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Home Visiting: Stakeholder views and experiences of home visiting in Ireland - A vision for the future

Report Number Two

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Early Supports for families

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UNITES Project: Stakeholder views and experiences of home visiting in Ireland - A vision for the future

Report Number Two

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EXECUTIVE SUMMARY

Background

National policies such as *Better Outcomes, Brighter Futures (2015), First 5 – A Whole of Government Strategy for Parents and Babies (2019)* and *Supporting Parents: A National Model of Parenting Support (2022),* recognise the importance of, and reflect a strong and enduring commitment to, supporting early childhood development and wellbeing through the provision of accessible, high quality and evidence-led supports. For instance, a key goal of 'First 5' is to develop strong and supportive families and communities, including a commitment to the development of universal parenting supports (also reiterated in the National Model of Parenting Support Services) and, importantly, in the context of the current study, an evidence-led approach to home visiting services across a continuum of need (DCEDIY, 2022). Indeed, a wealth of both national and international evidence indicates that the home environment, and therefore services provided in the home, provide a crucially important context, and support, for healthy child development and wellbeing (e.g. Bradley & Corwyn, 2008).

The UNITES project: Aims and Objectives

The UNITES project was commissioned (in 2022) by the Department of Children Equality Disability Integration and Youth (DCEDIY). The project involved two separate, but related stages, the aims of which were: **(1)** to profile and critically review home visiting provision in Ireland; and **(2)** to elicit the insights, views and experiences of a wide range of stakeholders involved in managing, implementing, delivering or receiving home visiting programmes and services across the country. The ultimate goal of this work was to identify some proposed actions or 'options' that provide key stepping stones toward a more standardised and sustainable 'model' of home visiting service delivery in Ireland.

Specifically, the **objectives of the Stage One of the UNITES project** were to conduct an in-depth review of the national literature in order to: (a) map/scope out the home visiting context and provision in Ireland; and (b) to critically examine relevant evidence around the effectiveness and implementation of home visiting programmes nationally (and contextualised with reference to the international literature). This review, presented in a companion report **(Report Number One, Hickey et al., 2023),** profiled 10 home visiting programmes across the country, as well as 5 other support services which incorporate a home visiting element, but which are not traditional/dedicated home visiting providers. All operate within the early learning, education and prevention and early intervention spheres.

The findings of this review highlight the considerable diversity of home visiting provision across Ireland. However, we also identified a number of common approaches and mechanisms, such as the strong relationships developed between Home Visiting Practitioners (HVPs) and parents, a shared goal of promoting child development and enhancing parenting skills, and the use of evidence-informed and evidence-based approaches for optimising child outcomes. Further information is available in our first report.

The **objectives of Stage Two of the project** were to: (a) elicit, using multiple methods, the insights, views and experiences of a wide range of stakeholders involved in managing, implementing, delivering or receiving home visiting programmes across Ireland; (b) to critique the findings in the context of both our earlier national (scoping) review (i.e. Report Number One) and a smaller separate review of the international literature which was undertaken in parallel. The findings of this stage of the research

are reported here **in this second and final report**. The report concludes with a number of suggested, largely stakeholder-informed options that should help to enhance the standardisation, optimal effectiveness and sustainability of the home visiting sector in Ireland.

Method

A large sample of approximately 100 stakeholders took part in a number of different components of Stage Two of the project including: **(1)** a 'What Works' workshop conducted as part of the Collaborative Action Research Network (CARN) Conference on 28th October 2022; **(2)** a national online survey; **(3)** a series of one-to-one interviews (which included a small sample of mothers), focus groups and group discussions; **(4)** a small number of observational/shadowing in-home visits with HVPs and families; and **(5)** a co-participatory 'stakeholder engagement' workshop which was held in late 2023.

Key findings

Collectively, a number of key themes were identified from the qualitative data (i.e. relating to activities 1, 3, 4 and 5 above) including: **(1)** the benefits of home visiting programmes and other support services; **(2)** multi-level and sector-wide challenges; **(3)** interagency partnerships and collaboration; **(4)** qualifications, training and supervision; and **(5)** macro-level and sector-wide challenges/barriers.

Overall, the findings highlight **the importance and considerable benefits of home visiting programmes** for strengthening child health and development, supporting parent health and improving parenting skills. Home visiting was seen as particularly beneficial for socially isolated or more at-risk families, who may be less likely, or unable, to engage with more traditional healthcare or parenting programmes.

The role of HVPs in supporting, and promoting, child and family wellbeing, particularly among the most vulnerable populations, **is wide-ranging, focusing on child development, parent-child relationships, family care, advocacy and the provision of both practical and social support.** An example of the support provided by HVPs is outlined in the pen portrait below (Box A) which was one of a number developed on the basis of the shadowing/observation element of this project.

Importantly, our findings reflect **a generally highly qualified workforce** that regularly engages in Continuous Professional Development/training and who are committed to supporting, and advocating for, the families in their care. However, the albeit smaller than expected, number of responses to the national survey showed that while most participants were satisfied in their current role, two-thirds indicated that their **salary did not adequately reflect the responsibilities** of their role, and a similar proportion felt that **their service was "filling a gap".** More detailed data gathered through the one-to-one interviews and focus groups illustrate how these issues are compounded by both structural and personal challenges for which HVPs are often ill-prepared (e.g. high levels of mental health difficulties, alcohol and substance abuse, domestic violence) land/or a lack of formal protocols or mechanisms for referral on to other support services.

The increasingly **complex and heavy workloads of HVPs**, coupled with a **perceived lack of recognition** within the early years sector were particular sources of frustration, and raise concerns about their continuing capacity (and remit) to provide early intervention support to high-risk families. This perceived lack of understanding and recognition of their contribution within the early years sector is also reflected, to some extent, in existing government policy which fails to recognise explicitly the role and impact of home visiting on family and child outcomes.

Box A: Pen Portrait One (based on shadowing/observation and interview)

Name of programme: Community Mothers, Athlone
Referral source: PHN (due to poor mental health/ postnatal depression)
Duration of engagement with service: Approximately 18 months

The family in receipt of home visiting support comprised a young single mother (pseudonym 'Ciara') in her early 20s and her 18-month-old child, both of whom were living in an apartment complex with the child's maternal grandmother who was also present during the visit. The HVP (pseudonym 'Jean') had been visiting the family for over 18 months and on this occasion, she carried two large bags of developmentally appropriate toys to the home.

It was clear from the body language, tone and level of familiarity, that Jean and Ciara shared a close relationship; their interaction was very comfortable, informal and relaxed. They discussed the events of the previous week, including progress with accommodation, the child's developmental progress and the mother's mental health. Ciara described her difficulties with parenting alone and remarked that she would not know what to do without Jean's support.

During the visit, Jean sat on the floor and engaged with the baby while providing positive feedback to both the baby and Ciara regarding the child's developmental progress. The child was very comfortable and positively responsive towards Jean and she stated a number of times how Ciara was doing 'a good job'. Ciara also talked about her positive experience of a baby and toddler group (delivered by Jean). The grandmother spoke positively about the help and support provided by Jean which had helped to alleviate some of her stress and worry concerning her daughter and granddaughter.

Ciara described the difficult living situation where three generations were sharing one bedroom, which was further compounded by her own poor mental health as well as her mother's ill health. Thefamily have been residing in Ireland for 16 years, 10 of which were in Direct Provision. Ciara's mothersaid that her daughter had no friends and that they would not be able to manage without Jean's kindness and friendship. Jean later informed the researcher that in previous weeks, she had attendedmeetings with the council and a local TD regarding the family's cramped and unsuitable livingcircumstances and that the situation was now under review.

