PEOPLE IN CRISIS

Program Evaluation

Presented to:
Victorian Order of Nurses
by
The Edmonton Social Planning Council

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INTRODUCTION

BACKGROUND

The Victorian Order of Nurses People in Crisis program provides professional nursing care to victims of family violence and those who have suffered other disruptions to normal family living. Through this program, the V.O.N. offers a variety of nursing services to residents of three battered women's shelters (WIN House I, WIN House II and Safe Place) as well as to the Youth Emergency Shelter.

Demand for this nursing service has increased dramatically with the result that severe strains have been placed on program resources. To attempt to meet this increasing demand, V.O.N. has proposed to expand the People In Crisis program. However, an evaluation of the current program was deemed essential before any substantial expansion of the program was implemented.

In June of 1986, V.O.N. contracted with the Edmonton Social Planning Council to undertake a comprehensive evaluation of the People in Crisis program. This document describes the evaluation, reports the findings of the study and offers a number of recommendations for the consideration of the V.O.N. Board of Directors.

Because expansion of the program to include the Youth Emergency Shelter was just occuring as this evaluation began, the focus of the study was on the nursing service offered at the three women's shelters. Consequently, while this report does make references to the program at Y.E.S.S., the majority of comments pertain only to the nursing services at WIN House and Safe Place shelters.

PURPOSE

The purpose of this study was to conduct a comprehensive summative evaluation of the People In Crisis program. The information gathered through the evaluation study was viewed as essential in:

a) making informed decisions regarding future directions for the program; and

b) making adjustments and improvements to the service currently in place.

The overall goals of the evaluation were:

- to determine the effectiveness of the People In Crisis program
- to identify the strengths and weaknesses of the program and to indicate where changes may be required to improve the program
- to provide information to assist in funding decisions
- to devise a system for ongoing data collection and monitoring

ORGANIZATION OF THE REPORT

This report comprises five sections and appendices. The first section is an introductory section containing the background and purpose of the study.

Section 2 describes the overall approach to the evaluation, the process followed and the methodology used.

Section 3 contains the evaluation questions which guided the research.

Section 4, which is by far the largest section, presents the evaluation findings and an analysis of the results.

In the final section, a number of recommendations for improvement of the program are offered.

HOW THE STUDY WAS DONE

THE EVALUATION APPROACH

In conducting a program evaluation, there are numerous approaches which could be used. Our approach in this instance was chosen to fit with our general philosphy of evaluation research and with our understanding of the nature of the People in Crisis program. We believe that, to ensure useful and relevant results, the evaluation approach should be tailored to the specific program, taking into account such aspects as the type of service provided, the sensitive nature of the client groups and the concerns and issues of the evaluation users.

Given our understanding of the People In Crisis program, the information needs of the various groups of decision-makers and the limitations on time and funding, we elected to use a naturalistic approach. That is, the evaluation was based on the needs, issues and concerns of those who would be using the results. To facilitate this approach, we worked closely with the groups involved, continuing to identify and clarify issues and concerns throughout the study.

Another feature of this approach was that, rather than a research design being finalized prior to beginning the evaluation, it emerged as the issues and concerns were identified. In keeping with the naturalistic approach, we used a variety of data collection techniques and sources of information.

THE EVALUATION PROCESS

Before an agreement was reached to proceed with the evaluation, a number of dicussions took place between Social Planning Council and V.O.N. representatives. These discussions centred around important preliminary questions such as:

Why do you want to evaluate?
How will the evaluation results be used?

What resources are available for the evaluation?
What constraints are there on the evaluation?

The responses to these preliminary questions were instrumental in developing the evaluation proposal. Once the proposal had been submitted to VON and approval had been received, the work of the evaluation began. The following section describes the process followed in conducting the evaluation. It should be noted that these were not separate and distinct steps but rather parts of a process in which many activities overlapped.

1. Establishing the Steering Committee

In keeping with our belief that an evaluation should centre on the concerns and issues of the evaluation users, our first step in the process was to establish an Advisory Committee. The committee consisted of two VON staff members (the executive director and the nurse who delivers the program), a representative from the VON Board of Directors, representatives from the two client agencies, a member of the United Way's Research and Evaluation panel and the principal evaluator from the Edmonton Social Planning Council. Committee membership and terms of reference are contained in Appendix A.

The two initial tasks requiring the efforts of the Advisory Committee were:

a) to review the evaluation proposal and provide feedback and suggestions on the approach, the methodology and the sources of information.

b) to develop the evaluation questions which would guide the research.

The Committee met on three occasions to complete these tasks. Once the questions had been developed, the Committee was not called upon to meet again until the study was nearing completion. However, regular contact was maintained between the committee members and the evaluators. The final

meeting of the Committee took place at the end of the study when the members participated in a discussion of the evaluation results and recommendations.

2. Developing the Evaluation Questions

As mentioned previously, the concerns and issues of those who would be using the evaluation findings were considered to be crucial in designing the research. Consequently, the identification of these concerns and issues and their translation into specific evaluation questions required a substantial amount of time.

We believe it is accurate to say that the questions posed in the study represent the diverse concerns of the eventual evaluation users as expressed by their representatives on the Advisory Committee. The questions emerged following three committee meetings and many telephone calls. They were organized into seven categories by the evaluators.

3. Reviewing Relevant Literature

The relevant literature was searched for materials pertaining to similar programs and particularly for any references to evaluation of such programs. However, it was found that very little material exists in this area, primarily because such programs are rare. In fact, in Canada, the three women's shelters served by the People In Crisis program are apparently the only ones in which a nursing service is provided at the present time. Some references to the role of the nursing profession in providing services to victims of family violence were found and will be reviewed in a later section of the report.

4. Designing the Evaluation

As the evaluation questions were identified, the design of the study was developed. Based on the query, "How can we best gather the information to answer this question?" the following methods were chosen:

- face to face interviews
- observation of the program
- telephone interviews
- analysis of relevant documents
- review of literature
- analysis of a daily log kept by the nurse delivering the program

Interview schedules were designed and samples for interviewing were selected.

