

Greater Than the Sum of Its Parts:
An Exploration of Family Home Visiting Programs
Involving both Volunteer and Paid Visitors

by

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Submitted in partial fulfilment of the requirements for
the degree of Master of Social Work

at

Dalhousie University

Halifax, Nova Scotia

November 2011

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DALHOUSIE UNIVERSITY
SCHOOL OF SOCIAL WORK

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Dated: 25 November 2011

Co-supervisors: _____

Readers: _____

DALHOUSIE UNIVERSITY

DATE: 25 November 2011

AUTHOR: Maura K. Donovan

TITLE: Greater Than the Sum of Its Parts: An Exploration of Family Home Visiting Programs Involving both Volunteer and Paid Visitors

DEPARTMENT OR SCHOOL: School of Social Work

DEGREE: MSW CONVOCATION: May YEAR: 2012

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DEDICATION

To all the parents who courageously welcome home visitors into your families' lives. Your commitment to your children, and your indomitable vision of a good future for your families, make this work possible – and deeply rewarding for those who are privileged to do the visiting.

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ABSTRACT

The goal of this international study was to gain insight into a little-known approach to family home visiting: programs that make use of *both* volunteer and paid visitors. Using a qualitative embedded multiple case study design, I interviewed volunteers and staff at three such programs regarding the development of the service, and the strengths and challenges of this approach.

Key findings suggest that this approach allows programs to provide preventative, universally available services; and to serve a greater number and broader range of families. These were important features given the local targeted, reactive service delivery systems. Common challenges included funding difficulties and some limited communication and workload issues.

This approach shows promise as a way to increase program accessibility and impact. Considerations for program planners include the costs of qualified staff to coordinate volunteers and do home visiting, and organizational readiness to deploy volunteers effectively in home visiting roles.

LIST OF ABBREVIATIONS USED

CMP	Community Mothers Programme
ECD	Early Child Development (<i>defined on page xvii</i>)
ECEC	Early Childhood Education and Care (<i>defined on page xvii</i>)
ESP	Extra Support for Parents Volunteer Service
FDN	Family Development Nurse
FSW	Family Support Worker
GBA	Good Beginnings Australia
IFS	Integrated Family Support Program
RCT	Randomized control trial
UCHD	Utah County Health Department
WBUC	Welcome Baby Utah County

GLOSSARY

I. Terms specific to home visiting programs:

Home visitors	All those who visit families in their homes on an on-going basis; this term includes both paid and volunteer visitors.
Volunteers	In this thesis, 'volunteers' refers to home visitors who are not paid to visit families.
Staff	Paid employees, both part-time and full-time. Staff may or may not do home visiting as part of their work.
(Program) Manager	The title of Manager refers to the senior staff person for each of the three home visiting programs involved in this study. I have used this single term to reduce confusion for the reader; however, this is not actually the title of any of the three senior staff persons. One is a Program Co-ordinator, one a Program Director, and one a Director of Early Childhood Initiatives.
Front-line staff	In this thesis, this term refers to staff members who work directly with families in their homes, and <u>who are not program managers</u> . For some front-line staff who took part in this study, home visiting comprised most of their workload; for others, it was a smaller part of their workload. All front-line staff members in the programs that took part in this study had duties in addition to home visiting. Their responsibilities varied, but examples included supporting and supervising volunteer visitors, leading parent groups, managing and maintaining a group of volunteers in one geographical area, and doing administrative work for the program.
Paid home visitors	In this thesis, this term refers to staff members who work directly with families in their homes, <u>including</u> program managers.
Mixed-delivery	Refers to home visiting programs, such as those that took part in this study, that have both paid and volunteer home visitors.

Continued ...

II. Other terms used in this thesis report:

Anglo-Saxon countries

For ease of language, I have chosen to use the term “**Anglo-Saxon**” to describe, as a group, the countries that are the focus of this study. Sven Bremberg, Director of the Swedish National Institute of Public Health, used this term in reference to the United Kingdom, Ireland, Australia, New Zealand, Canada, and the U.S., in his May 14, 2009 address to the “Putting Science into Action” early child development conference in Sackville, New Brunswick (Bremberg, 2009). As will be outlined in this thesis, “Anglo-Saxon” countries are distinct in their approach to both early child development and the role of government; distinct, that is, from other wealthy, industrialized states such as France, Germany, Japan, Korea, and the Scandinavian nations.

The term “Anglo-Saxon” itself refers to the dominance of both the English language and British-derived values and beliefs within these nations’ cultures, institutions, and governments. However, it must be noted that Anglo-Saxon is not a fully accurate term: Ireland is committed to maintaining and supporting Irish language and culture despite centuries of British dominance, and both Canada and New Zealand have rejected a monocultural national identity, and have enshrined in law the critical importance of bilingualism.

Early child development (ECD)

Encompasses all facets of young children’s health, well-being, security, development, and learning. In this thesis it means the prenatal period until age five (inclusive).

Early child development programs/ services

Encompasses a wide range of initiatives for young children and their families. Early child development (ECD) services may be in-home or located in various out-of-home settings; they may be specifically for young children (e.g., pre-school, child care, and community programs, such as those found at libraries and recreation centres), or for parents (parenting courses), or they may be two-generation services (play groups, parent-and-child programs, home visiting).

Early childhood education and care (ECEC)

Refers specifically to group programs for young children ages birth to three-and-a-half (Ireland) or four (the U.S., Canada and Australia) – that is, preschool, nursery school, and licensed child care programs (both full-time and part-time). In Canada, the U.S.,

Australia, and Ireland, ECEC programs are *most often* outside of the formal school system (Organisation for Economic Co-operation and Development, 2006), and are not universally available.

In comparison, the year of school prior to grade one (known in much of the U.S. and Canada as “kindergarten”) is a universally available program that is usually part of the public school system. Kindergarten is considered by experts in the field to be an early childhood program because of the developmental needs of the children. The same is true for the Infant Classes in Irish primary schools; these first two years of school are “usually comprised of 4, 5, and 6 year-olds” (Corrigan, 2003, p ii). In this thesis report, references to early child development services do not include either kindergarten or the Infant Classes, but refer to programs outside of the formal education system.

Perinatal The time surrounding the birth of a baby – in this thesis, pregnancy, birth, and the first few months of an infant’s life.

III. International equivalents of terms commonly used in...

Canada and the U.S.:	Ireland:	Australia:
public services	statutory services	public services
non-profit, not-for-profit	voluntary services	community, non-profit services
elementary education	primary education	primary education
prenatal	antenatal	antenatal
post-partum	postnatal	postnatal
full-time equivalent (FTE)*	whole-time equivalent (WTE)*	full-time equivalent (FTE)*

**FTE and WTE are used to describe staffing complements, particularly in organizations that have a number of part-time positions/staff members.*

V. Gender and language in this thesis report

Language and gender roles in families

This study is grounded in an understanding of the multiple factors that impact family life. Examples include the gendered nature of family work, the structural forces that impinge upon families, the uniqueness of family and individual experiences, the multiple configurations of families, the various roles and responsibilities evident within family life, the complexity of social identity, and the dynamic and shifting nature of family life. While an exploration of the interconnected complexity of these factors is beyond the scope of the thesis, an understanding of these factors has influenced the language of the report. For example, the language I use to refer to parents is fluid throughout the thesis report. The reader will note that the terms families, parents, caregivers, mothers, and fathers are used to describe the adults who are raising infants and young children, with the term “mother” being used most frequently. Similarly, the terms couple and partner are used uniformly in reference to all significant intimate relationships, regardless of the duration or legal status of the relationship, the individuals’ biological or non-biological relationship(s) with the child(ren), and whether or not those involved were of the same or different sexes.

Gender and language in reference to study participants

Throughout this thesis report, when the second-person singular form is used in reference to a paid or volunteer home visitor, or to a study participant, the word ‘she’ is used. While male front-line staff and volunteers do work in various roles within family support services and parent education, the vast majority of home visitors who work with families with infants (the focus of this study) are women. Additionally, specific to this study, while not all those contacted or interviewed for the study were women, the small number of male participants means that attributing quotes to a male speaker would make it easier for some readers to identify the speaker.

ACKNOWLEDGEMENTS

Go raibh cead míle maith agaibh:

A hundred thousand thanks to you

While one person's name gets attached to a thesis, it takes the effort and support of so many others to actually bring it to fruition. This is especially true for students who are also juggling other major responsibilities – in my case, parenting and full-time employment. Indeed, the sheer number of people who have contributed to this thesis makes it impossible to name everyone individually. I wish to express my deepest gratitude and appreciation to each of you, and in particular:

- My supervisors, Drs. Judy MacDonald and Megan Aston, and thesis committee member Dr. Carolyn Campbell. This has been an extraordinary learning experience, and it could not have happened without you. There were also many difficult and uncertain moments; I shudder to think of how things would have progressed without your belief in me and your deep knowledge of qualitative feminist research. I am grateful for your steadfast guidance, support, and patience.
- The faculty and staff at the Dalhousie University School of Social Work, for your encouragement and guidance throughout my MSW studies.
- Mentors Brenda Beagan, Josephine Etowa, Sheri Price, and Erna Snelgrove-Clark, for your encouragement in the early days; Cheryl Tatano Beck, for your key advice back in 2007; and ADHD coach Gillian Smith, for guiding me through many difficult stages with humour, perseverance, and an expertise akin to magic.
- IWK Health Centre staff members in Primary Health, Research Services, Women's Health, and the Health Sciences Library, for the many forms of guidance and assistance provided, and in particular:
 - Anne Cogdon and the Primary Health team, for your patience and support throughout this process; and
 - Extra Support for Parents staff members past and present, and especially Susan DeWolf and Emma Kathleen, for all the times you took on extra responsibilities so that I could meet a thesis deadline, and for your unwavering and clear-sighted support. Through everything you do, you nurture success in others; this time, I have been the beneficiary.

Continued...

- The many colleagues, friends, neighbours, and extended family members who supported me, and my family, all through this endeavour, especially those who provided advice on the research and writing, and those whose homes and offices were an oasis when I needed a place to work without interruptions.
- The volunteers and families of Extra Support for Parents who, over the past fourteen years, have been the best teachers and companions on this amazing home visiting journey.
- The Nova Scotia Health Research Foundation, for providing funding for this project. Funding the research projects of ‘mid-career’ graduate students is absolutely crucial: family and financial obligations can make it impossible to leave paid employment for an extended period, and yet it’s very difficult to do a thesis without that dedicated time.
- The three study programs and Agency Contact Persons, and especially the fourteen study participants. You willingly shared your insight, experiences and time, and in doing so, you have provided a new understanding of a little-known form of family service. Your passion and commitment are inspirational; I hope I have given them justice.
- Finally, I am forever grateful to my family – my parents, Pat and Dave Donovan, my sister Amy Donovan, and especially my partner Lynn and our son Liam: **a hundred thousand thank you’s** for your love and support, and for your patience with my absence and preoccupation over such a long duration. I look forward to many thesis-free times together.

CHAPTER 1: INTRODUCTION

This chapter outlines the purpose and goals of the present research project, which was a preliminary exploratory study into family home visiting programs that make use of both volunteer and paid visitors. This chapter also provides a brief overview of each of the following: the field of home visiting, the broader socio-political context in which these home visiting programs operate, the historical relationship between social work and home visiting, and my own experiences working in this field.

1.1 INTRODUCTION TO THE PRESENT STUDY

1.1.1 Why Research Mixed-Delivery Home Visiting Programs?

Since 1997, I have coordinated a home visiting program for families with young children in Halifax, Nova Scotia, Canada. This program was launched in 1995 with volunteer home visitors only; in 2003, funding was secured to add a full-time professional Family Support Worker to the team. This addition changed the program in the ways we had hoped it would, and in ways that went beyond what we had envisioned; at the same time, of course, it did not solve all of the challenges we faced. These experiences, which are described in greater detail in Section 1.5, prompted me to search for published literature on other programs with this structure. I wondered: Did other programs have similar, or different, combinations of paid and volunteer home visitors? Had they experienced similar benefits and challenges, or were their experiences different?

I also have a keen interest in program development and the broader context of service delivery – that is, how do programs and organizations develop? What forces have an influence on their development, either positive or negative? Therefore, I wondered whether other programs that had either only paid home visitors, or only volunteer visitors, had considered expanding to have both types of visitors, and if so, what factors had enabled or inhibited this plan.

However, while my search of the literature revealed a large body of published research and evaluations on home visiting programs, there was barely a mention in this literature that some programs might have both volunteers and paid visitors. Over time, I learned that some other programs actually did have both types of visitors; however, that fact was either not mentioned in the literature, or was noted briefly but not explored as part of the research or evaluation questions. This increased my curiosity: why was this consistently the case? Given that I was preparing to write a Master's thesis, it seemed timely to pursue these questions further, in order to gain more insight into what I have called "mixed-delivery" home visiting programs.

1.1.2 Overview of the Research Goals, Process, and Questions

In undertaking this preliminary exploratory study, my primary goal was to deepen my understanding of these mixed-delivery programs – that is, their development, characteristics, strengths, challenges, and opportunities. The study was descriptive in nature, rather than comparative or evaluative; I did not set out to measure or evaluate either the programs themselves, or their volunteer or paid visitors.

As will be described in detail in Section 5.7, starting in 2007, I began an extensive search to locate as many mixed-delivery programs as possible, eventually finding and corresponding with a total of eight such programs in four countries. Three of these programs, from three different countries, took part in the present study.

The study employed an embedded multiple case study research design. Methods included semi-structured interviews with fourteen individuals (all current or former program staff or volunteers), and a review of relevant agency documents. During the data collection phase, I also kept a personal research journal.

Through this study, I have examined the historical development and key program characteristics of each programs, as well as the following core research questions:

1. What are the experiences of those who work and volunteer in mixed-delivery home visiting programs? (*for example, the experiences of volunteer visitors*)

working with paid visitors, paid visitors working with volunteer visitors, and supervisors working with both)

2. What do volunteers and paid staff identify as the strengths, challenges, and dilemmas of this approach to home visiting?
3. What has allowed these strengths to exist? Why are they considered to be strengths?
4. How do volunteers and staff deal with the challenges and dilemmas?
5. What can this approach contribute to the field of home visiting generally?

1.1.3 Potential Benefits of This Study

An increased understanding of this approach to service delivery will contribute to the knowledge base regarding two specific areas of practice: home visiting for parents of young children, and the engagement of volunteers and paid staff within the same in-home program. The findings will be of value to organizations doing in-home work with other vulnerable or marginalized populations, both locally and internationally. Finally, the findings highlight potential areas of focus for future research.

1.2 THE BROAD CONTEXT: CHALLENGES FACING YOUNG CHILDREN AND THEIR FAMILIES

A growing and multi-disciplinary body of research into human development tells us that the prenatal period, infancy and early childhood set a child's lifelong trajectory for health, well-being, and overall ability to function in the world (McCain, Mustard, & Shanker, 2007; United Nations Children's Fund [UNICEF], 2008). However, widespread social and economic changes in recent decades mean that parents with young children face new and deepening stressors (Canadian Council on Social Development [CCSD], 2006; Moore, 2008; Scott, 2005). As a result, they may actually have fewer resources available to them than parents in previous generations (McCain et al., 2007) and increasing needs for support (National Collaborating Centre for Determinants of Health, 2008, p. 10). As well, despite some gains in women's equality, many mothers still face

daunting challenges linked to mothering, such as post-partum depression or anxiety (Pacific Postpartum Support Society, 2002), or the difficulties of raising children alone, often struggling to survive on a very limited income (CCSD, 2006; Ross, 2006).

In light of this, governments in most wealthy western countries have introduced a comprehensive web of universally available services and supports for families and young children (Kershaw & Anderson, 2009; Organization for Economic Co-operation and Development [OECD], 2006; UNICEF, 2008). National governments in wealthy, capitalist Anglo-Saxon countries have not followed suit, despite the fact that young children in these countries experience high rates of preventable delays and difficulties (Hertzman, 2009; Kershaw & Anderson, 2009; UNICEF, 2008).

In recent decades, across these Anglo-Saxon countries, an array of services has been introduced at local and regional levels, aimed at supporting the healthy development of young children and/or the well-being of their families. These programs are generally stand-alone and often targeted, as opposed to universally available. As a result, what families experience has been described as “chaos” (McCain et al., 2007): a fragmented and confusing jumble of often under-resourced, stand-alone services, working with limited capacity and/or restrictive eligibility criteria. Not surprisingly, this scenario falls far short of a coordinated system that can readily identify needs across the population and facilitate timely access to services.

This broader socio-political context, and its implications for families, children, and the programs that serve them, are discussed further in Chapter 2. It is within this difficult context that these services, including the home visiting programs outlined below, do their best to meet the needs of families.

1.3 THE SPECIFIC CONTEXT: HOME VISITING FOR FAMILIES WITH YOUNG CHILDREN

Among early child development and family support services, one fairly widespread approach is home visiting programs. As described in Section 3.1, these are

separate and distinct from the 'early' (perinatal) public health home visiting programs with which many people are familiar. Families involved with these 'longer-term' home visiting programs are visited for anywhere from a few months to several years; regular visits may be made on a weekly, bi-weekly, or monthly basis (Pennock & Ross, 2002). The services provided vary, but commonly include some combination of emotional support, parenting and life skills education, information on infant and child development, community referrals, and advocacy (Knoke, 2009). Some programs provide additional services, such as crisis intervention, practical help with caring for the child(ren), accompaniment to appointments, and/or direct access to parent groups, preschool programs, or other services operated by the same organization (Black & Kemp, 2004; Kelleher & Johnson, 2004; Paris, Gemborys, Kaufman, & Whitehill, 2007; Pennock & Ross, 2002; Zercher & Spiker, 2004). A large body of literature on home visiting (presented in Chapter 3) describes the processes and features of different program models, and indicates that various models can have a range of impacts on parent and child well-being (Kitzman, 2004; Olds & Kitman, 1993¹; Pennock & Ross, 2002).

The vast majority of these longer-term programs are delivered by paid home visitors. However, throughout these wealthy Anglo-Saxon countries, there are also a

¹ Articles by Krugman, Olds & Kitman, Powell, Weiss, and Wasik (1993) are cited throughout this thesis. Each article formed part of a 1993 issue of the journal *The Future of Children*, dedicated entirely to family home visiting; a follow-up issue was published in 1999. The chapters were written by experts in the field, at a time when home visiting had just experienced a decade of rapid growth and change. The chapters contained a deep philosophical and practical understanding of the essence of home visiting, and came from a progressive, holistic, yet realistic and analytical vantage point; many of the themes raised still resonate. Wherever possible, I have also used more recent sources; however, in the intervening years, much of the published literature on home visiting has shifted to discussing meso- and micro-level issues, bypassing the larger descriptive, analytical and philosophical issues in pursuit of determining the exact outcomes and effectiveness of various home visiting models for different populations of families. While these are important questions (and indeed, they arose out of the recommendations from the 1993 and 1999 issues), they do not contribute in quite the same way to the broader discussions on this unique field.

number of volunteer home visiting programs. The programs with paid visitors, and those with volunteer visitors, have many features in common, but also differences (see Chapter 3 for details). Finally, a much smaller number of programs with *both* paid and volunteer visitors are also in operation; these mixed-delivery programs are the focus of the present study.

1.4 THE INTER-DISCIPLINARY CONTEXT: HOME VISITING AND ITS RELATIONSHIP WITH SOCIAL WORK

1.4.1 The Historical Relationship between Home Visiting and Social Work

Internationally, the field of home visiting for ‘vulnerable’ families with infants and young children is not primarily located within the realm of social work, either at its earliest roots or at the time of this writing. The field is most closely linked with nursing, although home visitors, program managers, and other program staff may have backgrounds in early childhood education, family studies, health education, human services, social work, and other disciplines. Additionally, many programs employ ‘paraprofessional’ or ‘lay’ home visitors, who are often from the same community and/or cultural background as the parents being served. They usually bring to their role relevant life experience, on-the-job training, and their own personal characteristics, but are often not required to have relevant professional education (Pennock & Ross, 2002; Powell, 1993; Wasik, 1993).

While social work has not been at the forefront of home visiting, home visiting played a central role in the earliest development of the field of social work, particularly in the direction that this fledgling new profession would take. Home visiting’s distant ancestors were the “friendly visitors” of Elizabethan England, laypersons who “provided care to the poor in their own homes.” (Wasik, 1993, p. 141). In the late 1800’s, Florence Nightingale advocated nurse home visiting for the sick and lay home visiting for rural mothers in England. Ever the visionary, she saw a role for both ‘lay’ and professional visitors, and also called for specific training for in-home workers – “anticipat[ing] two of the most significant issues facing the field of home visiting a

century later” (Wasik, 1993, p. 141). In Europe and the U.S., nurse home visitors provided life-saving public health education to new mothers (Council on Community Pediatrics, 2009), while across the United States, they cared for “ the urban poor, especially. . . the new immigrants who flooded the country at the turn of the twentieth century” (Wasik, 1993, p. 141). Throughout this time, there were also thousands of volunteer home visitors, generally women who were organized by local charitable societies and drawn from the ranks of the upper classes. Nurses and volunteers were soon joined in these efforts by teachers and members of the new profession of social work (Wasik, 1993).

Some of these newly established home visiting programs were grounded in a philosophy that “environmental conditions significantly influenced personal problems and illnesses” (Wasik, 1993, p. 141). Indeed, social work pioneer Jane Addams, and many of her (paid and volunteer) colleagues in the Settlement House movement, did home visits as one part of their outreach and social change work. Their visits allowed them to have contact with those who could not come to the Settlement House; these individuals and families were often experiencing significant difficulties. In this context, home visits were used to educate people as to their options and rights, and to gather information needed for individual and/or class advocacy (Meigs, 1970) – not to convince individuals and families to change how they lived. Given the deplorable housing and workplace conditions, extreme poverty, and lack of access to basic services that many in the inner cities experienced during the late 1800’s and early 1900’s (Weiss, 1993), there was no shortage of issues upon which to take action.

However, many other home visiting services of this time were modeled on the belief that the poor created their own problems by being lazy, impulsive, and generally of poor moral character (Carniol, 2005; Weiss, 1993). In a speech given in 1890, emerging social work leader Mary Richmond stated, in reference to working with low-income families: “we have aimed to send to each family that needs an uplifting hand, a patient, persevering, faithful friend, who, by the power of that strongest thing on earth, *personal influence* [emphasis added], will gradually teach them habits of industry and

self-control” (Richmond, 1930, p. 41). Richmond naively believed that, if volunteer home visitors could be sent “...through all the miles of wretched commonplace and squalor, into each miserable semblance of a home, it would bring a new standard of decency, order and self-control, a new hope and expectancy, to which the poor would slowly but surely rise” (ibid.). Over time, Richmond and many others began to see both the complexity of the problems faced by poor people, and the shortcomings of a volunteer workforce. As well, many volunteer visitors became “mediators, advocates, and brokers” (Weiss, 1993, p. 116), and some launched broader-based campaigns to improve living and working conditions (Weiss, 1993). The original friendly visitor concept, however, left a lasting impression, as it was a precursor of social case work, which – under the growing influence of individually-based psychoanalytic theories (Wasik, 1993) – would eventually evolve as the dominant model of social work in the U.S. and Canada.

1.4.2 Home Visiting Today

Today in-home health, social, and educational services encompass a broad range of programs, designed to meet the needs of different populations who are considered to be vulnerable or at-risk, such as frail senior citizens (Shugart, 1992) and isolated families with preschool-age children (Olds, Sadler, & Kitzman, 2007). As will be discussed in Chapter 3, home visiting programs for parents and young children have experienced shifts in their philosophical and theoretical orientations over the decades, and today, follow any number of approaches, structures, and mandates (Weiss, 1993). Within this field, there is a substantial body of knowledge regarding infant and child development, parenting skills, and family functioning. This is back-lit by the ever-present awareness of the critical importance of healthy early human development, and the gap between what the research evidence *says* and what we *do*, both as a society and as parents/caregivers (see Chapter 2 for details). Depending on their philosophical/theoretical orientation, home visitors within these programs recognize the right, and/or the responsibility, of all parents to have the necessary information,

understanding, skills, and resources to create a stable and caring family life. Home visitors help parents gain this information and understanding, develop these skills, and access these resources. As outlined below, it is in part this ‘knowledge’ component of family home visiting that necessitates an interdisciplinary home visiting workforce, in which social workers can play an important role.

1.4.3 Social Workers in an Interdisciplinary Milieu

Social workers do not typically have the health assessment and education expertise of nurses, nor the parent education backgrounds of family studies graduates, nor the child development knowledge of early childhood educators. Social workers who are employed in family home visiting programs *need* these professions, and the expertise that they bring. For example, social workers’ education in social welfare and social justice informs our understanding of the legal and human rights violations that are committed against young children who must live in significantly compromised circumstances. However, when we also understand the comprehensive long-term developmental damage that is done to such children, we have powerful new tools to use in our work with parents, colleagues, and policy makers.

For our part, social workers also have important contributions to make within home visiting programs, particularly in two key areas. First, social workers’ understanding of the importance of community resources and social supports can facilitate home visiting programs forging strong connections with community-based organizations, and can help families access all relevant options and supports. This is an area in which social workers may have a stronger focus than workers in some other professions.

Second, social workers can help home visiting colleagues to view families’ realities within the context of various forms of oppression and unjust social and economic structures, and to develop a critical analysis of how these forces have impacted families, both historically and at present. This is due to the centrality of these issues within the profession, given that “principles of human rights and social justice are

fundamental to social work” (International Association of Schools of Social Work, n.d.) and that “social workers are change agents in society and in the lives of the individuals, families and communities they serve” (ibid.). This unique professional background has impacts in two key areas:

- **Understanding and working well with diversity among families.** Social workers and other health and human service professionals often receive professional education regarding the needs of different groups in society. Examples include immigrants and refugees, single parents, people (parents) with (dis)Abilities, adolescent parents, and families who belong to indigenous ethnic and racial groups that have been marginalized (e.g., aboriginal peoples, African Canadians, Roma, Travellers). Given social work’s orientation toward justice and equity, social work education often includes not only the more common informational content on these groups, but a critical analysis of the effects of power, privilege, and oppression, framed within the view that every individual, no matter how marginalized or ‘othered,’ has an inherent worth and dignity.

This is especially important because most home visiting programs rely on many different visitors to provide support to families in that most personal of environments – their own home – and, in volunteer-based programs, that roster of visitors is always changing. Thus, support and mentoring from staff who have a solid knowledge base and critical analysis may be key to volunteers’ ability to work successfully with a broad range of families.

- **Understanding the root causes of families’ difficulties.** This critical social analysis helps home visiting programs from slipping into an individual, deficit-based model of practice – which, echoing Mary Richmond’s approach to some extent, might be summed up as “if we educate ‘these people,’ they will change, and their problems will be solved.” This approach can blame parents and pathologize their difficulties, thus preventing the establishment of supportive and enduring alliances with clients. It can also mean that home visitors ‘miss’ the root causes of problems, making it much more difficult to help parents actually address and resolve the complex challenges they face (for example, the medical-psychiatric model obscures the social roots of many mental health problems). An individual model of practice can also “burn out” workers who, lacking a socio-political analysis, may hold themselves or their clients responsible for parents’ slow and uneven “progress.”

In contrast, when a home visitor understands a family's reality and the forces that have shaped their lives, listens to parents, and validates, informs, and empowers them, that visitor can play a key role in enabling parents to move forward in substantial ways. This analysis can 'round out' the rich repertoire of skills possessed by home visitors from professional backgrounds outside of social work.

Social workers, who witness so much suffering, inequality, and injustice, can also benefit immeasurably – as professionals and as individuals – from being involved in the preventative work of early child development. The 'upstream' focus of early childhood work has many moments of hope and promise. For example, when a young mother and father, each from very difficult family backgrounds, grab hold of the current information on healthy child development, and consciously work together to do things differently with their own children, this creates a great deal of joy, pride, and hope for the future. In my own experience, this can have a profoundly positive effect on parents – and workers, too.

1.5 THE PERSONAL CONTEXT: THE RESEARCHER'S EXPERIENCE

1.5.1 Program Overview

Since 1997, I have worked as Co-ordinator of the Extra Support for Parents Volunteer Service (ESP). ESP is a home visiting program of the IWK² Health Centre, the regional children's and women's hospital in Halifax, Nova Scotia, Canada. ESP began in 1995 with volunteer home visitors only; in 2003, we added a full-time, paid, professional Family Support Worker.

ESP serves parents and caregivers in the local metropolitan area who have infants, and who are also dealing with challenges to health, well-being, post-partum adjustment, family stability, and/or positive parent-child relationships (Extra Support for

² The IWK Health Centre was created through the 1996 amalgamation of the Grace Maternity Hospital and the Izaak Walton Killam Hospital for Children.

Parents Volunteer Service [ESP], 2008a). These challenges may be long-standing, and even intergenerational in nature, and may include poverty, low literacy or education levels, mental health challenges, social and economic exclusion, and/or a difficult family history (such as instability, conflict, or violence). Challenges may also be shorter-term, stemming either from the transition to parenthood itself (e.g., post-partum anxiety or depression, multiple births), or from a specific event that has occurred around the same time as the arrival of the baby (such as a recent illness or death in the family, separation, or immigration to Canada). Many families involved in the program are dealing with several such stressors at once.

ESP volunteers are generally matched with one family at a time, and visit for three hours weekly, most often for about three to four months (though the duration of a 'match' can range from a few weeks to over a year). Volunteers provide emotional support, information on parenting and community resources, and practical help with the children. Volunteers take part in three mandatory day-long training programs, and attend one two-hour training session each month, which feature guest speakers on relevant topics and are also a place to discuss challenges that volunteers are encountering in their ESP role. In recent years, the number of active ESP volunteers has ranged from 25 to 50 (ESP, 2008a), depending on the challenges and successes of our various volunteer recruitment efforts.

ESP's professional Family Support Worker role was introduced to allow the program to meet the needs of families with more complex issues and challenges. We had found it very difficult to serve these families, both in the short-term (the in-home experience was often stressful for volunteers), and in ways that would actually alter their difficult circumstances or future trajectories. Thus, the Family Support Worker (FSW) is a full-time staff member who has the education, skills and expertise to assist families in ways that may not be appropriate, realistic or feasible for a volunteer. The FSW provides parenting education and intervention, helps families address difficult life issues, and acts as an advocate and support person (ESP, 2008a). The individual holding

this position must possess extensive knowledge of child development and family functioning; an analysis of social forces, oppression, trauma, and healing; and a combination of relevant prior employment, life experiences, and post-secondary education in a professional field. Equally important are the personal qualities – such as self-awareness, insight, non-defensiveness, flexibility, candor – which allow the FSW to work effectively in very challenging circumstances. The duration of FSW service varies greatly, depending on family needs, and can range from one visit to a few years; the majority of families receive service for three to nine months. Many families successfully transition to other services around the time of closure with the Family Support Worker; some transition to being matched with an ESP volunteer.

1.5.2 The Researcher's Experience and Perspective

Having a team of volunteers working in conjunction with a Family Support Worker has strengthened ESP in many ways, and yet at the same time, has heightened some of our challenges. We are better able to serve families with more complex needs; this is due to the FSW's skills and knowledge, as well as her flexibility. She can spend an increased amount of time with a family during a crisis; in comparison, a volunteer's availability is most often dictated by her pre-existing commitments to work, family, and so on. This combination of flexibility, knowledge, and skill is particularly helpful when families are having difficulty in their interactions with institutions and individuals who have power over them. As has been well-documented in the literature, many vulnerable and marginalized families face numerous difficulties in their attempts to engage with service providers (Centre for Community Child Health [CCCH], 2010).

ESP's volunteer home visitors, in turn, play important roles that are not normally provided by paid staff from any agency in our community, such as watching the children while an exhausted mother sleeps, or providing non-judgmental peer support during a difficult time. In my experience, many mothers express amazement that a kind and trustworthy person is coming to help them each week, without being paid, and that this person believes they are worthy of such support. For some women who have had few

positive role models or people who believed in them, the volunteer-parent relationship can be life-altering (Acton, 2005; Paris & Dubus, 2005).

Because ESP volunteers and paid staff are working in the same program, there is a continual two-way flow of information. Anecdotally, I have seen this flow of information reduce the stress level of both paid staff and volunteer visitors, and facilitate positive developments for families. While it is possible to have on-going communication between people working or volunteering with different agencies, I have observed barriers to making this happen, such as busy schedules, lack of familiarity or trust with others in various agencies, and the restrictions of privacy laws.

As outlined above, my experience tells me that, for our program, having both staff and volunteers doing in-home work is a responsive, flexible, and effective means of service provision, and is particularly effective in enhancing our capacity to serve vulnerable families. While our first formal program evaluation, conducted by an external evaluator (Acton, 2005) was primarily focused on the work of the volunteers, evaluation feedback from parents and volunteers echoed many of these observations.

However, we have also experienced some challenges, mainly relating to two areas, communication issues and the availability of staff and volunteers compared to families' needs. These are briefly outlined below.

1. Communication issues: When two home visitors are working with the same family, this adds to the number of parties who must be kept 'in the loop'. As a result, miscommunication and misunderstandings can sometimes occur.

2. The availability of staff and volunteers compared to families' needs.

Sometimes families need the services of the Family Support Worker, but we cannot offer this because our FSW is already carrying a full caseload (15 to 20 families). Other times, parents who are working with the FSW may also need the services of a volunteer; if there are no volunteers available, or if the family's situation is too challenging, we cannot offer that support.

Additionally, my own time restrictions as the program's Coordinator have resulted in two tiers of support. Those families who were initially visited by the FSW (through the intake process) have ready access to the follow-up services of

a staff member, as needed. In contrast, those families who were initially visited by the Coordinator have much less access. While families in this latter group are generally less vulnerable and/or more well-supported than the families visited by the FSW, some do need the time and attention of a staff member. Most often, I do not have this time to give.

Finally, while our team can generally provide tailored services, we cannot change the difficult and unjust social and economic factors that shape families' lives. This is a source of frustration and sadness for ESP staff and volunteers, and is perhaps experienced more often since adding the Family Support Worker position, as we now work more closely with families who face many heartaches, challenges, and risks.

1.5.3 'Use of Self' in This Thesis

This research process has been informed by my own experience in the field, and specifically, my experience coordinating a mixed-delivery home visiting program. Throughout the thesis report, I have interspersed my own learning, experiences, and insights with those of the study participants. Indeed, in several instances, to varying degrees, I have analyzed and discussed study participants' comments through the lens of my own experiences. Throughout this document, I have stated up-front which analyses were based on my own experiences (in the Findings sections, these are separated from the main text and titled "Researcher's reflection"), and which came from the analysis of a particular participant, from the literature, or from the shared experiences or insight of several participants. Additionally, I have tried to remain aware of my own biases and limitations, not just in relation to my location as someone who works in this field, but in general; these themes are discussed in detail in Chapter 5.

1.6 THEORETICAL PERSPECTIVE

Both this research study and my social work practice with families are framed by structural-feminist theory and relational-cultural theory. Structural theory highlights the inequitable and exploitative nature of societal structures and institutions – government, the justice and educational systems, the private sector, media, and so on –

and the intersection of various forms of oppression within our economic and socio-political system (Mullaly, 2007). Feminist theory calls critical attention to the continued marginalization and oppression of women in society (Carniol, 2005; Hill Collins, 1994; Rossiter, 1988), which is centrally relevant to the idea of serving overburdened and isolated families at a time of life when women are particularly vulnerable. Relational-cultural theory³ focuses on the importance of authentic, empathic, reciprocal and supportive relationships, particularly in women's lives (Jordan, Kaplan, Miller, Stiver & Surrey; 1991; Miller & Stiver, 1997).

These theories inform and support my work, and help me to analyze, understand, and re-frame the many situations that I confront on a day-to-day basis. The weaving together of these theories also creates a strong foundation that helps me navigate between the different program philosophies that I outline in this paper. These theories are discussed further in Chapter 4, Theoretical Framework.

³ At the time of this writing, "Relational-cultural theory" was the term commonly used; when first introduced by Jordan, Kaplan, Miller, Stiver and Surrey in 1991, it was called "self-in-relation" theory [R. Paris, personal communication, 5 March 2010].

CHAPTER 2: THE SOCIO-POLITICAL CONTEXT

Home visiting programs in western, Anglo-Saxon industrialized countries operate within a paradox of increasing family and child vulnerability throughout all corners of society (McCain et al., 2007), mounting scientific evidence regarding the critical importance of early child development (UNICEF, 2008), and wholly inadequate responses from government (Kershaw & Anderson, 2009). These colliding forces, and their impact, are outlined below.

2.1 THE LONG REACH OF EARLY CHILDHOOD

In recent decades, a substantial body of research has given us compelling insight into the development of the human brain in the first several years of life. On this topic, the science is clear, strong, and plentiful: children's experiences from the prenatal period to age five have a greater impact – greater than at any other time of life – on all areas of their development (McCain et al., 2007; OECD, 2006). Within these critical years, the prenatal and infancy periods have the greatest impact overall (McCain et al., 2007), and present the greatest return on public investment (Kershaw & Anderson, 2009; Kilburn & Karoly, 2008; OECD, 2006). Key among the impact areas are children's ability to learn throughout their lives, regulate their emotions, form healthy relationships, act in pro-social ways, and maintain lifelong physical and mental health – or illness (UNICEF, 2008). As McCain, Mustard and Shanker assert in their landmark 2007 report, *Early Years Study 2*,⁴ the first months and years of life set a child's lifelong *trajectory* for health, well-being, and ability to function in society:

⁴ The 1999 *Early Years Study* and the 2007 *Early Years Study 2* are internationally acclaimed 'gold-standard' reports in the ECD field. The *Early Years Study 2* gathered evidence from a range of disciplines, including neurobiology, medicine, nursing, demography, economics, early child development, and sociology. The authors and their research team analysed and synthesized this data, and presented a comprehensive, integrated report that could be understood by a fairly broad audience.

A new measure of clarity and a deeper understanding of the kinds of environments that promote or impair the developing brain are emerging. The roots of economic productivity and health risks in adulthood are found in early childhood. The convergence of independent research in neuroscience, developmental psychology, epidemiology, population health, molecular biology, and economics is remarkable: the earliest experiences of children reach long into adulthood (p. 17).

The critical components to setting a child on a 'good' trajectory are, on the surface, not complicated. They include responsive interaction from caregivers; a great deal of physical contact and closeness with loved ones; cognitive stimulation through talking, singing and reading to the child; developmentally appropriate opportunities to learn through exploration and play; and access to health care services; also key is the *absence* of both violence in the child's home and chronically high levels of stress or dysfunction among family members (McCain et al., 2007; Moore, 2008; UNICEF, 2008). However, in recent years, respected international organizations and experts in the field have sounded the alarm that, for a number of reasons, some or all of these factors are not present for a significant number of children from Canada and other wealthy, capitalist, Anglo-Saxon nations (McCain et al., 2007; OECD, 2006; UNICEF, 2008).

2.2 BARRIERS TO OPTIMAL HUMAN DEVELOPMENT

According to McCain et al. (2007), the most important factors in determining healthy early human development include socio-economic status, neighbourhood characteristics, parenting style, family (dys)function, and maternal health (particularly mental health and substance use). As will be explored in the following paragraphs, these factors have pervasive and long-term impacts. However, even among families who do not have risks in any of these areas, family isolation and lack of participation in quality ECD programs are linked to increased chances of vulnerability by school entry (McCain et al., 2007; UNICEF, 2008). As well, given that ever-increasing numbers of mothers of young children are in the work force (close to 70% in Canada) (OECD, 2006), the question of not only home environments, but equal access to quality early childhood

education and care programs as well, are major considerations in healthy child development.

For those children with multiple barriers to healthy development, the picture is especially grim. Many vulnerable families face not one or two risks to family stability and child well-being, but several often complex and enduring risks. Structural risks include poverty (CCCH, 2009), living in a dangerous and troubled neighbourhood (McCain et al., 2007); and lack of access to transportation, children's services (such as quality child care and early intervention) (Doherty, 2007), education, employment, and adult services (such as mental health and addictions) (Taylor, Edwards, & Gray, 2009). In Anglo-Saxon countries, few measures are in place to ameliorate these difficulties, and in recent decades, the social safety net has been gutted (Mullaly, 2007), and income equality has been increasing (Scott, 2005). In contrast, other wealthy western nations have been able to significantly reduce, or even eliminate, some of these inequalities and structural barriers (OECD, 2006; UNICEF, 2008).

There are also risks that can only be reduced through changes made by parents and caregivers themselves; however, these too are significantly influenced by societal forces, inequality, and structural barriers. These risks include mental health difficulties, addictions, abusive relationships, a lack of ability and/or trust in interacting with people outside the family (CCCH, 2010), and problematic parenting styles – that is, approaches that are too harsh, too lenient, or chaotic and unpredictable (Matusicky & Russell, 2009). Again, in Anglo-Saxon countries, there is a lack of services in place to help families prevent or overcome these problems.

Further, these difficulties often interact with one another, compounding the negative effects. For example, Melbourne, Australia- based Centre for Community Child Health (2009) has warned that “the stress that is often associated with poverty” (p. 1) impairs the parent-child relationship, which in turn “compromises child development and stymies ... human potential” (p. 1).

Finally, a growing body of literature speaks to the fact that families with elevated risks and fewer resources are actually *less likely* to access and remain involved with services than families with lower risks (CCCH, 2010; Olds et al., 2007; Tough et al., 2006; Watson, White, Taplin, & Huntsman, 2005). The Centre for Community Child Health (2010) has identified three levels of barriers – family, relational, and program – that contribute to this troubling phenomenon. Family-level barriers make it difficult for families themselves to access or prioritize a service, even if that service is welcoming, skilled, and barrier-free. These include barriers that are both external to the family (e.g., poverty, lack of transportation) and internal, such as mental health difficulties or “beliefs about the necessity and value of services” (CCCH, 2010, p.2). Relational barriers are “beliefs, attitudes and skills” that compromise the ability of either service providers or vulnerable families to engage successfully with one another in a helping relationship (CCCH, 2010, p. 2). Program-level barriers include characteristics of the service or institution itself, which prevent marginalized and vulnerable families from taking part. These include, among other things, “cost of services, limited availability ... inflexible appointment systems, lack of affordable child care” and “the absence of an outreach capacity” (CCCH, 2010, p. 2).

Many experts have stressed the importance of programs in the health, social service, and education fields being able to work well with vulnerable and marginalized families (CCCH, 2010; Doherty, 2007; McCain et al., 2007; Olds et al., 2007). However, they have also cautioned that even highly responsive and effective services cannot, by themselves, significantly reduce families’ difficulties. Poverty and other structural risk factors have such a tremendous impact on young children’s well-being (CCCH, 2009), that these also need to be addressed, and at a broader level (Gomby, Culross, & Behrman, 1999).

Western Anglo-Saxon countries such as Canada, the United States, and Australia are among the wealthiest in the world. They purport to value human dignity, individual rights, social and class mobility, and education. Given their low birth rates and aging

populations, one would expect them to invest in the abilities and success of all of their children. Instead, as outlined above, many young children face multiple barriers to healthy development, and as described in the following section, these countries continue to be characterized by significant gaps in the public support system.

2.3 CHAOS ACROSS THE LAND – AND NARY A GOVERNMENT RESPONSE IN SIGHT

Parents and guardians in most wealthy, industrialized Anglo-Saxon nations are struggling daily to do what is best for their children, but in comparison to previous generations, they are often working with fewer resources and facing greater economic pressures and care-giving expectations (Moore, 2008; Scott, 2005). Their governments have not made healthy early child development and family support a priority (OECD, 2006; UNICEF, 2008). Instead, successive governments have framed this issue within the long-held beliefs that the needs of young children are best met by their parents (Corrigan, 2003), these issues are a matter of neither public concern nor expenditure (Bennett, 2008; McQuaig, 2004), and government should provide programs and services only as absolutely necessary (Mullaly, 2007). While each of the Anglo-Saxon nations has its own strengths and weaknesses in this arena, as a group, these countries offer limited means-tested financial supports and/or employment-contingent parental leave; high rates of child poverty (UNICEF, 2010); and a thin patchwork of residual, underfunded, poorly regulated and often inaccessible early child development and family support services (OECD, 2006; UNICEF, 2008).

Very recently, some large-scale government-initiated programs have been introduced in a number of jurisdictions within these wealthy Anglo-Saxon countries. Australia has made significant improvements to its maternity leave provisions (Hayward, 2010) and has increased funding for certain early child development programs. Ireland, Ontario and several states in the U.S. are implementing some form of universal pre-school for the year before school entry (generally, age four; in Ireland, age three-and-a-half) (Citizens Information, 2011a; Morgan & Nadig, 2006).

However, with the exception of this Ontario initiative and Quebec's child care and parental leave initiatives (Japel, 2009; Monsebraaten, 2008), Canadian governments are not following suit. Indeed, Canadian family policy experts Kershaw and Anderson (2009) have warned that "family policy innovations in the United Kingdom, Australia and New Zealand [will soon] begin to leave Canada behind" (p. 686). As well, even though the above-noted initiatives are much needed, they are mostly stand-alone, single-focus programs. They are not what UNICEF, the Organization for Economic Co-operation and Development (OECD), the Council for Early Child Development (CECD) and other organizations have called for – a comprehensive, multifaceted, and integrated national strategy for healthy early child development and family well-being (McCain et al., 2007; OECD, 2006; UNICEF, 2008).

In the U.S. and Canada in particular, the present system of government supports for families is both insufficient (Calman & Tarr-Whelan, 2005; McCain et al., 2007; OECD, 2006; UNICEF, 2008) and outdated (Kershaw & Anderson, 2009; Scott, 2005). It has not been designed or funded to optimize early development, protect families from becoming vulnerable, or provide adequate supports during times of economic or social vulnerability (Carniol, 2005; Scott, 2005). The result: families must rely largely on their own financial resources and informal support systems. When these are not adequate in meeting their needs, parents face significant challenges in accessing any type of income supports or family-friendly programs – delays, low payment levels, high incidence of ineligibility due to exclusive criteria, and often, a complete void of relevant programs (Campaign 2000, 2008; Kershaw et al., 2009; OECD, 2006; Scott, 2005). As noted by Scott (2005), benefits in these countries are increasingly reliant on employment: unemployment insurance, maternity and parental leave, and supplemental health benefits (including drug plans and access to home care services), are all tied to employment. In the U.S., even basic health care is tied to employment status (Scott, 2005).

2.3.1 No Place at the Table: Young Adult Parents in Anglo-Saxon Economies

The absence of government supports leaves some populations of parents and children more vulnerable than others. Young parents are one such group. In Canada and other countries, government and corporate cutbacks and restructuring, followed by increasing credentialism in most fields, have meant that for more than twenty years now, there has been no meaningful place for young adults in the economy (Moore, 2008; Scott, 2005). Thus many young people attend post-secondary education and/or working, with the simple goal of increasing their *chances* of being able to earn a living wage (OECD, 2006). Some of the most striking results of this phenomenon are decreased birth rates and a trend toward delayed childbearing in many wealthy, industrialized countries (OECD, 2006). In Canada, those youth and young adults who do have children pay a heavy price: low wages, combined with a lack of affordable housing and child care (Campaign 2000, 2008) and a dearth of family-friendly public policies (Kershaw & Anderson, 2009; Scott, 2005; UNICEF, 2010) mean that young parents face extremely high rates of poverty (McCain et al. 2007) and limited opportunities to improve their situation. This is just one example of a sub-population that has been particularly poorly served by the “hands-off” approach of Anglo-Saxon governments.

2.4 THE VULNERABILITY AND SECOND-CLASS STATUS OF MOTHERS

The process of becoming a mother has been described as a “critical and often stressful” transition (Olshansky, 2003, p. 263). In ideal life circumstances, women go through many cognitive, emotional, and social processes to make this transition to parenthood and to develop a “new normal” (Mercer, 2004, p. 230). Yet many mothers’ life circumstances are far from ideal; they are struggling with multiple stressors (CCSD, 2006) that can disrupt, thwart, or severely impair this already challenging process (Acton, 2005; Paris & Dubus, 2005). Mothers can be left feeling alone, overwhelmed, inadequate, and/or angry (Acton, 2005; Taggart, Short, & Barclay, 2000).

Despite gains in women's equality over the past several decades, inequality still shapes many aspects of women's lives. This is particularly the case during a vulnerable time such as the perinatal and postpartum periods, when women are giving birth, recuperating from childbirth, facing the often-unprecedented demands of newborn care, and dealing with a range of stressors such as emotional, financial, and relationship changes. Institutionalized inequities accentuate this situation; for example, Canadian parental leave policies provide a false aura of universal protection amidst several key exclusions and weaknesses that leave many women with inadequate maternity leave benefits, or none at all (Felesky & Kirshner, 2005; Kershaw, 2009). Internalized societal ideals regarding motherhood can compound this vulnerability in particularly cruel ways: one manifestation is the belief that a mother alone should be able to meet all of her baby's needs, and that to ask for or accept help, indicates weakness – or even failure – as a mother (Rossiter, 1988). In my own professional work, I find this to be a common belief among many new mothers.

Hrdy (2009) shows the fallacy of this belief through extensive research into the biological and social history of human emotional development. She posits that, even among primates, human babies are uniquely demanding; thus, mothers and their infants were never meant to be alone, and the practice of the isolated nuclear family (or the mother-child dyad) goes against the survival of *homo sapiens* as a species. Yet in so-called wealthy and 'advanced' societies, millions of women struggle, alone, with the burdens of a new baby – and oftentimes, other life stressors as well.

Beyond the immediate perinatal period, mothers face other disadvantages because of sexism and misogyny. Women are still clustered in lower-paying occupations such as the service industry (Scott, 2005; UNICEF, 2008), and are less likely than men to be in higher-income positions (OECD, 2006). Women face violence and abuse in intimate relationships, and must overcome many complex legal, safety-related, financial and personal challenges in order to leave such relationships, heal from these experiences, and create a new and safe home environment for themselves and their children

(Atkinson, 2008). As well, the lack of family-positive public policies affects women more dramatically than men (Kershaw, 2009; UNICEF, 2008); indeed, the lack of child care in Canada and the U.S. has allowed the gender equality rankings of both countries to slip (UNICEF, 2008). Meanwhile, in Ireland, the lack of child care has relegated the majority of mothers of young children to low-paid, part-time employment with limited benefits and job protections (OECD, 2006). The lack of child care *subsidies* has disadvantaged Irish women further, as “on average, Irish parents pay more than 50% of the costs of child care. Without subsidisation or the capping of fees charged by providers, many women in low and moderate income jobs are unable to access child care of an acceptable level of quality” (OECD, 2006, p. 28). Thus, institutionalized sexism and misogyny continue to deny many women and children in these countries opportunities, rights, and quality of life.

Societal beliefs and social structures merge in powerful ways, as illustrated by one deeply ingrained cornerstone of wealthy Anglo-Saxon countries: the concept of a public-private split, with early child development and family matters being classified as part of the private realm (Neysmith, 1998; Rossiter, 1988). This theme contributes to the exclusion of mothers from employment and schooling, and helps keep discussions of healthy child development and a national child care strategy relegated to the sidelines. Neysmith (1998) argues that issues of care-giving in general have been sidelined within the public policy arena in part because of sexism, and in part because of this public-private split: as long as something is a private matter, it does not belong in the discussion on public policy. Not surprisingly, the ability to embrace “private” responsibilities as public issues has been key to success in the development of public policy in Sweden (Bremberg, 2009) and other countries – where accordingly, the gender gap has narrowed (OECD, 2006; UNICEF, 2008).

2.5 THE SERVICE DELIVERY CONTEXT: VOLUNTARY SERVICES IN A NEO-LIBERAL/NEO-CONSERVATIVE ERA

Since the 1980's, in both Canada and the U.S., there have been significant changes to the voluntary sector and to volunteering. Features of this trend include fewer people volunteering (Colman, 2003), a high percentage of volunteers who are aging (Scott, 2005; Volunteer Canada, 2010), and decreased participation among those who have traditionally formed the bulk of the volunteer pool (Colman, 2003). Further, those who are volunteering are at risk for burnout: they are contributing more hours because the volunteer load is being shared by fewer people (Colman, 2003).

These shifts have taken place on the heels of government policies that dramatically *increased* the demand for volunteers. In the 1980's and early 1990's the focus of governments (including Canada, the U.K., Australia, and the U.S.) was deficit reduction, leading to significant budget cuts (Mullaly, 2007; Scott, 2005). Governments slashed public services, eliminated universal programs, discontinued programs that supported stability and reduced inequities (such as non-profit and co-op housing), and restricted eligibility for income security programs such as unemployment insurance (Ascoli & Cnaan, 1997; Scott, 2005). These changes created a crisis of basic necessities for many of the most vulnerable people in these societies (Ascoli & Cnaan, 1997; Scott, 2005). This, in turn, increased the demand for services provided by community-based organizations, many of which rely on volunteers (wholly or in part) to deliver their programs (Colman, 2003).

At the same time, many governments also began changing the way that non-profit organizations were funded. Across Canada and the U.S., core operating funds were replaced with short-term project grants, which often did not cover funding for overhead expenses. Groups struggled, and are still struggling, to keep their doors open without adequate funding for administrative costs, to undertake fundraising campaigns to cover these and other essential expenses, and to meet the increased demands for

services – often going many years without increases to staff salaries (Eakin, 2001; Roberts, 1998).

A prime effect of all of these factors was an increased reliance on volunteers in the U.K., U.S., (Ascoli & Cnaan, 1997) and Canada (Colman, 2003). However, Ascoli and Cnaan (1997) found that “It takes the work of many volunteers to equal the work of one paid employee. Volunteers also tend to serve where they choose, not necessarily where they are needed” (p. 319). Ascoli and Cnaan (1997) also cautioned that:

“the voluntary sector cannot compensate for cuts in the national social services budgets ... as important as volunteerism and voluntary action are to a democratic society, they have neither the strength nor the resources to be the key social service provider” (p. 322).

In wealthy Anglo-Saxon countries, many volunteer home visiting programs were proposed, piloted, and established between the early 1980’s and the late 1990’s (Misener & Knox, 1990; Taggart et al., 2000) – the same period when governments were slashing budgets and new needs were becoming apparent, if not urgent (Misener & Knox, 1990; Roberts, 1998). While volunteer programs have many benefits (Black & Kemp, 2004; Taggart et al., 2000), the inherent challenges cannot be ignored. In my own experience in Nova Scotia, Canada, volunteers’ commitments to family, work, and/or education usually come first; if there is a crisis, people must drop their volunteer work in order to deal with other pressures. Thus, the volunteer human resource pool is not stable or predictable, and in fact, is largely outside the control of program administrators (Ascoli & Cnaan, 1997).

Matching ‘higher-needs’ families with volunteers can be quite difficult. This may be due to the complex nature of a given situation, potential threats to volunteer safety, and/or a parent’s compromised interpersonal skills or responsiveness due, for example, to severe mental health problems (Black & Kemp, 2004; Downie, Clark & Clementson, 2004; Gray, Spurway, & McClatchey, 2001). Such factors are often beyond the control of these parents; however, a program’s reliance on volunteers can potentially leave vulnerable families without service.

2.6 GETTING IT RIGHT: COUNTRIES INVESTING STRATEGICALLY IN EARLY DEVELOPMENT

Many industrialized countries – including Sweden, Norway, Denmark, France, Iceland, and Finland – have moved to implement adequate family support policies and an integrated, universal system of early childhood education and care (McCain et al., 2007; OECD, 2006; UNICEF, 2008). For example, as in most Scandinavian countries, all Swedish parents are eligible for parental leave of up to 18 months – benefits are not tied to recent employment – and low-income parents receive a financial supplement during the first several months of each child’s life (OECD, 2006). All families receive home visits, and starting at their first birthday, Swedish children “by law... have the right to pre-school education” (OECD, 2006, p. 410), though adequate parental leave means that few children enrol in Swedish pre-schools (early childhood education and care programs) before 16 months. In contrast, Canadian children have no such right; in all parts of Canada, outside the narrow mandate of the child protection system, *no one* is responsible for the overall well-being and development of children ages birth to five.

Cuba, a much poorer nation, has an acclaimed system of health care, parenting, and child development programs: health care and parenting supports are comprehensive and integrated, and include community clinics, parents’ groups, grandparents’ groups, and child care services. Additionally, young children are assessed at least once a month by a family physician, who monitors all aspects of child development; there is no fee for this service (Keon, 2009; Tinajero, 2009).

Together these measures provide families with parenting support and information, greater financial stability, and comprehensive quality early child development services – thereby reducing – to varying degrees – child and family poverty, child development delays, costly health and social problems, and the need for remedial services later in life (OECD, 2006; Tinajero, 2009; UNICEF, 2010). These comprehensive family support and early child development systems have shown favourable returns on investment, and benefits to society as a whole, in diverse domains

including gender equality, family poverty, economic growth, children's health, and improved school performance and social adjustment (McCain et al., 2007; OECD, 2006; UNICEF, 2008).

Summary

This chapter has outlined the socio-political context of families with young children in wealthy western Anglo-Saxon countries, with a particular emphasis on the lack of coordinated and effective family policy initiatives, and the fragmented and under-resourced family and child services sector. This chapter has also demonstrated the significant need for comprehensive systems that help ensure healthy early child development and family well-being for all. The next chapter explores the literature related to one specific early childhood intervention – longer-term family home visiting programs.

CHAPTER 3: REVIEW OF THE LITERATURE

In this chapter, I provide an overview of family home visiting programs and the associated literature. The chapter begins with a brief overview of the major types of family home visiting programs, the recent history of longer-term home visiting programs, and an explanation of what is meant by the term ‘paid home visitor.’ I then focus in on longer-term home visiting programs, providing a more in-depth description of the programs themselves and the associated literature. Programs with paid visitors are presented first, followed by programs with volunteer visitors. The chapter closes with an overview of mixed-delivery programs and the dearth of literature on such programs.

3.1 OVERVIEW OF FAMILY HOME VISITING

For the purposes of this study, home visiting programs for families with infants and young children have been divided into two very broad – and at times, overlapping – categories:

- **‘Early’ home visiting programs** (e.g., Public Health/Community Health nursing services). These are most commonly provided by public health units or maternity hospitals in recognition of the particular risks, and the steep learning curve, associated with the perinatal period. Service duration, intensity, and eligibility (not all are universally available) vary widely from one country to another.
- **Longer-term home visiting programs**, most often ‘targeted’ to a particular geographical area or sub-population of families deemed to be vulnerable or ‘at-risk.’ Specific to staffing, I have divided these programs into three sub-categories:
 - programs with paid visitors
 - programs with volunteer visitors
 - programs with both paid and volunteer visitors (in this thesis, I have referred to these as mixed-delivery programs)

As the focus of this study is mixed-delivery programs, only those programs included under the umbrella of 'longer-term home visiting programs' are included in the present literature review. A descriptive overview of each sub-category precedes the literature review on that sub-category. The chapter ends with a discussion on key issues arising from the literature review.