Despite the widely reported benefits of home visiting, there is **considerable variation across the sector in terms of overall governance and funding streams which pose a significant barrier to optimal effectiveness/impact and sustainability.**

Furthermore, while most programmes (as mentioned by participants and also included in our earlier review) were either evidence-informed or evidence-based, there was **limited evidence of up-to-date evaluations** (especially economic studies). A need was indicated for more comprehensive standardised assessments **and regular monitoring and evaluation activities** to assess outcomes over the longer-term and to support programme development, effectiveness and sustainability.

The **lack of a national home visiting infrastructure**, including appropriate governance and policy support, coupled with continuing funding instability and uncertainty (fuelled by a reliance on fluctuating public funds and other socioeconomic factors), are significant barriers to the successful

delivery/implementation, effectiveness, impact, availability and sustainability of home visiting provision. These challenges appear to have been compounded by the COVID-19 pandemic and the cost-of-living crisis, both of which have added to the vulnerability of many families and intensified the demand for home visiting support, while requiring HVPs and services to adapt rapidly to meet many new challenges.

An at-a-glance summary of all of the findings is provided below in Table A (in line with the five overarching themes mentioned above).

Table A: Summary of the findings

Theme	Findings
Benefits of home visiting programmes (and other support services)	• **Provides unique support** that adopts holistic and family-focused approaches • **Promotes child development and wellbeing**, enhances parent-child relationships and supports parent well-being • **Builds trusting relationships with parents/families** that facilitate ongoing engagement and access to wider supports • **Reduces stigma and negative intergenerational outcomes** • **Incorporates, and responds to, 'the voice' of the parents and children**; advocates for children/parents and provides regular practical support • **Uses evidence-based and evidence-informed** programmes and practices.
Multi-level and sector-wide challenges	• **Increasing levels of need and complexity** (e.g. homelessness, poverty, greater family diversity, increase in parental and child mental health) are placing greater demands on staff. • The **HVP role increasingly involves "holding families"** such as those on waiting lists, or who require more specialised services (e.g. Speech & Language Therapy, Occupational Therapy, psychology, social work and mental health service support). • There is a **perceived lack of professional recognition** of the value and impact of the HVP role, particularly with regard to their work with vulnerable and at-risk populations.
Interagency partnerships and collaboration	• **Interagency working is crucial** for effective service coordination and for enhancing family outcomes. • There is **a lack of formal protocols** around engaging families and facilitating more effective interagency working. • **Limited availability of, and widening gaps in, service provision** negatively impact HVPs' capacity to provide adequate support. • **Children with disabilities and additional needs** are not receiving appropriate targeted care and services.
Qualifications, training and supervision	• **HVPs are generally well-qualified** and regularly engage in ongoing training/CPD and reflective practice. • There is **considerable variation** in terms of staff qualifications and level of experience across programmes. • **Regular CPD is essential** to meet the increasingly diverse and changing needs of families.

	• There were **mixed views regarding the minimum level of qualifications,** although all participants highlighted the importance of personal attributes and 'soft skills'.
Macro-level and sector-wide challenges/barriers	• **Funding and resource constraints** (e.g. insecure and short-term funding streams): ○ **Hinder expansion** and the long-term provision/sustainability of services ○ **Negatively impact staff salaries** and retention ○ Mean that HVP **salary levels are not seen as commensurate with their level of responsibility and expertise.** • **Monitoring and evaluation**: ○ Evidence-based and evidence-informed programmes are considered important, but there is **a need for some adaptability/flexibility** to meet families' needs. ○ There is a **lack of standardised measurement frameworks** and monitoring systems to support programme development, implementation and impact. ○ There are **very few long-term follow-ups.** ○ There is a marked **absence of economic evaluations.**

Conclusion

This study is the first to provide an in-depth exploration of home visiting at a national level in Ireland. The findings provide important and useful insights into the views and experiences (and attendant challenges) of some of the wide range of stakeholders who work in the home visiting sector in Ireland; these include not only the many frontline practitioners, but also those occupying managerial/co-ordinator, research and other support/advocacy roles.

The combined findings reported here and in our earlier companion report (Hickey et al., 2023) provide, for the first time in a national context, an important basis to inform the identification and careful consideration of some proposed actions that may be used as key stepping stones toward **a more standardised, effective and sustainable 'model' of home visiting provision** in order to enhance outcomes for vulnerable children and their families in Ireland. To this end, we have presented later in this report, a largely stakeholder-informed 'menu' of options which may be implemented on a short-, medium- or longer-term basis, with the support of appropriate funding and other requirements (e.g. appropriate and effective leadership, commitment and creativity).

These suggested options/actions straddle four broad topic areas including: (a) the HVP role, training and qualifications; (b) funding and its relationship to the viability, accessibility and sustainability of services; (c) interagency, cross-disciplinary and multi-sector working and collaboration; and (d) the

implementation of collaborative intra-sector mechanisms and structures. These are not designed to be exhaustive, but rather to highlight a number of critical areas that should be prioritised for the future development, optimal effectiveness and sustainability of the home visiting sector in Ireland. A graphical summary of these is provided below.

Figure A: Key learnings and options for the future development and sustainability of home visiting provision in Ireland

SECTION 1: INTRODUCTION

1.1 Background

Over the last 20 years, there has been a considerable expansion of home visiting programmes and other support services across Ireland. More recently, the impact of the cost of living and housing crisis, as well as the legacy of the COVID-19 pandemic and the growing demands on health and socialcare services and supports, have placed increasing pressure on home visiting providers to meet the needs of children and families.

Families seeking home provider help and support are often struggling with complex needs (e.g., mental health, addiction issues and domestic violence) which are compounded by the increasing demands on health and social care services, including increasing numbers of children presenting with speech and language difficulties, child developmental problems, undiagnosed disabilities and child safeguarding issues. Despite these challenges, Home Visiting Practitioners (HVPs) continue to play a critical role in supporting families and promoting child well-being, although their full potential and impact can only be realised by establishing a sustainable, universal, well-resourced and progressive model of integrated service delivery.

1.2 The UNITES project: Aims and Objectives

The UNITES project was commissioned in 2022 by the Department of Children Equality Disability Integration and Youth (DCEDIY). The aims of the project were: **(1)** to profile and critically review home visiting provision in Ireland (***Report Number One***)**;** and **(2)** to elicit the insights, views and experiences of a wide range of stakeholders involved in managing, implementing, delivering or receiving home visiting programmes and services across the country. The ultimate goal of this work was to identify some proposed actions or 'options' that may be used as key stepping stones toward a more standardised, effective and sustainable 'model' of home visiting service delivery in Ireland ***(Report Number Two)*****.**

The project involved two separate, but related stages designed to address the above aims. The objectives of *Stage One* were to: (a) conduct a scoping review of the national literature in order to map/scope out the home visiting context and programme/service provision in Ireland; and (b) to critically examine relevant evidence around the effectiveness and implementation of home visiting programmes and other support services nationally (contextualised with reference to the international literature). **The results from Stage One of the project are presented in a companion report (Report Number One, Hickey et al., 2023).**

The current report presents the findings relating to *Stage Two* of the UNITES project, the aims of which were to: (a) elicit, using multiple methods, the insights, views and experiences of a wide range of stakeholders involved in managing, implementing, delivering or receiving home visitingprogrammes across Ireland; (b) critique the findings in the context of both our earlier national reviewand a separate scoping review of the international literature which was undertaken in parallel (i.e. Report Number One); and (c) to use the findings to inform the identification and consideration of some proposed actions or 'options' that may be used as key stepping stones toward a standardised and more sustainable 'model' of home visiting service delivery in Ireland.