5. Collecting and Analyzing the Data

Data was collected over a three month time period by two evaluators. Some difficulties were encountered in obtaining the sample sizes planned. This was due in part to time constraints but also to unanticipated problems in making contact with some sample groups (ie. current and previous clients). Moreover, the interviews proved to be lengthier than was originally anticipated.

Once the data was collected, it was analyzed in an attempt to answer the original evaluation questions. Because of the large number of questions, answering each one individually was deemed to be too unwieldy. Consequently, analysis has been done by major categories of the questions with a focus on the more significant findings and the issues which emerged from the study.

THE METHODOLOGY

To gather the information needed to answer the evaluation questions posed in this study, the following methods were used:

1. Document Analysis

In order to gain familiarity with People In Crisis, the evaluators reviewed a number of documents pertaining to the program. These included:

- the proposal for program expansion submitted to the United Way

- a program plan document prepared by the nurse who offers the program

- two documents outlining the purpose and objectives of the program

- the report of the WIN House demonstration project entitled, Children of Domestic Violence

- a variety of other documents relating to the program

2. Interviews

Interviewing was the major data gathering method used in the study. Face-to-face interviews were conducted with thirty people including:

- current shelter residents (12)
- shelter staff (10)
- directors of client agencies (3)
- board member of client agencies (1)
- V.O.N. director (1)
- V.O.N. board member (1)
- V.O.N. nurse who provides the program (1)
- V.O.N. provincial representative (1)

Interviews were based on structured but open-ended questionnaires. These interviews ranged in length from 20 minutes to 2 1/2 hours.

In addition, telephone interviews were conducted with eight previous shelter residents. The rationale for interviewing previous residents was that current residents might be unduly biased in favor of the program if they were presently receiving services and that such a bias would likely be absent in previous residents. A number of informal interviews also took place throughout the study. Finally, it should be noted that many staff members and several residents who were not among those interviewed, offered unsolicited comments to the evaluators about how valuable they feel the program is.

3. Observation of the Program

The evaluators spent about a day and a half directly observing the program in the shelters. This observation provided important information about how the program works and why it is viewed as being so successful.

4. Review of Relevant Literature

Literature was reviewed in an attempt to find out more about the role of nurses in assisting victims of family violence and particulary in working in battered women's shelters. To locate such literature, contact was made with the National Clearinghouse on Family Violence in Ottawa and a library search was conducted at the University of Alberta and the Alberta Department of Social Services. However, the results of the literature search were very limited. Some references were found to the role of nurses in helping battered women but only one article was found relating to nursing programs in women's shelters. The paucity of relevant literature can be attributed to the fact that such programs as People in Crisis are very rare indeed.

5. Review of Daily Log

The nurse who works in the shelters was asked to keep a two-day log documenting all program activities for that duration. The purpose of requesting the log was two-fold: one, to provide an in-depth description of program activities and two, to point to the type of information that should be collected on a regular basis to describe program recipients and services.

EVALUATION QUESTIONS

THE NATURE OF THE PROGRAM

1. What is the purpose/mission of P.I.C.?

2. What are the specific objectives of the program?
   - explicit
   - implicit

3. Are the objectives relevant, appropriate, measurable and meaningful?

4. How is the program delivered?
   - agencies involved
   - staff involved
   - locations
   - characteristics of the settings

5. a) What specifically are the services offered by P.I.C.?

   b) What special delivery considerations exist with regard to the clients and setting?

   c) What are the major features of the program and what priority is given to each?

6. What is the volume of service delivered?
   - number of nurse/client contacts (with mothers and children)
   - number of referrals made
   - time involved by type of activity

7. a) What relationships exist with other groups, organizations and individuals?

   b) What is the nature of each relationship?

8. a) What does the program cost and how is it funded?

   b) What other resources have gone into the program?

HOW THE PROGRAM DEVELOPED

1. How did the People in Crisis program come about?

2. a) What client needs were identified and how?

   b) Have the needs changed over time, and if so, how?

3. Have the objectives changed since the programs's inception? If so, how?

4. How has the program delivery changed since it was begun?

5. a) Were other alternatives originally identified to meet the expressed need?

   b) Why was this particular chosen?

   c) Have alternative programs been considered since this program was begun?

THE PROCESS

1. a) How do shelter residents become aware that the nursing service is available?

   b) Are there any barriers inhibiting clients from using the services of the P.I.C. program?

   c) If so, what are they?

2. What is the process followed in the People in Crisis program in providing services to clients?

3. a) What, specifically, are the components of this process?

   b) How is the Denver Developmental Scale used?

   c) What are the advantages/disadvantages of using this tool?

   d) Are other tools used in providing services to clients?

4. a) What follow-up services are provided to clients?

   b) What is involved in follow-up home visits?

   c) Are follow-up services sufficient?

   d) If not, what are the effects on the client of insufficient follow-up?

   e) Is the nurse able to see clients for follow-up within a reasonable time after they leave the shelter?

   f) If not, how could this situation be rectified?

5. a) Would use of public health services negate the need for V.O.N. to make follow-up home visits?

   b) What are the relative advantages and disadvantages associated with the provision of follow-up services by either V.O.N. or public health?

6. a) What improvements could be made in the process of providing the People in Crisis program?

   b) Are there areas/components of the program that should be expanded or reduced?

7. Could program delivery be reorganized to make more effective use of the nurse's time while maintaining the quality of the program? How?

ADMINISTRATION AND STAFFING

1. a) How is the program administered?

   b) What are the supervisory and communication channels?

   c) What administrative and clerical support is provided to the program?

   d) How are absences due to holidays or illness covered?

2. Why is the People in Crisis program delivered by nurses?

3. a) What are the qualifications required in nurses delivering the program and why?

   b) Are there job descriptions for the staff involved?

   c) Are job descriptions consistent with the goals and objectives of the program?