3.1.1 A Recent History of Longer-term Home Visiting Programs

Within the last twenty-five to thirty years, in many wealthy Anglo-Saxon countries, several factors occurred that led to the growth of longer-term home visiting programs that specifically serve families who face barriers to overall well-being and healthy child development. Some of these factors were outlined in Chapter 2 - namely, widespread social and economic changes that have increased families' isolation and vulnerability, changes in societal awareness of child abuse and neglect (Council on Community Pediatrics, 2009; Krugman, 1993), and an ever-growing body of scientific evidence regarding the lifelong impact of children's earliest experiences. Simultaneously, governments in these countries were making deep funding cuts to universal programs, such as public health nursing, and re-framing the role of government, from a liberal to a conservative paradigm (as discussed in Chapter 2). One result was that, even within the context of a growing awareness of families' increasing needs and young children's heightened vulnerability, governments were not willing to restore – let alone increase – funding to public health programs; neither were they willing to fund new universal or large-scale programs outside the public health system.

Throughout the 1980's, some not-for-profit agencies and local governments (state, provinces, and municipalities) took action, introducing various pilot and demonstration home visiting programs (Council on Community Pediatrics, 2009; Molloy, 2002). Given their more limited resources and longer-term nature, these programs were most often directed at families or neighbourhoods with identified risk factors (Johnson, Howell, & Molloy, 1993; Wade & Fordham, 2005). Some promising early

results, most notably from Hawai'i Healthy Start and the Nurse Home Visitation pilot project in the U.S. (later the Nurse-Family Partnership), spurred the enthusiastic launch of similar initiatives elsewhere (Council on Community Pediatrics, 2009). Over time, research from other locales showed more modest benefits, and some of the Hawai'i findings were refuted by a large-scale 1999 evaluation (Council on Community Pediatrics, 2009); experts in the field began to advise that earlier expectations had been set too high (Gomby et al., 1999; Weiss, 1993).

While these developments may have slowed the pace of implementation, new programs continued to be launched. Indeed, at the time of this writing, targeted longer-term home visiting programs, staffed by paid home visitors, have been introduced across many, if not most, regions of wealthy Anglo-Saxon countries (National Collaborating Centre for Determinants of Health, 2008). In Canada, many programs are operated in partnership with public health units. In many communities, there are also other targeted in-home services that serve specific populations of families with young children – most commonly, early intervention programs for children with developmental delays and (dis)Abilities. Many child welfare departments also provide some type of in-home service for families involved with the child protection service itself. First Nations organizations, family resource centres, and immigrant service agencies are among other groups that might offer in-home programs for specific populations.

Across all jurisdictions, the common theme is that there are no population-wide, universally available services; children and families are not *entitled* to even basic on-going services unless they meet certain pre-determined criteria. Universally available public education systems, while not perfect, are useful as a point of comparison here: they are legislated to “make room” for all children, and to do so at bare-minimum standards – for example, by maintaining certain student-teacher ratios and providing bus service in rural areas. In comparison, within a residual and targeted system (described in Section 7.11), minimum service and access standards are often not

legislated; many people are left outside the realm of eligibility, while others qualify, but must wait for long periods to access scarce resources.

3.1.2 Who Is A 'Paid Home Visitor'?

In the present study, the term 'paid home visitor' does *not* refer to visitors in 'early' home visiting programs (either targeted or universal). Rather, it refers strictly to paid home visitors who work within a program that is either separate from the standard public health perinatal/early home visiting service, or is an adjunct to that service. These paid home visitors often work with a smaller caseload of families, and visit families at more regular and frequent intervals, than would a visitor through a standard perinatal public health program. Further, their work often focuses on family-specific goals, such as reducing risks to children's safety and well-being, improving basic family stability and functioning, or increasing families' access to services; that is, reducing health and developmental inequities resulting from factors that are both external and internal to the family.

Therefore, in this thesis, the term 'paid home visitors' includes all those who:

- are paid to work in this capacity, whether part-time or full-time, and whether home visiting comprises a majority or a minority of their job duties;
- come from all educational and employment backgrounds, with and without specific professional designations or training.

In this thesis, the term 'paid home visitor' may include a program manager or coordinator, if that individual regularly works with families in their homes, over a period of several weeks or months. Indeed, such is the case for all three programs that took part in the present study. In many volunteer home visiting programs, the program manager does an initial visit with some or all families, but does not carry a 'caseload' of families; this definition does not include those staff members.

3.2 PROGRAMS WITH PAID VISITORS

3.2.1 Overview of Programs with Paid Home Visitors

At the time of this writing, many Canadian provinces, as well as jurisdictions in the U.S., New Zealand, Australia, Ireland, and the U.K, offer longer-term home visiting programs for families with young children, staffed by paid home visitors. While many of these programs have been initiated and funded by state or provincial governments (Nova Scotia Department of Health, 2002; Santos, 2005; Wade & Fordham, 2005), some were launched as research projects, and others are initiatives of local agencies (Pennock & Ross, 2002; Powell, 1993). The vast majority begin serving families in pregnancy or early infancy, and are targeted at parents and children who are assessed at having certain risks (Kitzman, 2004; Pennock & Ross, 2002; Wade & Fordham, 2005).

These programs vary widely in mandate, structure, services, and approach (Council on Community Pediatrics, 2009; Olds & Kitman, 1993; Pennock & Ross, 2002; Powell, 1993; Weiss, 1993). Many (but not all) use either standardized screening processes and/or pre-set criteria that determine who is eligible to take part (Gomby et al., 1999; Pennock & Ross, 2002; Powell, 1993). Pre-set criteria may include adolescent parents, families with a special-needs or low-birth-weight infant, or those with a limited income. Some programs also restrict enrolment in order to reduce or manage complexity; for example, Nurse-Family Partnership program sites accept first-time mothers who have a low income and educational level, but not those who have had a previous live birth, even when that child is being raised by someone else (D. Busser, personal communication, March 2010). Home visits may be scheduled weekly, bi-weekly, or monthly; some programs start out semi-weekly and decrease in frequency over a period of one to several years. Many programs follow a prescribed curriculum, and have stated objectives regarding infant/child development, parent-child attachment, child health and safety, life skills, nutrition, family functioning maternal life course, children's school readiness, and/or prevention of child abuse and neglect

(Council on Community Pediatrics, 2009; Olds & Kitzman, 1993; Pennock & Ross, 2002; Zercher & Spiker, 2004).

When longer-term home visiting programs first began to be more widely implemented, many had a focus that could be described as “uni-dimensional” – an outgrowth, perhaps, of the family home visiting programs of the mid-twentieth century, which had focused on specific objectives, such as early intervention for children with (dis)Abilities (Wasik, 1993). In uni-dimensional programs, services focus on achieving fairly narrow goals that most often relate to children’s well-being (Kitzman, 2004, p. 4) – goals that are developed and outlined by the programs themselves, with little input from families. However, throughout the 1990’s, experts in the field urged home visiting programs to adopt a more “multi-dimensional” approach, as research findings have consistently suggested that the most significant long-term benefits come from these programs (Olds et al., 1999; Zercher & Spiker, 2004). Multi-dimensional programs “consider both program and individual client goals,” and “address the life development of the mother, family life, child care giving, and the fostering of overall development” (Kitzman, 2004). This finding is supported in reviews conducted by Pennock and Ross (2002) as well as Zercher and Spiker (2004), who observed that these more effective programs may be “more expensive to develop, implement and maintain” (p. 5).

3.2.2 The Literature on Paid Home Visiting

Over the past twenty-five years, in the U.S. in particular but also in other wealthy, western Anglo-Saxon countries, there has been a steady stream of literature published on these programs. This large body of work includes many randomized control trials and program evaluations; studies that have examined one aspect of a program, such as factors affecting families’ rates of retention and attrition (Daro, McCurdy, Falconnier, & Stojanovic, 2003); some longitudinal studies; and several systematic reviews of the literature (Olds et al., 2007; Olds & Kitzman, 1993; Pennock & Ross, 2002). There are also program evaluations and qualitative studies looking at both processes and outcomes. It should be noted that some of the landmark publications,

particularly those that discuss and describe longer-term home visiting *as a phenomenon*, date from the 1990's; hence their frequent reference in this thesis.

There are shortcomings in the existing body of research on home visiting: for example, many earlier studies did not actually measure the outcomes that the programs set out to achieve (Olds & Kitzman, 1993), and evaluators have encountered difficulties when attempting to measure accurately various outcomes (Gomby, 1999). Over time and at the urging of experts in the field (Kitzman, 2004; Santos, 2005), researchers have started to become less focused on attempting to measure the impacts of individual programs or demonstration sites, and more concerned with ascertaining what factors do and do not make home visiting work, and for whom (Harvard Family Research Project, 2003). In the U.S., national models have continued to pursue and publish this type of evaluation data, and some are presently running trials in other countries (J. Deming, personal correspondence, 30 March 2010). However, much work remains; as recently as 2009, both an American Academy of Pediatrics and the (Canadian) Centre of Excellence for Child Well-Being urged further research into various program characteristics (Council on Community Pediatrics, 2009; Knoke, 2009). Indeed, it was not long ago that Kitzman (2004) asserted that the field of home visiting was “still in its infancy as far as determining the relative importance of any specific characteristic is concerned” (p. 5).

3.2.3 Outcomes of Programs with Paid Visitors

As noted in Chapter 1, while specific objectives vary from program to program, home visiting programs aim to achieve a number of child-focused, and/or-family-focused goals. Experts in the field conclude that home visiting can make a positive difference in a range of areas (Olds & Kitzman, 1993; Pennock & Ross, 2002; Zercher & Spiker, 2004), but they also caution that the findings vary from one program to the next, and can be contradictory (Knoke, 2009). While some program models have found statistically significant outcomes for child safety and/or development but not for family functioning or maternal life course (Fergusson, Grant, Horwood, & Ridder, 2005), Knoke

(2009) advises that in general, “there is more consistent evidence that home visiting has positive effects on parental competencies” than on reducing child abuse and neglect (p. 4). Doherty (2007) asserts that the evidence shows greater child development benefits to ‘at-risk’ children from child-focused programs, such as quality child care, than home visiting or family resource programs (Doherty, 2007).

One area that has consistently shown positive impacts is home visitors’ roles in helping increase families’ successful access to and engagement with, a range of key health care and social service programs. Visitors can play important and effective roles as facilitators, advocates, navigators, accompanists, and support persons, and can interpret and reinforce medical and other information as part of a family’s follow-up care (Council on Community Pediatrics, 2009; Olds & Kitzman, 1993; Tough et al., 2006). This is a key finding, particularly given the traditionally low rates of engagement and retention in formal health and social services among vulnerable and marginalized families (CCCH, 2010; Tough et al., 2006; Watson et al., 2005;) and the overall importance of early intervention, care, and treatment.

Several experts have concluded that while families do benefit from home visiting, overall outcomes are not as dramatic as originally anticipated (Gomby et al., 1999; Kitzman, 2004) and that home visiting may not be “the low-cost solution to child health and developmental problems that policy-makers and the public have hoped for” (Zercher & Spiker, 2004, p. 5). Weiss (1993) pointed out that the widely held “high expectations” (p. 117) of home visiting as a panacea were actually a one-hundred-year throwback to lofty proclamations that friendly visitors could solve the problems facing the urban poor.

Accordingly, Weiss (1993) and others have stressed that home visiting alone cannot address the many problems associated with poverty, marginalization, and parents’ difficult life experiences; rather, they “are best funded as part of a broad set of services for families and young children” (Gomby et al., 1999, p. 7). Several experts have concluded that home visitation is most effective when it is delivered in conjunction

with quality early childhood education and care programs (Doherty, 2007; McCain et al., 2007; Zercher & Spiker, 2004).

While calling attention to the limited impacts of home visiting programs, Gomby et al. (1999) also urged a commitment to continued service provision, in concert with investigation into the most effective methods and approaches:

The findings indicate that home visiting services are not a silver bullet for all that ails families and children, but then no single program or service strategy can be. These research results should not dissuade us from action. Children continue to grow, and their families continue to want and need support and services. It is up to us to strengthen existing services and craft new approaches to meet the needs of families and children. (p. 24)

3.2.4 Key Factors in Program Effectiveness

There are many indicators that program design, emphasis, intensity of service, and home visitors' educational background are key factors in the outcomes achieved in various domains (Knoke, 2009; Pennock & Ross, 2002; Zercher & Spiker, 2004). However, as noted earlier, some of these findings are contradictory, and there is no clear consensus as to whether a certain set of characteristics is most likely to lead to the most impactful home visiting program, and if so, what those characteristics would be. Findings do suggest that programs should be "carefully designed" (Olds & Kitzman, 1993, p. 1) and "adhere to established program models" (Kitzman, 2004, p. 5). The common occurrence of reduced frequency of visits (fewer actual visits than the number originally planned) is one example of a clearly problematic 'straying' from a program model, as intensity of service has frequently been cited as a key ingredient in successful programs (Kitzman, 2004; Olds & Kitzman, 1993; Zercher & Spiker, 2004).

3.2.5 The Question of Targeted or Universal Services

In 1991, the U.S. Advisory Board on Child Abuse recommended that a nationwide program of universal, voluntary (not mandatory for parents) home visiting be developed and introduced (Krugman, 1993), and that this system rely on a mix of volunteer and paid home visitors. Santos (2005) has argued for universal home visiting

services on the basis that, as it is impossible to predict which families will abuse or neglect their children, and as the costs of child abuse and neglect are extremely high, all families should have access to in-home services as a preventative measure. However, many experts have argued in favour of targeted home visiting programs (Kitzman, 2004; Knoke, 2009; Olds & Kitzman, 1993). The authors of an analysis of outcomes of American home visiting programs suggested that valuable resources be allocated to programs targeted at families who have consistently been shown to benefit from home visiting, “such as low-income single teen mothers” (Zercher & Spiker, 2004, p. 5). At the time of this writing, this is the approach most often followed in Anglo-Saxon countries.

3.2.6 Debates Regarding the Qualifications of Paid Home Visitors

The qualifications of home visitors have been the subject of ongoing debate in the literature, with discussions centering on which types of visitors have been found to have the greatest impact on families: professionally trained individuals (most often, but not always, nurses) and all others, who are often lumped into a single group, and referred to as either lay or paraprofessional home visitors (Olds, 2004; Paris et al., 2007; Wasik, 1993; Zercher & Spiker, 2004). Given that professional visitors are, technically, only those who can register with a self-governing professional body, the paraprofessional or lay group would include individuals with an almost infinite range of educational, employment, community, and life experiences. (For example, looking at education alone, a visitor with less than a high school education, and one with a Master’s degree in women’s studies, could both be considered paraprofessionals.)

While the research is still quite thin, and the findings are not unanimous, some experts have advised that programs be staffed by trained professionals, such as nurses (Olds, 2004) or “public health nurses or very well-trained para-professionals” (Pennock & Ross, 2002, p. 10). However, many recommendations to hire nurses appear to be based on a comparative study conducted by Olds et al., (1999) which compared nurse home visitors with lay home visitors. A stinging critique of this particular study points out that:

...the researchers limited the paraprofessional visitors to those who only had high school education and excluded anyone who had any college preparation in the helping professions, as well as anyone who had a Bachelor's degree in any area. These paraprofessionals were also paid \$US 8.45 per hour (in 2002 dollars). These conditions perhaps ensured that the paraprofessional group for this 'comparison' were not only non-nurses, but generally a poorly paid and poorly educated group (Watson et al., 2005, p. 11).

While this issue is not the focus of this study, both the prevalence of the question, and the intensity of the debate surrounding it, make it worthy of note.

3.3 PROGRAMS WITH VOLUNTEER VISITORS

3.3.1 Overview of Programs with Volunteer Visitors

Across industrialized, wealthy Anglo-Saxon countries, there is also a smattering of *volunteer-based* home visiting programs for families with infants. Most often, these programs tend to be part of a non-profit organization, rather than a health authority or government agency; each program serves all or part of a city, borough, or county (as opposed to an entire state or province); and these programs may be funded by one or more government or non-government sources (Acton, 2005; Black, Kemp, & Samson, 2004; Paris & Dubus, 2005; Taggart et al., 2000). Many volunteer visiting programs are universally available, in that they are available to any parent with a new baby, any first-time parent of a newborn, or any 'new-baby' family that is dealing with a difficult or stressful situation (usually loosely defined). However, some programs do have more strict eligibility criteria, such as single-parent families, or infants with medical or developmental concerns (Black & Kemp, 2004).

The roles of volunteer home visitors tend to overlap with the roles of paid home visitors, in that both provide emotional support, infant and child development information, tips and strategies on everyday parenting dilemmas, and a link to community resources for parents (Black & Kemp, 2004; Kitzman, 2004; Pennock & Ross, 2002). One difference is that many, though not all, volunteer visiting programs also provide instrumental assistance in caring for the children (Byrne & Kemp, 2009). While

babysitting is generally *not* part of the volunteer role, practical help and/or respite care (while the parent is in the home) are often key volunteer contributions (Acton, 2005; Black et al., 2004; Paris & Dubus, 2005; Taggart et al., 2000).

3.3.2 The Literature on Volunteer Visiting

A review of the literature has revealed a much smaller body of mostly qualitative research that has been published on these programs. The findings include themes identified *by parents*, such as the importance of having another adult to count on, practical help with the child(ren), emotional support, information and mentoring. Parents also consistently comment on the satisfaction with their relationship with the volunteer and their gratitude for having assistance and support through a difficult time (Black et al., 2004; Black & Kemp, 2004; Byrne & Kemp, 2009; Paris & Dubus, 2005). One randomized control trial (RCT) found that parents who had had a volunteer visitor showed a statistically significant difference in terms of both social supports and age-appropriate expectations of their infants (Kelleher & Johnson, 2004).

A randomized control trial and later follow-up study of the Community Mothers Programme in Dublin, Ireland, showed significant benefits for intervention families (Johnson et al., 1993; Johnson et al., 2000); this program has been loosely replicated in several locales in Ireland, England and Australia.

Two systematic reviews of evaluations of volunteer home visiting programs have been conducted, both by Lynn Kemp and associates at the University of New South Wales. Their 2004 review of evaluations includes data from fourteen volunteer visiting programs in Australia and other Anglo-Saxon countries. Because of the differences in volunteer duties from one program to the next, the relatively small number of evaluations included in this review, and the different methodologies used, a traditional systematic review was not possible (Black & Kemp, 2004). The reviewers also identified ambiguities and weaknesses in all fourteen studies – for example, some program evaluations did not measure what the programs set out to do, while other programs did not have clear objectives from the outset. As well, the findings from some evaluations

contradicted those of others; and, the small number of participants enrolled in the RCT's meant that, in some cases, causal connections could not be made. However, the authors did find that across programs, parents consistently "felt improvements in the areas of emotional well-being, social well-being, and parenting attitudes and confidence" (p. 4). One impact area – parenting attitudes and beliefs – was shown to have statistically significant results in all three randomized control trials included in the systematic review (Black & Kemp, 2004).

In their more recent review of evaluations, Byrne & Kemp (2009) found that volunteer home visiting programs have tended not to try to evaluate program outcomes regarding children's health and development; thus, almost no data had been gathered on the impact of volunteer home visiting on the children whose families are visited. The authors do not propose a reason(s) why programs have not pursued this type of data. Thus while these reviews and individual studies help the reader to gain a better picture of some processes and outcomes of these programs, it is difficult to draw conclusions about program impacts from this small body of literature.

In my own experience, mothers have often come to our program with a pre-formed, and largely positive, idea in their minds of who a volunteer might be – a supportive peer, a knowledgeable mentor, or a grandmother figure for their children. As noted earlier, many women have expressed amazement that someone is willing to support them – and without recompense. This openness to working with a volunteer as opposed to a paid staff person is part of what Brudney (1990) called the *volunteer intangible*, which he described as:

...the unique qualities brought by citizen participants to government agencies. Clary (1987) shows that volunteers are more readily able than employees to build relationships with clients characterized by acceptance, approval, empathy, care, regard, respect, understanding, and trust (pp. 319–320).

Brudney (1990) went on to say that "not only does the emotional support provided by volunteers help raise clients' self-esteem and self-confidence, but it also increases the motivation to accept and profit from the tangible forms of assistance offered by

government organizations” (p. 320). In my professional experience, I have seen that the *volunteer intangible* can positively impact a mother’s perception of herself and her worth, and affirm both the difficult nature of her situation and the idea that she does not have to carry her family’s burdens alone.

A striking finding of the 2005 external program evaluation of Extra Support for Parents was the extent to which both parents and community partners reported that ESP volunteers had helped families access important health and social services. Volunteer actions such as identifying appropriate resources, helping parents become comfortable with the idea of accessing a particular service, accompanying parents to appointments, debriefing and strategizing with parents after a difficult appointment, and the very act of being a ‘friendly face’ who is affiliated with the health care system, all contributed to this outcome (Acton, 2005). These findings are consistent with research findings from other volunteer visiting programs (Black et al., 2004; Kelleher & Johnson, 2004) and, as noted in Section 3.2.3, programs with paid visitors as well.

3.4 LITERATURE ON MIXED-DELIVERY PROGRAMS

The current review of the literature has revealed just six studies that mentioned having both paid and volunteer visitors; none examined the impact of having both types of visitors in the same program. Five studies were from programs that are no longer in operation, and one study was from a program that may or may not be in operation at present (perhaps under a new name). Three of these programs were primarily staff-based home visiting programs (with volunteer visitors used as an adjunct to the main service). The other three could be classified as primarily volunteer-based programs – that is, their volunteer visitors provided in-home services to the majority of program families, while a smaller team of paid staff served a minority of program families.

Within the primarily volunteer-based programs, one study examined *paid visitors’* work with higher-risk families as part of the former Kempe Community Caring Program in Denver, Colorado. In this study, the program’s in-home volunteers were only mentioned once, in reference to the practice of switching families from working

with a volunteer to a paid visitor when family situations became too complex for a volunteer (Gray et al., 2001). A second study involved a qualitative examination of parents' and volunteers' experiences in a Perth, Australia program. The study did not examine the work of the paid home visitors, all of whom were public health nurses. The authors did state that "families considered likely to benefit from home visiting ... are offered either volunteer home visiting or, in cases of high complexity, nurse home visiting" (Downie et al., 2004, p. 191). The authors also commented that "it is possible that this approach provides complementary elements that would not be available under a purely professional home visitor approach" (p. 191).

The other three reports on mixed-delivery programs were from primarily staff-based Australian home visiting services that made use of volunteer visitors as an adjunct to the work of the paid staff. Each of these programs ceased operation several years prior to the present study. All three programs produced comprehensive evaluation reports, which did note that the programs had both volunteer and paid visitors. To varying degrees, these reports named or discussed some of the challenges and outcomes related to each role (Bryce, 2000; Flynn & Hewitt, 2007; Thomson, 1997); however, their focus was not to examine aspects of having both volunteer visitors and paid visitors *within the same program*. It is interesting to note that, in all three program evaluations, families and/or volunteers themselves expressed that the volunteers' roles, as prescribed by the programs, were too narrow, and did not optimize the skills and contributions that the volunteers had to offer. This is not a finding that I have seen in the literature on programs that only, or mainly, make use of volunteer visitors.

The mixed-delivery Community Mothers Programme (CMP) of Dublin, Ireland, was externally validated by a 1990 randomized control trial and a 1997 follow-up study (Johnson et al., 1993; Johnson et al., 2000), with impressive findings. However, this research was conducted on volunteer-visited families only (staff-visited families were not included in the study), and the program has been presented in the literature as a volunteer program. The Community Mothers Programme involves trained volunteers

from predominantly low-income areas making monthly visits to new mothers. A team of Family Development Nurses coordinate all aspects of volunteer recruitment, training and supervision, and visit a small number of program families as well. For one year following the birth of a family's first child, these visitors deliver a strengths-based parent education and support program that "focuses on health care, nutritional improvement and overall child development" (Johnson et al., 2000, p. 337).⁵ The program was found to have had a statistically significant impact on infant immunization rates, mother and child diet, duration that the infant was fed breast milk or formula, and "reading to the child, language, educational and cognitive development of the child" (Molloy, 2002, p. 41). Two aspects of mothers' self-esteem showed statistical significance, while two other aspects showed little or no difference between the control and intervention groups. In the follow-up study, intervention group mothers (of then-eight-year-old children) were more likely to check their children's homework each evening, take their children to the library regularly, and to disapprove of corporal punishment (Johnson et al., 2000).

3.5 QUESTIONS AND CRITIQUES ARISING FROM PRACTICE AND THE LITERATURE

3.5.1 The Invisibility of Mixed-Delivery Programs

In the existing literature, there is almost no mention that some programs have both paid and volunteer home visitors. As noted earlier in this chapter, and as outlined in the description of my own attempts to locate such programs for the present study (Chapter 5), it would appear as if such programs simply don't exist. However, these programs have been around for many years, and once informed the recommendations of the federally mandated U.S. Advisory Board on Child Abuse and Neglect. In 1991, the Advisory Board released a report strongly recommending that a voluntary, universal infant home visiting program be developed and implemented across the U.S., as a population-wide means of stemming the tide of child abuse and neglect. At this time,

⁵ The Community Mothers Programme was a participating program in the present study.

the Board “was aware of models that ... used volunteers for low-risk families and paid professionals to serve high-risk families” (Krugman, 1993, p. 187). The Board proposed that all parents should be visited and assessed following the birth of their baby, and based on that assessment, offered either “professional (high-risk) or volunteer (low-risk) support”(Krugman, 1993, p. 187).

The U.S. government response to this report was “disappointing” by all measures, and no such program was trialled or adopted (Krugman, 1993, p. 190). Undaunted, in 1993 Richard Krugman, former Chair of the Advisory Board, continued to assert that “it is essential to explore combinations of volunteer and paid visitors for low- and high-risk families” (p. 191). He argued that this would accomplish several goals: “Home visiting would be destigmatized, professionals would be freed to work with higher-risk families, and by the end of the decade ... one might begin to see a reduction in the incidence of child abuse” (p. 191). Despite what must have been a high-profile report at the time, I have found virtually no mention of such a concept in the home visiting literature from that point forward. Within the U.S., volunteer and paid visiting programs have continued to be developed and implemented, but I have only learned of a total of five mixed-delivery programs in the U.S., each developed separately from the others, and located in different regions of the country.

However, over the next few years, this idea *was* embraced by a number of organizations in Australia, and at least seven Australian programs with both paid and volunteer visitors were launched. Three of these were demonstration projects that featured professional visitors as the central service component, with volunteer visitors as more of an adjunct (Bryce, 2000; Flynn & Hewitt, 2007; Thomson, 1997); as noted in the previous section, none of these three programs were in operation at the time of this writing. The Karitane family service organization in Sydney developed a large volunteer program and later added paid visitors, and a Community Mothers Programme (involving nurses and volunteers) was launched in Perth (Downie et al., 2004). Starting in 1996, a

new organization, Good Beginnings Australia (GBA), also embraced the concept, for similar reasons as those touted by Krugman (1993).

Good Beginnings' initial four volunteer visiting pilot sites included professional home visitors in two locations (Wellesley, 2000). In 2000 and 2001, Good Beginnings staff presented at conferences and workshops, touting the benefits of having volunteer and professional visitors within the same program (Prichard & Polglase, 2001; Wellesley, 2000). However, at the time of this writing, most of Good Beginnings Australia's volunteer visiting programs have closed, and GBA's site in Hobart, Tasmania is their only program that still has both professional and volunteer home visitors.⁶ While Good Beginnings Australia has produced a few evaluation reports over the years, these have been focused on volunteer visiting, not on the combination of volunteer and paid visitors (Cant, 1999; Good Beginnings Australia, n.d.; Hiatt, 1994 as cited in Byrne & Kemp, 2009; The Benevolent Society, 2009).

In the previously mentioned 2004 systematic review of evaluations of volunteer home visiting programs, there is no mention that some of the programs have both volunteer and paid visitors (Black & Kemp, 2004). In Byrne and Kemp's 2009 review of program evaluations, however, the researchers excluded a handful of programs that had both paid and volunteer visitors on the grounds that these were not purely volunteer programs.

As noted previously, the 1990 evaluation of the Dublin-based Community Mothers Programme involved families who were visited by the program's volunteers, but not those visited by Community Mothers' nursing staff. Some other mixed-delivery programs have also conducted research and/or program evaluations; I do not know whether staff-visited families were excluded from, or included in, these reports (Black & Kemp, 2004; Cant, 1999; Paris & Dubus, 2005).

⁶ Good Beginnings Australia's Hobart site was a participating program in the present study.

Indeed, even in conducting the 2005 formal program evaluation of Extra Support for Parents, our focus was almost exclusively on the impact of *volunteers* on families, and families' experiences with their *volunteers*. In our case, I am aware of the reasons for this: our primary concern was documenting the volunteers' work, as their value had been questioned by a key funder; as well, the Family Support Worker position was still a new addition to our program. However, in our case and others, the omission of some service providers may call into question the accuracy of the findings, as the program description, service delivery methods, and contributing factors could be considered incomplete and/or misleading.

Additionally, as noted in Section 1.1.1, in our own program (Extra Support for Parents Volunteer Service [ESP], 2008b) and in my research on other mixed-delivery programs, I have found that the volunteer aspect is almost always the public face of the service; sometimes paid home visitors are not mentioned (C. Suppiah, personal correspondence, May 2007; Lauren & Mark Rubin Visiting Moms Program, 2010). Thus, the historical development of these programs, as well as how programs present themselves publicly and the reasons why, are key questions for this study.

3.5.2 Program Orientation: Changing Families, Society, or Both?

As noted earlier, in the past three decades, many municipal and provincial/state governments have developed home visiting programs with paid visitors. This has often been in response to public pressure to address the increasing incidence of child abuse, neglect, and other threats to children's safety and healthy development (National Collaborating Centre for Determinants of Health, 2008; Olds et al., 2007; Santos, 2005; Watson et al., 2005; Zercher & Spiker, 2004). Thus it is perhaps not surprising that the official discourse around these programs often fits within the dominant capitalist, neo-liberal/neo-conservative ideology of the time (the 1980's to the present); that is:

- Child-rearing is the private responsibility, right and domain of parents (Neysmith, 1998; Rossiter, 1988); unless absolutely necessary, government should not interfere in the private lives of citizens (Mullaly, 2007).

- Beyond “basic government services” (Mullaly, 2007, p. 85), it is not up to the state to provide for the populace. Housing, child care, home care, transportation, and other support services should be provided by “the normal channels for meeting needs – family and the market” (Mullaly, 2007, p. 85); only when these channels “are not functioning properly or if an individual cannot make use of them because of illness or old age” (p. 86) are social welfare programs necessary.
- As outlined by Mullaly (2007), the neo-conservative view of social problems is that they “are mainly due to individual fault and deviance” (p. 87), while the liberal approach supplements this with an acknowledgement that the complex nature of industrialized society does cause harm to some individuals. Accordingly, those who need help in their parenting roles are treated somewhere between the liberal approach of “care, cure and protection” (p. 102) and the neo-conservative approach of “coercing, cajoling, and convincing ... [as well as] threats of removing children and other intimidation tactics” (p. 87).
- Universal and other large-scale social programs, with their bureaucracies and heavy front-line salary expenditures, cost taxpayers too much money, encourage reliance on the state, and “undermine individual freedom” (Mullaly, 2007, p. 85). Any necessary programs should be targeted at high-needs populations and be residual (Mullaly, 2007) in nature – that is, they should exclude all those not deemed to be ‘in need.’

Many socially and fiscally conservative governments in wealthy Anglo-Saxon countries are primarily concerned with containing costs, minimizing ‘waste’ in government expenditures, and allowing for the growth of the free-market economy (Carniol, 2005; Mullaly, 2007). For these governments, targeted longer-term home visiting programs seemed an appealing way to prevent child abuse, neglect, and developmental delays (Olds & Kitzman, 1993). Indeed, the stated focus of these programs, as reflected in their goals and their outcome measurements, is that parents will make changes to their knowledge, beliefs, values, and/or practices (Gomby et al., 1999; Kitzman, 2004; Zercher & Spiker, 2004). This ‘behavioural’ approach is consistent with the conservative view that *individual parents* are deficient, and that making such changes will solve their difficulties. The ecological approach popular with many home

visiting programs views a person in the context of their family and society (Weiss, 1993), but consistent with a liberal ideology, does not call for “fundamental change” (Mullaly, 2007, p. 102) in powerful and inequitable societal structures.

However, many, if not most, families served by longer-term home visiting programs with paid visitors have been marginalized and oppressed in a number of ways (Kitzman, 2004; Pennock & Ross, 2002; Weiss, 1993), sometimes over several generations. I have found that families’ difficult social and economic circumstances are not always identified in the literature as a significant and negative force in their lives. When these are noted, oftentimes there is neither a critique of the structural inequities of the economic system and the social safety net, nor an analysis of the injustice of these circumstances, nor a call for broad-based changes (Nova Scotia Department of Health, 2002; Olds & Kitman, 1993; Zercher & Spiker, 2004).

This is in spite of the fact that several experts in the field have raised the alarm regarding these issues. As far back as 1993, Weiss urged home visiting programs to “include attention to a wider range of psychosocial and economic obstacles to healthy development and family functioning” (p. 120). Citing the recommendations of two previous systematic reviews, Pennock and Ross (2002) emphasized that home visiting programs must be implemented within in a context of a range of available services and effective poverty reduction strategies. However, it appears that while new home visiting programs have continually been introduced, poverty rates and inequality have also continued to grow (UNICEF, 2008).

These divergent philosophical orientations are important to highlight because, as noted in Section 1.4.3, they can translate into home visitors working with families in very different ways. A behavioural perspective uses a lens that focuses on individual practices and may foster an attitude of blame upon an individual, first for having certain practices or status in life, and second for being unable or unwilling to change these. In comparison, using the social determinants of health (Public Health Agency of Canada [PHAC], n.d.) as a lens encourages home visitors to see a family’s situation as influenced

by powerful and inequitable externally based factors, with the resulting focus on support, consciousness raising, advocacy, and (in some programs) social change efforts. This is also consistent with the critical social analysis of the social work field. Indeed, social workers' analysis of power, oppression and privilege, when combined with a social determinants of health 'lens', can stimulate important dialogue regarding the causes and consequences of inequality, thus increasing awareness across the health and social services sectors.

In this chapter, I have provided an overview of home visiting programs and the associated body of research and evaluations, highlighting the invisibility of mixed-delivery programs, within both the sector and the published literature. Chapter 4 describes the theoretical framework of the present study.

CHAPTER 4: THEORETICAL FRAMEWORK

Health care and social work with women and their families in the post-partum period are shaped by the powerful experiences of childbirth and adoption, as well as the wonder, demands, and tremendous life changes that accompany becoming a parent of a newborn. It is within this context that home visiting with ‘new-baby families’ is conducted. In my experience, home visiting is also shaped by three additional – and powerful – forces: social and economic inequity in general, the marginalization and oppression of women in particular, and the potentially transformative relationship between a home visitor and a mother. Thus, as outlined below, this study is rooted in theories that speak to these three phenomena.

4.1 STRUCTURAL THEORY: *INEQUITY FROM THE START*⁷

Canadian social work theorist Mullaly (2007) presents structural social work as drawn from the intersections of four foundational elements: “a reconstituted socialist ideology... the radical social work camp... critical theory, and... a social change view of society” (p. 244). Upon this foundation, Mullaly (2007) builds an integrated conceptual framework of structural social work that is holistic, inclusive, and centrally oriented toward changing society and social structures, as opposed to changing individuals:

Structural social work views social problems as arising from a specific societal context – liberal/neo-conservative capitalism – rather than from the failings of individuals. The essence of [the foundational elements of structural social work] is that inequality: (1) is a natural, inherent (i.e., structural) part of capitalism; (2) falls along such lines as class, gender, race, sexual orientation, age, ability, and geographical region; (3) excludes groups from opportunities, meaningful participation in society, and a satisfactory quality of life; and (4) is self-perpetuating (p. 244).

⁷ This is a play on words: ‘Equity from the Start’ was the vision of the former pan-Canadian organization, the Council for Early Child Development (www.councilecd.ca).

Canadian social work educator and author Carniol (2005) describes conservative capitalism as an economic and social system that subscribes to the following beliefs: “the best government is the least government” (p. 6); problems should be left to the market to solve; and people are the architects of their own destiny – thus, one’s success is to one’s credit, and failure is one’s own fault. Carniol (2005) argues that while ‘meritocracy’ is hailed as the *modus operandi* in Canada, it is actually a falsehood that serves to mask and perpetuate pervasive patterns of “greater and greater inequality” (pp. 5-6) and “unjust privilege” (p. 7).

Carniol (2005) posits that the insistence of capitalist, western, Anglo-Saxon-rooted governments on the supremacy of the market has created many problems for the citizens of these countries: cuts to public programs and services, deeply entrenched racial oppression, and the unencumbered globalization that has left many people worse off than they were a generation ago. He decries the ‘corporate dictatorship’ (p. 23) that has meant governments cow-tow to corporations, allowing them to pollute the air, water and soil; move operations (jobs) to countries where they can pay lower wages; and weaken hard-won labour, environmental, and social-support standards. Indeed, in a stark prediction of the economic collapse of 2008, Carniol (2005) criticizes the corporate recklessness (p. 20) that has characterized economics in Canada and other Western countries over the past few decades.

Mullaly (2007) also critiques globalization, weaving together the impacts of the international economic crisis in the 1970’s and 1980’s and the subsequent rise of neo-conservative and neo-liberal ideologies, the dismantling of major welfare-state programs and national institutions by federal governments, and the concurrent global corporate restructuring and structural adjustment. He compares the right-wing, market-driven approaches taken by Canada and other countries in the 1980’s and 1990’s with the actions of social democratic governments, who “responded by attempting to maintain and consolidate the welfare component... of welfare capitalism” (p. 19). Such measures have helped protect citizens of these countries from the low

wages, instability, and unpredictability of the globalized market, while ensuring these countries' economies have access to continued international participation.

In addition to the critique of capitalism, Mullaly (2007) outlined three central tenets of structural social work that especially resonate with home visiting work. The first is a critical analysis of the "dominant ideology" (p. 245); that is, an examination and questioning of the deeply imbedded – and largely invisible – values of a society. These values are "transmitted to all members of society through the process of socialization" (p. 245). The dominant ideology, in turn, "determines the nature of a society's institutions and the relations among its people" (p. 245). If that dominant ideology is "liberal/neo-conservative" (p. 247) and therefore based on "inequality, individualism, capitalism" (p. 245) and the accompanying oppression, exploitation, and concentrated allocation of resources and power, the same will be true for the institutions and the social relations of that society (Mullaly, 2007). The result is widespread institutionalized systemic privileges and inequalities (Carniol, 2005; Mullaly, 2007).

These inequitable and exploitative systems are maintained vigorously and successfully by those with the power to influence policy, intimidate dissenters, and sway or maintain public opinion:

Despite a rash of high-profile corporate scandals, large corporations remain credible institutions – in no small measure because their commercials, newspapers, TV networks, and magazines all deliver the same message: big corporations create jobs, supply what we need, and pay taxes (Carniol, 2005, p. 20).

Indeed, the pervasiveness and invisibility of the dominant ideology ensure that even those who are harmed by these structures – that is, the majority of people in a society – to some degree accept or identify with this world view. Accordingly, we act in ways that support and promote the status quo (for example, using our limited power as 'consumers' in ways that actually reinforce power imbalances; being silent in the face of injustice against others). Many people are unaware of both the dominant ideology and the corresponding structures and public policies that have contributed to their own

difficult situations and the difficulties of others; even when they have this awareness, many feel powerless to challenge the status quo. It is no accident that the success of a system that purports to be democratic, but is actually based on systemic inequality, is dependent in part on widespread misinformation and a sense of powerlessness.

The second tenet is that structural social work embraces all forms of social work practice as potentially transformative, while also highlighting that similarly, any social work role can also be oppressive and can reinforce inequality, oppression, and privilege (Mullaly, 2007, p. 249). Structural social work embraces a wide range of tactics and roles that can be used to further social change and the redistribution of resources. According to Mullaly (2007), “Structural social workers seek to change the social system and not the individuals who receive, through no fault of their own, the results of defective social arrangements” (p. 245). This supports my own belief that social services (including in-home support programs) play at least two roles: our programs serve as what Mullaly (2007) calls “band-aids” (p. 247), in that they help ‘prop up’ existing inequitable social and economic systems and social relations; and at the same time, they are instruments of progressive change for both individuals and society. While individual programs are not generally powerful enough to affect the broader social change that staff and volunteers may know is needed, when staff and volunteers take the knowledge we have gained through working closely with families, and we use it to inform social change efforts carried out in solidarity with other groups, we can contribute to broad-based structural changes. And, when we (social workers, other paid workers, and volunteers) support parents and caregivers to become involved with social change efforts, then we have helped ensure that we have not appropriated others’ voices, and have facilitated greater democracy and ‘first voice’ participation in social change work.

Finally, the third tenet of structural social work that resonates for me is that it rejects any hierarchy of oppression, calling instead for the recognition and elimination of “all sources and forms of oppression” (Mullaly, 2007, p. 249). Families involved in

home visiting programs vary tremendously in their identities, situations, backgrounds, strengths and challenges, and their experiences of privilege, oppression and marginalization. As well, these experiences are constantly changing and shifting at this time in their lives (as in the example of a woman who, in the course of her first pregnancy, goes from being coupled, employed, and childless, to a single mother living on a very tight income comprised of maternity benefits and income assistance).

Acknowledging, respecting, and working with each family's individual experiences allows volunteers and staff to connect meaningfully with parents, and to provide multi-faceted support for their often difficult journeys. Additionally, those working with families during these times of major life changes can do a great deal of consciousness-raising with parents – most often with mothers, but also with fathers, other adults and older children in a given family, and those we encounter through our work, such as school officials, health and social service providers, and landlords. Workers and volunteers can educate parents and others on their own privilege and oppression, and that of other groups in society as well. Perhaps most importantly, there are many opportunities to hear mothers' concerns and fears, gently challenge their internalized stereotypes and myths, provide them with a new and more empowering perspective, link them to others who are in similar situations, inform them of their rights, affirm their inherent worth and dignity, and support them when they resist or oppose unfair treatment.

4.2 FEMINIST THEORY: AS IF WOMEN TRULY MATTERED

While I reject the idea that one form of oppression is more important or damaging than another, I would also argue that the experiences of childbirth and parenting in any given society are influenced almost universally by the status of women in that society (Kitzinger, 1980). Patriarchal capitalist culture is structured to “define and control” women (Thornham, 1999, p. 38), which results in pervasive economic and social inequality (UNICEF, 2008). While each woman's experience of privilege and oppression are unique to some degree, even a woman who has enjoyed a significant

amount of privilege in her life can find herself at the mercy of institutions that were not set up to meet her needs and do not prioritize her safety, well-being or security (Felesky & Kirshner, 2005); women who have not been privileged are more vulnerable, and therefore at greater risk of suffering from the effects of this sexism and misogyny (Mullaly, 2007; OECD, 2006; Ross, 2006). This oppression does not ‘trump’ other forms of oppression – and in fact, for some families, the effects of racism, classism, ableism, ageism, or other forms of oppression are felt far more acutely than the effects of sexism (Hill Collins, 1994). Thus, while I don’t see a feminist perspective as the *sole central* component of a comprehensive and integrated critical analysis of diverse families’ experiences, realities, and needs, I do see it as a *key foundational* component of this analysis.

In industrialized, Anglo-Saxon countries, women’s lives are shaped by widespread beliefs and cultural norms that assign different roles, strengths, goals, responsibilities, emotions, and value to men and women, based primarily on ideas of gender (Rossiter, 1988). When women consciously or unconsciously embrace these pervasive beliefs, they may blame themselves for their isolation, unhappiness, and dissatisfaction with their close relationships, as well as for not being able to ‘do it all’ (Felesky & Kirshner, 2005; Paris & Dubus, 2005; Paris et al., 2007; Rossiter, 1988). In my own experience, I have seen these same social, cultural and economic forces cause women to stay in abusive relationships; to literally make themselves sick with stress and/or overwork; to unquestioningly accept poor treatment and lack of support from partner, family and/or friends; and to and live in ways that go against their own beliefs and values.

Rossiter (1988) argues that, as long as mothers see their circumstances as random, individual, or the fault of women in general, these powerful social forces impinging upon them will maintain their destructive invisibility. In my experience, many women served by Extra Support for Parents are struggling, alone, surrounded by misogynist and sexist beliefs and values, often without anyone to talk to about what

they are experiencing (and internalizing), and no one to offer a different view. A feminist analysis allows mothers to see and name these powerful forces, to stop blaming themselves, and to begin to see themselves and their world differently. Feminist theory also critiques the highly gendered construction of social and economic structures – such as public policy, government programs, and the workplace – and highlights the relevance of inequitable social structures to the everyday lives of women and families.

I believe that a structural-feminist analysis is central to understanding the experiences and challenges of parents of infants in western, Anglo-Saxon capitalist countries. It can allow staff and volunteers to survive the work without burning out, as it shifts the blame for overwhelming social and personal problems away from service users and providers, and instead on to inequitable social structures and the dominant ideologies that support them. Structural-feminist theory can help us to make sense of these situations: to name and understand their root causes, and to identify that, if governments were to make different policy decisions, we could have better ways of supporting parents (and mothers in particular) and their young children. Perhaps most importantly, structural-feminist theory allows us to help service users to shift responsibility for these situations away from individuals, to society at large.

4.3 RELATIONAL-CULTURAL THEORY: THE MOTHER-HOME VISITOR RELATIONSHIP

Relational-Cultural Theory⁸ identifies five essential components of healthy relationships: connectedness, empathy, mutuality, reciprocity, and authenticity (Jordan et al., 1991). Miller and Stiver (1997) described relationships that have these five elements as “growth-fostering relationships” (p. 16). They argued that growth-fostering relationships play a key role in women’s lives and our ability to thrive; indeed, when relationships are not growth-fostering, we experience a disconnection that interferes with our sense of well-being and efficacy: “If we have found it disconnecting and

⁸ See page 15 for an historical footnote regarding the term “Relational-Cultural Theory.”

dangerous to put forward our feelings and thoughts, we begin to focus on methods of not representing our perceptions and feelings” (Miller & Stiver, 1997, p. 54). In these situations, self-doubt, fears, confusion, and self-blame swirl around unabated, eating away at our sense of self, and preventing our growth and development. Repeated and/or severe incidents of this disconnection can be profoundly damaging, and can rob us of the essential elements of good mental health: connectedness, confidence, self-worth, agency, joy, and hope (Miller & Stiver, 1997).

Paris and Dubus (2005) applied the work of Jordan, Kaplan, Miller, Stiver, and Surrey (1991) specifically to mothers of newborns, arguing that many vulnerable new mothers are in fact dealing with a crisis of relationships. Relationships that may have sustained new mothers in the past are, for any number of reasons, no longer accessible to them, while relationships that have been negative or conflict-prone may now be seen as undesirable or a threat to the well-being of the child or the family. At the very same time, mothers of newborns are experiencing the monumental life changes and intense personal demands brought on by having a baby (Thomas, 2001; Mercer, 2004); thus they are in acute need of supportive relationships that will help them process, understand, and integrate these life changes (Paris & Dubus, 2005).

As well, in industrialized Anglo-Saxon societies, many mothers of infants find that the needs of others – baby, older child(ren), partner, house, extended family, employer, and so on – leave no time or energy for their own basic self-care or well-being. This situation is heightened when women are dealing with additional stressors such as poverty, a recent loss or trauma, social or cultural isolation, or an abusive relationship (Black & Kemp, 2004; Olshansky, 2003). As noted in Chapter 2, our transient society leaves many parents of young children living in communities where they do not have established relationships with neighbours, co-workers, friends, relatives, et cetera. These are the very relationships that have supported and sustained generations of parents, particularly mothers. Yet, without the presence of growth-fostering relationships, mothers of infants can feel trapped, invisible, and alone (Paris, 2008; Paris

& Dubus, 2005). Women's partners may also struggle, sometimes alone, through these difficult times. The resulting effects can be negative and wide-ranging (McCain et al., 2007; Olshansky, 2003; Paris, 2008; Paris & Dubus, 2005).

In these isolating and overwhelming situations, in order for a woman to thrive, there is a great deal of work to be done in understanding and unpacking her new reality, her changing identity, and her own beliefs and values – and as well, how these have been shaped by social, cultural, familial, and personal factors. Without authentically supportive relationships in one's life, it can be very difficult to do this work; yet many isolated new mothers are not in a position to go out and create a new support network. They may not know where to turn, may have fears or discomfort about seeking help and support, and may have very real difficulties accessing services (due to lack of transportation, a premature or medically fragile baby, language barriers, being ineligible for certain programs, and so on). In my own work experience, I have seen that, for these and other reasons, mothers may simply not feel comfortable taking one or more young children out to a parent-child group or a friend's house. Indeed, even a stretch of very cold, hot, or wet weather can keep some parents and young children at home, isolated from others, for an extended period. Thus, a supportive and accessible third-party presence – such as a home visitor – can be a critical 'bridge' in a woman's healthy post-partum transition and her overall well-being.

When a home visitor facilitates a connected relationship, she provides a much-needed source of support and comfort, and in turn, a base for facilitating positive changes in a woman's life (Paris & Dubus, 2005). This is because this type of connection "leads to the possibility of speaking one's true thoughts and feelings" (Miller & Stiver, 1997, p. 54) which is essential for psychological wellness, and for change, growth, and development. Thus a mother's growth-fostering relationship with her home visitor is not an end unto itself, but can be used as a springboard for developing and nurturing, and in some cases changing, other life relationships – between a mother and her child(ren), her partner (or future partner), other family members, friends, co-workers,

and so on. Without a home visitor, some mothers would indeed find a way to make this connection, but many participants in home visiting programs face barriers that would make it difficult to do this. Indeed, my own experience working in an in-home support program, I have seen that some mothers have had precious few such relationships in their lives thus far.

Relational-Cultural Theory describes both the characteristics, and the importance, of genuinely supportive relationships. It captures the essence of home visiting – what allows it to work and, given the compromised and difficult social context of many mothers of infants, why it is needed.

4.4 SUMMARY

Together with the body of knowledge relating to early human development (as outlined in Chapter 2), these three theoretical perspectives form an operational foundation. One component of that foundation – structural-feminist analysis – helps us to understand both families’ real circumstances and the root causes of their struggles. Another component helps us to see the critical importance of truly supportive – or ‘growth-fostering’ – relationships, particularly in the lives of mothers of infants, and allows us to understand the parent-home visitor relationship as one type of growth-fostering relationship. This also highlights the relevance of home visiting programs in our fragmented and transient society.

At the same time, this theoretical foundation also asserts that home visiting programs alone cannot solve the social, economic, and personal challenges faced by families with young children: inequitable social and institutional structures create poverty and marginalization, while a targeted and residual system leaves a glaring lack of accessible programs and services for families. These factors, in turn, create the conditions that allow for abuse, isolation, ill health, and compromised child development to exist and persist, while the evidence regarding early human development tells us that these influences can have significant detrimental effects on

children, hampering their ability to function and be well throughout their lives. Thus home visiting programs comprise one piece of a much larger 'healthy development and family well-being' puzzle – a puzzle that, with most pieces scattered about and several others missing altogether, has yet to be assembled.

CHAPTER 5: METHODOLOGY

5.1 PURPOSE OF THE STUDY

The purpose of this study was to gain greater insight into mixed-delivery home visiting programs for families with young children. Specifically, I explored the various influences on the development of these programs, and the strengths, opportunities, and challenges of having both paid and volunteer home visitors in the same service.

As described in Section 5.4, below, I employed a case study approach to undertake a qualitative study of three home visiting programs from three different countries. A qualitative case study approach allows participants' voices – their experiences, insights and feelings – to be the primary source of data that informs the findings. This is consistent with feminist theory, which posits that individuals are the experts in their own lives. This approach also creates space to make visible the structural influences that have affected families as well as programs; and particularly, the social, economic, and political forces that have either supported or hampered these programs in their efforts to provide services in their community. Thus, this research approach is consistent with my theoretical perspective.

5.2 RESEARCH QUESTIONS

This study explored the following core questions as they related to the three participating family home visiting programs:

Case Description Questions:

- A. What is each program's mandate, mission, philosophy, role, scope, and structure? What services are provided?
- B. How and why did these programs come to have both paid and volunteer visitors? Where applicable, has the work of these programs changed since the shift to having both paid and volunteer visitors? If so, in what ways?

- C. What external and internal factors have shaped the program’s development, mission, scope, and roles? *[for example, but not limited to: the socio-political context (including the local health care/social service context and broader political/social/economic trends); knowledge, ideology, values, and beliefs; funding limitations and opportunities; the priorities of the host agency and/or those managing the program]*

Research Questions:

1. What are the experiences of those who work and volunteer in mixed-delivery home visiting programs? *(for example, but not limited to, the experiences of volunteer visitors working with paid visitors, paid visitors working with volunteer visitors, and supervisors working with both)*
2. What do volunteers and paid staff identify as the strengths, challenges, and dilemmas of this approach to home visiting?
3. What has allowed the strengths to exist? Why are they considered strengths?
4. How do volunteers and staff deal with the challenges and dilemmas?
5. What can this approach contribute to the field of home visiting generally?

5.3 RESEARCH DESIGN

This qualitative study employed an embedded multiple case study research design. Data collection methods included semi-structured interviews with fourteen participants from three home visiting programs, located in three different countries; a review of relevant documents and reports from the participating programs; and a personal research journal during the participant recruitment and data collection phases. The details of this design are described below.

5.4 CASE STUDY

Case studies “investigate a single phenomenon” (DePoy & Gitlin, 1998, p. 142) and are “particularly helpful when little is known about a phenomenon” (DePoy & Gitlin,

1998, p. 147). In this study, the phenomenon in question is mixed-delivery home visiting programs for families with young children. Given the dearth of research on these programs, case study seems a particularly suitable approach.

As Stake (2005) asserts, case study itself is not a method, but is instead “defined by interest in an individual case” (p. 443). A case study can be carried out using qualitative and/or quantitative methodologies (Stake, 2005). Given the limited scope of a Master’s thesis, a feasible starting place for this topic was to conduct exploratory research into the experiences and insights of people who are intimately familiar with these programs. I considered interviewing parents who had been involved with the programs as well. However, this can be more complicated, time-consuming, and ethically challenging, than working only with volunteers and staff members. Challenges include additional ethical considerations due to privacy, confidentiality, and unequal power relations; the logistical and cost-related considerations of a long-distance international study; and the matter of contacting a sufficient number of parents to get a representative sample of program families. Thus, my main source of data was interviews with individuals who work or volunteer for these programs; however, direct input from parents would be one logical direction for future studies.

Multiple data sources are an important feature of case studies, as they allow for a more thorough immersion into and understanding of the case (Stake, 2005), and also for triangulation. Triangulation is collecting data on the case(s) from multiple sources. It serves to confirm the findings emerging from the data, as well as to “use multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation” (Stake, 2005, p. 454). Multiple data sources strengthen a qualitative study’s credibility (DePoy & Gitlin, 1998), a concept that is akin to internal validity in quantitative research (Bryman & Teevan, 2005). For these reasons, my understanding of each program and its unique context was also informed by a range of relevant written materials provided by the programs themselves (such as agency reports, policy and training manuals, and program web pages). While case study data collection methods

often include observation, observation was not considered for this study. This is due to two factors: the impracticalities and costs of observing home visiting 'in action,' for an international study of this size and scope (Master's thesis), and the belief that interviews and documents would provide sufficient information and insight for a preliminary exploratory study. However, if one were to undertake further research on mixed-delivery home visiting programs using case study methods, the observation of volunteer-staff interactions, volunteer training sessions, staff meetings, home visits, and the like, may provide valuable insight into both what these programs do, and how they do it.

An embedded case study considers each "part" of a case – in this situation, each person interviewed from a particular agency – as a distinct component of the case, likely to reveal new and different information and perspectives (DePoy & Gitlin, 1998). An embedded approach to case study has supported a key objective of mine – that is, hearing the various perspectives of people who serve in different roles within a given program. As outlined below, interviewing people who served in four or more different roles in each program allowed for different voices to be heard.

5.5 STUDY PARTICIPANTS

For the present study, I conducted semi-structured telephone interviews with fourteen individuals from three programs. As described in the following pages, study participants included volunteer home visitors (n = 6), paid home visitors (n = 3), and program managers (n = 3). As well, one individual spoke to the history of a particular program, and one individual from a partner agency was added as a participant after data collection had begun (see page 69 for details). The study participants, and the rationale for interviewing them, are outlined below.

Program History Participants: I interviewed someone who was familiar with the historical development and the socio-political context of each program. In two cases, this program history participant was one of the main four respondents from the agency;

in the third, this individual had played a central role in establishing the program. The program history participants provided important background information, such as when and why the program was founded, what services were provided at the outset, and the significant issues that influenced the program at that time. I was able to glean more historical information on two of the programs than on the third program, as the individual who served as that program's history participant had not been involved with the agency at the start of the program, and relied upon information that had been passed down by others.

Volunteer and Paid Home Visitors: I interviewed two volunteer home visitors, and one paid home visitor from each program, in order to hear first-hand accounts of their experiences working within mixed-delivery programs. I wanted to be sure that the study included the perspective of different types of home visitors, with all of the influences and dynamics that go with their respective positions. I interviewed more than one volunteer because the volunteers most often spend less time working with families each month than do paid staff; interviewing two volunteers for each program increased the range of volunteer experiences and insights that could be included.

Program Managers: Finally, the senior staff person within each program (referred to here as 'manager') brought the 'bird's-eye view' of the home visiting service. The manager balances the demands of the overall program, observing as different home visitors handle situations in different ways, witnessing the strengths and weaknesses of the program as a whole, and navigating the program's place in the community, sponsor/partner organizations, and funding spheres.

At the outset, I assumed that the paid and volunteer visitors would *uniquely* bring the lived in-home experience. Further, I had not factored in the presence of a program curriculum in two of the programs. However, as outlined below, both the program models, and the roles within these programs, were somewhat different than I had assumed:

- 1. In two of the study programs, the service is comprised of monthly visits *and* an infant development/parenting curriculum that the visitors share with parents at each visit.**

In these two programs, in addition to the assistance, care, knowledge, and experience that each visitor herself brings to each family, the curriculum also plays an important role. Additionally, having *volunteers* deliver a parenting curriculum was a model of service that was new to me, in that a curriculum is part of neither my own program, nor most volunteer home visiting programs that appear in the published literature.

- 2. Within the three programs, there is a wide variation in both employment status (ranging from 10 hours per week, to full-time) and responsibilities among the front-line paid staff who do home visiting.**

While I had originally searched for programs with “paid home visitors” whose in-home work comprised at least 50% of their workload, I found that this was not the arrangement among all programs. As a result, throughout much of the findings chapters of this thesis report, I have switched from using the term “paid home visitor” to “front-line staff member.” This better reflects the staff members’ mix of responsibilities, which, in addition to home visiting and providing back-up and consultation for volunteers, may include program administration, the coordination of services to families, and/or volunteer recruitment, training and coordination. The workload of front-line staff and managers is illustrated in Table 3 (page 124).

- 3. In each of the three study programs, the managers also carry a small caseload of families.**

In these three programs, the vast majority of families visited by the manager are not simultaneously visited by another staff person or a volunteer; that is, to each family on their ‘caseload’,⁹ the manager is the sole representative of the program. When working with these families, the managers play roles that are the same as, or somewhat similar to, other paid or volunteer visitors in the program. This is different from both my own experience and what I had previously learned about other home visiting programs, whereby managers visit families once or twice as part of the ‘intake and matching’ process, but do not carry a ‘caseload’ of families whom they visit regularly.