1.3 Home Visiting: Terminology

As outlined in our first report, home visiting programmes, services and supports, both in Ireland and elsewhere, differ considerably in terms of their aims, staffing, duration, implementation, intensity, and timing. Therefore, as outlined in our first report, there is, as yet, no universally agreed definitionof a 'home visiting service'. Thus, for purposes of this research, we have adopted the broad definitionof a 'home visiting service' provided by Sweet and Appelbaum (2004) who refer to it as "*an umbrella term that implies a strategy for delivering a service* [in the home]*, rather than a type of intervention…"*(p. 1435). The term 'home visiting programme', on the other hand, is used throughout this and our earlier report to refer to a structured intervention/approach which is delivered typically *as part of* a wider home visiting or family support service (although these programmes can also operate as stand-alone provision). We also refer within both of our reports, to what we describe as 'other support services' to refer to a smaller number of services that incorporate a home visiting component as partof their work, but which do not follow a traditional or dedicated home visiting service model. Lastly, we use the term 'Home Visiting Practitioner' (HVP) to refer to all staff who work within the home visiting sector, regardless of their background, experience or qualifications.

1.4 Home visiting provision in Ireland: a brief summary

As described in our previous companion report, **10 home visiting programmes** were identified and included in our review (see *Appendix 1),* all of which are currently being delivered in Ireland typically as part of, or in association with, one of the following four State & community/voluntary sector initiatives/services: the ABC programme; the Home Visiting Alliance (HVA); Infant Mental Health Networks; and Tusla Child and Family Agency. These fall broadly into two categories including: **(i) parent/family-focused programmes** which are delivered entirely or partially in the home and aim to promote positive parenting, early learning and/or enriched home environments (n=3); and **(ii) early childhood programmes** (n=7) that specifically target families from the earliest years (e.g. from pregnancy up to school entry) and typically aim to support parents to enhance their child's and their own health and wellbeing. We recognise, however, that there may be some degree of overlap between these two categories.

An additional **5 other support services** were also identified and included because they describe services which provide home visiting support for young children and their families as part of their routine delivery, albeit these are not home visiting service providers as such and neither do they focus solely on young children and their families. Nonetheless, there is a home visiting element to their work that involves delivery to young children and their families. These include two education-focused services which are mainly of a niche/specialist nature and designed to target specific educational needs (e.g. disability, language development) and three disability-focused services and supports aimed at supporting families of children with a severe to profound cognitive delay or life limiting condition (Table 2).

Further information is provided in our companion report which comprises four sections on: profiling and describing home visiting provision across Ireland; examining the development and nature of provision; assessing the evidence of impact/outcome achievement based on the academic literature; and exploring aspects of implementation (Hickey et al., 2023).

1.5 Stage Two activities

Stage Two of the project involved five separate, but interrelated elements/data collection activities designed to provide insights into, for example, the Home Visiting Practitioner (HVP) role, perceived strengths and limitations of home visiting services and supports in Ireland, the nature and extent of interdisciplinary collaboration/engagement, funding supports, standardisation and possible training and qualifications. These activities included:

(1) an initial exploratory 'What Works' workshop/ informal discussion which took place as part of the Collaborative Action Research Network (CARN) Conference on 28th October 2022)[1];

(2) a national online (anonymous) survey of home visiting personnel/stakeholders administered to provide a snapshot of their role, experiences and views;

(3) a series of one-to-one interviews with key informant stakeholders and focus groups/group discussions with HVPs (including a small number in management roles);

(4) in-home observation of a small number of families currently receiving home visiting services and shadowing of the HVPs who work with them, as well as a small number of interviews with both participant groups; and

(5) a co-participatory 'stakeholder engagement' workshop/event toward the end of the project, designed to provide a forum to enable key stakeholders to comment on, and discuss, the key findings from the study and to co-identify any additional issues/gaps or possible future developments.

1.6 Structure of this report

The remainder of this report is divided into three key sections which include more detailed information on the above in terms of our overall methodological approach *(Section Two)*, the findings pertaining to each *(Section Three)*, and a final discussion section *(Section Four)* which involves a synthesis and critical appraisal of the findings in the context of both the national and international literature, and concludes with some suggested next steps for the future development of the home visiting sector in Ireland.

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[1] The workshop findings were used to inform subsequent elements of the study.

SECTION 2: METHOD/APPROACH

This second section of the report describes the methodological approach involved in each of the above five key elements of Stage Two of the UNITES project (in approximate chronological order).

2.1 Initial informal workshop (CARN conference)

2.1.1 Participants and Settings

The CARN workshop, which was conducted in hybrid format, was attended by 88 people in total, including 40 professionals who attended in person and 48 who were online (on Microsoft Teams). The predominantly female attendees were from a range of backgrounds including home visiting management, board members, HVPs, therapists, researchers, and others representing organisations such as the HSE, CYPSCs, Tusla, Preparing for Life, ParentChild+, Life Start, Community Families, Infant Mental Health, the Katherine Howard Foundation, Dublin City Childcare Committee and various ABC sites. No formal or personal data (including names) were collected in view of the exploratory and preliminary nature of the discussion/consultation, nor was the event recorded. All attendees indicated that they were happy to be involved and were informed that they were under no obligation to contribute if they felt uncomfortable in so doing.

2.1.2 Measures

A workshop discussion schedule was developed by the research team, focusing on a number of key issues that were considered to be of interest from our initial review of both the national and international literature, including: understandings and perceptions of the role of HVPs; awareness of services and supports; links to the community; interdisciplinary engagement, training and supports; and the strengths and limitations of HV services more generally.

2.1.3 Overall Approach

At the outset, the team delivered a short presentation on the UNITES project (available upon request) including background, aims/objectives and methods, and engaged thereafter in an active and open Q&A discussion and feedback session relating to home visiting services in Ireland. The researchers subsequently initiated an informal discussion based on the topics outlined above. Attendees were then invited to form break-out groups both in-person and online, where each group comprised four to six attendees. The workshop questions were asked aloud and presented on a screen for the groups to discuss. In-person attendees provided their (group-based) answers on a sheet of paper while the online group used the chat box facility. An anonymous Vevox link (www.vevox.com) was also made available during the workshop and remained open for 10 days thereafter, to allow participants the option to add any additional information.

2.1.4 Analysis

All written and online (anonymised) responses, from both the Chatroom and the Vevox platforms, were collated and analysed (in combination with the researchers' notes) using Braun and Clarke's (2019) Reflexive Thematic Analysis (RTA) which is described later (p.4); a similar but more in-depth approach was used for the analysis of the one-to-one interviews and focus groups/group discussions.

2.2 National Survey

An anonymous online survey was co-designed by the research team in collaboration with a number of key home visiting stakeholders (with whom it was shared in advance for comment and feedback). This was designed to elicit a wide range of information relating to respondents' role, qualifications, training/CPD undertaken, benefits and challenges of home visiting, previous experience of implementing evidence-based practice, adaptation of practice/flexibility, interagency collaboration, job security and job satisfaction. The survey was set up using Qualtrics software and distributed widely to home visiting services in Ireland during October-November 2023. A total of **41 participants** completed the survey (although more people clicked on the link to the survey, but did not take part). Descriptive statistics were used to describe and summarise the data (using IBM SPSS Statistics v.29).

2.3 One-to-one interviews and focus groups

2.3.1 Participants and settings

Overall, **59 participants** took part in online one-to-one key informant interviews or focus groups/small group discussions, each of which typically lasted one hour. A small number of individuals participated in two or more elements of the study.

