psychologically and socially, are

considered flourishing. Flourishing is associated with the best emotional health, fewest days of work absenteeism and fewer limitations of daily living. In contrast, individuals with low levels of subjective well-being and functioning are considered languishing; with pure languishing being associated with symptoms of major depressive disorder. The concept of languishing refers to poor emotional health with limitations of daily living. Moreover, languishing has been described as feelings of emptiness, loneliness, stagnation, hollow, a shell or void to name a few. Lastly, Keyes explains the presence of mental health as flourishing and the absence of mental health is characterized as languishing. Keyes states that, "measures of symptoms of mental illness (depression) correlate negatively and modestly with measures of subjective well-being" (p.209).

Keyes suggests that further research is needed on languishing adults and their risk for depression and suggests that mental health promotion is a pre-emptive for treatment. He notes that data analysis for two studies found a positive correlation between psychological and emotional well-being and depression. For example, the psychological indicator scaled showed that mental health is not just the absence of mental illness and that, "mental health is best viewed as a complete state consisting of the presence and absence of mental illness and mental health symptoms" (Keyes, 2002, p.210). Keyes argues that, conceptually, and using empirical measures, emotional, psychological and social symptoms mirror that of the symptoms of DSM III used to diagnose major depressive disorder (DSM-V is now used to diagnose this disorder) (American Psychiatry Association, 2013). Therefore, Keyes states that, "mental health is best operationalized as a syndrome that combines symptoms of psychological and social well-being" (p.210). The results of Keyes' study indicate that, just because an individual is functioning, does

not mean that they are mentally healthy, and conversely those that have a mental illness may be functioning well.

Chapter II: Literature Review

The purpose of this literature review was two-fold: (i) to examine what is known about the determinants of mental health of families with young children; (ii) to identify the evidence regarding mental health promotion interventions and/or programs aimed at this particular population. An extensive literature review was conducted using electronic databases CINHAL, PubMed and Cochrane Library using the following keywords: determinants; mental health; families; parents; children; mental health promotion; interventions, and community. The following is a summary of the literature review findings.

Determinants of Mental Health of Families with Young Children

Early Childhood Development

The most crucial period of time for the development of the human brain is prenatally and through the first five years of life, when rapid cell growth and maturation leaves the brain vulnerable to many negative factors (United Nations International Childhood Education Fund [UNICEF], 2011, DeSocio, 2018). Prenatal exposure to severe stress, poor maternal nutrition and substance use have been documented to lead to adverse birth outcomes including low birth weight, preterm birth and poorer mental health outcomes later in life. This can have substantial impacts on the development and health of the fetus (Allen, Balfour, Bell, & Marmot, 2014; DeSocio, 2018). Prenatal factors affecting infant mental health in response to maternal stress during pregnancy have also been shown: “During pregnancy, the developing infant shares the mother’s physiological and emotional environment mediated through the placenta” (DeSocio, p. 902).

During infancy, through the process of bonding and attachment with a primary caregiver (or caregivers), the infant begins to develop security and trust, building positive pathways in the

brain. This process is essential for the infant's mental health, with the absence of such attachment causing irreversible damage to the infant brain (Allen et al., 2014; Brownell et al., 2016; Kingston, Tough, & Whitfield, 2012). Infants' brains are 'wired' through sensory stimulation, which is strongly influenced by their environments and significantly impacts developmental and mental health outcomes: "[E]nvironment affects not only the number of brain cells and number of connections among them but also the way these connections are wired" (UNICEF, 2011, p.1).

Children's mental health is the capacity for them to enjoy life, have educational opportunities and the freedom and protection from risk and harm (UNICEF, 2011). The environment in which infants and children are raised has significant impacts on their mental health. Children internalize their environment and shape their expectations regarding life, relationships and roles based on what they experience around them (Allen et al., 2014; Brownell et al., 2016; Kingston et al., 2012). Children who have been exposed to stressors such as domestic violence and abuse may experience psychological distress resulting in mental disorders (Allen et al., 2014; WHO, 2014).

Maternal responsiveness has also been associated with better mental health outcomes during infancy, suggesting that when a mother responds to her infant's cues this 'wires' the brain, building trust and security, resulting in positive infant mental health (Allen et al., 2014; Brownell et al., 2016). This parent-child interaction is significant in the development of children's positive mental health and well-being. In contrast to loving nurturing relationships, infants and children exposed to trauma, and or neglect, may suffer irreversible brain damage including fewer brain cells and matter, cognitive impairments, and

mental health issues (Allen et al., 2014; Brownell et al., 2016; UNICEF, 2011).

According to a nationwide longitudinal study, one in every four young people suffer from some form of mental disorder, which suggests that the 'root cause' begins in early childhood (Paananen, Ristikari, Merikukka, Gissler, 2013). There is also evidence that young children with lower income experience higher rates of mental disorders: "Among children as young as three and five years of age, social, emotional and behavioral difficulties have shown to be inversely distributed by household wealth as a measure of socioeconomic position" (WHO, 2014, p.16). The mental health of youth is of significant concern with increasing rates of mental health issues, which are evolving, complex and begin in early childhood (WHO, 2014; VIRGO, 2018).

Parenting

Parenting is an important and challenging role that critically influences children's mental health and well-being. The role involves nurturance, guidance, teaching, and protection from harm. It is not surprising that children's mental health is strongly influenced by how they are parented, which ultimately affects their emotional development. In fact, inconsistent, insensitive, and unpredictable parenting creates ambivalence in children; which can lead to mental health issues and disturb their attachment with their parents (Achtergarde, Posteli, Wessing, Romer, Muller, 2015; Mordoch & Hall, 2008). This is consistent with other research that has found avoidance and neglectful parenting to be associated with the poorest mental health outcomes for children (WHO, 2011). Conversely, high parental

warmth and support has been associated with better mental health outcomes for children (Achtergarde et al. 2015).

Parenting style also influences the mental health of children, with an authoritarian style of parenting being associated with the best mental health outcomes for children. Although this type of parenting has been criticized for being controlling, it is known to set clear boundaries, and expectations resulting in overall better mental health outcomes for children (Nanninga, Jansen, Knorth, & Reijneveld, 2015; Achtergarde et al., 2015). Moreover, this parenting style leads to favorable results in children including greater feelings of self-worth, self-efficacy, greater emotional and social competence, lower risk for emotional or behavior problems and more adaptive behavior (Achtergarde et al., 2015).

Often, parents have experienced their own childhood traumas which may have repercussions on parenting behaviors and child development (Johnson et al., 2017). Adverse childhood experiences (ACEs) are traumatic events in one's childhood such as physical or emotional neglect, physical, sexual or emotional abuse, domestic violence, family separation, family member substance use, mental illness or incarceration. These stressors not only have short term effects on children's mental health, they have long term health effects into adulthood (Felitti et al., 1998). In fact, the higher numbers of ACEs are associated with increased likelihood of high risk behaviors such as smoking, alcoholism, increased number of sexual partners, and adult-onset diseases including heart disease and

cancer. The relationship between ACEs and adult depression, anxiety and substance use, has also been documented (Felitti et al., 1998).

Adults who experience negative childhood events, and then become parents, are likely to experience a parenting style that is affected by their past experiences (Johnson et al., 2017). For example, parents may copy the behaviors they observed as a child such as emotional, physical or sexual abuse, thereby depriving their children of the safe, nurturing, stimulating environment needed for optimal growth and development (Johnson et al., 2017). Furthermore, parents with a high ACE score may also experience health-related sequelae related to their childhood such as heart disease, lung disease, cancer and depression (Felitti et al., 1998).

There is value in screening parents for ACEs, especially during the critical first few years of parenting when families are the most vulnerable. According to Johnson et al., (2017) a potential method of screening is to have HVs complete parental ACE screening due to the relationship that has already been established, and other questionnaires are already being completed in the home.

Poverty

Poverty has an enormous impact on the mental health and well-being of individuals and families. Individuals with a mental illness may end up in poverty, and conversely those living in poverty may also have a mental illness. This is most likely due to poverty being a significant risk factor for poor mental health (Canadian Mental Health Association [CMHA], 2019). In fact, the most significant social determinants of health (SDOH), are poverty and mental health, as they intersect with all other determinants of health ([CMHA], 2019; Simon, Beder, Manseau, 2018). There is strong evidence to support a causal

relationship between poverty and mental health which impacts individuals and families: "Poverty leads to mental health and developmental problems that in turn prevent individuals and families from leaving poverty, creating a vicious, intergenerational cycle of poverty and poor health" (Simon et al., 2018, p2).

The mental health effects of poverty are broad and reach across the lifespan, with detrimental effects on children's mental health being well documented. Poverty has been associated with deficits in children's development and well-being, and children in poverty report more mental health conditions: "Poverty in childhood is associated with lower school achievement; worse cognitive, behavioral, and attention-related outcomes; higher rates of delinquency, depressive and anxiety disorders; and higher rates of almost every psychiatric disorder in adulthood" (Simon et al., 2018, p.1). Furthermore, in regards to childhood anxiety and depression, data confirms the vulnerability of Canada's poorest children. Data from a Canadian National Longitudinal Survey of Children and Youth between the ages of 2 to 5 at initial interview, found that the depth of current poverty was associated with anxiety and depression, and persistent poverty was associated with antisocial behaviors (Strohschein & Gauthier, 2017). Poverty is independent of parenting behaviors, therefore poverty alone contributes to poor mental health outcomes in children and youth.

Poverty has significant negative impacts on the mental health of young adults with many of them parenting young children. The Calgary Health Region Population Survey used regional data surveillance to document the prevalence of mental disorders in relation to socio-economic status (SES), using the 'Low Income Cutoff' (LICO), (Currie, Fiest, & Guyn, 2013). Often used as a measure of poverty by Statistics Canada, LICO may be described as, "income threshold below which a family is likely to spend significantly more

of its income on food, shelter and clothing than the average family. A family with an income below the cut-off is considered to have low income" (CMHA, 2019; Statistics Canada, 2019). The results of this regional survey found a positive correlation between the SDOH and major depressive disorder, with young adults between the ages of 18-24 experiencing higher rates of mental health disorders as compared to those with higher incomes. Moreover, these young adults with low SES were 2.5 times more likely to experience anxiety and depression (Currie, Fiest, Guyn, 2013).

Work-Family Conflict

Families often experience the negative effects of work-family conflict when parents struggle to meet the financial needs of the household, and parental obligations with their children (Cooklin et al., 2016). The conflict occurs when there is incompatibility with the demands of work and family, which directly correlates to family mental health issues and compromising family life. Parents may become overwhelmed with the challenges of child rearing and work; which most often occurs during the middle-aged years when parenting, career development/enhancement intersect (Cooklin et al., 2016). This is when families need the most support and resources to assist them through this difficult and exhausting time.

Interestingly, mothers and fathers report distinct differences in their experience of work family conflict (Cooklin et al.). Mothers report that stress is associated with taking time off work for family obligations, and they appear to be the most affected by working conditions. Fathers' experiences are determined by a combination of factors, and they are mostly affected by poor job quality. Conversely, parents with flexible jobs and paid family leave are less likely to report work-family conflict. This suggests that perceived positive job quality may be a protective factor for positive mental health status for parents. Therefore,

families could benefit from public policies that address work-family conflict and support families with these challenges.

Indigenous Populations

Manitoba is a Canadian province of about 1.3 million inhabitants, with Indigenous people representing approximately 15% of the total population (Statistics Canada, 2016; Winnipeg Regional Health Authority [WRHA], 2014). Yet, this group has the highest rate of poverty and overall poorer health outcomes as compared to non-indigenous people, and account for the majority of health disparities in the province (Katz et al., 2019; National Collaborating Centre for Aboriginal Health [NCCAH], 2010; [WRHA], 2014). In fact, "Manitoba has the highest rate of Indigenous child poverty, both on-reserve at a shocking 76% and off reserve at 39%.....these rates are much higher than those of non-Indigenous children" (Manitoba child and family report card, 2016, p15).

The high percentage of mental health disorders among First Nations on-and-off reserve is alarming, with mood and anxiety disorders being the most common, followed by substance use and suicide (Katz, et al., 2019; [VIRGO], 2019).). The rates of mood and anxiety disorders among this population group has a higher prevalence than among all other Manitobans. In fact, a staggering 50% of First Nations adults living on reserve experience depression. These rates are even higher among First Nations living off reserve (Katz et al., 2019). This makes sense in that those individuals living off reserve are away from their families, culture, beliefs and land.

The rates of substance use disorders among First Nations is two to three times higher than those who are non-indigenous. Over half of First Nations living on-reserve see alcohol and substance use as a challenge for their communities (Katz, et al., 2019). The rates of suicide among First Nations is also extremely high, five times the rate of all other Manitobans.

Moreover, suicide attempts and suicide ideation is higher among First Nations then non-indigenous (Katz, et al., 2019).

Many of the mental health issues facing First Nations stems from the history of colonization and intergenerational trauma, resulting in high rates of anxiety, depression, substance use and suicide (Nelson & Wilson, 2017; Katz et al., 2019; [WRHA], 2014). In an effort to address the mental health needs of First Nations both on-and-off reserve, various ways of healing need to be explored such as ceremonies, guidance from Elders, meaningful activity, and connections with land (WRHA, 2014).

Community Programs Aimed at Preventing Mental Illness and Promoting Mental Health

Preventing mental illness and promoting mental health are terms that are often used interchangeably, yet they focus on different things. Prevention efforts aim to reduce the risk factors associated with mental disorders including poverty, abuse and neglect; whereas promotion efforts focus on protective factors such as coping strategies and support systems (Enns et al., 2016). Mental health promotion efforts aim to improve the well-being of individuals and families through the promotion of resilience, positive perspective, building capacity, and relying on inter-sectorial linkages (CMHA, 2016). These efforts have been associated with positive outcomes including an ability to withstand environmental stresses, improved self-esteem, and mental well-being, which ultimately affects overall health (Enns et al., 2016).

Although there is clearly a need for both prevention and promotion efforts, unfortunately many of these strategies are under recognized and underfunded. In fact, less than five percent of Canadian health care funding is spent on both of these efforts combined,

despite the evidence that mental illness is costing the health care system an estimated $50 million annually (Enns et al., 2016; VIRGO, 2018). This lack of financial support for mental health services may be attributed to the stigma attached to mental disorders, including the perception that mental health solutions are impractical, minimally effective and that mental illness is irreversible (Enns et al., 2016). Also, despite the growing research on the importance of promoting mental well- being, there are barriers on how to effectively promote it or how to promote it equitably, thereby creating challenges for programming (Welsh et al., 2015). Furthermore, most strategies focus on preventing mental illness rather than promoting well-being, and are primarily focused on parenting and preventing childhood behaviors, rather than promoting the mental health and well-being of families. Lastly, in an effort for mental health promotion strategies to succeed, the challenges lie in efforts not only at the individual level but also at the familial, community, structural and societal levels to address the broader SDOH that influence mental health.

Community-Based Programs for Families

In the community, programs are offered to families in many different settings with a variety of interventions based on goals and desired outcomes. Enns et al. (2016) conducted an extensive international review of mental health promotion interventions, and found that community programs are delivered within schools, homes, clinics and counselling centers--with the majority taking place in school settings. Most programs emphasize parent education and utilizing skills to prevent children's aggressive behaviors, while interventions for children often include creativity, play and physical activity.

The limited research that does exist suggests that only a few programs specifically aim to promote the well-being of families with young children in the community, and that

the most effective ones are delivered within home settings (Enns et al., 2016). Home visiting programs are essential to the integrated health care system and have shown success in building capacity, health education, advocacy and support for families (Chartier et al., 2015; Garcia et al., 2012; Gulnar et al., 2015; Welsh et al., 2015). The following is a brief overview of the literature surrounding the most commonly offered mental health programs in the community.

Parenting programs. Typically, parenting programs are not designed to promote the well-being of families, rather they focus on improving children's behaviors and preventing mental disorders. Many of these programs were created in response to the research indicating the strong influence that parenting has over a child's behavior, which ultimately affects the rest of society. Therefore, parenting in itself has substantial influence and consequences for society in its entirety (Stewart-Brown, &Schrader-McMillan, 2011). There is conflicting opinion in the literature on parenting programs, with some research showing a positive effect on children's mental health (Welsh et al., 2015), while others have found these programs do not foster the cultural aspects that contribute to the mental health and well-being of families (Eni & Rowe, 2011).

However, the evidence does show some positive results for both parents and children in regards to parenting programs. For example, ‘Nobody's Perfect' is a parenting program for young children up to five years of age and was developed in Canada (Nobody's Perfect, 2017). The program encourages and builds on parenting skills and evaluation has shown parental reports of increased feelings of efficacy and satisfaction with parenting (Canadian Institute for Health Information, 2009). ‘Triple P’ is a well-known parenting program that has shown to be effective in fostering a child's strength and assisting parents in creating a positive

environment to raise their children. This population-based prevention strategy aims to strengthen parenting and is offered in many different countries around the world. Overall, this program has had many successful evaluations and has been found effective in improving children's negative behaviors (Welsh et al., 2015).

Although parenting programs address children's behavior, which can be argued is a component of their mental health, there are many barriers that need to be addressed for such programs to be successful. Some key issues with parenting programs include the stigma attached to them in that they are perceived as only needed for families with problems, their high literacy levels and their potential to not look at the broader context in which parenting takes place. Also, families new to the country or from culturally diverse backgrounds will need to be educated on parenting within the context of Canada (Cohen et al., 2016).

Cohen et al. (2016) have put forth key recommendations to ensure programs use a diversity, equity and anti-oppression perspective and consider challenges with specific groups such as single parents, Indigenous families on-and-off the reserve as well as orientating newcomers on parenting. These authors remind us that there needs to be more than just offering parenting programs; families' basic needs must be met and appropriate referrals must be made beyond the program to strengthen capacity. Therefore, families would benefit from programs that address and assist families with their social needs, especially for vulnerable populations.

School programs. The majority of mental health strategies are offered in school settings; but they focus on preventing mental illness, rather than promoting mental well-being (Enns et al., 2016). These programs also focus on school-aged children, rather than the preschool years which are the most fundamental to the human brain. However, they have

shown to be successful at reducing risky behaviors for school-aged children and some have shown to somewhat promote the well-being of children. For example, 'Roots of Empathy' for preschool and elementary schools, seeks to increase children's empathy; thereby preventing emotional and behavioral challenges. The results of this international program have shown increased self-esteem and decreased feelings of worry, which can be argued are contributing factors to the mental health of children (Roots of Empathy, 2010).

The 'Let's Start' program was developed for Indigenous children in Australia to help them transition to the school setting. The program was designed to work with parents, staff and students to support children's environmental changes (Gulnar et al., 2015). The key findings of this program include improved self-esteem, increased confidence and socialization. Moreover, many children who were reluctant to participate in the school program found themselves enjoying the aspect of socializing with others.

These are all positive aspects that contribute to good mental health at the individual level. However, there are many barriers that exist with implementing school programs including the lack of financial support and available staffing for programs to function. Most importantly, these programs do not involve the entire family unit which is a major influence on children's mental health. Many of children's mental health concerns stem from problems within the family (Enns et al., 2016). Therefore, it may be more beneficial to implement mental health promotion programs in the early years and include the rest of the family.

Home visiting programs. Home visiting programs such as FFHV and TF were developed for families living in conditions with multiple parenting challenges, and the potential for risking the well-being of their children (HCM, 2010). Many home visiting programs around the world focus on using maternal-child strategies, mostly because

concentrating on maternal- child health is a strategy that will affect the entire family including the rest of society (Song, Kim, & Ahn, 2015). The postpartum period is an important time of transition for women, who are learning to cope with stresses such as physical pain from childbirth, psychological stressors and concerns for the baby. Women are vulnerable to stress during the postpartum period because they face new tasks, challenges and may lack confidence in their new role (Song et al, 2015). Approximately 10-15% of women experience mental health issues such as depression and anxiety during the postpartum period. Women of low SES have even higher rates of postnatal distress which ultimately affects the entire family unit (Song et al.). Therefore, access to appropriate, effective and evidence-based mental health promotion in the postpartum period is essential to reduce postpartum stress and promote the well-being of families.

A systematic review of psychological interventions for women with postpartum stress found that, in general, mothers participating in programs promoting their well-being experienced less stress than women who did not participate in the programs (Song et al., 2015). In fact, women receiving any type of psychosocial intervention positively benefited with improved feelings of well-being. There is also evidence that home visiting programs are the most effective if they last longer than 6 months and have more than 12 home visits (HCM, 2010). This makes sense because it takes time to build rapport in a relationship.

Furthermore, home visiting programs are the most effective for parent-child well-being because they are multi-focused, targeted and medium- to long-term. However, the benefits of these programs may be short-lived if there is not ongoing support for mothers

(Stewart-Brown, & Schrader-McMillan, 2011).

A qualitative study on parents' and children's perspectives of their mental health and well-being (Coverdale & Long, 2015), found that parents viewed their mental health on a continuum from very poor to very good. They described a range of feelings and emotions including stability, happiness, ability to cope and being confident. Both parents and children expressed a desire to spend more quality time together as a family, which they felt contributed to their overall mental health. The authors state that, "it is well recognized that relationships within families are a key indicator of influencing mental health and well-being" (p.30). The authors were able to identify key constructs for good emotional well-being which included: support from family and friends, good family relationships, and empathy. Empathy was also a key indicator for both parents and children where they were able to understand their own emotions as well as others. Being loved and supported was essential to overall feelings of happiness and well-being.

Addressing Mental Health Inequities

Health inequities are differences in health statuses between population groups that are unfair, avoidable, socially produced and systematically unequal in distribution (Welsh et al., 2015). There is a growing concern about the health inequities that exist with vulnerable populations or groups that are socially excluded or marginalized in some way such as newcomers, francophones and families from culturally diverse backgrounds (Cohen et al., 2016). These families often experience the negative impacts of the SDOH and have poorer mental health outcomes (Brownell et al., 2012; Welsh et al., 2015). Therefore, health equity needs to be addressed in community-based mental health programs and there needs to be policy changes that meaningfully impact and address socially determining factors such as

crime, poverty, and social exclusion (Enns et al., 2016).

There appears to be many challenges with addressing the mental health needs of socially excluded or marginalized families, including a lack of coordination among health care professionals, lack of clarity involving providers' roles and a lack of sufficient clear mandates (National Collaborating Center for Healthy Public Policy [NCCHPP], 2017). Various recommendations have been made including developing an understanding of mental health promotion among various sectors; implementing mental health promotion across the lifespan; advocating for inter-sectoral collaboration; focusing on the underlying SDOH; and lastly, establishing evidenced-based guidelines for integrating mental health promotion (NCCPH).

In an effort to promote the mental health and well-being of Canadians and to reduce health inequities, the NCCPH (2017) developed a collection of resources. This collection was designed to increase understanding of population mental health promotion for children and youth, and to discuss how to better integrate and strengthen public health practice in this area: "Our hope is that this collection will inspire and guide public health practitioners and professionals to explore positive mental health for children and youth as an essential focus for public health practice" (p.1).