While the three managers who took part in this study were not interviewed in great depth about their own home visiting work, all three managers did speak of this work in their interviews, and their understanding of home visiting was clearly informed in part by their own home visiting experiences.

⁹ I use the term ‘caseload’ for ease of description. It does not appear to be in common use in any of the three study programs.

‘Program partner’ study participant: During the course of the interviews, all study participants from one program mentioned by name a particular individual as a key player in the operation of their program. Two participants suggested that I interview this individual, who is a full-time staff member at a partner organization, in order to get more information on how their partnership works overall. Additionally, I learned that this individual had been employed at the partner organization during a period of time when no other study participants had been involved, and would be able to fill in some of the historical gaps. For all of these reasons, I consulted with my thesis supervisors, and decided to interview this individual. The interview format for this staff member was different from that used in any other interview, as it focused on specific questions relating to the partnership and the program’s history and development.

In summary, conducting interviews with a total of four to six different individuals from each organization allowed me to gather a breadth and depth of data regarding each program. Seeking the experiences and insights of a number of people in different roles also increased the credibility of the study (Stake, 2005), while staying within a reasonable size and scope for a Masters-level qualitative study (for further information on credibility, see Section 5.8).

5.5.1 Benefits of Employing a Multiple Case Study Approach:

By having three separate “cases” (programs), I was able to look at the common themes that emerged *across* programs as well as among people working in both similar and different capacities. DePoy and Gitlin (1998) describe this ability to “examine the same phenomenon across several different cases” (p. 144) as a key feature of multiple-case studies. Multiple-case studies, also known as collective case studies, are looked at as a group, regardless of whether or not they are intrinsically similar, with the belief that “understanding them will lead to a better understanding, and perhaps better theorizing, about a still larger collection of cases” (Stake, 2005, p. 446). Indeed, while I was interested in learning more about each of these fascinating programs, in part for their own sake, I was ultimately driven by a desire to present new information that would be

useful to those who want to learn more about mixed-delivery home visiting programs *in general*. And while generalizability is not the goal of this research endeavour, Geertz (1973) has argued that the characteristically “thick description” of qualitative research provides readers with enough detailed information to make their own “judgments about the possible transferability of findings to other milieus” (as cited in Bryman & Teevan, 2005, p. 150).

Involving three programs in the study has also allowed me to shed light on some of the different structures and approaches used by mixed-delivery programs. This will be useful for those who are developing new programs or making changes to existing services. Finally, involving three programs also allowed the data analysis to focus on what Stake (2005) has stressed is a key question of case study research – that is, are there characteristics that can be uniquely, or uncommonly, found within this phenomenon?

5.6 ETHICAL CONSIDERATIONS

Ethical considerations, as well as measures taken to prevent and reduce and ethical dilemmas and protect study participants, featured prominently in the design and execution of this study. These are described throughout this section and Section 5.7, Sample Selection.

5.6.1 Ethical Considerations: The Researcher as Someone who Works in the Field

There were advantages and disadvantages to conducting research on a topic that is central to my own social work practice. Advantages included having an in-depth understanding of the field of home visiting, awareness of the nuances and dynamics of this type of program, passion for the topic, and the likelihood that I have been received with greater trust by participants. Conversely, in some instances, this was also a disadvantage; there were times when, using my own experiences as a reference point, I assumed I understood what a participant was talking about, and did not ask for further details, only to discover during the transcript review that there may have been other

meanings to what was said. I then had to examine the rest of the material from that interview to see if clarity could be gleaned elsewhere; in several cases, I contacted the participant to seek clarification. As a novice researcher, this was a frustrating, though valuable, learning experience.

Other potential disadvantages included the possibility of being so influenced by my own work that I could not – or did not want to – see or hear something that was different from my experience, or that challenged my understanding or unconscious beliefs. Further, despite my familiarity with all aspects of home visiting programs, I have never been a volunteer or paid home visitor *per se*. As well, there are ethical risks in having dual roles; namely, it could be argued that I have an interest in both the success of the program that I co-ordinate, and the viability of in-home support programs in general. As I was not conducting a program evaluation, these issues were not quite as potent as they might be in another type of research. I have tried to remain aware of these factors at all times, and I took a number of steps (outlined in the following pages), to unearth, understand, and mitigate these potential biases.

5.6.2 Ethical Considerations: The Researcher's Social Location

There are also aspects of my own personal identity and location that may have affected the study. The fact that it was an international study, and/or that it was being conducted by a student, a Canadian, a woman, someone who coordinates a home visiting program, a social worker, and other factors, may have played a role in some potential participants' decisions regarding whether or not to become involved.

Among those individuals who chose to take part in the study, these aspects of my identity and location may have been a positive factor; I did not encounter any questions or comments that indicated hesitation or negative ideas regarding aspects of my identity. Indeed, some participants specifically expressed an interest in either the international context of the study or “helping out” with a student project. It is impossible to know all the ways in which these and other factors may have affected the

study. While I went into the study with an awareness of these factors, and a willingness to examine and discuss these as the study progressed, very few questions arose.

5.6.3 Anticipating and Addressing Potential Ethical Dilemmas

I took several steps to prevent and reduce ethical dilemmas. First, my own workplace/program was not included in the study, as all staff and volunteers report to me. This power imbalance could have put study participants in a compromised situation that might have resulted in negative repercussions for staff and volunteers, the program, and the study. Second, the study was set up so that participants would be recruited through a contact person who was not their supervisor, which reduced the potential for staff and volunteers to feel pressured to take part; these steps are explained in Section 5.7. Third, I repeatedly communicated to participants, both verbally and in writing, the voluntary nature of study participation, my openness to feedback on all aspects of the project, and the importance of fair and ethical processes.

I also kept a personal research journal during the participant recruitment and data collection phases of the study. This allowed me to document my own journey and supported a self-reflective research process, especially during the time when I was in contact with participants and potential participants. The journal helped me to sort out my thoughts, resolve qualms and dilemmas, and figure out how to overcome barriers I was facing in the research process. I found this to be a helpful tool, but as I moved into data analysis, I found I did not need it any longer. Overall, I did not have very many ethical struggles; when I did encounter these, I wrote about them in the journal and/or contacted my lead supervisor about them.

All of these steps helped me to be conscious of my own biases, be open to other perspectives and realities when collecting and analyzing the data, be aware of potential ethical conflicts, examine how my biases may affect the study, and account for these biases as part of my data analysis.

5.6.4 Ethical Considerations in Protecting Study Participants

All participants were asked several times if they were taking part freely, and if they had any questions, concerns, or hesitations about taking part. Any such hesitations and questions were discussed openly; however, these generally related to scheduling and time commitments and individuals' own questions regarding whether or not they met the eligibility criteria. No concerns that were raised related to intra-agency conflicts, a desire for anonymity specifically within the program, or fears of repercussions. Rather, all fourteen participants' comments and sentiments consistently reflected a great deal of collegiality, mutual respect, and appreciation among and between staff and volunteers; and a dedication to the program and the families, volunteers, and staff involved.

One example of a step I took to ensure ethical practices occurred during the design phase. I asked some paid home visitors in my local area, each of whom had had experience dealing with strained worker-management relationships, for advice on the most ethical way to recruit paid home visitors as study participants. Considering that this work is their livelihood, I wanted to ensure that the research did not have a negative impact on study participants' employment status. The home visitors' unanimous response was that paid home visitors should not be approached by their supervisor, and that protecting participants' identity *within their own agency* should be built into the study design. These concerns were reflected in the study design, participant documents, and instructions to each of the three Agency Contact Persons.

I took extra care with the matter of identifying study participants. The information sent to potential participants (Appendices E, F, and G) stressed that, although all efforts would be made to maintain confidentiality and anonymity throughout the research, participants may be identifiable to some readers due to small participant numbers, and to the fact that each program would be named. These risks were also discussed with each participant prior to each interview. Where relevant, participants and I discussed how certain information was to be presented, and whether

it would be necessary to omit details, or take a passage out of quote form, so as not to identify the speaker. Additionally, I removed the names of people, program characteristics, organizations, and places, and altered some terms or colloquialisms that are used only in one locale or country, if such terms might identify the individual. However, even with these measures in place, it is likely that some readers will know, or assume they know, who is speaking at various points in this thesis.

5.7 SAMPLE SELECTION

Because there were two levels of recruitment – program and participant – the sample selection process had several stages. These stages, and the associated ethical considerations, are described in detail in sections 5.7.1 to 5.7.6 (presented in sequential order in Table 1, *Stages in the Sample Selection Process*, page 75).

5.7.1 Finding Eligible Programs for the Study

After an extensive search spanning three years, involving literature and Internet searches as well as telephone and email correspondence with many individuals in seven countries, I was able to locate a total of eight home visiting programs with both paid and volunteer visitors. An overview of this process follows, below.

Initially, I was looking for a minimum of five programs to agree to take part: three for the study, and two as back-up programs. This was because any research project runs the risk of participant attrition, and without programs or individuals to take the place of those who leave a study, an entire project can be at risk.

A significant challenge of this study was finding out about these programs, as there are no central organizations that co-ordinate mixed-delivery or volunteer visiting programs, and some programs do not have a web site or any published works. An added factor is that different terms are used to describe home visiting programs, and,

while I have used the term mixed-delivery to describe programs with both volunteer and paid visitors, there is no such term in common usage.¹⁰

Table 1: Stages in the Sample Selection Process

Stage in the sample selection process	Section	Page	Associated Appendices
Finding eligible programs	5.7.1	74	<u>Appendix A</u> : Introductory Letter to Home Visiting Programs and Related Organizations/Networks (<i>seeking eligible programs and leads to programs</i>)
Contacting eligible programs to determine their interest in the study	5.7.2	78	<u>Appendix A</u> (above) <u>Appendix B</u> : Eligibility Criteria & Checklist (<i>Self-assessment for agencies/programs and study participants</i>) <u>Appendix C</u> : Initial Information for Volunteers and Staff (<i>to aid in their decision re involving their program in this study</i>)
Obtaining official approval from programs	5.7.3	79	No additional documents were required.
ETHICS APPROVAL GRANTED			
Confirming agency / programs' participation	5.7.4	80	<u>Appendix D</u> : Memorandum of Understanding for Participating Programs
Recruiting participants	5.7.5	80	<u>Appendix E</u> : Text of Sample Recruitment E-Mail (<i>served as electronic 'cover letter' to Appendices F & G</i>) <u>Appendix F</u> : Participant Recruitment Letter for Eligible Home Visitors <u>Appendix G</u> : Information and Consent Form for Study Participants
Dealing with any issues arising in participant recruitment	5.7.6	81	N/A

¹⁰ Jack, DiCenso and Lohfeld (2005), and Wade and Fordham (2005), have used the term 'blended' in reference to Ontario's province-wide targeted early childhood home visiting initiative, *Healthy Babies, Healthy Children*. This program has both professional visitors (public health nurses) and lay visitors, but does not have volunteer visitors. Byrne & Kemp (2009) used the term 'mixed-model' to describe programs with volunteer and paid visitors. Because the term 'model' is often used in reference to program content and structure (as opposed to staffing), I chose to use the term 'mixed-delivery.'

Between February 2007 to April 2010, I took steps to locate appropriate programs. This must not be confused with participant recruitment as, in this study, there were two layers of participation: the program/agency level, and the individual level. Communication with individuals regarding their own interest required prior Ethics approval; communication with programs did not, and was pursued with the permission and encouragement of Dalhousie University's Office of Research Ethics Administration. Given that there are a limited number of organizations that fit the study criteria, these contacts were made to ascertain whether enough programs were interested in taking part; if not, that would have raised questions about the study's feasibility.

In 2007, I started this search by contacting home visiting programs that I had heard of over the years. Throughout 2008 and 2009, via the literature review, I learned of a few more programs that might meet the criteria, and contacted those as well. Early in 2010, I undertook several rounds of on-line searching and email correspondence (see, as an example, *Appendix A: Introductory Letter to Home Visiting Programs and Related Organizations/Networks*). Over this three-year period, I pursued all leads – from provincial health departments across Canada, to national home visiting associations in the U.S., to dozens of individual programs in Australia, England, Ireland, Scotland, Israel, the U.S., and Canada.

From this effort I learned of a total of eight programs, in four countries, that were eligible to take part in the study¹¹ (for eligibility details, see *Appendix B, Eligibility*

¹¹ After data collection was complete, I learned of two additional mixed-delivery programs. One was launched in 2010 through Boulder County Public Health (Colorado, U.S.A.); nurses visiting families with premature infants offer weekly in-home volunteer support to those who need additional assistance (D. Koehler, personal communication, 28 October 2010). The second program, Cradlelink (Keystone Child, Youth & Family Services, Bruce and Gray Counties, Ontario, Canada), serves families in need of extra assistance who are not eligible for in-home services intended for 'higher-risk' families. Cradlelink nurses visit families at monthly/bi-monthly intervals, to support healthy infant development and family well-being. Volunteers visit the same families weekly, providing emotional support, practical assistance, help with appointments or shopping, and links to local resources (J. Sells, personal communication, 27 October 2011).

Criteria & Checklist). Of these eight programs, two had initially shown an interest in taking part (in 2007 and 2008, respectively), but by the time that I officially approached programs about the study in 2010, both were dealing with other commitments and concerns – including some funding uncertainties – and declined participation. A third program had recently lost its funding, and in fact ceased operations in the two months between the time I first contacted them and the time I received Ethics approval. A fourth program was interested in the study, but they are part of a much larger organization that requires a lengthy internal Ethics Review process; this would have taken several months. Given the tight timeline for this study, such a delay was not an option. However, by late May 2010, when the Ethics review was completed, I had located three programs, in three different countries, that were eligible to take part, interested in being involved, and able to do so. At that time, a fourth program coordinator expressed an interest in taking part, in the event that another program had to drop out of the study.

Since case study methodology is contextually based (Stake, 2005), an international study encompassed a greater amount of information; thus, at the outset, I had sought to enrol three programs from one country. However, this was not possible. Additionally, both the program models and the roles played by paid and volunteer home visitors varied widely, from one study program to another. While all of these differences contributed to the richness of the findings, they also increased the amount and complexity of the data.

The plans and contingency plans outlined in Sections 5.7.2 to 5.7.6, below, were put in place to facilitate clear communication over long distances, across time zones, and between cultures, and to address potential ethical issues, attrition, or ineligibility of an agency or individual. Throughout, my goal was to ensure that the research design maintained its rigor – that the study was informed in a systematic, ethical, and consistent way across the three cases (programs).

5.7.2 Contacting Eligible Programs to Determine Their Interest in the Study

In my initial communication with this small group of mixed-delivery programs, my contact person was most often the program manager; in April and May 2010, I emailed these individuals with an overview of the study (*Appendix C: Initial information for Volunteers and Staff*), and a timeline outlining what would be required if their program were to take part. I also provided information to allow programs to ascertain whether they had enough staff and volunteers who would meet the study criteria (for details, see *Appendix B, Eligibility Criteria & Checklist*). I also clarified that, while I was preparing my submission for Ethics Review, I did not yet have Ethics approval from Dalhousie University; and that because of this, I was not recruiting individual study participants at this time.

I asked that my initial contact person do three things:

1. Determine if she was in an appropriate position to be the Agency Contact Person during the study, and if not, to approach someone to act in that role (duties outlined on final page of *Appendix D: Memorandum of Understanding for Participating Programs*). All three participating programs were able to provide an Agency Contact Person who met this criteria. These individuals played key roles in participant recruitment, and in accessing program documents.
2. Determine what I, as the researcher, needed to do to satisfy the agency's ethical, practical, or other concerns.
3. Obtain feedback from staff and volunteers regarding their interest in ***their program*** (not individuals) taking part in the study.

This third request was made to ensure that there were enough home visitors (both paid and volunteer) who might be willing to put their names forward to take part in the study. In order to help ensure that visitors were choosing to participate freely, I requested that the written information provided be presented to staff and volunteers; and that they, as a group, make a recommendation regarding whether or not their program should take part. The program managers each took their own approach to

ascertaining interest from those involved with the program. They did not send out a notice to all volunteers; further, as none of the programs had an upcoming gathering or meeting of all volunteers, time didn't allow for the matter to be raised in a group setting. All agencies responded that they had a sufficient number of volunteers who met the eligibility criteria, and assured me that two or more eligible volunteers would step forward.

Two managers did bring the matter to their paid staff teams, and received a positive response. The third agency presented a unique situation, in that there was just one front-line staff member; without that individual's participation, the program could not take part. I discussed this dilemma with the manager early on, and explained the potential problems of a supervisor asking a direct-report staff member about taking part, and the importance of the staff member having free choice in this matter. After Ethics approval was obtained, the manager approached the staff member about taking part, making it clear that participation was truly voluntary. The staff member agreed to take part. When I first spoke with this staff member, we had a thorough discussion regarding participation; I asked if she wanted to take part, and provided assurances that, if she did not wish to participate, I could enrol another home visiting program in the study. She readily agreed to take part.

5.7.3 Obtaining Official Approval from Interested Programs

Once each manager reported back that staff and volunteers were indeed interested, we moved forward with getting official approval from the program's sponsor/host agency for their participation in the study. I had anticipated that each organization might have its own standard procedures that would necessitate the submission of additional information; however, for the three programs that took part, this was not the case. All three managers were able to confirm their program's participation fairly promptly. In the programs that agreed to take part during the Ethics review process, this approval was contingent on the project receiving Ethics approval.

5.7.4 Confirming Agency Participation

As soon as I received word that the Dalhousie University Health Sciences Research Ethics Board had completed the Ethics Review process, I communicated to the three programs that Ethics approval had been granted and we could now proceed with the next steps. Each program manager confirmed their program's participation and assigned an appropriate Agency Contact Person for the study. I then forwarded each agency a Memorandum of Understanding, signed by myself and one of my thesis co-supervisors on behalf of Dalhousie University. The Memorandum of Understanding (*Appendix D*) outlined the responsibilities of both the researcher and the program. This step was taken to prevent any misunderstandings as the study progressed. The manager of each program signed and returned the Memorandum of Understanding.

5.7.5 Recruiting Participants

I spoke by telephone with each Agency Contact Person (A.C.P.) to explain the study and the role of the A.C.P., and to answer any questions. Once the Memorandum of Understanding was signed, I asked the A.C.P. to forward to eligible volunteers an email from me (*Appendix E: Text of Sample Recruitment Email*), with two attached documents: a letter of introduction (*Appendix F: Participant Recruitment Letter for Eligible Home Visitors*) and the Information and Consent Form (*Appendix G: Information and Consent Form*). One program informed me that they did not communicate with their volunteer visitors through email; thus I made arrangements with the A.C.P. to print, photocopy, and distribute to volunteers paper copies of the e-mail and attachments. As relevant, I also made arrangements with the A.C.P. regarding interviewing someone from the agency who was familiar with the historical development of the program.

I asked the A.C.P. to make sure that potential participants had an opportunity to ask the A.C.P. any questions they may have regarding the study, and that they were reminded to contact me (the researcher) via email or telephone to indicate their

interest. Having individuals contact me directly, as opposed to contacting the A.C.P. or program manager, was part of ensuring that staff and volunteers were taking part freely.

Responses to the call for participants came in fairly quickly, and I began communicating with those who expressed an interest. I asked several questions to confirm their eligibility, invited their questions about the study, and asked them to provide whatever contact information would allow for them to participate easily and confidentially. Once an individual was confirmed as a participant and all consent documents completed and returned, I contacted that individual by telephone. I thanked her for taking part, reiterated the main points in the Information and Consent Form (voluntary participation, confidentiality, storage of data, and so on), asked if she had questions about the research process, scheduled a telephone interview at a mutually convenient time, and emailed her a list of the main interview questions (*Appendix J: Sample of Pre-Interview Email to Study Participants*).

I had put in place some contingency plans, in the event that there was an insufficient number of participants from a given program. I took steps to enrol alternate participants, was prepared to enrol a back-up program, was open to returning to the Dalhousie University Health Sciences Research Ethics Board, if changes to the study design were required. Fortunately, this did not happen.

5.7.6 Issues Arising during Participant Recruitment

Participant recruitment proceeded fairly smoothly, though not exactly as I had anticipated. Not all of the programs followed to the exact letter all of the steps that I had outlined in the study design; for example, in one agency, a staff member who supervised volunteers approached them about taking part. Upon hearing of this, I made sure to discuss on the telephone, with all volunteer participants, the voluntary nature of the study, and to seek verbal confirmation (in addition to that provided in their consent form) that they were freely choosing to take part. Without hesitation, all participants

readily confirmed that this was the case. Indeed, in their conversation and tone, their responsiveness in scheduling interviews, and their patience with long interviews and the vagaries of long-distance communication, I sensed only good will and genuine interest from all participants.

The eligibility criteria had stated that it was preferred that all participants have a minimum of two years' experience with the home visiting program, and that exceptions would be made if/as necessary. All but two of the individuals who came forward had been involved with their respective programs for longer than two years; the remaining two individuals had been involved for less time, but their role and/or particular experiences with the program indicated that they had important contributions to make. Thus they were accepted as study participants.

Finally, I had initially hoped that all of the volunteers who took part would have experience that was specifically relevant to working with paid home visitors (front-line staff), and visa-versa. However, not all volunteer participants had this experience. I had made some assumptions about how these programs had developed historically, and also about the structure of the programs. These assumptions were not always correct, and as a result, those staff-related contributions that *volunteers* brought to the study were somewhat different from what I had anticipated. However, all of their contributions were still rich, relevant, and informative.

In the recruitment of front-line staff, some things also went a little different than I had planned. On the day that I first telephoned one particular agency, a front-line staff member who was filling in during a manager's absence answered the phone. I explained the study to this individual, who responded enthusiastically, "I'd like to take part myself!" From that point on, even though the manager later consulted with the other front-line staff, this individual remained interested in the study, and ended up taking part.

The method of participant selection outlined above, purposive sampling, allows for the people who are directly affected by the topic to take part (DePoy & Gitlin, 1998;

Salahu-Din, 2003). My hope was that the selection process would produce a group of people with a great deal of experience in the field and a willingness to reflect on this experience. Indeed, this was the case.

5.8 ENSURING RIGOUR AND TRUSTWORTHINESS

How is a social research project deemed to be worthy of the attention of other researchers, practitioners, and program/policy developers? For case study research, it is essential that the findings accurately and fully represent the case(s) studied (DePoy & Gitlin, 1998; Stake, 2005). Similarly, from a critical feminist research standpoint, the research process must have “integrity” and the data collected must “ring true” (Ristock & Pennell, 1996, p. 50) – that is, it must be valid to the study participants. Guba and Lincoln (1994, as cited in Bryman & Teevan, 2005) “argued that there are many possible accounts” (p. 150) of the social world, not one absolute or common truth, as is traditionally presumed by quantitative – and some qualitative – researchers. Guba and Lincoln (1994) also proposed that qualitative research must incorporate the thorough, systematic rigour necessary to present an account that is marked by *trustworthiness*. Trustworthiness consists of four elements: transferability, credibility, dependability, and confirmability (as cited in Bryman & Teevan, 2005, p. 150).

Transferability, one component of trustworthiness, speaks to the importance of providing readers enough information that they may determine the potential relevance and applicability of particular findings to other situations, populations, or problems. A report’s “rich accounts” of the study topic are what allows the reader to make such a determination. These accounts include the background and contextual information; the analysis of the themes, issues and anomalies that emerged; the description and insight provided by participant quotes; the outline of research methods employed; the findings and recommendations presented; and the researchers’ reflection on the process. As noted earlier, these elements combine to allow readers to make “judgments about the possible transferability of findings to other milieus” (Bryman & Teevan, 2005, p. 150).

A report's ability to allow readers to accurately determine transferability is developed methodically and incrementally throughout the entire research study. In this study, I took measures to ensure the systematic and transparent collection of data from each case, a thorough analysis of the raw data that was gleaned, and a well-documented and comprehensive presentation of relevant findings.

Credibility refers to the idea that the findings reflect an accurate account of the topic studied (Bryman & Teevan, 2005). In the present study, in order to allow participants to share fully and honestly, interviews were designed and carried out with attention to establishing rapport, communicating questions effectively, receiving and working with all responses yielded, making use of respectful probing, and encouraging the addition of relevant information outside of the researcher's questions. Interviews were digitally recorded, transcribed word-for-word by a paid professional transcriptionist, and then carefully reviewed by the researcher to identify and correct any errors in the transcription. Where relevant, my own interpretations of participant responses were added to the transcripts, in brackets. Participants were then sent a copy of their transcribed interviews in order to ensure the accuracy of the information collected. Participants were asked to indicate any corrections and return the transcript within one week of receipt. All fourteen participants did respond, some by telephone and others by email; all had at least one correction or clarification. This step, a form of respondent validation (Bryman & Teevan, 2005), as well as the triangulation provided by analysing relevant agency documents and interviewing several people from each program (Stake, 2005), helps ensure the credibility of a case study.

The final two components of trustworthiness, dependability and confirmability, are achieved in concert with each other. *Dependability* is the assurance that the findings are not skewed by actions taken by a particular researcher that could not, or would not, be taken by other researchers carrying out the same study in another place and time (Bryman & Teevan, 2005). Guba and Lincoln (1994) described *confirmability* as demonstrating that "personal values or theoretical inclinations were not overtly allowed

to sway the conduct of the research and findings deriving from it” (as cited in Bryman & Teevan, 2005, p. 150). I took several measures to establish dependability and confirmability. As noted earlier in this proposal, throughout the research process, I strived to be reflexive – that is, aware of my own role, influence and biases (Ristock & Pennell, 1996). In addition to the reflective journal mentioned earlier, I kept a detailed log of each step of the research process. I undertook a check-and-balance exercise to ensure inter-rater reliability; another researcher reviewed and coded one transcript. This allowed me to compare another researcher’s results with my own coding, and to make any needed changes to my coding practice. I also captured in the data analysis those responses that were anomalies and, after the first interview, began to weave into subsequent interviews questions regarding any significant ‘outlier’ responses relevant to the topic, thus consciously creating opportunities for themes to arise that I would not have originally named. I also shared a few transcripts with my supervisors, and discussed my analysis with them.

These steps were integrated into all phases of the study, and served to strengthen the trustworthiness of the findings.

5.9 DATA COLLECTION

5.9.1 Relevant Written Materials (Agency Reports, Proposals, et cetera)

I sought to review two types of agency documents: those that provided an overview of the program (mission and vision, history, funding structure, and so on), and those (such as program funding proposals and evaluations) that were specifically relevant to having both paid and volunteer visitors. However, only a few documents obtained spoke to this second point. Participating programs also provided a number of other documents, including curriculum materials for parents, volunteer training manuals, promotional materials, and copies of print media coverage. One program had been written up in several academic journals, and I received copies of those articles as well. I also accessed relevant information from the web sites of two of the programs.

I also asked each Agency Contact Person to identify relevant documents and advise on accessing these materials. Further, whenever a study participant mentioned a certain resource or publication, I sought out those materials as well.

Reviewing these materials played an important role in gaining a thorough understanding of each case, or program, involved with the study. This serves a triangulation function, which contributes to the credibility of the research. Since the study is researching the *programs*, and not individuals *per se*, the program documents helped me to develop an accurate picture of the programs as a whole. Indeed, perhaps the most important function relating to triangulation was gaining insight into the factors that have influenced the historical development of each program. The written materials gave me historical information that enabled me to ask questions, and bring in relevant dates and details, regarding aspects of each program's history that participants may have otherwise forgotten.

5.9.2 Interviews

Semi-structured interviews were conducted via telephone. It was anticipated that each participant interview would run from 60 to 90 minutes; however, most interviews ran from 90 to 120 minutes, and all of the interviews with the managers ran longer than this. The managers' interviews were conducted in two phases: the first part included most of the interview questions, while the second part included any questions we had not been able to cover originally, clarifications arising from the document review, and late-emerging issues that arose from the interviews.

At the start of each interview, I asked participants to confirm verbally that they had read the information and consent form, inquired whether they had any questions about the study, and if so, addressed those questions. A few participants had not read the information and consent form; in those situations, I read out the form to them and obtained their verbal consent to take part. This consent was recorded by me on paper during the interview, and transcribed as part of the transcription process.

The interviews explored how people understood the mandate, mission, philosophy, scope and structure of their program; each participant's role within the program; participants' experiences relating to the program having paid and volunteer visitors; the strengths and challenges of the mixed-delivery approach; and how participants dealt with the challenges (see *Appendix H: Interview Guide*). The interviews with long-serving staff and volunteers also covered the internal and external factors that had influenced the program over time.

The interviews were semi-structured, allowing me to make sure a range of topics were covered, but at the same time, ensuring participants had the time and space to reflect upon various aspects of their work, share freely, and go into detail as required. I tried to provide sufficient time and space to allow for the transition from the everyday work of 'doing' to the deeper work of being and reflecting; to begin to develop a rapport that would allow participants to speak openly and authentically; and ultimately, to facilitate the exploration and sharing of the richness of participants' experience and insight (Kirby & McKenna, 1989).

Once I began conducting the interviews, it became clear that participants had a great deal of relevant information to share that was directly related to the research questions. I quickly determined that those interview questions not absolutely central to the research questions had to be eliminated, as the amount of time required of participants would have become unreasonable, and ultimately, the amount of data collected would have been unmanageable. Indeed, the three managers' interviews were very long precisely because I asked both the 'core' research questions and a number of contextual and historical questions.

One of the interview questions that I removed was originally part of Case Description Question A (Section 5.2, page 63). Question A pertained to each program's mandate, mission, philosophy, role, scope, and structure, and the services provided. Although I had also planned to ask participants, "What are the roles, if any, of empowerment and/or social change efforts in your program?" I had to abandon this

question. While participants from one program spoke of the importance of their program-wide empowerment approach, no participants specifically named social change efforts as an example of their program's work.

The data collection process, and the interviews in particular, did make room for what Stake calls "late-emerging issues" (Stake, 2005, p. 453). Limiting the analysis and discussion to a predetermined outline of themes runs counter to the desire to hear what participants have to say; rather, one interview should inform the next. Thus, the structure, process, and tone of the interviews encouraged the naming and exploration of relevant new issues, right up until the end of the data collection.

5.10 DATA ANALYSIS

Through this study, I aimed to develop a rich description of these programs, which would give voice to their existence, and provide insight into their dynamics, strengths, and challenges. Drawing from my own professional experience and theoretical perspective, and my review of the literature, I began the study with some ideas and questions about home visiting programs. I collected data based in part on these ideas and questions, and also on the issues raised by participants during the interviews. Data analysis commenced with the collection of the first pieces of data; that is, ideas and issues were identified throughout the data collection process, allowing for additional relevant issues to be included in subsequent interviews. This was followed by thematic analysis of the data, outlined below.

Once the interviews and review of agency documents began, I compiled reflective memos, paying attention to my own role as researcher and my influence on the project and on participants, as well as my feelings, reactions, and new ideas that were brought out through the data collection process. As noted on page 84, I sent each transcript and any related interpretive notes to each participant for feedback on the accuracy of the transcription and interpretation. I then made follow-up contacts, via

email or telephone, with about half of the participants, in order to ensure a response from all participants.

Around this same time, I began the process of methodically reading and re-reading the interview transcripts and the written materials, to categorize the responses into codes and themes. I started this process with four interviews that represented participants across both roles and programs. Open coding, carried out manually, was used to identify broad categories, or *codes*, that were raised by these four participants. Each broad code was then organized into a separate electronic document, so that responses from subsequent participants could be added to these broad codes. Within each broad code, responses were then divided into smaller groupings, or sub-codes, according to the specific topics and issues that were raised by participants. Once all of the transcript information was organized into broad codes and sub-codes, these were reviewed and analyzed to clarify and better organize them, gain an understanding of what codes had emerged in this first round, and begin to make links between codes that seemed related (Bryman & Teevan, 2005). As more interviews were completed, this process was repeated, until the data set was complete.

Ideas and experiences that ran counter to any given category or theme were also noted, and linked back to that theme for further examination and reflection. This process of reading, naming, organizing, refining, connecting, and eventually selecting the most salient and relevant categories – as well as writing reflective memos relating to the initial findings – continued until relationships could be proposed between various categories, codes, and the original research questions. From these relationships, and the integrative memos that accompanied this stage of the analysis, the main findings emerged (Strauss & Corbin, 1998).

CHAPTER 6: DESCRIPTION OF PROGRAMS AND STUDY PARTICIPANTS

As noted in Chapter 5, within case study research, the ‘cases’ themselves are of primary interest, and often, they have not had much previous public exposure. For these reasons, while “there is no standard format for reporting case study research,” (Merriam, 1988, p. 193, as cited in Creswell, 2007), cases are typically described in detail. This allows the reader to develop a thorough and accurate understanding of the case(s). In the present study, which follows a multiple embedded case study design, the three home visiting programs are the “cases.” As such, the case descriptions in this chapter include an overview of each program’s mandate, structure, philosophy, and historical development, as well as contextual information on the community/region in which the program is located, and any other relevant program features.

In part because these case descriptions are lengthy, the reader may wish to reference *Appendix L: Overview of Four Mixed-Delivery Home Visiting Programs*, throughout this and the remaining chapters. Appendix L (pages 285-287) provides, in table form, a brief comparative overview of the three study programs, and in a separate column, information on a fourth mixed-delivery program – Extra Support for Parents Volunteer Service, where I am employed. This table also serves to present a simple, high-level overview of four programs within this relatively unknown sub-sector of home visiting.

Chapter 6 concludes with a summary of the main similarities and differences between the three programs, and a shorter description of the fourteen study participants. This description contains information on the study participants’ roles, experience, and background within the home visiting field.

6.1 COMMUNITY MOTHERS PROGRAMME (Dublin, Ireland)

6.1.1 Program Overview

The Community Mothers Programme ('the Programme') is a large and well-established universal home visitation service that operates in 12 local areas within Dublin, Ireland (population 1.3 million) (Molloy, 2002). The Programme follows a 'monthly-visit, curriculum-based' model that provides information on parenting and infant development, emotional support, and connections to community resources; neither paid visitors nor volunteer visitors provide practical/instrumental assistance (for a summary of program details, see *Appendix L: Overview of Four Mixed-Delivery Home Visiting Programs*, pages 285-287).

At the time of the present study, the Programme had over 150 volunteer 'Community Mothers' and a staffing complement of 11 whole-time equivalents (WTE's). Within this staff team, there was a manager, Secretary, and seven full-time and four part-time Family Development Nurses, each of whom acted as a co-ordinator for one of the 12 local areas¹². The Family Development Nurses (FDN's) recruit, orientate, train, support, and supervise volunteers; receive and distribute referrals of new babies to the program; and carry a small caseload of families (5 or more) themselves. In several of the twelve local areas, the Community Mothers Programme also offers a weekly Breastfeeding Group and/or one or more weekly Mother and Toddler Groups.

The Community Mothers Programme operates under the auspices of the Health Service Executive, or H.S.E., which is responsible for the delivery of health services for all of Ireland (population 4.5 million) (Central Statistics Office, 2010). While the Community Mothers Programme follows a range of H.S.E. policies and procedures – in areas from bookkeeping to occupational health and safety – the Programme also has some operational autonomy within the larger H.S.E. structure.

¹²At the time of this study, one local area was without a nurse.

In the 12 local areas where it operates, the Community Mothers Programme is **universally** offered to all first-time parents regardless of their age, income, marital or health status, or other factors. The Programme is voluntary, and in some areas, up to 80% of families become involved (Bardon, 2006). The programme serves about 1900 families each year.

The Programme follows a ‘monthly-visit, curriculum-based’ model. A home visitor (either volunteer or paid) visits each family once a month, in the family’s home, starting shortly after the birth of the baby. Each visitor, or ‘Community Mother,’ brings curriculum materials to explain, discuss, and leave with the parent(s). The materials are relevant to the child’s development at that specific age, and focus on what to expect at this stage, how to optimize infant development and create a healthy parent-child relationship, and how to deal with infant care challenges. Visitors also make time in every visit to enquire after the mother’s well-being, discuss her concerns, and answer her questions. Each visit lasts about one hour. The visits continue until the child is 12 months old, unless a family wishes to discontinue the program sooner.

At the time of this study, in some of the Programme neighbourhoods, there were enough volunteers for the Programme to be offered for 24 months. The second 12 months is an extension of the original program, and arose out of the findings of the 2000 follow-up study, which found Programme mothers to have poor diets and inadequate nutritional intake (Johnson et al., 2000). While mothers’ nutrition is integrated into the program curriculum during the first 12 months, the extension into the second year has allowed for more focused work on this topic, for those parents who choose to continue with the program.

6.1.2 The Local Context

All of the local areas served by the Community Mothers Programme are considered to be “disadvantaged areas with high birth rates” (Molloy, 2002, p. 23); common challenges in these areas include poverty, drugs, crime, inadequate and

substandard housing, social isolation, and a lack of opportunities for youth. In recent years some of these areas have seen a sharp increase in new immigrants and refugees, especially from Nigeria, other parts of Africa, and some Eastern European countries, particularly Poland and Lithuania. A few of the local areas also have one or more communities of Travellers – a distinct, centuries-old culture indigenous to Ireland and historically nomadic. Travellers experience high rates of poverty and social and economic exclusion; indeed, “Traveller children are among the poorest groups of children in Ireland” (OECD, 2006; p. 354). For almost twenty years, the Community Mothers Programme has specifically reached out to Traveller communities, and as was shown in a 1996 study, the Programme has been successful in providing services to Traveller families (Fitzpatrick, Molloy, & Johnson, 1997).

As explained by study participants, Public Health services in Ireland are universally available (and well accepted) by families; however, in comparison to the more comprehensive Health Visitor services available to families in Northern Ireland, England, Scotland and Wales, the services of each public health nurse are spread thin. This is because, as a Family Development Nurse explained, “public health is very broad in Ireland. It deals with ... birth to the grave.” Those first-time parents who live in neighbourhoods served by the Community Mothers Programme have an additional avenue for support; within the first few weeks after giving birth, they are automatically contacted by a Community Mother and offered the Programme. Those families can then receive both services. As explained by study participants, there is no overlap in jurisdiction or mandate because the public health nurses’ periodic “statutory visits” are focused on the child (newborn care and feeding, immunization, and so on), whereas the Community Mothers provide non-medical “mother-to-mother support.”

The Community Mothers Programme was designed to be integrated with the local public health service. As the program manager described, each “Family Development Nurse is actually a public health nurse who has been seconded full time into this Programme, and she has gone through the training process with me to ‘de-role’

and take onboard this Programme, to work within this philosophy.” The Family Development Nurse remains linked to the Local Health Office: she is part of the interdisciplinary health team in that area, her salary is paid from the Local Health Office budget, and her work space may be located within the Local Health Office. This allows for a circular arrangement of reciprocal referrals and communication regarding the well-being of families, and ensures that each Family Development Nurse has access to other health professionals for consultations, support, and volunteer training resources.

Since its founding in 1988, the Programme has operated continuously in the same 12 local areas, but has not been able to obtain funding to expand to other neighbourhoods. Indeed, with a recession-era moratorium on hiring in effect across the Irish civil service at the time of this study, the Programme was at risk of not being able to replace any nurses who resigned or retired.

6.1.3 Programme Philosophy and Curriculum

The Community Mothers Programme is deeply rooted in the central theme of empowerment. Empowerment is key at every level of the program – for mothers, volunteers, and staff. The Programme is based on the belief that when people are empowered, they will make optimal contributions and be more likely to reach their potential (Molloy, 2002). As the manager explained, “Your goal, really, is to make sure that everyone grows in the Programme – the parents, the Community Mothers, the Family Development Nurses.” This approach requires all involved to work from a place of genuine respect, trust, and inclusion – for everyone, by everyone:

The philosophy of the Programme is simple but profound. It aims to turn into reality the view that parents are the best experts with their own children and it works to support the parents in achieving the goals they have for bringing up their children. The Programme also tries to avoid any strong emphasis on professional advice.... (Molloy, 2002, pp. 25-26)

One of the most important aspects of the Programme is the “de-roling” of newly hired Family Development Nurses. This is important for two reasons: first, nurses have

traditionally been schooled and employed within hierarchical institutions where the “nurse knows best,” whereas in the Community Mothers Programme, nurses must work “in partnership with the community” (Molloy, 2002, p. 23). Second, as each Family Development Nurse is responsible for running all aspects of the Programme in one local area, it is essential that she embrace it and live it herself (Molloy, 2002).

The front-line tools for helping women become empowered as mothers are the skills and approach of the Community Mothers, and the infant development curriculum that is delivered to the families through the program. The curriculum uses simple illustrated sequences about family life, which provide a relaxed, easy-to-read approach to introducing parenting and child development information. The parents in the illustrated sequences are presented as capable, creative, and down-to-earth; there are no glossy brochures with airbrushed models. This entire approach was designed to support parents in seeing themselves as the experts on raising their children:

...If parents in disadvantaged areas can be encouraged to find solutions to their own childrearing problems, if they are given the relevant information...and there is no attempt to pressure them to take on particular strategies, most parents will in time arrive at solutions for their children that are effective and which will be applied far more enthusiastically than if the parent were merely obeying/responding to the suggestions of others (Molloy, 2002, pp. 26-27).

The Community Mothers Programme posits that the volunteers are experts as well – experienced mothers who know a great deal about parenting, and who are capable of delivering the program in keeping with the program philosophy and the real lives of parents. The program manager emphasized that a Family Development Nurse who embraces the Programme’s philosophy is “working in partnership with the volunteers, and she totally respects that they are mothers themselves, and that they have all this expertise.”

Another aspect of the philosophy is that volunteers live in the same local area as the families. The benefit of this is that they know and understand their neighbourhood, and have some experiences and perspectives in common with the parents. As one

volunteer explained: “You know, everybody is sort of the same. We can all communicate with one another on the one level.” This volunteer went on to say that similarly, the FDN’s familiarity with the local area is also important, even though she may not live in the neighbourhood: “I see the Programme working because [the nurse] has been working so long in the area and she knows how people live, and what struggles they have, and what struggles they don't have.”

In keeping with this philosophy, every volunteer *and* every staff member within Community Mothers Programme is a home visitor, with her own roster of five or more families; this includes all Family Development Nurses and the Programme Director (manager). In the words of one staff member, “We are all Community Mothers.” This was an intentional decision made at the outset of the program, with a threefold purpose: to keep the staff members’ skills fresh in delivering the curriculum, allow them to have a ‘finger on the pulse’ of what families with newborns were experiencing at any given time, and increase their understanding of the challenges volunteers faced in home visiting.

6.1.4 Programme Structure

The Local Health Office provides the Family Development Nurse with the names and contact information for each child born in the area; the nurse then ensures that these families are matched with a Community Mother. Each family is contacted by a volunteer, who asks if they would be interested in receiving the service. Families who live outside one of the designated areas are not eligible to receive the program.

In each area, the Family Development Nurse is the sole staff resource person for 18 to 20 volunteers; she handles all of the recruitment, screening, orientation, training, and support for this group of women. Together, she and the volunteers serve up to 200 local families each year through home visiting, and in several of the twelve areas, many additional families through the Breastfeeding Groups and Mother and Toddler Groups.

6.1.5 The Role of the Family Development Nurse

When asked to describe the role of the Family Development Nurse, one volunteer responded:

She would be ... what would you call it? The cement. She would be what people *build* on. She's the backbone of the whole [operation] ...between the Mother and Toddler [Groups], and the Community Mothers, and the Breastfeeding [Group], she's the rock really, to be honest with you. She organizes us all.

As noted earlier, each Family Development Nurse carries her own 'caseload', visiting five or more families each month, and providing them with the same curriculum and support as the volunteers provide. As will be discussed further in the Findings, Chapter 7, the FDN may assign herself families who have more complex needs, and she takes on any families whose volunteer can no longer visit them. However, it should be noted that direct in-home service does not comprise a majority of a FDN's workload, and that most of the families involved with the Programme are visited by a volunteer.

A key responsibility of each Family Development Nurse is to provide on-going training and support for volunteers. To this end, the nurse visits each Community Mother in her home, once a month; at this time, the volunteer updates the nurse on her visits and the families' progress, and receives support, supervision, and mentoring. In addition, every six to eight weeks, a group of about five Community Mothers meets in the home of a local Community Mother, for a group learning session. Participants shared that a strong alliance can develop from this close, collaborative, and dependable working relationship, and from the shared vision of healthy child development and mothers who are supported and empowered.

6.1.6 Programme History and Development

The roots of the Community Mothers Programme are in the Child Development Project, a 1980 home visitation pilot that ran in six sites in Ireland, Wales and England. In Ireland, there was no funding to continue nurses in this specialised role after the pilot project had finished. However, the project was seen as valuable and needed, so it was

thought that the work could be continued by using volunteers. From 1983 to 1985, a second pilot phase, involving volunteers, ran in four areas of Dublin. One of those sites was co-ordinated by the present-day Director of the Community Mothers Programme, who was able to develop and implement a volunteer model, with herself acting in a combined capacity of local nurse/resource person and volunteer co-ordinator. In 1988, the Director was invited to implement this new model in each of the 10 Local Health Offices (health districts) of Dublin. As funding was limited, one neighbourhood was selected from each of 8 health districts, while two neighbourhoods were chosen from the remaining two health districts (Molloy, 2002).

The original program curriculum was developed in Britain. Over the years, the Community Mothers Programme adapted it to be more relevant to Irish culture and context, and has continued to adapt it over the years in keeping with changes in best practice, and in response to local needs; for example, the Programme has developed a breastfeeding guide, and a bilingual Irish–English book of nursery rhymes.

6.2 WELCOME BABY UTAH COUNTY (Provo, Utah, USA)

“We really would like... parents to know that, ‘You know what, you can't do it by yourself. You need help and you need to reach out. And it's okay, because everybody needs help. It's not just families who are in dire straits that need help, every parent at some time has needed help with a child that pushes their buttons, or whatever they do.’”

- staff participant, Welcome Baby Utah County

6.2.1 Program Overview

Welcome Baby Utah County is a unique home visiting service that rallies varied resources within Utah County in order to provide information and support to first-time parents. This program is available, in one form or another, to all first-time parents of newborns in Utah County. How different families connect with the service, and which

type of home visiting they receive, is a somewhat complex matter, and is explained in the following pages.

Welcome Baby follows a ‘**monthly-visit, curriculum-based**’ model, whereby home visitors provide emotional support, information on parenting and infant development, and connections to community resources; neither paid visitors nor volunteer visitors provide practical/instrumental assistance (for overview of program details, see *Appendix L: Overview of Four Mixed-Delivery Home Visiting Programs*, pages 285-287). The Welcome Baby curriculum was developed and written locally, and provides “age-paced”¹³ information on everything from infant care to developmental milestones, and from stress management to post-partum depression.

Welcome Baby operates within the fiscally and socially conservative environment of the state of Utah (Davis, 2010; Falconer, 2011). Public funds are limited, and there is not a strong public support for universal programs. Indeed, less than half of all Utah County first-time parents qualify for any type of home visit(s) from the Utah County Health Department; as described in Section 6.2.4, those who qualify do so on the basis of identified risk factors. A key premise of Welcome Baby is the belief that “low-risk families can have high-risk days;” thus, extending support to these families may reduce emergent risks, as well as pre-existing risks which were not identified at the time of birth. Additionally, as one staff participant shared, while many of these families may be “pretty much smooth sailing” in the longer term, all new parents can benefit from current information on child development and parenting. Therefore, in order to extend home visiting and parenting support to as many first-time parents as possible in Utah County, two separate organizations, from two different sectors, have committed to delivering the Welcome Baby program – *together*. This

¹³ “Age-paced” refers to providing information about a child’s development at the time when the child is at or nearing that specific age. This is in contrast to providing information in one fell swoop (for example, via a parenting book).

requires an unusually high level of ongoing collaboration and operational interdependence.

One of these organizations, United Way of Utah County, has both staff and volunteers who do home visiting through the Welcome Baby program. The other organization, the Utah County Health Department (through its Bureau of Child Health Services), has both nurses and (paid) outreach workers who visit families in their homes, but does not have any volunteer visitors. Because the focus of the present study is programs that house volunteer visitors and paid visitors *within the same organization*, this study was concerned primarily with the United Way component of Welcome Baby. Interviews were not conducted with any home visitors from the Utah County Health Department (UCHD). However, interviews were conducted with both the current and former Directors of the UCHD Bureau of Child Health Services. Together these participants provided an historical perspective of Welcome Baby and insight into the present-day partnership between the two ‘wings’ of the program.

6.2.2 The Local Context

At the time of this study, Utah County had a population of roughly 545,000, (Utah State Data Center, 2010) most of whom lived in a 30-kilometre line of towns and small cities running north-south, wedged into the plain that lies between the Wasatch Mountains to the east, and Utah Lake to the west. According to U.S. Census Bureau figures, the state of Utah has the highest fertility rate in the United States (Bulkeley, 2005); in Utah County, there are 12,000 births each year, roughly 4000 of which are to first-time parents. This birth rate is fuelled by Utah County’s religious and cultural composition: according to study participants, 85% of the population belongs to the Church of Jesus Christ of Latter-Day Saints, while about 10% are Spanish-speaking Catholics; both communities have higher-than-average birth rates. As well, Utah County is home to two large universities, both of which have a high percentage of married Latter-Day Saints (Mormon) students. Indeed, 2005 Census Bureau figures showed that “in Utah, women married at a median age of 21.9 and men at 23.9 – both the youngest

ages” of all U.S. states (Bulkeley, 2005, p. 1). Each of the two universities “attracts many young couples at the peak of their child-bearing years” (Davidson, 2010, p. 1). All of these factors combine to create a unique situation of many young parents with young children living throughout the County.

This reality is contrasted with a very limited availability of public health and other services for families with young children; most publicly funded services are reserved for the minority of parents and children who have specific risks and vulnerabilities. Around 1990, the Utah County Health Department began working toward extending their targeted home visiting service to all families in the county. In an attempt to obtain resources to offer home visiting to all first-time parents, Utah County representatives lobbied, made funding applications, and worked in collaboration with agencies across the state. Initially the goal was to staff these services with paid home visitors, but funding from the state government was not forthcoming. Once United Way of Utah County became involved, the idea of volunteer visitors was raised, and in 1999, United Way agreed to sponsor a county-wide volunteer-based home visiting program. This was a crucial development: lobbying efforts in other parts of Utah were not fruitful, and to this day, no other county has been able to extend their home visiting services to the general population of “lower-risk” parents of infants.

Developing a curriculum was a key step in establishing this program. In the late 1990’s, the Utah State Parent-Teacher Association provided funding for an editor and, for the better part of a year, the Director of the Bureau of Child Health Services, Utah County Health Department, spent some part of every work day writing a curriculum and sending draft segments to the editor. By 1999, with the new curriculum completed and United Way’s support in place, the dual-track Welcome Baby program was launched.

6.2.3 Welcome Baby’s Program Structure: Two Agencies, Four Types of Visitor

As noted above, two completely separate organizations share the day-to-day delivery of the Welcome Baby Utah County home visiting program. This operational

partnership is larger-scale, and more interdependent, than many service delivery arrangements that are commonly called “partnerships.” The delivery of core services is dependent on not only a shared vision, but shared ways of operating and ongoing communication. As a result, in order for the program to succeed, any disagreements, problems, or misunderstandings between these two organizations must be worked out. At the time of this study, the two ‘point persons’ at each organization had a very strong relationship; they were in contact almost “every other day,” they shared a common “commitment and passion for young children,” and both were committed to making their community a good place for young children and their families.

While the managers’ leadership is important, the partnership also includes all of the home visitors and other staff members, in both ‘wings’ of the program. For example, nurses from the Utah County Health Department speak at volunteer training sessions, act as a resource for volunteers, staff, and families, and go on home visits with volunteers and United Way staff as requested. On a regular basis, each agency makes referrals to, and accepts referrals from, the other. Each agency also plays a role in updating the parent education materials used in the curriculum.

In total, Welcome Baby offers four different types of home visitors to families with newborns. All of these home visitors, from both organizations, are considered part of the Welcome Baby Utah County program, and all use the same Welcome Baby curriculum as part of their in-home work with families.

Two of the four types of home visitors are affiliated with United Way of Utah County: approximately fifty volunteer visitors and two paid (non-nurse, unilingual) staff members. The other two types of visitors are staff of Utah County Health Department: twelve health nurses and three bilingual Outreach Workers. Both the nurses and the Outreach Workers visit families who screen into the Health Department’s services. The Outreach Workers are salaried employees who work with Spanish-speaking families who

have language barriers and additional risk factors,¹⁴ such as limited social support, a lack of familiarity with American parenting practices and cultural norms, and limited or no understanding of American health and social service systems.¹⁵

The result of this unique arrangement is that, despite very limited public funding for health and social programs, all Utah County first-time parents, regardless of their circumstances, have the opportunity to receive the Welcome Baby age-paced infant development curriculum, a supportive listening ear, and information on community resources, via monthly home visits, for the first year of their child's life. The various Welcome Baby Utah County home visitors, and their specific roles, are outlined in Table 2, page 104, and described in detail in Sections 6.2.4 through 6.2.7.

6.2.4 The Utah County Health Department 'Wing' Of Welcome Baby

The UCHD's Bureau of Child Health Services provides post-partum/infancy services to specific subgroups only. Infants who are at risk for developmental delays, such as "prematurity, low Apgar scores, birth trauma, substance abuse, and need for parenting skills" (Utah County Health Department, n.d.) qualify for services, as do parents under age 18, Spanish-speaking parents with any risk factors (as described in Section 6.2.4), and parents who are in receipt of Medicaid.¹⁶ Most of these families are eligible to receive monthly visits from a health nurse, up to the child's first birthday.

¹⁴ At the time of this study, two of the twelve public health nurses on this team were also fluent in Spanish. They provided some of the home visiting services to Spanish-speaking families, particularly relating to prematurity or infant medical conditions.

¹⁵ At the time of this study, Utah County Health Department had grant-based funding for bilingual Outreach Workers; one was employed full-time and two worked half-time.

¹⁶ Medicaid is the publicly funded U.S. medical insurance system for individuals living on low incomes. Those Utah County families who are in receipt of Medicaid, and have no other identified risk factors, are offered one postpartum visit by a public health nurse. This visit is funded by Medicaid, and aims to ensure that parents are aware of relevant community resources. If additional home visits are needed or requested by these families, visits can be provided by either a nurse or a volunteer, as appropriate.

The Utah County Health Department nurses are experienced in working with families that have multiple risks, barriers, and burdens. When implementing the Welcome Baby curriculum, they position this information within the widely varying needs and concerns of each family.

Table 2: Home Visiting Roles Within Welcome Baby Utah County

Title of home visitor role	Paid or volunteer?	No. of visitors in role	Profile of families served	Families visited each month
UNITED WAY OF UTAH COUNTY (<i>'volunteer' wing of Welcome Baby</i>)				
Welcome Baby volunteers	volunteer	~50	Families whose only risk factor is being first-time parents; also, a small number of parents with greater risks who turn down the UCHD services (below) but are open to having a volunteer visitor.	Most volunteers visit 2 or more families/month.
manager	paid	1	Families with increased vulnerabilities, who may not be appropriate to match with a volunteer, but who do not qualify for UCHD services.	5-10 families/month
Pt-time staff member	paid	1	Families requesting a PAT-certified home visitor and other low- to medium-risk families as required.	5 families/month
UTAH COUNTY HEALTH DEPARTMENT (UCHD)				
Health nurses	paid	12	Families with established vulnerabilities, as determined by a list of 20 risk factors.	40-60 families per FTE/month. (Range is due to variations in travel times).
Outreach Workers	paid	3 (2.0 FTE)	Spanish-speaking families with additional vulnerabilities.	

6.2.5 The United Way ‘Wing’ Of Welcome Baby

At any given time, the United Way ‘wing’ of Welcome Baby has roughly fifty active volunteers, and several others who are on leave. About two-thirds of the volunteers take on two or more families at a time, with a small percentage of these taking on three or more. Each volunteer makes one monthly visit to each family, using the Welcome Baby curriculum (outlined in Section 6.2.7) to provide age-paced information and support. Visits are made more often, as families require. Common topics of discussion are breastfeeding questions and challenges, sleep problems, infant development, and the adjustment to parenting. Many parents served by this ‘wing’ of Welcome Baby are young couples in their late teens or early twenties, including a large group of first-time parents attending one of the two universities in the county, who may be far from home and family. This ‘wing’ of Welcome Baby also serves a number of single mothers and new immigrants.

At the time of this study, the staff team at the United Way ‘wing’ of Welcome Baby consisted of a full-time program manager and one part-time staff member. Originally, home visiting was not part of either staff member’s portfolio. Shortly after arriving at United Way in 2006, the present manager made the decision to introduce staff home visiting within Welcome Baby as a way to reach more families, especially those who had one or more elevated risk factors.

United Way Welcome Baby also makes extensive use of college interns, twelve months a year. The interns handle recruitment of both families and volunteers and make upgrades and additions to the program website, databases, and program manuals. The program is dependent on the interns, as the two-member paid staff team is not large enough to handle the workload alone.

At the time of this study, the interns, part-time staff member, and manager all acted as day-to-day resource persons for volunteers. The manager tended to support volunteers through the more challenging scenarios, and also accompanied volunteers on home visits, as needed. Much of the manager’s time was also spent on the program’s

broader goal of developing a multifaceted system of support for Utah County families with young children. In addition to the primary partnership with the Utah County Health Department, United Way's 'wing' of Welcome Baby also has other partnerships that contribute to the program's operation; however, space does not permit a description of these arrangements in this report.

6.2.6 Program Philosophy

All Utah participants stressed the importance of information and support in helping first-time parents successfully transition to new parenthood and facilitate their children's well-being. However, Utah participants emphasized different aspects of Welcome Baby's philosophy. One participant described the program as having a strengths-based approach: "when you go into the homes, you're not looking at deficiencies. You are looking at what strengths do these parents have." Another emphasized what Powell (1993, p. 29) has called the "Information is Primary" approach to home visiting: that is, if parents are equipped with information on child development, they will be more confident and capable, their children will be healthier, and families will thrive. Yet another participant expressed that it is important for parents to believe in themselves and be empowered as the experts on their own children:

One of my goals would be to make them realize that they're the expert in their baby's life, that they know their baby better than anyone else, that they are fully capable to make decisions for their children ... I bring them information, but they can take it or leave it. I always tell them, "Maybe this is a good suggestion, but only you know what works best for you and your baby and your schedule, and your personalities and temperament."

6.2.7 The Curriculum and the Service Provided To Families

Both the Welcome Baby curriculum and the program name are the property of the Utah County Health Department; the Health Department "shares" these with United Way. The focus of the curriculum is infant and early child development, but the program is flexible, and visitors – paid and volunteer, nurse and non-nurse – are encouraged to respond to families' individual needs, concerns, and questions.

Not all families can receive the same *duration* of service through the Welcome Baby program. The Welcome Baby curriculum goes up to 36 months of age, and those families who are served by volunteers and staff from the United Way ‘wing’ can receive monthly visits for up to three years, if they so choose. Only a small percentage of families are actually involved for the full three years; many families receive 4 or 5 monthly visits, and a significant number receive 11 or 12 visits. In comparison, those families served by nurses and Outreach Workers from the Utah County Health Department are only eligible for service for roughly the first 12 months of their child’s life. This is because the Health Department’s resources are limited and staff must make room in their caseload for new families. In these 12 months of service, Health Department staff work to ensure that infants are developing on schedule, parents have grasped basic infant development and parenting information, and families have been connected to any other needed services.