A total of 118 potential key informant participants were contacted in the first instance via email and invited to take part in one-to-one interviews (and provided with a detailed Information Sheet). Subsequently 30 individuals (25 females, 5 males) provided their written informed consent to take part (25% response rate) and interviews were conducted during February – May 2023. Interviewees represented a wide and diverse range of statutory agencies and community organisations working within the Irish home visiting sector, including: Tusla; the HSE; the Home Visiting Alliance (HVA); Preparing for Life; Community Mothers/Families; Lets Grow Together; Lifestart; Parent Child+; Barnardos; the Jack and Jill Foundation; the Childhood Development Initiative; and several Family Resource Centres that provide home visiting services. Participants held a range of mainly managerial or board member roles (e.g. Senior/Area Managers, Programme Managers, Assistant Directors, CEO, Executive Director) as well as senior research roles[2].

Subsequently, a recruitment poster was designed and distributed online via Twitter ('X') and sent to both the HVA (who had offered to help with participant recruitment) and key informants who had been previously contacted by the research team (see *Appendix 2).* A total of 30 participants[3] subsequently agreed to take in six online focus groups or small group discussions (ranging from 2 to 7 people and conducted during May-June 2023). All focus group/small group discussion participants were women; one had previously taken part in a one-to-one interview. The vast majority of these participants were frontline HVPs, whilst three held HVP management roles, but also had experience working as HVPs.

All interview and focus group participants represented home visiting services across most counties in Ireland including (in alphabetical order): Carlow, Cavan, Clare, Cork, Donegal, Dublin, Galway, Kerry, Kilkenny, Leitrim, Limerick, Laoise, Louth, Mayo, Meath, Monaghan, Offaly, Roscommon, Sligo, Tipperary, Waterford, Westmeath, Wexford and Wicklow. (Two services provide home visiting programmes in both the Republic of Ireland and Northern Ireland, while another offers home visiting services on a nationwide basis.)

[2] Some specific work roles have been withheld here in order to maintain the anonymity of participants.

[3] Initially, 39 potential participants had expressed a willingness to be involved and had contacted the research team, but they did not subsequently provide their consent to participate.

2.3.2 Interview schedules and Topic Guides

Interview schedules and topic guides were developed on the basis of: (a) reviews of both the national and international literature; and (b) the findings from the initial CARN workshop. The one-to-one interviews explored the perceptions and experiences of participants regarding, for example, home visiting in general, the professionalisation of HVPs, governance of home visiting services and training and qualifications for HVPs. Four separate interview schedules were devised according to stakeholders' role and organisational affiliation (e.g. senior key informant, Home Visiting Local Area Manager/Coordinator) (*Appendix 3*). Similarly, the small group/focus group interviews explored the role of HVPs, how their role differed from other services, qualifications/training/supports and skills, benefits of, and barriers to, home visiting, professionalisation and governance, targeted/ universal provision, diversity, and interagency collaboration (*Appendix 4).* Key points or any gaps in the findings from the one-to-one interviews were subsequently addressed in the group discussion schedules/Topic Guides.

2.3.3 Analysis

All interviews and focus groups/small group discussions were transcribed verbatim both manually and with the assistance of the Microsoft Teams transcription function. Transcripts were also cross-checked with the recordings to ensure reliability. Data were then analysed independently by two researchers using Braun and Clarke's (2019) RTA approach (and facilitated by MAXQDA software). This involved four main stages as outlined below.

(1) ***Inductive familiarisation***: This first stage involved an in-depth and detailed review of participant responses to identify the initial narrative and any patterns across the data. Transcripts were subjected to close and repeated reading followed by team discussion. Familiarisation notes were made to document possible themes and consider the possibility of deeper, latent meanings based on contextualisation, contradictions, and supportive, explanatory narratives. The notes were then reviewed numerous times and familiarisation notes edited/expanded. This familiarisation phase allowed for an initial analysis of the data and consideration of possible themes. During this phase, there was a consideration of why patterns, narratives and possible themes were conceptualised, based on the first researcher's assumptions and contextual experiences when analysing these data.

(2) ***Coding:*** Coding involved analysing the words and concepts and refining the underlying patterns of shared meaning to develop single observational aspects of the narrative. This is an interpretive activity involving interrogation, collective description and interpretation of the data. Some codes were semantic, based on the surface and explicit meaning evident in the data, while others were latent, capturing underlying patterns, assumptions, and ideas.

(3) ***Generation of themes:*** During the third stage of the analysis, codes were managed and organised into themes using MAXQDA. This process allowed for ease of conceptualisation and further re-analysis of similar codes whilst also allowing for the identification, definition and continuous re-assessment of themes based on the narrative and similarities evident in the coded data as well as relatedness to the research questions.

(4) ***Reflexive consideration***. Throughout the analysis, the researchers used reflective diaries while coding, analysing, and interpreting the responses, and they worked together to ensure that only the data provided were analysed, while acknowledging that confounding factors may consciously and unconsciously influence the interpretation of data (Patel, 2017). The researchers collated and

discussed their individual analyses and a number of key themes and subthemes were then identified, each of which is described in Section 3.2 later in this report.

2.4 In-home observation of families/shadowing of HVPs and interviews

2.4.1 Participants and settings

Four home visiting services (Community Mothers, Preparing for Life, Parent Child Plus and Lifestart Growing Child) expressed interest in facilitating in-home observations/shadowing of HVPs and subsequently service managers provided written informed consent for organisational involvement in this element of the research. Five HVPs (all female) were subsequently shadowed during home visits with 10 families over a two-day period in November 2023. Those who agreed to participate, had worked for a minimum of three years within the home visiting sector. They provided their written informed consent to take part in this element of the study, after which they acted as gatekeepers and informed families (of their choice) about the research. Once the selected families agreed to participate, they were required to provide their written informed consent to the HVP which was then conveyed verbally to the research team. All participants were required to have good levels of conversational English and to provide their written informed consent when in the presence of the researcher and before the shadowing visit began[4].

The participating families included 10 mothers (6 of whom were lone parents), 2 fathers, 1 grandmother and 14 children, from a number of ethnic backgrounds (e.g. Irish, South African, Indian and Syrian) and living in different types of residences (two houses, four apartments and three International Protection Accommodation Service (IPAS) Centres)[5] in locations across the country (i.e. counties Athlone, Donegal, Dublin, Galway and Westmeath). Three of the 10 families were receiving the Community Mothers programme and three each were receiving the Parent Child Plus and Lifestart Growing Child programmes respectively; one was receiving the Preparing for Life programme.

Family engagement with home visiting varied depending on the reason for referral and the service with which they were involved. Reported sources of referral to the home visiting services (according to the 9 mothers who agreed to take part in interviews) included PHN (x 2), Social Worker (x 1), maternity hospital (x 3), Speech and Language Therapist (SLT) (x 1) or self-referral (x 2). Reasons for referral related to mental health difficulties, homelessness, little/no family or social support, and living in isolated rural communities. For example, three mothers reported having mental health difficulties, two of whom were living in Direct Provision. Another mother who described herself as 'homeless', was living with her mother, having spent over 10 years in an IPAS centre.

Four of the HVPs and nine mothers also took part in one-to-one interviews. [One child, aged four years, chatted independently with the researcher regarding her experience of home visiting and noteswere taken by the researcher.] Thus, insights from this aspect of the study were based on observation/case notes and one-to-one interviews. No personal or distinguishing information was

[4] Four versions of the UNITES information Sheet and consent/assent form were customised for the home visiting service, the HVP, the family member(s) in receipt of home visiting and any children who were capable of providing their (verbal) assent.

[5] One visit was conducted in a local cafe in Dublin as this was more convenient for the mother.

collected in order to protect participant confidentiality. A number of pen portraits based on the observational work, are provided later in the report (*Boxes 3 and 4; Appendix 5).*

2.4.2 Measures and overall approach

The average time allocated to home visits was approximately 30 minutes per family. During this time, the participants were closely observed 'or shadowed' by the researcher. This shadowing was conducted in line with the ethnographic approach adopted by Quinlan (2008) whereby rich, thick descriptive data are used to capture the local, everyday experiences of families in their naturalistic settings. The researcher was careful to maintain a physical and emotional distance from the participants at all times. This method was key to understanding the relational dynamics between the HVP, caregivers and children while remaining cognisant of the limitations of ethnographic shadowing as a data collection method.