Universal and Targeted Programs

Generally speaking, there are two ways that community programs are offered; either from a universal or targeted approach. Universal programs are offered to everyone regardless of criteria, whereas targeted programs are offered to specific eligible sub-populations—usually those from disadvantaged backgrounds. Throughout the literature there is a general consensus that both approaches may be beneficial, however targeted

programs such as FFHV and TF address the social gradient of health (Cohen et al., 2016; Welsh et al., 2015). Welsh et al. (2015) found that interventions for families are successful in building children's strengths and support positive parenting with both universal and target programs. However, they acknowledge that targeted approaches do not necessarily promote well-being at the population level. Cohen et al. (2016) argue that universal parenting programs have the potential to not be universally appropriate and programs should consider the potential for inequitable outcomes when planning them. This is echoed with other authors that have found postpartum home visiting programs more effective with targeted groups and ineffective in universal approaches for addressing postnatal depression (Stewart-Brown, &Schrader-McMillan, 2011). Welsh et al. (2015) argue for 'proportionate universalism' which emphasizes interventions that provide support proportionate to need. However, these authors had not found any mental health promotion strategies that are based on this model.

Addressing the Mental Health Needs of Indigenous Families

Canadian history includes colonization, the residential school system, systemic oppression and assimilation among Indigenous people. As a result, health inequities exist among Indigenous people as compared to mainstream Canadians, impacting the health and well-being of children, "Children living in poorer households, in rural areas and from culturally diverse, or Indigenous backgrounds report lower rates of cognitive, social and emotional well-being than their counterparts" (Welsh et al., 2015, p.42). It should be mentioned that these health inequities that exist are not an Indigenous issue, but rather the result of the historical systemic issues (Eni & Rowe, 2011). In order to close the health equity gap, community programs need to consider health equity in policy and decision-

making including acknowledging the impact of colonization on families, and implementing culturally sensitive programs (Cohen et al., 2016).

Eni and Rowe (2011) argue that different approaches are needed to promote the mental health and well-being of Indigenous populations. The authors reviewed the literature on mental health promotion interventions and made specific recommendations for Indigenous people such as story-telling, mentoring, workshops and home visits. They explain how education needs to be explicitly about teachings and the impact of historical trauma as well as the value of knowledge and traditional practices. Culture was identified as a protective factor that has a huge impact on mental health and well-being. There are also different traditions and teachings (NCCAH, 2013) for example the term mental health is often replaced with "wellness". Indigenous people also view mental health promotion as a healing process involving the family and community. Their traditions may include feasts, ancestry, land teachings and ceremonies (Eni & Rowe, 2011). Eni & Rowe (2011) made recommendations when working with Indigenous people such as encouraging mental health promotion strategies such as cognitive behavioral techniques, relaxation and exercise, mindfulness, increasing self-awareness, confidence and self-efficacy. However, very few interventions look at the environment and reducing the often inevitable stressors within the home.

One exception is 'Strengthening Families' a sister program to FFHV that is offered in Manitoba's First Nations communities and funded through the Manitoba federal government (Maternal child health program in First Nations communities, 2017). This maternal-child health program offers ongoing support to families in First Nations communities and enhances the physical, psychological, cognitive, and social development of all family

members. A qualitative study was conducted on this maternal-child home visiting program and found that single parents struggle with the demands of caregiving and work (Eni & Rowe, 2011). Indigenous families also view their community as an extension of their family where everyone assists in raising children. This may be different than the traditional western view of a family. Connection to land was also vital to feelings of belonging, and many expressed feeling safe on the reserve and disconnected from other environments (Eni & Rowe, 2011).

Eni and Rowe (2011) note that there are many barriers with promoting mental health among Indigenous populations in First Nations communities such as the high cost of living in remote areas, lack of employment or decent paying jobs, lack of education beyond grade eight, food and housing security, water safety, lack of community programs, and lastly, a loss of culture from the negative effects of the residential school system. They found that Indigenous people want to incorporate their language, culture and traditions into programming and many expressed a need to strengthen and connect with their youth. This may be achieved through communication and building of relationships between elders and youth. Promoting the well- being of Indigenous children may produce desirable outcomes; however, it does little to address the structural factors associated with this disadvantaged group and their vulnerability to daily living conditions that are damaging to their health. This signifies the importance of interventions at the socioeconomic, political and cultural context to produce structural changes.

The mental health needs of First Nations living off reserve may include more traditional beliefs and practices such as ceremonies, guidance from elders and connections with family and land as part of their pathways to healing processes (WRHA, 2014). Others

may believe in more modern or western practices of healing, such as medication and referral to health care providers. In fact, the percentage of First Nations seeking primary care services for mood and anxiety disorders, substance use and suicide are lower than other Manitobans (Katz, et al., 2019).

Summary

Mental health is necessary for overall well-being. There is strong consistent evidence about the determinants of mental health, allowing for opportunities for early intervention and improved outcomes for families. There is limited research on mental health prevention and promotion programs in the community, however the research that does exist shows the majority of interventions taking place within school settings rather than within families' homes. There is a need for community programs that address the mental health needs of families, especially for the most disadvantaged groups, such as families living in poverty, from culturally diverse backgrounds and those with young children under five years of age. The most meaningful and effective programs are offered in home settings within the context of the entire family unit. However, there are challenges with mental health promotion programs in that they need to be promoted equitably and need to be adapted for specific populations for them to be successful. Changes also need to be made at the political level to address social inequities.

TF is a community-based mental health promotion strategy that is offered to disadvantaged families with young children in Manitoba, Canada. There is limited qualitative research on this intensive home visiting program in regards to the effects on families' mental health and well-being, nor is there much evidence regarding parents' or service providers' perspectives about the effectiveness of these types of programs more

broadly. This study will make a contribution toward filling this knowledge gap.

Chapter III: Methodology

The purpose of this study was to capture parents' and home visitor's perspectives of the TF program, and to explore the impact of the program on families' mental health and well-being. A descriptive qualitative design was used to give meaning to the participants' experience, and to provide a comprehensive and valid description or summary of the phenomenon in question in its natural setting (Creswell, 2013). The following is a description of the methods used for this research study.

Description of Study Sampling

Background. During the perinatal period, Public Health Nurses (PHNs) in Manitoba meet with parents to complete a Universal Screening Tool to assess the presence of risk factors that negatively affect healthy child development. The Families First screening form is based on the Parkyn tool. This tool was developed by Helen Parkyn in 1985 and was used to screen mothers and infants on 14 factors associated with risks such as parenting problems, congenital and acquired health challenges, developmental and family interaction. The Parkyn tool is the most widely used home visiting screening tool in Canada (Pan-Canadian Inventory of Public Health Early Home Visiting, 2009). PHNs fax this confidential tele-form to HCM where the data is entered into a secure database. Families that score 3+ on the screening form are eligible for an in-depth parent survey with a PHN. The parent survey is based on the Kempe Family Stress Checklist, a psychosocial assessment used to measure families' stress (Pan-Canadian Inventory). Parent surveys address the SDOH and, due to the nature and sensitivity of topics discussed (childhood abuse, trauma, parenting practices, mental health issues), the process involves

building trust and developing a relationship with families. Parents who score +25 or greater on the parent survey are offered FFHV and TF.

Home visitors (HVs) are para-professionals who have the knowledge, training and skill necessary to work with disadvantaged families in the community. Their Families First work is guided by the Growing Great Kids (GGK) and Growing Great Families (GGF) curriculums, and is intended to educate parents on the social, emotional and physical development of children including enhancing the parent child interaction. HVs also implement the TF program, guided by Keyes (2012), through educating parents on fostering their mental health and well-being and working with families to flourish daily.

Sampling. This study used purposeful sampling. In qualitative research purposeful sampling selection occurs when subjects who possess the characteristics required for the study, or who have experience with, or are involved in, the phenomenon of interest, are chosen as participants (Streubert, & Carpenter, 2011). In this case, 10 parents (singles and couples) who were participants in the TF program, and 10 home visitors, were recruited in a rural region of Manitoba. Inclusion criteria for parent participation were English-speaking parents, 18 years or older, those who have scored +25 or greater on a parent survey, have voluntarily enrolled in the program, and have been participating for at least six months. These families are typically the most structurally disadvantaged and are often ethno-culturally diverse. Attempts were made to include demographic and ethno-culturally diverse families such as single parents (n=4), fathers (n=l), Indigenous parents (n=3), low socio- economic status (n=9) and blended families (n=2). Exclusion criteria included parents that have scored less than +25 on the assessment survey and have not been offered the program, or parents who have been in the program for less than six months. 'Clinical positive' families-i.e., those who were offered the program based on clinical

judgement and not the scored assessment survey-were also excluded. Inclusion criteria for home visitors were that they must have completed TF training, used the TF program with families for at least 12 months and be English-speaking. Home visitors who had been working less than 12 months and those who had not taken TF training were excluded.

Data collection. The purpose of data collection is to gather, accumulate and measure data systematically for later analysis and interpretation; with the goal of finding meaning, answering questions and evaluating outcomes (Munhall, 2012). In this study, data was collected through face-to-face, semi-structured interviews with parents and home visitors in one health region in the province of Manitoba. Invitation letters (indicating the purpose of the study and asking for participation) were distributed to eligible parent(s) (Appendix C), and home visitors (Appendix D) on behalf of the researcher by the Families First Coordinators (see Appendix E for the letter that was sent to the coordinators regarding this research study). After the invitation letters were distributed to parents and home visitors, those individuals who were interested in participating contacted the researcher directly. This way, the coordinators did not know which home visitors were participating in the research study and the home visitors did not know which families were participating in the study. The researcher was not in any position of power with either the parent(s), and or home visitors; these measures were taken to prevent coercion and ensure voluntary participation in the research study.

The first ten parents and the first ten home visitors who met the inclusion criteria, and expressed an interest in participation in the study were accepted. Participants were then mailed or emailed the appropriate consent form (Parents: Appendix F; Home Visitors: Appendix G) prior to initiating the interview. Participants then had the option of a) reviewing, signing, and scanning-or returning a hard copy-of the completed consent form via email or regular mail to the

researcher prior to the scheduled interview; or b) reviewing the consent form and having it with them to the scheduled interview if they had any questions. The researcher also provided the option of sending a hard copy via Canada Post to the participant's address, in the event that they did not have email and or scanning capabilities. In any case, before commencing the interview, the research began by asking participants if they had any questions, and reviewed the consent form with participants as needed. Once all questions were answered by the researcher and if the participant agreed to participate in the study as outlined (signed the consent form), then the researcher began the interview using the interview guide.

The researcher was flexible in meeting participants wherever they felt the most comfortable. Interviews with parent(s) and home visitors took place in a variety of locations including homes, community health offices, outdoors, and restaurants. All interviews were conducted by the researcher. These semi-structured interviews were approximately 45 minutes in length for all participants and were recorded using a hand-held digital recording device. Both parent(s) (Appendix H) and home visitors (Appendix I) were asked a series of questions regarding their involvement with TF and the impact on their families' mental health and well-being.

Throughout the interviews, the researcher used field notes to give further insight into the essence of the interview, including reflective thoughts which were later used for data analysis. Field notes are a useful analytical strategy that involves the researcher writing down their own thoughts and insights into the interview and the participant's experience (Creswell, 1998). The use of field notes is a holistic approach in that they are used to fill in the gaps and give meaning to the interview. The researcher used reflective notes to capture her thoughts, ideas, questions and insights into her observations during the interview, which provided the foundation for

subsequent analytical writing and conceptual reasoning. The researcher assigned a fictitious "code" name to participants and began the interview stating, "this is an interview on [date] with [code name]." The audio recordings were then transcribed verbatim by a qualified transcriptionist who signed a pledge of confidentiality (Appendix J). The transcriptionist removed participants' names or any identifying features. The participants' code names were also assigned to the researcher's reflective notes.

A master list of participants' names and code names was kept in a password-protected file. Once the transcription was complete, the transcriptionist gave the password-protected electronic transcript to the researcher and did not keep any copies of any study files. All transcribed documents (no names or identifying features) were then uploaded to the University of Manitoba secure H drive. Digital audio-recordings were kept in the researcher's computer and any additional documents, such as handwritten journal notes and other raw data, was kept in a locked cabinet in the researcher's home office. If documents needed to be shared with Dr. Benita Cohen (thesis supervisor) they were transferred onto a password protected USB.

Data analysis. This study used a variety of analytical strategies to capture the essence of the data which included field notes, and identifying codes, categories and themes that assisted in identifying patterns and relationships (Munhall, 2012). Data analysis began with the researcher immersing and reading through all of the collected information to obtain a sense of the overall data (Creswell, 1998). Audio-recordings of interviews were transcribed verbatim using Microsoft Word, then each transcript was read at least twice. A Microsoft Excel spreadsheet was created and populated by data cut and pasted from the transcripts. The spreadsheet was organized according to questions responses; this way, the responses to each question by each participant were more easily identifiable and analyzed. Written field notes were also reviewed and

summarized to give clarity and further insight into the participant's perspectives, their demeanor and overall sense of their feelings about the program. These were also added to the Excel spreadsheet.

A systematic approach, guided by the 'Framework Method' (Gale, Heath, Cameron, Rashid, Redwood, 2013) was used to complete the data analysis process. This method is a flexible tool that may be used with any methodology to generate themes and make sense of the data. The Framework Method for qualitative data analysis suggests separating the data into codes and categories thereby grouping them into clusters around similar ideas and concepts. Codes and categories are not synonymous and in fact are two distinct concepts. Codes are “essence-capturing and essential elements of a research story that, when clustered together according to similarity and regularity, they actively facilitate the development of categories" (Saldena, 2009, p.8). Codes are words or short sentences that "symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldena, p.3). In other words, strong language words were noted, patterns and frequency of codes were identified, and important statements were grouped into categories and themes were generated. This step was carried out by reviewing the Excel spreadsheet containing the data for all participants. A column at the right side of the spreadsheet was reserved to begin identifying codes next to each participant's data. Themes are interpretive concepts that explain the data and are articulated and developed by comparison between and within cases (Saldena, 2009). Through the comparisons of codes and categories, themes were generated and causality of relationships were observed.

Data interpretation. The process of interpretation entails understanding and making sense of the data as the researcher classifies statements, explores relationships and reconstructs

the individual's existential experience in a narrative (Munhall, 2012). Creswell (1998) suggests the researcher take a step back and think about what is the larger meaning behind the narrative and what is going on in the particular situation. Qualitative research seeks to understand, illuminate, and extrapolate in an attempt to relate to similar situations. In this study, general over-arching themes and sub themes were identified by going above and beyond the codes and categories and a narrative was developed regarding parents and home visitors socially constructed perspective (Munhall, 2012) of the TF program in relation to their mental health.

This study was guided by 'Keyes' Mental Health Dual Continuum in the context of families' mental health and well-being. In particular, it explored the extent in which the TF program promotes flourishing or a sense of well-being from the perspectives of parent participants and home visitors. The conceptual model gives meaning to mental health being on a continuum rather than fixed, which is likely to occur for all members of the family unit. The model describes the emotional, psychological and social aspects of mental health that is influenced by many factors such as stress, coping strategies and supports.

Steps to Ensure Trustworthiness

In this qualitative research study, trustworthiness was ensured through dependability, credibility, transferability and confirmability (Holloway & Galvin, 2016). Dependability means that the research findings were consistent and accurate. This was established through clearly defining the process of data collection and analysis, use of an audit trail (in the form of an Excel spreadsheet) which will allow other researchers to follow the path of the study, and to see how the researcher came to the conclusions she did. The content of the research was described in detail to help guide other researchers to carry out a similar study. Credibility has been argued as the most important step to ensure trustworthiness, known as internal validity, where the

"researcher's findings are compatible with the perception of the people under study" (Holloway & Galvin, 2016, p.309). Member checking is the opportunity for participants to review their transcripts transcript by including a place on the consent form to indicate if they were interested. This was offered to participants, yet none of them indicated they wanted to review their transcript. However, debriefing with committee members did occur.

Transferability is the extent that findings are applicable or transferable to other settings or meaningful to individuals in similar situations (Polit & Beck, 2012). Transferability was created using thick descriptions so that others may assess how the findings apply in their contexts (Streubert & Carpenter, 2011). Lastly, confirmability exists when the data can be traced back to their original sources and when the findings achieve their goal and not the researcher's preconceptions. This was established through the use of an audit trail and written records to follow constructs, themes and interpretation of the data. Data was also reviewed with the researcher's advisor.

Ethical Considerations

Ethical approval was obtained from the University of Manitoba Human Ethics Research Board and access approval was obtained from the RHA where the study was conducted. The ways in which ethical principles were applied are outlined below.

Respect for persons. Invitation letters were distributed to all parents and HVs who met the inclusion criteria and only those who were interested in participating in the study contacted the researcher directly. This allowed participants the free will to give informed consent.

Participants were treated with dignity and respect, and the researcher was not in any position of power, thus preventing coercion and ensuring voluntary participation in the research study.

Concern for welfare. Families participating in the TF program are some of the most disadvantaged, as identified by PHN's and other health care providers who have referred families to the program for increased support. Some individuals in the family unit have experienced trauma and psychological distress, which is challenging to talk about during an interview. Many HVs have also experienced sensitive issues such as vicarious trauma or emotional effects from families. Therefore, due to the nature and sensitivity of the topic of mental health, including the vulnerability of families, ethical considerations were highly thought out.

Justice. Prior to interviews, participants were given a research package explaining the research study, confidentiality, anonymity and requesting signed informed consent. It should be noted that transparency was important when working with families, because it shows trust and respect. Therefore, measures were taken to ensure data was ethically sound including full disclosure to participants regarding the purpose of the study. Participants were made aware that due to the small sample size it was not possible to guarantee anonymity in the reporting of findings. However, participants' names and other identifying information was not recorded; and, although direct quotes of statements participants made during the interview may be used in a final report, no identifiable information will be linked with the statements.

Compensation. Participants were given a $25 gift card at the beginning of the study in appreciation of their participation. This low monetary gift card was given to prevent undue

inducement and is justified for at-risk families, and to compensate HVs for their time when not working.

Confidentiality. Consent forms and transcripts were kept electronically and any paper documents were destroyed according to the University of Manitoba's policy for destruction of confidential material. Confidential data (consent forms, master list of participants names/codenames, or any other document or file with personal identifiers) were destroyed as confidential waste within three months following the end of the study. Anonymous data (e.g., transcripts and digital audio files without personal identifiers) may be kept up to one year following the end of the study. Information gathered in this research project may be published or presented in public forums.

Reflexivity. The researcher is a Public Health Nurse employed by the RHA where the study was conducted. In an effort to prevent potential biases the researcher maintained a neutral stance, continually re-evaluating and challenging preexisting assumptions. Reflection with an advisor also occurred.

Chapter IV: Perspectives of Parents

This research study provided first-hand perspectives of the Towards Flourishing (TF) program from 10 parents in rural Manitoba. Parents interviewed were from various backgrounds, ethnicities and socio-economic status. All parents interviewed were of low socio- economic status, with six living in unstable housing, four single parenting and three self-identified as Indigenous. There was one male and female couple interviewed; otherwise, all parent interviewees were female. The interviews took place in various geographical locations throughout the region with the majority taking place in the closest rural city and surrounding eastern areas. Four parents lived in the city, the largest in the region with a population of just over ten thousand. According to Statistics Canada (2016), this population has a lower household income than the provincial median. All of the other parents lived in small rural communities in the eastern part of the region, with the exception of one parent who lived in the northwest part of the region. All parents had been program participants for greater than one year with many being involved prenatally.

Interviews with parents revealed three over-arching themes and several subthemes. The main themes identified were: Social and structural determinants of mental health; Parents' perceived benefits of TF; Ways that TF could be improved. These themes are described in detail below.

Social and Structural Determinants of Mental Health Among Parents

Parents identified a variety of stressors impacting their mental health including: a lack of supports, finances, housing, transportation, relationships, parenting, work-life balance and self-care. Overall, parents said their mental health was better when they had emotional and practical supports, their relationships were good, their children were healthy,

they were able to maintain a decent work-life balance, they had enough money to meet their basic needs, stable housing, transportation, and some time for themselves. The following is a more detailed discussion of the stressors impacting families' mental health that were identified by parents. Please note that a pseudonym will be used when referring to a particular parent's comments.

Supports

Parents reported that a lack of supports was their greatest stressor, negatively impacting their families' mental health and well-being. Supports were primarily described as emotional in nature i.e., having someone to talk to and check in on their needs and emotional well-being. However, they also described practical supports such as helping with children or preparing meals. Parents reported that they often needed someone they could talk to, validate and normalize their feelings. Most parents were able to identify some sort of support, whether it was friends, family, people in the community, or their home visitor. However, they all said they had limited supports available to them. Overall, parents said that when they were emotionally supported they were able to cope better with life stressors. As Louise stated:

> Well, I would have to say that just having someone to talk to and bounce ideas off of and validate makes me feel so much better in life. It makes me feel supported in life, I don't feel so alone and then I'm able to cope with stress so much better.

Another parent, Emma, explained how the support she received in the community positively impacted her mental health. She was going through a marital separation and did not have much of a support system, yet was relying on her community supports:

> Our family needs support. I would say that the main thing we need is consistent

> supports. I really don't think I would be where I am today if it wasn't for the support I received here in the community. Just feeling supported in the struggles of life is reassuring.

Emma attended a Healthy Baby group in the region where she found the support of other moms and health care providers. It made her feel good knowing that other people cared. She was able to share her story with others, and not feel judged. The support she received in the community helped her through a marital separation, and most importantly made her feel understood, and built up her self-esteem thereby improving her mental health.

Another parent Jennifer felt that her family relied heavily on her for emotional support and, at the end of the day, she needed someone to talk to. She felt a huge weight had been lifted after talking to others, and her mental health was better when she had the emotional support. Allison was a single parent and, not only did she rely on grandparents for emotional supports, she also needed their practical support with her daughter:

> My parents both help with [daughter]. I rely heavily on my parents for picking her up from daycare, feeding her and taking her to appointments, since I don't have anyone else. You know, it's really hard trying to raise my daughter alone and not having a lot of support.

Allison admitted that she could not parent her daughter without her parents. Their support decreased her stress related to the responsibilities of parenting.

Conversely, parents who were not feeling well supported identified this as a huge stressor for their families. Families struggled when they did not have the support of others checking in on their families' well-being, and ensuring their needs were being met. Parents who were single, separated or divorced reported they especially relied on supports from

their friends, family and home visitor when they were available. Sarah found that having a lack of support impacted her family's mental health by creating feelings of isolation and loneliness. She lost both of her parents when she was young; she had no family or friends for support and was concerned for her son's well-being:

> I'm also sad that [son] doesn't have any family or friends with kids close by because we live in the country. It's few and far between that we have people here. He doesn't have any cousins, aunts or uncles around. So it's both hard on him and hard on us not to be able to have the freedom or support that I feel some families have.

Another example of how a lack of supports negatively impacted parents' mental health was illustrated by Fay. Her boys were toddlers, extremely active, and a lot of work. This was especially true because her husband frequently worked outside the home, sometimes seven days a week. Fay felt very alone with parenting:

> In all honesty, I have no support from my husband with the boys. I do the majority [of parenting] and he works late at night. He's a workaholic, and he can't say no to others. So you know it's tough raising the boys alone. I feel very sad and alone.

Not only was Fay lacking the support from her partner, she was also not getting the support from her family or in-laws. It was also concerning that she could not name a friend she could call when needed. Her mental health was impacted with feelings of isolation, loneliness, anger and resentment, mostly towards her husband for not supporting her in the struggles of parenting. These struggles included caring for the children while her husband worked long hours, preparing all of the meals for the family along with the emotional challenges of parenting.