6.2.8 New Directions and Future Plans

Welcome Baby strives to offer parents various ways to access support and information. Indeed, at the time of this study, for United Way of Utah County and the Utah County Health Department, the overall goal was to develop and implement a *system* that supports the healthy development of each child in Utah County. As one staff member described:

Basically Welcome Baby, when it started up ten years ago, the vision of it was to have kind of a system in place for families ... Our whole purpose was if we universalize and we take the stigma out of getting help, then we are more likely to get everyone kind of coming into that net.

One aspect of this system is the 2010 launch of a telephone- and web-based initiative, “Help Me Grow.” Help Me Grow builds on two existing local services – the 211 Community Information Line and individual community-based paediatricians¹⁷ – in

¹⁷ In the U.S., most children – including those with no health conditions – see a paediatrician as their primary care provider.

order to help families get the support and care they need, earlier and more seamlessly. In a quiet but clear stance against the traditional silos that pervade health care and social services, this new initiative has purposely embedded a direct line of communication between a non-medical, community-based outreach and monitoring program and each child's health care provider. In doing so, Help Me Grow models what could be possible if communities were to adopt an integrated system of care for children and families.

In 2009, the United Way 'wing' of Welcome Baby provided a home visitor to 5% of first-time parents in Utah County. Many more parents were offered longer-term volunteer home visiting than the number who chose to become involved. The manager speculated that this low uptake was due to the "rugged individualist" way of thinking that dominated local belief systems, the result of which was that many new parents were reluctant to ask for help with child-rearing. In part to address this gap in uptake, 2010 saw the launch of both the above-noted *Help Me Grow* initiative, and a one-time home visit pilot project. In this pilot, new parents in one Utah County community are offered a single home visit from a volunteer visitor, who provides information on infant development and community resources. At the time of this writing, organizers were optimistic that this short-term option would appeal to some parents who did not want to register for a program or make a longer-term commitment, but who would like to have more information. As the Welcome Baby manager explained, this approach is "just another way of... spreading a system so that we get those [families] who want the least intrusive type of approach."

6.3 VOLUNTEER HOME VISITING AND FAMILY SUPPORT PROGRAM, GOOD BEGINNINGS AUSTRALIA (Hobart, Tasmania, Australia)

6.3.1 Program Overview

In Hobart, the capital city of the island state of Tasmania, Good Beginnings Australia runs the Hobart Early Years Centre. The Centre offers three core programs: Volunteer Home Visiting and Family Support, Dads Connect, and the Integrated Family

Support Program. The Centre also offers parent-child interactive groups and parenting education sessions/programs; these are scheduled as needed and as funding permits, and come under the umbrella of the Volunteer Home Visiting and Family Support Program. The Hobart Early Years Centre's umbrella organization, Good Beginnings Australia (described in Sections 6.3.3 and 6.3.5), is a national non-profit parenting and family support organization, with program sites in several locales across Australia.

The Volunteer Home Visiting and Family Support Program follows what is described in this thesis as a '**weekly-visit, broad-scope**' model of service delivery: during weekly visits, paid and volunteer visitors provide information on parenting and infant development, emotional support, and connections to community resources, as well as practical/instrumental assistance. Home visitors are not responsible for sharing particular information or curriculum materials with the parents at each visit (for overview of program details, see *Appendix L: Overview of Four Mixed-Delivery Home Visiting Programs*, pages 285-287).

Unlike the Community Mothers Programme and Welcome Baby Utah County, the Volunteer Home Visiting and Family Support Program is not automatically offered to first-time parents with newborns. Parents must be referred to the program, either by someone else or by referring themselves. Any parent living in the greater Hobart area, who has one or more children ages eight years and under, and who is seeking support, parenting guidance, or help (such as information, strategies, practical assistance), is eligible to receive services. About one-third of families involved with the program have an infant (or infants) under 12 months of age. In another 40% of families, the youngest child is between one and four years old. In the remainder of families, the youngest child is five to eight years old.

The families served by the Volunteer Home Visiting and Family Support Program are diverse in terms of economic background and family composition. Most are Caucasian and Australian-born, with more humanitarian (refugee) families coming to the program in recent years. The families have a wide range of strengths, and their

needs and concerns range from the straightforward to the complex; as described in Section 6.3.4, below, the program is structured to be responsive to these differences. Paid home visitors, called Family Support Workers, tend to be matched with those families who have more complex needs and issues than the families who are matched with the volunteer visitors (called Community Parents). In-home service is provided to families in a number of ways: via either a Family Support Worker *or* a volunteer, or both at the same time, or each in succession. This flexibility allows the program to tailor its services, and thus, according to the program manager, “offers families choices, different pathways.... [and] opportunities” for accessing relevant support during difficult times.

At any given time, roughly two-thirds of the families involved with the Volunteer Home Visiting and Family Support Program are matched with a volunteer, while one-third are receiving the services of a Family Support Worker; a small percentage receive service from both, at the same time. In offering a balance of practical assistance with the children, information/education, and emotional support, the service combines three domains which, as described by a staff participant, include “doing, and talking, and walking alongside” parents.

6.3.2 The Local Context

Hobart is located on the island state of Tasmania, population 500,000 (Tasmania’s Population, 2008). The greater Hobart area itself has a population of roughly 212,000 (Hobart City Council, n.d.). As the state capital, Hobart has many amenities, but it is also quite isolated; it’s a four-hour drive to the communities that are clustered on the other side of the island, and a four-hour flight to Sydney.

Study participants informed me that Tasmania is the poorest of all Australian states, and about 40% of the families in the Volunteer Home Visiting and Family Support Program have very low incomes. Most of Hobart’s public housing complexes – referred to as ‘broad-acre housing estates’ – were built in areas of extreme geographical isolation, far from the city centre, and lacking public transportation, employment, child

care services, social programs, and diversity in the socio-economic background of the residents. Families who live in these complexes face systemic (structural) barriers to services and opportunities, as well as ongoing financial hardship; those parents living in broad-acre housing estates who request Good Beginnings' services are often dealing with social isolation, parenting challenges, mental health concerns, and/or a major life crisis as well.

Hobart also has a sizable middle-class population, many of whom are employed in government or academic positions; about 40% of families in the Volunteer Home Visiting and Family Support Program are from this group. These families may be new to Tasmania, far from family and friends, and unsure of where to turn during a difficult time.

6.3.3 Program Philosophy

The philosophical approach of Good Beginnings Australia, called the 'Connect' Approach, is strengths-based. It focuses on place-based (local), relevant, responsive, and respectful community development, particularly in concert with families who have experienced marginalization. This approach is similar to the well-known American movement, 'Asset-Based Community Development' (abcdinstitute.org).

Programs operated by Good Beginnings are committed to engaging with families and communities in a respectful, open, honest, and collaborative way; to respecting differences (individual, cultural, local, et cetera); and to providing services that are participant-driven and effective. Social change and community development are areas of focus, as are outreach and responsive programming for diverse populations of families with young children. Their philosophy is exemplified in the Good Beginnings Australia mission statement:

Good Beginnings is a national charity that works in partnership with communities to provide early childhood intervention services and engages in advocacy that will build capacity of parents and carers.

Our range of socially inclusive early child development services helps children and their families flourish which in turn contributes to effective communities. (Good Beginnings Australia, n.d.)

One staff participant stressed that the Hobart Volunteer Home Visiting and Family Support Program is committed to supporting those families who request assistance, simply because they have asked for it, and not because they meet prescribed criteria for risks to well-being. The purpose of the program is to effectively respond to the needs and priorities of these parents; emotional support and education on parenting strategies/approaches are major areas of focus for both staff and volunteers. Program materials and study participants indicated that *how* this work is done is perhaps just as important. As one study participant described:

...the main mission... [is] to help families build resilience, and to work with their strengths to empower them to do what they need to do in life. And not to fix it for them. And I guess to come from a genuine and respectful point of view, and non-judgemental.

6.3.4 Program Structure

Volunteer Visitors

Good Beginnings volunteers are called Community Parents. They are most often matched with one family at a time, visit weekly for 1.5 to 2 hours, and provide a range of services that can include listening and emotional support, adult company, parenting and child development information, and practical assistance with the children. Good Beginnings volunteers and staff are not permitted to do housework, nor can they babysit children while a parent is out of the home.

Volunteer Community Parents must be parents themselves. New volunteers complete 35 hours of pre-service training, which covers a variety of topics, such as parenting, child development, and communication. The pre-service training program was developed by the national Good Beginnings Australia office, and is accredited by Australia's National School of Volunteering as part of a nation-wide training recognition

system. Once volunteers complete the pre-service training, on-going support and supervision are provided on an individual basis by all members of the staff team (the Coordinator, Family Support Workers, and the program's Administrative Officer). Volunteer social events and additional training sessions are also offered from time to time.

Specific guidelines are followed in assigning volunteer or staff visitors to families. As a rule, volunteers are not matched with parents who have untreated mental health difficulties, active substance abuse problems, or current child protection orders (that is, court-ordered involvement). The Coordinator also assesses families for potential risks to volunteer safety. Families with any of the above-named risk factors are assigned to a Family Support Worker instead of a volunteer.

Front-line Staff (Family Support Workers)

The Family Support Workers (FSW's) provide a similar service to the volunteers, though they generally work with families who have more complex needs. At the time of this research, Good Beginnings had two FSW's in the Volunteer Home Visiting and Family Support Program, and another five FSW's in the Integrated Family Support Program (described in Section 6.3.5). All but one of these seven FSW's were part-time.

All of the Family Support Workers are required to have relevant post-secondary education, training, and skills – in particular, the ability to work well with families who have more challenging needs. These families may face greater barriers to accessing services and at the same time, increased challenges regarding family well-being and healthy child development. The FSW's also take on advocacy, referral, and accompaniment roles, interacting with several professionals from different fields, alongside or on behalf of families. They often use more direct strategies than do the volunteers; volunteers most often use strategies such as listening, affirming, role modeling (CCCH, 2008, p. 9), as well as problem-solving with parents, and sharing their own relevant experiences. The use of direct strategies involves asking direct questions

regarding one's concerns, and addressing difficult matters head-on. This requires certain skills and confidence, as well as familiarity with a range of complex social issues; it also entails taking risks. These are not always appropriate or reasonable to expect of volunteers.

Duration of Service

The duration of service through the Volunteer Home Visiting and Family Support Program varies widely; volunteers and families may be matched for as little as three months, but are most often matched for about nine months, and can continue the 'match' for longer, if required, as there are no funding restrictions that limit the duration of the volunteers' service. A staff participant reflected on the difference that a volunteer match of two years had made in the life of one single mother, who had, in the space of those two years, dealt with homelessness and an abusive partner:

With high anxiety and some doses of mental health issues, she's been able to build resilience and esteem and empowerment, to get out and have her own house, and raise a child, and do a university course. Even though I guess there's still some remnants of all that there – and people carry these for years and years – but she's able to be resilient enough to get up and get going, and to live her life, with more of a quality of life than before.

In comparison, federal funding for the FSW's limits their service to 12 months, so when a family actually requires longer service, this presents an administrative challenge. Fortunately, the program has also received funding from a source that does not have these restrictions; if it is determined that a family requires the extended services of an FSW, their file is closed, new goals are identified in order to meet the outstanding needs, and a new file can be opened. On average, families work with a Family Support Worker for 3 to 6 months.

Partnerships

While Good Beginnings Hobart does not operate within any ongoing partnerships, staff members offer a range of short-term parenting groups, often in

partnership with other organizations. The program receives referrals of families from many community-based and government agencies.

6.3.5 Program History and Development

The roots of Good Beginnings Australia (GBA) are in Australia's largest city, Sydney. From 1988 to 1994, attempts were made to respond to concerns about child and family well-being through a community-based response – volunteer home visiting. A few national and local groups stepped up to offer support to these fledgling initiatives, which eventually became known as Good Beginnings. Finally, in 1997, the Australian government funded “a network of Good Beginnings Volunteer Home visiting and Parenting Programs” (Prichard & Polglase, 2001, p. 1). Hobart was chosen as one of four pilot sites across the country, and within the year, the Hobart home visiting program opened its doors.

From the outset, there was always at least one part-time Family Support Worker in Hobart, serving as part of the Volunteer Home Visiting and Family Support Program and working with those families that required more intensive and skilled support services. However, funding for the Family Support Worker role has fluctuated over the years, which has meant corresponding changes in the full-time equivalents of this position. Most of the Family Support Workers' time is devoted to working directly with families in their homes; however, the FSWs also provide support and supervision to the volunteer visitors, and from time to time, they lead or co-lead parent education groups.

Today, Hobart is one of about 13 active GBA sites across Australia; each site provides one or more of the many programs offered by GBA. While volunteer home visiting was the original method of service delivery for GBA, at the time of this study, only two sites still offered home visiting: Hobart and a smaller program in Sydney, which does not have Family Support Workers on staff.

At the time of this study, the government of Tasmania had recently introduced a new state-wide social-service intake, assessment, and referral system, called the

'Gateway,' to serve families and children and ultimately, to prevent child maltreatment. One of the provisions of this system is the aforementioned Integrated Family Support Program (or IFS – pronounced '*ifs*' – for short). GBA Hobart is one of several agencies that have received funds to employ Family Support Workers under IFS. These Family Support Workers do the same work with families as the FSW's in the GBA volunteer program. A Family Support Worker from the Volunteer Home Visiting and Family Support Program described the relationship between these FSW's: "We've all got similar backgrounds and qualifications. And the families that we work with all have the same sorts of problems. We share information, support we do work very much as a team."

The only significant difference named by study participants is that the IFS clients are mandated by child protection to receive parenting education and family support services. A child protection "order" may be in place, whereby a judge has set out the terms and conditions of what parents must do in order to either keep their children with them, or have their children returned to them. As one Good Beginnings staff member explained, the mandatory nature of the IFS service changes the dynamics:

... there's a lot of pressure from Child Protection to achieve the sort of outcomes that they think are desirable, which aren't always in accordance with what we might think are desirable. Whereas in the volunteer home visiting program, we're far more autonomous. The families come voluntarily ... they seek out our services voluntarily, and I just find it's a more positive area to work in.

A benefit of these two service streams being housed together is that each family receiving services through IFS is eligible to be matched with a volunteer Community Parent, provided that this does not present difficulties or dangers for a volunteer, and that any mandatory child protection 'orders' have ended. The Good Beginnings manager explained that, in addition to these caveats, some of the IFS families don't need a volunteer; thus, about 10% are actually matched with a volunteer Community Parent, either during or after their involvement with the IFS Family Support Worker.

6.4 SUMMARY OVERVIEW OF THE THREE STUDY PROGRAMS

6.4.1 Differences between the Three Programs

As described in the previous three sections, each of the three study programs was unique. Each had its own mandate, program structure, and (fairly complex) funding and staffing arrangements. Each operated within a distinct local context, with variations in the home community and country, the population and geographical area served, the health and social service structures, and the dominant values and beliefs. While the roles and responsibilities of both the volunteers and the program managers were more similar than different across programs, the responsibilities of the paid front-line staff varied considerably from one program to the next. These variations are described in Sections 6.1.5, 6.2.3, and 6.3.4, and the responsibilities of paid home visitors (both managers and front-line staff) are outlined in Table 3 (page 124).

Differences in Program Model

Two study programs, Community Mothers and Welcome Baby, followed what I have termed a **'monthly-visit, curriculum based'** model, and were *universally offered* to first-time parents who lived in the catchment area. Volunteers in these two programs were generally matched with more than one family at a time; indeed, in one program, it was not uncommon for volunteers to visit five to ten families at one time. Monthly home visits were roughly one hour in duration, and involved discussions on family adjustment and functioning, maternal well-being, and child development and parenting. Paid and volunteer visitors in these programs did not provide practical assistance with the children. Although at times there may have been differences in the populations served by volunteer visitors and paid visitors, in these two programs, the paid and volunteer visitors' in-home *roles* were largely the same.

The third program, Good Beginnings Australia, followed a **'weekly-visit, broad-scope'** model. Volunteers provided emotional support as well as practical assistance (help with care of the children, assistance going on outings or to appointments, et cetera) but, depending on each family's needs and priorities, may or may not have

provided parents with extensive information on child development and parenting, and did not deliver a parenting curriculum. Families could access this program if they were referred, or if they self-referred; thus the program was ***universally available***, but not universally *offered*. In this program, the volunteer visitors and paid visitors often played somewhat different roles; paid visitors may were usually more involved than volunteers in parent education, problem-solving, advocacy, and helping families to stabilize and improve their overall living situation.

6.4.2 Similarities across the Three Programs

The three programs also shared several characteristics in common.

- All three programs were launched following a concerted, multi-year effort marked by extensive planning, collaboration, lobbying, seeking funding, and/or pilot-testing.
- All three have had volunteer home visitors, as opposed to paid home visitors, at the centre of their program. While the staff members' in-home work was an important component of each program, volunteer-centred features included the following:
 - ◆ a large number of volunteers who provided in-home services to the *majority* of families in each program;
 - ◆ all program staff were expected to work well with volunteers; and
 - ◆ for the most part, volunteer visiting was the public face of each program.

This is different from programs where volunteer services may be an adjunct to the program's central services, which are provided by paid staff; in such programs, volunteers may play more limited roles, and/or be fewer in number, and/or work mainly with a designated staff member(s), such as a volunteer coordinator.

- As was the case with many home visiting services, all three study programs offered parent groups, and/or parent-child groups, which strived to meet a range of educational and social needs for different populations of families.
- In all three study programs, the managers carried a small 'caseload' of families (see Section 5.5, item #3, for details).

- While each program differed in the exact composition of the families they served, each served a wide range of families – wide enough for the programs to be described as universal in nature. Staff and volunteers from all three programs mentioned the importance of providing services to certain vulnerable populations, such as single parents and mothers with post-partum depression or anxiety, as well as those with mental health concerns generally. Child development delays and dis(Abilities) were also noted frequently in the examples provided by participants. Finally, one or more participants from each program identified both teenage mothers and newcomers (immigrants and/or refugees) as current or emerging priority populations.
- All three programs worked primarily with mothers, but there was frequent mention (in the interviews as well as the program documents) of fathers, and more limited mention of other family members. For example, one volunteer stated that home visitors would go over the program’s curriculum with a child's father, if he were the one at home on a particular day.

These programs’ emphasis on mothers reflects several factors, such as the predominant cultural practices regarding gender and parenting, and the greater level of intimacy and vulnerability inherent to home-based programs. In my own work in the field, and through this research process, I have seen that some changes are happening within programs in this sector. For example, some in-home programs have begun to include male volunteers or have hired a male front-line staff member, some have successfully integrated fathers into the groups that they offer, and one of the three study programs has developed groups for fathers and fathers-to-be. While this discussion is largely beyond the scope of this thesis, it is important to note that much work remains to be done regarding both gender roles and women’s equality.

6.5 OVERVIEW OF THE INDIVIDUALS WHO TOOK PART IN THE STUDY

Fourteen individuals from three home visiting programs were interviewed for this study. Six volunteers were interviewed, two from each participating program. All of the volunteers were parents themselves; at the time of this study, two of the three programs required that volunteer home visitors also be parents. Four of the six volunteers had college diplomas or university degrees in health, human services, or education.

Eight staff were interviewed. Four were nurses by training; at the time of the study, one of these worked in a program coordination and front-line service capacity, two were in program management roles, and one was retired. The other four staff members had college or university preparation in management, community services, family studies, or counseling. Most staff and volunteers brought other relevant life experiences to their in-home work as well. No study participants were social workers.

The length of time that participants had worked or volunteered with their respective home visiting programs varied considerably, and ranged from 1 year (2 participants) to over 20 years (2 participants). The intensity (hours per month) of study participants' involvement also varied widely, and was not static over the duration of their employment/volunteer work; for example, some volunteer and staff participants had taken educational or parental leaves of absence. Volunteers' time commitment ranged from roughly 2 to 15 hours per month, while the paid staff worked anywhere from 10 hours per week to more than 40 hours per week.

It is notable that over half of study participants had, in the past or at the time of the study, also played other roles within these programs. Two study participants had been involved as program parents, back when their own children were infants. Three volunteers from two different programs had, in the past or at the time of the study, volunteered in different roles within their program. Two staff members had been volunteer visitors before being hired in their present roles, and four staff members (from all three agencies) had, over the years, held another paid position in the program or its sponsor agency. This range of roles and responsibilities speaks to both the study participants' commitment to the programs and the breadth and depth of their experience.

In this chapter I have described the three study programs, and highlighted some of their significant commonalities and differences. The following chapter presents the findings from the present study.

CHAPTER 7: FINDINGS

Organization of the “lessons learned” from this study

Lincoln and Guba (1985) described the overall results or outcomes of case study research as the “**lessons to be learned**” (Lincoln & Guba, 1985, p. 362, as cited in Creswell, 2007, p. 225). The “lessons learned” from the present study are organized into four categories: findings, researcher’s reflection, discussion, and analysis.

- The **findings** are presented in Chapter 7, and include the experiences, insights and perceptions of the study participants as shared in the interviews, as well as the information gleaned from the review of agency documents.
- The **researcher’s reflection** brings my perspective into the mix – based on my own years of experience in the field. There are three such “researcher’s reflection” segments, all in Chapter 7. Each is marked by a text box. These segments allow for a few key insights gained from my own experiences to be included in the report, but to remain separate from the findings that have come from the study participants and programs.
- The **discussion** weaves together the findings on one or more themes, and looks at what they might mean; while the **analysis** situates the findings, discussion, and the researcher’s reflection within my theoretical framework and the broader socio-political context of home visiting, early child development, and family well-being in wealthy western Anglo-Saxon countries. The discussion and analysis are presented together in Chapter 8.

Recommendations for practitioners and policy makers, as well as recommendations for future research directions, are also included in Chapter 8. Finally, in Chapter 9, *Conclusion*, I provide a high-level overview of the “lessons learned,” and reflect on the implications of the present study for the public policy realm, the fields of social work, health care, and early child development, and my own professional practice.

7.1 OVERVIEW OF FINDINGS

Participants from all three programs, and across all roles, believed that having both volunteer and paid home visitors within the same program was of benefit to families, volunteers, staff, and the programs overall. Most believed that this feature was essential to their program's success, and felt strongly that having either *only* volunteer visitors, or *only* paid visitors, would be a real detriment to the program.

Participants described a series of complementary strengths possessed by paid and volunteer home visitors which, when used in concert with one another, allowed for several positive and important things to happen within these programs. In section 7.2, these complementary strengths are described, and I argue that these form a 'foundational layer' of strengths. In the sections that follow (7.3 to 7.7), I demonstrate how these complementary strengths interact to create important benefits and outcomes.

Challenges and weaknesses are the focus of Sections 7.10 to 7.15. Overall, study participants did not identify many weaknesses internal to their programs. The weaknesses they did name were different for each person, with no one weakness standing out. When asked about program weaknesses, one long-time volunteer responded, "I think the program is a good program. I think that is really a question for the people [parents] that take part in the program."

All study participants named both strengths and challenges that were, *and* those that were not, directly related to having both paid and volunteer visitors within the same program. However, in keeping with the focus of this thesis, only the strengths and challenges pertaining directly to having both paid and volunteer visitors are presented.

Consistency of Findings

The research findings were fairly consistent across programs and roles. Overall, study participants within each program tended to have a consistent understanding of their program's mandate, and to value the same things about their program. Across

programs and roles, participants shared a great deal of passion – for healthy child development; for making sure that parents were supported in the work of raising young children; and for recognizing the critical importance of parenting in our society. Participants were also passionate about the power and effectiveness of home-based services, the importance of these services being available for families, and the value of having both volunteers and staff in such work.

There were some differences in the findings across programs; these are largely the result of different program models, and are discussed in Section 7.7.4. As well, some study participants had more of a critical analysis of existing social structures and the lack of support available for families, while others expressed less of this.

The main inconsistency in the findings was around the understanding and valuing of one specific aspect of the paid staff members' work. I have described this as the **“ongoing, direct-service, in-home work”** that front-line staff and managers do with families on their own 'caseloads.' More simply put, this is the staff members' own home visiting work. This work is separate from the direct-service work that paid staff provide to families who have been assigned to a volunteer, but who also require some form of service from a staff member on either a short-term or ongoing basis. (Duties of both managers and front-line staff can be grouped into three broad categories, as outlined in Table 3, page 124.)

At the time of the interviews, thirteen of the fourteen study participants were involved with a home visiting program (the fourteenth participant gave an historical perspective). All of these thirteen participants stated that they were aware that program staff could assist volunteers in dealing with the challenging situations they encountered in their 'matches,' that the staff members sometimes went on visits with volunteers, and that staff could 'take on' families that were too complex for volunteers; all participants valued these aspects of the staff members' work. Additionally, seven of these participants were very familiar with the direct-service, in-home work that staff did, and described that work freely.

Table 3:

Responsibilities of paid staff who do home visiting
(sample = three mixed-delivery home visiting programs)

Please note:

- Columns **do not indicate** the distribution of work in each of the three responsibility areas. The distribution of duties varies considerably from one program/role to another.
- Each different type of job responsibility is underlined.
- The two forms of direct-service work carried out by paid staff are shown in bold, and underlined.

Management/ Administration	Home visiting	Consultation, support, and intervention
<p>May include a range of duties, such as:</p> <p><u>1. Program Administration</u> (e.g., volunteer recruitment, screening, & training; family and volunteer documentation)</p> <p><u>2. Service co-ordination</u> (receiving and assessing family referrals, matching families and volunteers).</p> <p><u>3. Program management</u> (<i>managers only</i>: human resources, strategic planning, financial management, reports to funders, and so on)</p>	<p><u>Ongoing, direct-service, in-home work with families.*</u></p> <p><i>*These families are visited regularly (i.e., weekly or monthly) by the staff member; that is, the paid staff member is their home visitor.</i></p>	<p><u>1. Providing consultation, guidance, and support to volunteers</u> in the <i>volunteers’</i> work with families.</p> <p><u>2. Providing direct services to families who are matched with a volunteer:</u> intervention, education, assessment, support, referrals, & advocacy (<i>this work can take place in-home, over the telephone, at groups, et cetera. It may be short-term, or longer-term.</i>)</p>
<p>Group leadership: Some front-line staff and managers also <u>lead, co-lead, or advise</u> education and support groups (parent groups and/or parent-child groups).</p>		

However, six of these thirteen participants did not have a full and clear understanding of the “ongoing, direct-service, in-home work” carried out by paid staff members (both managers and front-line staff) *in their own program*. These six participants came from all three programs; most were volunteer visitors. Their level of

awareness and understanding varied; for example, four of the six had a general idea, but could not describe in detail the work the program staff did with families, while one volunteer visitor was not sure who in the program was paid and who was a volunteer. Additionally, two participants from the same program expressed a different understanding of the value and necessity of one staff member's home visiting work. While one paid home visitor articulated on several occasions that the staff-visited families were not eligible for other services, the second participant expressed a belief that other home visitors "could take those families."

Thus, within the study sample there was not a common level of awareness and understanding of the roles, necessity, and value of the "ongoing, direct-service, in-home work" of staff members. This is important to note because, as discussed in Section 7.12.2, securing funding for paid home visiting/front-line staff positions was identified as a common challenge across all three programs. It seems that internal awareness and congruency regarding this work and its value should be a cornerstone of programs' efforts to develop sustainability and support for this work.

Additionally, the fact that six participants had a limited understanding of the staff members' in-home work did affect the data that was collected: not as much information was gathered on this topic as had been anticipated prior to the start of data collection. However, that anticipation is my responsibility: I had assumed something, based on my own professional experience and my own perspective as a paid staff member, which did not turn out to be accurate. It should also be noted that a considerable amount of data was still collected on this topic.

7.2 THE COMPLEMENTARY STRENGTHS OF PAID AND VOLUNTEER VISITORS

Study participants shared many stories and insights of how having both paid and volunteer visitors allows programs to benefit from the particular strengths of each role. What emerged from these examples was a picture of how this program structure leverages the unique strengths of each role to actually reinforce and advance the work

of the other, allowing each to accomplish things that would not have been possible without the strengths of the other.

Participants described an interplay that was multi-layered and dynamic. It varied according to the skills and knowledge of the staff and volunteers involved, the particular mandate and scope of each program, and most centrally, the needs and assets of individual families. As well, it was a back-and-forth not only between visitors, but also among the different services provided by each program. Further, it was a cumulative process, whereby many actions reinforced one another to build toward the common goal of delivering responsive and comprehensive services to a broad range of families. Indeed, several participants described a reciprocal flow of communication and actions among staff and volunteers, a generous sharing of time and expertise driven by a shared passion for families' well-being, which seemed to be a source of satisfaction comfort, and pride for those who took part in this study. As one front-line staff member explained,

...we know we've got the back-up of volunteers we can draw on if we need to. And for the volunteers, they know they've got the back-up of us if they need to draw on us. So it's very mutually supportive and enhancing, I think. And very cost effective!

As related in the many stories and experiences shared by study participants, it appears that these benefits were made possible by the complementary strengths that paid and volunteer visitors each brought to their work. I have grouped these strengths into five main categories: skills and knowledge, roles, availability, identity (as perceived by parents), and costs. The complementary strengths are described in the following section, 7.2. An overview of these complementary strengths is presented in Table 4, page 127.

Of course, both types of visitors also shared characteristics in common, such as the provision of information; a non-judgmental and supportive presence; and the ability to reduce barriers to service by going to families' home. However, as will be shown in

Table 4: Complementary Strengths Of Volunteer and Paid Visitors

Type of strength	Specific strengths of <u>volunteer</u> home visitors, <u>as a group</u>	Specific strengths of <u>paid</u> home visitors,* <u>as a group</u> <i>(*including front-line staff and, to varying degrees, program managers)</i>
Identity, as perceived by parents <i>(Section 7.2.1)</i>	<ul style="list-style-type: none"> • Community member, non-professional, unpaid; “have no expert associations.” • Concept of “volunteer intangible” engenders good will for program parents. 	<ul style="list-style-type: none"> • Seen as a content ‘expert’ or authority on child development, parenting, or health; thus, has credibility in naming and addressing important issues (<i>‘expert’ can also be viewed negatively; see Section 7.2.1</i>).
Skills & knowledge <i>(Section 7.2.2)</i>	<ul style="list-style-type: none"> • Lived experience as a parent; can act as a peer mentor. Volunteers’ “normal experience of parenthood... helps [parents] put it all in perspective and relax.” • May have knowledge, insight relevant to parents (e.g., familiar with services in local area, or first-hand experience with post-partum depression). 	<ul style="list-style-type: none"> • Skilled in working with more vulnerable or challenging families. • Can work in situations not appropriate for volunteers, such as “severe mental health, drugs and alcohol, and child protection” issues. • Can assess situations and make referrals (e.g., developmental delays, mental health). • Familiarity navigating systems with/on behalf of families.
Roles <i>(Section 7.2.3)</i>	<ul style="list-style-type: none"> • Role is always relationship-based & preventative, not issue-specific; “more relaxed.” • Consistent support person. • Range of roles: volunteers can work “more at a practical level or just social contact for isolated families” (GBA). 	<ul style="list-style-type: none"> • Consultation, coaching, & support for volunteers in their in-home work. • Provides more in-depth education on relevant issues. • Intervention role when needed (crises, advocacy, education; can also step in to clarify volunteer role & protect volunteers).
Availability <i>(Section 7.2.4)</i>	<ul style="list-style-type: none"> • Flexible visiting schedule, including evenings & weekends. • Volunteers’ place of residence (GBA) or language spoken (CMP) may extend program to more families. 	<ul style="list-style-type: none"> • Can take on families when volunteers would normally be assigned (e.g., if no volunteer is available, or if a volunteer has to go ‘on leave’). • Consistency over many years (CMP) or for duration of service (WBUC).
Costs <i>(Section 7.2.5)</i>	<ul style="list-style-type: none"> • No direct cost per volunteer, nor per hour of service (though volunteers are not “free”); ‘workforce’ may be expanded as needed. 	<ul style="list-style-type: none"> • Location of some programs in the non-profit sector can reduce costs relative to professional staff in public sector (<i>see Section 7.5.2</i>).

the following sections, it was the ability to use the *complementary strengths* of each type of visitor, in concert with one another, that allowed these programs to truly expand the reach, responsiveness, and comprehensiveness of their services.

7.2.1 Identity (*as perceived by parents*)

Participants from all three study programs shared that staff members and volunteers were often perceived differently by parents. Indeed, the stories shared suggest that this particular perceived difference may have prevailed even when volunteers and staff members shared many aspects of their own personal identities in common (for example, age, experience raising children, values and beliefs, and post-secondary education). As presented below, this was because each visitor's **identity** within the home visiting program as either a *paid* or *unpaid* visitor often affected parents' perceptions.

Participants from all programs and roles stressed the common perception among parents of a volunteer visitor as a caring and non-threatening person – a community member who helped others without expecting financial compensation. As one program manager described:

A volunteer is seen very differently from a paid professional, I think Because it's just your community helping each other I mean, it's just someone in the community who is taking the time out of their life, and their day, to come and see you because they care about you, and they want to see things improve in your life, or help you, or whatever. And they've been there, done that [themselves], and they just want to give additional support. I think it is a very different view than somebody who is in a professional program and assigned to you. I think it says a lot when somebody comes out and they're not paid.

This manager went on to stress the importance of the volunteers as peer role models for new parents, particularly in a society that has professionalized parenting: "...parents need to know that you don't have to be a professional to be a good parent. I don't think professionals give that message all the time."

Participants noted that parents were often more relaxed, and less fearful of being judged, with volunteers than they were with staff members. Different participants pointed to two reasons for this:

First, those volunteers who had children of their own came to their home visiting roles *as parents*. In contrast, even those staff members who were parents themselves came to their work primarily because of their education and training, not as parents; and, they brought with them their professional designations and their responsibilities to their employers. As one staff member expressed:

... a paid home visitor is coming from an institution or an organization, and it's in someone's life. A [volunteer] is a parent from the community who bridges that gap [between the family and the community]. They don't come as an institution or an organization with all that behind it And for my peace of mind, it's the community who should look after each other. And the [volunteer] offers that bridge.

The second reason cited by participants was that, because of the official professional 'hat' that a staff person wore, parents viewed the staff member as an "expert." This can be a positive, in that people tend to view an expert as someone who has advanced and accurate knowledge in a particular subject, and as a result, increased credibility. Indeed, participants from all three study programs shared that an important role of front-line staff members and managers was to become involved in some type of expert capacity. Whether this involved assessing child well-being, discussing a difficult issue, providing advocacy, or clarifying the role of the volunteer visitor, participants' stories illustrated how the staff member as expert was an important function in these programs.

However, when attempting to make a program accessible and appealing to families, and in particular families who are fearful of judgment and have had negative experiences with "experts" in the past, the other side of the expert coin must be considered as well. That is, it can be intimidating or threatening for parents to consider welcoming an "expert" into one's *home* – particularly when the "expert" is also

employed by a health or social agency. These passages, from two front-line staff members and a volunteer (hailing from two different programs), also speak to this phenomenon:

... when you are coming in as an experienced paid person, then automatically they tend to see you as the expert, even though you are certainly not trying to operate in that role at all. And so that is where having the volunteers alongside really, really helps. That is one of the strengths of the volunteers, I find, is that they have no expert associations attached to them.

I think sometimes the volunteer, because she's a local woman and she has raised her family well in the locality, the mother feels more relaxed by saying, "Well, I didn't do exactly as the [staff member] said. I did it this way." You know? They feel more open.

For me, having my own children and going into people's houses, I'm just an ordinary Joe ... I think people will connect with me more. I don't mean they don't connect with [staff member], but would connect with me, and say, "Oh, she's the same as me.

A staff member from another program echoed this sentiment:

The benefit [of having volunteers] ... is enormous for the families, because the volunteer comes in and she'll say things like, "Oh, yes, my children did that too." And suddenly it all falls into perspective for some poor stressed-out mom. You know, it's the normalcy of it ... the normal experience of parenthood that the volunteers can bring to these families. And it just helps them put it all in perspective and relax.

The "volunteer intangible:" opening doors to families' involvement

Several participants, across all three programs, expressed that the very *idea* of a volunteer – an unpaid stranger who cares – can break down barriers that paid staff may not be able to overcome. One staff participant stated that volunteers were uniquely valuable “ ...because they have been motivated to do it, not by financial gain or because it's part of their professional pathway So it's very willing, and very voluntary ... And the families pick up on that.” As described in Section 3.3.2, this concept has been called the ‘volunteer intangible’ - the phenomenon of ‘good will’ that occurs simply because someone is serving others without remuneration (Brudney, 1990). Thus the ‘volunteer

intangible' can help some parents to overcome hesitations or negative ideas they may hold about becoming involved with a formal program or service.

7.2.2 Skills & knowledge

Staff members' skills and knowledge

Participants from all programs and roles stressed the critical importance of the skills and knowledge of home visiting staff, including front-line staff members, managers, and, in the case of Welcome Baby, staff of the Utah County Health Department as well. In all three programs, one or more full-time staff members had many years of experience working directly with families in their homes. This meant that staff members were skilled in navigating difficult situations and issues, and knew how to work with the more vulnerable or challenging families. Home visiting staff members could assess situations (e.g., developmental delays, mental health) and make referrals. They were also familiar with the health and social service systems, and could navigate those systems with and on behalf of families. While there were some differences noted in staff expertise, based on each program's mandate and other resources available in each community, examples shared by participants suggest that home visiting staff from across the three programs shared many common skills and areas of knowledge.

Finally, participants from all three programs stressed that staff could work in situations where volunteers could not work, such as "severe mental health, drugs and alcohol, and child protection" issues. This related to staff members' skills and knowledge, but also, and perhaps even more so, it arose from a recognition of what was and was not appropriate to ask of a volunteer.

The front-line staff roles in the three study programs would be classified as professional or highly skilled paraprofessional home visitors, rather than lay home visitors (as described in Sections 1.3 and 3.2.6). Managers in the present study stressed that important traits of front-line staff members were their interpersonal abilities, attitudes, beliefs, skills in working well with families and volunteers from diverse backgrounds, and post-secondary education in a relevant field (one program required

that front-line staff members be public health nurses). Front-line staff in these programs were not required to be from the same community, or have had similar life experiences, as the families involved in the program; as presented in Section 3.2.6, these are often requirements for paid lay home visitors. Further, all but one of the front-line positions carried a fairly high level of autonomy when working with complex family situations, which is not usually the case with lay home visitors.

Volunteers' skills and knowledge

Volunteers also brought important skills and knowledge to their roles. Perhaps the most important of these were their lived experience as parents, which enabled them to act as a peer support person and mentor. The participant quotes presented in the previous section (7.2.1, Identity) illustrate how important it was for parents to have caring, well-informed support from a non-professional source.

As noted earlier in this thesis, in a highly transient and competitive society, where great pressure is put on mothers to be a “perfect mother” or a “supermom” (note there is no “superdad” phenomenon in popular culture), many women from all walks of life live in fear of being judged as a “bad” mother (Pacific Postpartum Support Society, 2002; Rossiter, 1988). Indeed, in the absence of extended family and well-established friendship networks, many new mothers go through this major life change alone, without a supportive peer group to act as a mirror to their own experience. Thus being able to access an alternate form of support – some way to gain an affirmative reflection of one’s own new, intense, and often challenging experiences – cannot be underestimated (Paris, 2005). Participants’ experiences suggested that a volunteer who was herself an experienced mother could provide this “mirror.” Additionally, some volunteers brought important insight from specific experiences that they shared in common with parents, such as post-partum depression, or raising children in the same neighbourhood. As one staff member explained, volunteers’ “normal experience of parenthood... helps [parents] put it all in perspective and relax.”

Even when volunteers and parents did not share similar backgrounds or specific life experiences, their listening skills, non-judgmental presence, and knowledge of child-rearing allowed them to make a difference for families. One experienced volunteer shared the following story about a ‘match’ she had had with a sixteen-year-old single mother. Through regular visits, the volunteer had followed the mother’s progress over the previous year, and had seen her develop into a responsible and capable parent. However, because of her young age and limited support system, this mother was still being followed by a child protection agency.

... when the child was 12 months old, the Family Services [*child protection*] had a big [case] conference, with [home visiting program manager] ... and myself, and the mother and her child, and the mother's grandmother, and a psychologist [*therapist*]. And we all were talking to see whether the young mother didn't need to have Family Services intervening anymore, or checking up on her. And we all were asked how we felt that this young mother was doing. And I said I felt that she was doing a fabulous job. And then when the psychologist was asked to talk, he said he felt that in the beginning, that she was doing really well but after a while, she just stopped going to him. So one of the members of the Family Services said, “Oh, why did you stop going?” And her reply was, “Well, when [the volunteer] came along, I just felt so easy with her. I could ask her anything, nothing seemed to shock her, and I didn't feel I needed anybody else.”

This example illustrates how skilled volunteers could form enduring and effective alliances with parents from diverse, and sometimes quite difficult, backgrounds.

7.2.3 Roles

Complementary nature of staff and volunteer roles

One volunteer Community Mother explained how volunteers and staff played different but complementary roles, sometimes for the same families:

We [volunteers] are more like really just to make sure that ... You know the way mothers tend to feed their baby, and not really look after themselves? Just to remind them that they need to look after themselves too. Just to give them a little helping hand – you know, nothing too serious. Whereas [staff member] would do more of the serious side of ... Like if [there was a] breast feeder who

wasn't breastfeeding, [staff member] would go and ... she's great at getting the mothers back breastfeeding ... she's great at things like that.

Similarly, the Good Beginnings Australia manager expressed that, “Whilst the professional worker would do well to *address issues*,” with families, the regularly scheduled preventative visits by volunteers are more aimed at “ ... early intervention work, the early years, building the foundation for the parents to be able to build on and to carry through” as their children grow.

These quotes describe two complementary features of mixed-delivery home visiting services that are not often found in health and social services within wealthy, western Anglo-Saxon countries. As described in the following sections, these features were on-going, preventative, relationship-based services (which allowed for the prevention and early identification of difficulties), and – from within the same program – ready access to more intensive intervention and support services as needed.

The Preventative Role of Home Visitors

The three home visiting programs were preventative by nature, in that home visitors provided a *regularly scheduled* service that was relationship-based, and they did so whether or not there was a problem at hand. For example:

- In the two curriculum-based programs, the monthly visits were premised on the presentation of infant development information, and the importance of checking in and providing ongoing emotional support to first-time parents.
- In the third program, Good Beginnings, the volunteer arrived each week, ready to provide emotional support, parenting information, and practical assistance with the children; she committed to spending 1.5 to 2 hours with the family, regardless of the level or type of support needed that day. As one staff member expressed, in Good Beginnings, the volunteer relationship was characterized by the fact that the volunteer could be "just there to hang out, talk, care for the children [that's] the beauty of informal support, and time spent."

Indeed, while both staff and volunteers in the study programs worked in this preventative role, it was more common for volunteers to do so; as a group, they served a much larger proportion of the families overall than did the staff members, and they served almost all of the families who did not have complex pre-existing challenges. Participants shared that, through this process of regular, preventative visits, families and home visitors got to know one another and form a trusting relationship. This relationship supported parents through their everyday ups and downs, helped keep small problems from growing larger, and helped prevent the occurrence of problems in the first place – all through the *consistent, regular* provision of information, a listening ear, and someone who could help parents to strategize and address issues.

The Consultation, Intervention, Education and Support Roles of Paid Visitors

While most of the staff members interviewed also served a small number of families in this ongoing, relationship-based home visiting role, they played a wide range of additional roles, and were thus engaged with a much larger number of families and volunteers overall. They provided volunteers with guidance, support, education, and mentoring. They provided families with education and support on particular issues, made referrals to specialized services, and advocated for parents and children as needed. Staff also played various intervention roles – for example, during a time of crisis within a program family, to clarify a volunteer’s role or the program mandate, or to take over as a family’s home visitor, if needed.

The ‘consultation, support and coaching’ roles played by staff were highly valued by all six volunteer study participants, who expressed that the availability and ‘back-up’ of staff helped them to feel secure in going out to do their work. These volunteers reported that they could take on new families without having to worry about leaving a family without any service, even if the situation was challenging, as they knew that the staff team was there to support them in their role, and if necessary, to take over that role. Examples from two programs include:

- One volunteer explained that “If you feel you are getting in too deep and it's getting way over your head, you've got someone who will take over from you, who will have the knowledge to deal with the situation and put things right.”
- An experienced volunteer, who had been matched with a number of families who were dealing with challenging issues, explained how the program manager helped her deal with these situations:

I think the supervisor is really excellent. She knows how to handle a lot of situations. It's nice to ... have someone to model for me ... she helped me a lot to feel comfortable with the right questions and how to just approach the new mom ... when I did have a difficult situation with one of the parents, I invited her to just come and observe. And she did, and I got her opinion of what she thought would be helpful. So it was just nice to have kind of like an expert in there, too ...

This volunteer explained that she routinely told new mothers that the program manager usually joined the volunteer for one visit to each family, just to meet the mother and make sure the volunteer was doing a good job. This explanation facilitated an “observational” visit without making a parent feel like there was anything to be worried about, thereby circumventing one of the challenges of home visiting: the constant solitary nature of the role. This volunteer went on to say that, in these complex situations, “I always felt like I had a back-up with [the manager].”

- One volunteer related that this support system led to more families being matched with volunteers. She argued that, if there were no in-home staff to provide support or to take over for a volunteer, volunteers might have shied away from situations where there were any sort of “problems in the family,” instead focusing on

the cases that [are not] very complex ... In this instance, the program would serve maybe more ... not-so-complicated cases because, all of the volunteers, they've got *training*, but I think the experience and the knowledge of the paid workers is very important [It wouldn't be] fair to the volunteer to actually deal with a very complex case, without being paid for it. Because that is really too much to ask, I think Because that's clearly the support worker's job, not the volunteer. It would be just, I think, too much for volunteers, and too much responsibility. And ... I assume that people would drop out of the program.

Staff participants echoed these sentiments, stressing that a key role of both front-line staff members and managers was supporting volunteers through more challenging family situations. As one manager stated, having “a lot more support” from a staff member could be the deciding factor in whether a volunteer could continue to work with a particular family for the duration of the program.

7.2.4 Availability

Participants expressed that having a large group of volunteers from which a program could draw increased the number of families who could be served at any one time, as well as the service that could be provided across various geographical areas. Further, as a group, volunteer visitors brought greater flexibility than staff members in the times and days when they could visit families, often allowing for a better ‘match’ between the program and families’ needs. As one staff member explained, volunteers “can spend longer; they can be more frequent; they can visit at the weekends if it suits them. And that is really valuable for us, to have people who can go in at the weekend and visit with the family.”

At the same time, as outlined below, staff members’ availability also contributed to these programs. Participants from all three programs reported that there were times when a staff member was assigned to visit a family, in situations where normally a volunteer would have been assigned. This happened most often when a volunteer and family had already been matched, but the match could no longer continue – for example, when there was a change in a volunteer’s availability (due to schedule, available transportation, illness, et cetera). In some of these situations, another volunteer might have been assigned to a family; however, as illustrated in the examples below, if no other volunteer was available, or if the volunteer was withdrawing because the situation was too complex, a paid staff member could be assigned:

- If no volunteer was immediately available at the time of referral, the manager of Good Beginnings could support a family for a period. This was because the

manager could “be very flexible and jump in and out as needed;” as a result, families with pressing needs did not have to wait to receive service.

- As with the other two study programs, front-line staff (nurses) from the Community Mothers Programme could take on a volunteer’s families when a volunteer had to go ‘on leave’ suddenly. The program manager explained that this was “another benefit of having the Family Development Nurse able to take on a small caseload.”

Participants shared that this flexibility in assigning visitors allowed programs to provide families with both greater access to services, and increased continuity of service.

7.2.5 Costs

All three program managers, as well as many other study participants, stressed the cost-effectiveness of having volunteers deliver home visiting programs. One question that study participants were asked was, “What would your response be, if you were informed that your program could no longer have volunteer visitors?” One manager responded with a great deal of passion, focusing on volunteers as an economically sustainable way of building strong and caring communities:

I would say that we are not using a vital resource in our community. I think that having volunteers is an untapped resource that we have. And I also think that no matter how many paid programs we have, we’re never going to have the money to do what needs to be done. I mean, my whole focus, and my whole life, has been spent building *communities*, because we don't have enough money to build government programs.

Another manager emphasized the evidence that volunteers in her program had been shown to be effective: “...the [heart] of the Programme is the volunteers doing it. That is what’s positive about the Programme – the Community Mothers. We've shown that with our evaluations.” Indeed, a randomized control trial and follow-up study on the Community Mothers Programme found that this volunteer, peer-led intervention, using a monthly age-paced curriculum, had a statistically significant impact on parenting practices.

The question of ‘costs’ is linked to the complementary strengths of *Skills & knowledge* and *Roles*, and is explored further in Section 7.5, *Increased Cost-effectiveness*.

7.2.6 Summary of the Complementary Strengths of Paid and Volunteer Visitors

As outlined above, volunteer and paid visitors contributed complementary strengths in five key areas. The interplay of these strengths produced benefits that could, in turn, be grouped into five broad themes: greater accessibility and appeal to a broad range of families, increased capacity to respond to the emergent and wide-ranging needs of different families, enhanced ability to serve families who have more complex issues, increased cost-effectiveness, and enhanced program quality, consistency, and cohesiveness. It must be noted that, because of the complex interplay between visitors, each of these themes is linked to the others.

These themes are described in Sections 7.3 to 7.7, as follows:

- 7.3 Greater Accessibility and Appeal To A Broad Range Of Families
- 7.4 Increased Capacity to Respond to Emergent Needs of Families
- 7.5 Increased Cost-Effectiveness
- 7.6 Enhanced Program Quality, Consistency, and Cohesiveness
- 7.7 Enhanced Ability to Serve Families with More Complex Issues

7.3 GREATER ACCESSIBILITY AND APPEAL TO A BROAD RANGE OF FAMILIES

All three study programs prided themselves on having a broad appeal for families from different backgrounds and situations, who – depending in part on their background or situation – may have experienced different barriers to accessing services. The following examples illustrate the impact of this broad appeal:

- One Australian staff participant explained that “we have quite a few support agencies [in the region], and they tend to deal very much with the lower socio-economic ‘hard-core’ cases. And you’re not going to get a middle-class family wanting to access help from there.” The Good Beginnings Volunteer Home Visiting and Family Support Program, however, was viewed as being available to

all families, regardless of socio-economic background. This same participant stressed that this made the program accessible to a wider range of families:

I think that makes it easier, for particularly the more middle-class families, the well-educated families who are very embarrassed to be asking for help, and don't want to be seen to be going to the sort of agency that deals with the lower socio-economic issues ours, because it has the volunteer component, it's just support for families ... support for any families, universal families. And that does make it a lot easier, I think, for those parents who would otherwise be intimidated or embarrassed about seeking help.

This participant went on to emphasize that, within the standard intake process of this universal “volunteer” program, families could simply be assigned a paid visitor if their situation was more complex, “without them having to feel that they’re a ‘hard case’” (the benefits of providing ‘seamless service’ are discussed further in Sections 7.7.2 and 7.7.3).

- In some of the 12 Dublin neighbourhoods where Community Mothers was universally offered to first-time parents, up to 80% of mothers agreed to receive the program (Bardon, 2006). In 2008, 9.5% of families in the program were teens and 53% were single mothers (Community Mothers Programme, 2008). Given that it is uncommon for organizations to successfully engage and retain high numbers of people who are more marginalized (Byrne & Kemp, 2009; CCCH, 2010; Watson et al., 2005), it is to this program’s credit that they maintained these high rates of involvement.

As universally available services, these programs were not stigmatized as being only for families who are ‘at risk’ – a factor which, as some participants expressed, can dissuade families with all levels and types of ‘risk’ from becoming involved. Neither were the programs limited by eligibility criteria that would exclude some families. Several participants stated that this idea of being **universally available** was one of two key factors that created the broad appeal for families. This universal availability was made possible by the low costs of volunteer visitors, as well as the availability and the skills and knowledge of the paid visitors. The second key factor that created broad appeal for families was linked to the volunteers’ identity, as the program was viewed by the public as being **delivered by volunteers**. The phenomenon of the ‘volunteer

intangible,' as discussed in Sections 3.3.2 and 7.2.1, can create a willingness among individuals to agree to receive a program or service; thus for these programs, having volunteer visitors literally “opened doors” to families’ lives. Several participants, from all three programs, stressed that without these open doors, the programs would not have been able to serve as many families.

As outlined in Section 7.4, below, this greater appeal and accessibility to families was backed by the ability to serve families in different ways, and with different types of visitors, depending on each family’s needs.

7.4 INCREASED CAPACITY TO RESPOND TO EMERGENT NEEDS OF FAMILIES

“I think it [having volunteer and paid visitors] enriches the program because there are those levels and layers of support that we can provide.”

- Study participant, Good Beginnings Australia

Participants from each study program related that the mixed-delivery approach allowed their program to serve families according to individual families’ needs – both at the start of service, and over time, given that needs could change and issues could emerge. Participants expressed that the mixed-delivery structure allowed programs to tailor the support provided to each family’s unique needs; and that the complementary roles of the paid and volunteer visitors allowed for more comprehensive services to be provided, from within the same program. These findings are presented in the following sections.

7.4.1 Greater Ability to Tailor Support to Each Family’s Unique Needs

Participants stated that having different types of home visitors provided options in the sometimes challenging task of assigning families to visitors. The skills and knowledge, availability, and roles of home visitors enabled this flexibility:

- Families with complex, challenging situations could be matched with a staff member from the outset, instead of being matched with a volunteer (for detailed description, see Section 7.7).

- In all three programs, if a family was assigned to a volunteer visitor, and it became apparent later on that a family's needs were too complex for a volunteer, that family could be transferred to a paid visitor. Indeed, in the Welcome Baby Utah County program, families could be switched to one of three other 'types' of visitors, all of whom were part of the same overall program.
- In all three programs, a volunteer could arrange for a staff member from within the program to visit a family in order to assess and address a specific issue; the volunteer might or might not have been present for this visit. Volunteers from all programs expressed appreciation for the expertise, guidance, intervention and support that staff provided in this role. Additionally, in both the Community Mothers Programme and Welcome Baby Utah County, this staff member may have been a registered nurse; participants cited this as key in meeting the needs of families with infants, as it increased the range of issues that could be assessed and addressed without having to 'refer out' to another agency.
- All study participants from Good Beginnings felt strongly that the mixed-delivery model of service allowed their program to respond effectively to families' unique needs, regardless of each family's circumstances. A front-line staff member from this program explained the benefits of having both volunteer and paid visitors:

Personally I feel it enhances it enormously. I've got several families that I am working with and will need to continue to work with for some time. But I've also been able to put volunteers in place. I will have been working with the family longer, and I'll be working more with probably more the emotional components of the relationship, whereas the volunteer is probably going to be working more at a practical level or just social contact for isolated families; just a friend really, a befriending sort of situation. I think that is one of the real positives of the program is that it meets various different needs, at various different levels.

Participants shared that this flexibility and responsiveness helped ensure equity of access for all families, regardless of their situation or their changing/emerging needs.

7.4.2 Families Were Supported by a Whole Program, Not by a Single Visitor

Participants from all three programs shared examples of families forming a supportive rapport with, and/or receiving services from, more than one individual from their program. These were made possible by the complementary strengths of availability, roles, identity, skills and knowledge, and costs. The examples in Section 7.4.1, above, illustrate how this looks in action, as do the following:

- While families in the two programs that follow a ‘monthly-visit, curriculum-based’ model were not usually assigned long-term to *both* a paid visitor and a volunteer visitor, this occurred fairly regularly in Good Beginnings (see Section 6.3 for details); these ‘matches’ may have been either simultaneous or sequential. One Good Beginnings volunteer speculated that parents in difficult situations may have felt that “more people care about you” because of working with both a professional in-home worker and a volunteer. This volunteer went on to explain that, once families had transitioned from a paid to a volunteer worker, the support of the professional worker was still available to them: “if they’ve got more complex issues, they can still have the rapport with the paid worker; they can at any stage call them or see them. And if they don’t [have complex issues], the volunteer visitor is enough maybe.”
- As described in Section 6.3.5, Good Beginnings also offered the services of Family Support Workers through the Integrated Family Support Program (‘IFS’), which served families referred through the child protection system. Roughly 10% of the families who were involved with an IFS Family Support Worker went on to be ‘matched’ with a Good Beginnings volunteer visitor.
- In the Community Mothers Programme, parents could develop and maintain their connection to program staff and volunteers through participation in weekly breastfeeding and parent-child groups.

Participants from all three programs stressed that these *relationships* were key to facilitating progress and important changes in families’ lives. This theme is explored further in the Researcher’s reflection, below, and in Section 7.4.3, which follows.

Researcher's reflection

These programs' structure afforded multiple opportunities for a family to develop a supportive relationship with two or more staff/volunteers. My own professional experience tells me that, for isolated and vulnerable caregivers in particular, this can have many benefits – encouraging the development of trust, increasing support options, and affirming a parent's worth. Additionally, consistent with the principle of "skill and ability beget future skill and ability" (Heckman & Carneiro, 2003, p. 1), each supportive relationship helps lay the foundation for vulnerable parents to take positive action in the future.

Additionally, the relationship between *staff and volunteers* is, in itself, of value to program families. In my own experience, families' difficulties can go unaddressed when their volunteer is unsupported or ill-equipped to deal with a situation. Over the years, a handful of parents have shared with me that because they perceived their volunteer to be ill-prepared to deal with an issue, they held back on disclosing a problem. Conversely, many times when a volunteer has provided an ongoing communication link between families and staff, or a staff member and volunteer have been able to work as a team to support a family, progress has been made on important issues. Thus families who know that their volunteer is well-supported by a larger network may feel more confident to take risks in the volunteer-parent relationship, or to contact the program directly to request additional help. As one Good Beginnings staff member commented, "I think the synergy of having the paid worker and the volunteer is of enormous benefit to the families."

7.4.3 Complementary Roles Provided More Comprehensive Services

Participants also shared examples of how these complementary roles allowed families to receive comprehensive services from within one program, which meant that families did not have to go from one program to the next, seeking services. Specifically, as outlined below, the structure of these programs facilitated both the prevention and early identification of issues, *and* the addressing and resolving of those issues.

Study participants stressed that the preventative, relationship-based nature of home visiting allowed for a trusting rapport to be developed, as well as the early identification and discussion of difficulties. In the programs involved in the present study, this relationship most often developed between a parent/parents and a volunteer, as the large majority of families were assigned to a volunteer visitor (see Section 7.2.3, *Roles*).

Participants also described how this parent-volunteer relationship was supported by one or more staff members who provided both consultation to volunteers and direct service to families, even though those families were *primarily* served by a volunteer. In other words, the volunteer and parent had ready access to one or more staff members who had the availability, as well as the skills and knowledge, to take on a direct-service role and address difficult issues; there was no referral process, no wait list, and no uncertainty about what to expect from the staff member(s) of an outside agency. Thus, the mixed-delivery approach allowed parents to access *both* a consistent, on-going source of in-home support, and as needed, the expertise of a skilled professional¹⁸ (see Section 8.2 for discussion regarding the impacts of this integrated program structure).