4. Are orientation, ongoing education and in-service training made available to program staff?

5. a) Is there an appropriate process of staff evaluation in place?

   b) Is there a process of assessing job satisfaction?

6. Is there a role for other kinds of staff?
   - intermediate health care workers such as Home Health Aides
   - volunteer health care workers assisting the nurse or H.H.A., i.e. V.O.N. staff

THE PERSPECTIVE OF V.O.N.

1. Why is the program provided with V.O.N.?

2. a) How does the P.I.C. program fit in with the philosophy and mandate of V.O.N.?

   b) To what extent does it reflect the standards/definition of professional nursing care?

3. What does V.O.N. gain from providing this service?

THE PERSPECTIVE OF THE CLIENT AGENCIES

1. How does the People in Crisis program fit in with the philosophy and mandate of the client agencies?

2. a) What are the expectations of the client agencies with regard to the P.I.C. program?

   b) Are these expectations being met? If no, why not?

3. a) What are the client agencies' expectations of the P.I.C. nursing staff?

   b) Are these expectations being met? If no, why not?

4. What do the client agencies and their staff gain from this program?

5. a) What is the nature of the setting in which the nurses are required to function in delivering the P.I.C. program?

   b) To what extent does the program fit this setting?

6. a) What are the values and beliefs of the client agencies which impinge on the work of the staff nurses (and vice versa)?

   b) How are these values and beliefs expressed?

   c) To what extent are these values and beliefs reflected by the program and by the nurses?

7. How do the staff of the client agencies participate in this program?

8. Is the amount of service provided to each shelter adequate?

9. Does the program hinder the shelter staff in any way?

PROGRAM EFFECTS, CLIENT BENEFITS AND EVALUATION

1. a) Is the People in Crisis program meeting the needs that it is intended to meet?

   b) Are there needs that the program could be meeting but currently is not? If so, why?

2. a) To what extent is the program meeting its objectives?

   b) What are the constraints/enablers to the program meeting its objectives?

3. a) In what specific ways do clients benefit from this program?

   b) Does the program provide benefits to clients above what the shelter staff is able to provide?

   c) Do clients function more effectively after counselling?

   d) Do clients learn from the educational component?

   e) What unique information do clients receive from the nurse that they don't receive from shelter staff?

4. a) Do clients feel comfortable contacting the nurse? Why or why not?

   b) Do clients initiate contact:
   - in the shelter?
   - after they leave the shelter?

5. a) What is the nature of the nurse-client relationship?

   b) How does this contribute to the goal of assisting clients?

   c) Are there any ways in which this relationship could be improved?

6. What kind of information do clients:
   - expect from the nurse?
   - ask of the nurse?
   - receive from the nurse?

7. a) How is the information presented to clients?

   b) What factors inhibit clients from remembering information presented to them?

   c) How could information be presented to clients so as to be more useful to them?

8. Is the method of selecting clients within the shelters effective and appropriate?

9. Are there specific services provided through P.I.C. that could be provided more effectively (or efficiently) through another source?

10. a) If P.I.C. didn't exist, what would the clients lose? i.e. How would they be effected if service was withdrawn?

    b) Who, if anyone, would provide the service and how cost efficient and effective would this alternative be?

11. How is P.I.C. viewed by others in the community?

12. a) What benefits does this program have for the larger community or for specific elements of it?

    b) How is the program perceived by potential funding sources? (e.g. United Way, government, private foundations).

13. How is client progress determined?

14. How is client satisfaction with the program assessed?

15. a) What ongoing program monitoring is in place?

    b) If none, how could such a system be developed?

    c) What information should be collected and how?

EVALUATION FINDINGS

THE NATURE OF THE PROGRAM

The People In Crisis program was established in 1979 to provide a nursing service to WIN House battered women's shelter. Currently, the program provides 27 hours of service a week to two WIN House shelters and the Safe Place Shelter located in Sherwood Park. In addition, one day of service per week is provided to residents of the Youth Emergency Shelter (YESS).

Purpose and Objectives

The purpose of this program is to provide nursing services to women, children and youth using the facilities of emergency shelters. Nursing services in this context are very broadly defined and are based on a model of holistic health care. This model will become more evident with the description of the services provided.

As stated in the proposal to the United Way for expansion funding (March 3, 1986), the goal and objectives of the program are as follows:

Goal: To promote health and well-being and to prevent illness and further injury within the context of the client's crisis situation.

Objectives:

1. To identify health problems and the effects of long term stress;
2. To encourage clients to seek appropriate help and treatment once the health problems have been identified.
3. To provide pertinent health related information to victims and those caring for them;
4. To provide emotional support and counselling to victims and potential victims;
5. To encourage clients to utilize available community resources;
6. To encourage good parenting;
7. To report detected or suspected child abuse for investigation;
8. To work in collaboration with others to break the cycle of family

violence;

9. To encourage clients to take responsibility for their actions and their lives and to recognize their strengths;

10. To share nursing knowledge with staff and volunteers working at shelters so they may provide more informed assistance to clients;

11. To ensure the confidentiality of clients.

As part of the evaluation, we considered the question of whether the objectives are relevant, appropriate, measurable and meaningful. This is a difficult question to answer as it involves making value judgements. However, what seems clear from the interviews and the documents which were examined is that the objectives are not widely recognized and accepted among those individuals involved in the program. The need to reconsider the objectives from the perspective of what the program actually does and should be doing became apparent from the comments of the respondents. In other words, the objectives should be reviewed and subsequently revised to be more relevant and meaningful and to more accurately reflect a concensus with regard to the program activities. The input of the shelters would be helpful in this respect.

As for the question of whether the objectives are measurable, in our judgement, they are not. However, this should not necessarily be construed as a weakness. Given the nature of the program, objectives which are measurable may not be the most appropriate. What is important is that the objectives be relevant, that they be based on a concensus and that they be linked to program delivery through a strategy or action plan. It might also be useful to enunciate standards of service separately from the objectives. Finally, the objectives need to be more widely circulated to enhance understanding of the program.