Relationships

Another contributing factor negatively impacting families' mental health is their interpersonal relationships. Patients said their relationships with their partners changed when they had children. Some struggled with the transition to parenthood, others had difficulty with a lack of intimacy and exhaustion. Most struggled with a lack of communication with their partners and a few said the chaos in their home was intolerable. When one parent did most of the childrearing, or when one partner worked away, it caused problems for the relationship. Other factors contributing to relationship distress included family dynamics, such as blended families and in-laws. Katie said her relationship with her partner changed when they had children. She struggled to nurture her relationship with her partner resulting in a lack of intimacy, mostly due to exhaustion:

> It's mostly because you know, the baby comes and then things [the relationship] got worse. I think what happened is, so we focus on the baby and then forget about us. We forgot about us. I feel like I do it all, plus I'm exhausted by the end of the day.

She also said the fighting escalated and they communicated less when the baby was born. Parent recognized they needed time alone or away as a couple but often felt they did not have the support or money to do that. Often, there was a lack of communication between partners, sometimes resulting in separation and divorce. Katie described this in her relationship with her husband:

> Our relationship is in trouble. It's always communication because he interprets versus listening to my words. Definitely, I would say that communication with my husband is very poor. We've been in marriage counselling. I'm not sure if we can make it though.

Their lack of communication created a lot of fighting and negative feelings towards one

another. Another example was provided by Louise. She was trying to communicate with her husband, but felt her relationship was holding her back in life and that she was not able to move forward with her partner mostly due to a lack of communication. This created feelings of isolation for one partner when their emotional needs were not being met. At the time of the interview they were in the process of separating.

There also seemed to be problems with relationships when one parent worked away, and the other parent felt the burden of childrearing on their own. For example, Deena said her husband worked away all the time, and she often felt alone and had to parent her two boys by herself. She felt this contributed to her mental health issues, especially because one of her children has cognitive impairments and needed extra care:

> When he's on the road I do it all myself and sometimes my depression is so bad I can't do it and I let the boys take care of themselves, which I can't because one of my sons has autism. I struggle when he's on the road. I mean our relationship really struggles when he's on the road.

This also contributed to their relationship distress and the boy's bad behavior, and acting up, when dad was on the road. Emma felt a similar burden of parenting on her own, however her situation was the result of a partner with depression, which negatively impacted their relationship. She was feeling the stress of being caregiver to her children and husband. Emma said their separation was hard on the family unit, and she struggled with the guilt of leaving the family home. She was worried it would be interpreted as her abandoning her family.

Family dynamics also played a role in the mental health of blended and extended families. For example, Joanne explained that the relationship between her partner and his

mother is very bad. This caused a lot of stress within the family, which was further exacerbated with her mother in-law's lack of support. Another parent, Katie, mentioned her dad has bi-polar disorder and refuses to be medicated. She was used to their dysfunctional relationship, however when she had her own child things changed in their relationship. Katie began to resent her dad for not taking his medication and getting the help he needed. Ultimately, this impacted their relationship along with her child's relationship with his grandfather.

Some parents reported that the chaos in their home was unbearable Deena wanted the fighting to stop. She said the arguing, bickering, and fighting was intolerable and she just wanted things to be calm. She also felt her relationship with her husband was not good and they struggled with having a blended family:

> What it really comes down to is that the boys need a step-father and I need a more supportive partner. We need someone who's more understanding towards us and just more supportive of our needs. We also need someone that's going to be around.

Deena felt her partner struggled to show his step-children attention and they never bonded. Therefore, all of the relationships within the household suffered. She felt the family would be a lot happier if there was not so much chaos and fewer relationship problems with her partner.

Finances

An obvious stressor for families with young children, particularly those of low socio-economic status, is finances. In fact, all parents said that limited finances were a stressor for their families, often resulting in poorer mental health outcomes such as anxiety and depression. Many parents reported they were struggling to pay their monthly bills, with

some accessing resources such as income assistance, government housing and the food bank. This impacted parents' mental health when they were excessively worrying about how they were going to 'make ends meet' as one parent stated. Belinda was a single mother with two young boys receiving income assistance, and often worried about having enough money for her family's basic needs. Deena reported that finances were really taking a toll on her mental health and that worrying about paying bills caused her anxiety and depression. She was always worrying about money, how they were going to pay the bills and take care of the family. This caused her many sleepless nights, which eventually led to her depression.

Financial concerns were worse for single parents as they only had one income to support the entire family. This often resulted in single parents relying on others for financial support. For example, Allison was a single mother raising her 3-year-old daughter who said she struggled with money, even though she was working full time:

> I'm not getting any child support from her dad. I mean zero support from my ex, no child support, nothing. So really it's just me supporting the both of us which is hard. You know it's really upsetting having to rely on my parents financially when I'm an adult, and should be able to take care of us. I feel like a failure.

She relied heavily on her parents for financial support. The financial dependency on her parents impacted her self-esteem, confidence, and overall mental health.

Although finances were a stressor for parents, there was not a lot that they needed or wanted, only for their basic needs to be met. When asked what her family needs to be mentally healthy, Katie explained she just wanted enough for her son and family's needs, nothing less and nothing more. When parents were more financially stable, and were not worrying about finances, their mental health was much better. They felt more secure, less

anxious, and could focus their energy on things other than worrying about how they were going to provide for their families.

Work-Life Balance

Maintaining a good work-life balance was important to parents. They wanted to be able to financially provide for their families, yet also spend enough time with them. Although parents received a sense of accomplishment from work, and they needed it financially, they were concerned with not having enough time or energy to spend with their families. The demands of work and family life was a stressor, and often created challenges for parents. They reported various reasons for this stressor such as seasonal work, disability, unemployment, going back to school and shift work. Most parents were exhausted due to working or going back to school and caring for their families. An example of this was Belinda who was a young, separated mother of two. She was receiving income assistance and in the process of going back to school. She was concerned with her ability to balance school, studying, and spending enough time with her family:

> I feel very strongly about going back to school and [one of her children] is ready to be with other kids. I just don't know how I'm going to do it all. I'm worried that I won't be able to spend enough time with them and study.

These concerns were exacerbated with parents doing shift work, or those who worked away from the family for periods of time, which further created challenges to spend enough time together. Emma and her partner worked for the same company, doing seasonal and shift work, but they had opposite schedules. Emma reported that they rarely spent time together as a family, especially during the summer months:

> What was so difficult was that our jobs were 6 months of lay-off time. We didn't

spend very much time together as a family in the summer months, but then in the winter we would spend all this time together. It just wasn't good for our family.

She felt that her life was not well balanced, and as a result began to notice her family's poorer mental health such as behavioral difficulties in the children, and the marriage suffered. Ultimately, Emma and her partner were not able to cope with this stressor and separated, creating different challenges for this family. There were also challenges when parents worked away from the family for long periods-of-time. Many parents reported that when their partner worked away they found it stressful, and when their partners were home they were too exhausted from their job to enjoy time with their families. Parents need increased support while they are going to school, when their partners work away, and they also need an appropriate work-life balance.

Transportation

Considering the large geographical location of the region, many families struggle with transportation. Rurally, there is limited access to transportation, compared to the city of Winnipeg where there is more access to services such as buses and taxis, and where there may be more access to services within walking or cycling distance. For the most part, families had only one vehicle per household, often leaving one partner without transportation during the day. A few parents reported they had no access to a vehicle and relied on family members for things like getting groceries or picking up their children from daycare. Sarah reported that, living rurally, she struggled with the isolation and had no access to a vehicle during the day. She also had to wait for her partner to get home from work to be able to run errands for the family. Another example was Belinda who had no access to a vehicle and struggled to find transportation:

Well, I have no car so basically I have to wait for someone to take me to where I

need to go, which is stressful. Sometimes I have to ask [family friend] for a ride. I'm not sure what I will do for daycare.

Lack of transportation also created challenges for families when they were not able to attend their appointments. Louise mentioned she was not able to follow up with the public health nurse one day, and often missed appointments with her doctor because she did not have transportation. Moreover, her self-esteem was negatively impacted when she could not keep the appointments. A lack of transportation was stressful for parents, and prevented them from going to community programs. These programs provided parents with support, education about parenting, healthy child development and a support group for new mothers transitioning to parenthood.

Housing

Housing issues were also reported by parents to be stressful, especially the challenge of finding affordable, and stable housing for their families. There were a number of associated housing issues mentioned such as having to wait for a government housing subsidy, overcrowding in their homes, having to move back with parents, or having to live with in-laws or with a separated partner. These household dynamics related to living with parents, in-laws or separated partners caused a lot of anxiety for everyone in the home sometimes resulting in anger, frustration, relationship breakdown and negative effects on everyone's mental health. Allison said that moving back home with her parents was hard, and she struggled with the space issues, and self-esteem for not having her own place to live with her daughter. She felt inadequate, and subsequently her mental health was impacted.

Belinda was waiting on a government housing subsidy and was living with her former partner and his sister. Her housing was unstable and temporary:

> We are on the waiting list for housing and I'm hoping we get something soon or else, I'm not sure what we will do. I mean [former partner] says we can stay here for a bit but it's really not ideal. We need our own place to live.

Interestingly, some parents continued to live together while they were separated, mostly due to finances, lack of housing and for the sake of the children. Other parents decided to separate and live apart. Either way, these living arrangements created challenges for families and almost always affected children. For example, Emma was separated from her husband, yet they continued to live together due to finances, and neither of them wanted to leave the home. The children were confused with the living arrangements, and the fighting was not healthy for anyone, especially the kids. Emma left the home which further created challenges when her children would ask her why she was not home at night. Emma said she felt horrible going to bed at night knowing that her children were going to bed without her. These housing challenges, including a lack of available, affordable housing often created emotional issues for families, in particular for the children when their parents lived in separate residences.

Parenting

All of the parents interviewed had children under five years of age. In spite of different family dynamics such as dual parenting, single parenting, living with grandparents, and blended families, a common theme among parents were reports that their anxieties

started or were exacerbated when they had children. They acknowledged that their anxieties were primarily related to their children's growth and development.

Some parents struggled with childhood trauma, and found it challenging to not repeat the same mistakes their own parents made when they were children. Other struggles included finding childcare, co-parenting, discipline, managing difficult behaviors, blended families and structure in the home. Parents reported that their main concern was for the physical, emotional and mental well- being of their child(ren), especially their growth and development. Katie shared that her anxieties began when her son was admitted to the neonatal intensive care unit, and she constantly worried about him. When he came home, she was always worried about his weight. She was so consumed with ensuring her child was growing, developing and most importantly, gaining weight, that she lost sight of everything else and developed anxiety. Allison said she felt better when her child was understanding and grasping. Parents acknowledged that their mental health was tied to their children's well-being. As Belinda described:

> I know that when it comes to mental health that I would say that's when you get the happiest, and when your mental health is the best, when you see your children growing and thriving. It means so much to me when I see them growing.

Conversely, the more that parents worried about their children, the poorer their mental health outcomes were.

Routine and structure in the home made families' lives easier and subsequently happier. Transitioning from stage to stage with their children, such as introducing solids or adjusting to the new baby, often caused increased anxiety. The temperament of the child also impacted parents' mental health, with some children being more demanding both

physically and emotionally. This was the case with Deena who explained that one of her sons is a very spirited child, very strong-willed and she found parenting exhausting. Structure and routine in the home was challenging for families especially where one parent worked away. Deena struggled with disciplining the children while her husband worked away, especially with one of her children being diagnosed with autism and ADHD and taking medication. She felt this contributed to her depression and it also affected her parenting:

> I went through a depression when I had my middle child. It got to the point where they [the kids] weren't even doing nothing bad and I just went and lost it on them. I couldn't handle it no more. He's never home and I'm stuck alone with them boys.

In rural areas there is limited access to childcare resources as compared to the city, where there are more options available. Finding childcare was difficult for most parents and it was even harder for those working shiftwork, or for those who required childcare five or six days a week. There were also parenting stressors with co-parenting and blended families. Joanne said she struggled with co-parenting her step-son and noticed significant behavioral changes, with one of her children in particular, when they went to their biological mother's home. Joanne's mental health was greatly impacted by these events:

> Well, it just really depends on the days and the weeks. I mean because on the days that he's doing better [after being at his mom's house] then those days are probably good for us. And then maybe if he's not doing good, then those weeks are worse.

She struggled to co-parent with her husband's ex-wife, which caused her to be unhappy in the marriage and in the home. Allison said that moving back home with her parents was hard. She struggled with self-esteem as she tried to parent her own child without judgement

from the grandparents:

> ... and then parenting my own child, it's like, it's my say now, you guys can't say that, I'm her parent. How am I supposed to parent my own child when I feel like she has two other parents? It's so frustrating.

These complex family dynamics contributed to stress in the home for some families.

Emma said she struggled with showing empathy with her children because she was never shown love herself as a child. Her mother withheld affection as punishment. She noticed herself beginning to parent like her own parents which was concerning to her. Deena also worried about repeating negative parenting behaviors that she had experienced as a child:

> Let me tell you my upbringing wasn't the greatest. Dad was an alcoholic and mom always made dad out to be the bad guy. Then, when I grew up I realized who was the bad parent. I see myself doing some of the same things. I don't want to repeat that.

These childhood traumas affected parents long into adulthood and impacted how they parented. For example, some parents repeated the same behaviors as their own parents such as negative coping strategies or poor parenting.

Self-Care

It was not surprising to hear parents say, that when their children were born their self-care needs were minimally met. Self-care was identified by parents as primarily meeting their emotional and physical needs. This lack of self-care included simple activities of daily living, such as forgetting to shower or brush their teeth because they were too busy

caring for the baby or not being able to spend time alone or with friends. Emma explained this by saying:

> Your mental health takes a huge hit when this other person comes in your life and is suddenly the most important person in your life. When you have a baby, there is no time for yourself anymore it's all about them.

Parents put their children's needs before their own, and they rarely, if at all, had time for themselves for rest and relaxation. Sarah was constantly trying to find the time for self-care to keep her mental health stable. Deena reported she could see herself getting worse with the lack of self-care. She noticed herself declining, emotionally, mentally, and physically and she was not taking care of herself. Parents felt guilty if they took time for themselves or wanted time away from their children or partners. Self-care could be as simple as taking a few minutes to unwind. Belinda was reading once a month to improve her mental health, and her ability to cope since she was always taking care of others and never rejuvenating.

Many parents reported they had experienced mental health issues at some point in their lives such as anxiety, depression, obsessive compulsive disorder, postpartum depression, panic attacks, exhaustion, and or extreme guilt. Some parents reported they were getting counselling or involved with mental health resources in the community. Some were taking an antidepressant for a mental health diagnosis. Katie struggled with postpartum depression with both of her children. She felt very ashamed, guilty and mostly alone. She did receive counselling and attended community groups and realized she needed to care for herself to be able to care for her children.

Along with their mental health, parents were also concerned with their physical

health. A few parents reported they had high blood pressure, diabetes, insomnia and were taking prescribed medications. These parents said they wanted to make lifestyle changes. As Katie declared:

> I have high blood pressure and I'm on medication so the goal is to keep on exercising to reduce the weight and get off of it. It also helps with my mood and de-stressing so it's a lifestyle.

Overall, parents felt better mentally when their self-care needs were met.

Parents' Perceived Benefits of Towards Flourishing

While interviewing parents, all of whom had been involved with TF for more than a year, it became apparent that many of them had started participating in the program prenatally. In fact, only three of the ten participants had not been involved prenatally. This is significant as the program aims to involve families during the prenatal period to maximize the benefits. This also shows that PHNs are reaching families and completing the parent surveys prenatally. There was an overwhelming amount of positive reports by parents about TF and the benefits to their families' mental health. TF benefited families in a variety of different ways including home visiting services, TF strategies and resources. Overall, parents said the support they received and the strategies learned positively impacted their families' mental health and how they coped with life stressors. The following describes parents' perceived benefits of TF and its impact on their families' mental health.

Home Visiting

All of the parents said their HVs provided ongoing support to their families by checking in on them weekly, bi-weekly, or monthly depending on their needs. HVs positively impacted families' mental health in several ways. First, they provided ongoing

emotional support for families to talk about their feelings, worries, and concerns about life, mostly raising young children. Second, they normalized and validated those concerns. Lastly, HVs provided families with resources and coping strategies for life stressors. All of this resulted in ongoing support for families which made them feel better about themselves, and ultimately improved their mental health.

Parents were in agreement that having a HV was the best part about being involved with TF. They enjoyed the socialization aspect of having someone to talk to, as well as the emotional support. Jennifer described it this way: “I love my home visitor. I mean it's really nice to have a grown-up to talk to once a week and someone to check in and say how are things this week, which really makes me feel supported.” Sarah concurred with this saying:

> The biggest thing for me is just knowing that someone cares. I look forward to having her there to ask questions. She's so positive every week. That was a really big deal to me. To have someone to normalize my feelings, my worries. She validated and normalized all of my fears.

Louise was going through a separation with her husband and felt the support she received from her HV was meaningful:

> I'm so happy with my home visitor coming in and being supportive. When I think about it, she's kept me going, she's a huge support, she's a lifeline. I would not be where I am without her support, I really mean it.

It was somewhat of a different situation for Emma and her husband, who were going through a separation, yet both received emotional support from their HV:

> We would have our home visits when we were both home at the same time, because he was struggling too, he had his own depression he was struggling with so it just

made sense to address some issues together. She said I'm here for the both of you. Their HV told them that she was there to support both of them and would visit with them together or separate at either homes. The emotional support HVs provided allowed parents to feel a sense of being cared for, comforted, companionship and non-judgmental positive reinforcement. This was established through HVs' ability to normalize and validate parents' feelings and giving reassurance, thereby decreasing their anxieties and fears. As Emma explained: “My home visitor is great, she just makes me feel supported in the struggles of parenthood and she normalized certain behaviors we didn't recognize if they were normal or not so she was a big support.”

It was not uncommon for families to experience multiple stressors. HVs offered support to parents and assisted them in coping with these stressors. Emma mentioned that her home visitor offered support in ways of learning to deal with things they had no idea how to deal with. There were also comments made about HVs assisting parents with problem solving; such as Fay, who said her husband worked long hours and she often relied on her HV to help her problem-solve and talk things through about her children. Parents felt their HVs really cared about them. There was a connection and relationship developed between the HV and families. Parents said they were really appreciative of the self-care reminders from their HVs and felt this showed they were cared for. As Joanne explained:

> Basically, she wanted to know what I'm doing for me because, especially when you have young kids, a lot of times you don't remember to think about yourself, and then it can snowball into not coping well. Acknowledging the fact that I need to take time for my own mental health needs.

Sarah felt that her parenting depended on her being mentally healthy and that you cannot be

a mom if you are not mentally well. Having a HV remind her of ways to be mentally healthy, which really helped her and she felt that it was good for building self-esteem. Louise said her HV gave her lots of reassurance and encouragement:

> She's been very encouraging for me to go to playgroup or send her to daycare once a week or something just to give me a break. I'm really happy with the program, even though I haven't been able to keep on track with home visits, I'm really glad it's there.

Even when parents were not able to keep their scheduled home visits they were appreciative of the services. Parents wanted the service available regardless of how often they were able to keep their scheduled home visits.

Towards Flourishing Strategies

All parents were familiar with TF's nine everyday strategies, and were using them with their HVs, on their own or with family members. Some parents were more familiar with certain strategies then others. This was to be expected given the amount of strategies and language involved with TF, including variations in the way it is introduced by HVs. It was not surprising that the most commonly used strategies identified by parents were the simplest and quickest strategies, such as nasal breathing and physical activity. This makes sense since parents need easy and tangible ways of coping under stress. There were also variations in the way parents used the strategies and how often they used them. Some parents modified the strategies to meet their needs. Regardless of how they were using the strategies, parents felt they were easy to remember and found they were positively impacting their families' mental health. Additionally, the strategies allowed parents to feel more grounded and made them aware of their surroundings, which in turn improved their

mental health. The following is a detailed description of parents' perceived benefits of TF strategies.

Nasal breathing. Parents used nasal breathing the most out of all the TF strategies. They felt it was the quickest and easiest strategy to use when they were feeling stressed or anxious describing it as calming, relaxing and de-stressing. It was a strategy they could teach their families, and they found it improved everyone's mental health. Parents said they were introduced to the strategy by their HVs who provided them with the evidenced-based information about the cooling effects on the brain. Their HVs encouraged them to use the strategy for coping with strong feelings of anxiety, but also as a method of preventing anxiety in the first place. Louise described her experience with the strategy:

> My home visitor went through the breathing exercises with me. I was agitated one day. She went over it with me and it just kind of calmed me down and relaxed me and I still do them. I've been able to calm myself down when I start to get anxious.

Parents said that nasal breathing was an easy strategy they could teach other family members, mostly their children. They would encourage their children to do nasal breathing when they were feeling stressed, angry, upset, frustrated or just needed to calm down. Joanne said she showed her whole family how to do nasal breathing when they were struggling with an issue and now her children are using it. This strategy was mentioned repeatedly by parents as the best way to calm themselves and their children down quickly.

This strategy is versatile and it was common for parents to use nasal breathing with other strategies, such as three-minute breathing break and progressive muscle relaxation (described below). Some also modified the strategy by using nasal breathing with meditation exercises. For example, Jennifer said her HV recommended taking time for herself and

finding ways to relax, so she found nasal breathing worked really well with meditation. When she can't fall asleep at night she uses a meditation app and finds the combination is calming and relaxing and allows her to fall asleep. Jennifer felt it was important for her mental health to get rest and relaxation. It was apparent that this strategy was useful for coping and parents were able to modify the strategy to maximize its benefits.

Three-minute breathing break. Parents described this as a great strategy for those needing permission to take a break from a particular stressor and not feel guilty about it. Parents said their HVs taught them when and how to use this strategy by encouraging them to recognize when they needed a break. It was common for parents to use this strategy when they were feeling stressed out, not coping well with their children, and needed a few minutes alone. Emma said she used this strategy to give herself a few minutes of quiet and called it, "mommy time out." After taking a few quiet minutes to herself, she would feel calmer, more relaxed and better able to cope. Belinda said that for first time parents or those with newborns, it was a good strategy for dealing with stress. “You learn to walk away and take a break if you are feeling frustrated with their crying. You just walk away for a few minutes, he's fine and you feel better.” This strategy helped parents to understand that it is better for their mental health to take a break when they are feeling overwhelmed, to prevent shaking their infant in frustration. It is much better if parents are given permission to take a break while being reassured their baby will be fine for a few minutes.

This was also a good strategy to use with young children who desperately needed a time out to calm themselves down. For example, Allison said she used the strategy with her daughter when she recognized they both needed a break, but especially when she noticed that her child needed a break. Allison said she found it necessary for both her own, and her

child's, mental health: "…separate the two of us, think about it and then I can never walk back in the room and be mad at her. We've both calmed down. At first I felt so guilty, but now I appreciate those moments." She initially felt guilty about taking a breathing break. However, with the assistance of her HV she began to realize it was well needed for both herself and her child, especially being a single parent.

A few parents reported they were modifying the three-minute breathing break and using it with meditation, nasal breathing and for self-care. They felt the break allowed them to be mindful, think clearer and recognize their thoughts and feelings. Parents were also using the strategy with nasal breathing and to do things for themselves, such as checking their texts or making appointments, which they felt were important for their self-care.