¹⁸ Indeed, in a smaller percentage of cases within the study programs, a paid home visitor offered families the preventative *and* the expertise-based roles, all in the same person.

7.5 INCREASED COST-EFFECTIVENESS

Several participants from all three programs reported that their program provided cost-effective home visiting services. Outlined briefly in the sections below are the main examples of cost-effectiveness that were shared by participants: making use of volunteer (unpaid) visitors, operating in the non-profit sector, having high-calibre volunteers, increasing volunteer retention and satisfaction, and the benefits the volunteers' involvement brought to the volunteers themselves, their families, and their communities.

7.5.1 The Cost-Effectiveness of Volunteer Visitors

Study participants across all roles and programs spoke of how having volunteer visitors greatly increased the number of families that could be served by programs with limited resources (see also Section, 7.2.5, *Costs*). For example, staff members in the Community Mothers Programme estimated that having a team of volunteers allowed the program to serve two to two-and-a-half times the number of families that could be served with their existing budget, if there had been only staff delivering the service. The following two examples illustrate the cost-effectiveness of particular programs' use of volunteers:

- In Utah, the monies that fund the volunteer 'wing' of Welcome Baby came to the United Way from completely different sources than the funding for the Utah County Health Department nurses (who also delivered a portion of the Welcome Baby home visiting program). As discussed in Section 8.3.1, if the volunteer 'wing' of Welcome Baby were not in existence, these monies would not necessarily go toward programs that support families and young children.
- In Good Beginnings, the availability of a team of volunteers often reduced the workload of the paid Family Support Workers (FSW), particularly once families had been served by a FSW for some time, and their situation had stabilized. With a family's agreement, the FSW could match that family with a volunteer, and gradually withdraw from making regular visits herself. As a Family Support Worker explained:

... because they are often isolated families, they haven't got family support or they've got dysfunctional family support, you know, you do become that steady point in their lives And you can't just drop out of it, without doing damage. So I find that ... easing a volunteer into a family, before I leave, makes for a much more comfortable transition for that family.

Thus volunteers provided these families with continued support, but freed up some of the FSW's time, enabling her to take on other families.

7.5.2 The Cost-Effectiveness of Professional Visitors in the Non-Profit Sector

Like others in the non-profit sector, paid home visitors come from a range of educational and professional backgrounds, and work under varying terms and conditions, and oftentimes, lower wages compared to the public sector. One study participant argued that there were significant cost savings in having paid home visitors who came from diverse educational backgrounds and worked in the non-profit sector, rather than just having registered nurses working for public-sector health agencies:

I also think it is a very inexpensive way to expand the system of home visitation. You've got the nurses who are – they're pretty expensive. And then you've got the volunteers. And then you've got ... that middle of the road ... between the two, and you're not paying anywhere near what you are for a nurse.

7.5.3 High-Calibre Volunteers

Adding to the cost-effectiveness was the *calibre* of volunteers that these programs were able to attract. A manager from one program marvelled, "I have some volunteers, they are better qualified than even the parent educators I see in [another local early child development program]. I had one who was a nurse practitioner with 35 years of experience with at-risk families." Indeed, staff participants from all three programs expressed that having volunteers who were capable and confident enhanced a program's ability to effectively serve families with complex situations. As outlined below, findings from this study suggest that having staff members who were themselves skilled home visitors may contribute to the retention of these high-calibre volunteers, as

the volunteers consistently expressed deep appreciation for the support and guidance they had received from those staff members who also did in-home work.

7.5.4 Increased Volunteer Satisfaction and Retention

The six volunteers who took part in the present study had been matched with families who were dealing with a range of situations and challenges. Two of the striking findings of this study are that none of the six felt that they had had an assignment that was ‘too much’ for a volunteer; and, all six stated that the support of one or more paid staff members was available to them, whenever needed. Additionally, as is outlined in Section 7.2.4, *Availability*, several volunteers expressed that knowing staff members could take over for them allowed them to go ‘on leave’ as needed, or to ‘pass on’ a challenging family to a staff member, without worrying that these families would be left on their own. Indeed, a few participants shared that their continuation as a volunteer visitor was dependent on their program having staff in this ‘back-up’ role. As one experienced volunteer expressed:

... let's face it, we *are* volunteers. We do a 6-week course, but I mean, we're only just touching on the surface of a lot of the problems. And so that's when the paid staff come in and take over, if it all gets too much ... having been in [this home visiting program] for as long as I have, I don't think I would go to another organization that only had volunteers, because you don't know what is going to crop up within a family that's going to need help.

Researcher's reflection

As noted in Chapter 5, participants of the present study had not, in the past, been directly involved in programs that had volunteer visitors but no staff visitors. However, prior to having a Family Support Worker in the program where I am employed, the absence of an in-home staff member did cause difficulties for our program's volunteers. In particular, there were several instances where volunteers wanted to end their involvement with a particular family because the situation was

Continued ...

Researcher's reflection, continued ...

too complex or demanding, but they felt they must continue because they did not want to leave a vulnerable family without support. For many volunteers, this added an ethical and moral dilemma to an already overwhelming situation. These volunteers ran into a range of difficulties – for example, compromised levels of service provision, physical and psychological effects of stress, a growing sense of resentment at their powerlessness in this situation, and occasionally, boundary and role violations. These are the same difficulties that are encountered by paid staff (from all fields and sectors) who are overworked and under-supported, and are often referred to collectively as 'burnout'. My comparative experiences, taken in concert with the insight of participants in the present study, point to the presence of paid home visitors as a protective factor for both families and volunteers.

7.5.5 Value-Added: “The Volunteers Are Benefitting as Well as the Parents”

Separate from the benefits experienced by families, volunteers and staff across all three programs spoke at length of the many positive outcomes that took place simply by having lay persons – citizens – engaged as volunteer visitors. The examples shared illustrated that volunteers, their families, and the community at large all benefited from the training provided to volunteers, the skills and confidence they gained, the relationships they formed in the community, and their increased awareness of community resources and services. One paid staff member, who had also been a volunteer visitor in the same program, stated that, “We've had a lot of volunteers for whom it's been quite a life-changing experience for them to work in this field ... it's given them a sense of competence and usefulness, and boosted their self-esteem. And often it can change their own parenting.”

One manager spoke of the ripple effect of the volunteers' involvement – in essence, a form of community development – which adds up to many contributions to their communities:

There have been huge spin-offs for the volunteers as well. They become empowered. They can network in their communities. They have set up spin-off initiatives. They've got involved in other community initiatives. Their growth and development is impacting on their own families – like, none of that would happen in a professional model.

However, as this same staff member noted, the 'spin-off' effects of volunteers' involvement posed a measurement challenge for these programs:

... it's huge, what is going on, [compared] to what you're actually able to capture. And all that would be missing, I think, with the professionals doing it, because we go home at five o'clock Whereas when you're in the community, it's very different. The volunteers will see [community members] in the evenings...or they're out at something, or they're shopping So that's the benefit[s] And they're very hard to capture. They are all additional things that are going on, that maybe don't show up as well in evaluations.

Indeed, this challenge is not unique to home visiting programs that have both paid and volunteer home visitors; it is a common and longstanding challenge for all organizations that rely on volunteers, especially when volunteering enhances individuals' skills, capacities, and connections within their communities. It is worthy of note here because of the large numbers of volunteers relative to paid staff in these organizations; proportionally, these benefits may be quite pronounced, yet they are difficult to capture and measure.

The impacts of cost-effectiveness are discussed in Section 8.3.

7.6 ENHANCED PROGRAM QUALITY, CONSISTENCY, AND COHESIVENESS

“[Visiting families] keeps me very much in tune with what is happening in the area, first of all, and also with the philosophy of the program.”

- front-line staff member

Study participants pointed to many benefits of having staff members who carried their own 'caseload' of families. As discussed throughout the present chapter, a number of these benefits related directly to the enhanced services that the programs can offer *to families*. However, participants also shared several examples of the

'program-level' benefits of staff members' in-home work. These included: ensuring staff were in touch with the core work of the program, orientating new staff to their role, using what had been learned in home visits to improve the program, strengthening the program's philosophy and structure, creating a stronger volunteer-staff team, and ensuring staff maintained a broad range of home visiting skills. These benefits, in turn, *indirectly* benefited families. These are presented briefly in the following sections.

7.6.1 Ensured that Staff Were 'In Touch' With the Core Work of the Program

Study participants stressed that, by carrying a caseload of families, and doing home visits on a regular basis, staff in their programs stayed current in many key ways. They regularly practised the very same skills, used and imparted the same information, and were faced with the same dilemmas, as the volunteer visitors. As one manager described, "I tend to have a couple [families] running at any one time as ongoing work, partly to keep involved and not to remove myself from the coal face."

Another manager shared an experience that illustrated the value of carrying one's own 'caseload,' even though the demands of managerial responsibilities made it difficult to fit in the visits: "I went out to do a visit yesterday with a young girl I had loads to do, but I went out it would have been so much easier for me *not* to do that, and just to be *talking* about what we do." She explained that the visit helped her maintain her own skills, knowledge, and familiarity with the in-home role; for example, the young mother she visited had questions about a new method of birth control, and as the manager was not familiar with this new method, it challenged her to find out the relevant information and bring it back to the mother. This manager, as well as a number of other participants from all three programs, also emphasized the unique and experiential nature of home visiting: without doing it oneself, it would be difficult to understand what home visitors in the program were experiencing.

7.6.2 Orientated New Staff to the Role and the Program

The manager of the Community Mothers Programme stressed that the best way for new staff to learn about the program, the Community Mother role, and the challenges of that role, was by working *in* the role. This was particularly important given that new staff were being trained, simultaneously, in the approach and curriculum of the program, the home visiting role, and the co-ordination and supervision of volunteer visitors; there was a great deal for them to learn: “I think it is important, to do their own visiting; they *learn* by doing... The [staff] learn a lot about the program, by doing those visits And I think you’re bringing that back” to the program as a whole.

7.6.3 Staff Used Their Learnings from Visits to Improve the Program

As one staff member related, staff were in a unique position to take action with the learnings that they brought back from their home visits: “I know when I go in to [see a family], and I have a problem, well – I know some [volunteer] will have that same problem So I have that in my mind. I put it on the agenda [for the next volunteer session]: ‘Has anybody come across this, or has any mother said this or that?’”

In the two curriculum-based study programs, various ‘age-paced’ child development and parenting materials were used at each visit, by both staff and volunteers. Many of these materials were developed locally, by program managers and others affiliated with the program. One manager stated that there were benefits to having these same staff members use the materials with families: “I find that ... things that I've developed ... forms, materials, and that, you’re actually using them yourself. And if there are any difficulties with them, it becomes clear to you.” This manager suggested that, while important feedback was also received from in-home staff and volunteers, the materials could be revised more quickly when the staff member who developed them was able to test their application.

7.6.4 Strengthened the Program Philosophy and Structure

Operating within the program's structure and philosophy were important for all three programs, but especially for the two curriculum-based programs, Welcome Baby Utah County and the Community Mothers Programme. In these two programs, the curriculum itself, as well as the approach or philosophy used to conduct the visits and share the curriculum materials, were important program features.

Several participants from both programs noted that the program model and philosophy were reinforced and strengthened because the staff were actively involved in home visiting, as the staff were always "very much in tune" with the model, and could maintain their own skills in implementing the curriculum. One experienced volunteer explained that having staff who were both 'fluent' in the program's curriculum *and* able to occasionally accompany volunteers on home visits allowed for the curriculum to be implemented more consistently, in spite of the program being delivered by so many people: "I think we do need staff members to come on home visits. I think they more regulate how the visits should go, and what should be accomplished, and it's... more uniform as the volunteers go throughout the community, so that we are all doing the same thing."

7.6.5 Created a Stronger Volunteer-Staff Team

Participants from all three programs related that, when staff were actively doing home visiting, this increased cohesion among team members – between managers and front-line staff, and between staff and volunteers. As one manager explained, "It keeps you on the same level as everyone. You're part of a team - I have a role to do, but I'm part of a team, and we can share the experiences."

Volunteers and staff alike stressed that, in the eyes of these programs' volunteers, the credibility of staff members was increased because they are "singing from the same hymn sheets, and experiencing the same issues" as the volunteers. One volunteer shared that: "When they [staff] are visiting families, I believe they're doing

exactly what I am doing.” This knowledge gave the volunteer confidence in the guidance that staff provide:

I like being able to hear that they [staff] are going through the same thing as a volunteer it's nice to be able to hear somebody else's ... viewpoint of their families, and what's going on in their families, so that we can feel like we have kind of a basis to go off of – you know, that if certain situations arise, we *can* ask somebody else for emotional support, just for being a home visitor. Instead of [the staff] just being in the office.

An Irish volunteer stated that, without the Family Development Nurse, “I couldn't see the program being as successful as what it is. And I wouldn't be probably as confident. Like she's just ... She really is the backbone of the whole program.”

7.6.6 Allowed Staff to Maintain a Broad Range of Home Visiting Skills

Visiting families in their homes once or twice, as part of the program's intake process, is common for managers of volunteer home visiting programs (Black & Kemp, 2004). However, in curriculum-based home visiting programs, in order to maintain their own familiarity and skill with the materials the volunteers are using, staff must use the entire curriculum with families. Additionally, one manager stressed that, only by working with a family over time does a staff member keep up their skills in addressing the many issues that can arise as a parent becomes more comfortable with a home visitor:

Honestly, you don't even develop a rapport until you are 3 or 4 months into the visits. You really don't; you don't have a clue. I mean, think of your life – in if you know [meet] somebody one time, you are not going to reveal things; but somebody who is consistently coming to see you, then it changes ”

As noted earlier, staff members' skills in working with families were appreciated by all volunteers in the present study; additionally, two volunteers from different programs stressed the importance of being able to observe the 'role modeling' of staff members during home visits. One volunteer said it helped her stay true to the program's philosophy and approach with families:

I think the role-modeling is one of the best ways to *teach* new volunteers, and to make sure it continues that way having staff members keep emphasizing the most important parts of the program, when they came in with me on visit, I think was really important. You know, you come back to the basics, the continual basics of why this [program] was implemented.

The second volunteer related a situation whereby the staff member's approach helped an anxious first-time mother become more relaxed, and at the same time, demonstrated to this volunteer how to do the same:

She [staff member] went on the floor with the baby, and [was] sort of like, talking with the mom, but really focusing on the baby as well. It was also my first volunteer role [*first match with a family*], and it was modelling I *did* like that, that she was showing me. She was playing with the baby and she went on the floor, and just immediately, it was more, I think, comfortable for the mother and for the baby that she was on the floor; sort of less distance between them.

Without this modelling, the volunteer may not have thought of using this approach, or may have even wondered if it was too informal or familiar, and thus inappropriate. Instead, the volunteer not only learned that getting down on the floor was an option, she witnessed first-hand the positive impact of an experienced staff member doing just that.

Finally, one manager noted that having managers do home visits is different from the approach taken by many programs, especially within larger public agencies: "it's part of your role really, part of the program; whereas, in the bureaucracy...You would be seen as a senior manager, and you'd certainly operate [solely as a manager]..." However, each of the three managers in this study, and a number of other paid and volunteer participants, stressed that doing home visiting maintained the manager's ability to support the volunteers and front-line staff in their work.

7.6.7 Summary

Throughout Section 7.6, I have illustrated the program-level benefits when volunteer visitors were joined by one or more staff members who also carried a 'caseload' of home-visited families. These staff members' home visiting work allowed

them to hone, maintain and pass on their vital skills and knowledge, which formed a cornerstone of the complementary strengths that paid visitors brought to the program.

Among other impacts, staff members' skills and knowledge played a crucial role in increasing these programs' capacity to serve vulnerable families with more complex challenges. These findings are presented in the following section.

7.7 ENHANCED ABILITY TO SERVE FAMILIES WITH MORE COMPLEX ISSUES

Study participants from all three programs pointed to several ways that having both paid and volunteer visitors specifically allowed their program to provide service to families who faced multiple risks to child and family well-being. These caregivers (described in this section as 'vulnerable families') may need highly skilled and sensitive support, in-depth parenting and life skills education, advocacy, and/or case management. In these situations, paid staff brought their skills and knowledge, their availability to become involved in a consulting or in-home role, and their professional identity as content or systems "experts."

As has been noted earlier in this chapter, program staff could become involved with these families in a number of ways:

- aiding volunteers in their home visiting roles (but not meeting with families themselves);
- becoming directly involved for a limited time (that is, meeting or speaking with families to address specific concerns or issues, or 'triaging' families into specialized services); or
- working directly with vulnerable families on a longer-term basis.

These functions are presented in-depth in the following sections, and are discussed and analyzed in Section 8.5.

7.7.1 Staff Helped Volunteers to Successfully Work with Vulnerable Families

"And that's where the beauty of having that extra staff, family support staff there, can be a wonderful adjunct to the program."

- Program manager, Good Beginnings Australia

All study participants expressed that the expertise and availability of program staff members was essential in supporting and guiding volunteers in their in-home work. As outlined throughout the present chapter, this staff support was seen as being particularly important in enhancing volunteers' ability to work successfully with vulnerable families.

7.7.2 Staff Availability Reduced Barriers for Vulnerable Families

As outlined below, participants gave several reasons as to why it was helpful to have a staff member within the same program who could become involved for a period, or take over for a volunteer, rather than having to refer 'out' to other organizations.

First, some programs and services are specialized, and their role is narrow; while they may help a family address one specific concern, they may not deal with other issues. One manager gave the following example of this problem: "Child Protection and say, [a local organisation that focuses on a specific dis(Ability)] and so on, would tend to deal directly with the issue that's presenting, as they call it" but not with other issues faced by a family. Thus in these situations, even if a family is able to be transferred successfully to such a program, there may still be significant gaps in the services they receive. This participant expressed that in comparison, home visiting programs tend to be broader, and they interact with the family from a "holistic" perspective, working with all identified needs and strengths.

Second, switching agencies can introduce barriers to service, as it presents both an additional demand and a new level of vulnerability. As one manager expressed, when families are already feeling vulnerable, exposed, or overburdened, "you can't play with people like that and shift them about, and to get to know another person again, tell their story again." Another manager explained how stigma and fear can create barriers to services: because one local family support organization was seen as being connected to the local child protection agency, families frequently rejected the suggestion of receiving services from that particular organization. For these reasons, when programs

have to 'refer out,' some families may end up receiving little or no service. Participants stated that having skilled program staff who could work directly with families reduced the need to 'refer out,' therefore increasing accessibility and timeliness of services, and providing a more seamless experience for families during a difficult time.

7.7.3 Together, Volunteers and Staff Triage Families into Needed Services

One manager described having both paid and volunteer visitors as “a way to get more eyes out into the community. The more we could build this system, the better we could see, and kind of triage people into what they needed.” Indeed, it appears that, in all three study programs, volunteers and staff worked together as a type of social and health care 'triage' team. This phenomenon is described below.

Participants across all roles and programs related that volunteers were often the first person outside of a family to notice problems, or to be made aware of family issues, and that sometimes volunteers needed assistance in dealing with these challenges. Participants stated that a volunteer would commonly bring such a concern to the attention of a staff member, who either guided and supported the volunteer in addressing the matter, or became directly involved with the family. In sharing many examples of this process, participants described what sounded like a seamless, integrated system of support and service, whereby those who had the most contact and trust with a family – most often, volunteer visitors – become the holders of important information, and could then involve staff members to help address the situation.

Participants shared that oftentimes in these situations, referrals must be made to specialized services – such as early intervention or child psychology – or to programs that deal with child protection, addictions and mental health, or violence against women. Study participants from all three programs related that staff knew the health care and/or social service systems very well; often they were the ones to facilitate these referrals, and follow families' progress, as needed. Thus these tasks were not left to

volunteers, who may not have had the knowledge, comfort, skill, or time to take on these roles.

7.7.4 Staff Could Work Directly with Vulnerable Families

While emphasizing that many volunteer visitors were highly skilled and capable, study participants from all three programs – and across all roles – also expressed the importance of paid staff being able to work with those families who have the most complex needs. Due to the volume of material related to this finding, and because each program’s situation was somewhat unique, each program is presented separately here.

First, however, an important difference between program models should be noted. Almost all study participants from the two ‘universally offered’ programs, Community Mothers and Welcome Baby Utah County, stated that the in-home work carried out by program staff was important, but they did not single out staff members’ ability to take on the more complex family situations as the *most* important function of staff members. This was different from Good Beginnings, where all study participants specifically stressed the importance of staff members being able to work with those more complex family situations. It appears that there were three reasons for this difference:

1. The two ‘universally offered’ programs were for first-time parents of infants *(and, while both programs did serve some second-time parents, that population is in the minority in both programs).*

First-time parents are, as a group, perhaps among the ‘least complex’ populations of parents: experiencing a “significant life transition,” they are “more likely to seek professional assistance” (Abram & Coie, 1981, as cited in Watson et al., 2005) and to accept new ideas (Goodman, 2006) than experienced parents. Thus, as the manager of the Community Mothers Programme explained of that program’s clientele: “The parents, they may be in communities that have issues, that experience disadvantage, but they are first-time parents; they don't necessarily have any issue or big problems.” This manager stated that, while they did “come across families that would have issues or identify issues” and that “the Family Development Nurse will visit those families,” the volunteers could successfully provide the program to the vast majority of families.

In comparison, Good Beginnings Australia assisted any parent whose youngest child has not yet turned eight. Therefore, this program worked with a higher proportion of families whose difficulties were longer-standing and more entrenched. Additional skills, knowledge, time, and effort may be required to work with a higher proportion of these families.

2. The two ‘universally offered’ study programs worked with a somewhat representative cross-section of the entire population, while Good Beginnings Australia worked with families who have an identified need for support, assistance, and/or guidance. Again, a higher proportion of these families may require a visitor who can bring additional time, skills, and knowledge.

3. In Utah County, those families who were identified as having the most complex challenges (either social or medical) were offered the services of a public health nurse from the Utah County Health Department. Only rarely were the most vulnerable families referred to the volunteer “wing” of the program. When this did happen, it was usually in situations where an eligible family turned down the public health service, but the nurse believed the family could benefit from the information and support of a volunteer’s monthly visits, and would also be appropriate for a volunteer. If the nurse proposed a volunteer visitor, and the family agreed, the nurse then made a referral to the program’s volunteer ‘wing.’

The situations where paid home visitors were required to work directly with vulnerable families are described below, and are organized by program.

Staff Members’ Work with Vulnerable Families: Community Mothers Programme

As discussed in Section 6.1, in this program, the central role of each of the eleven Family Development Nurses was to train and support the 18-20 volunteers in their local area. Participants reported that a mixed format of on-going individual and small-group support from the Nurse, when combined with the program’s empowerment philosophy, the volunteers’ own life experiences, and their familiarity with the challenges facing families in their local area, made for a team of skilled and confident volunteers. The manager stressed that the staff could not assume that a challenging family situation would be too much for a volunteer:

... there are a lot of families that ... maybe we'd feel it mightn't be appropriate for volunteers to visit, but they are very *happy* to visit those families. They [volunteers] are in those communities, and they mightn't see it the way we see it And the issues that we're a bit put out about, or have a little bit of difficulty with, it mightn't affect them as badly. So from that point of view, it's very difficult to decide what is a family that they wouldn't be able to visit.

Indeed, study participants from the Community Mothers Programme reported that the volunteers were able to work well with many of the mothers who have difficult situations. An experienced staff member reflected that "I wouldn't see that I could do visits better than them, to be perfectly honest with you."

However, the Family Development Nurses also played an important role in this program's direct in-home work with families. As the program manager explained, "to take the five families that we ask her [*each nurse*] to visit, I just think that gives them a little bit of leeway in a sense. There might be 100 families on their program [in that local area], or 120 [at one time] but there may be still five families that it's beneficial for her to take on." Study participants shared that there were two main situations where this was 'beneficial': when there was a lack of available volunteers, and when a family situation was too challenging, dangerous, or otherwise inappropriate for a volunteer.

Participants outlined a range of family scenarios that may be inappropriate or too complex for a volunteer. For example, the program had a policy of removing a volunteer whenever child protection services have become involved in a family's life. As the manager explained, this was to prevent a volunteer from ending up in a compromised, awkward, or dangerous situation, in her own neighbourhood:

Because we don't want her to be seen as policing her community, or causing difficulties for her or her family in the community. So that would happen, and then the nurse would then give the family the option of ... being visited by them [the nurse]. But it still would be on a voluntary basis. If they [the parents] don't want it, that is fine.

The manager stressed that the program's priority was to "make sure that it's always a very positive experience" for each volunteer, and to ensure that "you're not exploiting them, by asking them to take on families that maybe they're finding too much for them."

The program manager was clear that this policy and practice was not primarily about whether or not the volunteers were *capable* of working with families in these situations, but about recognizing what was and was not appropriate to ask of an unpaid worker: "It's in relation to the fact they *are* volunteers, and maybe you're asking too much of them we are the paid workers, and we will take on that role."

Staff Members' Work with Vulnerable Families: Welcome Baby Utah County

Prior to the 1999 establishment of Welcome Baby's volunteer 'wing' in 1999, the Utah County Health Department was only able to visit new-baby families with specific risk factors, leaving out that *majority* of first-time parents in the County who didn't qualify for their services. However, within this larger "lower-risk" group, there were some first-time parents whose risks are more substantial or complex. One study participant described how these situations were handled within United Way Welcome Baby:

If I look at a family and I see that the mother is 17, 18 – which is not considered high- risk because we have so many 13- to 15- year-olds having babies ... if they are younger, if they look like they are maybe a little bit more at risk financially, or ... they've called in [to Welcome Baby] and they are really concerned, or feeling overwhelmed or whatever ...

... these families were usually assigned to a staff member from the United Way 'wing' of Welcome Baby. This is because staff members, who had been trained in the Parents as Teachers program as well as the Welcome Baby curriculum, had "more information to take to them, and we're more consistent."

It must be noted here that study participants from this program commented on the high level of competence of the volunteer visitors. Volunteers worked well with

many of the “lower-risk” first-time parents who did have one or more vulnerabilities (such as isolated new immigrants and young couples living far from home), but who did not qualify for Utah County Health Department nursing services or other targeted programs. However, there was a smaller group of families who come to United Way Welcome Baby, a group that I will describe here as ‘medium-risk,’ for whom a match with a volunteer may not have been as successful or appropriate. The manager reflected that without staff members who could work with these ‘medium-risk’ families, they

wouldn't be serviced at all It wouldn't be like, “Oh, well, we'll have to give the nurses [this referral];” the nurses have to take the highest risks. So basically those middle groups would not be served. But then they are probably the ones that are kind of like, on the seesaw – you know, if you tip them too far ... [*they can run into more significant problems*].

The program manager also noted that two features of Welcome Baby's volunteer ‘wing’ actually made that service more appealing to some vulnerable families. First, as discussed in Section 7.3, this program was not restricted to families with certain risk factors, so parents may not have felt that a referral to the volunteer visiting program meant they were labelled as deficient or incompetent. The second feature was the program's location within a non-profit organization – that is, somewhat distanced from government agencies: “I'm thinking of the teenage mothers that I've visited, the 17-and 18-year olds. They seem to be more receptive to having me – from United Way, a neutral ground – come, rather than the public health nurse.”

Thus some features that were particular to the Welcome Baby's volunteer ‘wing’ may have actually *increased* the likelihood that some ‘medium-risk’ and ‘higher-risk’ families would agree to receive service. If the volunteer ‘wing’ did not also have paid staff who could work with these families, this particular sub-group of more vulnerable parents may be missed altogether.

Staff Members' Work with Vulnerable Families: Good Beginnings Australia

"And it's got some wonderful flexibility to it, of course, where the Family Support Worker can dive in and work with the family for a while before handing over to the volunteer."

- Manager, Good Beginnings Australia

A central role of this program's Family Support Workers was to provide ongoing, direct-service, in-home work with families who faced more complex situations and issues. The program manager stressed that if Good Beginnings did not have paid home visitors, this would mean "shutting out people with difficult issues such as family violence, mental health, severe mental health, drugs and alcohol, and Child Protection orders. Because a volunteer home visitor should not be placed in those situations." Good Beginnings' volunteer policies support this position.

Two participants also cautioned that, in some instances, assigning a paid home visitor protected *families* as well. The manager spoke of ensuring that a family gets the best possible service *from other agencies* when the home visitor advocates for the family:

Not that they [volunteers] would be out of their depths as such, but you'd want to ensure that you are delivering someone to the family that can be backed up and followed through with, on I guess, a more *qualified* basis. Which you would most likely be, then, having to talk to other professionals, and that gives you some sort of credence to get in the door.

A Good Beginnings volunteer noted that, in these complex situations, home visitors must be knowledgeable about certain health and social issues. Reflecting on a previous experience where a mother had had depression, and had received services from a staff member before being matched with the volunteer, this volunteer stated, "I think at the beginning, it would be very hard as a volunteer to start off to develop a sort of goal plan for me, it would be a bit of trial and error, because I didn't know that much ... about depression." This volunteer also felt that, from a service user's

perspective, being supported solely by a volunteer would be less than ideal: “maybe [the mother] wouldn't get as much help as they needed at the time of the crisis.”

This volunteer also pointed out that, in working with some vulnerable families, home visitors may need to be well-versed in relevant legislation and regulations: “You know, it's quite complex. You need to know about the rules of Child Protection.”

In summary, these examples from the three study programs illustrate the importance that participants placed on having staff members who could work directly with the more vulnerable and ‘at-risk’ families.

7.8 REPERCUSSIONS IF THESE PROGRAMS DID NOT HAVE IN-HOME STAFF

During the interviews, all participants who were presently working or volunteering directly within one of the three study programs (n = 12) were asked the following hypothetical scenario question regarding program staffing:

“Imagine that someone in a position of authority were to say to you, and to the [name of program] overall, ‘We have to make some changes to this program. From this point on, you can only have **volunteer** home visitors in your program – no paid staff who do home visiting.’ What would be your reaction?”¹⁹

When presented with this scenario, participants expressed a range of reactions – including shock, disbelief, dismay, sadness, reluctant resignation, and a preparedness to fight to maintain the present structure of their program. Several participants, from all programs and across all roles, expressed that many positive features of the present structure would be lost. Given that many of the participants’ responses were detailed

¹⁹ Throughout Chapter 7, I have also cited participants’ responses to the converse scenario, which reads: “Imagine that someone in a position of authority were to say to you, and to the [name of program] overall, ‘We have to make some changes to this program. From this point on, you can only have **paid** home visitors in your program – no volunteer home visitors.’ What would be your reaction?”

and passionate, I have included the following sections specifically in order to report on this question.

7.8.1 Volunteers' Perceptions of Their Program without Front-Line Staff

Several volunteers shared that they would have to think long and hard about volunteering for a program that did not have the kind of staff back-up and guidance that they had at the time of the study, as the home visiting work would become too risky; or, that they would only accept the most straightforward and 'low-risk' of family situations. However, some volunteers hesitated as they said this, realizing that this would leave the more vulnerable families in their community without the important information, support and reassurance that a home visitor provides. Obviously struggling, one volunteer paused, and after a moment, said simply, "It wouldn't work. It just wouldn't."

7.8.2 Assessing Family Risks and Accepting Only 'Sure Bets' for Success

Participants in two of the study programs reflected that the absence of staff members who can do in-home work would leave them with the challenge of having to determine, prior to beginning service, which families were a 'sure bet' for success with a volunteer visitor. Several participants expressed that this scenario would likely mean turning away those families with obvious, or even probable, risks.

7.8.3 Families with More Complex Needs Might Not Be Served At All

Participants from two study programs expressed that if the more vulnerable/'medium-risk' families were turned away by the home visiting program, many would not be eligible to receive services from other organizations, given that, in their communities, services are spread very thin. As a staff member from Dublin explained, if this program did not have a team of Family Development Nurses, this would "have implications for the parents and the Community Mothers, both," one of which would be the loss of the program's "facility" to serve those families who are too complex, or potentially dangerous, for a volunteer.

7.8.4 Programs May Have Less Impact

Finally, participants across all three programs stated that while the absence of front-line staff members would leave some of the more vulnerable families in the community without service from any organization, the *less* vulnerable families would still be served by the home visiting program. Indeed, one study participant shared that, prior to strengthening the program’s volunteer component and adding home visiting by staff members, “I felt like it was kind of ... It was a nice ‘feel-good’ program for [sponsor agency], but it wasn't really doing anything of real substance until we really moved it forward.” Adding to the irony of this hypothetical scenario was the fact that these three programs prided themselves on being able to serve virtually *all* families who were interested in their services – a feature that was dependent on having staff members who could do home visiting.

7.9 SUMMARY OF FINDINGS RELATING TO STRENGTHS

As outlined throughout the present chapter, the findings of this study suggest that programs were strengthened in several key ways by having both paid and volunteer visitors. Participants believed that they were better able to provide consistent and responsive services, to remain true to their programs’ philosophy, and to meet the needs of both a greater number and broader range of families, including those who were vulnerable and face greater risks to child and family well-being. Additionally, there may have been several cost benefits to having both volunteer and paid visitors.

The following sections, 7.10 to 7.15, outline the challenges faced by mixed-delivery programs, as identified by study participants.

7.10 OVERVIEW OF FINDINGS RELATED TO CHALLENGES

All study participants were asked about challenges and drawbacks to having both volunteer and paid visitors in the same program (for details, see *Appendix H: Interview Guide*). Those participants who stated that they had not experienced any challenges themselves were asked if they were aware of any challenges or drawbacks within the

program as a whole, vis-a-vis having both volunteer and paid visitors. Aside from funding-related difficulties, which were raised by several participants, most participants mentioned just one or two challenges; further, not all of these were related to having both paid and volunteer visitors. In this thesis, only those challenges that relate directly to having *both paid and volunteer visitors in the same program* are presented.

Overall, the most significant finding relating to challenges and drawbacks is that participants did not consistently name the same issue(s) across all programs and roles. Rather, some challenges were named by several participants, others were named by a few participants, and others by just one participant.

Additionally, when asked what aspects of their program could be changed or improved, there were no responses that could be described as emphatic or urgent; as demonstrated in this quote from a volunteer, some study participants seemed to struggle to find something to say:

I don't know [*pause*]. I don't know, I haven't thought of that I think that maybe, putting a time limit on visiting families. Because sometimes you know when they don't want you anymore. Maybe putting a time limit of, maybe, a year. Because a lot of times, you can pick up problems by then, or at least give them the tools to observe their child, so they'll pick up on it, or whatever. But maybe that's it ... I think it is a good program.

In a way, it is not surprising that participants felt positively about their programs. All three managers were keen to have their programs take part in the study; if they had been experiencing problems, they may have been less inclined to pursue participation. All study participants took part voluntarily; a self-selecting group such as this may be less likely to be experiencing a number of difficulties. Any staff or volunteers who had complaints or concerns may have declined participation for fear that their criticisms would be identifiable in the report. As well, *volunteers* who are not happy with a program have the option to leave, as they aren't relying on their involvement as a source of income; thus the feedback from any current group of volunteers, in any program or sector, may be somewhat skewed in favour of satisfaction. Additionally, the

goal of this study was not to evaluate or measure these programs, but to gain a better understanding of them; the study design reflected this. At the same time, most participants readily named several examples of the benefits of having both paid and volunteer visitors. These concrete illustrations demonstrate that, across programs and roles, participants *were* informed by many positive experiences.

The relevant challenges that were named by participants across the three programs included:

- operating within residual, reactive and targeted service delivery systems;
- securing and maintaining adequate funding, particularly for front-line staff members;
- some episodic difficulties arising from the programs' operational context (that is, small programs located within larger organizations and partnership arrangements).
- challenges internal to the programs themselves (difficulties encountered in managing, working and volunteering within a mixed-delivery program)

These are presented in sections 7.11 to 7.14, and discussed and analyzed in Chapter 8.

7.11 THE SOCIO-POLITICAL-ECONOMIC CONTEXT: THE IMPACT OF RESIDUAL/TARGETED SYSTEMS

“Every day, every day you’re hearing [of] cutbacks ... and making more people's lives more difficult.”

- *Volunteer home visitor*

All three programs involved with the present study operated within a social services and family support structure that was residual, targeted, and largely reactive. In a **reactive** system, services are designed and delivered in response to the needs of parents and children who have already encountered significant difficulties, such as child abuse or neglect, developmental delays, and behaviour problems. In a **targeted** system, families must qualify for services by meeting certain pre-determined, ‘means-tested’ criteria; only those who meet the criteria can receive service (Doherty, 2007). In a

residual system, eligibility criteria such as means tests are used to determine who may receive services and benefits. The bulk of the population does not qualify for residual services, so they may not fully understand the roles played by those services, nor identify these programs as valued and worth protecting. Thus one consequence of residual systems is the vulnerability of the services themselves; as noted by one study participant, residual services often enjoy less public support and funding stability than do universal programs such as public education:

“It goes against what ... [Nobel Prize-winning American economist James] Heckman says about the economics of early childhood, in the sense that yeah, you want to focus on the high-risk, but you also want to focus on the general population, to rally the support that’s needed for the high-risk.”

Ironically, as a result of this residual structure, programs aimed at serving those with higher risks and needs tend to be more vulnerable to funding cuts than those programs that serve the entire population.

In contrast, **universal** programs are designed to ensure access to services for all, prevent problems before they arise, and detect and address problems as early as possible. As noted in Section 2.6, universal early childhood programs may be home-based or centre-based, and may be aimed primarily at children, caregivers, or both; they may also include family policy measures, such as universal parental leave benefits. Such services recognize that any family can encounter difficulties, and that all parents need access to support and information; therefore, they have space for everyone, including those who don’t appear to have particular risks or challenges. As one manager in the present study put it, “Even though we have a lot of families on paper that don't look high-risk, they still have situations that [may have risks but] may not be on paper.”

All three study programs operated within residual, targeted and reactive family/social service systems. These systems were characterized by the historical and hegemonic beliefs that universal programs are too costly for the value they offer (Doherty, 2007; Krugman, 1993; Santos, 2005; UNICEF, 2008, p. 17); that young children are primarily the private responsibility of their parents (Corrigan, 2003); and that the

vast majority of parents (and especially mothers) can and should be able to provide all that their young children need to develop properly (Rossiter, 1988).

The reality of operating within the resulting targeted, residual and reactive systems is quite different. Many parents from all backgrounds struggle without adequate information and resources (Matusicky & Russell, 2009; Watson et al., 2005). Parents are increasingly isolated from informal supports, and they face barriers to accessing formalized programs (Corrigan, 2003; McQuaig, 2004; OECD, 2006). The absence of prevention and early intervention during the sensitive periods of development means that some children will never fully overcome their difficulties with cognition, learning, behaviour, and/or emotional regulation. As has been emphasized by experts in a number of fields, there are tremendous social and economic costs to our collective failure to provide for young children (Heckman & Carneiro, 2003; McCain et al., 2007).

In the following sections, the impact of this situation is presented separately for each program, as the socio-political-economic context varies considerably from one country to the next.

7.11.1 The Impact of Residual/Targeted Systems – Utah

The United States is perhaps the least ‘universally’ oriented of all wealthy western industrialized countries, given its status as the only such nation without some form of universal health care program, and its historical and continuing emphasis on individual, rather than collective, rights and responsibilities. According to one Utah participant, at the time of the present study, there was “much more of a move in the U.S. of just focusing all resources on the very most at-risk” – a description that, as noted earlier, fits only a small percentage of the general population. For the vast majority of Utah families with young children, there were few or no services available to prevent difficulties or address them early on: “the resources aren't there.” For example, as outlined in Section 6.2.1, most Utah County first-time parents did not receive even one

post-partum home visit or telephone call from a public health nurse; it was up to parents to seek help from their paediatrician (assuming they could afford to see a doctor). An added problem was that, since it was up to parents to seek out help and information, a child who experienced a delay or difficulty may not have been seen by a specialist until after she or he started school. In the absence of a universal system that automatically followed all young children as they developed, problems inevitably did arise for Utah families, and may not have been addressed until much later, as described by a Welcome Baby staff member:

Those children that are developmentally delayed but not enough to be plunked into early intervention, and the parents don't have some of the information they need to support that development ... or they don't know the resources out there ... they just figure, "Oh, everything will be okay." And then they get to [school], and you've lost those two years.

Again, due to the nature of early human development, losing "those two years" is particularly significant at this time of life, when so many aspects of children's development are being established.

7.11.2 The Impact of Residual/Targeted Systems – Tasmania

In Australia, the situation was similar, as observed by one study participant: "The approach by the government is becoming more targeted. So it's trying to pick up those groups [of people] that are so-called 'most in need.'"

Tasmanian families who were referred or mandated to state-funded family service programs were assessed and categorized centrally through a system that measured risks and vulnerabilities. Following an initial assessment, families deemed to have elevated risks to child well-being or safety were categorized as a '4' or a '3,' while those with less significant or minimal risks were categorized as a '2' or a '1', respectively. One participant explained that government was "very interested" in funding programs for "vulnerable families"; that is, those who either scored a 3 or a 4, or who were part of a population identified by government as having higher risks, such

as “young parents under 25, disabilities, mental health, culturally and linguistically diverse, and... aboriginality.”

Yet in another part of Australia, a state government had earlier run into difficulties as a result of this very approach:

When that [targeted approach] was introduced years ago, they tackled of course the pointy end, the 3's and 4's, and left the 1's and 2's under-funded. And so what has happened is a big ... up-swelling of 3's and 4's, years later. And they now think it's because the 1's and 2's weren't attended to. And hence the early intervention wasn't there until it built up, becoming much bigger.

This participant emphasized that “if there's nothing there for the universal net, then they creep on in time. And we've had some experience of that...” This participant went on to describe the repercussions faced by some seemingly “lower-risk” families, who were looking for support services, but were not initially referred to the volunteer home visiting program: “They’ve sat out there in the community,” unable to receive help or intervention, “and they've come back through ... nine months later, with some issues ... that is, to me, quite disturbing.” This participant stressed that this was the kind of problem that occurs within targeted systems.

The Tasmania state government’s approach to meeting the needs of families with ‘lower risks’ was that “universal [services] should be [delivered via] groups, more so than [via] direct family support work.” This participant went on to explain that this approach could not meet the needs of the entire population, as “some people don't enjoy groups” or may not “want to share your issues and problems in a group,” or may face problems with transportation and access. Therefore, those who worked in universal services such as the home visiting program found that “it’s a big part of the work ... to try and help people *into* groups.” Service providers who had been told by a family that they were unwilling or unable to attend a group were put in a position of trying to get these same parents to warm to the idea of a group, simply because that was the only service available to them.

Ironically, as documented in the Good Beginnings Australia national office's January 2010 report to a major funder, caregivers' participation in groups can create an increased demand for the very services that are not funded:

While the focus for these programs is group based activity, we have noted an increase in the demand for individual family support. This demand is arising as participants build an initial relationship in the group environment and some self-esteem. In some instances Good Beginnings has been able to respond by identifying alternate funding to support intensive programs, but this is not always available (Good Beginnings Australia, 2010, p. 11).

Indeed, it is as if parent groups extended an open door to families, but once inside that door, there was not always someone who could meet families' real needs. This is one of the very dilemmas that, in providing skilled staff members who can do in-home work, mixed-delivery home visiting programs have attempted to avoid; here it has arisen again, in a somewhat different context.

Another difficulty expressed by Good Beginnings study participants was that targeted programs were often mandated to focus their work only on one particular issue or concern. This meant that support and intervention were not provided for other issues faced by a family; these may have gone unaddressed, even as a service provider attempted to deal with one specific issue: "So what the government funding is trying to do is splice it all off ... so that [if] there is one child with autism ... generally what would happen is, that child would be treated, but the family as an environment would tend not to be Which isn't holistic, and which isn't universal." In contrast, the Good Beginnings home visiting program "also deals with autism, mental health, drugs and alcohol, family violence, relationship issues, all things that are becoming 'targeted group' money ... [and it] actually ticks off [*addresses*] all those things, without being targeted."

This participant also noted that, ironically, a universal service such as the home visiting program was "not acknowledged for dealing with all these issues." Indeed,

Good Beginnings had long struggled to secure and maintain funding for in-home Family Support Workers in the Volunteer Home Visiting and Family Support Program, in part because of the lack of “recognition for the more intensive families that are involved in the program.” This challenge echoes the one experienced by Good Beginnings Australia’s group programs, as described above: both services were funded to meet the seemingly straightforward (read: low-cost) needs of those families deemed to be lower risk. However, as in Utah, many Tasmanian families who might have been assessed as lower risk actually struggled with difficult issues or, over time, encountered significant problems; when these needs emerged, more intensive (individual) services were “not always available.” (ibid, p. 11). In order to effectively meet the *real* needs of these “lower-risk” families, funding for staff to do intensive (individual) work was required.

7.11.3 Giving ‘Lip Service’ to Primary Health Care – Ireland

As outlined in Chapter 2, Ireland also had a dearth of preventative universal early childhood services. Study participants reported that, while all twelve of the neighbourhoods served by Community Mothers experienced social and economic disadvantage, they were by no means the only such areas of Dublin. As one study participant lamented, “there are some areas that would need it just as much” as the neighbourhoods that received the program, and yet:

... it’s not going there. I mean sometimes when moms are ... being re-housed or something, they’ll say, “Oh, is the program going in [a certain area]?” And I say, “No,” and it’s sad. Or somebody says, “Oh, my friend is in such-and-such area.” And I say, “I’m sorry, I can’t ... I’m not covering that area.” And it *is* sad. And they say, “Oh, but that’s not fair. So-and-so is getting it, and [she] found it so good.”

However, since its founding in 1988, the Community Mothers’ Programme budget had never been expanded to serve families beyond the original twelve local areas of Dublin.

A Lack of Attention to Prevention

As one Dublin participant reflected, in a system that was primarily targeted, residual, and reactive, prevention did not grab the attention of the public, nor the funding dollars of government:

Prevention is not necessarily ... people often say what we're not doing is not 'sexy.' ...We work with mothers, infants, the disadvantaged ... and they're not necessarily seen as the most important, even though all the research would say that it *is* important ... and that prevention is so positive. ...I don't think it's just Ireland, I think it happens in other countries as well ... they [government policy-makers and funders] often get caught up with the crises, and that takes up a lot of resources. But what we're doing is very slow, and there's very little adrenaline in it. So from that point of view, often it doesn't get the resources that it should.

Not investing in prevention has its consequences, however – consequences that are often borne, years later, by various government departments, and most painfully, by vulnerable children and families. As one study participant pointed out: “Now, at the moment [in government and policy circles] they are talking in relation to a lot of the children ... they find that they're in [state] care, and that the child protection services aren't what they should be. But ... [research has shown that this program] was really positive at *preventing* child abuse” (as cited in Johnson et al., 1993; and Johnson et al., 2000).

This participant also asserted that, with its focus on prevention and education, its philosophy of empowerment for all involved, and its ability to effectively reach first-time parents in disadvantaged areas, the Community Mothers Programme was “very much primary health care. Whereas now they [*government*] are coming into primary health care, but ... It's not primary health care, it's GP's²⁰ ... It's not *strong* primary health care.”

²⁰ general medical practitioners

“Strong primary health care” involves not just increased availability of traditional primary *care* services, such as physicians and nurses within medical practices. It also involves a change of mindset – away from the old top-down model of health and social services, where the professional health care provider is the “expert” and the general public is the patient-recipient (Nova Scotia Advisory Committee on Primary Health Care Renewal, 2003). It involves active citizen participation – both in maintaining and directing our own health and well-being, and in shaping and contributing to the overall system in a range of ways (*ibid*). In *particular*, Primary Health Care involves the participation of people who have been socially and economically marginalized, as these groups have endured higher rates of chronic disease and injury, and traditionally have not been involved in either disseminating health information or influencing how systems and services operate (World Health Organization [WHO], 2008, pp. 35-36).

In order for the health care system to widely adopt an approach such as that of the Community Mothers Programme, there would need to be not only the will to fund the service, but, as one participant stated, a drive to spearhead widespread systems change as well: “When you look at the system, the system operates top down and it's hierarchical. You're coming up the other way – the empowerment model. So in fact, you would be in conflict [with the system as a whole].” This “systems change” pertains to not just the actual empowerment/community development philosophy, but also to the bureaucratic manner in which the day-to-day work is carried out in these programs: “You have to be creative, you have to be innovative; you know, all the sort of things that would be less about rules and regulations – and that's the way the system works, really.”

This participant reflected that, had the Community Mothers Programme been supported over the years, it could have spread across Dublin and even throughout the country; the philosophy could have even been extended to other populations, well beyond first-time parents. Had that happened, the many benefits of the program – to families, volunteers, and communities – would have been felt much more widely.

Further, had health authorities invested in preventative programs such as Community Mothers, “It would have put them on a firm footing really, and then I think they would have been able to pitch for more resources ... but it didn't work out like that.”

This participant’s comments, below, showed her mixed feelings about the way that things had unfolded over the years. While she felt a deep sadness that the powerfully transformative ‘empowerment approach’ had not been widely adopted, and that, as a result, families in many areas were not able to receive this “positive, preventative” service, at the same time, she did not want to lose sight of what *had* been accomplished:

Initially I used to get very angry and upset and everything, but now I just say ... I'm *wise*, really ... And now I say to myself, “Look, this was very innovative and very radical for its time, and ahead of its time ... probably 20 years ahead of its time. At the end of the day, we got quite far, really, and loads of families have benefitted from it, loads of Community Mothers, a lot of the nurses have benefitted” ... I would actually say under the circumstances, [it’s an achievement to be able to] say, after 20 years, it's still running ... While a lot of people didn't get [the program], still we were able to deliver a very positive program to quite a number of people. So from that point of view, it was very positive.

Community Mothers: Attempting to Fill the Service Gaps

In several areas where the Community Mothers Programme operated, staff and volunteers had gone beyond the program’s mandate and, without additional financial resources, started weekly Breastfeeding Groups and Mother and Toddler Groups, most often because there were no such services in the area. The Mother and Toddler Groups provided women who had completed the Community Mothers Programme ongoing contact with both the Programme and other families in the community, and a chance for the children to play in a semi-structured group setting. As one study participant described, attendance at the weekly made a difference for the children: “You can see a difference in the child when they're going to the preschool, and the teachers know exactly which kids have been in the mother and toddler group, that are going to the preschool There's no [difficulty with transition] ... They just go straight in.”

In this particular neighbourhood and a few others, children ‘graduated’ from a Mother and Toddler group directly into Early Start, the government-funded preschool program for three-year-old children who live in areas that experience disadvantage.²¹ Unfortunately, in the twelve areas served by the Community Mothers Programme (all of which experienced disadvantage), only a handful of the dozens of primary schools have had both a Mother and Toddler group and an Early Start program.

This gap is an illustration of how, as in Canada, the US, and Australia, there are many Irish children and families who do not benefit from the ‘windows of opportunity’ of the early years. Indeed, participants from all three study programs stressed that the residual, targeted and reactive systems excluded many children and families from the services and information needed to ensure that all families were supported, and that all children could reach their potential.

7.12 FUNDING CHALLENGES

As will be outlined in this section, study participants across the three programs named funding challenges as a major concern. The main areas of concern cited were finding a place within funding schemes, maintaining funding for paid staff to do in-home work, and the perceived need to prove the “worth” of a program through research outcomes. These are outlined in the sections below.

7.12.1 Finding A ‘Place’ Within Funding Schemes

At the time of this study, these three home visiting programs were well-established in their communities, and had shown multifaceted indicators of program success. They had multiple and well-utilized referral pathways, including some complex and interdependent referral partnerships; each program had times when they had to

²¹ Early Start programs are located in Irish primary schools. They are designed to help prepare children for school entry and success, overcome gaps or delays in early child development, and begin to develop a positive and involved relationship between parents and their children’s schools (Citizens Information, 2011b).

prioritize which families to serve due to high demand; and they drew volunteers from the local community, sometimes retaining the same skilled volunteers for several years. All of these factors indicate that the programs were needed in their communities, and were valued by families and by local health and social service agencies. Additionally, as noted in section 6.1, the Community Mothers Programme had shown, in a randomised control trial and follow-up study, that its model effectively improved several aspects of first-time mothers' parenting practices.

However, all three programs still struggled to 'find their place' in terms of adequate and stable funding. None of the three fit neatly within an established, dependable funding stream for programs providing education and support to a broad range of families. As a result, while each program's funding situation was somewhat different, at the time of this study, all three programs had recently experienced, or were currently struggling with, funding concerns, uncertainty, and shortfalls. These difficulties are detailed in the following sections.

7.12.2 Funding For Paid Home Visitors

At the time of this study, two of the three study programs had had funding withdrawn – at least temporarily – for a part-time staff position. Both funding losses were a direct result of the global recession. The third program had not experienced a direct funding cut, but had recently developed and launched two new initiatives without the benefit of additional funding to handle the increased workload.

In all three programs, managers identified that the component of their funding that had either already been lost, or was most difficult to obtain, was funding for paid staff whose work includes home visiting. As one program manager explained:

... the volunteer coordinating is not ... I mean, people understand the need for that. But I think that probably the combination of ... having professional visitors with volunteers.... pretty much it's [unusual] to do that. So that may be ... our biggest setback. I think [paid] home visitation is a hard sell."

This manager went on to say that, when compared to home visitation by volunteers, home visitation by paid staff was “expensive,” and that, in a “conservative” area where “the political view that people should be helping themselves” prevailed, it was difficult to gain financial support for human service programs.

Another manager also noted that the program had “quite successfully” secured funding for administration and volunteer co-ordination, but that it was only “when monies become available, then [a paid home visitor] has been put on. It has been quite a fight at times, to attract money [for paid in-home workers] ... I guess the ‘cheapness’ of the program is in the volunteers. Those are the people who aren't paid, and you can cover a lot of people...” for less money. Thus, funding for paid in-home workers had “in the past been balked at, by governments particularly.”

At the time of this study, the third manager had had to make some temporary changes to the program, and had taken on extra duties, because of the loss of funding for a part-time staff member. Not wanting to let down the volunteers who were trained and eager to serve families in that staff member’s catchment area, this manager took on some of the administrative and volunteer co-ordination work that the staff member had been doing. For their part, the volunteers agreed to work with some families who would have normally been visited by the staff member, as well as their own ‘match’ families. This manager reflected that, out of this difficult situation had come an innovative arrangement which, at the time of the study, was working out: the families were receiving the program, and with some support from the program manager, the volunteers were using their skills and interests to contribute to their community. These things would not have been possible if the program had been shut down in that local area when the staff position was lost. Additionally, this arrangement allowed some experienced volunteers to take on new responsibilities, which they welcomed.

However, this manager also observed that any future staff losses would not likely be absorbed so easily: “... I’m having to give a much bigger input, and if you’re giving that input into one area, that’s fine. But if you had to give it [to the entire

program], would it be possible? I don't think it would.” Given that the former front-line staff member’s hours of work comprised less than 5% of the entire staff complement of the home visiting program, and that carrying the work of the remaining staff members would represent about 90% of the staff complement, this seems an understatement.

7.12.3 Chicken and Egg: The Tyranny of Evidence

At the time of this study, two of the program managers expressed a wish to undertake research on their programs, in order to demonstrate the effectiveness of their services. Not surprisingly, being fairly new at their roles and busy with many program changes, neither had had the time to begin such an undertaking.

Both of these managers expressed the view that if they had research ‘evidence’ that showed the impact of their program, it would help them to get on more solid footing in terms of funding. However, both stated there were barriers to undertaking such a project. One manager was discouraged by feedback from a researcher in the field, who said “to give credibility to the volunteer program, [one would need] up to a million dollars to conduct proper research to prove its worth, or not, through that means.” The manager of the second program echoed these concerns: “ ... to run a control group for research is ... you're talking about some major funds. And so, to show that the program is evidence-based, is difficult.” Both managers were specifically speaking of the benefits that might be gained by conducting a randomized control trial.

Data collection is a challenge for many non-profit human service organizations (Gronbjerg, 2010, p. 291). At present, the basic client feedback and evaluation systems employed by study programs, as described by the managers, are not optimal for amassing data on program impact. Further, the study programs do not have specific staff resources dedicated to compiling and analysing the data that is collected. One manager expressed frustration with the emphasis on programs having to prove their worth through difficult-to-implement research, in order to be funded: “it’s a quality service, and the need is there, and why not keep it going, and fund it more?”

Expanding a program's data collection and analysis in order to track information that might better 'speak to' funders and policy makers can be a major undertaking; developing and implementing these changes may require a significant investment of initial and on-going resources. These programs had very limited resources, they were isolated from other similar programs or 'umbrella' groups that could assist in the development of such measures, and attempting to measure outcomes of home visiting programs is a complex undertaking (Byrne & Kemp, 2009; Gomby, 1999; Gomby et al., 1999). Added to this is the fact that there is no guarantee that collecting this type of on-going evaluation data will result in an improved funding situation. Thus research and evaluation may or may not become a priority for these programs in the future.

Further, all home visiting programs that deliver some or all services via *volunteers* have an additional challenge when it comes to reporting program outcomes. As outlined in Section 7.5.5, consistent with the published literature on volunteer home visiting, participants reported that the volunteers' involvement had numerous positive effects on the volunteers themselves, their own families, and the broader community. These outcomes can be difficult to track and measure for evaluation purposes.

Finally, even *compelling* research evidence gleaned from a rigorous program evaluation may not guarantee funding stability. Such is the situation of the Community Mothers Programme. As noted earlier, this program's funding had not been increased (in real dollars) since it was introduced in 1988. Further, at the time of the present study, Community Mothers was subject to the same recession-era moratorium on hiring that had been implemented across the Irish civil service. Thus the hiring moratorium, while not a funding cut *per se*, could effectively *eliminate* this universal service in any local area where a staff member resigns or retires. This dilemma is poignantly illustrated in the reflections of the manager of the Community Mothers Programme:

... when I look back now, I was so idealistic My biggest disappointment ... was that I actually thought that, if I went in and really did a first class evaluation that was a randomized control trial, and that we deliberately pursued it to get it peer reviewed, and ... published in reputable journals, like the British Medical Journal,

that ... the resources would come to us So that, to me, has been the biggest learning, but also the biggest disappointment ... I now can say clearly that just because you're in the policy documents doesn't mean that you're going to get resources.

At the same time, this manager believed that research and evaluation *had* played a crucial role in the program's very survival:

I do believe that was one thing with the evaluation: while we didn't get additional resources, we're still here after all those years. Which a lot of people from outside the country would be quite *surprised* that we survived, because they would actually see that ... a lot of programs like ours didn't survive, and don't survive, even in other countries. So from that point of view, I think the evaluation was very important, and very valuable.

This program manager speculated that, if there were to be funding cuts in the future, this research may continue to serve the program well: "I think I would be able to put forward a *very* big case ... Whereas a lot of volunteer programs have not actually gone through the rigorous evaluation, and I think that's why they can be at a bigger disadvantage than we would be."

7.13 CHALLENGES RELATED TO THE OPERATIONAL CONTEXT

Each of the three programs' funding and institutional context was different from the next. However, each was sponsored and funded by one or more larger organizations; their very existence and financial stability depended on these sponsors. Indeed, all eight mixed-delivery programs that I had been able to contact prior to the study were part of larger organizations; therefore, challenges with these institutions are worthy of discussion here.