A 45-item 'Good Practice Checklist', adapted from the Scottish Model of Infant Participation (McFadyen et al., 2023) was used throughout the observations to explore five key areas of practice (see Table 1). Observation notes were also taken during the shadowing process. Once the home visit was completed, both parents (where applicable) were invited to be interviewed, but only mothers agreed to take part (the two fathers who were present, were working from home at the time of the interview). Further information on the home environments is included in *Appendix 5*.

Table 1: Home observation: key 'areas of practice'

Space and Environment	Evaluate the appropriateness of the area within which the home visit was conducted
HVP and Child Interactions	Explore how the HVP engages, communicates with, and interprets, the child during home visits
Child Voice	Gather data regarding the child's experience of the home visit through their verbal and non-verbal cues
HVP and Parent Interactions	Review the dynamic between caregivers and the HVP and how the HVP and caregiver influence and positively regard one other
Influence	How the home visit is influenced by the family and whether or not the HVP considers and informs the family in this regard.

Two semi-structured interview schedules (for the HVP and parent respectively) were developed on the basis of our reviews of both the national and international literature, as well as the findings from our earlier qualitative work. The HVP interview explored experiences and perceptions of working as a home visitor, training received, and benefits and challenges of the role. The parent interview explored the experiences and perceptions of receiving home visiting services, HVP/family relationship and perceived challenges and recommendations (see *Appendix 6*). The researcher also met with several other home visiting service staff during the shadowing process. Notes were taken on these informal conversations and followed up by email to ensure that all relevant information pertaining to home visiting was included in the research.

2.4.3 Data Analysis

All observation notes, interviews and checklists were transcribed manually. Transcripts were also cross checked with case notes and recordings where available, to ensure reliability. The data were then analysed using Braun and Clarke's (2019) RTA approach described earlier.

2.5 Stakeholder Engagement Event

Over 60 key informant stakeholders were invited to attend a Stakeholder Engagement Event hosted by the UNITES research team in DCEDIY offices in November 2023 (2pm to 4.30pm); 25 attended on the day. The aim of this event was to identify and agree some ways in which a more standardised approach to home visiting service provision might be agreed and implemented in Ireland.

This event opened with a presentation by the researchers of the main preliminary findings of the UNITES project. The key informant stakeholders were subsequently invited to discuss any additional themes/topics considered to be important (e.g. to address any gaps in the research). A co-participatory group-based discussion then took place whereby participants in groups of six, were given one theme each to discuss. Each group then provided collective feedback on future steps/recommendations related to their theme. Other groups had the opportunity to agree/disagree, or raise other potential considerations pertaining to the same theme. A graphic harvester was also present to visually capture the workshop proceedings. A brief online Workshop Evaluation Questionnaire (see *Appendix 7*) was devised and circulated to all attendees approximately four weeks after the workshop (following the Christmas break), to which two people responded (positively).

2.6 Ethical Considerations

All data collection elements of the study received ethical approval from Maynooth University's Social Research Ethics Sub-Committee and were conducted in line with the ethical code of conduct of the Psychological Society of Ireland (PSI). An additional detailed application was prepared and submitted to Tusla for approval of the home visit observation/shadowing work and interviews. A detailed Information Sheet and Consent Form were devised by the research team and adapted for different participant groups (e.g. home visiting services, HVPs, families in receipt of home visiting and children who could provide consent). All participants were given an anonymised participant number, and any identifiable/potentially identifiable data were removed.

All interviews were recorded with participants' written informed consent and participants were fully debriefed afterwards. Participants were also advised of their right to review or remove data at a later date should they so wish (and prior to analysis); 20 participants who had taken part in the one-to-one interviews requested that their interview transcripts be returned to them for cross-checking (only minor amendments were made). Family participants were provided with a shopping voucher as a small 'thank you' for their time and participation. All interview data were uploaded to a secure password-protected folder on OneDrive.

SECTION 3: FINDINGS

The following section presents the findings, firstly, from the online survey, followed by the combined findings from remaining research activities outlined earlier.

3.1 Survey findings: A snapshot of HVPs in Ireland

3.1.1 Demographic/background characteristics

All 41 participants were female, typically aged in their 40s or 50s (age range 20s to 70s) and almost equally divided in terms of full- versus part-time employment. Approximately half were HVPs (n=21), followed by programme coordinators, Family Support Workers, project workers, PHNs, and managers (see *Table 2*). Approximately half (49%) had been in their current role for 2 to 5 years and a further one third for 6 years or more; more than half (54%) worked 30+ hours per week with most of the remainder working 16 to 29 hours.

Most participants described themselves as 'professional' (73%) as opposed to 'paraprofessional' (with nobody selecting the 'other' category). As noted in our companion report (Hickey et al., 2023), home visiting staff are typically described and categorised within the international literature as 'professionals' or 'para-professionals'. The term 'professional' is typically used to denote nurse-led services/programmes or roles that requires specialist professional training, whereas 'paraprofessional' programmes and services are delivered by a community-based workforce with aligned background qualifications (Olds et al., 2004; Rusch et al., 2019)). This differentiation of home visiting roles has also been used in the national literature (Brocklesby, 2019). However, for purposes of our work, we have categorised home visiting roles into the following:

- Specialist professionals/service providers (e.g. trained nurses/educators);
- Professionals and/or community-based service providers (e.g. social care professionals, child care professionals); and
- Paraprofessionals/volunteers/peers (e.g. local community members, mothers, people with lived experience).

Parent/family-focused programmes in Ireland are principally delivered by community-based professionals while specialist professionals are largely involved in the delivery of disability-targeted services. However, a small number of programmes use a volunteer/peer-led or paraprofessional model.

To explore this aspect of the findings in more detail, we conducted a series of Chi square tests of Independence to examine the extent to which there were any associations between 'professional' and 'paraprofessional' status and a number of key occupation-related factors including whether respondents were in full-or part-time employment, number of hours worked per week and broad level of education/qualifications. No statistically significant associations were found, suggesting that the reported status had no bearing on any of these. However, this finding should be interpreted with caution in view of the small sample size.

Table 2: Profile of respondents

Demographic/background information	
Current occupation	**N (%)**
HVPs	21 (51)
Programme coordinator	10 (24)
Family Support Worker	4 (10)
Manager	2 (5)
Public Health Nurse	2 (5)
Project worker	2 (5)
Age of Participants (years)	**%**
>70 years	1 (2)
60 - 69	6 (15)
50 – 59	11(27)
40 – 49	14 (34)
30 – 39	8 (20)
20 - 29	1 (2)
All female participants in paid employment	**%**
Full-time employment	20 (48)
Part-time employment	21 (52)
Time in current role*	**%**
Less than 2 years	7 (17)
2 – 5 years	20 (49)
6 – 10 years	4 (10)
11+ years	10 (24)
**(M = 7.29, SD = 7.28)*	
Number of hours worked per week*	**%**
10 – 15 hours	6 (14)
16 – 29 hours	13 (32)
30+ hours	22 (54)
** (M = 28, SD = 8.83)*	
Described themselves as:	**%**
'Professional/specialist professional'	30 (73)
'Paraprofessional'	11 (27)
Highest Qualification	**%**
Bachelor's degree (honours)	12 (30)
Postgraduate qualification	11 (27)
Higher certificate	10 (24)
Ordinary Bachelor's degree	4 (9)
Leaving Certificate	3 (7)
Other (not stated)	1 (2)

3.1.2 Qualifications, Training and Evidence-Based Practice

Respondents were typically well-qualified and approximately two-thirds held a Bachelor's Degree (mainly honours level) or postgraduate qualification. Qualifications ranged from Level 5 to Level 10 and the most commonly mentioned fields included early childhood care and education (ECCE), child development, psychology, social care/social studies and nursing. Many participants also reported additional qualifications/training in infant mental health, infant massage, leadership and change, parenting programmes, neurodiversity, community and addiction studies and trauma-informed practice. Almost two-thirds (63%) stated that they felt 'moderately' or 'well prepared' for their current role as a result of their current qualifications (see *Figure 1* below).