Three good things. For the most part, this strategy was well received by parents. One parent stated that on her bad days, which were frequent, she struggled to find anything good about her day and often gave up on this strategy. However, most parents really liked this strategy because it focused on the positives rather than the negatives in their lives, and this positive thinking improved their mental health. Parents were using this strategy by themselves, with their HVs, children, partner, extended family and at work. Joanne said:

> I really like this strategy because I would say that I'm more of a negative thinker so I like this strategy because it forces me to think about the positives and not dwell on the negatives which I usually do.

Fay said she is more of a positive thinker and really liked a coping strategy that focuses on all positive things in one's day. She felt it was important for her boys to see her talking about the positive things in life to raise happy children.

Most parents were using the strategy with their HVs, families, and friends and felt it

was a relatively easy one to implement. For example, some were using it with their children and partner at the dinner table or while driving in the car. One mentioned using it with their in-laws and friends, and another was using the strategy at work with her co-workers. This strategy also allowed families to connect with one another about their days in a positive way. Allison, who noted that she typically gravitates towards the negatives in her life, described how she uses the strategy with her daughter:

> I try to do it every day, but for sure do it once a week. It makes us feel better, more connected, makes me not as stressed out. We tend to focus on the negatives when the positives should always shine brighter.

One parent struggled to pull out the positives in her day, especially when she was having a bad day. However, she still found some benefit in using this strategy. She found that doing the strategy made her more aware of how she was feeling. She realized it was better to use this strategy on those bad days for less negative thinking. Even if parents were able to recognize simple things--for example, being thankful for a few minutes alone or reading a book or taking a bath--they found it useful.

Connecting with others and belonging. Both of these strategies were intertwined by parents, and they did not view them as separate. Moreover, they reported them as the same strategy when either talking about their sense of inclusion and or relations with others. Parents reported that their HVs encouraged their families to think about things they enjoyed and brought them various community resources for them to connect with. Parents seemed to enjoy this strategy since it made them connect with others they may not have without their HV's encouragement.

During home visits, parents said they talked with their HVs about activities they

enjoy doing in their spare time, such as resting, reading, and cooking. They also talked about other people or resources they connect with such as community programs, friends, family groups, and other interests. Jennifer liked this strategy because:

> It really makes you think about the benefits of connecting with other people. It makes me think about who are the people I connect with? Then you can find out who you connect with and get along with and utilize that.

Connecting with others and belonging improved families' self-esteem. It made them feel important, meaningful and a part of something. When families connected with others they found themselves looking forward to outings, and began participating in community activities and connecting with those of similar interests. HVs expanded on this by providing families with various resources to encourage families to connect with their communities. When families connected with others it impacted their mental health in positive ways. It allowed them to talk about their feelings with others, and their children played and connected with other children. Jennifer was evidence of this by taking her children to a play group where she connected with other moms and let her child socialize with others: “At play group we both get to socialize with others, and we both feel better afterwards. I've used connecting with others. I am very involved in the community and I find that's been very helpful for my mental health.”

Another example of how this strategy can positively impact mental health was illustrated by Louise, who wanted to connect with her Indigenous background by attending a sun dance every year. She felt a deep connection when she attended them and wanted to continue the tradition:

> It was important for me to connect with my heritage so I started going to the sun

dances again, and feeling like I have a spiritual family. At first, I wasn't really sure if I belonged but then I realized that I do.

It was important for Louise to connect with her culture and it positively impacted her mental health. Feeling a sense of belonging by participating in her cultural traditions improved her self-esteem.

Creating a vision. This strategy was not frequently used by parents on their own; however, those who were familiar with it found it helpful. This strategy was described by parents as an activity they did with their HVs, whereby they envisioned what it is they wanted for themselves and their families. These visions could be anything from personal achievements such as exercising, and saving money to family and parenting goals. Louise found this strategy helpful because it really got her thinking about what she needed at the time. The strategy allowed her to identify what she envisioned for herself and her family. Another parent found creating a vision helpful with identifying how she wanted to parent her children. HVs encouraged parents to write down or draw their vision for their families, and keep it for future reference. When parents were able to envision and express (verbally or by writing or drawing) what they wanted for themselves and their families it positively impacted their mental health. As Louise explained, creating a vision of what she wanted for her family gave her a purpose to work towards.

This strategy was difficult for some parents who struggled to find purpose and meaning in life. In fact, the strategy does have the potential to make their mental health worse in some situations if they are not able to identify what it is they want out of life for themselves and their families. For example, Belinda said she was not able to do the activity because she didn't even know what she wanted for her family and struggled to be hopeful.

She felt horrible for not being able to identify things she wanted for her family. However, with her HVs assistance she was able to envision the little things like her daughter finishing kindergarten or spending time together as a family during the holidays. This strategy did appear to need more guidance from HVs as compared to the other strategies that parents independently used.

Physical activity. Every parent interviewed mentioned that physical activity was something they were doing on their own, as a family, or they wanted to do more of it. Parents reported that physical activity was good for their families' mental health and they noticed a difference in family members' moods when they were active as compared to when they were not getting enough exercise. Overall, physical activity made everyone in the home less irritable, improved mood, and was a huge stress reliever.

For some families, being physically active was already part of their routine and they continued to do this since they noticed the benefits to their mood, and they felt good and had more energy after being active. Parents reported various forms of physical activity for their families such as walks or engaging in sports or other community activities. Katie said her HV encouraged her to use this strategy for mental health promotion and she found it extremely beneficial:

> We get lots of physical activity. I mean we walk outside to the rec center, and there's stroller fitness too, so I do that and it feels good to get outside. It's a good stress reliever to enjoy the outdoors with family.

Parents also wanted to be a good role model for their children. HVs encouraged simple activities such as walking, playing, taking their kids to the park. Parents felt more connected with their children when they spent time with them. They also appreciated the gentle

reminders to be more physically active.

A few parents reported they wanted to be more physically active with their families and were making efforts to do this. Some stopped playing sports when they had children and were trying to get back into it. Sarah started playing softball again on the advice of her HV. She said it made her happy to play on the team. One parent said she was trying to be more physically active to get healthy. She was experiencing high blood pressure, however her partner was often tired after work, which prevented them from going outside or being active together (this also caused problems for their marriage). When parents were lacking physical activity or everyone was shut in the house they were more irritable, moody and mental health was poorer.

Progressive muscle relaxation. Only a few parents were familiar with this strategy, but those who were said they used it frequently. They also said they had taught the strategy to their children; and it was also common to combine this strategy with others to maximize its benefit. Fay used progressive muscle relaxation mostly before bed to relax her. She was shown the strategy by her HV, tried it one night, and found it helpful. She has been using it ever since:

> I use this strategy to relieve stress and I use it by relaxing every muscle in your body, starting with your head, even your brain, down to your toes and I sleep much better when I use it. It's so relaxing and helps me sleep better.

Louise had been using the strategy for years and had shown her daughter how to do it herself. After teaching her child to tense certain parts of her body, be aware of it and then let her muscles relax she noticed that her child was able to fall asleep quicker. There was one parent who combined the strategy with nasal breathing and meditation. She found she was

able to maximize the strategies' benefits when she combined them. For example, she would start with nasal breathing and meditation and move on to progressive muscle relaxation until she was fully relaxed. This allowed her to recognize what her tense body feels like and how to relax herself.

Self-monitoring. Many parents found this strategy a bit more challenging as it requires monitoring certain unhealthy behaviors and goal-setting. This can be difficult for families when they have to first acknowledge their behaviors, monitor them and work towards changing them. Overall, parents found this strategy beneficial for their families. Parents found goal setting beneficial for small achievable goals. As one person explained: "I try to set myself personal goals once a week. Probably four out of seven get completed." No matter how many goals get completed she felt good accomplishing anything because it was better than nothing. This strategy allowed parents to take a step back so that they could think about things they would like done differently, and any behaviors they would like families to change.

Parents found this strategy easier to use with their children than themselves. With their children they used it for things like encouraging them to do chores and monitoring this behavior with a check-list. When they used the strategy for themselves they found it more challenging because they needed to recognize a negative behavior to stop and start a more positive one. For example, Katie used this strategy for self-care and to monitor her meals throughout the day to ensure she is eating and not just caring for her son.

In summary, throughout this study it was evident that parents were using TF strategies on their own, with their HVs and families. They also found the strategies beneficial to their families' mental health and well-being. All of the strategies were used by

parents however some were used more often than others. Parents independently used the simpler strategies on their own and with their families, yet they wanted their HV's guidance for the more complex strategies. For example, parents felt comfortable using nasal breathing, three-minute breathing break, and physical activity with their families; however, they wanted the guidance of the HVs for connecting with others, belonging and self-monitoring. A few parents felt that their partners could benefit from TF strategies; however, they found it difficult to talk to their partners about them or, when they did, their partners were not receptive. They felt it would be more beneficial if HVs could provide the information about TF strategies to their partners.

Community Resources

Families were well informed of various community resources through their HVs. However, TF provided them with more mental health resources including the mental health screening forms, community programs and a connection to the regional health authority's Mental Health Promotion Facilitator (MHPF). Many parents were well connected to resources in the community and mentioned the following health-related programs and services: Mental Health Worker; Anxiety Disorders of Manitoba; Cognitive Behavioral Therapy; Step N Out; Coping with Change; Dialectic Behavioral Therapy; Public Health Nurse; Physician; Nurse Practitioner; the MHPF; and Growing Years. The local library was also mentioned as a resource.

Families were accessing a variety of financial and social resources such as employment and income assistance, the prenatal benefit, rental assistance, the food bank, and childcare subsidy, to name a few. There was also mention of waiting lists for housing and limitations on the food bank (i.e. you can only go every two weeks). Parents said their

HVs brought them information about community resources and encouraged them to connect with others. Emma said:

> My home visitor is really good at telling me about things that are going on in the community that I can use. For example, I was able to take my kids last summer to an outdoor group in my area. She brought the information and told me how to register.

Parents said they were better informed of mental health resources through TF. Allison felt TF was a great resource for single parents:

> I'm a single mother so I figured any resource would be helpful. It was introduced to me in a non-intimidating way and it's helped me to recognize where I may be struggling and what resources I could use. I am now aware of all of the community resources.

Sarah said that she and her HV talked about connecting with other people:

> My home visitor, she just gently encouraged me to consider to meet people and I did do it and I was glad that I tried it and I wouldn't have done it if someone hadn't been providing me with the resources.

Her HV made it easy to try something new by getting her the information, places and time to go, so she didn't have to think about it. HVs facilitated the process of connecting families with their communities.

TF offers parents a unique opportunity to complete a mental health screening package which is then reviewed by the MHPF in the region. Upon reviewing the forms, the MHPF sends a copy of her assessment to parents and HVs, along with suggestions on strategies they could benefit from. Another component of this involves the MHPF facilitating a community group for Coping with Change, which is intended for mothers to

learn to cope with the transitions of parenthood and ways to ensure their self-care. Katie mentioned that the MHPF's presence at these groups further allows parents to connect with a mental health resource, "I forget what her name is but I really like that mental health person that comes every first Thursday of the month. She has different topics and the last one was on postpartum depression." Parents said they felt better about their mental health knowing there was a professional assessing them through the MH screening forms and feedback provided by the MHPF. The role of the MHPF was very well received.

How The Towards Flourishing Program Could Be Improved

When parents were asked how they felt TF could be improved, they had some thoughtful suggestions. A few parents felt there should be better advertising or awareness of TF. They often talked to friends or family about it and no one knew about the program. These parents also felt the program should be available to everyone and seemed confused about why it was not universally available, which further contributes to the stigma attached to the program. Another suggestion was to have access to TF resources online so that families could access them as needed. Joanne felt that an app, possibly on her phone, would be helpful. She could use it to remind her to keep track of 'three good things' or she could monitor her 'physical activity'. Louise felt there were a lot of information handouts that often got lost or thrown out. She suggested a binder to keep all of her handouts together so that she could refer back to them as needed. She also suggested an exercise workbook that she could do the activities at her own pace and write down her thoughts and feelings.

An important finding was that parents said they wanted someone to call in their time of need. Parents said that it was great that HVs were there to support families and they develop such close relationships. In fact, many parents considered their HVs to be friends.

As Louise stated:

> I have said to my home visitor. You're a friend. I know you're here because it's your job and you're getting paid to be here but I feel like you're here and you genuinely care about me and my family.

However, often when they needed someone to talk to they did not want to bother their HV and understood there were boundary issues. One parent suggested having a family support line or number they could call to talk to someone about their stressors.

Chapter V: Perspectives of Home Visitors

This research study provided first-hand perspectives of the Towards Flourishing (TF) program from ten HVs in the Interlake-Eastern area. The interviews took place in seven communities throughout the region. HVs had a wide range of home visiting experience, from two to 17 years, and they were all familiar with TF strategies and were using them with the families whom they work with. In this chapter, those similarities are identified, but the unique and/or contrasting perspectives of HVs' regarding TF will be emphasized. Interviews with HVs revealed the same three over-arching themes as with parents: What families need to be mentally healthy; perceived benefits of TF; and how TF could be improved. These themes are described in detail below. Areas where the perspectives of HVs and parents differed will be noted.

Social and Structural Determinants of Mental Health

There were strong similarities between parents' and HVs' perspectives when discussing what families need to be mentally healthy. HVs identified a variety of stressors negatively impacting their families' mental health, all of which were similar to parents and included: a lack of supports, finances, work-life balance, transportation, housing, parenting and self-care. HV's reported that these social determinants of health greatly affected the mental health of families: the greater the stressors in their lives, the poorer their mental health outcomes were. The following is a more detailed discussion of the stressors impacting families' mental health that were identified by HVs, as well as their perceptions of what families required in order to be mentally healthy. Please note that a pseudonym will be

used when referring to an individual HV's comment.

Supports

Parents and HVs both reported that supports had the greatest impact on their families' mental health. They both said that families need emotional and practical support from a variety of sources such as family, friends and the community. Parents' mental health was also better when they had someone to talk to and check in on their family's needs. In fact, HVs said they noticed a direct correlation between families that were not well supported and poorer mental health outcomes such as anxiety and depression. HVs also understood that they themselves were a support to their families by checking in on them and providing them with emotional support. As June described:

> The feedback I got just today was that the most important thing for the client is that she be listened to validated and understood. They like that best from our perspective of the home visitor coming in to listen to what's happening, checking in on them, finding out how things are going.

June mentioned that a trusting relationship developed over time between her and the parents, and that they truly cared for the well-being of one another.

The main difference between parents' and HVs' perspectives about supports was that parents mentioned how a lack of support from their family was their greatest stressor. Parents said they needed support with caring for their children, doing inter-generational activities together as a family or simply driving them to get groceries. Although HVs mentioned these things, they mostly focused on a lack of community supports. Cassidy said:

> I would say that there's definitely not enough supports for parents not enough out in the area for families to access. We have very little programs for families. I think

there needs to be more ways for people to access community resources.

June made a similar comment:

> I think what parents really need is supports, and there definitely is not enough programs in the community for families. If they had more community support then I think a lot of families, they could really benefit from that and do so much better.

HVs said there should be increased community supports for families and felt a huge responsibility to connect them with resources which they said were often limited. These community supports included preschool programming, healthy baby groups, and resource centers.

Relationships

HVs reported many similarities to parents in regards to stressors in interpersonal relationships, in particular between partners. They said many family homes are chaotic and dysfunctional with many relationships ending in separation and or divorce. One unique difference between parents' and HVs' perspectives was that, although they both felt there were communication issues, HVs mainly felt it was an issue of parents lacking appreciation for their partners. Cassidy said the following:

> I would say that with many of my families the partners seem to lack appreciation for one another. They don't feel like they're valued or appreciated and then there is some sort of breakdown in the relationship. Showing appreciation really goes a long way.

HVs felt that partners needed to value and nurture their relationships and show appreciation for one another.

Both HVs and parents described family situations that were chaotic and not functioning well, with some experiencing abuse, neglect and violence. However, there was

one noteworthy aspect of this discussion where the responses of HVs and parents differed. As Marie stated:

> What makes it so difficult for families is the dysfunction or chaos in their homes. There are some families that are dealing with family members that have addictions, now that's hard on the whole family. It impacts everyone in the home.

HVs felt that when there was a family member with an addiction it affected the entire family functioning, whereas parents did not mention this as a stressor.

Finances

Both parents and HVs reported that families struggled with finances and often have difficulty coping with this stressor. They said that parents often experience anxiety and depression due to financial concerns, in particular for single parents. As June described:

> I have this client. She is a single parent struggling with money. She had to juggle paying her bills, which caused her a lot of stress. So now that she's got this extra money it's helped her and she's not as stressed as she had been previously.

HVs felt that financial struggles were common among families given the economy, and the lower socio economic status of most families in the program.

One notable difference between parents' and HVs' perspective about finances was that, even though they both mentioned families were accessing various community resources (e.g., the food bank, income assistance, government housing), HVs talked about the stigma attached to using these resources, whereas parents did not mention this as a barrier. In fact, most parents had accessed community resources at some point in their lives. Cassidy explained the stigma she felt parents experienced when accessing resources:

> The food bank is very intimidating out in the rural areas. People talk and it's a small

> community, and then they know who people are [using the food bank] and sometimes these families only need to access it once per month but then people talk.

Holly made a similar comment:

> There are times when families hold out [accessing resources] because they are embarrassed or ashamed. But you know eventually they have to, and then they realize it's not that bad. So yeah, there's definitely still that stigma attached to using services.

Regardless of how often families were using these resources, HVs felt they should be able to do so without being judged.

Work-Life Balance

HVs reported the importance of parents maintaining a good work-life balance for mental health. They understood that parents wanted to provide for their families, yet also spend enough time with them. When this was disrupted, it caused a lot of anxiety for families. HVs recognized parents were exhausted from working and raising a family. They also said this sometimes contributed to parents not being able to cope which sometimes resulted in separation or divorce. HVs felt that families needed more work-life balance in their lives.

There was a difference in parents' and HVs' perspective about work-life balance, in that parents talked about wanting to spend more time with their children, whereas HVs talked about the impact on children's mental health when work-life balance was not maintained. As Sam stated:

> When there's no consistency and children don't know what to expect or when to expect their parent home it creates feelings of insecurity and it just needs to be better

balanced for the children. It's so hard on them when their parents aren't around. The conflict with work-life balance added increased stress to families that may already have stress and difficulty coping with the lack of balance.

Transportation

Many families had limited access to transportation, with most having only one vehicle per household. HVs and parents both said that transportation issues were huge, in particular for families living rurally, with many feeling isolated in their homes. Parents said that transportation issues prevented them from attending appointments and community programs which further added to feelings of isolation. While HVs voiced the same transportation concerns as parents, they did identify another issue. As Betty reported:

> I would say that there are times when one partner may need to go to the city and there's only one vehicle and mom's home with the kids all day and dad's taking the vehicle. They lose that independence. It really impacts their mental health when one partner is home all the time and doesn't feel independent.

HVs felt that a lack of transportation interfered with parents' ability to be independent. This made the parent (mostly mothers) feel isolated and dependent on their partners, which impacted self-esteem.

Housing

HVs reported many different living and housing arrangements that were stressful for families. Some parents were waiting on government housing, others were living with friends or couch surfing and a few moved back home with their parents. All of these unstable

housing situations were difficult for families with many of them not satisfied with where they were living.

One difference between parents' and HVs' reports was that, while parents mostly talked about finding affordable, stable housing, HVs mostly mentioned the negative impacts of parents' living arrangements, the most common being when parents moved back home. For example, Sam talked about the experience of one of her single parents who moved back home and was living with her parents:

> If she wanted to go out with her friends, her mom was like where are you going? What are you doing? What time will you be home? So, her mom was still being a mom to an adult child. When they don't have a place to live and are dependent on others like the grandparents it affects their mental health. So they live at the grandparents because they can't afford to live somewhere else to start a life but they don't really want to be there.

Sam said this parent already felt like a failure having to move back home, and then her own parents are taking away her autonomy. This impacted her mental health by causing her a lot of guilt contributing to lower self-esteem.

Another stressor for families, not mentioned by parents, was the impact of government housing. It was unsettling to HVs when some families were not able to get adequate housing, meaning that even if there was housing available it was not always what families wanted. As Wanda described:

> I have one mom whose mental health is affected because she's tried to get housing and they don't have anything in the community she lives in. They wanted her to move somewhere else for housing so that's causing her mental stress. That's not where her

> job is or where her supports are.

These housing issues contributed to parents' stress and anxiety when they were concerned with where they were going to get stable housing.

Parenting

There were many similarities between parents' and HVs' perspectives about parenting. They both felt that parenting was a stressor and parents' mental health was better when their children were thriving. HVs said parents' mental health was worse when they were concerned with developmental or behavioral issues with their children. For example, June agreed that parents often had difficulty coping when there were health concerns for their children:

> This family has a genetic history of mental illness so it's starting to show up in her 5 year- old. They're looking at diagnosing her at this young age and the parents are not coping well. I am not sure how they are going to deal with her having a mental health diagnosis.

June said that when parents experienced challenges with their children their own mental health was impacted.

HVs mentioned that first-time parents were significantly more anxious then those who had more children, with many fixating on their child’s weight. They felt that first-time parents had difficulty adjusting and transitioning to parenthood, which was something that parents did not mention. Sam described it this way:

> I really think it's the whole parenting thing, they don't sleep, they're anxious, they aren't used to caring for someone else. Some really have trouble adjusting to being a

parent. We don't give them enough credit. Like parenting is so hard.

HVs understood that parenting is challenging and were able to validate this for parents, in particular for those who were having difficulty transitioning to parenthood. Some parents said they grew up without loving, nurturing caregivers, some were neglected or abused and some experienced childhood traumas. HVs said that as a result, many parents struggled with showing love and empathy towards their children. Wanda said that some parents grew up without a good parenting role model. They could have grown up around alcohol, drugs, neglect, or abuse. She further elaborated on this and said for parents who have grown up and have stopped the cycle of abuse, neglect, and substance use, she often praises them:

> Wow, you're finally breaking the cycle. Something that you grew up with and that could have been something your parents grew up with. But now you're realizing you don't want that for your children. They've done a complete 360 and changing how they're parenting.

HVs recognized that some parents had broken the cycle of abuse they experienced as a child or their negative parenting behaviors and have worked towards positive parenting.

Self-Care

Both parents and HVs recognized that parenting was challenging, and that most parents lacked self-care. HVs encouraged parents to take time for themselves, to get enough rest, good nutrition, and to take care of their own mental health needs. Betty said most parents were not very good at taking care of themselves, resulting in mental health concerns. Moreover, she noted that some parents do not even realize they are under stress until they are in crisis:

I remember having this one mom, she had severe postpartum depression. Every time

> I went to visit her, she was home and she was crying. I just felt like her mental health was so bad and she needed so much more then we could offer.

HVs said that parents need to take care of their mental health because, when not properly identified and treated, this has the potential to impact the entire family unit. They also said that parents were not taking care of themselves because they were trying to meet the needs of their families and not their own. For example, if mothers had an opportunity to take time for themselves or care for their families, they chose the latter. HVs also said that mothers needed to take control of their mental health and recognize when they are not doing well. As Cassidy explained:

> Parents need to recognize their own mental health needs. Being able to recognize when they need those coping skills for their own mental wellness. They need to understand the warning signs and get care when they need or prevent their mental health from getting worse.

HVs educate families on TF strategies, assist them with recognizing warning signs of mental illness and the concepts of languishing and flourishing. They also give parents the reassurance and permission to take time for themselves.