In all three study programs, these larger organizations played various roles, most of them positive: they may have been a significant source of funding, referrals, program materials, expertise, and/or extensive infrastructure support. They may have been a key ally in a program's ongoing efforts to improve the health of families and children in their community. Indeed, one staff participant stated that the best thing about her home visiting program was the close relationship they had with a partner agency.

However, there were also challenges with these partner relationships, and because there was a significant power imbalance in these relationships, the home visiting programs could be left with little or no say in decisions that directly affected them. For example, study participants from two programs spoke of differences in philosophy that can made it harder for their program to be true to its own values. The following examples highlight some of the most difficult experiences with partner/ sponsor organizations, as raised by study participants:

- When staff of the home visiting program were needed for a population-wide initiative, the sponsor organization decided to remove all the front-line staff from their regular work for several months. The staff were not replaced during this time, and the manager was advised to temporarily shut down the home visiting program.
- One study participant recalled a situation where a staff member from a close partner organization ‘weighed in’ with the opinion that a family who had been set to receive the home visiting program was actually not eligible for the service. The volunteer was removed from this assignment, and the parents informed that they could not receive the service.

While these specific examples occurred in the past, and may have been isolated, they highlight the vulnerability of smaller programs to the priorities of larger organizations.

7.14 CHALLENGES SPECIFIC TO MIXED-DELIVERY PROGRAMS

7.14.1 Staff Working Well With Volunteers

Five participants named challenges that related specifically to staff members’ ability to work well with volunteers. These are outlined below.

Three of the five responses would fall under the category of “problems with staff members’ ability to work well with volunteers and/or families”; **however, the three participants who shared these concerns stated that these problems were not occurring in their programs at the time of this study.** One was a hypothetical problem identified by a volunteer : “Well, if the personalities don't get along ... Where someone feels like ... the staff member is too overbearing with a family, or the connection isn’t

[good] ... I could see that.” The second was a problem that a volunteer had witnessed in another organization: “it could be that sometimes the paid worker bosses around the volunteers. But that is not happening with this [program].” A third participant, a staff member, mentioned that in the past, she had worked alongside a paid home visitor who did not value volunteer visitors; that worker did not seem to understand volunteers’ roles, and did not see how they could make a meaningful contribution to families’ lives.

These responses show an awareness among participants that this *could* be an issue, and that when it did happen, it was problematic. Thus while the matter of staff members’ ability to work well with volunteers or families was not actually named as a present-day concern in any of the three programs, it is an important issue to note.

The remaining two challenges named were related to staff communication when making volunteer-family matches. Most of the volunteers interviewed for the present study had not been matched with a family following a time when a paid staff member had worked with the family; there were only four or five situations shared where this had been the case. Within these situations, two examples shared suggested a problem with communication. In one situation, a staff member did not share important family information with a volunteer until after the match was underway; in the other, a mother did not understand the role of the volunteer, and thus expected her to do things that were outside her scope of responsibilities. While only two such examples were shared, and only one of these was understood by the participants involved as having caused problems, it is important to make note of these two “miscommunications.” This is because proportionally, these incidents represent about half of the total number of situations where a volunteer was matched with a family following that family’s involvement with a staff member. This high proportion suggests that, potentially, this is an area of concern. As outlined below, my own experience also informs my understanding of the this issue and my decision to include these two examples in the findings.

Researcher's reflection

In the program I co-ordinate, we often match volunteers and staff with families, either concurrently or sequentially. With several individuals involved – volunteer, staff, parent(s) – it can be difficult to keep all ‘players’ informed at all times. One study participant – a staff member who was involved with one of the above-noted ‘miscommunications’ – alluded to this dilemma: “I try not to make it [matching a volunteer and family] a complicated thing, where there's lots of people involved.” Yet sometimes involving all of the necessary people is the only way to ensure things are done properly. This sentiment is echoed in this same participant’s later reflection on how one of these situations was handled: “That might have been where I might have needed to ... pay a visit [to the family] with the volunteer.”

In my own experience with the Extra Support for Parents Volunteer Service, almost every time that we, as a staff team, have not been thorough and vigilant about fully informing volunteers and families before a match begins – and there have been several such instances – we have later regretted this. Covering all of the information, with all of the involved parties, is laborious: it involves a lot of logistics and small bits of information to communicate, and it’s time-consuming. However, it *is* necessary: the volunteer needs to have all of the information that is relevant to the family’s needs for support. Further, the volunteer’s role must be thoroughly explained to families, so that parents don’t make incorrect assumptions about what the volunteer’s role will and will not be. When introducing a volunteer at the tail end of a staff member’s service, there may be many issues to cover and discuss; this information can get lost.

This matter is of particular concern in programs, such as the one where I am employed and one of the three study programs, where staff and volunteers are providing service to the same families, either concurrently or sequentially. This is because there are so *many* opportunities to fail to communicate important information, and because most of these families are in a vulnerable and stressful situation to begin with; their experience with the home visiting program should not increase the stress, uncertainty, or missed opportunities in their lives.

7.14.2 Managing Mixed-Delivery Programs

Three challenges were named that related specifically to the management of programs with both paid and volunteer visitors. As outlined below, these included the difficulty in replacing specialized staff members, the challenges of recruiting and retaining enough volunteers, and the heavy workload experienced by program managers.

Difficulties Replacing Highly Specialized Front-Line Staff

In the Community Mothers Programme, the role of the front-line staff person was highly specialized. In addition to being a registered nurse with a public health background, newly hired Family Development Nurses undertook an 18-month training process. In this time, they became skilled in coordinating a team of in-home volunteers, and comfortable with delivering the Community Mothers curriculum themselves. Perhaps more importantly, they were trained in the philosophy of the program, a process that is referred to internally as “de-roling.” The program manager shared that this lengthy ‘in-the-job’ training process had meant that, when a Family Development Nurse leaves her position, it was very difficult to replace her. This was especially true for temporary leaves, given that there was not enough time within a temporary leave to adequately train a new Family Development Nurse. At times over the years, Local Health Offices had replaced Family Development Nurses during temporary leaves; however, at the time of this study, no staff were being replaced, due to a broad hiring moratorium.

Recruiting and Retaining Enough Volunteers

Several participants, from all three programs, noted that recruiting and retaining enough volunteers could be a challenge; they also shared many examples of the wide-ranging repercussions of having a shortage of volunteers. Of course, this problem is not unique to programs with both paid and volunteer visitors; it can also be a challenge for

services that rely solely on volunteer home visitors, and indeed, is a common concern across all sectors that rely on volunteers (Volunteer Canada, 2010).

This challenge is worthy of note here because of an additional impact that was unique to these mixed-delivery programs: when there were not enough volunteers, both the staff members who did in-home work, and the families who were being *served by those staff members* at that time, were directly affected. Staff members must have either increased their caseload, or prioritized families to receive the service. The former option left staff members with increased workloads, which could be difficult for both staff and the families who were already being served; the latter option left some families with no service. Staff participants shared several examples of the dilemmas caused by these situations.

Study participants also stressed that recruitment and retention of volunteers required a significant investment of staff time. As one manager described, staff members were “always recruiting, training, monitoring and supporting there’s a lot of energy in that.” Successful recruitment and retention also required staff to have a great deal of *skill* in working with volunteers; both volunteers and staff members who took part in this study raised this point many times during the interviews.

Heavy Workload for Managers

At the time of this study, all three program managers were working long hours, with their time split between several divergent roles. They each carried a small caseload of families, on top of extensive program management, program development, and supervisory (staff and volunteers) responsibilities. However, in the interviews, no manager stated that the workload was too much for one person. Instead, they accepted the heavy workload; indeed, one manager seemed to see it as a natural consequence of being dedicated to the program: “If I had to do 5 jobs, I'd do it, or 6 jobs to keep it going, regardless.” Moreover, all three valued the home visiting aspect of their role. As another manager said, “I love visiting families.”

One manager reflected that ‘melding’ two former positions into one manager role had been possible because of having a capable staff team. Not surprisingly, this same manager later related that, in terms of working directly with families, “the challenges are ... time: spreading yourself way too thin, and not giving the families due time” because of juggling many other responsibilities.

Another manager recalled having to manage the home visiting program alone, when the front-line staff members had been seconded away from their regular duties: “I nearly went frantic [at that time]; it was going on for months I was very tired, I have to say.” A volunteer study participant shared that she had recently run into a former manager of the home visiting program, who was now in a new position elsewhere:

And you know, she said to me, “It's so good. I can now sleep through the night.” Because she said when she was head of [the home visiting program], she would often wake up in the middle of the night with a problem, trying to work out how she could solve it And now she's got a different job, and she said it's just lovely: “I'm able to do my work and come home, and I don't have to worry about everybody after hours...”

The demands of managing a program that is not adequately funded for the workload can take a toll.

7.15 SUMMARY OF THE CHALLENGES FACED

Common challenges reported by study participants included funding difficulties and some limited communication and workload issues. Participants identified both strengths and challenges in their relationships with larger sponsor and partner organizations. At the time of this study, all three programs were working with a reduced staff complement relative to their workload, and all three had had challenges recruiting enough volunteers to meet the demand. Obviously, this impacted the services that families received. When a manager could not fit in a home visit due to other responsibilities, when a front-line paid worker had no time available to take on additional families, and when there weren't enough volunteers for the number of families waiting for the program, families were affected.

CHAPTER 8: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

Chapter 7 presented the study findings, including the experiences, insights and perceptions of study participants; the information gleaned from the review of agency documents; and three key 'reflection' segments that were based on my own experience in the field. Chapter 8 presents the discussion and analysis.

The discussion weaves together the findings on one or more themes, and looks at what they might mean. The analysis situates the findings, discussion, and the researcher's reflection within my theoretical framework and the broader socio-political contexts of home visiting programs, early child development services, and family well-being in wealthy western Anglo-Saxon countries. The discussion and analysis are presented together, and are organized by theme. The recommendations for future research, practice, and policy directions follow.

8.1 OVERVIEW: GREATER THAN THE SUM OF ITS PARTS

Findings from this study suggest that having both volunteer and paid visitors in the same program allowed for important benefits that would not be experienced if these programs had made use of either paid or volunteer visitors alone. Further, the sum of these benefits was greater than would be realized by simply having paid and volunteer visitors working side-by-side – that is, in the same community but in separate organizations. It appears that there were two reasons for this: First, these programs were able to take the strengths of volunteer visitors and those of paid visitors, and put them to use *in concert with* one another, thus creating layers of new possibilities and benefits. Second, the application of these complementary strengths allowed mixed-delivery programs to avoid or address some of the challenges commonly faced by home visiting programs with either paid visitors or volunteer visitors. These two concepts are discussed below.

I. Programs could put to use, in concert with one another, the complementary strengths of paid and volunteer visitors, thus creating new and additional benefits for families.

This phenomenon is perhaps best illustrated by taking the reader through the process of layering the complementary strengths upon one another. As a starting point, the volunteer ‘face’ of a universally available home visiting program may have been seen as less threatening and stigmatizing than targeted staff-based services, thus increasing the appeal for families. This, in turn, increased the likelihood that some families would become involved with a given program, including both families who were not eligible for other services, but who were in need of information and/or support, and some quite vulnerable families who faced complex problems and elevated levels of risk.

As outlined in Sections 7.2.1 and 7.3, this was the first ‘layer’ of strengths: being universally available, and having volunteer visitors as the public face of the program, opened doors for families’ involvement. This first layer resided largely with the volunteers. Additionally, one of these two volunteer strengths made the other possible: delivering the program via volunteers allowed for universal availability due to reduced costs. As discussed in Section 8.3, if programs had had to rely solely on paid visitors, this would have severely limited the number of families who could be served.

However, once a family’s door was opened to a home visiting program, challenges and complexities sometimes emerged or arose; some of these were beyond what volunteers could be expected to address independently, or at all. Having paid home visitors ‘on hand’ allowed these programs to accept referrals of families whose situations may have been too difficult or dangerous for a volunteer; the option was always there to assign, or re-assign, a family to a staff member instead. This was the second layer of strengths; it resided primarily with paid staff who did home visiting, and in this capacity, paid visitors contributed four key strengths.

First, paid visitors allowed a program to fulfill its promise of being universally available. This would have been difficult to accomplish with volunteer visitors only, given that some family situations were not appropriate for a volunteer.

Second, paid visitors protected a vulnerable family's ability to not only *access* but also to *benefit from* the program. That is, the skill level and in-depth knowledge of paid visitors helped ensure that the program could respond in ways that were relevant to these families' needs. For example, if a family needed extensive advocacy, or parenting and life skills education amidst a chaotic living situation, the staff member could provide that. Thus paid home visitors helped vulnerable parents reap the universal benefits of these programs, such as emotional support and parenting information, while also facilitating progress on the unique challenges facing each family. This strength brought by paid visitors, in turn, contributed to the stability and well-being of those families who had greater risks for negative experiences and outcomes.

Third, paid staff provided guidance and support to volunteers who were dealing with challenging home visiting situations; fourth, they protected volunteers from those scenarios that were dangerous, inappropriate, or too stressful; and fifth, they understood the challenges, joys, and dynamics that were unique to working within families' homes. Several volunteer participants shared that this last point increased the credibility of staff members among volunteers. These three functions, in turn, help create a capable, confident, and well-supported volunteer team. Indeed, the findings of the present study suggest that these staff functions may have increased volunteer satisfaction and retention, and thus, the efficiency and cost-effectiveness of these programs (for discussion, see Section 8.3).

The third cumulative layer of strengths resided with both paid and volunteer visitors; at this level, staff and volunteer contributions were like interwoven threads going in numerous directions, changing and adapting based on the needs of each situation. Three examples illustrate this interwoven third layer:

- A volunteer may have taken on challenging family situations, skilfully and without hesitation, because she has been well-supported by staff through similar scenarios in the past. This is an extremely cost-effective method of service delivery, made possible by having staff with both the skills and the time to provide extensive guidance and support for volunteers as needed.

- A staff member may have taken over for a volunteer who had to go on leave, allowing for that volunteer's family/families to continue receiving the program. (This human resource flexibility is discussed further in the following section, 8.1 – II.)
- For all three study programs, having a strong corps of volunteers, as well as a strong staff team, were by nature symbiotic and interdependent arrangements. For example, the successful recruitment, development, and retention of volunteers was dependent on the skills, effort, and availability of staff. The staff, in turn, depended on having an adequate volunteer complement to serve the bulk of the families in their program, as this allowed staff members to focus more time and energy on their own home visiting and program coordination work. Again, the increased strength of one party contributed to the strength and success of the other.

At this third cumulative layer, the directions taken by volunteers and staff also depended on the parameters and structure of each program. For example, in the Community Mothers Programme, volunteers may have met a family weekly through the Mother and Toddler Group; over time, if volunteers identified a possible child development delay, they could sensitively bring in the program's Family Development Nurse for assessment and referrals. From this point on, a mother may have been supported by both the volunteer group leaders and the nurse, as she navigated the often difficult process of specialist appointments, diagnoses, therapies and treatments. In Good Beginnings Australia, a family that was initially assessed as being too high-risk for a volunteer may have worked with a Family Support Worker for several months, and subsequently have been matched successfully with a volunteer, thus benefiting from a longer-term peer support relationship.

Together, these volunteer and paid visitors could engage a larger and more diverse group of families, and could provide these families with a broader range of relevant and responsive services that facilitated family and child well-being. Thus the complementary strengths of paid and volunteer visitors mutually reinforced one

another, allowing for visitors in both roles to accomplish things for and with families that each could not achieve alone.

II. These complementary strengths allowed mixed-delivery programs to avoid or address some of the challenges commonly faced by each type of home visiting program.

The previous section outlined the ways in which the complementary strengths of paid and volunteer visitors supported and enhanced one another's work. In doing so, these visitors also overcame or minimized some of the common challenges faced by programs that make use of only volunteer, or only paid, visitors. As outlined below, human resource challenges were a key illustration of this phenomenon.

Section 7.2.4, *Availability*, highlighted the belief – shared by participants from all three study programs – that having both paid and volunteer visitors has provided flexibility and options when assigning home visitors to families. For example, in programs where all home visitors are paid staff, all families must be assigned to a paid visitor; this is an expensive proposition, and can significantly restrict the number of families who can be served by a program. Volunteer visitors help address this gap through their larger numbers and greater affordability; sometimes they also bring relevant life experiences or skills that members of the staff team may not possess, such as speaking the same language as a family.

As a workforce, however, volunteers present challenges that are beyond the control of the program, such as needing to resign or go 'on leave' suddenly because of other commitments; further, it is unethical to rely on volunteers to do work that is stressful, potentially dangerous, or beyond their skills and knowledge. When these situations arose in study programs, paid visitors could be assigned, and as one manager described, staff could also "jump in" and take on families when no volunteers were available. Thus, while the introduction of either paid or volunteer visitors to a pre-existing home visiting program may serve to meet a specific program goal (for example,

expanding the number of families served), such a move may simultaneously address other challenges as well.

As outlined in the following section, these complementary strengths, and the resulting synergy, are also an example of what can be accomplished when services are integrated.

8.2 A POWERFUL EXAMPLE OF THE BENEFITS OF INTEGRATED PREVENTATIVE SERVICES

The programs involved with this study had fully integrated two preventative services – volunteer and paid home visiting – that most often are housed, managed, and delivered separately. Further, both the additional services that were housed within these three programs (such as parent-child groups) and the close partnerships with other services (notably, public health) enhanced families' access to services, as well as service providers' communication regarding families' well-being. This structure provided both on-going, relationship-based services, which allowed for the prevention and early identification of difficulties, and – from within the same program – ready access to more intensive intervention and support services when needed. As discussed below, this is a rarity within the prevailing residual, targeted and reactive social and family service 'systems' in Anglo-Saxon countries.

Integrating a prevention component into services

In researching this thesis, it has become clear to me that in most wealthy, western Anglo-Saxon countries, it is not the norm for staff from health and social service agencies to provide preventative in-home services. Rather, staff-based services tend to be both goal-oriented and specific to either a vulnerability or a pre-existing problem (as in the example in Section 7.2.3, involving a mother who had stopped breastfeeding). Once a goal is reached, or a problem is averted or resolved, the staff member's involvement may end (particularly in programs with no user fees); in the absence of a particular vulnerability, longer-term preventative home visits are not offered. This is the

nature of reactive systems of service and care, whose parameters are often shaped by limited budgets and high demands for services.

As described in Section 7.4.3, in this western Anglo-Saxon context, programs with volunteer and paid visitors can uniquely offer families both a preventative, relationship-based service *and* an expertise-based service, from within the same program. Many examples shared by participants in the present study suggest that this combination makes services more comprehensive, more streamlined, and more accessible for families. As discussed in Section 2.2, this is particularly important for vulnerable and marginalized families, who may face increased external and/or internal barriers to accessing services; for these families, a referral 'out' to other programs may be less successful. Ironically, many of these families also face greater risks for negative outcomes if they do not receive those additional services. It is in these situations where in-house staff availability may be most impactful.

Systems-level integration

Program-level integrative measures, such as co-location and operational collaborations, are important steps that can be taken by home visiting organizations and others in the health and social services fields. However, as participants in the present study have shared, small pockets of integrated programs cannot compensate for a lack of universally available, comprehensive, preventative early child development *systems*. As outlined in Chapter 2, many experts in the field of early human development have urged governments of wealthy Anglo-Saxon countries to develop such systems. Despite many international examples of the benefits, and compelling evidence that our present approach is ineffective and costly, these governments have not heeded this call. As an example, the Community Mothers Programme has been shown as an effective method of preventing child maltreatment and increasing mothers' use of positive parenting methods (see Section 6.1.1 for details). Yet neither this program, nor other similar prevention programs, have been adopted by the field of child welfare, in any of the

countries in question, as a widespread model for reducing the incidence of child abuse. Indeed, as one study participant related, those responsible for policy directions seem to be “caught up with the crises,” unable to step back from the overwhelming problems of today long enough to think about creating a better scenario tomorrow.

This is where collaboration and integration are needed on a much larger scale. Directors of child welfare units, policy makers, senior government officials, and elected representatives who are interested in stemming the tide of abused and neglected children must look outside of their own expertise and portfolio, to the areas of prenatal and early child development, family-centered public policy, poverty reduction, and social and economic inclusion. The same is true for those in the education field who wish to stem the growing tide of students in need of remedial services. We now have examples of many successful initiatives, as well as a growing body of research, that point to real solutions. Adopting these solutions involves collaboration at a level that is new and daunting, as the goal is nothing short of making major changes to complex bureaucratic systems. However, *not* making these changes means staying on the same destructive path, rife with escalating human and fiscal costs and declining returns on our investments.

A word of caution regarding integration of services

The destiny of each program involved in the present study was tied to one or more larger organizations, which acted in various important capacities vis-à-vis the home visiting programs: funder, administrative sponsor, operational partner, or some combination of the above. The relationships with sponsor organizations and close partners have had many positive effects on each study program, which should not be overshadowed by the negative aspects. At the same time, it is also important to note that, as outlined in Section 7.13, these larger organizations had priorities and influence that was, at times, in conflict with the best interests of the home visiting program. This could leave the programs, and the families who rely on their services, in a very vulnerable position. This was especially true when this power imbalance was combined

with the ongoing challenges in maintaining secure funding for paid staff who do in-home work.²²

The findings of this study also indicate that, in any kind of integration of services, actions must be taken to protect those factors that have contributed to the success of a program or program model – for example, philosophical approaches, appeal to volunteers and families, curriculum used, or flexibility to respond to families’ real needs. Programs that are forced to operate in a context of undue barriers, protocols, activity restrictions, or service interruptions may find it quite difficult to achieve previously documented outcomes, or even to maintain commitment from an unpaid workforce. Indeed, the same might be said of families’ involvement.

8.3 A MIXED-DELIVERY STRUCTURE MAY ENHANCE COST-EFFECTIVENESS

Volunteers are widely seen as a cost-effective way of delivering home visiting. Findings from the present study suggest that the mixed-delivery approach may maximize the cost-effectiveness of a volunteer-based service because of the consistent support, education, and protection that can be provided to volunteers by a team of staff members who are themselves skilled home visitors and parent educators. This arrangement appears to support the development of volunteer skills and knowledge, and may also contribute to the retention of the high-calibre volunteers that are so important to these programs. Study participants from all three programs stressed that together, these elements allowed programs to make contributions to families’ well-being that they would not have been able to make with the same financial resources and only paid *or* volunteer visitors. Thus, the findings from the present study suggest that this particular program structure may be more cost-effective than program models that have only volunteer visitors, or only paid visitors.

²² Thus, while the challenges relating to lack of autonomy are not necessarily unique to mixed-delivery home visiting programs, these programs are perhaps particularly vulnerable because the front-line staff play such important roles in these programs.

Further, given that volunteer recruitment, screening, and orientation involve major commitments of staff time, successful volunteer *retention* contributes significantly to efficiency and cost savings within these programs. Additionally, as volunteers become more experienced in their in-home roles, they can often serve an increasingly broad range of families, while also requiring less staff time for supervision, support, and guidance; thus, the longer volunteers stay with a program, the more valuable and less 'costly' they are to that program. As a group, then, longer-serving volunteers increase a program's internal capacity, allowing the program to serve a broader range of families, and ensuring the best use of limited resources.

For all of these reasons, it could be argued that *any* measures that increase the length of time that volunteer visitors stay with a program, also serve to increase that program's cost-effectiveness. Providing the support and guidance of a strong staff team, who are themselves skilled in home visiting and parenting education, may be one such measure. This is a question that warrants further investigation in future research studies.

8.3.1 The Leveraging Power of Volunteer Programs in the Non-Profit Sector

Any considerations of cost-effectiveness must take into account not only the direct dollar amounts spent on services, but other important, sometimes less obvious, factors. One clear example relating to this study is the contributions of unpaid volunteers; this has received some attention in the literature. There are also other considerations; for example, the monies invested in one program or sector cannot always be accessed for, or transferred to, another program/sector. A case in point is the United Way (volunteer) 'wing' of Welcome Baby. The budget allocation provided to Welcome Baby by United Way is raised by United Way; it comes from their annual campaign, planned giving, donations made specifically to Welcome Baby's volunteer program, and other sources (United Way of Utah County, 2009). By accessing and pooling monies from the community, United Way chapters leverage community resources and channel them to local programs, such as Welcome Baby. These resources

are in addition to the tax base that supports public-sector programs such as the Utah County Health Department.

If United Way did not sponsor this volunteer visiting program, these additional resources would not be made available to a public agency such as a county health department, since United Way does not fund government programs; nor would a public health agency be in a position to fundraise such monies. Further, if Welcome Baby's volunteer 'wing' were not in existence as a destination for these donations, some percentage of these monies would not be donated to the United Way. This is because some donors who specifically give to Welcome Baby may stop donating to United Way of Utah County.

The end results of having a United Way-linked volunteer 'wing' of Welcome Baby are a net increase in the overall financial resources directed to families and young children in Utah County, and a corresponding increase in the number of families with infants who receive some form of information and support from Welcome Baby Utah County. It seems to me that, in an era of cuts to public services, and in a socially and fiscally conservative region with a high birth rate, this is a remarkable victory of creativity, commitment, and collaboration.

If cost-effectiveness is measured narrowly, these factors may not be included in the calculations. Thus, when considering cost-effectiveness, the question must be asked: if this program were not in existence, could equivalent funds be generated or accessed to serve families in need? If the answer is "no," or "only partially," the measurement of cost-effectiveness must account for the full impact on the community – that is, the loss of both the service *and* the funds.

8.4 BENEFITS OF PAID VISITORS WORKING IN VOLUNTEER-BASED PROGRAMS

8.4.1 Allows for Successful Implementation of Home Visiting Curriculum

In the two curriculum-based programs, the curriculum is one of the core services provided to families, as it not only provides relevant age-paced information, but also

acts as a vehicle for starting discussions, and ultimately helps parents to build confidence and create a better home environment. As discussed in Section 7.6.4, study participants across the two curriculum-based programs felt that having managers and front-line staff who also delivered the entire curriculum to families had wide-ranging benefits; some participants stated that it was essential to their program's success. As I am not aware of any curriculum-based, volunteer-only visiting programs, I cannot offer any comparative data. However, participant feedback from the present study suggests that curriculum-based volunteer visiting programs that do not have paid staff who also deliver the curriculum, may be challenged in attempting to meet their mandate.

8.4.2 Universal-Plus: Different Sizes Fit Different People

Mixed-delivery home visiting programs are in a unique position to provide what could be called “universal-plus” services to families. These programs do this by providing *equality of service* to families from very different backgrounds, while acknowledging and working to meet the *different needs* of these families. This is illustrated by the universally offered, curriculum-based programs that took part in this study. In these communities, families with different social and economic backgrounds had the same access to support and up-to-date information on parenting and child development (thus, it's **universal**), and further, this support was tailored to their individual needs (it's inclusive and relevant – the **plus**). It's not ‘one-size-fits-all’ (which does not usually fit ‘all’); further, it doesn't happen in a group environment, with its inherent barriers. Thus, in Utah County, a Spanish-speaking single mother with limited education could receive visits from a bilingual and culturally adept paid home visitor; her neighbours, a teenage couple with conflictual extended-family relationships, could receive visits from a public health nurse; and a third family in the area, a professional couple, could receive visits from a volunteer. All three families had access to the same parenting information, from the same program, as well as emotional support and connections to relevant community resources. Further, everyone received the same message: you and your child really *matter*.

Without these services, in a residual and targeted system with severely limited public programs, that professional couple may have been eligible for no service beyond sporadic visits to their paediatrician. The Spanish-speaking single mother may have struggled to understand the confusing information provided by a unilingual anglophone nurse or physician; not comprehending the health and social service systems, she may have withdrawn from services and experienced additional hardship and isolation. The teenage couple may have qualified for, and benefited from, targeted public health nursing; however, if they were concerned about the possible stigma or risk associated with a targeted public-sector program, they may not have accepted that service. In that case, they may have struggled, alone, with the challenges of new parenthood and longstanding family problems, leaving two young parents and their vulnerable infant in a conflictual, low-income, and chronically high-stress environment.

As research on the Community Mothers Programme has shown, a very high percentage of families in a community can be included in this universal-plus approach, even those families with considerable barriers and challenges. This is something with which even our most prized universal programs, such as public education, struggle. In the residual and targeted systems in which these home visiting programs operate, it is a very rare accomplishment indeed.

8.4.3 How Might 'Volunteer-Only' Programs Manage Without Paid Visitors?

This study is not a comparison of different types of home visiting programs, and questions of how volunteer home visiting programs meet families' more complex needs are beyond its scope. However, on this topic there are two points that are useful to raise, in the context of the present study:

1. Availability of other services to serve families with more complex needs

In their 2004 international review of evaluations of 14 volunteer home visiting programs, Black & Kemp (2004) reported that families whose needs were too complex for the participating volunteer visiting programs were referred to local professional

services. However, participants from two programs involved with the present study reported that, in their communities, few such services exist. Further, participants from all three programs emphasized the many benefits of universally available services. Finally, examples provided by participants suggest that mixed-delivery programs are able to meet the difficult-to-predict, and sometimes complex, *emergent* needs of families in an accessible, timely, and seamless way, without having to discontinue services.

2. Challenges in Staffing the Manager/Co-ordinator Position

It must be noted that, in home visiting programs that have volunteer visitors only, the program manager does provide guidance and support to volunteers; in some programs, she provides an amount of intervention and support with families as well. However, in these programs, the manager may be the *only* staff member, or may be aided by a part-time or full-time administrative assistant (Black & Kemp, 2004, p. 17). When one individual is responsible for program management, the oversight of all volunteer-family matches, and all aspects of volunteer coordination, there may be little time for families, or even for volunteers. As Black and Kemp (2004) reported, “The consequence in one program was that the coordinator ‘had to limit both the amount of face-to-face contact with volunteers and the extent of volunteer recruitment to the program’” (Elix & Lambert, 1995, as cited in Black & Kemp, 2004, p. 17).

Additionally, when hiring a single staff member to run a program, organizations may have to prioritize the many skills they are seeking. The lower salary levels in the non-profit sector (Gardner Pinfeld, 2010; Gregory & Howard, 2009) may make it that much harder to attract individuals who are skilled in several divergent domains. As described below, two of the three programs involved in this study have experienced staffing scenarios that starkly reflect these fiscal and human resource challenges:

- Many of the Good Beginnings program sites across Australia have, at various times, had part-time Co-ordinators. Additionally, one participant related that, during a period when the Hobart site did not have any funding for Family

Support Workers, “I think the former Coordinator gave up one day a week so there could be some hours” for a Family Support Worker.

- In its first several years, Welcome Baby’s volunteer ‘wing’ was run by successive Vista placements through AmeriCorps, a federally funded work-experience program for young adults. While this was an affordable way for an organization such as United Way to launch a new program, the nature of this arrangement virtually ensured that staff members did not have the ideal mix of skills and experience to manage such a program: each Vista placement was contracted for one non-renewable 12-month term. Reflecting on this staffing model, one study participant reflected that the Vista staff “were not very consistent, and ... it was just so temporary. You know, ‘I’m going to be gone in a year so I’ll do what I want. But I don’t really care what happens, because I’m just moving on.’” This participant went on to say that, at that time, the program “wasn’t as [well-] advertised, it didn’t have the numbers [of families served], it didn’t have the commitment from the people working there.” In comparison, at the time of the present study, under the guidance of a professional manager, the program was making “a great contribution to our community.”

As the focus of the present study was not how volunteer-only home visiting programs manage complex family situations, and as I have not located any literature that speaks directly to this issue, more research may be needed on this matter. As noted previously, for the three study programs as well as other mixed-delivery home visiting programs, it is an ongoing challenge to secure and maintain adequate funding for the front-line staff who are key to the program’s ability to serve higher-needs families. Ironically, as discussed below, the findings of this study strongly suggest that the ability to work with vulnerable families is a particular strength of these mixed-delivery programs.

8.5 MULTIPLE BENEFITS TO WORKING WELL WITH VULNERABLE FAMILIES

8.5.1 Successfully Involving Families with Elevated Risks and Barriers...

As discussed in several places in this thesis, within volunteer-based home visiting programs it is widely believed that the idea of a volunteer visitor increases initial access

for some families, particularly those caregivers reluctant to get involved with professional or formalized services. At the same time, the presence of front-line staff and managers who can also work directly with families allows mixed-delivery programs to welcome more vulnerable families into the fold, and then effectively *respond to* the real and complex needs that may emerge. Given the increased risks to long-term well-being faced by these families, and the corresponding economic, social and human costs, those programs that can both engage *and* effectively serve these families should be supported. The combination of a volunteer-based family home visiting program with staff ‘reinforcements’ appears to be one such example.

8.5.2 ...Thus Enhancing the *Entire System’s* Ability to Serve These Families...

Skilled home visiting staff (and in some situations, skilled volunteers) can support vulnerable parents in the complex process of accessing and navigating a wide range of needed services. Home visitors can advocate for and with parents, and can facilitate the development of essential interpersonal and self-advocacy skills – thus helping families to not only connect with services, but to successfully *stay connected* with them. Thus, findings from the present study suggest that programs that engage and retain families with multiple risks and barriers, and also act in this facilitative capacity, actually improve the *entire system’s* ability to serve, care for, and work with these families.

8.5.3 ...And Impacting the Long-term Development of Vulnerable Children

As discussed in Chapter 3, the published literature has highlighted that many home visiting program models have a positive impact on parents, particularly mothers, and on key aspect of parent-child relationships, such as attachment. However, the findings are not as consistent these when it comes to demonstrating an impact on children’s physical, cognitive, emotional or social development. In relation to ‘volunteer-only’ visiting programs, this finding could be because programs don’t attempt to measure child outcomes (Byrne & Kemp, 2009), or that they do not have the research and evaluation capacity for such measures, or that, since direct contact is most often

with the mother, and volunteers are generally not specialists in child development, it would follow that these programs' greatest impact is on mothers.

Indeed, research has consistently shown that, while some home visiting program models have positive impacts not only on parenting practices and social/community supports, but also on children's development, the greatest impacts come from **reducing poverty** (CCCH, 2009) and from children's participation in **high-quality early childhood education and care programs**. Ironically, the most vulnerable families are more likely than other families to live in poverty (McCain et al., 2007; OECD, 2006), and less likely to access ECEC programs (Cote et al., 2007; Japel, 2009; OECD, 2006). In Quebec, it was found that children from disadvantaged families had less access to *quality* ECEC programs than children from more advantaged families (Japel, 2009).

The findings of the present study offer an interesting opportunity in this regard. Home visiting programs that can successfully provide ongoing services to vulnerable families may be in a unique position to support the healthy development of the children in these families, because of home visitors' roles in helping parents access quality early child development programs and reduce family poverty. For example, home visitors may help parents to overcome a myriad of internal and external barriers that may prevent them from *accessing* and *staying involved with* quality early child education and care programs – barriers such as parents' negative attitudes toward child care, a lack of awareness of available preschool or day care programs, or difficulties navigating systems that might reduce the costs. Having children enrolled in an ECEC program, in turn, can create the necessary time and space for parents to take key steps toward reducing family poverty, such as returning to school or work (Japel, 2009; UNICEF, 2008). Additionally, separate from whether or not children are enrolled in an ECEC program, skilled home visitors may be able to help vulnerable families take steps toward increased financial stability, such as accessing subsidized housing or income support programs.

Depending on a parent(s)' own resources and skills, and the structural barriers they face, accomplishing all of these things may require the assistance of an

experienced paid staff member; volunteers do not always have the time, skills or knowledge to provide these services. This is where paid home visitors within mixed-delivery programs can act to increase a program's impact on the development of vulnerable children. Again, this is a 'value-added' feature of these programs.

However, as outlined in Chapter 2, in these Anglo-Saxon countries, there are often formidable structural barriers and a shortage of available services. Even the most skilled and tenacious home visitor cannot create a child care space or an affordable and safe housing unit, where none exists; nor can she improve the quality of sub-standard ECEC programs or make costly programs more affordable. Thus while these mixed-delivery home visiting programs have the potential to play a key role in improving child development outcomes, as long as there are not enough services and supports available for those who need them, this potential will remain limited. Indeed, it would be prudent for evaluation studies that seek to measure the impact of home visiting programs on child development, to also measure the local availability of quality ECEC programs and other poverty reduction tools, such as income transfers, child care subsidies, affordable housing, public transit, and employment opportunities. Home visiting programs should not be evaluated on these outcomes if those services known to affect change are not locally available.

8.6 FUNDING-RELATED CHALLENGES

As outlined in Section 7.12, in the past and at the time of this study, all three programs faced challenges in securing and maintaining adequate funding. The greatest challenges related to securing and maintaining funding for staff to do in-home parenting education and family support work. However, funding in general was seen as a challenge, and was seen by participants across all three programs as stemming from both an undervaluing of universal and preventative programs, and the low priority within government of family well-being and healthy early child development. Two program managers also identified the lack of research and evaluations on these types of

programs as a challenge. These findings are discussed and analyzed in the following sections.

8.6.1 Funding for Paid Visitors

The difficulties that study programs have experienced with obtaining adequate funding for front-line staff are reflective of the hegemonic individualistic belief systems of capitalist, Anglo-Saxon countries, including the assumption that parents – and mothers in particular – will take care of all of their young children’s needs. This poorly informed (and often ideologically driven) stance results in a short-sighted societal and governmental position regarding early child development.

These funding challenges may also reflect a deep ignorance, and/or disregard for, those families who have been described in this paper as vulnerable and marginalized, or ‘medium-risk.’ These are not the families who are involved in child protection or other intensive services, nor those whose children have extensive medical or developmental needs; residual, targeted systems are designed to provide such families with some measure of services. Indeed, as one manager explained, funders “only want to invest in the highest-risk families,” although these families actually comprise a relatively small percentage of the population overall. Instead, these are the much larger group of families – perhaps a majority of families in the population – who have some combination of chronic risk factors: too little money, many stressors but few social supports, limited child development information, and/or mental health difficulties. These families are confronted daily with messages that *they alone* should be able to raise their children and do it well; accordingly, they qualify for few or no services, but often face challenges that grow over time (McCain et al., 2007).

This is particularly true when families also lack viable options for economic sustenance, as long-term poverty has many destructive effects of its own (CCCH, 2009). This combination of low income and lack of support services stacks the deck against

these families, a disproportionate percentage of whom are led by single mothers, visible minority and aboriginal parents, and caregivers who live with (dis)Abilities.

As the literature describes, among Anglo-Saxon governments, there is a reluctance to recognize the needs of the great majority of families, unless those needs can be met through 'cheaper' means, such as sporadically placed volunteer home visiting programs, help lines, online parenting resources, or parent-child groups. When families cannot access these less expensive services, or when the complexity of their needs makes such services inappropriate or inadequate, those families are out of luck. This approach leaves a large group of 'at-risk' families without services.

Study participants have echoed the findings in the literature, which state that, when effective and responsive longer-term services are provided to these families, some of their difficulties can be resolved, reduced, and/or avoided. Often the complexity of this work means that (more expensive) skilled, paid staff members – either alone or in concert with volunteers – need to be involved with such responsive and longer-term services.

This under-served group of families are themselves more invisible, misunderstood, and scapegoated – some may even be vilified – than the more mainstream, lower-risk families who typically do well with the more straightforward support, such as volunteers visitors. Yet the more vulnerable families may not be *quite* high-risk enough to qualify for services from intensive 'targeted' programs. Thus, because of funding challenges that are themselves influenced by an under-valuing of these families, those who have greater needs are actually at increased risk of *not* having services available to them.

To illustrate the depth of these funding challenges, a comparison with public health services is useful. In Anglo-Saxon societies, public health services have a longstanding place within the health care system. Yet in many communities, including those in the present study, public health services are often not funded to a level that is

adequate to meet the needs in the community; how much harder, then, is it to secure funding to provide *non-medical* in-home parenting services, particularly for vulnerable families? Thus both the work itself, and the families most in need of service, are undervalued and misunderstood.

The following example from Utah illustrates the structural difficulties in meeting the needs of families who have elevated risks and/or complex needs, but do not qualify for intensive, targeted services. Thanks to dedication, not system design, some of these Utah County families have been able to receive service.

- At the time of this study, funding for home visiting in Utah County was severely limited (see Section 6.2). However, an interesting arrangement was developed to provide some staff availability for ‘medium-risk’ families. The two staff members in the United Way (volunteer) ‘wing’ of Welcome Baby had training in the Parents as Teachers (PAT) parent education program. In order for them to maintain their certification with PAT, both staff members were required to work with a minimum of five families each year. This ensured that they carried a small caseload at all times, comprised mainly of ‘medium-risk’ families. Some of these families were too complex to be matched successfully with a volunteer, but (as described in Section 7.7.4) they did not qualify for home visiting from the Utah County Health Department or other targeted services. Instead, partly owing to the PAT requirements, they were able to receive home visits from a United Way Welcome Baby staff member.

This arrangement was one of several examples of the creativity and efficiency of the Welcome Baby Utah County program – of how limited financial resources were used for the maximum community benefit. However, it was also a precarious situation: if, in the future, Welcome Baby’s United Way (volunteer) wing does not have staff members with both the commitment to these families, and the skill and availability to serve them, they may ‘fall through the cracks’ of this system.

Questions are also raised about how this program will continue to serve this population as Welcome Baby moves toward its goal of serving more first-time parents in Utah County. Without consideration of this matter, a situation could arise over time,

whereby those most at risk, and those least at risk, receive appropriate service, but an increasing number of 'medium-risk' families do not.

8.6.2 Funding Challenges Due to Program Models

As the United Way Welcome Baby manager explained, in the U.S., federal funding for volunteer home visiting "is a difficult thing ... I sat on [regional funding body] for the last two years, on home visitation. And it has been really interesting to see. There's three programs [*models*] that basically they are supporting." These three models are Nurse-Family Partnership, Healthy Families America, and Parents as Teachers. Two of these models strictly employ paid staff to deliver their targeted, curriculum-based programs (J. Kesner, B. Dew, C. Wessel; personal correspondence, 30 March 2010). The third model, Parents as Teachers, allows volunteers to deliver their curriculum, but requires completion of an intensive training program that may be too time-consuming for volunteers and too costly for volunteer programs. Indeed, United Way Welcome Baby staff members expressed regret that their program could not afford to train their volunteers in the Parents as Teachers curriculum.

Further, virtually all of the larger-scale American studies that have examined the effectiveness of home visiting models were carried out on programs that *only* have paid home visitors. It appears that there is just one home visiting program in existence which uses volunteers, *and* may have been researched sufficiently to be viewed as 'evidence-based,' *and* has shown strong results from that research: the Community Mothers Programme. Given that none of Community Mothers' research has been conducted in the U.S., and that the programs modeled after Community Mothers have been located outside the U.S., it is questionable whether the U.S. government would consider this research to establish a funding path for home visiting involving volunteers.

As noted in Section 3.2.1, eligibility criteria for participation in Nurse-Family Partnership programs is limited to families who do have certain risk factors – yet do *not* have other risks. Thus some vulnerable families who would be excluded from Nurse-

Family Partnership programs, would actually be eligible to receive service from each of the programs that took part in this study. Yet, if all three study programs were located in the U.S., not one would meet the criteria for the above-noted federal funding for home visitation (United States Department of Health and Human Services Press Office, 2010; Parents as Teachers, n.d.). Thus, ironically, three in-home programs that would *not* be eligible for U.S. federal funding have reported that they quite comfortably serve families with greater risks and challenges than those families served by one of the federally sanctioned, 'gold standard' U.S. programs.

Meanwhile, in Australia, universally available volunteer-based home visiting programs had enjoyed support in previous decades, but, as described in the following section, recent years have seen a shift to targeted programs with paid visitors, and several volunteer-based programs have ceased operations. As a result of all of these factors, when managers think about trying to prove the worth of their programs, they can be left feeling that there is a mountain to climb. As the manager of Welcome Baby stated:

...Nurse-Family Partnership, they put their research in place 30 years ago. You know, they've got longitudinal studies that are 24 years old. So how are you going to do that? I mean, you had community people that built [this program]. They weren't thinking, "Oh, I'm going to develop this so I can get [certain funding]."

8.6.3 Universal And Volunteer Home Visiting Programs: A Difficult Road Ahead?

The landscape of government funding for family service programs is constantly shifting. Models, approaches, and programming for various issues fall in and out of favour with changes in governments and public opinion, the emergence of new evidence, and the rise of certain schools of thought. Regardless of the trends, it appears that in western, Anglo-Saxon countries, neither *universal* nor *volunteer* home visiting programs reside within a favoured circle.

Indeed, through my correspondence and Internet searches over the past several years, I have learned that much has changed. Over the past 15 years, some former volunteer home visiting programs in the U.S. appear to have ceased doing in-home work: some have switched to paid home visitors working specifically with 'at-risk' families, volunteer hospital visits in the immediate post-partum period, and/or volunteer telephone support. Some American and Canadian programs (Kurnetz, 1983; L. Nuk, personal correspondence, 2000, 2002), appear to be no longer in existence; I have not been able to learn what became of them or why.

In Australia, while targeted home visiting programs staffed by professional home visitors are growing in number (F. Byrne, personal correspondence, 16 August 2010), several universally available volunteer programs have closed in recent years. For example, in 2005, Good Beginnings Australia was running home visiting programs at sixteen sites across the country: eleven volunteer programs, and five mixed-delivery programs (Good Beginnings Australia, 2005). At the time of this writing, only two of these sixteen programs remained in operation. In April 2010, the Community Mothers Programme in Perth, Western Australia, closed due to lack of funding; it had followed the mixed-delivery model (i.e., nurse visitors and volunteer visitors) of the Dublin Community Mothers Programme. Meanwhile, in the UK, some universal volunteer home visiting programs have also closed down, and some have experienced funding challenges over recent years [C. Suppiah, personal correspondence, March 2010]. Finally, of the eight home visiting programs that were approached to be involved with this study, all but two expressed concerns related to their funding situation that that time.

The scope of the present study did not allow investigation into why so many volunteer home visiting programs are no longer in operation. However, this international trend raises questions about the reasons for these closures, and what this may mean for both families in those communities and the programs that are still in operation. Therefore, it is recommended that research be undertaken as to the reasons

for these closures, their impacts (as known), and the current status and situation of the present-day complement of all home visiting programs that have volunteer visitors, including those that also have paid visitors. This recommendation is outlined further in Section 8.7.4.

8.6.4 Summary of Funding Difficulties

In the absence of legislated program standards for families with young children, organizations such as home visiting programs struggle not only to meet the high demand for their programs, but to simply stay in existence. At every turn, they have to argue, justify, and fight for resources, and they are vulnerable to the changing priorities of funders and larger sponsor organizations. This is one of the hallmarks of present-day residual, reactive and targeted systems: programs that are actually key to well-being are delivered sporadically by voluntary sector organizations, whose services can fairly easily be reduced or withdrawn, in part because they fall outside of the realm of statutory government responsibility. Given the lack of public understanding of the nature of these services and the needs of the families they serve, and the lack of value placed on preventative and early childhood services, this struggle shows no sign of easing.

8.7 RECOMMENDATIONS FOR FUTURE RESEARCH, PRACTICE AND POLICY

8.7.1 Limitations of the Present Study

This present research was a preliminary exploratory study of three home visiting programs. It was small in scope, and provided a snapshot of three programs at a given time in their development and operation, based on the experiences and insights of four to six people who were involved with each program as volunteers or staff members (and one representative of a key partner organization). Thus, input was not received from a majority of those who volunteer or work in the programs. Time limitations did not enable me to interview a program history participant for one program; as a result, the historical perspective on that program was not as full and complete as for the other

programs. The findings were filtered, to some extent, through my own lens, as the researcher and as someone who works in this field.

In a case study of three programs, the researcher(s) would normally conduct their research on-site, gleaning all the rich information provided therein; however, the scope and budget of the present study did not allow for international travel. In part as a result of this, there may be aspects of the programs' local and national contexts, and the programs themselves, that were missed and/or misinterpreted.

My own experience in home visiting, combined with my status as a novice researcher, led to a potential shortcoming of the study. As noted in Chapter 5, on several occasions, participants related an experience, opinion, or sentiment that, at the time, made sense to me and seemed to require no further clarification; my own familiarity with home visiting allowed me to easily understand and relate to participants' responses. Not having previously conducted original research, I did not know how much I would later wish I had probed more. I was able to address some of these instances through the interpretations that I added to the transcripts; through the member validation exercise, participants had the opportunity to confirm, correct, or add to my understanding of what they had said. However, if I were to do interviews again, I would approach the exercise with a more well-developed plan to probe even those responses that seemed fairly straightforward, as this is key to being certain of one's understanding.

8.7.2 Dissemination of Findings

Broad dissemination of the findings is a priority; with this in mind, I will seek participation in conferences, and may undertake knowledge transfer activities with specific groups, such as home visitors, program administrators, or policy/program developers. Each program that took part in the study will receive an electronic copy of the thesis, as will those individual participants who expressed an interest. All participating programs and individuals, along with organizations that have expressed an

interest in this project, will receive a plain-language Executive Summary, suitable for inclusion in an agency newsletter or posting on an agency web site. The Executive Summary will also be sent to email lists and online forums whose members are drawn from related fields –home visiting, volunteer management, family services, program development and evaluation, and health system transformation. I may also pursue publication of the findings in a peer-reviewed journal such as the *Canadian Journal of Public Health* or the *Non-profit and Voluntary Sector Quarterly*.

8.7.3 Recommendations For mixed-delivery Home Visiting Programs

- 1. Programs should increase awareness regarding the full scope of work of the paid staff members, especially the nature, extent, and value of the direct services that paid staff provide to families.**

Specifically, awareness should be increased among those closest to the program – volunteer visitors, sponsor organizations, community partners, referral sources, and funders. Increased public awareness is also suggested.

As discussed in Section 7.1, several study participants had limited knowledge of the in-home work that paid staff do with families, particularly families who were assigned solely to a staff member (that is, families who were on a staff member’s own caseload). However, as discussed previously, this direct work with families played a crucial role in several aspects of each program, and this was the area most often cited as presenting funding challenges.

Lack of awareness of staff members’ in-home work was consistent, perhaps, with the public face of the programs; as discussed in Section 6.4.2, in all three programs, volunteer visitors were the focus. Study participants stressed the benefits of programs being viewed publicly as volunteer home visiting services. None of the three programs had an adequate staff complement to respond to any increase in referrals of families in need of extensive home visiting by paid staff. This is a potential outcome of publicizing the presence of skilled professional home visitors; programs that attempt to raise awareness of the services provided by staff members may be in a difficult position.

However, given the funding challenges facing these and other mixed-delivery programs, particularly funding for the in-home work of paid staff members, a lack of awareness of the nature, extent and impact of staff members' direct work with families is clearly not in the programs' best interest.

Staff members' work should be communicated with both seriousness and a pride in the ways that this delivery model makes important differences for children and families. These programs are in an excellent position to educate people regarding the multifaceted effectiveness of providing 'higher-needs' families with longer-term service that is supportive, responsive, and highly skilled. Everyone – volunteers, stakeholders & partners, potential funders, the public – needs to know exactly what these staff members do, why their work is effective, and how valuable it is.

2. As feasible, programs should seek out ongoing communication and/or collaboration with other home visiting programs, and in particular, other mixed-delivery home visiting programs.

One of my own reflections regarding this study relates to the benefits I have received from learning about other programs. To the extent that distance and busy schedules will allow, program staff should be supported in efforts to be in contact with other programs. As a starting point, with the permission of the manager of each program, I will be forwarding a contact list to all mixed-delivery programs.

3. As necessary, programs should enhance program evaluation and data collection.

Home visiting programs should review their current ongoing data collection and evaluation methods vis-à-vis tracking the impact of the program on families, volunteers, and the broader community. If these are found to be lacking, it is recommended that programs make it a priority to improve these mechanisms. Once effective systems are in place, relevant data can be collected on an on-going basis, and can provide key contributions to program planning, development, and evaluation. As this will require additional resources, funders are urged to support such efforts.

To reduce workload and increase access to data collection resources and options, programs may want to investigate the feasibility of developing these systems in concert with other home visiting programs, either in their home country or internationally.

Additionally, mixed-delivery programs that have not done so may wish to consider undertaking a comprehensive program evaluation of their service. Indeed, such an evaluation can lay the groundwork for improved data collection and monitoring, on an ongoing basis.

Programs must be wary of the automatic deferral to randomized control trials as the 'gold standard.' Conducting such a trial can be very expensive, and many home visiting programs have encountered difficulties or critiques when conducting such studies; further, an RCT may not capture the information that programs most want or need. Indeed, a range of qualitative research and evaluation methods can be employed to capture the rich experiences of families, volunteers, staff, and referral partners. These can be used in conjunction with ongoing data and statistics compiled by the programs themselves.

Programs can also collect ongoing data regarding having both volunteers and paid staff (For example: In the run of a year, how many consultations did program staff do with volunteers? With families? Regarding what topics and issues? How many times were families moved from working with one type of visitor to another, and what were the reasons? Were families' perceptions affected – positively or negatively – because a program was viewed as a volunteer service?). Additionally, small home visiting programs can investigate the possibility of making use of the large and ever-growing body of existing research and evaluation on home visiting; they may not necessarily have to conduct original research.

8.7.4 Directions for Future Research

Research Direction #1:

Further Research into Mixed-Delivery Home Visiting Programs

Further research is needed to continue to gain insight into these services. Research should be done with families to ascertain what benefits and challenges they see in having both paid and volunteer visitors. Families in these programs, as well as community partners and referral agencies, need to be heard, in the same way that staff and volunteers were 'heard from' in the present study. Because individual families and referral partners do not have the same depth and breadth of experience as volunteers and staff, a larger sample size would be warranted.

As well, there may be a role for comparative research, perhaps between three programs, or three branches of the same organization – for example, one study site with paid home visitors, one with volunteers only, and one with paid visitors only. Research could also be conducted using a control group with standard existing community supports, and an intervention group that also received service through a mixed-delivery home visiting program. This would allow for a clearer understanding of the differences between various types of programs, which could inform program developers and policy makers.

Further research on successful components of mixed-delivery programs is also warranted. There are 'best practice' guidelines for volunteer home visiting programs (Good Beginnings Australia, 1999) and program standards for the various models of home visiting with paid visitors. Similarly, standards should be developed to guide those in-home programs that wish to adopt a mixed-delivery staffing structure and approach. This would greatly aid such programs in avoiding pitfalls that others have already experienced and addressed, and contribute to the successful implementation of new mixed-delivery services.

Research Direction #2:

Immediate Research into the State Of Volunteer And Mixed-Delivery Home Visiting Programs

As outlined in Section 8.6.2, in conducting this study, two things have become clear. First, in recent years, and at the present time, there have been numerous changes and shifts taking place to, and within, programs that have volunteer (or both volunteer and paid) visitors. Second, many programs with both paid and volunteer visitors are facing challenges relating to funding. Reflecting on these findings, it is my recommendation that, as soon as possible, an international scan be conducted with regard to the present state of all family home visiting programs with volunteer visitors. Such a scan should include programs with volunteer visitors only, and those with both volunteer visitors and (one or more) paid visitors. The scan should examine these and other questions:

1. How many programs with volunteer home visitors are in existence at present?
2. How many programs have closed, or opened, or opened and closed, within the past twenty to thirty years?
3. What are/were the characteristics of each program? (size of program, scope and type of services, service delivery format, home base/sponsor agency, funding sources, size and roles of staff team, et cetera)
4. Are there common characteristics among the programs that have opened in recent years? Among those that have closed? Among those that have remained in operation?
5. How many programs have shifted from volunteers working in families' homes, to in-hospital and/or over the phone? Have other significant changes occurred – such as a shift to paid home visitors, or a change in funder or sponsor organizations? If so, what have been the impacts and outcomes of these changes?
6. Do programs have funding that is reliable and adequate? What are their funding sources? If programs have funding challenges, what are they?

7. How is volunteer home visiting viewed, or understood, in the communities where it exists? Has that shifted over time?
8. What about the availability of volunteers in changing economy and demographics? What are the characteristics of the people who are coming forward to volunteer? Have these shifted over time?
9. When programs close, **why is this?**
 - a). What happens to the families who, in the past, would have been served by these programs?
 - b). Are new programs and services replacing the volunteer home visiting programs? If so, are these seen as progress, or a step backward?
 - c). What about the social cohesion and social capital aspects of volunteer programs? Are these lost when a program closes?

Such research will provide insight into the course of events for programs that have closed, common challenges facing existing programs, and the viability of the sector overall. It may also identify adaptive and other strategies that have allowed some programs to thrive while others have been closed. Finally, it may shed light on the causes of program closures and the impacts on families and communities because of these closures.

***Research Direction #3:
What the Findings of This Study Do Not Support***

This study did not reveal any widespread or outstanding concerns regarding the challenges of paid and volunteer visitors working well *together*. All fourteen study participants expressed sincere appreciation for one another's work, and an understanding of the complementary and beneficial nature of the roles of both paid and unpaid visitors. Therefore, one area of further study that would *not* be specifically recommended is identifying and examining tensions and conflicts between paid and volunteer visitors who work in the same program.

This point is worth highlighting here because of the common reaction among individuals, upon hearing of this study, that the research would examine the tensions

and role conflicts between paid and volunteer visitors, and/or compare the two types of visitors to determine which type was “better.” These reactions were prevalent among individuals not directly involved with home visiting; however, some people involved with home visiting programs also made these assumptions. While there may be some home visiting programs that do experience difficulties in staff-volunteer relations, the findings from this study do not suggest that this is a priority area for further investigation.

At the same time, several participants (both staff and volunteers) did express that, because staff members had a significant influence on volunteers’ experiences in these programs, paid staff must be well-suited to working with volunteers. Thus a question that may be worth pursuing is, “What features – such as staff qualities and skills, or program policies and procedures – best support volunteer visitors’ effectiveness and retention in mixed-delivery programs?” Research on this question would also contribute to the development of guidelines for mixed-delivery programs (see Research Direction #1). I have only come across a few published articles that speak to this question. However, as I did not conduct a literature search specifically on this question, at this time I can only suggest that developing new knowledge and insight on this topic may be a useful endeavour.

CHAPTER 9: CONCLUSION

In this chapter, I will provide a high-level overview of the “lessons learned” from the present study, and reflect on the implications for the public policy realm, the fields of social work, health care, and early child development, and my own professional practice.

This study may well be the first to explore the challenges, strengths and opportunities of having both paid and volunteer visitors within the same family home visiting program. Using a qualitative embedded multiple case study approach, interviews were conducted with fourteen individuals affiliated with three established programs, in three different countries. A range of program documents were also reviewed, including training and publicity materials, historical information, reports to funders, and the results of a program evaluation and follow-up study.

Study participants expressed a deep commitment to families in their communities, and to home visiting as an effective way of providing parents of infants and young children with support, education, assistance, and information on community resources. Participants valued this particular mixed-delivery structure, and believed that it provided many benefits, not only to families, but also to volunteers, staff, and the program overall. Highlights of the strengths and challenges of this mixed-delivery program structure are outlined below.