Program Delivery

As mentioned previously, the program is delivered in three women's emergency shelters (two in Edmonton and one in Sherwood Park) and in one emergency shelter for youth. All are community-based, non-profit organizations. Service is delivered by two VON nurses, one working at the three women's shelters about four days a week and the other working at the youth Emergency Shelter for one day a week.

In the battered women's shelters, nursing service is provided to the women and their children. The maximum length of stay in these shelters is three weeks so nursing intervention is necessarily short-term. However, follow-up service is available in some cases.

In the Youth Emergency Shelter, the service is delivered in a group setting. In this context, the nurse plays an educational role rather than one of direct health care provision. In both the youth shelter and the women's shelters, the nurses act as a general resource to staff with regard to health care issues and the health care system. Because these shelters provide crisis accommodation and services, they differ substantially from most contexts in which nursing care is offered.

Because women and children who seek help from emergency shelters are facing crisis situations, they frequently experience a whole range of physical, pyschological and social problems. Consequently, any health care program which is offered to these client groups must take a holistic approach to meeting their diverse needs. Such an approach is clearly taken by the People in Crisis program. The evaluation provides ample evidence of the wide range of services offered to residents of the shelters and to the shelter staff. Summarized, the major services provided by the nursing program at the battered women's shelters are:

1. Assessment of medical and psychological problems.
2. Treatment of minor medical problems.
3. Referral to appropriate medical and community sevices as needed.
4. Education and consulting with residents on a variety of health-related topics such as: child care and development, nutrition, sexuality, parenting skills and women's health issues.
5. Counselling and support for residents.
6. Assessment of child development primarily through the use of the Denver Developmental Screening Test.
7. Advocacy on behalf of the residents through referrals and liaison with other agencies.
8. Consultation with shelter staff.

9. Liaison with public health units regarding communicable diseases and immunization.
10. Monitoring shelters with regard to health standards.
11. Follow-up with clients after they leave the shelters.

Although both staff and residents were convinced of the value of the nursing service, their responses when interviewed demonstrated a surprising lack of understanding of the role of the nurse and the services offered. Staff were to some extent cognizant of this lack as reflected by such comments as the following which were made by several staff members:

"Staff's knowledge of the program should be expanded."
"Staff should know more about services."
"I'd like to know more about the program - what Shirley does."

Likewise, both current and previous residents of the shelter expressed a limited view of the nurse's role.

There are particular characteristics of both the clients and the settings which have an impact on delivery of a nursing program. The clients are, without exception, in a crisis situation. They are essentially homeless and often suffering physical injuries as a result of violence. While shelter residents come from all walks of life, there is a tendency for them to be young, poorly educated, of low socio-economic status and possessing few skills. Because many of these people are seeking shelter from life-threatening situations, fear and anxiety are prevalent. Frequently, they have difficulty in trusting people. For these reasons, a nursing service offered in-house and hence, not requiring the residents to leave the safety of the shelter is of great importance. Furthermore, such a program must be sensitive to the psychological as well as the physical needs of the clients. There is every evidence that the People In Crisis program meets these requirements.

The volume of service provided through People in Crisis is difficult to specify due to the lack of recording procedures. Based on the evaluation results however, it is clear that the amount of service provided falls far short of meeting the demand and that the demand is increasing. The need for more

adequate documentation is obvious and will be dealt with in more detail in a later section.

Relationships With Others

Apart from close relationships with the shelters, the People In Crisis program has few strong links with other groups and individuals. Relationships do exist with the City of Edmonton and Leduc-Strathcona Health Units. There are formal elements of these relationships in that reporting of communicable diseases and other health concerns is required. However, there have also been attempts to establish a less formal relationship. The current relationship between the People In Crisis program and the health units seems somewhat uneasy but has been described as "getting better". Because we were unable to interview the public health nurses, this issue could not be explored in any depth.

Both shelter staff and the VON nurses refer shelter residents to specific doctors in the community. These relationships appear to be very positive as is the relationship with the AADAC worker who visits the two WIN houses. There is some contact with the Child Welfare system but this is minimal at this time.

The funding for People In Crisis comes exclusively from the United Way which provides $34,027 annually. Other resources which go into the program include administrative time on the part of VON and the shelters and some administrative support in the way of typing, photcopying and supplies. The VON nurses' cars are donated.

HOW THE PROGRAM DEVELOPED

The People In Crisis program began in 1979, within a year of the opening of WIN House I. The Board and staff of WIN House quickly recognized a need for health care services for the women and children they were sheltering. A WIN House board member who also sat on the board of V.O.N. arranged informally for a V.O.N. nurse to visit the shelter for one hour each week. When WIN II opened in 1982, the number of hours was expanded and a fee was instituted for the service.

In November 1985, a demonstration project was initiated at WIN House to examine the kinds of problems that children in the shelters were experiencing as a result of the abuse that they had suffered. As part of the project, the V.O.N. nurse was asked to administer Denver Developmental Screening Tests to the children in the study. During this project, the nurse was working three days a week at WIN House and two days at Safe Place. When the project was completed, the nurse continued to provide service to the shelters on a full-time basis until October 1985 when funding shortages necessitated cut-backs to 3/4 time.

Shortly after WIN House opened, the director and staff of the shelter began to realize that the residents were experiencing numerous health-related problems which required some form of medical attention. It has become increasing clear that, as a result of high levels of stress, long-term neglect and immediate crisis, residents of emergency shelters tend to have a higher than average occurance of health-related problems. The need for medical support became apparent very early on. While it appears that the needs have changed little since the program began, awareness of these needs has increased substantially. This increased awareness can be attributed in part to the demonstration project undertaken by WIN House. The results of this project served to emphasize the extent and severity of physical, social and psychological problems experienced by both mothers and children in the shelters.

Abuse is a health care issue. It frequently involves physical trauma to the body, requiring medical intervention. Moreover, the secondary effects of abuse, be it physical or psychological abuse are also health care issues. Depression, anxiety and drug dependency are common reactions among individuals who have

been abused. Many of the women have physical ailments related to stress and may be "so used to being run down that they don't realize they need nursing care" (shelter staff).