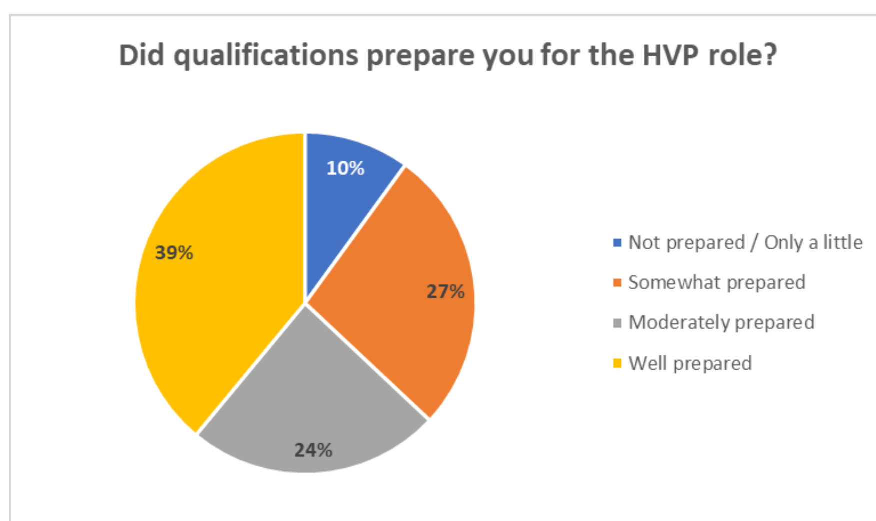


Figure 1: Did your qualifications prepare you for the HVP role?

Only three participants reported that they had not completed any training or Continuous Professional Development (CPD) as part of their role. Thus, the vast majority (n=38) reported engaging in training/CPD 'sometimes' (39%) or 'often' (61%) and this training was typically (for 89%) facilitated through their employer. Additionally, more than half (55%) had undertaken training/CPD through a national programme or organisation, while a further 37% sourcing their training/CPD independently. Typically, this involved on-the-job training or supervision (89%), although substantial proportions had also participated in didactic training (34%) and/or coaching (31%). When asked why they had engaged in such training, almost all of the respondents (92%) felt that they needed additional support to enable them to fulfil the duties of their role, or they wished to gain experience in a specific area (84%). In some cases, the training was undertaken for personal/career development (58%) or because it was mandatory (53%). An overwhelming majority (82%) agreed that the training they had received was sufficient to support them in their role, although one in ten disagreed in this regard (*Figure 2*).

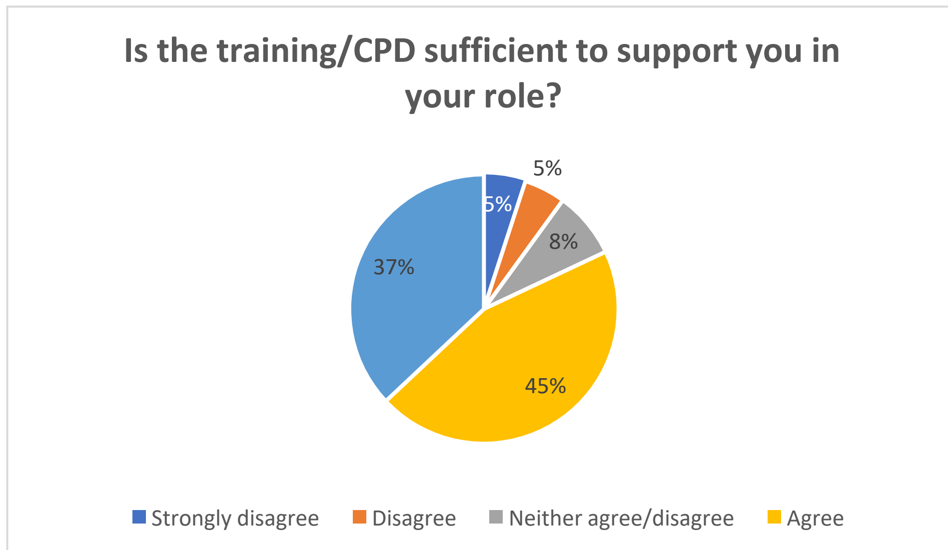


Figure 2: Is the training/CPD sufficient to support you in your role?

More than three-quarters of the sample (78%) reported that they are given opportunities for, and/or had undertaken training in, reflective practice in their roles. Most of the sample (85%) indicated that they 'often'/'always' adapt their practice to meet the needs of families (*Figure 3*). All but one respondent stated that they 'sometimes' (34%) or 'often' (63%) work with diverse families. Responses varied with regard to the extent to which participants felt they had the scope within their service and programme delivery to meet the needs of these diverse families, with more than one-third responding either 'little or no scope' (10%) or 'somewhat' (29%) to this question, with only one in five (19%) responding 'very much so' (*Figure 4 below*).

With regard to their use of evidence-based programmes, a large majority (85%) agreed/strongly agreed that an evidence-based programme produces better outcomes for families (*Figure 5*) and none disagreed in this regard. Most participants (71%) also had experience of delivering an evidence-based and manualised programme (e.g. Incredible Years, Parent Plus, Preparing for Life, Circle of Security, Doodle Den and Lifestart Growing Child) and all but four believed that these were important for their practice.

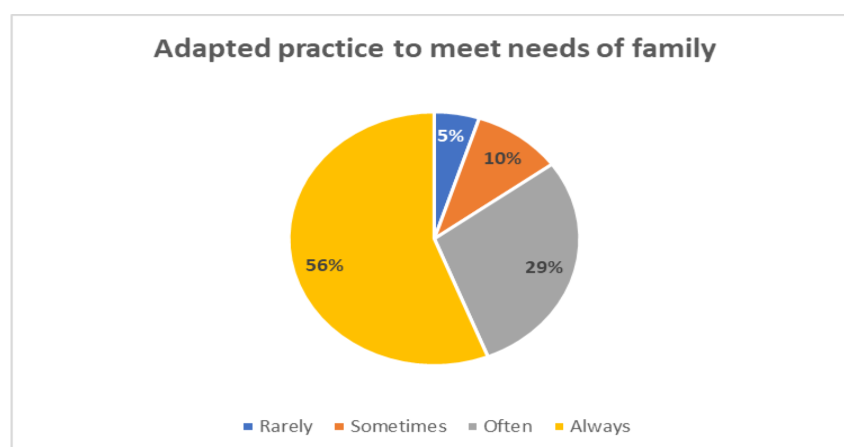


Figure 3: Do you adapt your practice to meet the needs of families?