Home Visitors' Perspectives of the Impact of Towards Flourishing on Family Mental Health

There was an overwhelming amount of positive reports from HVs about TF. Overall, HVs were pleased with having a mental health promotion resource they could use with their families. They felt TF was easy to implement and was a great addition to the standard FFHV curriculum. They valued having TF and found it benefited their families' mental health and

well-being by assisting parents in coping with life stressors.

Towards Flourishing Strategies

HVs said that prior to having TF they were not given a lot of guidance about promoting the mental health and well-being of families. They had limited resources and rarely engaged parents in the discussion of mental health. However, when TF was introduced it provided them with evidenced-based strategies they could teach to families while assisting them in coping with life stressors. They felt that TF was a great addition to the regular curriculum by intertwining the mental health component. HVs said they found it relatively easy to weave TF into their standard GGK and GGF curriculum. However, they did mention they needed gentle reminders during case reflections from their Families First Coordinators on where the strategies fit best into the curriculum. For example, if the HV was exploring the transition to parenthood with new parents, they may encourage parents to monitor how much self-care time they are getting; and problem-solve how they could incorporate this more into their routine. They also mentioned the significance of having the support of the Mental Health Promotion Facilitator (MHPF), which will be discussed later in this chapter. Lastly, HVs noticed a difference in the mental health of families that were consistently using TF strategies, and those that were not using them. The following is a detailed summary of HVs perspectives of TF strategies, and their impact on families' mental health.

Nasal breathing. This was by far the most commonly mentioned strategy by HVs (as it was for parents). They felt that all families should know how to use nasal breathing, and they felt strongly about showing them how to use it. They also said that families were using nasal breathing on their own and found benefit in the strategy. HVs felt families used

this strategy more than the others because it was easy to remember ("anyone can do it"), and the calming benefits were quickly achieved. All the HVs said the strategy was an ongoing recommendation. As Wanda declared:

> Everyone gets nasal breathing. That's just my mandate with TF because it works so well. I introduce all my families to nasal breathing, show them how to do it and encourage them to use it on their own. It makes everyone feel better quickly.

HVs also said it was a great strategy to use with children, in particular for those children who have difficulty calming themselves down. Another aspect of this strategy that HVs enjoyed was being able to educate their families on the scientific evidence supporting the strategy-- i.e., that it cools the brain and emotions. Nasal breathing was also used with other strategies. As Sam explained:

> There are a few parents who have told me they use it during meditation and they find the nasal breathing is very helpful. They are able to focus better, clear their mind, and are less anxious. It really helps them to quickly calm themselves down.

Although HVs talked about parents using nasal breathing with other strategies, parents mentioned ways they could modify the strategy to best suit their needs for sleeping, relaxing and decreasing stress.

Three-minute breathing break. This was a strategy that HVs encouraged everyone to use especially those needing a few minutes of quiet time alone. HVs felt it was an excellent strategy to give parent’s permission to be alone or take a breather for a few minutes to recoup. They also encouraged children to learn this strategy so that they could identify when they needed a break from a situation and go to their room to be alone. More

importantly, HVs wanted parents to recognize when they needed to take a break and not feel guilty about it.

Some of the benefits of a three-minute breathing break mentioned by HVs were that it allowed families an opportunity to recognize how they feel about a situation, and it gave them permission to remove themselves and take a breather. Parents' comments were similar, yet HVs recognized that, by letting a parent walk away once all of their child's need were met, this TF strategy was also a strategy for preventing Shaken Baby Syndrome.

Three good things. This was one of the most commonly used strategies that HVs use with families, as a way to bring out the positives in their lives. They said their families really enjoyed this strategy since it was simple, easy to implement and made them think more positively. It was also an easy strategy to teach to children, especially at a young age to increase their positive thinking. A unique difference with HVs was their ability to point out the changes they noticed in families that were using this strategy, compared with those who were not. When they were using the strategy, they were able to look on the brighter side of things and were more positive thinkers.

HVs mentioned that they would encourage parents to use the strategy with their families, but they would also practice it during their home visits. They found that if they did the activity during their home visits it reinforced the behavior. They would encourage parents to think about even the small things in life to be grateful for, such as enjoying a nice meal with their family.

This strategy was frequently mentioned as one of the best activities to do with children to enhance positive thinking. Sam noted that children really liked the strategy because it allowed them to share the positive things they experienced throughout their day.

Even if they only come up with something small, it was beneficial. (An interesting and unexpected finding was that HVs also found that when they used this strategy with their own children they noticed their children were happy to share the positive things about their days). They were generally happier, and HVs were able to focus the visits on more positive conversations. One of the HVs mentioned using this strategy with her own children and noticed their outlook on life improved as well. Lastly, it was mentioned that this strategy (like any new activity) needs to be done often to be effective.

Belonging. This strategy was described by HVs as a good way for families to identify and discover their sense of belonging with others, and in turn build up their self-esteem. While a few HVs seemed to view this strategy and Connecting with Others interchangeably (as most parents did), for the most part HVs focused on Belonging as a unique strategy. In general, HVs found this strategy was useful for parents who were not involved in any activities or did not express interests in things to do in their spare time. HVs found it beneficial for those needing confidence-building and identifying a sense of self.

HVs said it was important for families to feel a sense of belonging and that most are able to identify with some group; even just talking to other parents, children or joining a play group. HVs worked with families to identify things they liked to do, groups they belonged to or would like to belong to. They suggested a variety of ways for making families feel a sense of belonging. Marie gave some good examples of ways she would implement the strategy. For example, she may ask parents or their children if they play any sports or if they are involved in any activities outside of the home. She further elaborated explaining that when families feel a sense of belonging, "their self-esteem improves" which is an important component of mental health. Moreover, Marie said it is important for

families to feel a sense of belonging: "[T]hey need to connect with others outside of the home and feel like they belong to something." Belonging assists with identifying the emotional needs of families and improves their self-esteem.

HVs noticed a difference in families that were using this strategy. Initially, parents did not identify a sense of belonging but later were more confident in who they were, and the things they or their family enjoyed. HVs also noticed that when families were happier, they seemed to have friends to talk to and more things to talk about and appeared to have more self-esteem.

It should be mentioned that this strategy was challenging for parents who were more 'anti-social,' or who admitted to not liking to socialize with others. These parents rarely went out in their communities or took their children to activities. HVs found it challenging to get these parents to identify any sense of belonging and sometimes the strategy didn't work well. In these circumstances, the HVs would remind parents that they are part of the FFHV and TF and that this was a form of belonging. As June stated, “this I find has been food for some clients who didn't realize they had other supports out there. We have a look at home visiting being a support as well.” Families, at a minimum, could identify as being part of the FFHV program.

Connecting with others. HVs used this strategy with families to encourage them to connect with others in a variety of ways such as meeting other people, talking, sharing ideas, doing activities with others or join a group. June said she talked about this strategy frequently with families because she found that, "when they get out, when they connect with

other people, that makes such a big difference in how they feel." HVs assisted families in identifying ways of connecting with others and how this made them feel.

This strategy involves an activity known as the Circle of Support, which the HVs found also worked well in group settings. Parents did not mention this group activity. For example, Sam elaborated on how the activity facilitates connections and supports for families:

> In the group you've got these women connecting with each other and then one might know about a support so she's going to pass that on to another woman. I love doing groups. You might have one mom that is experiencing depression, or another mom that needs to get more sleep, you've got a single mom that's maybe not being supported, no childcare. One feels very alone and isolated. Everyone can offer something to one another.

In one interview, it became clear that this strategy does not work well for everyone. As Marie said, “I found the activity Circle of Support didn't work well in that it seemed to show what she didn't have. Her lack of support rather than the support that was there. This made her hesitant to do the activity.” Although, in these cases, Marie would remind parents that HVs are there for support, she said it would be helpful if there were other activities to choose from.

Wanda noted that this strategy was challenging for some parents who struggled with reaching out to others:

> It's very hard for some to reach out for supports in the community because you have to access the community in order to get supports. It's a fixed mindset really that

prevents them from doing a lot of stuff in life.

Marie said that families absolutely need a community connection and healthy coping skills and for parents to recognize when they need those coping skills for their own mental wellness.

Creating a vision. According to HVs, this strategy was beneficial to assist families in identifying what it is they think contributes to being mentally healthy. HVs said the strategy was well received, and most families benefited from using it. They did not mention, or perhaps were unaware, that parents reported only using this strategy with their HV, not on their own. HVs said they would talk to families about what it is they believe would contribute to a mentally healthy family, and what this would look like. Families were then asked to write down their thoughts and they would talk about them. Often, the entire family was able to contribute to the vision and add their comments to the activity. HVs said it was a good strategy for families to identify what it is they want, communicate this and work towards that goal. They also said they noticed families enjoyed talking about what it is they wanted by creating a vision for themselves. HV reported there were many benefits to this strategy including giving families the opportunity to voice their hopes and dreams, which in tum has the potential to increase their life satisfaction. This strategy can also help to identify what is important to families allowing them to work towards this vision.

However, this strategy was not always effective for parents who were not able to identify what it is they wanted for their families. Sam gave an example:

> ...this one parent, all she could see was four walls around her and her baby. I feel like she could only see the negative. She was not able to create a vision because she

wasn't hopeful and she wasn't sure what she wanted for her family.

There was a similar comment made by June who said she introduced the strategy to one parent who struggled to see the future as positive, possibly due to depression, which made her feel even worse. HVs said that, often, these parents lacked confidence in themselves. The difference between HVs' comments as compared to parents was that HVs were aware that the strategy does not always work well for everyone, in particular for those struggling with envisioning their future.

Physical activity. HVs felt that physical activity was a very important factor in keeping families healthy. Many families were already active, going outdoors and/or participating in other physical activities. For example, Mary talked about how one of her families loves to dance to stay mentally healthy. HVs noticed the benefits when their families were physically active. The benefits of physical activity identified by HVs included being together as a family, being healthy, being a good role model for their children, and decreasing stress and anxiety. HVs said they encouraged families to be physically active because they know it is good for their overall health. Many families were already active, going outdoors and participating in activities. However, there were some families that were not very active as a family. When there were families that struggled to be physically active HVs would sometimes model the behavior by going outside with them. As Marie stated:

> For those families that are having a hard time, we might just go for a walk. And then we'll just talk about how they felt after the walk. Incorporating physical activity during home visits gives us an opportunity to visit with them and model physical activity.

She found this very helpful and was able to connect with her families through physical

activity. HVs frequently talked about modelling behavior, whereas parents did not mention this as a benefit.

Progressive muscle relaxation. According to HVs, this strategy was not used as often as the others (for reasons discussed below). However, those who were using the strategy found it beneficial and continued to use it often. It was also a strategy that could easily be taught to young children to relax themselves.

There were a few reasons that HVs mentioned regarding why this strategy may not be used as often by families as the other ones. First, it requires the person to have some quiet time on their own to practice relaxing and tensing their muscles-- something that was not often available to these parents. Second, it is a more time-consuming strategy to implement compared to other strategies. Lastly, it is a strategy that appears to benefit some but not others. There were a few parents who reported to their HV that they tried the strategy but did not find it helpful. In fact, some parents were not even able to relax themselves enough to do the strategy. Most were using it before they went to bed or rested. Children were also shown how to use the strategy to calm themselves. HVs said those who were using progressive muscle relaxation reported they found it calming and relaxing and they were able to fall asleep quicker. Also, those who were using this strategy were using it daily and were maximizing its benefit.

Self-monitoring. This strategy worked well for families that wanted to change a specific behavior. It could be used with parents or children and was a simple tool to use to encourage their mindfulness. HVs reported there were many benefits of this strategy for their families, therefore they encouraged it for those wanting to change. As Betty described: "I get them to be mindful of their body and some are using it with their kids and partner."

Although it was often challenging for families to monitor behaviors, HVs said it was good for their mental health to recognize their needs. Some parents used the strategy to monitor certain behaviors they were trying to either increase or decrease. Others were using it to monitor an increase in certain behaviors such as eating healthy and exercising. It was also used with children to monitor and encourage certain behaviors.

A unique perspective was provided by Cassidy, who recognized that self-monitoring takes a lot of time. The parent needs to fill out a form and monitor their behaviors and then everyone can see it. So, for one family, she implemented a white board and when they were done with it they erased it. However, some parents told the HVs that they did not want others to view what they were monitoring for negative coping behaviors such as with substance use. The benefits of this strategy included the motivation to change the behavior and view the success on paper. When families reached a particular goal it made them feel good and they could celebrate with others. There is accountability in monitoring the behaviors. Monitoring also allowed families to change things they wanted to.

Role of The Mental Health Promotion Facilitator (MHPF)

HVs provided, or connected, families with a variety of community mental health resources such as the mobile crisis team, mental health worker, Anxiety Disorders of Manitoba, Cognitive Behavioral Therapy, Dialectical Therapy, support group known as Coping with Change and others that became available throughout the region. They wanted to ensure that families were well connected with mental health resources. Overall, HVs felt TF provided families with a better connection to community mental health resources and HVs very much valued the role of the MHPF.

There were many benefits of the role of the MHPF reported by HVs, which included

supporting the HVs, providing recommendations based on screening packages, and for facilitating Coping with Change (discussed further below). HVs explained how the screening packages are the first way they introduce TF to parents and most are receptive, albeit some parents say they do not want anything to do with a mental health program. However, those who do complete the introductory screening packages are provided with an assessment from the MHPF and individual recommendations regarding their mental health. They are also given recommendations on strategies to use for mental health promotion and coping. Lynne said that the TF introductory screening package that families complete and return to the MHPF is helpful when supporting families. HVs said they relied on the MHPF to provide guidance in regards to their families' mental health for those that have completed the in-depth mental health screening forms. As Marie stated:

> After parents complete the surveys then she [MHPF] takes a look and makes suggestions and includes resources and strategies to use with the family based on her assessments. It's very individual based. She [MHPF] has been an excellent resource to our program.

According to HVs, parent who complete the TF introductory screening packages, receive feedback including mental health promotion recommendations from the MHPF. Wanda said:

> The ones that are doing the surveys compared to the ones that aren't are much better connected. Some parents didn't even know they weren't doing that good until they receive feedback from their TF screening package. Then they realize that they really aren't doing as well as maybe they had thought.

The role of the MHPF along with the screening packages assist parents with their mental

health.

HVs said they also relied on the MHPF to facilitate a community group known as Coping with Change. This small community group for parents, located at various sites throughout the region, meets for 5 weeks to discuss the emotional transitions to parenthood. It discusses the often difficult transition that mothers may experience while giving them a chance to voice their realities. It also gives them an opportunity to talk about their feelings in a non-judgmental forum and connect with others. Moreover, mothers may have an opportunity to connect with the MHPF. HVs found that having this connection with the MHPF was an important component of TF.

Ways Towards Flourishing Could Be Improved

Although HVs believed that TF was benefiting family mental health, they made several recommendations to improve and enhance the program which were unique. In fact, none of the HVs' recommendations were mentioned by parents, and vice versa. Some of the recommendations made by HVs included implementing more strategies, activities involving fathers, more flexibility with home visits, less curriculum, and ways of supporting families when they need more than TF offers.

Additional Strategies

There was an abundance of suggestions made by HVs involving implementing more strategies, topics, and activities to meet the needs of all families. Although HVs knew that families were benefiting from TF strategies, they wanted more of them to integrate into their home visits. A few suggestions will be highlighted here. Sam suggested using laughter as one of the strategies. She felt that once you start laughing, the more you laugh, the better you feel. Another HV thought it would be a good idea to have more activities for

relationship building. Cassidy recommended having separate TF programs for specific age groups e.g. TF for kids, preteens, teenagers, fathers and infants. She felt a lot of the information was geared towards mothers and young children, and there should be more for other age groups such as fathers (this will be discussed further below).

Cassidy also suggested adding more of a visual component to the strategies, to accommodate different learning styles, such as including relaxing pictures, which would provide different beautiful environments for them to look at and choose one that makes them feel less stressed for body awareness. She felt that those who were more of a visual learner could benefit from this strategy. Wanda said that although TF is geared towards parents, she would like to see it more specific to infant's and children's mental health. She felt there needed to be a book for children so she created one of her own. The book was bright, visual, textured and included pictures of strategies and different ways of coping for children. The language in the book, and literacy level was specific to children. Wanda said that most people do not understand that infants and children have emotions and mental health too. Wanda said she made the book for children so that they could see what coping strategies look like for kids, just a different way for parents to look at their mental health and their kid's mental health. HVs said that all of these suggestions have the potential to build and enhance TF strategies for families.

HVs recognized that not all of the strategies and activities worked well for everyone. Marie shared her experience with the activity, 'Circle of Support,' which did not go particularly well. During this activity the parent "realized how little support she had" even though she was reassured by her HV that the FFHV program was a support. For this parent, a different strategy could have been more appropriate if there were more to choose from.

Also, certain strategies may not work well for parents who are separated or divorced, yet still co-parenting and living together. An example of this was provided by Marie who described a situation with one of her families where the parents were separated, yet still living together, having home visits and doing TF strategies and then posting them on the fridge. One of the parents expressed that she "didn't want to look at his stuff" which was awkward for Marie. The strategies Belonging and Connecting with Others were also a challenge for some families that struggled with self-esteem and socializing with others. HVs felt that they would benefit from additional activities to engage them with these strategies.

Some parents were difficult to engage in TF and they wanted nothing to do with talking about their family's mental health. As one HV described, it was "like pulling teeth" to engage them in TF. In these cases, HVs used innovative ways to gently discuss mental health. HVs said they needed to develop relationships and build trust with families before they could implement TF. As Wanda stated, "It depends on how much you can get them to share. Sometimes it takes a period of time." June noted that it was the approach to TF that determined how receptive parents were to the program. She does not just whip out the book with families; rather, she gently eases them into it. Sam described how she sometimes had to tailor the program to meet the needs of the family:

> I have to tweak it sometimes. I had a mom where I used Towards Flourishing when her husband left her. So I could use every single strategy and tweak it like what were your expectations with your husband? Well they were for him to stay with her forever. How are you going to cope with your husband leaving? It’s very beneficial to their mental health.

Sam said that, with this approach, families may not even be aware they are using TF as a

mental health promotion strategy, yet they may be benefiting from it.

Engaging Fathers

Children were primarily exposed to TF strategies through their mothers and HVs. Most fathers were not present when home visits occurred, and mothers found it challenging to explain TF to their partners. As June noted, "It doesn't always work well when one spouse is teaching another spouse a strategy, the relationship is different with their spouses, it doesn't function so well when one is trying to teach them [the strategies]." Sam said she has had a few fathers use TF strategies and they have found them helpful: "Unfortunately, most of the time you don't get dads but I've had a few and we didn't get through all of the strategies but he was open to a few." Sam agreed with Wanda, who noted that fathers seemed to like the introductory packages: "The men like the Towards Flourishing participation packages because they connect much more with the TF program and HVs." They felt men were able to do the packages at their own convenience. Mothers had stated they wanted partners/fathers present for the information or better ways of passing along the information. HVs said that fathers were occasionally part of the visits but, when the HVs started to practice a particular strategy, the fathers would often leave the room at that point. HVs offered an explanation that the TF program is aimed towards mothers and children. For

Emma, better engagement of fathers was important: "Dads struggle too, I think more than we realize. They feel inadequate where they can't do anything."

What To Do When Parents Need More

There was a general understanding among HVs that TF was a mental health promotion strategy and was not intended for those with acute mental illness or for use with someone in an acute crisis unless other resources were in place. As Sam explained:

> I had a mom who was acutely ill and we talked about the strategies and I could see this will not help someone in an acute phase, it’s more of a preventative, the nasal breathing would help but they need more.

It was also mentioned by other HVs that anyone with past traumas could benefit from TF; however, as Betty noted "traumatized parents need a lot more for their mental health due to the different levels of trauma." Although these families needed much more support than HVs were able to provide, they felt that there was still some benefit for families in using TF strategies and they still viewed it as an excellent additional tool.

HVs also reported that not all parents want to talk about their mental health issues, and HVs wanted more suggestions for engaging families. Cassidy thought that TF should be paired with counselling and felt this would be beneficial to families. She also felt that she did not have the skills to identify more serious mental health problems based on the survey completed by parents:

> I'm not a mental health worker, and I wasn't able to get to the core of the issue but a mental health worker may be able to. So, working together [HVs and MHPF] is a

good fit, but that's something I wouldn't have picked up on.

Other HVs suggested that it would be helpful to have a trained mental health worker visit families needing more support in the community.

Chapter VI: Discussion

The mental health and well-being of families, in particular those with young children, is of great significance given the literature indicating the first five years of life are the most fundamentally important in child development (UNICEF, 2011), and considering that the root of most mental disorders begin in early childhood (DeSocio, 2018; VIRGO, 2018). There is also evidence to support that the social determinants of health (SDOH) strongly impact mental health and well-being (Brownell et al., 2012; Welsh et al., 2015; VIRGO, 2018). Community-based mental health prevention and promotion programs are essential to the integrated health care system. These programs aim to support and provide the necessary resources for families' mental health needs (Chartier, 2015). However, there is limited research on the effectiveness of these programs in relation to mental health outcomes, especially from the perspectives of the program recipients and providers.

This study contributes to the literature by addressing what factors contribute to the mental health and well-being of families, and the impact of the Towards Flourishing (TF) program on families' mental health, from the perspectives of parents who participate in the program and home visitors who deliver it. This study further supports Keyes' (2002) theory that mental health is on a continuum, and is impacted by various social, emotional and psychological factors. The following is a detailed discussion regarding Keyes' mental health dual continuum as it relates to the findings of this study.

Mental Health Dual Continuum

According to Keyes (2002), there are two distinct concepts on opposite ends of the spectrum, languishing and flourishing. Keyes describes mental health as being on a spectrum that fluctuates with subjective well-being described in social, emotional and

psychological domains. Based on this theoretical framework, families that are mentally healthy have positive feelings of well-being and are more confident and resilient. All three domains described by Keyes were mentioned in some way by participants and are discussed below.

Emotional Well-Being

The emotional aspects of Keyes' framework describe the presence or absence of positive feelings of well-being, and perceived satisfaction in life. Keyes argues that mental health is the presence of an emotional state of well-being, and emotionally healthy individuals are more confident, and are able to recover more effectively from change in their lives. This was validated by parent participants in that those who were emotionally healthy were happier, had a more positive outlook on life, and HVs noticed they were in better spirits. Furthermore, families that were emotionally healthy coped better with stress in their lives, such as when a partner worked away from home, when there were relationship concerns, struggles with parenting or financial worries.

TF promotes emotional aspects of mental health by encouraging positive self-talk (three-good things), staying in the present (Nasal breathing, Progressive Muscle Relaxation, Three-Minute breathing break), Journaling, (Self-Monitoring, Creating a Vision), and diversion activities (Physical Activity). These strategies have been used successfully elsewhere (Luke & Alavosius, 2012; Embry & Biglan, 2008).

Social Well-Being

Keyes describes the domain of social well-being as including social actualization, social integration, social acceptance and social contribution. In other words, individuals are functioning well socially when they feel a sense of belonging within the community, when

they accept most parts of society, when they see themselves as contributing members of society and when they view society as meaningful.

Participants in this study reported that work and school were important to parents and feeling a sense of belonging within the community positively impacted families' mental health. Families that felt social connectedness--such as attending a group; meeting with their HV, friends or family; and participating in activities--felt better about themselves and were happier. Moreover, families that are involved in their communities feel better connected, supported and cared for.