When the program began, it provided services on a very small scale and was perceived as a support service rather than a program. Since it expanded so substantially, it has become an integral part of the service provided by the shelters. In addition, a wider range of services has been offered both to residents and shelter staff. The developmental screening through use of the DDST is one such service which was instituted in conjuntion with the demonstration project.

Alternative ways of providing health-related services have been considered. It was thought that regular visits to the shelter by a doctor would be a feasible way of meeting health care needs of residents. However, it seems that doctors have not been available to provide services directly to the shelters. Rather, the shelter residents must go to the doctor's office which necessitates leaving the safety of the shelter.

Public health units have also been approached about providing health services to the shelters but have been unable to do so due to lack of resources. Also, the mandate of the Public Health units makes it difficult to provide services within the shelters on a regular basis. Certainly, a crucial feature of the People In Crisis program is its ability to attend to the needs of the residents within the safety of the shelters.

THE PROCESS

Awareness and Barriers

Shelter residents find out about the nursing service in several ways. At Safe Place, an annnouncement is made at the morning management meeting on the days that the nurse will be at the shelter. Staff members also refer residents to the nurse as they become aware of any health-related problems. At WIN House, women are informed when they arrive at the shelter that nursing services are available. On the days that the nurse will be visiting WIN House, an announcement is made and any resident who wants to see the nurse will have her name put on the counsellor's list. This list is discussed with the nurse before she sees the clients.

At both Safe Place and WIN house, the nurse makes her presence known by introducing herself to new residents and informally joining groups of residents at coffee. For the most part, residents have no difficulty in finding out about the nursing service. However, those whose stay in the shelters is of short duration, may miss seeing the nurse because of scheduling.

At YESS, the nurse deals with clients in a group setting only and hence, there is no difficulty in making the service known to clients. YESS staff will also be posting signs publicising the nursing service.

It appears that every attempt is made at the shelters to ensure that the clients are able to access the nursing service. Moreover, the efforts of the nurse herself in approaching the residents and encouraging them to take advantage of her presence at the shelters, serves to reduce any inhibitions they may have in using the program.

There are, however, two factors which may act as barriers to use of the program. The first of these is scheduling. It seems that some residents may be unable to meet with the nurse because they are not at the shelter during the nurse's visits and alternate times cannot be arranged. The other difficulty lies in the lack of understanding about the services provided by the nurse. For residents who don't realize that the nurse provides more than traditional medical intervention, the opportunity to take advantage of the nursing services may be missed.

The Process

While most initial contacts between the nurse and residents are made by the nurse on the basis of a referral from staff, residents frequently contact the nurse of their own accord. Once contact has been made the nurse spends time with the resident (and/or) her children assessing the problem and providing whatever services are appropriate. Generally, the nurse reports back to staff following the visit, and, depending on the situation may write case notes on the clients' file. If referrals are to be made to community agencies, the nurse usually advises shelter staff who then make the necessary arrangements. If further visits between the nurse and the resident are required, the nurse arranges for these. In occasional cases, residents may require follow-up services when they leave the shelter. To obtain follow-up services, the client must fill out a request form.

During the demonstration project at WIN House, the Denver Development Screening Test was used frequently as part of the data gathering process. Since the project ended, the DDST is still used but it is not used often. Generally speaking, the instrument is used either when a mother expresses concerns about her child's development or when staff members express similar concerns.

The DDST provides a very crude indication of developmental lag and consequently, is intended as a screening tool rather than a diagnostic one. It is viewed as being useful in an educational sense as it can be used to teach mothers about child development and to encourage specific behaviors. While there are several advantages to the DDST there are also a number of concerns associated with its use. One concern is that it takes a long time to administer and that this time could perhaps be put to more effective use in the program. The test is also acknowledged as being culture-bound; that is, it has little relevance for parents and children of other cultures including native children. While there is much evidence to support the use of the DDST as part of the People in Crisis program, there may be some merit in assessing when and how it should be used.

Follow-up

Follow-up services for residents who have left the shelter are very limited due to time constraints. Generally, only in multi-problem cases is follow-up provided and then, only for a short duration. Follow-up involves similar services to those provided in the shelters. However, it also allows an opportunity for the nurse to monitor the situation of the client away from the protective setting of the shelter. To a large extent, follow-up involves providing much needed support to clients who are having difficulty coping with crisis situations.

Respondents in the study were virtually unanimous in their contention that follow-up services are far from sufficient. Even the follow-up that is provided is viewed as inadequate. The need for greater continuity of service and for more long-term care was strongly expressed. The result of the inadequacy of follow-up is that the women lack the support they need to make changes in their lives and consequently tend to move back into previous patterns (ie. neglecting their children, substance abuse, relationships with abusive partners). Thus, the risks of abuse and neglect and of depression on the part of the women are intensified.

There has been some discussion about follow-up services being provided by public health nurses. There would be some advantage to this arrangement in that it would allow all of the resources of the program to be directed toward serving clients in the shelters. However, given that a crucial element of follow-up is the support provided to the women, continuity becomes an important element. It was generally felt that follow-up could best be offered by the nurse who had worked with the clients in the shelter. Also, because of the current strain on the resources of public health units, service could well be too inconsistent to be of benefit. Provision of follow-up services by public health nurses would likely require substantial training in working with victims of family violence. While use of public health nurses in doing follow-up is certainly an option to be considered, there is overwhelming support for expansion of People in Crisis to cover this service within the program.

Except for the inadequacy of follow-up, there are few problems in terms of the process of providing services. Generally, there is a need for more

regular scheduling and for an office space for the nurses' use. The program would certainly be improved were it to be expanded to incorporate more follow-up and more opportunities for educational activities. Both of these activities would allow for greater emphasis on prevention with respect to both health concerns and family violence.

THE PERSPECTIVE OF V.O.N.