9.1 OVERVIEW: STRENGTHS OF MIXED-DELIVERY PROGRAMS

Study participants believed that having volunteers and paid visitors allowed for the best of both worlds – that is, the strengths of a volunteer home visiting program *and* a program with paid home visitors – to exist within the same service. The non-threatening image of a volunteer visiting program made programs more acceptable and appealing to families, and the volunteers themselves provided an informal, locally based and experienced ‘peer support’ workforce – at minimal cost. Participants also described how volunteer home visiting increased community cohesiveness, social integration, and

social capital. Equally important, the presence of one or more staff members who were adept at working with families ensured in-house professional experience, knowledge, and skills, which allowed programs to respond effectively to the wide range of needs presented by families.

Additional benefits were experienced because volunteer and paid visitors complemented and built on one another's strengths. A team of volunteers could visit many more families than the staff member(s) who would be employed with the same amount of money; they formed a trusting rapport with families, and were a regular and supportive presence in families' lives at a critical life stage. When volunteers required support for the issues that arose through home visiting, they could turn to staff members for guidance and back-up; volunteer study participants uniformly expressed that they had benefited greatly from staff guidance, expertise, and support. This, in turn, allowed volunteers to learn from each 'match' family experience, continually increasing their capacity to handle an ever-growing range of situations. Staff also acted as a protection for volunteers from having to work within family situations that were overwhelming or dangerous, as staff could be assigned to these families instead. However, volunteers in all three programs generally provided a great deal of information and support to parents on their own, which freed up staff to work with the families on their caseloads, assist other volunteers with complex situations, and carry out their administrative and management duties. Information shared by participants suggests that this structure may also enhance volunteer retention.

Two of the study programs provide a curriculum-based program of education and support. Study participants from all roles within these programs emphasized the importance of paid staff members (both front-line staff and managers) carrying out home visitor duties, stating that if staff members did not do home visits themselves, they would not be able to provide credible and relevant guidance to volunteers regarding the effective implementation of the curriculum.

9.2 OVERVIEW: CHALLENGES OF MIXED-DELIVERY PROGRAMS

Several participants shared one or more challenges relating to having both volunteers and staff involved in the same home visiting programs, though a few participants stated that they could not think of any such problems. Most of the challenges were named by a single participant, so few program-level difficulties stand out as common or widespread concerns.

The challenges that were raised across all three programs related to two areas. First, all three programs had had difficulties maintaining adequate funding, particularly for front-line staffing positions. Participants from two programs specifically reflected that it was difficult to get funding for paid home visiting; in targeted and residual systems, funders were most interested in either volunteer visiting, which was less expensive to operate, or funding for staff positions in programs designated for only the most at-risk families. Anglo-Saxon governments appear to be content to leave the majority of young families to struggle alone through their difficulties, even though over time, problems can escalate, and damage can be done at a developmentally critical time of life.

Second, programs were in a position of vulnerability vis-à-vis their larger sponsor/partner organizations. However, while at least one participant from each program provided an example of a difficulty in this area, these individuals, and most other participants, also stressed the many benefits of being linked to the larger partner and sponsor organizations.

An important lesson learned from this study is that several forces appear to be influencing these mixed-delivery programs, and they have the potential to create significant challenges. These forces are:

- the profound lack of research on mixed-delivery programs;
- a recessionary era that follows on the heels of over two decades of cutbacks to health, social service, and voluntary sector organizations;

- a limited societal valuing and understanding of the important benefits, to families from all backgrounds, of universally available programs – particularly those programs that can provide universal-plus services tailored to families’ needs; and
- a reluctance on the part of governments to accept that the vast majority of parents of young children need ongoing access to various forms of support and information.

These forces signal a potentially difficult road ahead for mixed-delivery and volunteer visiting programs.

9.3 THE PROMISE OF THIS MODEL – FOR FAMILIES AND BEYOND

Findings from the present study indicate that this mixed-delivery approach to in-home services shows promise as a responsive, cost-effective staffing model that increases service accessibility and impact and strengthens the capacity of communities to respond to pressing health and social needs of families with young children, and possibly other populations as well.

Indeed, the potential applications for this staffing model are diverse and exciting. Given the increasingly complex challenges confronting the health and social service sectors, and the realities of an aging population, socially fragmented urban centres, and depopulated rural areas, innovative models of care and service are required (Shugart, 1992). For example, the Nova Scotia government has committed to “broaden our focus from the treatment of illness, to include maintaining and improving health,” and to adopt new program and staffing strategies, such as the use of “non-clinical support services” (Nova Scotia Department of Health, 2008); this will necessitate significant changes in how health care is designed, accessed, and provided. The mixed-delivery approach may be of interest to those striving to meet the needs of different populations, such as isolated seniors, newly settled immigrants and refugees, families whose children have complex dis(Abilities), and people going through a crisis or difficult life transition.

Those considering such an approach must take into account the costs of qualified staff to coordinate and supervise volunteers, provide direct in-home services, and manage the program. They must also consider the readiness of sponsor organizations, such as health authorities, to deploy volunteer home visitors meaningfully and effectively, given that, in many instances, this would represent an entirely new approach to service.

9.4 IMPLICATIONS FOR MY OWN WORK IN THIS FIELD

This research has changed how I view the program I coordinate. I now see our work as part of a group of mixed-delivery programs that share many common features. In conversation, I find myself referring to the practices and philosophical approaches of other programs, to their developmental and funding milestones and challenges, and to the findings of various studies. I do this in part to help inform our thinking and practice, and in part to highlight to volunteers, staff, and others, that we are not alone in this work.

I have developed a deeper understanding and analysis of the roles that evaluation and research ‘evidence’ play in this field. This was one of my primary goals in undertaking original research. While I am discouraged by the challenges of conducting and analyzing research on these programs, and the lack of a clear path from evidence to program sustainability, I am nevertheless pleased to have a better understanding of this complex landscape.

I now see our actual and potential program impacts more clearly, and as a result, I have new ideas about how we can better meet the needs of families in our community. Some of these ideas involve strengthening our existing services, and some involve moving in strategic directions to be able to serve more families, more effectively. Given what I have learned about integrated systems, collaboration with multiple partners and stakeholders will be my top priority for any efforts at expanding services. However, the local context presents a daunting picture: three levels of government marked by silos

and separation; a targeted, residual and often punitive government social services system, and an underfunded non-profit sector with almost no infrastructure to support collaboration. Additionally, there is limited public understanding of the need for preventative and early childhood services; ballooning health care costs vie for limited health care dollars; and the funding opportunities from public, private, and charitable sources are severely limited.

Fortunately, there are also individuals and organizations in many corners who do see the need for integrated, universally available preventative services, and who understand the interconnectedness of the health, education, justice, social services, and economic sectors. The challenge is in whether, within this difficult environment, those of us in the latter group can mobilize sufficient awareness and pressure to bring about systemic change.

9.5 RELEVANCE TO THE HEALTH, SOCIAL SERVICES, AND EARLY CHILDHOOD SECTORS

As outlined below, the strengths and benefits of a mixed-delivery approach to service are relevant not only for other home visiting programs, but for health and social service systems overall.

- Mixed-delivery programs are an example of the benefits of integrated services, a concept long championed by many experts in early child development. Additionally, as outlined in Section 8.2, larger scale, inter-sectoral integration and collaboration must form the foundation of any solutions to the current crisis in early child development.
- These programs offer one model of a *tailored, responsive, and accessible* method of delivery for universal services. This is because they possess both the strengths of universally available programs, and the ability to tailor services to families with more barriers and burdens – a concept that I have called ‘universal-plus.’
- Several of the program features described above contribute to the study programs’ ability to serve families who have multiple and elevated risks to child and family well-being. Since it is widely recognized that these families are among the least

likely to engage and maintain involvement with formal services, and yet are more likely to experience significant difficulties and negative outcomes as their children grow, programs that can work effectively with these families should be supported, further developed and expanded, and adapted to other settings.

- These programs can provide families in difficult circumstances with the short-term or long-term services of a skilled staff member, without having to “refer out” to a separate service. As discussed in Section 8.5, this has multiple and far-reaching benefits, including improving the entire health and social service system’s ability to serve families who are at elevated risk for poor outcomes.

9.6 IMPLICATIONS FOR PUBLIC POLICY AND SOCIAL WORK

9.6.1 Public Policy and Home Visiting

Early childhood services such as home visiting can play an important role in helping to ensure that children’s early experiences protect their ability to learn, grow, relate well to others, enjoy mental and physical health throughout their lives, and make positive contributions to their families and communities. However, experts in the field have concluded that no single service can address existing problems and ensure healthy development for all young children (Gomby et al., 1999). Further, when early childhood services are fragmented, inadequately funded, and limited to certain geographic areas (as is the case with the programs and communities in this study), they can only serve a small percentage of families with young children in the overall population, leaving many to go without (McCain et al., 2007). This situation should be of prime concern to policy makers faced with ballooning budgets for reactive, remedial and tertiary-level programs in social services, education, justice, and health care. Prevention avoids the strain, heartache and failure that characterize these reactive programs. It is also more effective, and, given its higher rate of return on investment, less expensive as well (Heckman & Carneiro, 2003).

Philosophically, each of the three study programs shared many similarities, although they did not use the same words to describe their approaches. Terms used (by

study participants and in program documents) included empowerment approach, community development model, strengths-based, the Connect approach, asset-based, and parents as experts. This was true even for Good Beginnings, where many families were referred specifically due to an identified need for parenting education; one Good Beginnings volunteer related that each family was like a “boat in a storm in the middle of the sea, and we are like a ship. We come alongside and support them and help them, but we don't tell them what to do.” By and large, study participants also described many of the difficulties facing families as being externally rooted in the difficult social and economic structures of the larger community. One manager illustrated this poignantly. Reflecting on the high incidence of post-partum depression in the local area, she asked, with a tone of frustration and disbelief: “What have we done in our society, that women are so disconnected?” Many of the perspectives embraced by these programs are rooted in the feminist ideas that each woman is the expert on her own life, and that powerful, often oppressive, social and economic forces shape women’s lives.

As outlined in Section 3.5.2, these perspectives are quite different from the more individual and deficit-oriented stances officially adopted by many home visiting programs in the second half of the twentieth century, particularly targeted programs with paid visitors. These programs often focused primarily on child-related outcomes (see page 35 for details), and lacked a critical analysis of the social determinants of well-being and the difficult positions of overburdened parents – most commonly, mothers, and particularly, low-income single mothers. As a result, implicitly or explicitly, some programs seemed to ignore mothers’ needs and/or blame mothers for their own and their children’s difficulties. As noted earlier, this stance can both mask the socially rooted difficulties faced by families, and impair the formation of an empowering and supportive therapeutic alliance between mothers and home visitors. The three programs in this study have shown that it is possible to work for children’s well-being by explicitly supporting mothers, as women and as parents; by following mothers’ lead on

their parenting priorities; and by bringing families new information in ways that empower mothers to be the experts on their own children. Indeed, research from the Community Mothers Programme suggests that this approach is quite effective.

At times, individually focused and deficit-based approaches have been widely promoted by those who fund and/or write about targeted programs with paid visitors; however, this stance is in direct opposition to the values and beliefs espoused by many helping professions, including social work and nursing. Indeed, in a neo-liberal era rife with punitive ideological perspectives, it is possible that targeted, direct-service programs that are not rooted in one specific profession may be particularly vulnerable to adopting deficit-based and client-blaming approaches. Thus professional organizations, such as the Canadian Association of Social Workers, can have a key role to play in shaping these programs' approaches to practice, by advocating for strengths-based services with a critical social analysis (e.g., structural-feminist).

9.6.2 Social Work and Home Visiting

Those involved with the programs in the present study expressed that having a mix of volunteer and paid home visitors can both engage and retain vulnerable, overburdened, and at-risk families. These are the very same families who, without such intervention, may later become involved in services that fall under the purview of social workers – child protection, family preservation and reunification programs, foster care, and group homes. These families may also require services in which social workers play a significant role, such as mental health, addictions, and corrections.

All of these services are tertiary-level and expensive, and the problems that give rise to their necessity are often preventable. As outlined in Chapter 2, the damage done to young children because of these experiences may never be fully healed or remediated.

Social workers are all too familiar with these outcomes. Those who work on the 'receiving end' of these complex problems are in a unique position to call attention to

the need for effective prevention and early intervention programs; indeed, I believe that, as social workers, each of us has an ethical responsibility to do just that.

9.6.3 Implications for Those Who Shape Public Policy

Budget shortfalls, demographic realities, economic concerns, and decisive research on human development are converging with a message that should propel public policy makers, and major health and social agencies, to look upstream, at prevention and early intervention. This is where home visiting programs and other early childhood services reside. Additionally, as expressed by participants in this study, staff and volunteers of these mixed-delivery programs may have the skills and the organizational structure to work well with overburdened, under-supported families who face many risks. Investment in such programs can play a key role in intervening with families early on, thus reducing and averting the need for costly child protection, mental health, remedial education, and correctional services.

9.7 IN CLOSING...

As discussed in Chapter 2, societies have changed, families' realities have changed, and our knowledge of what children actually need in their earliest years has increased, but our support systems for families and children have not kept pace. Wealthy, post-industrialized capitalist countries have social-political-economic structures, and populations, with certain characteristics that increase child and family vulnerability. To varying degrees, many parents are left to fend for themselves.

Services such as home visiting programs, which *intentionally* insert sources of support and information into families' lives, can provide parents with information and support during the critical early years. In doing so, these programs can lay the foundation for parental confidence and competence, healthy child development, and enhanced connectedness to the local community. While home visiting cannot alleviate all of the structural and/or personal challenges faced by many families, the relationship with a volunteer or paid home visitor can strengthen parents' resilience in the present,

and for the future (Acton, 2005). Findings from the present study suggest that several features of mixed-delivery programs allow services to be extended effectively to a broader range of families, while maintaining budget efficiencies and building on the strengths of community volunteers.

This study marks the first step toward gaining a better understanding of home visiting programs that have both volunteer and paid visitors. Further research will continue to develop this understanding. At the same time, these programs face funding uncertainties due to the residual, targeted nature of family service systems in Anglo-Saxon countries, and the low priority placed on understanding and meeting the real needs of young children and their families. The attention of those in the field may need to be directed toward these pressing matters, in order to simply maintain existing programs. As one study participant, a volunteer visitor with grown children and grandchildren of her own, related:

I am just very pleased that there is an organization like [this program] around now. I mean, I felt, when I was younger, I had a lot of problems ... or not a *lot*, but I had problems. But I did have support, in that I had my parents and I had my parents-in-law. And I had a very good lot of friends around, that we would ring each other up and support each other if we had problems. But the problems seem to be getting larger and more diverse this day and age, for young mums. And I just think a lot of families might go under, without supports like [this program].

REFERENCES

- Acton, J. (2005, December). *Small things make a world of difference: Creating healthier and more resilient families* [Unpublished program evaluation]. Halifax, NS: Extra Support for Parents Volunteer Service, IWK Health Centre.
- Ascoli, U., & Cnaan, R. A. (1997). Volunteering for human service provisions: Lessons from Italy and the U.S.A. *Social Indicators Research*, 40(3), 299-327. doi:10.1023/A: 1006876528133
- Atkinson, R. (2008). *Safely on your way: Child custody and access information for women leaving abusive relationships and their service providers*. Halifax, NS: Legal Information Society of Nova Scotia.
- Bardon, A. (2006, October). Ireland: Mothers talking to mothers. *UNESCO Courier* [online version] (pp. 10-11). ISSN 1993-8616. Retrieved from <http://unesdoc.unesco.org/images/0019/001915/191574e.pdf>
- Bennett, J. (2008). Early childhood education and care systems in the OECD countries: The issue of tradition and governance. In R. E. Tremblay, R. G. Barr, R. DeV. Peters, & M. Boivin (Eds.), *Encyclopedia on early childhood development* (pp. 1-5) [online version]. Montreal, QC: Centre of Excellence for Early Childhood Development. Retrieved from <http://www.child-encyclopedia.com/pages/PDF/BennettANGxp.pdf>
- Black, M., & Kemp, L. (2004). *Volunteer home visiting: A systematic review of evaluations*. Sydney, AUS: Centre for Health Equity Training, Research and Evaluation, University of New South Wales. Retrieved from <http://notes.med.unsw.edu.au/CPHCEWeb.nsf/page/Reports>
- Black, M., Kemp, L., & Samson, V. (2004, November). *Karitane volunteer home visiting program evaluation*. Sydney, AUS: Centre for Health Equity Training Research & Evaluation. Retrieved from <http://chetre.med.unsw.edu.au/files/Karitane%20Final%20Report%20for%20printing.pdf>
- Bremberg, S. (2009, May 14). A perfect 10. Paper presented at the conference of the Council for Early Child Development, Sackville, NB.
- Brudney, J. L. (1990). Expanding the government-by-proxy construct: Volunteers in the delivery of social services. *Non-profit and Voluntary Sector Quarterly*, 19(4), 315-328. doi:10.1177/089976409001900403

- Bryce, H. (2000, August). Northern Lakes Home Visiting: External Evaluation. Northern Wyong Shire, NSW: University of Newcastle, UnitingCare Burnside, & Northern Lakes Home Visiting External Evaluation Team.
- Bryman, A., & Teevan, J. J. (2005). *Social research methods – Canadian edition*. Don Mills, ON: Oxford University Press.
- Bulkeley, D. (2005, October 13). Utah birthrate is tops. *Utah: Deseret Morning News*. Retrieved from <http://www.deseretnews.com/article/635152902/Utahs-birthrate-is-tops.html>
- Byrne, F., & Kemp, L. (2009). *Volunteer home visiting programs: A review of evaluations*. Sydney, AUS: CHETRE for the Department of Community Services on behalf of Families NSW.
- Calman, L. J., & Tarr-Whelan, L. (2005). *Early childhood education for all: A wise investment*. Retrieved from <http://www.familyinitiative.org>
- Campaign 2000 (2008). *Family security in insecure times: The case for a poverty reduction strategy for Canada – 2008 report card on child and family poverty in Canada* [Broadsheet report]. Toronto, ON: Author. Retrieved from <http://www.campaign2000.ca/C2000ReportCardFINALNov10th08.pdf>
- Canadian Council on Social Development (2006). *The progress of Canada's children and youth*. Ottawa, ON: Author.
- Cant, R. (1999). *Evaluation: National Good Beginnings Parenting Project: Executive summary*. Retrieved from <http://www.goodbeginnings.org.au>
- Carniol, B. (2005). *Case critical: Social services and social justice in Canada* (5th ed.). Toronto, ON: Between the Lines.
- Central Statistics Office (2010, September). *Population and migration estimates, April 2010*. Dublin, Ireland: Author. Retrieved from <http://www.cso.ie/releasespublications/documents/population/current/popmig.pdf>
- Centre for Community Child Health (2008). *Hobart Early Years Centre evaluation data for July, 2007 – June, 2008*. Victoria, AUS: Author.
- Centre for Community Child Health (2009, January). The impact of poverty on early child development. *Policy Briefs, 14*, 1-4. Melbourne, AUS: Royal Children's Hospital. Retrieved from http://www.rch.org.au/emplibary/ccch/PB14_Impact_Poverty_ECD.pdf

- Centre for Community Child Health (2010, June). Engaging vulnerable and marginalised families. *Policy Briefs, 18*, 1-4. Melbourne, AUS: Royal Children's Hospital. Retrieved from http://www.rch.org.au/emplibrary/ccch/PB18_Vulnerable_families.pdf
- Citizens Information (2011a). *Early childhood care and education scheme*. Retrieved from http://www.citizensinformation.ie/en/education/pre_school_education_and_childcare/early_childhood_care_and_education_scheme.html
- Citizens Information (2011b). *Early Start Programme*. Retrieved from http://www.citizensinformation.ie/en/education/pre_school_education_and_childcare/early_start.html
- Colman, R. (2003). *The Economic value of civic & voluntary work in Canada*. Glen Haven, NS: GPI Atlantic.
- Community Mothers Programme (2008). *2008 Annual Report*. Dublin: Author.
- Corrigan, Carmel (2003). OECD Thematic Review of Early Childhood Education and Care, Background Report – Ireland. Dublin: Department of Education and Science.
- Cote, S. M., Boivin, M., Nagin, D. S., Japel, C., Xu, Q., Zoccolillo, M., et al. (2007). The role of maternal education and nonmaternal care services in the prevention of children's physical aggression problems. *Archives of General Psychiatry, 64*(11), 1305-1312. doi: 10.1177/089976409001900403
- Council on Community Pediatrics (2009, February). The Role of Preschool Home-Visiting Programs in Improving Children's Developmental and Health Outcomes. *Pediatrics* 123(2):598-603 (American Academy of Pediatrics) . Retrieved from: www.pediatrics.org/cgi/doi/10.1542/peds.2008-3607
- Creswell, John W. (2007). *Qualitative inquiry and research design: Choosing among five approaches (2nd edition)*. Thousand Oaks, CA: Sage.
- Daro, D., McCurdy, K., Falconnier, L., & Stojanovic, D. (2003). Sustaining new parents in home visitation services: Key participant and program factors. *Child Abuse and Neglect, 27*, 1101-1125. doi:10.1016/j.chiabu.2003.09.007
- Davidson, L. (2010, March 24). Provo-Orem, Logan among national leaders in population growth. *Salt Lake City: Deseret News*. Retrieved from http://findarticles.com/p/articles/mi_qn4188/is_20100324/ai_n52899248/
- Davis, R. (2010, October 11). It's time for change in Utah County. [Online version]. Provo, Utah: Daily Herald. Retrieved from http://www.heraldextra.com/news/opinion/utah-valley/article_dc4a6a1b-aed9-582b-8712-58a25e71a632.html

- DePoy, E., & Gitlin, L. N. (1998). *Introduction to research: Understanding and applying multiple strategies*. St. Louis, MO: Mosby.
- Doherty, G. (2007, December). Ensuring the best start in life: Targeting versus universality in early child development. *Choices*, 13(8). Retrieved from <http://www.irpp.org/indexe.htm>
- Downie, J., Clark, K., & Clementson, K. (2004, December - 2005, January). Volunteerism: 'Community Mothers' in action. *Contemporary Nurse*, 18(1-2), 188-198.
- Eakin, L. (2001, September). *An overview of the funding of Canada's voluntary sector*. Ottawa, ON: Voluntary Sector Initiative Working Group on Financing.
- Extra Support for Parents Volunteer Service (2008a, July). ESP program overview [information package]. Halifax, NS: Extra Support for Parents Volunteer Service, IWK Health Centre.
- Extra Support for Parents Volunteer Service (2008b, April). Focus on ESP. Retrieved from <http://www.iwk.nshealth.ca/index.cfm?objectID=294396BB-D4F3-DBC0-0CF791E59396FFA4>
- Faulconer, J. (2011, April 13). "Beyond" the Provinces. [Online column, "Speaking Silence"]. Retrieved from <http://www.patheos.com/Resources/Additional-Resources/Beyond-the-Provinces-James-Faulconer-04-14-2011.html?print=1>
- Felesky, L., & Kirshner, M. (2005, Summer). The mother load. *Herizons: Women's news and feminist views*, 19(1), 28-30.
- Fergusson, D. M., Grant, H., Horwood, L. J., & Ridder, E. M. (2005). Randomized trial of the Early Start program of home visitation: Parent and family outcomes. *Pediatrics*, 117(3), 781-786. doi:10.1542/peds.2005-1517
- Fitzpatrick, P., Molloy, B., & Johnson, Z. (1997). Community mothers' programme: Extension to the travelling community in Ireland. *Journal of Epidemiology and Community Health*, 51, 299-303. doi:10.1136/jech.51.3.299
- Flynn, C., & Hewitt, L. (2007, June). Community Bubs program evaluation final report. Sandringham, Victoria: Southern Family Life Service Association Inc. Retrieved from www.familylife.com.au
- Gardner Pinfold (2010, October 14). The state of health of the non-profit/voluntary sector in Nova Scotia: A discussion paper. Retrieved from http://foco.ca/online_documents/Documents%20%20NS%20Nonprofit%20Sector%20Labour%20Force%20Discussion%20Paper.pdf

- Gomby, D. S. (1999). Understanding evaluations of home visitation programs. *The Future of Children, 9*(1), 27-43. doi:10.2307/1602720
- Gomby, D. S., Culross, P. L., & Behrman, R. E. (1999). Home Visiting: Recent program evaluations – Analysis and recommendations. *The Future of Children, 9*(1), 4-26. doi:10.2307/1602719
- Good Beginnings Australia (2010, January). Children and Parenting under the Family Support Program: Performance Report [unpublished report to federal government funding body, for the period 1 July 2009 to 31 December 2009]. Haymarket, NSW: Author.
- Good Beginnings Australia (n.d.). *About Us*. Retrieved from www.goodbeginnings.org.au/about-us
- Good Beginnings Australia (1999). Best practice guidelines for volunteer home visiting. Retrieved from www.goodbeginnings.net.au/pdf/guidelines.pdf
- Goodman, A. (2006, July). *The story of David Olds and the Nurse Home Visiting Program*. Princeton, NJ: Robert Wood Johnson Foundation.
- Gray, J., Spurway, P., & McClatchey, M. (2001, May). Lay therapy intervention with families at risk for parenting difficulties: The Kempe Community Caring Program. *Child Abuse and Neglect, 25*(5), 641-655. doi:10.1016/S0145-2134(01)00229-0
- Gregory, A. G., & Howard, D. (2009). The nonprofit starvation cycle. Retrieved from http://foco.ca/online_documents/Documents%20%20The%20Nonprofit%20Starvation%20Cycle.pdf
- Gronbjerg, K. A. (2010). The U.S. nonprofit human service sector: A creeping revolution. *Nonprofit and Voluntary Sector Quarterly, 30*(2), 276-297. doi:10.1177/0899764001302006
- Harvard Family Research Project (2003). Home visit forum. Retrieved from <http://www.hfrp.org/var/hfrp/storage/fckeditor/File/file/Home%20Visit%20Forum%20Research%20Projects.pdf>
- Hayward, Andrea (2010, October 13). Parental leave scheme in motion. *Australian Associated Press*. Retrieved from <http://news.smh.com.au/breaking-news-national/parental-leave-scheme-in-motion-20101013-16jn5.html>

- Heckman, J., & Carneiro, P. (2003, February). Human capital policy. National Bureau of Economic Research, Working Paper No. w9495. Retrieved from <http://www.nber.org/papers/w9495>
- Hertzman, C. (2009, December). The state of child development in Canada: Are we moving toward, or away from, equity from the start? *Pediatrics and Child Health, 14*(10), 674-677.
- Hill Collins, P. (1994). Shifting the center: Race, class and feminist theorizing about motherhood. In E. N. Glenn, G. Chang, & L. R. Forcey, (Eds.), *Mothering: Ideology, experience, & agency* (pp. 45-65). New York: Routledge.
- Hobart City Council (n.d.). *Economic profile*. Retrieved from http://www.hobartcity.com.au/Business/Economic_Profile
- Hrdy, S. B. (2009). *Mothers and others: The evolutionary origins of mutual understanding*. Cambridge, MA: Harvard University Press.
- International Association of Schools of Social Work (n.d.). Definition of Social Work. Retrieved 29 September 2011 from http://www.iassw-aiets.org/index.php?option=com_content&view=category&layout=blog&id=26&Itemid=51&lang=english
- Japel, C. (2009, May 14). *Quebec: A Canadian success story*. Paper presented at the conference of the Council for Early Child Development, Sackville, NB.
- Johnson, Z., Howell, F., & Molloy, B. (1993). Community Mothers Programme: Randomized control trial of non-professional intervention in parenting. *British Medical Journal, 306*, 1449-52. doi:10.1136/bmj.306.6890.1449
- Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T., et al. (2000). Community Mothers Programme – seven-year follow-up of a randomized control trial of non-professional intervention in parenting. *Journal of Public Health Medicine, 22*(3), 337-342. doi:10.1093/pubmed/22.3.337
- Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver I. P., & Surrey, J. S. (1991). *Women's growth in connection: Writings from the Stone Center*. New York: Guilford Press.
- Kelleher, L., & Johnson, M. (2004, July/August). An evaluation of a volunteer-support program for families at risk. *Public Health Nursing, 21*(4), 297-305. doi:10.1111/j.0737-1209.2004.21402.x
- Keon, W. J. (2009, February). Cuba's system of maternal health and early childhood development: Lessons for Canada. *Canadian Medical Association Journal, 180*(3), 314-316. doi:10.1503/cmaj.080487

- Kershaw, P., & Anderson, L. (2009, December). Is a pan-Canadian early child development system possible? Yes, when we address what ails Canadian culture. *Pediatrics and Child Health, 14*(10), 685-688.
- Kershaw, P., et al. (2009, May 14). *Why do Canadians suffer inadequate supports for families with children? What can be done? A pan-Canadian policy framework to achieve 15 by 15*. Address to the national conference of the Council for Early Child Development, Sackville, NB.
- Kilburn, M. R., & Karoly, L. A. (2008). *The economics of early childhood policy: What the dismal science has to say about investing in children*. Santa Monica, CA: Rand Corporation.
- Kirby, S., & McKenna, K. (1989). *Experience, research, social change: Methods from the margins*. Toronto, ON: Garamond Press.
- Kitzinger, S. (1980). *Women as mothers*. New York: Vintage Books.
- Kitzman, H. (2004). Effective early childhood development programs for low-income families: Home visiting interventions during pregnancy and early childhood. In R. E. Tremblay, R. G. Barr, & R. DeV. Peters (Eds.), *Encyclopedia on early childhood development* [Online version]. Montreal, QC: Centre of Excellence for Early Childhood Development; 2004:1-7. Retrieved from <http://www.excellence-earlychildhood.ca/documents/KitzmanANGxp-Home.pdf>
- Knoke, D. (2009). *Early childhood visiting programs*. CECW Information Sheet #73E. Toronto, ON: University of Toronto, Factor-Inwentash Faculty of Social Work. Retrieved from www.cecw-cepb.ca/sites/default/files/publications/en/HomeVisiting73E.pdf
- Krugman, R. D. (1993, winter). Universal home visiting: A recommendation from the U.S. Advisory Board on Child Abuse and Neglect. *The Future of Children, 3*(3), 184-191. doi:10.2307/1602550
- Kurnetz, R. (1983, winter). Hospital based parenting support for first-time parents: The Perinatal Positive Parenting program at the William Beaumont Hospital. *Infant Mental Health Journal, 4*(4), 294-296. Article published online: 13 February 2006. doi:10.1002/1097-0355(198324)4:4<294::AID-IMHJ2280040404>3.0.CO;2-J
- Lauren & Mark Rubin Visiting Moms Program (2010). *Program Description*. Retrieved from http://www.jfcsboston.org/fcs/visiting_moms.cfm
- MacDonald, J. E., & Friars, G. (2010). Structural social work from a (dis)Ability perspective. In S. F. Hick, H. I. Peters, T. Corner, & T. London (Eds.), *Structural social work in action* (pp. 138-156). Toronto: Canadian Scholars' Press Inc.

- Matusicky, C., & Russell, C. C. (2009, December). Best practices for parents: What is happening in Canada? *Pediatrics and Child Health, 14*(10), 665-666.
- McCain, M. N., Mustard, J. F., & Shanker, S. (2007, March). *Early Years Study 2: Putting science into action*. Toronto: Council for Early Child Development.
- McQuaig, L. (2004, November 22). In Europe: higher taxes, better child care. *rabble.ca* [online magazine]. Available at: <http://rabble.ca/print/columnists/europe-higher-taxes-better-child-care>
- Meigs, C. (1970). *Jane Addams, pioneer for social justice: A biography*. Boston: Little, Brown and Company.
- Mercer, R. T. (2004, third quarter). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship, 36*(3), 226-232. doi:10.1111/j.1547-5069.2004.04042.x
- Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Boston: Beacon Press.
- Misener, T. R., & Knox, P. D. (1990, September). Symbiotic and synergistic community-based volunteer home visiting program for postpartum families. *Public Health Nursing, 7*(3), 169-174. doi:10.1111/j.1525-1446.1990.tb00630.x
- Molloy, B. (2002, April). *Still going strong: A tracer study of the Community Mothers Programme, Dublin, Ireland*. The Hague: Bernard van Leer Foundation.
- Monsebraaten, L. (2008, October 24). Copy Quebec daycare, PQ leader says. *Toronto Star*. Retrieved from www.thestar.com/article/523608
- Moore, T. G. (2008). *Supporting young children and their families: Why we need to rethink services and policies*. CCCH Working Paper 1 (revised November 2008). Parkville, Victoria: Centre for Community Child Health. Retrieved from http://www.rch.org.au/emplibrary/ccch/Need_for_change_working_paper.pdf
- Morgan, G. & Nadig, S. (2006, September/October). Trends in Education and Care for Young Children. *Exchange*. Redmond, WA: Child Care Exchange.
- Mullaly, B. (2007). *The new structural social work* (3rd ed.). Don Mills, ON: Oxford University Press.
- National Collaborating Centre for Determinants of Health (2008, October). Discussion Paper: Public Health Early Child Home Visiting Forum. Antigonish, NS: Author. Retrieved from www.nccdh.ca/supportfiles/NCCDH_Dpaper-ECHV_July409.pdf

- Neysmith, S. M. (1998). From community care to a social model of care. In C. T. Baines, P. M. Evans, and S. M. Neysmith (Eds.), *Women's caring: Feminist perspectives on social welfare (2nd edition)* (pp. 233-249). Toronto, ON: Oxford University Press.
- Nova Scotia Advisory Committee on Primary Health Care Renewal (2003, May). *Primary Health Care renewal: An action for healthier Nova Scotians*. Halifax, NS: Author.
- Nova Scotia Department of Health (2002, November). *More support for new moms, babies and families* [Press release]. Retrieved from <http://www.gov.ns.ca/news/details.asp?id=20021126003>
- Nova Scotia Department of Health (2008, 17 January). *Province accepts all health system review recommendations* [Press release]. Retrieved from <http://www.gov.ns.ca/news/details.asp?id=20080117002>
- Olds, D. (2004). Prenatal/postnatal home visiting programs and their impact on the social and emotional development of young children. In R. E. Tremblay, R. G. Barr, & R. DeV. Peters (Eds.), *Encyclopedia on early childhood development* [Online version]. Montreal, QC: Centre of Excellence for Early Childhood Development; 2004: 1-7. Retrieved from <http://www.excellence-earlychildhood.ca/documents/OldsANGxp.pdf>
- Olds, D. L., Henderson, C., Kitzman, H. J., Eckenrode, J. J., Cole, R. E., & Tatelbaum, R. C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. *Future of Children, 9*(1), 44-65. doi:10.2307/1602721
- Olds, D. L., & Kitzman, H. (1993, winter). Review of research on home visiting for pregnant women and parents of young children. *The Future of Children, 3*(3), 53-92. doi:10.2307/1602543
- Olds D.L., Sadler L., & Kitzman, H. (2007). Programs for parents of infants and toddlers: recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry, 48*: 3/4, 355-391. doi:10.1111/j.1469-7610.2006.01702.x
- Olshansky, E. (2003, third quarter). A theoretical explanation for preciously infertile mothers' vulnerability to depression. *Journal of Nursing Scholarship, 35*(3), 263-268. doi:10.1111/j.1547-5069.2003.00263.x
- Organization for Economic Co-operation and Development (2006). *Starting strong II: Early childhood education and care*. Paris: OECD Publishing.
- Pacific Postpartum Support Society (2002). *Postpartum depression and anxiety: A self-help guide*. Vancouver, BC: Banyen Books.

- Parents as Teachers (n.d.). Supporting States in Developing Plans for Federal Home Visiting Initiative. Retrieved from http://www.parentsasteachers.org/images/stories/documents/FHVI_webinar_3-4-11forweb.pdf
- Paris, R. (2008). "For the dream of being here, one sacrifices ... ": Voices of immigrant mothers in a home visiting program. *American Journal of Orthopsychiatry*, 78(2), 141-151. doi:10.1037/0002-9432.78.2.141
- Paris, R., & Dubus, N. (2005, January). Staying connected while nurturing an infant: A challenge of new motherhood. *Family Relations*, 54, 72-83. doi:10.1111/j.0197-6664.2005.00007.x
- Paris, R., Gemborys, M., Kaufman, P., & Whitehill, D. (2007). Reaching isolated new mothers: Insights from a home-visiting program using paraprofessionals. *Families in Society*, 88(4), 616-626.
- Pennock, M., & Ross, J. (2002, January). *The effectiveness of home visiting services for early child development: A review of the evidence* [Unpublished report]. Halifax, NS: Population Health Research Unit, Dalhousie University.
- Powell, D. R. (1993, winter). Inside home visiting programs. *The Future of Children*, 3(3), 23-38. doi:10.2307/1602541
- Prichard, P., & Polglase, L. (2001, March). *Good Beginnings Program – National home visiting and parenting project – Innovative programs responding to families and communities*. Paper presented at the "Children, Young People and Their Communities: The Future is in our Hands" Conference, Launceston, Tasmania.
- Public Health Agency of Canada (n.d.). What determines health? Retrieved from <http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants>
- Richmond, M.E. (1930). *The Long View: Papers and Addresses*. Selected and edited with biographical notes by Joanna C. Colcord & Ruth Z. S. Mann. New York: Russell Sage Foundation, 1930.
- Ristock, J. L. & Pennell, J. (1996). *Community Research as Empowerment: Feminist Links, Postmodern Interruptions*. Don Mills, ON: Oxford University Press.
- Roberts, L. J. (1998, January). *Under siege: A study of non-profit, community-based agencies in an era of cuts*. Halifax, NS: Captain William Spry Community Centre, Metro Community Services Network, and Nova Scotia Association of Social Workers.

- Ross, R. (2006, January). *Struggling to survive: Women on employment support and income assistance in Nova Scotia provide their key recommendations for policy reform*. [Unpublished report]. Antigonish Women's Resource Centre, Every Woman's Centre, & Pictou County Women's Centre.
- Rossiter, A. (1988). *From private to public: A feminist exploration of early mothering*. Toronto, ON: The Women's Press.
- Salahu-Din, S. (2003). *Social work research: An applied approach*. Boston: Allyn and Bacon.
- Santos, R. (2005). Voices from the field – Research on home visiting: Implications for early childhood development (ECD) policy and practice across Canada. In R. E. Tremblay, R. G. Barr, R. DeV. Peters (Eds.), *Encyclopedia on early childhood development* [Online version]. Montreal, QC: Centre of Excellence for Early Childhood Development; 2005: 1-9. Retrieved from <http://www.excellence-earlychildhood.ca /documents/SantosANG. pdf>
- Scott, K. (2005). *The world we have: Towards a new social architecture*. Ottawa, ON: Canadian Council on Social Development. Retrieved from <http://www.ccsd.ca/pubs/2005/world/ world.pdf>
- Shugart, E. B. (1992). Using volunteer visitors in home care. *Journal of Nursing Administration*, 22(4), 42-45. doi:10.1097/00005110-199204000-00011
- Stake, R. E. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Taggart, A., Short, S., & Barclay, L. (2000). 'She has made me feel human again': An evaluation of a volunteer home-based visiting project for mothers. *Health and Social Care in the Community*, 8(1), 1-8. doi:10.1046/j.1365-2524.2000.00227.x
- Tasmania's Population (website - 2008). School of Sociology and Social Work, University of Tasmania. Retrieved from http://www.taspop.tasbis.com/webapps /site/588/1401/info/info-page.html?info_id=8
- Taylor, M., Edwards, B., & Gray, M. (2009). *Unemployment and the wellbeing of children aged 5 to 10 years*. Paddington, NSW: The Benevolent Society. Retrieved from <http://www. bensoc.org.au/uploads/documents/AIFS-report-unemployment-and-the-wellbeing-of-children-aged-5-to-10-yrs.pdf>

- The Benevolent Society (2009, October). *Volunteer home visiting: Evaluation of the Benevolent Society's program*. Retrieved from <http://www.bensoc.org.au/uploads/documents/volunteer-home-visiting-evaluation-full-report-mar2010.pdf>
- Thomas, T. (2001, spring/summer). Shut that kid up: Motherhood as social dislocation. *Journal of the Association for Research on Mothering*, 3(1), 62-74.
- Thomson, L. (1997). "A great start!" – *Home-start: An evaluation of home-start early parenting programs*. Australia: Copelen Child & Family Services.
- Thornham, S. (1999). In S. Gamble (Ed.), *The Icon critical dictionary of feminism and post-feminism*. Cambridge, UK: Icon Books.
- Tinajero, A. (2009, May 14). *Where there is the will, there is a way!* Paper presented at the conference of the Council for Early Child Development, Sackville, NB.
- Tough, S. C., Johnston, D. W., Siever, J. E., Jorgenson, G., Slocombe, L., Lane, C., et al. (2006, September). Does supplementary prenatal nursing and home visitation support improve resource use in a universal health care system? A randomized control trial in Canada. *Birth*, 33(3), 183-194. doi:10.1111/j.1523-536X.2006.00103.x
- United Nations Children's Fund [UNICEF] (2008). *The child care transition. Innocenti Report Card 8*. Florence, Italy: UNICEF Innocenti Research Centre.
- United Nations Children's Fund [UNICEF] (2010). *The children left behind: A league table of inequality in child well-being in the world's rich countries. Innocenti Report Card 9*. Florence, Italy: UNICEF Innocenti Research Centre.
- United States Department of Health and Human Services Press Office (2010, July 21). HHS allocated \$88 million for Home Visiting Program to improve the wellbeing of children and families: Press release. Retrieved from <http://www.hhs.gov/news/press/2010pres/07/20100721a.html>
- Utah County Health Department (n.d.). Retrieved from <http://www.utahcountyonline.org/Dept2/Health/Nursing/WelcomeBaby.asp>
- Utah State Data Center (2010). *Utah data guide*. Retrieved from www.governor.state.ut.us/dea/publications/02Utahdata
- United Way of Utah County (2009). *2009 annual report*. Retrieved from http://www.unitedwayuc.org/your_united_way/pdfs/2009%20Small.pdf

- Volunteer Canada. (2010, December). *Bridging the gap: Enriching the volunteer experience to build a better future for our communities*. Ottawa, ON: Author. Retrieved from [http:// www.volunteer.ca/study](http://www.volunteer.ca/study)
- Wade, K., & Fordham, J. (2005). Voices from the field – Prenatal and postnatal home visiting. In R. E. Tremblay, R. G. Barr, & R. DeV. Peters (Eds.), *Encyclopedia on early childhood development* [Online version]. Montreal, QC: Centre of Excellence for Early Childhood Development; 2005:1-6. Retrieved from <http://www.excellence-earlychildhood.ca/ documents/Wade-FordhamANG.pdf>
- Wasik, B. H. (1993, winter). Staffing issues for home visiting programs. *The Future of Children*, 3(3), 140-157. doi:10.2307/1602547
- Watson, J., White, A., Taplin, S., & Huntsman, L. (2005, May). *Prevention and early intervention literature review*. Ashfield, NSW: NSW Centre for Parenting & Research. Retrieved from [http:// www.community.nsw.gov.au/docswr/assets/main/documents/ eip_ literature_ review.pdf](http://www.community.nsw.gov.au/docswr/assets/main/documents/eip_literature_review.pdf)
- Weiss, H. (1993, winter). Home visits: Necessary but not sufficient. *The Future of Children*, 3(3), 113-28. Retrieved from http://www.kids.nsw.gov.au/uploads/documents/What_about_the_kids_full.pdf
- Wellesley, B. (2000, July 24-26). Why we think Good Beginnings is making a difference to children, families and the community. Paper presented at the Institute of Family Studies Conference, Sydney, Australia. Retrieved from [http://www.aifs.gov.au/conferences/ aifs7/wellesley.html](http://www.aifs.gov.au/conferences/aifs7/wellesley.html)
- World Health Organization (2008). *Primary health care: Now more than ever: The World Health report 2008*. Switzerland: Author.
- Zercher, C., & Spiker, D. (2004). Home visiting programs and their impact on young children. In R. E. Tremblay, R. G. Barr, & R. DeV. Peters (Eds.), *Encyclopedia on early childhood development* [Online version]. Montreal, QC: Centre of Excellence for Early Childhood Development; 2004:1-8. Retrieved from <http://www.excellence-earlychildhood.ca/ documents/Zercher-SpikerANGxp.pdf>

**Appendix A: Introductory Letter to Home Visiting Programs
and Related Organizations/Networks**

[Dalhousie University letterhead]

10 May 2010

Dear colleagues:

My name is Maura Donovan. I work in the field of home visiting, and am presently doing my Master of Social Work thesis on in-home services for families with infants and young children – specifically, **home visiting programs that involve both volunteer and paid visitors.**

As there seems to be little or no published literature on these programs, the goals of my research are to gain a greater understanding of this approach to serving families, and to then circulate this new knowledge to those working in the field and those who develop programs and policies.

The study is neither an evaluation, nor a comparison, of volunteer and paid visitors. It's an exploratory study; through it, I will seek to describe – not measure – these unique programs.

Please note:

- Home visitors may have different titles (Family Support Worker, In-Home Volunteer, etc.).
- In this study, the primary role of both volunteer and paid visitors must be working in families' homes on an on-going basis. However, home visitors may also have other duties.
- Paid visitors and volunteer visitors most often have different roles or job descriptions within a program (perhaps with some overlapping duties); however, they may also have the same roles.

So far, I have found just a handful of family home visiting programs with both volunteer and paid visitors – in Australia, the U.K., the U.S, and Ireland. The small number of programs, and the corresponding lack of published literature, has led me to do a wider background search. **I am hoping that you, or others you know, might be able to help me with the following questions...**

1. Are you involved with a program that has both paid and volunteer visitors? If so...

Ⓢ **I would love to hear from you!** Even if you think your program might not be able to take part in this study, I would still like to learn more about your service. It will help me to add to my overall knowledge about these programs.

Ⓢ **Would your program consider taking part in the study?**

If so, please contact me by email or telephone, at your earliest convenience. I can provide you with more information on the study, and what it would mean for your program to take part.

Ⓢ **What would you need to make your decision?** (i.e., more information, approval from your Board of Directors or an agency Ethics Committee...)

Continued...

2. Do you know of any other programs with both paid and volunteer visitors, either in your own country, or internationally?

If so, I would appreciate it if you could forward this information to that group, or send me a quick email with the name of the program.

3. Do you know of any articles, reports, evaluations, websites, or published research about programs with both paid and volunteer home visitors? (these written resources could also focus on programs that serve other populations, such as seniors or consumers of mental health services).

4. Do you know of anyone else I should contact? If so, I ask that you forward this email to that person, and/or send me their contact information. Also, if you are part of a relevant email group or online forum, I would really appreciate it if you would forward this message to that group.

I can be reached via the telephone number and email address below. As long-distance telephone charges will apply, please feel free to email me to let me know the best telephone number and times to reach you, or telephone me and have the charges reversed.

My interest in this topic comes from my experience coordinating the Extra Support for Parents Volunteer Service (E.S.P.), in Halifax, Nova Scotia, Canada. E.S.P. has both volunteers and one full-time staff person who work in families' homes. I am presently on leave from my work at E.S.P. to complete my thesis research (more information on E.S.P., and the study, can be found on the following page). This research study will be reviewed by Dalhousie University's Health Sciences Research Ethics Board prior to the recruitment of study participants.

I know that everyone is very busy and juggling multiple demands – especially in non-profit and community-based organizations that provide services to marginalized and vulnerable populations. **With this in mind, I am especially thankful for your time and assistance.**

Sincerely,

Maura Donovan
mdonovan@dal.ca
(902) 463-7149 (reverse the charges)

See page 3 for further information...

Information on Extra Support for Parents (E.S.P.)

Extra Support for Parents Volunteer Service (E.S.P.) is a program of the IWK Health Centre, a regional women's and children's hospital located in Halifax, Nova Scotia, Canada. At E.S.P., we provide in-home support for families who have a new baby (or babies) and who are dealing with stressful or difficult circumstances. Depending on each family's needs, E.S.P. volunteers provide emotional support, parenting information, hands-on help with the children, accompaniment to appointments and grocery shopping, and assistance accessing community resources and programs.

We also have a Family Support Worker (F.S.W.), who works with those families who are struggling with complex challenges and situations. Our F.S.W. provides parenting education, advocacy, and life skills education, and helps parents overcome barriers supporting their interactions with a range of health and social service providers, government agencies, etc. Some families receive the support of both a volunteer and the F.S.W., and some have one or the other (this depends on each family's needs, and also on the availability of volunteers and the F.S.W.).

For more info on E.S.P., contact Emma Kathleen, Program Assistant, (902) 470-7111 or extrasupport@iwk.nshealth.ca.

Information on the study

"An exploration of family home visiting programs that make use of both volunteer and paid visitors"

Principal Investigator: Maura Donovan, Master of Social Work student,
School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada

My MSW thesis will focus on home visiting programs that have both paid and volunteer visitors, and that serve families with infants and young children. I have done an extensive international search of programs, and from this, **I have found just a handful of family services that have both volunteer and paid home visitors.**

Once I have received ethics approval for the study, I will begin recruiting study participants from three participating agencies. (To avoid ethical conflicts, the program where I work will not be one of these). I am planning to interview two volunteer visitors, one paid visitor, and one supervisor/manager, from each program. The focus of the interviews will be their experiences: what it has meant to have both paid staff and volunteers working in families' homes, and (from their perspective) the strengths, opportunities, and challenges of such an approach. I am also interested in each program's history and development, and how they came to have both paid and volunteer visitors. Thus I will also look at relevant program documents (proposals, reports, etc.), and interview one person who knows the history of each program. **Through this study, I hope to gain greater insight about these programs, and to be able to pass on that knowledge to others.** I have received funding from the Nova Scotia Health Research Foundation, which has allowed me to take four months away from my job and focus on my thesis full-time.

I am very excited about this research project. I returned to graduate school specifically to learn more about conducting and analyzing research, and I am fortunate to be able to do my research on in-home support programs. I would welcome the opportunity to connect with anyone who also has a passion for this topic.

To learn more about the study, please contact me at:
(902) 463-7149 (*reverse the charges*) or mdonovan@dal.ca

**ELIGIBILITY CRITERIA & CHECKLIST:
AGENCIES/PROGRAMS
and STUDY PARTICIPANTS**

Title of research study: **‘An exploration of family home visiting programs that make use of both volunteer and paid visitors’**

Principal investigator: **Maura Donovan**, student in the Master of Social Work Program, Dalhousie University, Halifax, Nova Scotia, Canada

I. AGENCIES/PROGRAMS

To be eligible to take part in this study, a home visiting program must:

1. Operate as or within a non-profit, non-governmental, and/or governmental organization, **not in a commercial/for-profit setting**.
2. Provide in-home services to **families with infants** (babies 12 months of age and younger); families may have older children as well.
3. Provide these services on a **voluntary** (not mandatory) **basis, at no cost to families**.
4. Provide services to **families in a range of situations**, not one specific sub-group (for example, military families, parents of children with special needs).
5. Have, as part of their service, **volunteer home visitors**, who visit assigned families independently (alone) *, on a regular basis, over a span of weeks, months, or longer.
6. Have, as part of the same service/program, **one or more paid staff members who work in families’ homes**, visiting a number of assigned families independently (alone) *, on a regular basis, over a span of weeks, months, or longer. For these paid staff, home visiting must comprise a majority of their part-time or full-time work with the program.
7. Offer **in-home services that include some or all of the following**: emotional support, parenting education, child development information, instrumental (practical) help with the child(ren), referrals and/or accompaniment to community resources, advocacy, respite child-minding, transportation (e.g., to appointments), parent-to-parent mentoring, and community orientation. Volunteer and paid visitors may have different roles/responsibilities from each other, different roles with some overlapping duties, OR the same roles and responsibilities.

Criteria for agencies/programs continued on page 2...

* Not all home visits must be carried out alone. However, home visitors are **not** eligible if their role is dependent on another service provider visiting the family at the same time.

Continued - To be eligible to take part in this study, a home visiting program must:

8. Be located in a country from which there is some published, English-language research and evaluation literature on family services, including home visiting (volunteer and/or paid).
9. Have a sufficient number of staff and volunteers who fit the eligibility criteria to be study participants (**for full details, see *Eligibility Criteria for Study Participants*, attached**).

The list of participants from each agency includes:

- 1 paid home visitor** (and, *if possible*, 1 alternate).
- 2 volunteer visitors** (and, *if possible*, 1 alternate).

Ideally, each volunteer will have had somewhat different experiences with the program, and will therefore provide the study with a broader range of volunteer experiences and perspectives.

- 1 supervisor/co-ordinator of home visitors** (and, *if possible*, 1 alternate).
- 1 program history participant** (and, *if possible*, 1 alternate). This individual may be someone who is already being interviewed, or it may be an additional study participant.

Alternates: It is recognized that it may be difficult for programs to provide alternates for all of the different participant roles. However, if a program is not able to provide *any* alternates, that program may not be able to take part in the study. This study will involve only three home visiting programs; if two or more participants from the same program have to withdraw and there are no alternates, the data collected may be significantly compromised.

In agreeing to take part in the study, participating programs must:

1. If feasible and practical, obtain agreement to participate from home visitors as a group. This is particularly important when there is a small number of home visitors within a program, because the voluntary participation of one paid visitor and two volunteer visitors from each agency is a key component of this study.
2. Designate an Agency Contact Person to liaise with the researcher throughout the research process. Ideally, this person is not a supervisor of those who may be interviewed; however, this may be unavoidable, particularly in smaller organizations.
3. Be able to take part in the study during the data collection phase (June, 2010).
4. Agree to have program staff and volunteers take part on a completely anonymous and voluntary basis (without pressure from co-workers, supervisors, Board members, or others).
5. Agree to forward to the researcher copies of relevant program and agency documents, such as funding proposals, reports, evaluations, training manuals, and promotional materials.
6. Agree to have their program included and named in the thesis report, and in any subsequent presentations or published findings/articles.

Criteria for agencies/programs continued on page 3...

As well, eligible programs MAY (or may not):

1. Offer other services, in addition to home visiting.
2. Provide services to populations in addition to families with infants (for example, pre-natal education, programs for families with older children, support for those providing elder care).
3. Use a term other than 'home visiting' to describe their in-home work with families.

The following program characteristics are flexible:

- Eligible programs may serve families in a geographic area of any size or description.
- Eligible programs may offer in-home services that last from several weeks to several months, or longer.
- Length of service may vary from one family to another, or last for a prescribed length of time for all families.

Selection of agencies for the study:

If more than three agencies agree to take part in the study, the researcher and thesis supervisor(s) will consider the following factors in determining which three programs will be selected to participate:

- To what degree a program meets the eligibility criteria for the study
- An agency's capacity to participate (Will it be a strain on program resources? Does the program have a minimal number of eligible staff and volunteers, or can they provide alternates?)
- Geographical location of each program
- Program models
- Any other key factors that emerge, such as length of time program has been in operation, any unique aspects of a given program, etc.

II. STUDY PARTICIPANTS

To be eligible to take part in this study, individuals must:

1. Be a volunteer home visitor, a paid home visitor, or a supervisor of home visitors in a participating program; OR be a person who is knowledgeable about the historical development of a participating program.
2. Have a depth of experience in this work:
 - a. A volunteer home visitor* will have had several family 'matches' (roughly 150 hours or more working with families in their homes), preferably over a period of at least two years.
 - b. A paid home visitor* will have been employed by the organization, in a home visiting capacity, for at least two years.
 - c. A supervisor of home visitors* will have been employed in this capacity for at least two years. Duties related to working with home visitors (supervision, support, co-ordination, training, etc.) should form a significant part of the supervisor's job.

*An exception may be made if no one in this role meets the exact study criteria. If this is the case, the Agency Contact Person should discuss this with the researcher as soon as possible.

Criteria for study participants continued on page 4...

Please note: The focus of this study is the experiences and insights of people who work and volunteer in these unique programs. Many different experiences can inform your perspective. A few examples include:

- When a program has expanded or changed from having one type of visitor (paid or volunteer), to having both types, and some home visitors were involved with the service both before and after this change.
- When a volunteer and a paid visitor have been assigned to work with the same family during the same or overlapping time period(s).
- When a program matches a family with a paid visitor, and then later shifts the family to having a volunteer visitor (or visa-versa).
- **Any other relevant experiences** that have shaped your thoughts about this topic.

3. Be available for a telephone interview during the month of May or June, 2010. The interview will be scheduled for a time that is convenient for the participant (within reason, and acknowledging different time zones). International telephone charges will be covered by the study budget.

4A. Have access to an email address, so that the researcher can send each participant the transcribed (typed) record of her/his interview; and...

4B. Be willing to review the transcript and provide the researcher with any corrections or other feedback on the interview record (participants can 'opt out' of this step, if they so choose).

If you have ANY questions about these criteria, please contact Maura Donovan at mdonovan@dal.ca, or 0-902-463-7149 (reverse the charges).

Thank you!

Any questions you may have/notes to discuss with the researcher:

Appendix C: Initial Information for Volunteers and Staff

[Dalhousie University letterhead]

Information on the research project:

“An exploration of family home visiting programs that make use of both volunteer and paid visitors.”

May 21, 2010

Dear volunteers and staff in home visiting programs:

My name is Maura Donovan. I am looking for three programs that would like to be involved in a study on a unique type of service for families: **programs that have both paid home visitors and volunteer home visitors**. I work in such a program in Halifax, Nova Scotia, Canada. Through this program, I've learned that there can be many strengths to this type of service, and that there can also be challenges and struggles. I am very curious about other programs' experiences with this type of structure.

As you may know, across industrialized, wealthy English-speaking countries, there are many home visiting programs. Some have paid home visitors, and some have volunteers. A lot of research has been conducted on these programs. However, it seems that there are only a handful of services that have *both* paid and volunteer home visitors in the same program. As well, there is little or no research on these particular programs. Therefore, I have decided to make these programs the focus of my thesis research for my Master of Social Work.

This letter is specifically written for programs that have both volunteer and paid visitors. It provides a basic overview of the study, **to help programs make an initial decision about whether or not you might want to get involved**. In this letter I refer to a few other documents or information sheets that give more detailed information. I will send you these if you would like to know more about the study.

How will information be gathered for this study?

The study will involve three home visiting programs, possibly from three different countries. I will interview four experienced people who currently work with each program - two volunteer visitors, one paid visitor, and one supervisor/Co-ordinator. I will also learn about each program's history and development. I'll do this by interviewing one person who knows the history, and reviewing relevant documents that the agency sends me (such as annual reports). Unfortunately, because of cost, I won't be able to visit each program. All interviews will be done over the telephone.

All three programs that take part have to meet some basic eligibility criteria. For example, they must provide services at no cost to the families, and they must work with families who have infants (though they may also serve families with older children). They must visit each family over a period of time (the minimum is several weeks, but they can visit for several months, or longer). *The full criteria are found on the info sheet, “Eligibility Criteria & Checklist: Agencies/Programs and Study Participants.”*

- **This study is not a comparison of volunteer visitors to paid visitors.**
- **This study is not an evaluation of any type.** It seeks to *describe*, not measure, these programs.
- **This is not a study of the *families* involved in your program. The study will not ask questions about the families, nor interview parents, nor look at client records.**

What is the purpose of this research?

The goal of this study is to gain insight into home visiting programs that have paid and volunteer visitors. I want to bring forward the stories of these programs, so that people can have a better understanding of their existence, some of their strengths and challenges, and the things that may be unique about them. The study may also point to areas for further research in the future.