Social connectedness is crucial for good mental health and protects and promotes mental health (Saeri, Cruwys, Barlow, Stronge, Sibley, 2018). TF promotes the social well-being of families by encouraging them to participate in their communities and to visit with family and friends, and by informing them of community events, programs and other resources.

Psychological Well-Being

The psychological aspects of the Mental Health Dual Continuum include self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy. Families are functioning well when they have warm trusting relationships with others, and when they have someone to talk to and check in on their needs. An important aspect of families' mental health is feeling well supported and cared for by others. TF promotes the psychological aspects of mental health by providing families with the support of a HV, with whom they can develop a trusting relationship and not feel so alone.

According to Keyes (2002), having support increases positive feelings of well-being and satisfaction in life, with those having supports more likely to flourish. Feeling well supported

positively impacts all three of Keyes' theoretical domains by talking through difficult emotions, psychologically not being alone in the struggles of life and socially connecting with others. This was validated with participants reporting that those families that feel supported have symptoms of flourishing, such as higher levels of subjective well-being, psychological and social functioning. Therefore, this study supports Keyes' theory that parents' mental health is impacted by their subjective emotional, social and psychological well- being.

Social and Structural Determinants of Mental Health and How Towards Flourishing Addresses Them

The mental health and well-being of families is of great significance and is strongly impacted by the social and structural determinants of health (SDOH). The results of this study substantiate the impact that the SDOH have on the mental health and well-being of families. In fact, every participant mentioned some sort of socio-economic factor negatively contributing to mental health, with supports having the strongest impact on families' overall mental health. TF addresses the SDOH to some extent by providing families with the support, resources, and strategies necessary to cope with life challenges. TF also bridges the gap between mental health and public health to address the SDOH allowing for a seamless provision of care. The following is a detailed discussion of the findings:

The Social Determinants of Health

It is well documented that the SDOH strongly impact the mental health and well-being of families (Brownell et al., 2012; Welsh et al., 2015; VIRGO, 2018). Most families participating in TF were of low socio-economic status, and many were experiencing challenges such as a lack of supports, unstable housing and financial struggles. Considering that every participant reported some sort of socio-economic factor(s) negatively contributing

to mental health, it is imperative that families' basic needs are met for better mental health outcomes.

Supports. Research shows that those who feel well supported have better mental health outcomes as compared to those who do not feel supported (Cloverdale & Long, 2015; Hansen, Bibi Pedersen, Charlotte, Torp-Pedersen, & Rosenkilde, 2017). In fact, there is a direct correlation between a lack of social supports and poorer mental health outcomes (Hansen et al., 2017). Families need a combination of emotional support such as someone to talk to, and practical supports such as getting groceries or help with picking up children from daycare.

Hansen et al. (2017) describe what they refer to as functional aspects of support, consisting of emotional and instrumental support. They describe emotional support as having someone to talk to, and instrumental support as receiving help from others. These authors found that those with less emotional and instrumental support have poorer mental health outcomes as compared to those without. They also found that structural aspects of support, such as getting together or being in contact with friends and family, greatly impacts mental health, with those having more contact with others having better mental health outcomes. Those findings are similar to this study, where participants reported that families' greatest stressor was a lack of emotional and instrumental supports and feeling well-supported made the biggest difference in their overall mental health.

Families involved with TF are provided with the support of a HV, along with resources for government and community services. HVs assist families with accessing the necessary resources to meet their basic needs such as government housing, childcare subsidy, food banks and employment and income assistance. They also provide parents with

the emotional support needed while they are transitioning to parenthood, and raising young children.

Although parents said they needed both emotional and practical supports to flourish, it was the emotional support that made the biggest in their overall mental health. There are several potential explanations for this. First, feeling well supported gives parents a feeling of being cared for. Second, parents who feel well-supported are less anxious and stressed, possibly due to talking through problems, receiving validation and normalization. Parents also said they need ongoing, consistent support from a variety of sources including family, friends and the community.

Interestingly, this study showed that parents and HVs had different perspectives regarding supports. Parents reported that a lack of family support caused them a tremendous amount of stress, such as feelings of loneliness, poor self-esteem, anxiety and depression, which are all symptoms of languishing. HVs mostly mentioned families having a lack of community supports such as the community group, Coping with Change, or government programs such as Healthy Baby, both of which are only offered in a limited number of communities.

Supports are the underpinning of families' mental health, considering that they provide aspects of social connectedness, including emotional and practical supports needed to flourish. Families lacking the necessary supports needed to flourish are at risk of poorer mental health outcomes and symptoms of languishing.

Housing. Lack of affordable housing and poor living conditions have been linked with negative mental health outcomes (CMHA, 2019). Unstable housing has shown to contribute to both parents' and children's poorer mental health. Parents may experience

depression, anxiety and poor self-esteem, and children may experience behavioral morbidities (Singh, Lyrian, Baker, Bentley, 2019). Families with financially insecure housing--i.e., living with a separated partner or friends, or moving back home with parents or in-laws--are at risk for mental health problems, whereas families who are satisfied with their living conditions are at less risk for poor mental health outcomes (Singh et al., 2019). Moreover, housing insecurities may contribute to negative emotional and psychological well-being and symptoms of languishing. Therefore, it is imperative that families have stable, secure housing for them to be mentally healthy and flourish.

TF addresses concerns with housing by identifying which families are experiencing unstable housing and assisting them with accessing resources. The TF strategies also assist families in coping with challenges related to housing, for example parents may develop a plan on where they could find stable housing or have a goal of attaining certain resources. HVs support families by talking about housing challenges, and may assist with navigating the system and completing application forms.

Both parents and HVs felt that stable housing was imperative to families' mental health. Parents experiencing unstable housing had poor self-esteem, felt vulnerable and experienced anxiety. They felt that TF assisted them with problem solving, providing resources and accessing community services.

Work-life balance. The literature illustrates the difficulties parents experience while trying to maintain a work-life balance, and struggle to meet financial and parental obligations (Cooklin et al. 2016). Conflict seems to occur when there is incompatibility with the demands of work and home, which may compromise family functioning. For example,

parents may experience burnout with the demands of work which can impact job performance, and decrease their capacity for caregiving (Cooklin et al. 2016).

TF fosters the relationship between parents and children so that when parents are working away from home or going to school, they still feel connected to their family. TF provides families with the support and resources needed to cope with the difficult and exhausting period of parenthood. Another aspect of TF that is beneficial to parents is talking through the difficult emotions associated with challenges to work-life balance. Parents benefit from validation that they are doing the best they can when working and trying to meet the needs of themselves and their families. This positive reinforcement increased parents' self-esteem.

Parents in this study were strongly concerned with not having enough time and or energy to spend with their families, and often struggled to maintain a work-life balance. They found it stressful doing shift work, or going back to school and not spending enough time with their families. Furthermore, parents were exhausted from the demands of working and parenting, which impacted them emotionally when they were missing out on certain aspects of their families' lives.

It was interesting that parents mostly talked about the stress that working and raising a family caused for them, whereas HVs talked about the impact it had on children's mental health when parents were not readily available. HVs reported how difficult it was for children when they were away from their parents for long hours, and they were not always available when they needed them. One explanation for this difference in perspectives could

be that although parents recognize the impact on their children, they have no other choice but to work and go to school.

Transportation. The impact of transportation on health has been well documented, with those of lower socio-economic status experiencing more challenges with transportation as compared to those who are wealthier (Schalkwyk & Mindell, 2018). When it comes to mental health, those lacking transportation may experience negative impacts such as loneliness and isolation. This could be due to less frequent contact with family, friends and limited access to community services (Avila-Palencia et al., 2018).

TF assists families with troubleshooting ways of finding transportation, and other means of attending appointments and community services. HVs are knowledgeable on available transportation resources in the community, and may assist with accessing those services. However, there are limited resources for rural transportation creating access issues to community services.

Living rurally puts families at a disadvantage to accessing transportation services such as buses, taxis or shuttles. Moreover, families of lower socio-economic status are at a disadvantage due to barriers associated with transportation, such as limited use of a vehicle or no vehicle, and limited resources available in their own community. Families that have limited resources and access to transportation are at risk of not attending appointments or seeking care. Families with transportation issues often experienced feelings of isolation, in particular when they were not able to visit family, friends or access community services. Parents also felt dependent on others for transportation, creating a lack of autonomy, which in turn impacted their self-esteem and mental health.

Parenting. One aspect of parenting that is well documented throughout the literature

is Adverse Childhood Events (ACEs) and the impact of trauma on parenting, such as the ability to show empathy, love and affection. This can have detrimental effects to child development including mental health (Felitti et al., 1998; Johnson et al., 2017). Participants did mention childhood traumas, and how this impacted their parenting and their children's mental health. Some parents were able to work on their parenting behaviors and parenting skills with the assistance of their HVs, thereby showing their own children the love, support and affection they were never given. It was empowering for parents to be able to break the family cycle of abuse, poor parenting, and substance use. Due to the critical role of parenting on children's mental health, it is imperative that children are provided with nurturance, warmth and support for their emotional, psychological and social well-being (Achtergarde et al., 2015; WHO, 2011).

There is value in screening parents for ACEs, not only through the FFHV screening and parent surveys, but also during home visits once a relationship has been developed (Johnson et al., 2017). Challenges exist with families when there is substance use, addictions, divorce and abuse, which can have significant implications to relationships, and create dysfunction within the home (D'Onofrio et al., 2018). These ACEs impact both children’s and parents’ mental health. Children that have experienced adverse events such as divorce, parental mental illness or substance use have increased rates of anxiety and depression (D’Onofrio et al., 2018; Emery, 2019). Parents that were exposed to trauma as children often experience poorer mental health outcomes, such as depression and substance use as adults. They may also have a parenting style that resembles how they were parented (Johnson et al., 2017), yet their resilience may enable them to break the cycle of abuse that

they themselves experienced as children.

TF builds on this screening process by providing parents with enhanced mental health screening, and personalized recommendations from a Mental Health Promotion Facilitator (MHPF). This impacts parents' mental health by providing them with a mental health worker if needed, allowing for opportunities to identify those parents that are in crisis or in need of additional mental health services. TF provides families with information about postpartum depression, and mental health resources such as Coping with Change or encourage a mental health referral as needed.

Financial insecurity. Most families participating in the TF program were of low SES, and financial concerns were a huge stressor. Parents experienced anxiety, depression and difficulty sleeping, which can have significant consequences for individual and family functioning (Herrmann et al., 2018). Moreover, financial problems impact mental health with lower income being associated with languishing symptoms, and higher income being associated with symptoms of flourishing. Therefore, it is imperative to families' mental health that their socio-economic needs are met for better mental health outcomes.

Single parents may suffer more from financial hardship due to only having one income (Herrmann, Vogel, Pietzner, Kroll, Wagner, Schwarz, Muller, Kiess, Richter, Poulain, 2018). Both parents' and children's mental and emotional health are impacted by income. For example, parents with lower incomes have shown to have decreased satisfaction in life, and children experience more anxiety and depression. In contrast, higher income has shown to be a protective factor for children's emotional health (Herrmann et al., 2018).

TF ameliorates families' financial concerns by assisting them to navigate and access

community and government resources such as the food bank, childcare subsidy, employment and income assistance. They also support and assist parents with problem solving related to financial concerns. Furthermore, TF strategies assist families with coping when they are feeling stressed or anxious about finances.

Relationships. Both parents and children may experience the negative effects of relationship distress such as separation, divorce and blended families. In response to family dysfunction, children have shown to experience behavior and mood differences, self-blame, sadness, confusion, and difficulty with sleeping and eating. (Cohen & Weitzman, 2016). It is imperative that children understand they are not to blame for dysfunction within the family. These family dynamics can have significant negative impacts to mental health, especially for children exposed to family instability (D'Onofrio & Emery, 2019). Parents also suffer negative effects of relationship distress, for example, mothers are more likely to feel stressed and humiliated. Fathers often feel alone, may become depressed, anxious and abuse substances (Cohen & Weitzman, 2016).

TF addresses relationship distress by providing families with strategies to assist with coping while they are going through relationship challenges. HVs emotionally support families and assist parents with dealing with difficult emotions, problem solving and decision making. They also provide families with community resources, and assist them with accessing government services as needed such as legal aid, housing, and counselling.

Throughout this study is was evident that relationship problems created a lot of stress for families, with some parents and children experiencing feelings replicating those of languishing. For example, parents experiencing relationship distress experienced low levels of self-esteem, feelings of loneliness, guilt, depression, resentment and shame. Parents felt

that TF positively impacts their mental health by providing them with tangible strategies they can use to cope with stress, and having the support of a HV to talk about their challenges.

Self-care. There is a vast amount of evidence on the benefits of self-care (Patel, 2014; Dodou et al., 2016). Systematic reviews on self-care have shown long term benefits to many chronic health conditions such as heart disease, diabetes, arthritis and mental disorders (Patel, 2014). Children with asthma related symptoms that are taught self-care have shown improvements in their symptoms (Patel, 2014).

During the postpartum period self-care is crucial to mental health and well-being, in particular for those transitioning to parenthood. Dodou et al. (2016) found that during the transition period mothers need to practice self-care for their own benefit and health. Health care providers should also be encouraging self-care to mothers, so they understand the importance of taking care of themselves and valuing their bodies. It also empowers mothers to develop their own autonomy and knowledge so they have greater control over factors that affect their health.

The TF curriculum educates parents on the benefits of self-care, such as giving parents an opportunity to recuperate and regenerate. When parents are performing self-care they are nurturing themselves, which may be difficult for some parents, in particular those who have experienced ACEs. These parents benefit from TF in that they are able to work through aspects of their trauma and are referred to resources as needed. Parents are also

educated on the warning signs of mental health disorders, and when to seek additional services.

Parent participants in this study admitted they were not taking care of themselves as best they could, yet they understood it was an important aspect of good mental health, and for them to be good parents. Most parents were lacking self-care due to the competing demands of other obligations such as work, family or school. However, they appreciated the self-care reminders by HVs for two reasons: it made parents feel cared for; and it gave them permission to not feel guilty about taking care of themselves.

Key Features of Towards Flourishing that Promote Families' Mental Health

Towards Flourishing (TF), positively impacts families' mental health and well-being through a combination of factors including home visiting, TF everyday strategies, and community-based mental health promotion. There is literature to support the effectiveness of home visiting programs for positive maternal and childhood outcomes; the results are favorable and show the need for community-based home visiting programs for families.

Home Visiting

There is a vast amount of evidence to support home visiting programs as effective in reducing child maltreatment, building parents capacity, providing education, enhancing the parent-child interaction, improvements in child development, and supporting mothers and children. (Chartier et al., 2017; Sweet & Abblebaum 2004; Knoke, 2009; Sluppee & Adirim, 2012; Peacock, Konrad, Watson, Nickel and Muhajarine's, 2013).

Chartier et al. (2017) and Peacock et al. (2013) examined the effectiveness of the home visiting programs for disadvantaged families, in decreasing rates of child maltreatment, development and health outcomes of young children and those that are in the

welfare system. These authors conclude that home visiting is associated with substantially lower rates of children being taken into care, fewer hospitalizations for maltreatment and increased immunization rates. These population health outcomes should be recognized as effective strategies for improving child outcomes and reducing population-level health and social inequities.

However, there is limited evidence regarding the impact of home visiting on the mental health of parents, in particular for mothers. A meta-analysis found that overall, home visiting programs positively impact maternal and child health outcomes (Knoke, 2009). Mothers who participate in home visiting services have more realistic expectations of their children, provide a safer home environment, are less likely to use harsh discipline or punishment, use more positive parenting practices such as praise and positive feedback, provide more appropriate play materials, and the parent-child interaction was enhanced (Chartier et al., 2015; Knoke, 2009).

This study contributes to the evidence in that TF positively impacts maternal and child mental health outcomes, and assists with facilitating the parent-child interaction, through mental health promotion activities. HVs normalize the postpartum period, build parents capacity, provide education, enhance the parent child interaction, encourage self-care and support families. Parents felt that home visiting was the best part about being involved with TF and that HVs built up their self-esteem and feelings of well-being. Participants confirmed this, where families using the TF strategies daily or weekly (depending on which strategy they were using) noticed the positive impacts on families'

mental health. In fact, both parents and HVs noticed the positive aspects of using the strategies regularly--mainly, that families had a more positive outlook on life.

Variety and Accessibility of Towards Flourishing Strategies

HVs were integral in facilitating TF by educating parents on the program concepts and encouraging parents to explore which strategies worked well for themselves and their children. Perhaps not surprising, parents used the simpler strategies independently, yet they wanted the guidance of their HVs for the more complex strategies, such as self-monitoring, creating a vision or especially when their partners were involved. Possible explanations for this could be that self-monitoring requires accountability, and having a partner understand the concept is helpful in goal setting for the entire family. This is similar to the strategy creating a vision, where the entire family is involved in thinking about what they perceive as a flourishing family.

Families using the TF strategies found them beneficial to their mental health. Most of the strategies were well utilized with some being used more often than others, and a few worked better for children than others. Participants reported that the benefits of the TF strategies included overall better mental health outcomes such as decreased symptoms of anxiety and depression, improved sleep, better relationships, increased positive outlook on life, and increased self-esteem. Although parents were capable of doing the strategies on their own, they wanted their partners present during home visits. This makes sense since TF is family oriented and mothers/fathers want the support of their partners. It may be that some parents found it challenging to explain the TF concepts to their partners. Therefore, in an effort to increase partners' involvement with TF, HVs could assist families with finding

innovative ways to engage partners.

Enhancing Mental Health Promotion in the Community

Throughout the literature, there is a clear indication of the need for mental health promotion in the community setting, in particular for those families who are vulnerable (Towards Flourishing, 2012; Hinkle, 2014; Murphy, Pavkovic, Sawula, Vandervoot, 2015). There is growing evidence for effective mental health promotion strategies that are holistic, multicomponent, and targeted for specific vulnerable populations (Avdesh, Sujatham, Sharma, 2017).

The results of this study indicate a need for mental health promotion programs for the most vulnerable families with young children in the community. The TF program focuses on building families' capacity, which is a key factor in promoting mental health. The role of the Mental Health Promotion Facilitator (MHPF) is unique to the TF program in that it offers mental health support to families in the community, and paraprofessionals working in the home with parents and children. The role of the MHPF is integral to the TF program by providing parents with mental health promotion recommendations and supporting the HVs while they are promoting mental health with families. However, there is little published research on this role. The evidence that does exist discusses the benefits of promoting mental health in the community, and not specifically the role of the MHPF. This could be due to the role being new, and or they have different names and or responsibilities in other provinces, territories and countries (Hickle, 2014). The results of this study will help to fill the gap in knowledge about this important community-based mental health promotion role.

The process of implementing TF in the community involved collaboration between Public Health and Mental Health programs both with the goal of increasing communication,

consultation and referral processes, as well as enhancing and strengthening capacity. In fact, all RHAs secured the position of a Mental Health Promotion Facilitator (MHPF), which is an integral component to the program.

Extent to Which Towards Flourishing is Culturally Safe

Culture has been identified as a protective factor that has a huge impact on mental health and well-being (reference required). There are many different cultures, traditions and practices, for example the term mental health is often replaced with "wellness" in Indigenous cultures (reference required). Indigenous people also view mental health promotion as a health process involving the entire family and community. Traditions may include feasts, ancestry, land teachings and ceremonies. Moreover, mental health promotion education needs to be explicitly about teachings and the impact of historical trauma, as well as the value of knowledge and traditional practices.

Consultation with First Nations advisors has been an ongoing process throughout the development of the TF curriculum. This select group of advisors consisted of consultant's/knowledge keepers in First Nations. They assisted the TF team in developing culturally safe materials that meet the mental health needs of First Nations families. Moreover, consideration was given to ensure there was a diverse First Nations perspectives, including Elders, front line community workers and government representative. Several recommendations were made, which resulted in the refinement of materials to ensure not

only cultural safety, but also relevance to First Nations and all families in Manitoba (Government of Manitoba, 2012).

TF encourages families to draw upon their traditional values, Indigenous knowledge and traditional practices such as connecting with their land. Furthermore, the relationships developed between parents and HVs are intended to be culturally safe and relevant to First Nations Families (Government of Manitoba, 2012).

Study Limitations

As with all research, there were several limitations to this study that will be discussed.

Lack of Generalizability and Small Sample Size

Qualitative research is heavily context-dependent, is not intended to be generalized, and in fact should be left up to the reader to determine if the findings are relevant to them (Polit & Beck, 2012). Due to the smaller sample size the findings reported here cannot be assumed to represent all opinions. Moreover, a smaller sample size may unintentionally exclude those with meaningful things to say about TF. In comparison, a study with a larger sample size might have provided additional information about parents' and HVs' perspectives regarding TF, and possibly more in-depth findings (Polit & Beck, 2012).

Absence of Fathers' Views

Another limitation of this study was that most of the parent participants were women. While this is not surprising, given that mothers are more likely to be home during the postpartum period. It would have been ideal to have more fathers participate to gain a greater perspective of their experiences with TF, and their perceptions of the programs

impact on their families' mental health. Although efforts were made to accommodate fathers by being available for interviews in the evenings and on weekends, only one father participated.

Potential Biases

It is important to minimize potential biases that may be associated with research such as social desirability, which is the tendency for participants to answer questions in a manner that may be viewed as favorable by others. It can take the form of either over-reporting 'good behavior' or under-reporting 'bad' or undesirable behavior (Polit & Beck, 2012). This may have been the case with this study, where participants enjoyed the TF program and were possibly hesitant to say anything negative, resulting in over-reporting positive aspects of the program and under-reporting the negatives.

Another bias known as self-selection is where parents volunteering to participate are more comfortable expressing their views, and that those who could have offered different perspectives did not feel comfortable volunteering. Attempts were made to decrease these biases by providing parents and home visitors with the opportunity to express their concerns prior to the research study to reassure clients the information is confidential by providing an opportunity for informed consent and full disclosure about the purpose of the study. In addition, an effort was made to provide a 'safe space' for the participants. The interviews took place in the comfort of the families' home and other preferred settings, and the researcher is a public health nurse who is experienced with interviewing families about sensitive topics.

Chapter VII: Final Recommendations & Conclusion

Recommendations for Strengthening the Towards Flourishing Program

Towards Flourishing (TF) is a relatively new program that has yet to be formally evaluated, which allows for an opportunity to make recommendations to strengthen the program. There are many innovative ways to strengthen the TF program and address some of the gaps in service. Several recommendations to strengthen TF are discussed here.

Online Access

Technology is changing the way people access information, resources and communicate with others. Given the movement towards more modern ways of accessing information (Underwood & Farrington-Flint, 2015), it would be beneficial to have TF resources, strategies and activities online. It would also benefit parents to have a cell phone app where they could access TF strategies and keep track of their goals. This could possibly increase families' ability to access TF at their own convenience, and share the information with their partners. Providing families with innovative ways of accessing TF will only enhance and strengthen the TF program.

Less Curriculum

There is a lot of curriculum involved with both FFHV and TF, which may impede families' full engagement in the program. Most parents want to talk about their problems and although the curriculum is good for guidance, it should not be used for the entire visit. In fact, it would be beneficial if HVs allowed parents to lead the visits and indicate if they want to talk or use the curriculum. Perhaps this would allow for increased engagement in the

program for those that are wanting more than the curriculum.

Increased Flexibility in Home Visits

Most home visits take place during the day when mothers are home with their infants. This may work well for mothers during the first year when they are on maternity leave, however if/when they return to work it may not. There is also the concern that not all family members are able to participate in home visits during the day. There is no question that families need increased flexibility in their home visits, this may include visits in the evenings and weekends. It may also include going to locations other than homes to visit families such as schools, parks, and community programs.