The People in Crisis program is offered by V.O.N. because there is a demonstrated need for the service and nobody else is providing it. Hence, the program is consistent with the mandate of V.O.N. which is to provide nursing services where there is a need. In addition, the V.O.N. has a tradition of offering services specifically aimed toward the health needs of women and to generally promoting women's health care.

There is a tendency to view nursing care from a rather narrow perspective, reflecting perhaps the more traditional role of nurses in our society. However, professional nursing care is increasingly being seen in a much broader context which goes beyond psychological, social and emotional needs of the client. This holistic approach to health care is particularly well-suited to the needs of the clients in the People in Crisis program. Moreover, it fits well into the client-centred approach of the shelters.

The V.O.N. also derives benefits from offering this program. People in Crisis is viewed by V.O.N. as a challenging program which offers a vitality to the agency and which fits perfectly with the V.O.N. mandate. The program has national significance within V.O.N. in that it is the first program of its kind in Canada. Other V.O.N. branches are currently expressing great interest in the program and may be establishing similar programs in their own communities.

The People in Crisis program also allows V.O.N. to expand its age mandate which currently emphasizes the needs of the elderly. Finally, expansion into this service area has helped V.O.N. to diversify its program areas and hence, to broaden its funding base.

THE PERSPECTIVE OF CLIENT AGENCIES

The mandate of the battered women's shelters is to provide a safe and healthy environment within which the women seeking shelter can gain the strengths to make informed decisions about their futures. Thus, the aim is to go beyond providing basic shelter to offering a range of services and assistance which will meet many of the residents immediate and long-term needs. People in Crisis assists the shelters in achieving this mandate in a number of ways. First and foremost, the program makes a major contribution toward meeting the health needs of the women and their children. By so doing, it relieves much anxiety and enhances the sense of security and strength that the shelters are trying to encourage. The program also empowers the women by providing them with important information on a range of topics from nutrition and basic health care to child development. Providing information about community services is important in decreasing the isolation experienced by many of the women. The additional support, caregiving and advice offered by the program clearly helps the shelters to provide a valuable service to their clients and to increase the likelihood of dealing successfully with the crises. Given the resources available to the program, it would appear that the expectations of the client agencies are being met. However, expectations for more follow-up and education cannot be met unless the program is expanded.

The client agencies benefit from this program in a general sense in that it enables them to provide a more comprehensive service to their clients. More specifically, the staff benefit greatly from the assistance they receive from the nurse in helping their clients. The nurse acts as a resource to staff, consulting with them about clients and about specific health concerns. The opportunity to broaden their knowledge and skills through involvement in this program is appreciated by many of the staff. In additon, the nurse often plays a liaison role between staff and clients. Apparently, the program does not hinder staff in any way.

There are certainly a number of values and beliefs held by the client agencies which have an impact on the work of the nurse. These include the beliefs that:

- service must be client-centred
- a client makes her own life choices and these must be viewed as correct choices
- confidentiality demands must be met
- women do not deserve to be abused

The values and beliefs held by the centres tend to be implicit rather than explicit. It is expected that where there is disagreement between V.O.N. staff and the shelters, the philosophy of the centres must prevail in providing services. Because the values and beliefs of the nurse have been similar to those of the shelters, inconsistencies between service and philosophy have not arisen. On the whole, the program clearly reflects the values of client agencies.

Most of the staff members at the shelters participate in the program to some extent. For the most part, staff participation involves consulting with the nurse about residents' health problems and making referrals as recommended by the nurse. The role of child care workers at the shelters differs slightly in that they provide liaison between the nurse and the children.

There was significant agreement among respondents that the amount of service provided to each shelter is not adequate. Given the amount of time which has to be apportioned among the shelters there is often time only for the most urgent cases to be dealt with.

ADMINISTRATION AND STAFFING

V.O.N. is responsible for the People in Crisis program in that they provide a nurse to the shelters and that nurse is supervised by V.O.N. Moreover, the funding for the program goes directly to the V.O.N. If any problems arise in delivery of the program, they are dealt with directly within the shelters on an information basis or from one director to another.

A weakness inherent in the operation of this program relates to the informal nature of the arrangements between the V.O.N. and the shelters. No formal contract or service agreement exists and communication channels are rather ambiguous. Virtually all of the work of the nurse is done within the shelters with shelter clients and yet there is no direct accountability to the shelter administration and no input from the shelters to the nurse's performance appraisals. While this ambiguity has not resulted in any major problems, there is clearly some discomfort with it. Furthermore, should the program be expanded, the potential for problems to occur would be significantly increased.

Some administrative and clerical support is provided by the shelters in the form of typing and photocopying. However, most support of this nature is the responsibility of the V.O.N.

Some concern has been expressed that the nurse's absences are not always covered by replacement staff, resulting in a lack of continuity of service. This problem emphasizes the need for back-up staff for the program.

The People in Crisis program focuses primarily on the health needs of clients. While some of the services of the program (eg. support, counselling, referral) could conceivable be offered by persons other than trained nurses, the holistic perspective of the program would then be lost. It is clear that, in order to address the physical, psychological and social needs of the clients, the program is best provided by professional nursing staff.

However, because of the nature of the program and of the clients served, a nurse involved in delivering these services must have a particular

combination of professional and personal qualifications suited to the job. Professional qualifications which are felt to be necessary include:

a) basic training to a minimum of a B.Sc. or an R.N. level. It is strongly held by V.O.N. that a minimum of a B.Sc. is essential for this position. Respondents from client agencies however, specified training to an R.N. level.

b) a detailed knowledge of child development, family theory and emotional disorders

c) counselling, communication and teamwork skills

d) knowledge of psychological disorders and addictions

e) a good understanding of family violence and how to deal with it

f) a knowledge of community agencies

g) an awareness of alternative perspectives in health care delivery, particularly that of a client-centred approach

A concern which emerged from the evaluation is that a clear understanding of the nurse's role and the services which she is capable of delivering is lacking among both staff and clients. This is likely due in part to the fact that no job description exists for the nurse delivering the program.