This research project will examine the following main questions:

- ④ How and why did these home visiting programs come to have both paid and volunteer visitors?
- ④ What are the experiences of people who work or volunteer in these programs?
- ④ What do staff and volunteers identify as the strengths, opportunities, and challenges of having both volunteer and paid home visitors working in the same program?
- ④ How do they deal with the opportunities and challenges?

What is being asked of us now/today?

Home visitors and supervisors in your organization are being asked **whether you think that your program – as a whole – should take part in this study.** Volunteer and paid home visitors are a crucial part of this study. If a Co-ordinator or Director agrees that your program will take part, but no experienced visitors are available or willing to be interviewed, the study cannot move forward. Therefore, it is really important that home visitors are involved with deciding if the program should be involved. (If it's not practical to discuss this with home visitors as a group, other ways can be used – i.e., forward the info. by email, or discuss the study with a smaller group of home visitors)

At this time, no staff member or volunteer is being asked whether or not you (as an individual) want to be a study participant. That is called participant recruitment, and that will only happen:

1. after the study has been reviewed by the Dalhousie Ethics Board, AND
2. if your *program or organization* decides that they want to take part in the study.

Who is doing the study?

The research will be conducted by me as part of my Master of Social Work degree at Dalhousie University in Halifax, Canada. My interest in this topic comes from my experience coordinating the Extra Support for Parents Volunteer Service (E.S.P.), which is part of the IWK Health Centre. E.S.P. is an in-home support program for parents of infants. E.S.P. has about 30 volunteers and one full-time staff person (a Family Support Worker) who work in families' homes.

I have worked for E.S.P. since 1997, and from February to July 2010, I am on a leave of absence to complete my thesis research. (To avoid ethical conflicts, E.S.P. is not part of the study.) **I am thrilled to be able to do my thesis on a topic that is close to my heart, and especially to hear the experiences of other people who are involved in similar programs.**

If we decide to take part, what will be asked of us?

1. Your organization will provide me with copies of relevant program documents. Relevant documents are relate to *having both volunteer and paid home visitors.* This might include some or all of the following: funding proposals, program expansion proposals, annual reports, reports to funders, program evaluations, training manuals, and promotion/publicity materials.

I will not be looking at the files or records of staff, volunteers, or families.

2. Your organization will need to assign an Agency Contact Person.

The Agency Contact Person is the link between me and your program. She or he will need to commit the most time to the project (a total of about 5 to 10 hours, over the next several weeks). This person will provide staff and volunteers with information on the study, provide me with documents, and help make things flow smoothly for everyone. The Agency Contact Person is not interviewed for the study, and is not considered a ‘study participant.’

The Agency Contact Person can have just about any role in your organization (administrative assistant, home visitor, volunteer, etc.). Ideally, the A.C.P. will not be a supervisor of those who may be interviewed; however, this may be unavoidable, particularly in smaller organizations. This person should know the program well, and be able to 1) *easily* contact all eligible staff and volunteers by phone and/or email, and 2) access and share relevant program documents.

3. Four or five people from your program will need to commit to being study participants:

- ☀ **2 volunteer visitors**, each of whom has had several ‘matches’ (a total of 150 hours or more working with families), preferably over a period of at least two years.*
- ☀ **1 paid visitor**, who has been employed in this position for two years or more.*
- ☀ **1 supervisor of home visitors**, who has been in this role for two years or more.* Duties related to working with home visitors should form a significant part of the supervisor’s job.
- ☀ **1 person who knows the history and development of the home visiting program**. This may be someone who is already being interviewed, or it may be an additional study participant. She/he may be a current or former staff member, volunteer, or Board/committee member.

**An exception may be made if no available staff member or volunteer has been with the program for two years or more. Your Agency Contact Person will discuss this with the researcher.*

The total time commitment for study participants is between 2 and 4.5 hours. Participants will:

- a) **Read the interview questions prior to the interview, and think about the questions.** This will help participants prepare for the interview.
- b) **Take part in one audio-recorded telephone interview (about 45 to 75 minutes).** Each interview will be scheduled at a time that is convenient for the participant. Participants will not have to pay any international (long-distance) telephone charges. Interviews with home visitors and supervisors will focus on the participant’s experiences with the program, and their thoughts and feelings regarding the strengths, opportunities and challenges of this approach to home visiting. [For the ‘program history’ participants, the interview will focus on the history and development of the program, and how and why it came to have both paid and volunteer visitors].
- c) **Receive a transcript (typed copy) of their own interview**, which I will email to each participant as a password-protected attachment. **Review the transcript and provide any corrections, additions, or other feedback.** People can provide feedback by telephone, or by emailing comments to me. I will ask that participants provide feedback within one week of receiving the transcript. Participants can ‘opt out’ of this step, if they wish.

What, if anything, will we gain from being involved in this study?

Some people may enjoy being part of a project that might help other home visiting programs in the future. Some people may enjoy the chance to discuss their work. All participants will contribute to creating new knowledge on a topic where there has been little or no research in the past. However, there are no guaranteed benefits *per se*, from taking part in this study.

Are there any other details we should know about?

- **Staff and volunteers' participation is completely voluntary.** People who take part will be free to choose not to answer any question during the interview. A participant can also stop the interview at any time, for any reason.
- **Participants will be free to withdraw from the study, for any reason.** They must withdraw before I start the data analysis phase of the research. If a participant withdraws, all of her/his contributions to the study will be removed from the research. All records from that person's interview will be destroyed.
- **All efforts will be made to protect participants' identity.** No names will be used. However, it is possible that some readers will know (or think they know) who said something in the study. **If your home visiting program takes part, the program will be named in the study.** This may make it easier for some people who know your program to figure out who said what in the study. *More details are contained in the document, "Info. and Consent Form for Study Participants."*
- The senior staff person within your program must agree that each staff member and volunteer is free to decide whether or not to take part in the study. She/he must also commit that no person's employment or volunteering will be negatively affected by either taking part, or not taking part, in the study. *More detailed info. is contained in the "Memorandum of Understanding."*

What will be done with the information from the study?

All of the information will be analysed and written into a full thesis report (while programs will be named, individuals will not be named). A plain-language (non-academic) summary of the findings will be sent to participants, home visiting programs, and other organizations in the voluntary, health, and social services sectors. I will write up the findings as an article and submit them to academic journals. I may also present at conferences. I hope to get the information out as broadly as possible.

I/we have questions or concerns. Who should I talk to?

Please contact me directly, or if you prefer, talk with the person who gave you this information.

I know that everyone is very busy and juggling multiple demands – especially in voluntary and non-governmental service organizations. **With this in mind, I am especially grateful for your time and assistance.** I really hope your program will decide to get involved. However, I know that some programs may choose not to take part in the study, and I understand there are many reasons that can lead people to that decision.

I am happy to answer any questions or respond to any concerns you may have. I look forward to hearing back from someone within your organization, at your earliest convenience.

With much appreciation,
Maura K. Donovan

0-902-463-7149 (reverse the charges/call collect) or mdonovan@dal.ca

Appendix D: MEMORANDUM OF UNDERSTANDING (template)

[Dalhousie University letterhead]

Memorandum of Understanding (M.O.U.)

between **Maura Donovan**, MSW student,
Dalhousie University (“the researcher”) and
_____ (“the program”)

regarding participation in the thesis research project titled
***‘An exploration of family home visiting programs
that make use of both volunteer and paid visitors.’***

Dated ____ (day) _____ (month), **2010**

In this M.O.U.: ‘Program’ and ‘participating program’ refer to the *home visiting program*.

‘Agency’ refers to the *larger organization* that houses the home visiting program
(if applicable; for stand-alone programs, ‘agency’ refers to the program itself).

‘Study participant’ refers to *individuals who are being interviewed* for the study. It is
anticipated that all study participants will be connected to a participating program.

I. The program agrees:

1. To take part in the above-named study as a:

____ Participating program

OR

____ Alternate program (will take part if a participating program withdraws from the study).

- 2. To have their home visiting program (and the program’s name) included in the thesis report and any subsequent presentations, published findings, or articles.** The researcher will take all available measures to protect the identities of study participants. In all cases, no names or other personal information will be included, and no quote will be linked to a specific program or geographical location. However, it must be recognized that there are practical limits to anonymity in a small qualitative study where participating programs are named. Therefore, it is possible that some participants will be identifiable to some readers.
- 3. That all eligible staff and volunteers are free to choose whether or not to take part in the study,** without pressure from supervisors, directors, Board members, or others; AND that employment or volunteer work as a home visitor will not be negatively affected by whether or not someone takes part in the study.
- 4. That all eligible staff and volunteers will be able to take part anonymously.** This is particularly to ensure that staff participation is truly voluntary. Agency staff, volunteers, management, and Board members will not *necessarily* know who has or has not taken part in the study.
- 5. To obtain agreement to participate in the study from home visitors as a group, if feasible and practical.** This is particularly important when there is a small number of home visitors within a program, because the voluntary participation of home visitors (one paid, two volunteer) from each agency is a key component of this study. *In some situations, it may be more practical and feasible to seek input via other means – a mass email, talking about it with a smaller sub-group of home visitors, etc.*

Continued... (p. 1 of 4)

6. **To designate an Agency Contact Person (A.C.P.) to liaise with the researcher** throughout the research process. Ideally, this person will not be a supervisor of those who may be interviewed; however, this may be unavoidable, particularly in smaller organizations.

***** Please see p. 4 of this M.O.U. for the *Outline of Duties, Agency Contact Person.*****

7. **To provide the researcher copies of relevant documents**, specifically those that relate to having both volunteers and paid home visitors (such as funding/expansion proposals, annual reports & reports to funders, program evaluations, training manuals, and promotional materials).

8. **To provide clear and consistent direction and information to staff as to whether work time can be used for the interviews.**

9. **To provide flexibility and accommodation in terms of interview location and timing, as needed and requested.** However, since agency staff may not know who is being interviewed, this request may or may not arise during the course of the study.

II. The researcher agrees to...

1. **Provide information on all aspects of the study, and answer any questions or requests, in a clear, thorough, responsive and timely manner.**

2. **Consistently take all available measures to protect the anonymity and confidentiality of study participants.**

3. When confronted with a situation that may compromise the anonymity or confidentiality of participant(s), **consult with her thesis co-supervisors and/or the Office of Human Research Ethics Administration, Dalhousie University**, as to how best to proceed so that anonymity and confidentiality are protected.

4. **Ensure the security of all study materials.** This includes correspondence with participants, audio-recorded digital files, transcribed interview records, agency documents, and records associated with data analysis. All data storage will be in accordance with the requirements of the Human Ethics Review Committee, Dalhousie University; that is, all research materials will be stored secure location, in a locked file cabinet or a password-protected electronic file, until the end of five years after the study is completed. At that time, they will be destroyed.

5. **Ensure the anonymity of any families (clients) involved with the program** who are mentioned during the interviews or any other part of the data collection process. The researcher will remind study participants not to mention names in the interviews, and will instruct the transcriber not to transcribe client names or other identifying information that may be inadvertently shared. The researcher will take responsibility for ensuring that no identifying client information is recorded or revealed.

6. **Be flexible, respectful, and accommodating** in working with the agency and participants, especially with regard to interview scheduling, methods of communication, a participant's decision to withdraw from the study, and any follow-up correspondence. This is particularly

Continued... (p. 2 of 4)

important if a participant experiences adverse effects as a result of taking part in the study.

7. **Reimburse the agency or program for any outstanding costs incurred** in photocopying or shipping hard-copy agency documents to the researcher, if it is a hardship for a program to cover these costs.
8. **Ensure that any documents borrowed from an agency are returned to the agency, in good condition, no later than October 31, 2010** (and earlier, as requested).
9. **Reimburse study participants for expenses incurred due to their participation in the study, within the following limits:**
 - long-distance phone calls, made to the researcher only (pre-approval not required).
 - expenses such as child care or interpretation during the interviews (These expenses will be covered on a pre-approved basis only).

Please note: Documentation must be forwarded to the researcher in order to be reimbursed (original receipts, invoices, photocopy of telephone bill).
10. **Provide an Executive Summary of the study findings (electronic version) to the agency, and to each study participant who wishes to have a copy.**
11. **If the agency wishes, provide a copy of the full thesis (PDF format) to the agency.**

Maura K. Donovan

_____	_____	_____
Researcher name	Signature	Date
_____	_____	_____
Thesis supervisor's name	Signature	Date

Sent to the agency by ____ fax or ____ post or ____ email (scanned) on (date) _____, 2010.

On behalf of the agency and the home visiting program:

_____	_____	_____	_____
Name (printed)	Position within agency	Signature	Date

Returned to the researcher by __ fax or __ post or __ email (scanned) on (date) _____, 2010.

Post: Maura Donovan, c/o Dr. Judy MacDonald, School of Social Work, Dalhousie University, 6414 Coburg Rd., Halifax, NS, Canada B3H 2A7

Facsimile: (902) 470-7153 – [include all 4 pages of M.O.U. (this document) in fax. On cover page, indicate contact name and telephone number in case of problems with the transmission].

Email: mdonovan@dal.ca

Questions/concerns? Please phone Maura Donovan at: (902) 463-7149 (reverse the charges)

Continued... (p. 3 of 4)

Outline of Duties – Agency Contact Person

The A.C.P. can have just about any role in the organization (administrative assistant, home visitor, administrator, volunteer, etc.). Ideally, this person will not be a supervisor of those who may be interviewed; however, this may be unavoidable, particularly in smaller organizations. Regardless of the position held, this person should know the program well, and be able to 1) *easily* contact all eligible staff and volunteers by phone and/or email, and 2) access and share relevant program documents.

The role of the Agency Contact Person is to:

1. Throughout the study:

- Act as a liaison between the researcher and the agency.
- Facilitate the agency's involvement in the study.
- As needed, help resolve any communication, logistical, or other challenges between the researcher and participants.
- Maintain the agency's commitment to voluntary and anonymous participation for all, and particularly for paid staff, whose participation is key and whose livelihood depends on their employment with the program.

2. Initial phase:

- Inform staff and volunteers about the study, answer their questions regarding the study and direct them to contact the researcher as needed, and seek their agreement (as a group) for the **program** to become involved in the research.
- Contact the researcher as needed (for example, to seek further information or clarification).
- Provide the researcher with information regarding official agency requirements for participation (such as procedures for obtaining ethics committee or board approval)
- Ensure the senior staff member of the home visiting program signs the Memorandum of Understanding on behalf of the agency, committing to the voluntary participation of staff and volunteers, and confirming that no staff member or volunteer's status with the home visiting program or the agency will be affected by their participation or non-participation in this study.

3. Data collection phase:

- Provide the researcher with copies of relevant agency documents.
- Provide study information to staff and volunteers who are eligible to participate, and communicate the terms of taking part (participation is voluntary & anonymous, interested individuals should contact researcher directly, etc.).
- Contact a 'program history participant' to seek their agreement to take part, and arrange for their participation (this person may be a current staff member or volunteer, former staff or board member, community advocate/ally, etc.).
- Remind staff and volunteers to contact the researcher if they are interested in taking part.

PLEASE NOTE:

If the program, agency, agency contact person, or participants have any difficulties with, or wish to voice concern about, any aspect of this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance. She can be reached at (902) 494-1462, or patricia.lindley@dal.ca.

Appendix E: Text of Sample Recruitment E-Mail
(May 2010)

[Dalhousie University letterhead]

Background information:

From: my Dalhousie email address

To: the Agency Contact Person at each agency (program-specific info inserted for each)

To be forwarded by the Agency Contact Person to: Volunteer & paid home visitors

The subject line will read: "Participants needed from [name of program] for study on home visiting"

Attach:

Appendix F, Letter to Eligible Home Visitors, and
Appendix G, Information and Consent Form for Study Participants

Sample text follows.

Dear [name of Agency Contact Person],

As we discussed on [date], here is the information on the study for _____ volunteers and _____ [position titles]

Please forward this email **and both attachments** to all _____ and _____ [position titles]. If there are volunteers or staff who do not have an email address, please photocopy the memo and the attachments, and distribute to these individuals as soon as possible (in order to ensure equal access, they should receive it on, or close to, the same day as those who receive it via email).

As always, please let me know if you have any questions or concerns.

Thank you so much!

Maura

- **Are you an experienced _____ volunteer or _____ ?** [position titles]
- **Did you know that there is little or no research available on home visiting programs that have both paid and volunteer visitors?**
- **Do you have experiences, insights, feelings and/or opinions about paid and volunteer visitors working in the same program?**
- **Would you like to share these as part of a research study?**

Experienced _____ [name of program] volunteers and staff are needed to take part in a study.

The focus of the study is family home visiting programs that have both volunteer and paid visitors.

In order to take part in this study, home visitors must meet the following criteria:

1A. You are an _____ volunteer visitor, and you have had several family ‘matches’ (roughly 150 hours or more working with families in their homes), preferably over a period of at least two years. (An exception may be made if no available volunteer meets this criteria.)

OR

1B. You are a paid home visitor (_____), and have been employed as an [name of program] _____ [PHV position] _____ for at least two years. (An exception may be made if no available home visitor meets this criteria.)

2. You are available for a telephone interview between now and the middle of June, 2010.*

3. You have access to an e-mail address.*

**Further details on these two items can be found in the Information and Consent Form, attached.*

Please note: The focus of this study is the experiences and insights of people who work and volunteer in these unique programs. Many different experiences can inform your perspective. A few examples include:

- When a program has expanded or changed from having one type of visitor (paid or volunteer), to having both types, and some home visitors were involved with the service both before and after this change.
- When a volunteer and a paid visitor have been assigned to work with the same family during the same or overlapping time period(s).
- When a program matches a family with a paid visitor, and then later shifts the family to having a volunteer visitor (or visa-versa).
- **Any other relevant experiences** that have shaped your thoughts about this topic.

Do you meet these eligibility requirements?

Are you interested in taking part in the study?

If so, please read the attached document, “Letter to eligible volunteer and paid visitors.”

No attachments with this email?

or

The attachments are there, but you can’t open/read them?

Please contact your Agency Contact Person for this study, [name of A.C.P.], or the researcher, Maura Donovan at mdonovan@dal.ca, or 0-902-463-7149 (reverse the charges).
[add time zone info.]

Appendix F: Participant Recruitment Letter for Eligible Home Visitors

[Dalhousie University letterhead]

**Letter to eligible home visitors:
INFORMATION
ON TAKING PART IN
A RESEARCH STUDY**

Title of research study: **‘An exploration of family home visiting programs that make use of both volunteer and paid visitors’**

Principal investigator: **Maura Donovan**, student in the Master of Social Work Program, Dalhousie University, Halifax, Nova Scotia, Canada

25 May 2010

Dear volunteer and paid visitors who are eligible to take part in this study:

My name is Maura Donovan. As you may know, your home visiting program is taking part in a study that I am doing for my Master of Social Work thesis. The purpose of the study is to explore the experiences of people who work and volunteer in unique home visiting programs around the world. These programs have both paid staff and volunteers who work with families in their homes. I work in such a program in Halifax, Canada. I have not been able to find any research that looks at what it means to have both volunteer and paid home visitors in the same service. Therefore, I have decided to make this topic the focus of my thesis research.

I am now looking for experienced volunteers and staff to take part in the study (“study participants”). Several people will be interviewed from each of three home visiting programs:

- two volunteer visitors,
- one paid visitor,
- one supervisor of home visitors, and
- one person who knows the history and development of the program.

Please note: Eligibility criteria for study participants is outlined in a “recruitment e-mail.” This e-mail should have been sent to you along with this letter. If you have not yet seen the e-mail, please get in touch with your Agency Contact Person for the study, or contact me directly, by phone or e-mail.

On the next two pages, you will find important information to help you decide whether or not to put your name forward as a study participant. **More details on the study itself can be found in the attached document, “Information and Consent Form for Study Participants.”**

Letter to eligible home visitors: Information on participating in a study (p. 2 of 3)

A. PROTECTING STUDY PARTICIPANTS

Some of the basic "rules" (or principles) of research are:

- participants must be well-informed about a research study before they agree to take part;
- taking part must be voluntary (without pressure or coercion from supervisor, workmates, the researcher, or anyone else);
and
- people don't have the right to know who in their organization or community is (or is not) taking part in a study.

To ensure these principles are followed, this study has been designed in the following ways:

1. Your organization has agreed to these rules/principles (for details, see p. 1 of the Information and Consent Form).
2. Everyone who is interviewed must first read and sign an Information and Consent Form and return it to the researcher.
3. If you agree to take part in the study, but then change your mind, you can withdraw from the study (as long as the data analysis phase has not already begun).
4. I will respect the privacy and confidentiality of the volunteers and staff who do take part, and those who don't take part. I will not share names with anyone, inside or outside of your organization.
5. **To protect privacy and ensure voluntary participation, your Agency Contact Person will not send me a list of eligible staff and volunteers.** Interested home visitors will contact me directly (for more info., see Section B, below).
6. If you have any questions, you can either contact me (the researcher) directly, or you can ask your Agency Contact Person for this study.

B. PUTTING YOUR NAME FORWARD TO TAKE PART IN THE STUDY

There are two ways that participants can be selected for this study.

1. Individual home visitors who want to take part in the study can **contact me directly**, by email or telephone. **I will interview the first two eligible volunteer visitors, and the first eligible paid home visitor, who contact me from each program.** After that, if additional home visitors contact me, they will be asked if they are interested in being an alternate. This ensures that I am not making subjective decisions about who to interview.
2. The group of volunteer visitors or paid visitors from your program can meet together (preferably with no one else present, for privacy reasons). The group can determine which home visitor(s):
 - i) best meet the eligibility criteria (above), and
 - ii) have the time and interest to take part.The group should also designate an alternate, who can take part if someone has to withdraw. The main drawback to this approach is that everyone who is present will know whose names are going forward. If knowing the names is a problem for anyone in the group, this method is not recommended.

Letter to eligible home visitors: Information on participating in a study (p. 3 of 3)

B. PUTTING YOUR NAME FORWARD, continued...

If your team does take this approach, please designate someone to forward me (as soon as possible) the name(s) and contact information of the home visitor(s) to be interviewed.

If you have ANY concerns about the privacy of participant information within your organization, please feel free to contact me directly (or if you prefer, talk with your Agency Contact Person).

C. GETTING MORE INFORMATION/CONTACTING THE RESEARCHER

Do you have any questions?

The attached Information and Consent Form provides more details about the study. If you have any additional questions, please contact me directly (see e-mail and telephone info., below). If you prefer, you can also ask your Agency Contact Person.

Are you interested in taking part in the study?

Please read the entire Information and Consent Form. If you are still interested, I look forward to hearing from you as soon as possible!

You can e-mail me at: mdonovan@dal.ca.

INSTRUCTIONS FOR TELEPHONING: Ring me on **0-902-463-7149** and indicate you want to reverse the international charges ("call collect"). This is my home office line, and I am working on this study full-time; I am at this number most of the time.

I live in Halifax, Nova Scotia, Canada, which is ___ hours behind you in _____. The best time to reach me is any time after _____ o'clock, your time. You can contact me on a weekday or a week-end – whatever is best for your schedule.

I realize that this is a lot of information to absorb and sort through. I thank you for the time you have put into reading the information, figuring out your eligibility, and deciding whether or not you are interested in taking part. All of these, in themselves, are important contributions to this study.

With much appreciation,

Maura Donovan
Master of Social Work student
Dalhousie University, Halifax, Canada

**Appendix G: Information and Consent
Form for Study Participants**

[Dalhousie University
letterhead - 7 pages in total)

Title of research study:

***“An exploration of family home visiting programs
that make use of both volunteer and paid visitors”***

Principal Investigator: **Maura Donovan**

Master of Social Work student
School of Social Work, Dalhousie University, 6414 Coburg Road,
Halifax, Nova Scotia, Canada B3H 2A7
(902) 463-7149 (home office – *reverse the charges*) e-mail: mdonovan@dal.ca

Supervisors:

Dr. Judy MacDonald, RSW, PhD

Associate Professor
School of Social Work, Dalhousie University
6414 Coburg Road
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(902) 494-1347 (w)
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Dr. Megan Aston RN, PhD

Assistant Professor
School of Nursing, Dalhousie University
5869 University Avenue
Halifax, Nova Scotia, Canada B3H 3J5
(902) 494-6376 (w)
e-mail: megan.aston@dal.ca

Contact person for this study:

If you have any questions or concerns regarding the study, please contact me, Maura Donovan, at any time. You can reach me at the above e-mail address or phone number (*reverse the charges*). You may also contact my co-supervisors, Dr. Judy MacDonald and Dr. Megan Aston, by e-mail, telephone, or post (see above).

You are invited to take part in a research study.

You are invited to take part in a study through Dalhousie University titled: **“An exploration of family home visiting programs that make use of both volunteer and paid visitors.”** I am doing this study for my Master of Social Work thesis.

Your participation in this study is voluntary. If you choose to take part, you may withdraw from the study at any time before the data analysis has begun. The senior staff person within your home visiting program has signed an agreement regarding this study. She/he has agreed that staff and volunteers are free to decide whether or not to take part in the study. She/he has also committed that your employment or volunteer work will not be negatively affected by whether or not you participate. You may choose to tell others whether or not you are taking part in the study. However, as the researcher, I will not give out any information regarding who has, or has not, taken part in the study. This information will not be given to senior staff, or anyone else in your organization, or any other individuals.

The study is described on the following pages. This description tells you about the study, what is being asked of you, and any risks and inconvenience you might experience by taking part. Participating in the study might not benefit you at the time of your participation. However, I hope to learn things that will benefit others in the future, especially people who are involved with home visiting. If you have any questions or concerns about this project, please contact me directly. If you prefer, you can bring questions/concerns to your **Agency Contact Person** for this study,
_____ [name].

Purpose of the Study:

There is a large body of research on home visiting programs for vulnerable and overburdened families with infants and young children. This includes studies on programs with paid visitors, and those with volunteer visitors. **However, a thorough search has revealed no studies focusing on what it means for programs to have both volunteer and paid visitors.** I work in such a program in Halifax, Canada. I have decided to make these programs the focus of my MSW thesis.

This research project will look at the following questions: Why and how did these programs come to have both paid and volunteer visitors? What are the experiences of people who work or volunteer in these programs? What would they say are the strengths, opportunities, dilemmas and challenges of having volunteer and paid visitors working in the same program? How do they deal with the dilemmas and challenges?

The goal of this study is to gain insight into these home visiting programs. I want to ‘shed light’ on the programs so that people can have a better understanding of them.

- **This study is not a comparison of volunteer visitors to paid visitors.**
- **This study is not an evaluation.** Its purpose is not to evaluate staff members, volunteers, home visiting programs, or any program’s approach to working with families. It is a descriptive study – the findings will *describe*, not measure, these programs.
- **This is not a study of the *families* involved in your program. The study will not ask questions about the families. I won’t interview parents or look at client records.**

Study Design:

Through this study, I will interview volunteers and staff from three home visiting programs. I will also review funding proposals, annual reports, evaluations, training manuals, and publicity materials. My focus will be those documents that relate to having both types of home visitors.

This type of research is called a *case study*. Case studies explore a topic that has not been well-researched.

Who will be conducting the research:

The research will be conducted by Maura Donovan. It is part of my Master of Social Work degree at Dalhousie University. I am a social worker and since 1997, I have been employed with an in-home support program for parents of infants. To avoid ethical conflicts, this program is not part of the study.

- **This research is not being carried out by your home visiting program/agency.**

What will happen to the information gathered:

The interviews will be typed word-for-word by a professional transcriber. Any names mentioned in interviews will be left out of the transcription. All of the information will be analyzed and written into a full thesis report. A plain-language summary of the findings will be sent to participants, home visiting programs, and other organizations in the voluntary, health, and social services sectors. I will write up the findings as an article and submit them to academic journals. I may also present at conferences.

You can take part in this study if ...

1. You are an experienced staff member or volunteer from a participating program.
See ☀ list, below, for details on who is eligible.
2. You can do a telephone interview in June 2010. It will be audio-recorded.
3. You have access to e-mail, and are OK to receive a confidential, password-protected document at that e-mail address. Please see #3 below, for details.

I will be interviewing 4 or 5 people from each program:

☀ **2 volunteer visitors**, each of whom has had several ‘matches’ (roughly 150 hours or more working with families in their homes), preferably for a period of at least two years.*

☀ **1 paid visitor**, who has been employed in this position for two years or more.*

☀ **1 supervisor of home visitors**, who has been in this role for two years or more.*

Duties related to working with home visitors should form a major part of the supervisor’s job.

☀ **1 person who knows the history and development of the home visiting program.**

This may be someone who is already being interviewed, or it may be an additional study participant.

****An exception may be made if no eligible staff member or volunteer has been with the program for two years or more. Your agency contact person will discuss this with the researcher.***

Please note:

- ▶ I will interview the first two eligible volunteer visitors, and the first eligible paid visitor, who contacts me from each program. After that, if additional home visitors contact me, they will be asked if they are interested in being an alternate. This way I am not making subjective decisions about whom to interview.
- ▶ Alternates are important. If someone from your program withdraws from the study, an alternate who has the same role will be asked to become a study participant.
- ▶ The “recruitment e-mail message” that accompanies this Information and Consent Form lists some examples of home visitor experiences that are particularly relevant to this study.

What you will be asked to do:

- a) **Read the interview questions prior to the interview, and think about the questions. This is a way to help prepare for the interview.**
- b) **Take part in one telephone interview, which will be audio recorded.** The interview will be scheduled at a time that is convenient for you. I will telephone you, and there will be no cost to you. I expect that interviews will last about 45 to 75 minutes. Interviews will focus on your experiences with the program. I’ll ask about your thoughts and feelings regarding the strengths, opportunities and challenges of this approach to home visiting. [For the ‘program history’ participant from each program, the interview will be about the history and development of the program, and major influences on the service].
- c) **Receive a transcribed (typed) copy of your interview.** I will e-mail this to you as a password-protected attachment. I’ll ask you to **read it over and give me any corrections, additions, or other feedback**. You can provide feedback by telephone (I will phone you). You can also e-mail your comments to me. I will ask you to provide feedback within one week of receiving the transcript. If needed, I’ll phone you to remind you. You can choose not to do this part of the research, if you wish.

Possible risks and inconveniences to study participants:

There may be some risks in taking part in this study, such as:

- In answering the questions, you might think about difficult or stressful experiences. I will talk with you about who might provide additional support, if you need that.
- As noted below (see “Confidentiality”), all efforts will be made to protect your identity. However, it is possible that some readers will know (or think they know) who said something in the study. **Your home visiting program will be named in the study.** This may make it easier for people who know your program to figure out who said what in the study.
- **Your participation is completely voluntary.** You are free to choose not to answer any question during the interview. You can also stop the interview at any time, for any reason.
- **You are free to withdraw from the study, for any reason. You must withdraw before I start the data analysis phase of the research.** If you withdraw, all your contributions to the study will be removed from the research. All records from your interview will be destroyed.
- The senior staff person within your home visiting program has agreed that staff and volunteers are free to decide whether or not to take part in the study. She/he has also committed that your employment or volunteering will not be negatively affected by taking part, or not taking part, in the study.

Do you have any questions or concerns about any of these points?

If so, please discuss them with me or with your Agency Contact Person.

Possible benefits:

There are no guaranteed or expected benefits from taking part in this study. Some people may enjoy the chance to discuss their work. Others may be pleased to be part of something that may help people who are involved in home visiting in the future. All participants will contribute to creating new knowledge on a topic where there has been little or no research in the past.

Confidentiality:

- **All possible measures will be taken to protect your identity.** You will not be named in the thesis. You will not be named in any publications, presentations or reports as a result of the study. Real names will not be recorded with the information from your interview. Information will be summarized and quotes disguised as needed. This will also help prevent others from identifying participants. However, this is a small study, and your program itself will be named. Therefore, it is possible that some readers – especially people who have a connection to your program – will know (or think that they know) who said what in this study. If you have any questions about this, please ask me.
- The interviews will be transcribed by a professional transcriber. She will sign a confidentiality agreement. She will not be given the names of those interviewed.
- Both the researcher and transcriber will store all study information securely. Electronic information will be password-protected, and paper files will be stored in a locked file cabinet. No one else will have access to these files during or after the study. After the transcribing is complete, the transcriber will destroy all electronic and paper files.
- Nothing that you share in the interview will be discussed with others from your organization (including other study participants and your Agency Contact Person).

Confidentiality, continued:

- All research materials will be stored in a secure location, in a locked file cabinet or a password-protected electronic file, for five years after the study is over. In 2015, the files will be destroyed. This is following the rules of the Human Ethics Review Committee of Dalhousie University.
- When you are interviewed, I will ask that you not mention names or other identifying information about families involved in the program (now or in the past). If you do mistakenly share this kind of information, it will not be passed on to anyone else. It will not be recorded when the interview is transcribed. It will not be written or typed on any papers that are part of this study.
- Please know that there are certain things that fall outside the scope of confidentiality. This study is not about the abilities of home visitors and supervisors. It is not about the well-being of individual families involved in each program. However, I am required to report or follow up on some types of information that might possibly be shared. I have to report any information that indicates there might be imminent harm to an individual or group. I must also report any mandated reportable violations, such as child abuse or a breach of professional ethics. These must be reported to the relevant authorities or professional body in your area.

Compensation/reimbursement:

I very much appreciate you offering to share your valuable time and insights. There is no financial compensation for taking part in this study. It is not expected that taking part will cost you any money. However, if you need to contact me by telephone, I will reimburse you for this expense. If you need child care or an interpreter so that you can complete the interview, these costs can also be covered. These expenses will be covered on a pre-approved basis only. To be reimbursed, you must first send documentation to me (original receipts, photocopy of telephone bill, etc.).

Problems and Concerns:

If you have any difficulties with, or wish to voice concern about, any aspect of this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance. She can be reached at (902) 494-1462, or patricia.lindley@dal.ca.

Next steps

On page 7 of this document, you will see what is called a 'signature page.' It must be read and completed by all study participants. If you decide that you want to take part in this study, please read and complete the signature page, and e-mail the whole document back to me (see e-mailing instructions, page 6). You must complete page 7 and send this document from your own e-mail account. **Completing page 7 and sending the entire document from your own e-mail account takes the place of signing your name to agree to take part in the study.**

If you would prefer to sign and fax the signature page, that is no problem. You can fax it to (902) 470-7153. You must fax all 7 pages. Please mark the cover page "Confidential – attn. Maura Donovan."

Thank you very much for considering taking part in this important study, and for taking the time to read through this information letter. Please continue to pages 6 and 7.

Sincerely,

Maura K. Donovan

0-902-463-7149 (home office – reverse the charges) or mdonovan@dal.ca

**INSTRUCTIONS FOR COMPLETING AND RETURNING
THE 'SIGNATURE PAGE' OF THIS CONSENT FORM**

Dear study participant,

As a participant in this research project, I ask that you read this entire Information and Consent Form carefully (pages 1 to 7).

After reading it, **please complete the signature page (page 7) and return it to me by e-mail.**

You can do this in two ways:

1. - Save this document in a private location on your computer. Fill out the final page on that copy.
- Address a new e-mail message to me: mdonovan@dal.ca.
- Attach the completed document to that message.
- E-mail it to me with a short message such as "Here is my consent form for the study."

OR

2. - Cut and paste the entire document into the body of an e-mail addressed to me. (It is OK if the formatting is changed or messed up in the e-mail.)
- Type in your responses (under the heading 'Signature Page') and send the e-mail to me.

To complete the signature page (page 7), you will:

- Type in your name in the space provided.
- Type in "YES" after those statements that apply to you [at the lines with an asterisk (*)]. Leave the other statements blank.
AND
- Indicate how you would like to be contacted (telephone or e-mail) and fill in your contact info.
AND
- Type in today's date and your e-mail address in the spaces provided.

Please send this e-mail from your own e-mail account. Send it to: mdonovan@dal.ca

Completing the form and replying from your own e-mail account will show that you have agreed to take part in this study.

If you have ANY questions about this form, the study, or your participation, please contact me via mdonovan@dal.ca; or on my home office number, 0-902-463-7149 (reverse the charges).

Thank you!

Sincerely,
Maura K. Donovan

**Please continue to the signature page (p. 7) to complete and return
this consent form.**

SIGNATURE PAGE (Agreement to take part in a research study)

➤ For instructions on completing this agreement, please see page 6.

Title of Research Study: **'An exploration of family home visiting programs that make use of both volunteer and paid visitors'**

Principal Investigator: Maura Donovan, student in the Master of Social Work program, Dalhousie University, Halifax, Nova Scotia, Canada

I, _____ (*type your name here*) have read the entire Information and Consent Form (this document). I have been given the opportunity to discuss it, and my questions have been answered to my satisfaction.

I consent to participate in this research study. I realize that my participation is voluntary, and that I am free to withdraw from the study, for any reason, at any time before the start of the data analysis phase. I understand that I may be a participant OR an alternate for this study.

*I do consent to an audio-taped telephone interview. ___

*I do **not** consent to an audio-taped telephone interview. ___

I give permission for words and/or statements spoken by me in the interview to be quoted (without my name), both in the final report of the study, and in any presentations or publications.

*I do consent for use of my quotations. ___

*I do **not** consent for use of my quotations. ___ (you can take part in the study if you say no)

I understand that a transcribed (typed) record of my interview will be sent to me. I will be asked to review it and provide any feedback and corrections I may have.

*I do agree to review a transcribed record of my interview and provide any feedback. ___

*I do **not** agree to review a transcribed record of my interview and provide feedback. ___
(you can take part in the study if you say no)

My preferred method of contact with the researcher (to arrange for a telephone interview) is...

___ By telephone, at the following number(s): _____

Best times/days to telephone (your local time): _____

OR

___ By e-mail, using the following e-mail address: _____

OR

___ Either telephone or e-mail (I have provided both e-mail and telephone info., above). ___

Today's date: (yyyy/mm/dd) ____ / ____ / ____

If you are faxing this: Sign your name here to show your agreement: _____
You must fax all 7 pages to (902) 470-7153. Please mark the cover page: "Confidential – attention Maura Donovan."

If you are e-mailing it: Type your own e-mail address here: _____

Save this document, and send it from your own e-mail account to:

mdonovan@dal.ca

Completing the signature page and replying from your own e-mail account will show that you have agreed to take part in this study.

Thank you!!

Appendix H: SEMI-STRUCTURED INTERVIEW GUIDE

May 30, 2010

Title of research study: **'An exploration of family home visiting programs that make use of both volunteer and paid visitors'**

Principal Investigator: **Maura Donovan, student in the Master of Social Work Program, Dalhousie University, Halifax, Nova Scotia, Canada**

Terms Used:

Program refers to the service that provides home visiting to families with young children.

Organization and *agency* refer to the group that hosts/sponsors the above-mentioned program.

Organization of interviews:

Section I (questions 1 to 3): a program history participant from each program will be interviewed. Preferably, this person has been with the organization a long time and was involved prior to the organization implementing the 'mixed delivery' of in-home services.

Section II (questions 4 to 6) - a supervisor of home visitors from each program will be interviewed. This may, or may not, be the same person as was interviewed for Section I.

Section III (questions 7 and 8) - two volunteer home visitors and one paid home visitor from each program will be interviewed.

Section IV – (question 9) - both supervisors and home visitors (4 people) from each program will be interviewed.

All participants will be asked the questions listed under 'Conclusion.'

Please do not mention names of clients/parents/families. Any names that are mentioned accidentally will not be recorded by the transcriber. They won't appear in the written record of your interview and they won't be in any reports. Basically, they won't be recorded in writing anywhere.

Section I: Program History Participant

___ Remind participant that taking part in the study is voluntary. Seek confirmation that her/his participation is voluntary. (If there is hesitation, inquire further to ensure interview does not proceed unless participation is truly voluntary).

1. CONTEXT: COMMUNITY AND HISTORY

1A. When did you first become involved with this program? Why did you get involved, at the beginning? What was your role? (Did it change over time? Was it full-time or part-time, volunteer or paid?) How long were you/have you been involved with this organization? In this time, have you played any other roles? Are you involved now?

1B. How did this program begin? Who started it, why was it started, and when?

1C. Is this program part of a larger organization or its own organization? Tell me more about that (Why and how did this arrangement come to be, how has it worked, etc.)

1D. Where is this program located? What is important to know about the larger community/city/region? (Population, political climate, largest industries/employers, social service structure, health care system, socioeconomic and ethnic composition, any other relevant features)

1E. What barriers or struggles were encountered in trying to start this program, and/or in the early days (up to the first few years)? What supported or facilitated the program's development?

1F. What were the beliefs and approaches that underpinned the program? (approaches to practice, theoretical or philosophical foundations, etc.)

1G. Is there anything else you think I should know about the historical context and early days of the program?

2. SERVICES PROVIDED BY THIS PROGRAM AT THE BEGINNING

2A. When this program started, who was visiting families in their homes?
Volunteers or paid staff? How many?
What roles did they have (what was the scope of their work)?
What training/education/life or work experience did they have?

2B. Describe the families who were served at that time.

Who was eligible? (defined by life stage & circumstances, demographic or geographical requirements, etc.)

What were the challenges faced by many families in the program, at that time?

What was the nature and complexity of their need for support/service?

2C. What was the structure/form of the service (hours per week, visits per week, length of service)?

In the beginning, did the program offer other services to the families?

If so, what services were offered?

3. THE DEVELOPMENT OF A MIXED-DELIVERY IN-HOME SERVICE

3A. Does the program have the same structure today as when it was first started?

If not, how has it changed? (focus on the shift to having both paid staff and volunteers, if that was not the case from the beginning).

When did this happen?

What was the impetus, need or motivator? Why were changes made?

3B. How did it happen?

Were there barriers to making this change - if so, what were they? How did you overcome these? (*go into detail*)

What things facilitated or helped this change?

3C. What external and internal factors have shaped the program's development, mission, scope, and roles? [*for example, but not limited to: the socio-political context (including the local health care/ social service context and political/ social/ economic trends); knowledge, ideology, values, and beliefs; funding limitations and opportunities; the priorities of the host agency and those managing the program*]

If the study participant is not presently involved with the program, the interview can wrap up here with the Conclusion questions (see next page). If the program history participant is involved at present, questions 5B and 5E, and 5F will be asked of both this participant and the supervisor of home visitors:

(5B). Have the characteristics of the community you serve changed since the program was started? How? Have these changes affected your program and the services provided?

(5E). Are there services or supports that you believe are needed, or that you would like to offer for families, that are not an option within your present structure? Why are they needed? Why aren't they offered?

(5F). Some questions about funding: Of the services that you provide, which are funded? Who funds them? Does one aspect of your program get proportionately more funding than others? Is it easier to get funding for one aspect than another? If so, why?

CONCLUSION

Is there anything I have missed?

Is there anything else you would like to add, or ask?

Thank you for taking part!

What to expect from here...

- member validation: timeline, email address, etc.

- additional thoughts, you can contact me at...

- Inform participant that a copy of report will be provided to the agency/program.

Participant would ____ would not ____ like to receive a copy of the Executive Summary directly.

Section II: Supervisor of Home Visitors

__ Remind participant that taking part in the study is voluntary. Seek confirmation that her/his participation is voluntary. (If there is hesitation, inquire further to ensure interview does not proceed unless participation is truly voluntary).

4. PRESENT-DAY SERVICES

4A. What is your role? Are you working in this capacity full-time or part-time? (part-time: how many hours each week?) How long have you been involved with this organization? In this time, have you played any other roles?

4B. What is the home visiting program's mandate and mission? What is the program's philosophy or approach to working with families?

4C. Who visits families in their homes?

How many volunteers? How many paid staff? Are staff full-time or part-time?

What training/education/life or work experience do staff have?

What training/education/life or work experience do volunteers have?

4D. What roles do volunteers play? What roles do staff play?

4E. What families are served? Do volunteers and staff serve the same families?

Who is eligible? (Defined by life stage & circumstances, geographic area, etc.?)

At this time, what are the challenges faced by the families in the program?

What is the nature and complexity of their need for support/service?

4F. What is the structure/form of the in-home services provided to families (hours per week, visits per week, length of service)? Is it the same for paid home visitors and volunteers?

4G. Does your program offer other services for/with families? If so, what? Who uses those services? What is the relationship of these services to the home visiting aspects of your organization?

4H. Does the structure now look like you envisioned it to look when you started to look at having both paid and volunteer home visitors? Or did it develop differently? If so, how is it different, and why?

4J. What are the strategic and operational plans for the program? (next few years) Where would your organization like to take this program in the future?

5. PRESENT-DAY CONTEXT

5A. What external and internal factors have shaped the program's development, mission, scope, and roles? *[for example, but not limited to: the socio-political context (including the local health care/ social service context and broader political/ social/ economic trends); knowledge, ideology, values, and beliefs; funding limitations and opportunities; the priorities of the host agency and/ or those managing the program]*

5B. Have the characteristics of the community you serve changed since the program was started? How? Have these changes affected your program and the services provided?

5C. Presently, what services are widely available and used by many families who also use your program? (Public health, community health centres, mother-baby/family resource programs, etc.) Has this changed over the years since the program was founded?

5D. Do any of these programs provide in-home services to the families involved in your program? If so, tell me all about them: who runs the service, what do they provide, how useful or relevant is it in meeting the needs of the families involved in your program, how many families in your program are also involved in this program, what's the relationship between the two programs?

5E. Are there services or supports that you believe are needed, or that you would like to offer for families, that are not an option within your present structure? Why are they needed? Why aren't they offered?

5F. Some questions about funding: Of the services that you provide, which are funded? Who funds them? Does one aspect of your program get proportionately more funding than others? Is it easier to get funding for one aspect than another? If so, why?

6. PUBLIC PROFILE/UNDERSTANDING OF THE PROGRAM

6A. What is the exact name of the program that offers home visiting?
How did it get this name? Does this name reflect the services provided?

6B. How is the service publicized, advertised, or presented?
(In brochures, on web site, verbally by staff and volunteers, etc.)
Does this public profile reflect the services provided?
How do written documents (articles, evaluations, studies) represent the program and its services?
Does this presentation reflect the services provided?

6C. *If 'no' to the questions in 6B:* Why is it presented in this way?

CONCLUSION

Is there anything I have missed?

Is there anything else you would like to add, or ask?

Thank you for taking part!

What to expect from here...

- member validation: timeline, email address, etc.
 - additional thoughts, you can contact me at...
 - Inform participant that a copy of report will be provided to the agency/program.
- Participant would ____ would not ____ like to receive a copy of the Executive Summary directly.

Section III: Volunteer and Paid Home Visitors

___ Remind participant that taking part in the study is voluntary. Seek confirmation that her/his participation is voluntary. (If there is hesitation, inquire further to ensure interview does not proceed unless participation is truly voluntary).

7. YOUR ROLE (this is a preliminary section/overview - # 8 is more in-depth)

7A. What is your position in the program? Are you paid or a volunteer? How long have you been involved? In this time, have you played any other roles?

For volunteers: how many families have you been matched with? How long? A bit about their situations, if relevant?

For staff members: Are you full-time? If no, how many hours each week do you work in this role? How much of your job is working in-home with families?

7B. What is your role?

7C. What do you enjoy about this work?

7D. What do you find challenging or difficult in this work?

7E. What are the beliefs and approaches that underpin your work? (values, beliefs, approaches to practice, theoretical or philosophical foundations, etc.)
Are these the same as those of the program as a whole?

8. ROLES WITHIN THE PROGRAM (*explore these in depth, with probes*)

8A. Please give me some examples of volunteers and staff at work with families in your program.
Who does what, how does it happen, who does what work with families?
How are families affected? (*Great detail here*)

8B. IF APPLICABLE: Tell me about a situation, or situations, where a family was involved with you and another (paid/volunteer) home visitor from your program.
Why was it set up to have both of you working with the family?
How did it go? (*Explore roles, communication, progress, challenges, as relevant*)
What was that experience like for you? Why?
(*if more than one experience, ask about each one*).
How does that experience compare to times when you were matched with a family without another visitor?

8C. How does having paid and volunteer home visitors affect one another's work?
Are there any challenges or dilemmas? How are these dealt with?

8D. (*As relevant - For people who have been with the program long enough to know this*) What difference has it made to have both paid and volunteer home visitors in your program?
How are the services, the working conditions, the situations/families served, the experiences, or the outcomes **different**?
(*Great detail here*)

- 8E. If you could change anything about the home visiting program, what would it be? Why?
- 8F. What are the best features of this program? Why? (*if needed* - If you could only keep one or two aspects of the current home visiting program, and other characteristics had to be removed, what key aspects would you want to keep?) What has allowed these best features to exist?
- 8G. Are there services or supports that you believe are needed, or that you would like to offer for families, that are not an option within your present structure? Why are they needed? Why aren't they offered?
- 8H. In your opinion, what can this approach contribute to the field of home visiting generally? What would you say to those who are interested in knowing more about having both volunteer and paid home visitors in the same program?

Section IV. Program Impact (supervisors, paid visitors, and volunteer visitors)

9. PROGRAM IMPACT

9A. What difference(s) does this program make? (or What impact does your program have?)

For parents

For children

For volunteers

For staff

For others

9B. What is this based on? - your experience and interpretation, feedback from families, feedback from others (who?), program evaluation, research study?

9C. In your opinion, what allows or enables the program to make these differences or have these impacts?

CONCLUSION

Is there anything I have missed?

Is there anything else you would like to add, or ask?

Thank you for taking part!

What to expect from here...

- member validation: timeline, email address, etc.
- additional thoughts, you can contact me at...
- Inform participant that a copy of report will be provided to the agency/program.
- Participant would ____ would not ____ like to receive a copy of the Executive Summary directly.

Appendix J: Sample of Pre-Interview Email to Study Participants

Note: The email sent to each participant included only the interview topics relevant to her/his role (volunteer, front-line staff member, manager, or program history participant). This is a sample of an email sent to a program manager, who also provided program history information.

Dear [name of participant],

Here is the list of topics that will be covered in the interview. It's a long list, but some items will be quick, as we won't start 'from scratch' with each topic; we'll build on what I have read/learned about [name of program] thus far.

And while we will discuss a range of topics, we'll continually relate these topics back to the main focus of the study – that is, having both paid staff and volunteers who work with families in their homes.

Topics include:

- 1 - The reasons why the program was first developed and exists today; how it was started and by whom.
- 2 - Your role – then and now
- 3 - The local-regional/national context – then and now (social, political, and economic context; health care and social service context; gaps in service; etc.)
- 4 - A description of the program – then and now (size of program, services provided, structure, goals, underlying values/philosophy/approach, etc.)
- 5 - Families served by the program – at the outset, and now
- 6 - Program impact
- 7 - A closer look at having both paid staff and volunteers who work in families' homes:
 - how it works (who does what, with whom, and under what circumstances?)
 - what about this works well, and what is challenging?
- 8 – Funding
- 9 - Publicity and public awareness/understanding of the program
- 10 - Anything else that you want to add

Please let me know if you have any questions, if you have not received the Memorandum of Understanding or the consent form, or if you have any problems with either of these.

Thank you!

I look forward to talking with you on [day and date].

Maura

Appendix K:

CONFIDENTIALITY AGREEMENT FOR TRANSCRIBER/CODER

Title of research study: **‘An exploration of family home visiting programs that make use of both volunteer and paid visitors’**

Principal investigator: **Maura Donovan**, student in the Master of Social Work Program, Dalhousie University, Halifax, Nova Scotia, Canada

I, _____, will be (check one) ____ transcribing interviews OR ____ coding for inter-rater reliability for the above-named study.

I have agreed to keep strictly confidential all information contained within the associated digital audio files and/or paper files.

I will not record any names that may be noted in the audio recording or other materials. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the researcher, for purposes of clarification in transcription.

I will store all digital files in a password-protected directory on my computer and ensure no one has access to these files. I will store all paper files in a locked file cabinet in a secure location.

When my transcribing/coding work for this study is complete, I will delete all of the files – both digital audio files and transcribed (word-processing) files – that are associated with this study, and will destroy any paper files associated with this study.

Transcriber/Coder (print name): _____

Transcriber/Coder (signature): _____

Date _____

Principal Investigator (signature) _____

Date _____

Appendix L: Overview of Four Mixed-Delivery Home Visiting Programs

Program Feature	Programs that participated in the present study (accurate as of 2010)			Program where researcher employed
<i>Program Name</i>	Community Mothers Programme	Welcome Baby Utah County	Good Beginnings Volunteer Home Visiting and Family Support Program	Extra Support for Parents Volunteer Service
I. Background information				
<i>City, State / Province Country</i>	Dublin, Ireland	Provo, Utah, USA	Hobart, Tasmania, Australia	Halifax, Nova Scotia, Canada
<i>Sponsor/Host Agency</i>	Health Service Executive (HSE)	United Way of Utah County, in partnership with Utah County Health Dept (UCHD)	Good Beginnings Australia (GBA)	IWK Health Centre
<i>Host agency is what type of organization?</i>	National health authority	Local United Way chapter	National family service organization	Regional women's & children's hospital
<i>Geographical Area(s) serviced</i>	11 specific areas within the national capital (Dublin: 1,300,000)	County (mix of small cities, towns, & rural) (pop. ~500,000)	State capital and surrounding area (pop. ~200,000)	Provincial capital and surrounding area (pop. ~300,000)
<i>Population</i>				
<i>Operating Since</i>	1988	2000	1997	1995
<i>Program was initiated by</i>	Eastern Health Board (now part of HSE)	Utah County Health Department	Good Beginnings Australia	Friends of the IWK (hospital auxiliary)
<i>Eligibility: age of Child(ren)</i>	infant	infant	birth to age 8	youngest child 6 months or younger
<i>Eligibility: Other</i>	First-time parents of infants	First-time parents of infants	Stressful or difficult family situation	Stressful or difficult family situation
<i>Universally Offered or Universally Available?</i>	Universally offered in 11 designated local areas	Universally offered to those families who do not qualify for UCHD services	Universally provided upon referral (including self-referral)	Universally provided upon referral (including self-referral)
<i>Note: In all programs, service is dependent on the availability of volunteers & staff</i>				
<i>Number of Families served annually</i>	~2000	~200	63 (2007-2008)	70-100
<i>Number of Active Volunteer Home Visitors</i>	155	50	~30	30-50
<i>Number of Paid Staff (Total)</i>	8 full-time 4 part-time	1 full-time 1 part-time	5 (mix of full-time and part-time)	3 full-time
<i>Are some families assigned to prog. manager as home visitor?</i>	Yes	Yes	Yes	No

Program Feature	Programs that participated in the present study (accurate as of 2010)			Program where researcher employed
<i>Program Name</i>	Community Mothers Programme	Welcome Baby Utah County	Good Beginnings Volunteer Home Visiting and Family Support Program	Extra Support for Parents Volunteer Service
II. Program Description				
<i>Services provided: Education, Support, and/or Assistance?</i>	- Parent education on infant care & development - Emotional support - Community resource info. & referrals	- Parent education on infant care & development - Emotional support - Community resource info. & referrals	- Parenting information/education (<i>infant & older children, as relevant</i>) - Emotional support - Community resource info. & referrals - Practical assistance with children (<i>more often volunteers than FSW's</i>)	- Parenting information/education (<i>infant & older children, as relevant</i>) - Emotional support - Community resource info., referrals - Practical assistance with children (<i>volunteers, not FSW</i>)
<i>Curriculum-Based?</i>	Yes	Yes	No	No
<i>Program Philosophy</i>	- Parents are experts on their own children - Empowerment for mothers	-Teach and support parents using tailored information -Strengths-based	-The <i>Connect</i> Approach (strengths-based) -Social development in collaboration with local communities	- When parents are supported through a difficult time, they and their children will fare better
<i>Frequency of Visits: Weekly or Monthly</i>	monthly	monthly	weekly	weekly
<i>Duration (length of time) that families receive service</i>	1 year; in some areas, up to 2 years (as per availability of volunteers)	Up to 1 yr is standard, though many families finish after 4 or 5 visits; volunteers can visit up to 3 years as needed.	<i>Volunteers</i> : most often 9-12 months; indefinite to age 8. <i>Staff (FSW's)</i> : up to 1 year (longer in extenuating circumstances)	<i>Volunteers</i> : 3-6 months (longer in extenuating circumstances) <i>Staff (FSW)</i> : 3-9 months most common; no set length of service
III. Volunteer Visitors				
<i>Length of volunteer visit with each family (hours)</i>	1 hour/month	1 hour/month	1.5 - 2 hours/week	3 hours/week
<i># families served by a volunteer at any given time</i>	5; up to 15	- 1/3 of volunteers: 1 family - 2/3 of volunteers: 2+ families	Most often, 1	Most often, 1
<i>Volunteers report directly to:</i>	Family Development Nurse in local area	Director (<i>referred to as 'manager' in present study</i>)	Coordinator (<i>referred to as 'manager' in present study</i>)	Coordinator (<i>referred to as 'manager' in present study</i>)

Program Feature	Programs that participated in the present study (accurate as of 2010)			Program where researcher employed
<i>Program Name</i>	Community Mothers Programme	Welcome Baby Utah County	Good Beginnings Volunteer Home Visiting and Family Support Program	Extra Support for Parents Volunteer Service
<i>Volunteers are supported by</i>	Family Development Nurse in local area (if there is no FDN, Director)	Both staff (n=2) and interns (n=4)	All staff within the Volunteer Home Visiting and Family Support Program	All staff members
<i>Experience/ Background of Volunteers</i>	Experienced mother living in local service area	Almost all volunteers are parents	Must be a parent	May or may not have own children
<i>All programs seek volunteers with parenting/child development knowledge, who are mature and reliable, have a warm and caring personality, and can take initiative and work independently.</i>				
IV. Paid visitors (various titles)				
<i>Average # of families served by a staff member at one time</i>	5 or more (direct in-home service is a small part of staff members' work)	Director – 10 fam. Assistant – 5 fam.	Varies, as most front-line staff members (FSW's) are part-time.	Family Support Worker – 15-20 fam.
<i>Frequency of visits with each family</i>	Monthly	Once a month or more, as needed	Weekly, or as required	Weekly or bi-weekly; more or less often as needed
<i>Is service provided the same as volunteer service, above?</i>	Yes, although staff are nurses, so they have a broad scope of knowledge. Also, some families served by staff face more complex issues.	Yes, although some families served by staff face more complex issues.	Yes and no. FSW's provide more "direct strategies" to improve family functioning, more advocacy, and less instrumental assistance, than volunteers.	Yes and no. FSW provides in-depth parenting life skills education, problem-solving, intervention, and advocacy; much less instrumental assistance.
V. Program Evaluation and Research (see reference list for full citations of reports and articles below)				
<i>Program Evaluation Completed</i>	Yes; RCT and 7-year follow-up study published in peer-reviewed journals	No	Yes* (evaluation of all four GBA home visiting pilot sites)	Yes
<i>Date(s) of Program Evaluation(s)</i>	1993 (Johnson, Howell, & Molloy) 2000 (Johnson et al.)	N/A	1999, 2000 (Cant)	2005 (Acton)
<i>Has research been carried out on this program?</i>	Yes (RCT & follow-up study, above). Also, study on Programme's extension to travelling community published in 1997 (Fitzpatrick, Molloy & Johnson)	No	No *See also evaluation of Sydney, AUS volunteer visiting program co-sponsored by GBA & Benevolent Society (Benevolent Soc., 2009)	No

From: Donovan, M.K. (2011). *Greater Than the Sum of Its Parts: An Exploration of Family Home Visiting Programs Involving both Volunteer and Paid Visitors*. (Master's thesis).