Implementing More Towards Flourishing Strategies

There are a limited number of TF strategies that families can choose from. Therefore, it would be good to have more evidenced-based strategies that HVs can implement, and families can learn. This would give both parents and HVs the opportunity to use different strategies to promote mental health and well-being. An example of this could be to have a strategy or activity involving relationship building, which is not addressed in any of the other activities.

Advertising of Towards Flourishing

The FFHV program is well known across the province, unlike TF which is new and not widely known. There may not be an awareness that the TF program promotes the mental health and well-being of families. More advertising of TF could possibly increase self-referrals and those from health care providers, that may otherwise not have known about the

program. Better advertising of TF will promote an awareness of the benefits of the program.

After-Hours Mental Health Support

HVs are not always available for parents when they are needed for support. In fact, HVs usually visit with families once a week or less depending on their needs, this makes it unlikely for them to be around when parent need them. Although there is benefit in families learning to problem solve on their own, challenges may arise that parents want to discuss with their HVs. Often, this cannot wait until their next home visit. It would be beneficial to have an after hour's number that parents could call to assist them with concerns they feel cannot wait until their next visit. This would further promote the mental health of parents when they know they have someone they can call in a time of need.

Curriculum for Different Age Groups

It would be interesting to have a curriculum that promotes the mental health of different age groups. For example, TF could adapt the curriculum to include prevention and promotion activities specific to infants, children, adolescents and fathers. Despite there being a 'Towards Flourishing for All' strategy (which is a Mental Health Promotion tool adapted from the TF curriculum), it is not specific to different population groups. Tailoring TF will not only strengthen the program, it may engage other members of the household that may otherwise not be involved. One way of doing this would be to personalize a binder for each family member based on their age group.

Increasing Focus on Fathers

The majority of home visits are with mothers and children, with very few fathers present. This is most likely due to mothers being off on maternity leave, and home with their

infant, whereas paternity leave is often of shorter duration. Moreover, most of the information is geared towards mothers, children and the postpartum period.

There are limited mental health resources, services and supports for fathers, in particular for those living rurally. For example, 'Coping with Change' is a support group that is intended for mothers who are transitioning to parenthood, however there are no community support groups of this kind specifically for fathers. This gap in service places limitations on mental health services for fathers. Considering the important role that fathers have in parenting, it is imperative that fathers' mental health needs are met. One way of strengthening the TF program would be to have a support group for fathers transitioning to parenthood.

Recommendations for Strengthening Community Mental Health Supports for Families

TF is positively impacting families' mental health through home visiting services, everyday strategies and support. Nevertheless, there are a few recommendations to strengthen community mental health supports for families.

Mental Health Support for Home Visitors

Prior to having the TF program, HVs had limited guidance on supporting the mental health needs of families. However, with the implementation of TF, HVs were provided with a mental health promotion curriculum, along with the support of the MHPF. In an effort to strengthen mental health supports in the community, it would be beneficial to include outreach by means of connecting with the most disadvantaged families in the community. This may include developing the role of the MHPF, or possibly having more mental health workers available in the community. In order for this to occur, there needs to be increased funding for mental health supports in the community (VIRGO, 2018; Mental Health

Commission of Canada, [MHCC], 2015).

Historically, mental health funding has been chronically neglected (Baiiram, 2017), however recently the federal government has shown a commitment to Canadians with five billion dollars being transferred to provinces. The Mental Health Commission of Canada (MHCC) (2015) showed a commitment to changing the lives of those with mental illness by strengthening and increasing services and supports. This may be the catalyst for changing attitudes towards those with mental illness and increase funding at all government levels.

Improving the Mental Health of Indigenous Peoples

Manitoba's high percentage of Indigenous peoples is important in the context of strategic planning of mental health promotion programs. In particular, this population has the highest rates of depression and anxiety as compared to the rest of the province (Katz, et al., 2019; VIRGO, 2018). In an effort to understand Indigenous mental health, the province needs to inquire into the challenges and barriers that exist with this group.

A community needs assessment was conducted with focus groups consisting of both youth and adults living on Opaskwayak Cree Nation. One of the key highlights of this study was that over 50% of adults were diagnosed with depression, with very few community members accessing mental health counselling services (VIRGO, 2018). The VIRGO report made several recommendations for supporting the mental health of Indigenous peoples which includes: engaging Indigenous communities in the discussion, and include Indigenous health care professionals in system planning. This will assist with breaking down the jurisdiction barriers that impact both accessibility and coordination. Increasing cultural competency in health care providers along with cultural safety of clients may reduce the

demand for intensive services.

The province needs to sustain better efforts to meet the mental health needs of First Nations peoples. This may include more culturally informed services, land based programs and support for languages other than English (VIRGO, 2018). The mental health care system will not be able to meet the mental health needs of First Nations peoples unless there is a concerted and sustained effort to better meet the holistic needs of this population group.

Recommendations for Future Research

This was a relatively small study which, as most good studies do, raises even more questions than it answers. There are several potential areas for future research.

- It would be useful to follow up with participants (parents and HVs) to determine how sustainable the positive effects of the TF program are. This would identify if there are any changes that may need to be made to the program to increase sustainability.
- Further expansion on the scope of this research study to include all areas of Manitoba, and not just one health region, would also be helpful. This would allow for a larger sample size, which would provide more information about TF, as well as illuminating any differences between regions.
- Another recommendation would be to explore how TF can better meet the mental health needs of fathers. Further understanding of father's perception of TF would allow for an opportunity to enhance the program to increase engagement.
- The Truth and Reconciliation Commission of Canada (Truth and Reconciliation Commission of Canada) acknowledges the historical injustices and harms experienced by First Nations peoples. It would be interesting to evaluate the extent to which the main TF program is meeting the cultural needs of Indigenous clients. This

would allow for an opportunity to explore differences in cultural perspectives of mental health between Indigenous and non-Indigenous parents and HVs. Cultural aspects of mental health are important to explore since they influence beliefs about the origin and nature of mental health and wellness.

In summary, the above recommendations allow for opportunities to explore and expand on the research topic. By further expanding on research involving TF, there are opportunities to enhance TF for families and HVs.

Conclusion

Community-based mental health promotion programs are essential to the integrated health care system, in particular for disadvantaged families with young children. This study provided first-hand perspectives of 10 parents and 10 HVs participating in the TF program in one rural region of Manitoba. The results of this study demonstrated the impact that the SDOH have on families' mental health and well-being, with supports having the strongest overall impact. These findings were similar to the recent VIRGO report (2018) which indicates the impact that the SDOH have on mental health, and the need for more supports to be in place to assist those at risk for mental disorders. The VIRGO report was based on a team of experts that implemented a comprehensive qualitative and quantitative assessment of system-wide strengths and challenges, with respect to service access and coordination of mental health services in the province of Manitoba. According to this report, the mental health needs of Manitoban's are costly, begin in early childhood, evolving, population specific, and have solutions. Ultimately, there is a need for government policies that will improve income and housing security, and address the lack of accessible transportation services for families living in rural areas of the province, as inadequate access to these social

determinants of health were identified as key factors negatively influencing the mental well-being of parents in this study.

Study findings show that the TF program is positively impacting families' mental health and well-being by providing them with some of the necessary resources and supports to meet their mental health needs—i.e., TF is helping families to flourish. TF also addresses system-wide challenges with respect to accessibility of mental health services for families by providing home visits and a connection to a MHPF. This will only improve families' ability to access community mental health services and resources. However, more can be done, and recommendations for strengthening the TF program and community mental health resources and supports have been identified.

There is limited research on the impact of community-based mental health promotion programs as it relates to families' mental health, particularly for families living in rural Canada. This study paints a vivid picture of the mental health challenges faced by structurally disadvantaged families living in rural Manitoba and contributes to our understanding of the effectiveness of mental health promotion programs for this population.

Although further research is needed, this study provides important knowledge that gives meaning to both parents' and HVs' perspectives about what families need to be mentally healthy, and evidence of the effectiveness of TF on promoting families' mental health.

References

Allen, J., Balfour, R., Bell, R., & Marmot, M (2014). Social determinants of mental health. *International review of psychiatry*, 26 (4).

Al-Modallal, H., Abuidhail, J., Sowan, A., &Al-Rawashdeh, A. (2010). Determinants of depressive symptoms in Jordanian working women. *Journal of psychiatric and mental health nursing*.

American Psychiatry Association (2013). Diagnostic and Statistical Manual of Mental Disorders 5th Edition. Retrieved from https://www.psychiatry.org/psychiatrists/practice/dsm

Avdesh, S., Sujatham D., Sharma, M., (2017)). Mental health promotion: a narrative review of emerging trends. *Psychiatry, Medicine and Behavioral Sciences.* 30(5) p339-345.

Blumenthal, J. (2019). Music Therapy for Healthy Children and Families. *Healthy Child.* Retrieved from https://www.healthychild.com/music-therapy-for-healthy-children-and-families/

Brownell, M., Chartier, M., Nickel, N., Chateau, D., Martens, P., Sarkar, J., Burland, E., Jutte, D., Taylor, C., Santos, R., Katz, A. (2016). Unconditional Prenatal Income Supplement and Birth Outcomes. *Pediatrics*,137 (6).

Brownell M., Chartier M., Santos R., Ekuma O., Au W., Sarkar J., MacWilliam, L., Burland, E., Koseva, I., Guenette, W. (2012). How Are Manitoba's Children Doing*? Manitoba Centre for Health Policy*.

Canadian Institute for Health Information (2009). *Improving the health of Canadian: Exploring positive mental health.*

Canadian Mental Health Association (2017). *Mental health promotion in Ontario: a call to action.* Retrieved from http://ontario.cmha.ca/documents/mental-health-promotion-in-ontario-a-call-to-action/

Chartier, M., Nickel, N., Enns, J., Chateau, D. (2012). Home visiting programmes should be recognised as effective strategies for improving child outcomes and reducing population-level health and social inequities. Journal of epidemiology and community health. doi10.1136/jech-2017-209321

Chartier, M., Attawar, D., Volk, J., Cooper, M., Quddus, F., & McCarthy, J. (2015). Postpartum Mental Health Promotion: Perspectives from Mothers and Home Visitors. *Public Health Nursing*, 32 (6).

Chartier, M. (2015). *Towards Flourishing: Mental Health Promotion of Families. A final report on the Public Health Agency –Innovation Strategy funded demonstration project*.

Chartier, M., Nickel, N., Chateau, D., Enns, J., Isaac, M., Katz, A., Joykrishna, S., Burland, E., Taylor, C., & Brownell, M. (2017). Families First Home Visiting programme reduces population-level child health and social inequities. *Epidemiology Community Health.*

Chartier, M. J., Brownell, M. D., Isaac, M. R., Chateau, D., Nickel, N. C., Katz, A., Taylor, C. (2017). Is the Families First Home Visiting Program Effective in Reducing Child Maltreatment and Improving Child Development? *Child Maltreatment*, *22*(2), 121–131. doi.org/10.1177/1077559517701230

Cohen, B., Ateah, C., Chartier, M., Anderson De Coteau, M., Harris, E., & Serwonka, K. (2016). Report of an equity-focused health impact assessment of a proposed universal parenting program in Manitoba. *Canadian Journal of Public Health,* 107(1)

Doi:10.17269/ CJPH.107.5108.

Cohen, G., Weitzman, C. (2016). Helping Children and Families Deal with Divorce and Separation. *Official Journal of the American Academy of Pediatrics.* 110 (5).

Cooklin, A.R., Dinh, H., Strazdins, L., Westrupp, E., Leach, L.S., & Nicholson, J.M. (2016). Change and Stability in work-family conflict and mothers' and fathers' mental health: Longitudinal evidence from an Australian cohort. *Social Science and Medicine*.

Coverdale, G., and Long, A. (2015) Emotional wellbeing and mental health: an exploration into health promotion in young people and families. *Perspectives in Public Health*, 135 (1).

Creswell, J. (1998). Qualitative Inquiry and Research Design: Choosing Among Five Approaches. *Thousand Oaks: Sage publication*.

Currie, S., Fiest, K., & Guyn, L. (2013). Using Community-Level Mental Health Surveillance Data to Examine the Relationship of Depression Prevalence to Social Determinants of Health and Access to Mental Health Services. *Canadian Journal of Community Mental Health* 32(1).

DeSocio, J., (2018). Epigenetics, maternal prenatal psychological stress, and infant mental health. *Archives of Psychiatric Nursing* (32) 901-906.

Doornbos, M., Zandee, G., DeGroot, J., & De Maagd-Rodriguez, M. (2013). Using Community-Based Participatory Research to Explore Social Determinants of Women's Mental Health and Barriers to Help-Seeking in Three Urban, Ethnically Diverse, Impoverished, and Underserved Communities. *Psychiatric Nursing*.

Dodou, H., Rodrigues, D., Costa Lima, A., Oria, M., Castro, R., Mesquita, N., Queiro, A. (2016). Self-Care and Empowerment in Postpartum: Social representation of Puerperae. *International Archives of Medicine.* 9 (17).

Embry, D. D., & Biglan, A. (2008). Evidence-based Kernels: Fundamental units of behavioral influence. *Clinical Child and Family Psychology*.

Enns, J., Holmqvist, M., Wener, P., Halas, G., Rothney, J., Schultz, A., Goertzen, L., & Katz, A. (2016). Mapping interventions that promote mental health in the general population: A scoping review of reviews. *Preventative Medicine*.

Eni, R., and Rowe, G. (2011). Understanding Parenting in Manitoba First Nations: Implications for Program Development. *Family and Community Health*, 34 (3).

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards., V., Koss, M., Marks, J. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventative Medicine.*

First Nations Health and Social Secretariat of Manitoba. *Maternal child health program in first nations communities strengthening families.* Retrieved from *http://www.fnhssm.com/index.php/policy-areas/maternal-child-health*

Frankel, S. (2016). *Manitoba child and family poverty report card.*

Gale, N., Heath, G., Cameron, E., Rashid, S., & Redwood, S., (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13 (117). Doi: 10.1186/1471-2288-13-11

Ganster, D., (1998). The impact of social support on mental health and physical health. *British Journal of Medical Psychology*. 61 (1).

Garcia, C., Hermann, D., Bartels, A., Matamoros, P., Dick-Olson, L., & Guerra de Patino, J., (2012). Development of Project Wings Home Visits, a Mental Health Intervention for Latino Families Using Community-Based Participatory Research. *Health Promotion Practice*, 13 (6).

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4).

Government of Manitoba: Healthy Child Manitoba (2010). *Families First Program Evaluation: Evaluating the effectiveness of the Families First home visiting program in improving the well-being of at-risk families with preschool children*. Accessed from:

https://www.gov.mb.ca/healthychild/familiesfirst/ff_eval2010.pdf

Government of Manitoba: *Healthy Child Manitoba Act*. Retrieved from

https://www.gov.mb.ca/healthychild/about/hcmact.html

Government of Manitoba (2017). Healthy Child Manitoba: *Manitoba prenatal benefit.* Retrieved from https://www.gov.mb.ca/healthychild/healthybaby/mpb.html

Government of Manitoba (2008). Healthy Child Manitoba: *Triple P- The Positive Parenting Program: A Developmental Evaluation of Manitoba's Provincial Implementation*. Retrieved from

www.gov.mb.ca/healthychild/publications/triplep_implementation_fall2010.pdf

Government of Manitoba (2010). *Roots of Empathy: Effectiveness of the roots of empathy program in preventing aggression and promoting prosocial behaviour.*

Government of Manitoba (2012). Mental Health Promotion & Well-Being for First Nations Families: Exploring Cultural Relevance and Meaning. Retrieved from https://www.gov.mb.ca/healthychild/towardsflourishing/tf_mhp_wellbeing_firstnations.pdf

Gulnar, A., Nasreen, L., & Muhammad, A. (2015). Community mental health initiatives in Pakistan. *Journal of Art and Science*, 29 (22).

Herrmann, J., Vogel, M., Pietzer, D., Kroll, E., Wagner, O., Schwarz, S., Muller, E., Kiess, W., Richter, M., Poulain, T. (2017). Factors associated with the emotional health of children: high family income as a protective factor. *Eur Child Adolescent Psychiatry.* 27 (3).

Healthy Child Manitoba: *Towards flourishing strategy.* Retrieved from *https://www.gov.mb.ca/healthychild/towardsflourishing/tf_strategyoverview.pdf*

Hinkle, J. (2014). Population-Based Mental Health Facilitation (MHF): A Grassroots Strategy That Works. *The Professional Counselor.* 4(1) p1-18.

Holloway, I., & Galvin, K., (2016). Qualitative Research in Nursing and Healthcare. *John Wiley & Sons.* Retrieved from

http://ebookcentral.proquest.com/lib/umanitoba/detail.action?docID=4622920

Johnson, K., Woodward, A., Swenson, S., Weis, C., Gunderson, M., Deling, M., Cristiani, V., and Lynch, B., (2017). Parents' adverse childhood experiences and mental health screening using home visiting programs: A pilot study. *Public Health Nursing,* 34 (6).

Katz A, Kinew KA, Star L, Taylor C, Koseva I, Lavoie J, Burchill C, Urquia ML, Basham A, Rajotte L, Ramayanam V, Jarmasz J, Burchill S (2019). *The Health Status of and Access*

to Healthcare by Registered First Nation Peoples in Manitoba. Manitoba Centre for Health Policy.

Keyes, C. (2002). The Mental Health Continuum: From Languishing to Flourishing in Life. *Journal of Health and Social Research,* 43 (6).

Kingston, D., Tough, S., & Whitfield, H. (2012) Prenatal and postpartum maternal psychological distress and infant development: A systematic review. *Child Psychiatry and Human Development,* 43, 683-714. doi: 10.1007/s10578-012-0291-4

Knoke, Della (2009). Early childhood home visiting programs. Center of Excellence for Children's Well-being. Retrieved from https://cwrp.ca/sites/default/files/publications/en/HomeVisiting73E.pdf

Luke, M., and Alavosius, M. (2012). Impacting Community Sustainability through Behavior Change: A Research Framework. *Behavior and Social Issues.* 21 (1).

Manitoba child and family poverty report card 2015: A crisis that has become chronic. Retrieved from http://winnipegharvest.org/wp-content/uploads/2011/04/Manitoba-Child-and-Family-Poverty-Report-Card-2015.pdf

Mattejat, F., and Remschmidt, H. (2008). The Children of Mentally Ill Parents. Deutsches *Arzteblatt International*,105 (23).

Mental Health Commission of Canada (2012). *Mental Health Strategy for Canada: Changing directions, changing lives*. National Library of Canada.

Mental Health Commission of Canada (2015). *Statement on the future of mental health in Canada*. Retrieved from *http://www.mentalhealthcommission.ca/English/*

Membride, H., (2016). Mental health: early intervention and prevention in children and young people. *British Journal of Nursing,* 25 (10).

Montgomery, Phyllis., Brown, Stephanie., and Forchuk, Cheryl., (2011). Social Determinants of Health and Health Outcomes in Men and Fathers with Mental Health Issues. *Social Work in Mental Health*. 9 (2).

Mordoch, E., Hall, W., (2008). Children's Perceptions of Living with a Parent with a Mental Illness: Finding the Rhythm and Maintaining the Frame. *Qualitative Health Research*.

Munhall, P. (2012). *Nursing research: A qualitative perspective* (5th ed.). Mississauga; Jones & Bartlett.

Murphy, J., Pavkovic, M., Sawula, E., Vandervoot, S. (2015). Identifying areas of focus for mental health promotion in children and youth for Ontario public health.

Nanninga, M., Jansen, D., Knorth, E., & Reijneveld, S. (2015). Enrolment of children and adolescents in psychosocial care: more likely with low family social support and poor parenting skills. *European Child & Adolescent Psychiatry,* 24 (4).

National Collaborating Centre for Aboriginal Health (2013). *Fatherhood is forever: a resource booklet about fathering for first nations and metis parents in BC.* Retrieved from http://www.fnha.ca/wellnessContent/Wellness/fatherhood-is-forever.pdf

National Collaborating Centre for Aboriginal Health (2009-2010). *Social Determinants of Health: Poverty as a Social Determinant of First Nations, Inuit and Metis Health.* Retrieved from

http://www.nccahccnsa.ca/docs/fact%20sheets/social%20determinates/NCCAH_fs_poverty_EN.pdf

National Collaborating Centre for Determinants of Health (2017). *Foundations: definitions and concepts to frame population mental health promotion for children and youth*. Retrieved from http://nccph.ca/images/uploads/general/02_Foundations_MentalHealth_NCCPH_2017_EN.pdf

National Collaborating Centre for Determinants of Health (2016). *Health Equity 2.0.* Retrieved from www.nccdh.ca/resources/entry/health-equity-tools-2.0

National Collaborating Centre for Healthy Public Policy (2017). *Population mental health in Canada: summary of emerging needs and orientation to support the public health workforce.* Retrieved from *http://www.ncchpp.ca/553/Publications.ccnpps?id_article=1654*

Nelson, S., Wilson, K. (2017). The mental health of Indigenous peoples in Canada: A critical review of research. *Social Science and Medicine*. 176, p 93-112.

Nobody's Perfect (2017). Retrieved from *http://nobodysperfect.ca/home/*

Paananen, R., Ristikari, T., Merikukka, M. & Gissler, M. (2013). Social determinants of mental health: A Finnish nationwide follow-up study on mental disorders. *Journal of Epidemiology Community Health.*

Pan-Canadian Inventory of Public Health Early Child Home Visiting (2009). *National collaborating center for determinant of health.*

Peacock, S., Konrad, S., Watson, E., Nickel, D., Muhajarine, N., (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC Public Health.* 13 (17).

Peter, T., Roberts, L., Dengate, J. (2011). Flourishing in Life: An Empirical Test of the Dual Continua Model of Mental Health and Mental Illness among Canadian University Students.

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). China: Wolters Kluwer Health/ Lippincott Williams & Wilkins.

Public Health Agency of Canada (2017). *What determines health?* Retrieved from www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants

Roberts, G &Grimes, K. (2011). Return on Investment: Mental Health Promotion and Mental Illness Prevention. *Canadian Psychological Association*.

Saeri, A., Cruwys, T., Barlow, F. Stronge, Sibley, C. (2018). Social connectedness improves public mental health: Investigating bidirectional relationships in the New Zealand attitudes and values survey. *Australian and New Zealand Journal of Psychiatry.* 52 (4), 365-374.

Saldana, J. (2009). *The coding manual for qualitative researchers*. Los Angeles, CA: Sage.

Santos, R., Chartier, M., Whalen, J., Chateau, D., & Boyd, L. (2011) Effectiveness of school-based violence prevention for children and youth: Cluster randomized controlled field trial of the Roots of Empathy program with replication and 3-year follow-up. *Healthcare Quarterly.Vol.14.*

Satyanarayana, V. A., Lukose, A., & Srinivasan, K. (2011). Maternal mental health in pregnancy and child behavior. *Indian Journal of Psychiatry,* 53(4). Retrieved from http://doi.org/10.4103/0019-5545.91911

Simon, K., Beder, M., Manseau, M. (2018). Addressing Poverty and Mental Illness. *Psychiatric Times.* 35 (6).