Ongoing education and in-service training are available to the nurse both through the shelters and from outside sources. In the case of outside sources, the V.O.N. pays for the costs involved. There is some concern however, that the nurse may be too busy providing services to take full advantage of training opportunities.

In the past, appraisals of the nurse's performance have been very infrequent. However, steps have been taken to rectify this situation and it is anticipated that appraisals will be done on a regular annual basis. A further difficulty with regard to performance appraisals is that supervisory staff at

V.O.N. have not had expertise in the program content area and hence, appraisals have not been as relevant as they might have been. In addition to more frequent and relevant performance appraisals, there is a need to establish a process of assessing job satisfaction.

PROGRAM EFFECTS AND CLIENT BENEFITS

Needs and Benefits

Among those involved with the People in Crisis there is a fairly clear understanding of the wide range of needs which the program is attempting to meet. The evaluation provided ample evidence that, within the current contraints on time and resources, the program is meeting these needs to the greatest extent possible. There are needs in the areas of education and follow-up services that the program is currently unable to meet. Because the program necessarily focuses on crisis intervention, other elements such as preventive activities and long-term assistance tend to be neglected. Program expansion would alleviate this strain on resources and allow for a range of needs to be addressed more effectively.

Because the program objectives are unmeasurable and somewhat ambiguous, it is difficult to say whether or not People in Crisis is meeting its objectives. However, the fact that nearly all respondents expressed very positive feelings about the program would seem to indicate that it is meeting their expectations at least. Again, the limited resources must be viewed as a constraint to meeting program objectives.

Clients receive numerous benefits from the program, at least by their own reports and those of shelter staff. Those current and previous clients who were interviewed as part of the evaluation, noted that having the nurse available made them feel safe and provided them with much needed support. While most of the women approached the nurse with specific health concerns, they tended to receive help with a range of physical, psychological and emotional problems. Comments from residents include:

"I felt reassured when I knew everything was okay with my son."
"She's more helpful than the public health nurse."
"The service is great the way it is."
"The nurse is always available and she's very reassuring."
"She gave me a sense of being safe."
"She's very competent and gave me a sense of security."

"I could trust her judgement."
"The nurse was easy to talk to."
"The nurse was very supportive and non-judgemental."
"I could take my problems to her."
"I have nothing but good words for it (the program)."
"For some things you need a nurse - not staff."
"The nurse could explain things you didn't know."
"She made me feel really comfortable."
"She seemed to understand me and listened to me."

While these comments may appear to give testimony to the qualities of the particular nurse involved in providing services, it cannot be denied that they eloquently express the feelings of the women toward the program itself. It should also be noted however, that several of the respondents seemed to have insufficient knowledge about the nursing service, specifically about the sort of help they could expect from the nurse. These respondents tended to be ambivalent in the rating of the program.

In terms of actual behavior change resulting from this program, it would obviously be almost impossible to measure. That clients are provided with medical services which are helpful to them is not difficult to demonstrate. However, many of the benefits of this program are less tangible and can only be determined through self-report or to some extent, the observations of others. Certainly, the comments of shelter staff indicate that the residents receive benefits from the nursing program over and above what they receive from staff and that these benefits go a long way toward supporting the staff in their helping roles.

One of the major areas in which residents request information is child development. Many of them approach the nurse initially with specific concerns relating to their child's development and are eager to secure correct information. The informal teaching role of the nurse in this and other issues is widely viewed as a crucial one.

Much of the information which residents receive from the nurse is health-related, some specific to the client's ailments (or those of their children)

and some more general on such topics as nutrition and sexual health. Also, many of the mothers (perhaps a majority) approach the nurse with concerns about their children's health and only after trust is established, do they reveal their own problems.

Nurse-Client Relationship

All of the residents surveyed noted that they had felt very comfortable contacting the nurse and talking to her. This was also the perception of shelter staff. It was pointed out that a nurse is a recognized and trusted figure in our society and that this would account, at least in part, for the ease of clients in contacting and confiding in the nurse. In general, the nature of the relationship between the nurse and the clients is one of respect and trust. However, it was emphasized during the evaluation that the role of the nurse is not to give advice but rather to give information and encourage clients to make their own informed decisions.

Most often, information is presented to clients verbally in a one-to-one situation. While efforts are made not to overburden clients with information, particularly during the first few days of their stay, the fact that they are in a crisis situation may inhibit their ability to remember information clearly. Several people made the suggestion that verbal information be supplemented where appropriate by written material.

The Wider Community

Most of the services provided through the People in Crisis program are basic to the program and could not effectively be provided by another source. There are some aspects such as Denver Development Screening Tests which could perhaps be taken on by public health units. However, such services may be less effective if provided by public health nurses because of a lack of continuity and because most services could not be provided in-house.

Inasmuch as it contributes to the physical, social and emotional well-being of people in crisis, this program offers some benefits to the larger community. Family violence is widely recognized as an extremely serious problem

in our society. Research conducted by WIN House revealed that 87% of children aged 3 to 18 whose mothers had sought refuge at the shelter, had themselves been abused or neglected. A goal of the shelters in helping these victims is to break the cycle of family violence. In helping the shelters to help their clients, the People in Crisis program is contributing to the goals and hence, providing a service to the community.

ISSUES AND RECOMMENDATIONS

ISSUES AND RECOMMENDATIONS

1. A need for program expansion.

It quickly became evident during the evaluation that the demands far outweigh the service available through this program. This concern was expressed as a need for more time or for more service.

Recommendations:

a) That the program be expanded as requested by the V.O.N. with a focus on:

i) increased health education
ii) increased follow-up services

b) That follow-up services be provided within the parameters of a policy statement/strategy to be developed jointly by V.O.N. and the shelters.