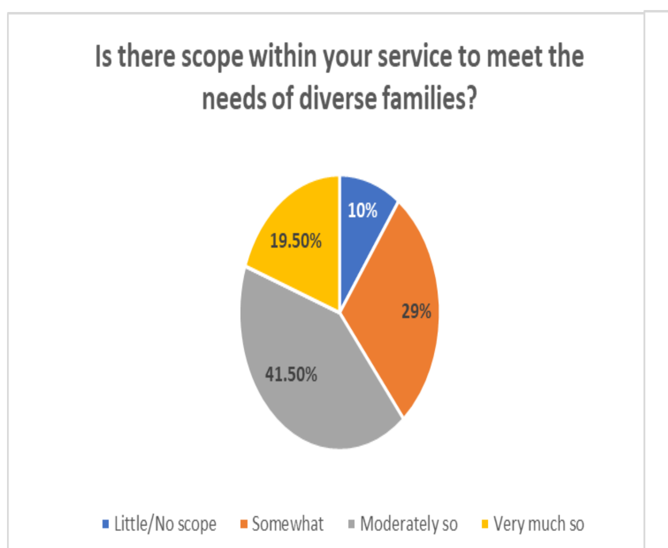


Figure 4: *Is there scope within your service to meet the needs of diverse families?*

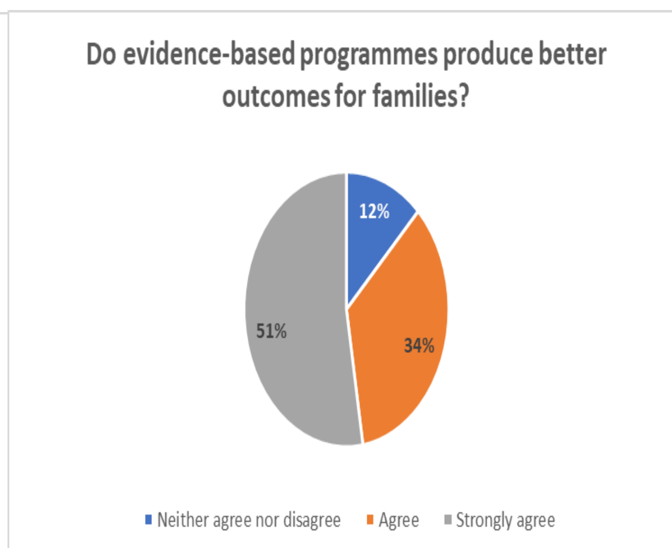


Figure 5: Do evidence-based programmes produce better outcomes for families?

3.1.3 Changing roles and collaborative working

When asked how supported they felt in their current role, the vast majority of participants reported that they felt 'very'/'moderately' supported (85%), although six felt only 'somewhat' (n=5) or 'not at all' supported (n=1) (*Figure 6*). Furthermore, over half (56%) indicated that they felt they had adequate job security in their current role, although more than one in four (27%;11/41) indicated that they felt less secure or insecure within their role.

Most participants (85%) reported feeling satisfied in their current role and the responses to the open-ended responses also indicated high levels of job satisfaction (e.g. *"I love my job"* and *"our role is such a rewarding job"*). Notably however, these comments were often counterbalanced by others on the lack of recognition and pay while addressing complex needs within a home visiting role was also reported as demoralising for some HVPs:

> *"I love working with families. I am good at what I do. I am very invested in my work. However, it is only this year after 17 years that my permanency is getting sorted; it has been a vocation."*

> *"Our role is such a rewarding job and at the end of the programme seeing how much bonding between the parents and child and even if it's the smallest improvement in development or speech and language or communication it's so rewarding to know I was part of their journey."*

> *"I absolutely love my job but find it difficult to support some families effectively. The cost of living is crippling for a large percentage of our parents. It's so difficult to see them struggling. Poor mental health is very apparent in a greater number of parents and children. An increase of children presenting with ADHD and Autism makes it difficult for us to support parents with a universal programme. Professional diagnosis is age 6. Much too late."*

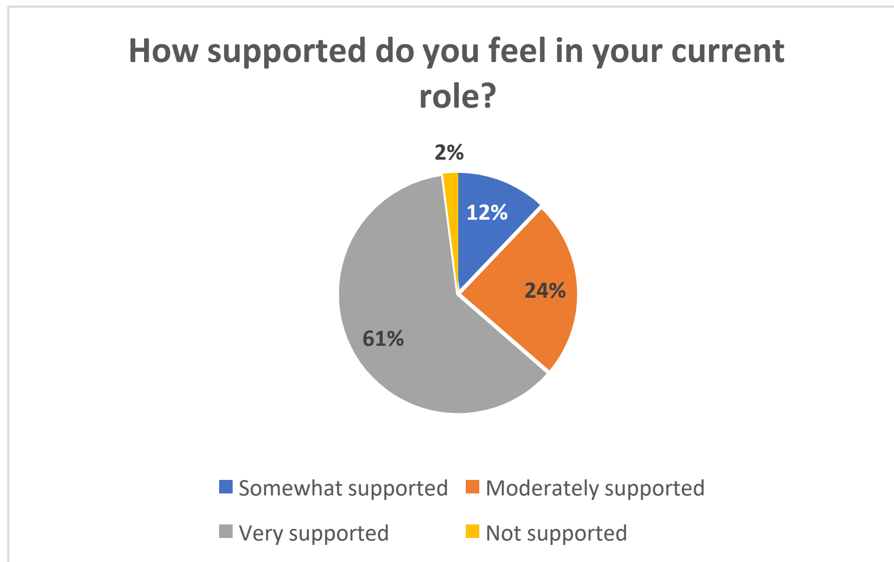


Figure 6: How supported do you feel in your current role?

When respondents who had been employed in the HV sector for more than five years (71%, 29/41) were asked to assess the extent to which the responsibilities of their role had changed over time, all but three indicated that their roles had changed 'a great deal' (55%) or 'moderately/to some extent' (38%) (*Figure 7*). Despite this, two-thirds of respondents felt that their salary did not adequately reflect the responsibilities of their role (*Figure 8*).

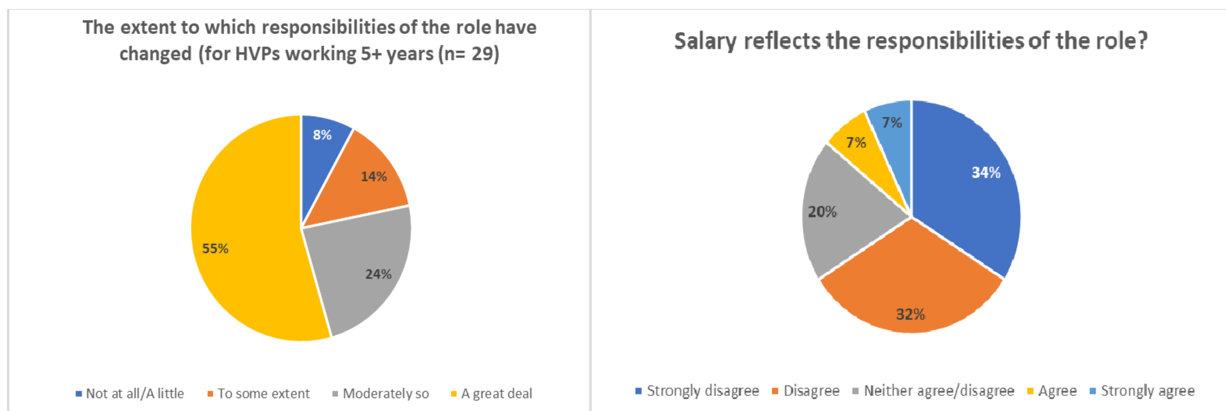


Figure 7: The extent to which your role has changed (for those employed 5+ years)

Figure 8: Does your salary reflect the responsibilities of the role?

When asked about the extent to which the requirements of their role could be met within existing resources (i.e. pay, working conditions, training), fewer than one in five (17%) indicated 'very much so', with more than one third (36%) indicating 'somewhat' or 'not at all' (*Figure 9*). Finally, more than two-thirds felt that their service was "filling a gap" either 'moderately so' or 'definitely', with only 12% indicating 'a little' or 'not at all' (*Figure 10*).