Smith, N., Siriwardhana, C., Hotopf, M., & Hatch, S. (2015). Social Networks, social support and psychiatric symptoms: social determinants and associations within the multicultural community population. *Soc Psychiatry Psychiatric Epidemiology*.

Song, J., Kim, T., & Ahn, J. (2015). A Systematic Review of Psychosocial Interventions for Women with Postpartum Stress. *Journal of Obstetrical Gynecological and Neonatal Nursing*.

Stewart-Brown, S., & Schrader-McMillan, A. (2011). Parenting for mental health: what does the evidence say we need to do? *Health Promotion International*, 26 (1).

Stewart, D., &Vigod, S. (2016). Postpartum Depression. *The New England Journal of Medicine*.

Streubert, H., & Carpenter, D., R. (2011). Qualitative research in nursing; *Advancing the humanistic imperative* (5th ed). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Supplee and Adirim (2012). Evidenced-based home visiting to enhance child health and child development and to support families. American Psychological Association. pg.1-5.

Underwood and Farrington-Flint (2015). Learning and the E generation. *John Wiley and Sons*. Pg.1-217.

UNICEF (2011). *Early Childhood Development: The key to a full and productive life*.

Turner, R.J., and Brown, R.L., (2010). Social Support and Mental Health. *A Handbook for the study of mental health. Second Edition.*

Truth and Reconciliation Commission of Canada: National Center for Truth and Reconciliation retrieved from http://www.trc.ca/

Welsh, J., Strazdins, L., Ford, L., Friel, S., O'Rourke, K., Carbone, S., & Carlon, L. (2015). Promoting equity in the mental wellbeing of children and young people: a scoping review. *Health Promotion International*, 30 (2).

Wille, N., Bettge, S., Ravens-Sieberer, U., & the BELLA study group, (2008). Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. *Eur Child Adolescent Psychiatry*, 17 (1).

Winnipeg Regional Health Authority (2014). The Culture of Well-Being. For First Nations, Metis and Inuit people in Winnipeg. Retrieved from https://www.wrha.mb.ca/indigenous-health/services/files/MentalHealthGuide.pdf

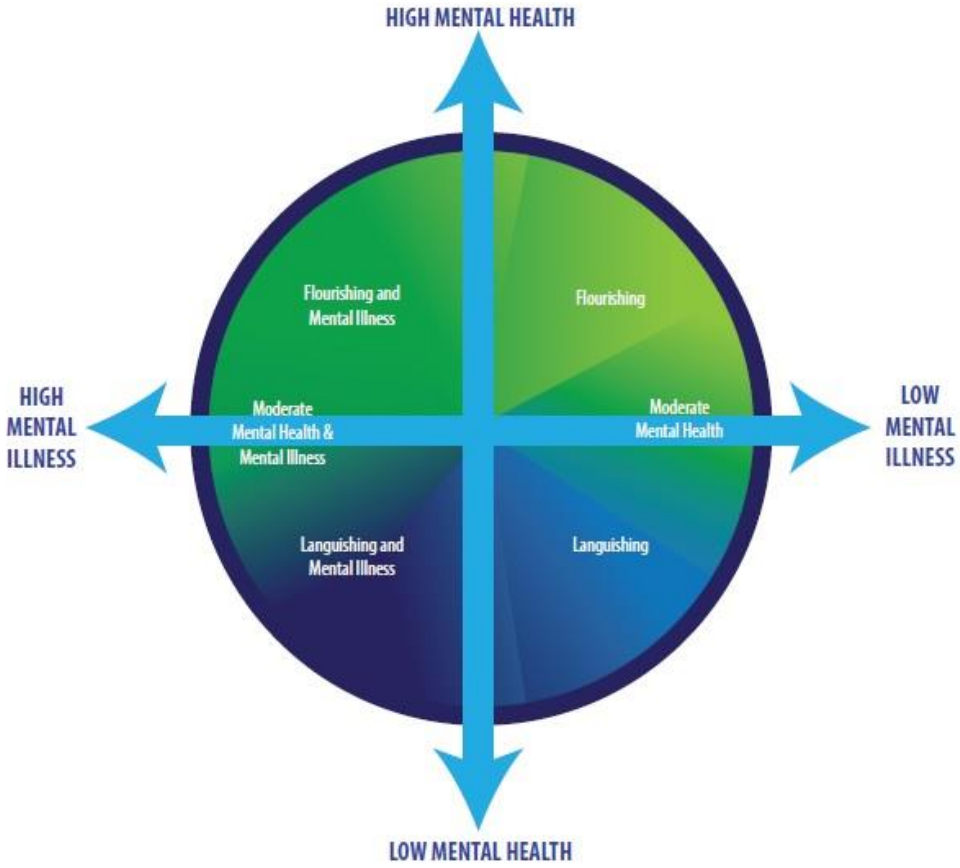
World Health Organization [WHO] (2014). *Social Determinants of Health*. Retrieved from http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf

Yearwood., E. (2010). Culture Bound: The Social Determinants of Health and Mental Health: Global Foundations for Improving Child and Family Mental Health. *Journal of Child and Adolescent Psychiatric Nursing.*

Zimmerman, F. (2005). Social and Economic Determinants of Disparities in Professional Help-Seeking for Child Mental Health Problems: Evidence from a National Sample. *Health Services Research*, 40 (5).

Appendix A

Keyes' Mental Health Dual Continuum



Appendix B

Towards Flourishing Strategies

Table 1: Nine Everyday Strategies

Strategy	Description
Nasal Breathing	This strategy may be used to help a person feel calmer and more relaxed quickly. It involves taking long deep breaths through the nose (or mouth if that is more comfortable) for 3-10 breaths and then return to normal breathing. It may be used when a person is feeling stressed, upset, frustrated or anxious. It should feel good, not uncomfortable with a calming and relaxing effect. When a person is calm, they are able to think more clearly in times of stress. Nasal breathing helps to lower the brains temperature, cool down emotions, and decrease anxiety. It can also prevent hyperventilating by allowing more oxygen to the brain. The benefits of this strategy include feeling calmer, more relaxed, mindful, and able to think clearer.
Creating a Vision	This strategy involves writing down thoughts and ideas that parents feel would contribute to a flourishing life. It allows parents to think about a vision, writing down goals makes a person more likely to work towards them. Parents are provided with a handout and encouraged to fill out their goals; children may also write down the goals they are working towards. Everyone benefits from working towards goals, having hopes, and dreams for their future, which increases life satisfaction. The benefits of this strategy include mindfulness, envisioning the future and goal setting.
Belonging	An important aspect of how we view and feel about ourselves as individuals comes from where we feel a sense of belonging. Feeling a sense of belonging and engaging with others of shared values impacts mental health. In fact, having a sense of belonging impacts self-esteem and self-identity. Children may be encouraged to draw a picture of groups or activities they belong to. The benefits of this strategy include improving self-esteem, self-identity, positive mental and social health.
Three good things	This strategy involves taking the time to recognize, and reflect on the positive things one experiences throughout their day. Recognizing what is good in our lives allows us to feel more positive, and reflecting on the positives can lead to a greater appreciation of strengths and supports. Moreover, when we learn to think more positive it shifts our way of thinking, and increases our mental wellness raising our overall satisfaction in life. Parents and children are encouraged to take the time to think about, and write down three good things about their day. It can be small and simple such as taking a hot bath or having time together as a family. The benefits of this strategy include increased positive thinking, being present, and a greater appreciation for life.
Connecting with others	Social connections have a huge impact on our health and well-being. Feeling connected contributes to positive mental health. When people feel connected they feel more supported, less isolated and part of the greater community. Sharing similar circumstances is empowering and allows us to feel less alone in our struggles. This strategy encourages parents to think about who they connect with, the benefits of connecting with others, and how they could improve those connections. This may include socializing your preschooler with play dates or volunteering at their school. These social connections have the potential to positively impact the mental health and well-being of families. The benefits of connecting with others include less likely to experience sadness, loneliness, low self-esteem, and problems with eating and sleeping.
Physical activity	Everyone benefits from being physically active, which can increase energy levels. Being physically active may include simple activity

	breaks like walking outside, dancing or playing in the park, all of which can decrease stress and feelings of anxiety. It is recommended that ten minutes of physical activity two to three times a day can benefit overall health, and decrease the likelihood of many health related illnesses such as type 2 diabetes, high blood pressure, stroke and some cancers. The benefits of this strategy include, increased energy, decreased stress, and feelings of anxiety and depression, helps to maintain body weight, and decrease certain health related illnesses
Self-monitoring	Recognizing what we want to improve in our lives can give us meaning and direction. Self-monitoring involves choosing a simple goal and keeping track of progress to reach that goal. Goal setting and planning tasks is a strategy that can be used to improve motivation, increase self-efficacy, and assist in making improvements in one's life. Moreover, engaging in goal setting exercises can help provide a direction and tracking one's success can reinforce motivation and enhance self-confidence. Children over the age of two are encouraged to set small, manageable goals using a check list to keep track. The benefits of this strategy include improved self-esteem and goal setting.
Three-minute breathing break	Taking a short break can help a person manage stress more effectively while being present in the moment. It allows a person to check in with their feelings, get in touch with themselves and make better decisions. Often, we are so focused on doing things for others and get caught up in our day to day functioning that we forget to take a minute to check in with ourselves and be present in the moment. The benefits of taking a three-minute breathing break include, being present, mindful, checking in with oneself, and better decision making.
Progressive muscle relaxation	This deep relaxation technique aims to relax the entire body while controlling symptoms of stress, anxiety and insomnia. It involves stretching, tensing and relaxing different muscle groups. When a person is more relaxed it makes it easier to cope with life stressors. It also allows a person to recognize when they are tense or anxious, and when they are feeling relaxed. This strategy may assist with reducing headaches and backaches caused by stress and muscle tension. It is also highly recommended to use with children. The benefits may include feeling calmer, more mindful, relaxed and decreased tension.

Appendix C
Question Guide for Parents

Script: "Thank you for agreeing to participate in this interview. Over the past year, your home visitor has been using resources called Towards Flourishing with you and your family. I would like to begin by asking you about your experience with these resources and the impact on you and your family's mental well-being (a positive sense of emotional well-being) and what your family needs to be mentally healthy. As a parent receiving these resources, your feedback is very valuable. It is expected that your views and suggestions will be used to improve the program for other families across Manitoba. Your participation is greatly appreciated."

The Towards Flourishing curriculum will be brought to the interviews

1) Please tell me about your experience with the Towards Flourishing resources.
   a) How long have you been using them?
   b) What is your overall impression of the resources?
2) In what ways has the Towards Flourishing resources helped you and your family's mental well-being?
   a) Do you feel the resources are important to parents and children's well-being? Is so, please explain.
3) Have you noticed a difference in how you feel since using the Towards Flourishing resources (i.e.: everyday strategies)?
   a) If so, please explain.
   b) What about your family members?
4) What do you and your family need to be mentally healthy?
5) What does your family struggle with the most?
6) How could Towards Flourishing be improved to better meet your families' mental health needs?
7) Has Towards Flourishing increased your knowledge of resources available in your community?
   If so, please explain.
8) Which of the Towards Flourishing strategies did you find the most helpful to you and your family?
9) Did your home visitors go through a particular topic that you found helpful?
10) Is there anything else that you would like to add that we haven't already discussed.

Appendix D
Question Guide for Home Visitors

Script: "Towards Flourishing (TF) was developed to respond to the needs of families during the postpartum period. This study aims to learn more about what is working well with TF and what isn't working well. Thank you for agreeing to participate in this interview. Over the past year, you have been using TF resources with parents during home visits. I would like to begin by asking about your experience with the resources and its impact on your families' mental health and well-being. I would also like to hear your views on what factors affect your families' mental health and what your families need to be mentally healthy. Your role as a home visitor and feedback is valuable. It is expected that your suggestions will be used to improve TF for other families across Manitoba. Your participation is greatly appreciated.

1) How long have you worked as a home visitor with the Towards Flourishing program in the Interlake-Eastern region?

2) Please tell me what you think about the Towards Flourishing program.
a) What is your overall impression of the program?

3) In what ways has the program impacted the mental health of the families that your work with?

4) What factors contribute to your families' mental health and well-being?

5) What do your families struggle with the most?

6) What do your families need to be mentally healthy?

7) Does the program meet your families' mental health needs?
a) If so, please explain.

8) How could the program be improved to better meet your families on program mental health needs?

9) Has the program increased your families' awareness of mental health resources?

10) Is there anything else that you would like to add that we haven't already discussed?

Appendix E

INVITATION TO PARTICIPATE IN A RESEARCH STUDY: FAMILIES FIRST COORDINATORS

Researcher: April Gage RN, BN, MN Graduate Student, College of Nursing, University of Manitoba [redacted]
Research Supervisor: Dr. Benita E. Cohen, RN, PhD, Associate Professor, College of Nursing, Faculty of Health Sciences, [redacted]

March 5th, 2018

Dear Families First Coordinators,

This letter is to inform you of the research project titled "Towards Flourishing: Perspectives of Parents and Home Visitors", that I would like to conduct with parents and home visitors on the Families First program in Interlake, Manitoba. The purpose of this study is to better understand the impact of the Towards Flourishing (TF) strategy on parent(s') mental health and well-being. The information gathered in this research study will be used to complete a Master's thesis. I am asking for the Coordinators' assistance with mailing invitation letters (attached) to all parent(s) and home visitors that meet the inclusion criteria. Inclusion criteria for parents will be: English speaking, 18 years or older, those who have scored +25 or greater on a parent survey (excluding clinically positive), have voluntarily enrolled in program, and have been on program for at least six months. Inclusion criteria for home visitors will be: English speaking, have taken TF training and are using the strategy with families, and have been a home visitor for 12 months or greater. After the invitation letters have been distributed, those individuals that are interested in participating in the study will be invited to contact the researcher directly. In order to maintain anonymity, it is important that you do not know which parent(s) and home visitors are participating in the study. It is anticipated that the information gathered in this research study will be used to improve future programming for families. If you have any questions or concerns regarding this research study, please do not hesitate to contact the researcher April Gage [redacted]. Your assistance is greatly appreciated!

Thank you,

April Gage

*This study has been reviewed and received ethical approval through the University of Manitoba Research Ethics Board and the Interlake-Eastern Regional Health Authority.

Appendix F

INVITATION TO PARTICIPATE IN A RESEARCH STUDY: HOME VISITORS

Researcher: April Gage RN, BN, MN Graduate Student, College of Nursing, University of Manitoba, [redacted]
Research Supervisor: Dr. Benita E. Cohen, RN, PhD, Associate Professor, College of Nursing, Faculty of Health Sciences, [redacted]

March 5th, 2018

Dear Home Visitor,

You have been invited to participate in a research project titled "Towards Flourishing: Perspectives of Parents and Home Visitors. The purpose of this study is to better understand the impact of the Towards Flourishing (TF) strategy on parent(s') mental health and well-being. As a home visitor involved with TF, you are in an ideal position to give valuable, first-hand information from your perspective. Your involvement would include an informal, 45-minute interview, and you will receive a $25 gift card for your participation. It is expected that the information gathered will be used to improve future programming for families. The information gathered from this research study will be used to complete a Master's thesis, and a summary of the results will be shared with participants, the University of Manitoba, Families First and the Interlake-Eastern Regional Health Authority. Every effort will be made to assure participants' confidentiality. If you would like to participate, please contact myself, the researcher April Gage [redacted]. Your participation is greatly appreciated!

Thank you,

April Gage

This study has been reviewed and received ethical approval through the University of Manitoba Research Ethics Board and access approval from the Interlake-Eastern Regional Health Authority

Appendix G

INVITATION TO PARTICIPATE IN A RESEARCH STUDY: PARENTS

Researcher: April Gage RN, BN, MN Graduate Student, College of Nursing, University of Manitoba, [redacted]
Research Supervisor: Dr. Benita E. Cohen, RN, PhD, Associate Professor, College of Nursing, Faculty of Health Sciences, 377 Helen Glass Centre for Nursing, 89 Curry Place, Winnipeg, MB R3T 2N2 [redacted]

March 5th, 2018

Dear Parent(s),

You have been invited to participate in a research project titled "Towards Flourishing: Perspectives of Parents and Home Visitors". The purpose of this study is to better understand the impact of the Towards Flourishing (TF) strategy on parent(s') mental health and well-being. As a parent involved with TF, you are in an ideal position to give valuable, first-hand information from your perspective. Your involvement would include an informal, 45-minute interview, and you will receive a $25 gift card for your participation. It is expected that the information
gathered will be used to improve future programming for families. All parents are encouraged to participate including single parents, fathers and parents of culturally diverse backgrounds. The information gathered from this research study will be used to complete a Master's thesis, and a summary of the results will be shared with participants, the University of Manitoba, Families First and the Interlake-Eastern Regional Health Authority. Every effort will be made to assure participants' confidentiality. If you would like to participate, please contact myself, the researcher April Gage [redacted] Your participation is greatly appreciated!

Thank you,

April Gage

This study has been reviewed and received ethical approval through the University of Manitoba Research Ethics Board and the Interlake-Eastern Regional Health Authority

Appendix H

Informed Consent Form for Parents

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: Towards Flourishing: Perspectives of Parents and Home Visitors.

Researcher: April Gage RN, BN, MN Graduate Student, College of Nursing, University of Manitoba, [redacted]

Research Supervisor: Benita E. Cohen, RN, PhD, Associate Professor, College of Nursing, Faculty of Health Sciences 377 Helen Glass Centre for Nursing, [redacted]

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of Study

This research study is being conducted to fu1iher understand parents and home visitors' perspectives of the Towards Flourishing program, and in particular the effects on themselves and their families' mental well-being. There will be a recruitment of up to 10 parents and up to 10 home visitors to participate in the study.

Study Procedures

If you take part in this study you will be participating in a one time, in person, 45-minute minute interview with the researcher, April Gage. Interviews will take place at your home or another location that is convenient for you. The interviews will be audio recorded using a hand held digital device and will be transcribed verbatim by a hired transcriptionist who will sign an oath of confidentiality. Data collected will be stored in a secure database and only the researcher and her advisor will have access to the information after the transcriptionist has finished their work. The researcher may also write some reflective notes during the interview. These notes will contain information such as the researcher's thoughts, ideas, questions, concerns, and insights into her observations providing the foundation for analytical writing and conceptual reasoning.

Participants will be asked questions about the Towards Flourishing (TF) strategy and their mental health and well-being such as "please tell me about your experience with the TF resources", and "in what ways has TF helped you and your family's well-being?".

Risks and Discomforts

There may be some potential for anxiety related to the sensitive nature of the questions. You can stop participating at any time. However, if you decide to stop participating in the study, we encourage you to talk to the researcher first.

Benefits

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit other families and home visitors involved with TF in the future. Participants will receive a debriefing of the study (by choice of mail or email) within 6 months from the end of the research study.

Costs

All the procedures, which will be perfo1med as part of this study, are provided at no cost to you.

Honorarium

Participants will receive an honorarium in the form of a $25 gift certificate, which will be given at the beginning of the interview by the researcher.

Confidentiality

Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All study related documents including electronic databases will bear only assigned initials of participants. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may inspect and/or copy this research study for quality assurance and data analysis purposes. All data containing participant's initials will be destroyed by December 31, 2018.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your care.

Questions

You are free to ask any questions that you may have about your treatment and your rights as a research participant. If any questions come up during or after the study or if you have a research-related injury, contact the Principle Investigator April Gage [redacted] For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with principle investigator April Gage and or her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or

family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as info1med as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Human Ethics Research Board. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Participant signature._____ Date_____
(day/month/year)

Pa11icipant printed name:_____

Please indicate if I may contact you to review your transcript (written version of your interview) for accuracy.

YES NO

Results of the study

At the end of the study, within 6 months a summary of the study findings will be created. If

you would like to receive a mailed or emailed copy please provide your address (mail or email) in the space below.

Mailing Address:

_____

_____

_____

And/or

Email Address:

_____

_____

Appendix I

Informed Consent Form for Home Visitors

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: Towards Flourishing: Perspectives of Parents and Home Visitors.

Researcher: April Gage RN, BN, MN Graduate Student, College of Nursing, University of Manitoba, [redacted]

Research Supervisor: Benita E. Cohen, RN, PhD, Associate Professor, College of Nursing, Faculty of Health Sciences 377 Helen Glass Centre for Nursing, [redacted]

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of Study

This research study is being conducted to further understand parents and home visitors' perspectives of the Towards Flourishing program, and in particular the effects on themselves and their families' mental well-being. There will be a recruitment of up to 10 parents and up to 10 home visitors to participate in the study.

Study Procedures

If you take part in this study you will be participating in a one time, in person, 45-minute interview with the researcher. Interviews will take place at your home or another location that is convenient for you. The interviews will be audio recorded using a hand held digital device and will be transcribed verbatim by a hired transcriptionist who has signed an oath of confidentiality. Data collected will be stored in a secure database and only the researcher and her advisor will have access to the information after the transcriptionist has finished their work. The researcher may also write some reflective notes during the interview. These notes will contain information such as the researcher's thoughts, ideas, questions, concerns, and insights into her observations providing the foundation for analytical writing and conceptual reasoning.

Participants will be asked questions about the Towards Flourishing (TF) strategy and their mental health and well-being such as "please tell me about your experience with the TF resources", and "in what ways has TF helped you and your family's well-being?".

Risks and Discomforts

There may be some potential for anxiety related to the sensitive nature of the questions. You can stop participating at any time. However, if you decide to stop participating in the study, we encourage you to talk to the researcher first.

Benefits

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit other families and home visitors involved with TF in the future. Participants will receive a debriefing of the study (by choice of mail or email) within 6 months from the end of the research study.

Costs

All the procedures, which will be performed as part of this study, are provided at no cost to you.

Honorarium

Participants will receive an honorarium in the form of a $25 gift certificate, which will be given at the beginning of the interview by the researcher.

Confidentiality

Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All study related documents including electronic databases will bear only assigned initials of participants. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may inspect and/or copy this research study for quality assurance and data analysis purposes. All data containing participant's initials will be destroyed by December 31, 2018.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your care.

Questions

You are free to ask any questions that you may have about your treatment and your rights as a research participant. If any questions come up during or after the study or if you have a research- related injury, contact the Principle Investigator April Gage [redacted] For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with principle investigator April Gage and or her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study. Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Human Ethics Board. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Human Ethics Research Board. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122. A copy of this

consent form has been given to you to keep for your records and reference.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Participant signature_____ Date_____
(day/month/year)

Participant printed name:_____

Please indicate if I may contact you to review your transcript (written version of your interview) for accuracy.

YES NO

Results of the study

At the end of the study, a summary of the study findings will be created. If you would like to receive a mailed or emailed copy please provide your address (mail or email) in the space below.

Mailing Address:

_____

_____

_____

And/or

Email Address:

_____

_____

Appendix J
Transcriptionist Confidentiality Form

I understand that the digital audio-recordings given to me to transcribe are data from a research project and that according to ethical principles of the research process, I am bound to uphold the confidentiality of the research process. This means that I will keep confidential all matters pertaining to the identity of the participants involved in the project. I will discuss the research project only with the researcher and keep confidential all matters associated with this process.

During the course of the transcription of the interview recordings, in order to maintain confidentiality, I will refer to the participants and any other individuals mentioned by pseudonym only. I understand that participant's names are not to appear on any transcribed data. Upon completion of my work on this project, I will return all research data to the researcher and will not keep any electronic or hardcopies of the transcripts or recordings.

Transcriber.....

Witnessed by Researcher.....

Date.....