2. A lack of understanding of the role of the nurse among both shelter staff and residents.

Recommendations:

a) That a training session be offered to shelter staff to provide them with the opportunity to learn more about the role of the nurse and how she can be of assistance to clients.

b) That information on the role of the nurse be included in staff orientation sessions and that this process be mutual in that the nurses providing services in the shelters will become more familiar with the role of shelter staff.

c) That written materials be prepared describing the nursing services available through People in Crisis and that these be widely circulated among staff, residents and referring agencies.

d) That a job description for nursing staff be developed for internal use.

3. Lack of regular scheduling.

While there are clearly some advantages to an open schedule (for example, flexibility), concern was expressed that in many cases, it interferes with access to services. Staff members and residents noted that they didn't know when the nurse was going to be there and this made it difficult for some clients to see her.

Recommendations:

That the schedule for the nurse(s) be rearranged to include some guaranteed times of attendance and some flexible times. Attention should be paid to the needs of the shelters in developing an appropriate schedule.

4. Concern regarding the ambiguity of the administrative relationship between V.O.N. and the shelters.

While this ambiguity is not causing any major problems at present, there was general agreement that the potential for such problems is great, particularly with expansion of the program. A major concern is the lack of accountability on the part of the nurse to the shelters whose clients are receiving the services.

Recommendations:

a) That a service agreement be drawn up betwen V.O.N. and each of the client agencies to outline accountability, standards of service, channels of communication and other matters.

b) That provision be made for the shelters to have input into regular performance appraisals of the nurses who deliver services.

5. Lack of monitoring, record-keeping and statistics.

A major barrier in evaluating this program related to the paucity of records describing volume and type of service provided and providing information about clients. This is also a problem for V.O.N. and for the shelters. As well, there was a perception that the program needs to be monitored on a more regular basis. There is currently no system in place for such monitoring, nor for collecting and compiling statistical information.

Recommendations:

a) That the shelter administration increase their investment in the program in an informal sense in order to facilitate ongoing monitoring.

b) That a format be devised to collect at a minimum, the following basic information:

i) number of clients served
ii) age and sex of clients
iii) presenting problem
iv) service provided
v) amount of time spent on each visit

A system for collecting and compiling these statistics could be developed jointly by V.O.N. and the shelters.

c) That V.O.N. supervisory staff become more involved in monitoring the program on a regular basis.

6. Lack of clarity in purpose and objectives.

Concensus on the objectives of the program seems to be lacking. It also appears that the purpose and objectives of People In Crisis have not been made clearly explicit.

Recommendation:

That V.O.N., with input from the shelters, clarify, enunciate and circulate the purpose and objectives of the program. Further, that an action plan or strategy for attaining the objectives be developed and that standards of service be established.

7. Concern regarding the counselling role of the nurse.

Some concern was expressed about the extent to which the nurse ought to be involved in a counselling role. Further exploration of this issue revealed that counselling per se was not really the problem. Rather, the sharing of information between the nurse and shelter staff was viewed as a potentially problematic area, particularly as the nurse is not directly accountable to the shelters.

Recommendation:

That a system for sharing of information with respect to the nurse's counselling involvement with clients, be incorporated into the service agreement mentioned in 4(a) above. Further, that expectations regarding in-service training for the nurse be specified in the agreement.

8. Need for a nurse's office and/or private space.

Lack of an office space or other private spaces to meet with clients was viewed as a detriment to the program.

Recommendation:

That, if at all possible, a separate room be designated at each shelter for use as a nurse's office. If this is not possible, that a space be set aside during each scheduled visit of the nurse for her exclusive use.

9. Lack of concensus regarding the use of the Denver Developmental Screening Test.

Concern was expressed about the time required to administer this test and about the possible negative consequences to the mothers in terms of their parenting image. Nevertheless, the potential benefits of the tool were widely recognized.

Recommendation:

That the use of the DDST in the program be reassessed and that the possibility of the Public Health nurses playing a role in administering the test be explored.

10. Concern regarding performance appraisals of the nurse.

While there was absolutely no suggestion of dissatisfaction with the nurse's performance, there was some concern that performance appraisals are too infrequent and that input from shelters is not included. Related to the issue is the fact that the nurse currently works in isolation with no sharing or support occuring with colleagues and that this has the potential of contributing to burn-out.

Recommendation:

a) That a system of annual performance appraisals be developed and that shelter staff be given opportunity for input to the appraisals.

b) That, when program expansion takes place, arrangements be made for some overlap in the nurses' schedule to provide opportunities for support and sharing.

11. Lack of arrangements to cover the nurses' absence from work.

Recommendation:

That the program be expanded and that scheduling be such that interruption of service to any shelter does not occur.

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APPENDIX

V.O.N.

People in Crisis - Evaluation

Advisory Committee

Terms of Reference

PURPOSE

The purpose of this Committee is to serve as an advisory body to the Edmonton Social Planning Council in designing and carrying out an evaluation of the V.O.N.'s People in Crisis program.

TASKS

- To provide input concerning the study design
- To assist in developing the evaluation questions
- To serve as a resource to the evaluation team with regard to information sources and methods
- To receive and review the final report(s)

MEMBERSHIP

The committee will consist of:

- One representative of the V.O.N. Board of Directors
- Two representatives of the V.O.N. staff, namely:
    - The executive director and
    - A staff nurse who delivers the program
- One representative of the United Way
- Two representatives of the agencies served by the program (one from WIN House and one from Safe Place)
- One member of the evlauation team (on an ex-officio basis)

MEETINGS

The Committee will meet a maximum of four times between July and September, 1986. Meetings will not exceed 1-1/2 hours in duration.

V.O.N.

People in Crisis

Evaluation

Advisory Committee Membership

Vicki Strang Executive Director, V.O.N.	488-7256
Peggy Marko Chair, V.O.N. Program and Education Committee	434-0057
Ruth Pinkney Director, W.I.N. House (Alternate - Marcia Tait)	474-3488
Lisa Walter Director, Safe Place	464-7232
Shirley Yakimishyn Staff Nurse, V.O.N.	488-7256
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Barbara Sykes Planner, Edmonton Social Planning Council	423-2031