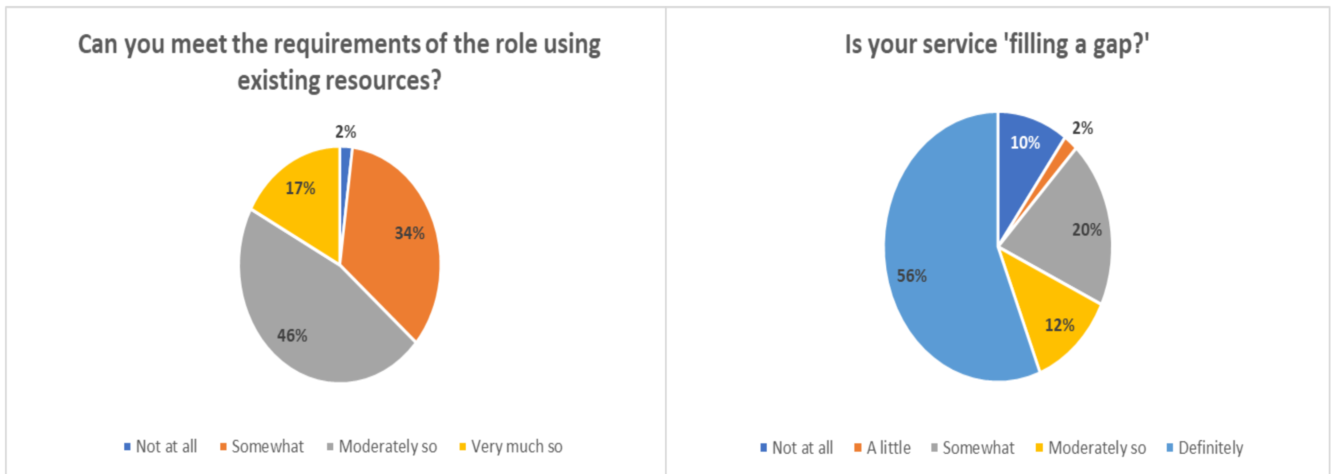


Figure 9: Can you meet the requirements of the role using existing resources?

Figure 10: Is your service 'filling a gap'?

Lastly, two-thirds reported that informal partnerships/collaborations with other services, provide them or their service with essential support. The informal partnerships highlighted within the survey included CYPSCs, local voluntary groups, Family Resource Centres, local libraries, food banks, St Vincent de Paul, parent forums, the Jack and Jill Foundation and the Area Based Childhood (ABC) programmes. With regard to the availability and targeting of home visiting services across the country, most respondents (81%) felt that they should be *both* universal and targeted (i.e., available to all families but also specifically targeted to those who may be considered vulnerable), although almost one in five (17%) felt that they should be universal only.

3.2 Stakeholder views and experiences: a 'deep-dive'

The findings from all elements of this study and including both the national and international review of the literature, provide important and useful insights into the views and experiences of some of the wide range of stakeholders who work in the home visiting sector in Ireland; these include not only the many frontline practitioners, but also those occupying managerial/co-ordinator, research and other support/advocacy roles. The results from the, albeit disappointingly small, online survey are broadly consistent with, and are amplified and supplemented by, the qualitative findings from the larger sample of stakeholders who took part in the one-to-one interviews (including a small sample of mothers), focus groups and group discussions.

Here, a number of key themes were identified including: **(1)** the benefits of home visiting programmes and services more generally; **(2)** multi-level and sector-wide challenges; **(3)** interagency partnerships and collaboration; **(4)** qualifications, training and supervision; and **(5)** macro-level and sector-wide challenges/barriers. (To ensure confidentiality, identifiers are included after all quotes as follows: practitioners (HVP); mothers (M); other stakeholders (O); focus group/discussion group members (G); CARN workshop attendees (W) and survey participants (S). One-to-one interviewees were also allocated a participant number.

3.2.1 Benefits of Home Visiting

The collective findings of the UNITES project, in line with the national and international literature (e.g. Duffee et al., 2017; Eckenrode et al., 2017), demonstrate overwhelmingly, the numerous benefits of home visiting. Services were seen, above all, as offering a holistic and family-focused ethos and approach to improving child outcomes by promoting child health and development, nurturing positive parent-child relationships, supporting parent health and well-being and facilitating positive family functioning. Notably, these services were also seen to differ from other early intervention/prevention initiatives by engaging and supporting families in the home, as illustrated by the comments of one high-level stakeholder/key informant who described *"a unique service, not a programme, but a unique service."* (O27). A total of five sub-themes were identified here, as described below.

(a) Reaching out to, and building relationships with, parents, families and the wider community

The strong relationships that HVPs cultivate with parents, families and the local community, was a recurring and predominant theme throughout all of the findings. Building and maintaining good relationships was deemed to be the single most important role of the HVP, and there was a strong consensus that home visiting services are *"delivered through relationships built with families"*. Participants consistently emphasised that while HVPs deliver a service comprising a specific programme or a given intervention/approach (plus attendant supports and the imparting of knowledge), relationships were seen as critical and central to the success of their service. The relationship between the HVP and the parent was seen as particularly crucial:

> "*Just for me, it's how important the home visitor and parents' relationship is.You know that's at the core and how much work has to be put into build and maintain that relationship for the home visitors, to have the capacity to reflect on if something went wrong or you know what's going on for Mom today - that is just so important. Some of the mams that we have worked with … they couldn't go to a group …they were embarrassed, or the people wouldn't understand what they were going through, or they just couldn't get themselves out the door. But having that friendly face arrive every week, that consistent, lovely person was really transformative for them – and just to have somebody believe in you, it's just fantastic*." (O16)

These relationships were also considered paramount for whole-family engagement and for encouraging access to additional community supports. It was also consistently reported that HVPs are in a unique position to provide effective early intervention and prevention supports in the home, based on both their skillsets and trusting relationships with parents. For high-risk families, a strong relationship was seen as, not only essential for retention and maintaining engagement, but also for reducing the level of risk, as one HVP explained:

> *"So for us, the relationship between the family visitor and the parent is key and I think that's why the programme works so well with families and certainly with families that have complex needs because our retention rates of those vulnerable families is really high. And one of the beautiful things that we see is that we're keeping them out of Child Protection, but we're also seeing them moving down the [Hardiker] scale[6]".* (G5)

Home visiting support also extends to, and therefore potentially benefits, all children in the family. Participants alluded, in particular, to the accessibility of their services and programmes through the provision of support in the home which also leads to improved engagement with families, and

[6] The Hardiker model is used to categorise different levels of need along a continuum from low risk (Level 1) to high risk (Level 4), enabling an analysis of needs and delivery of appropriate services.

especially those who are considered to be more vulnerable or 'at risk'. For example, one Programme Coordinator explained:

> "...*it* [HV] *removes barriers for parents because we're not expecting them to come here at a certain time in the week, and we're removing that, the barrier around access and transport and childcare and all of those things that inevitably get in the way when parents are having to reach out for support."* (O7)

Home visiting was also seen to facilitate engagement with wider supports within the community. For instance, one Tusla employee described the wide range of services accessed by one family based on an initial referral to a parenting programme:

> "*So, say we have mum referred in for a parenting programme … into one of our funded projects, and then we find within a couple of weeks that she* [the HVP] *has… got the children into the after school or The Breakfast Club, or dad has joined the men's group. She* [the HVP] *was in the home - they're* [the HVP] *seeing the needs... and trying to meet the needs"* (O2).

Given the existing economic pressures, some HVPs also reported an increase in demand for practical support for families and many participants discussed the extent to which support materials (and programme techniques) were important in enhancing their capacity to address family needs (whilst also helping them in their parenting role):

> *"We try to provide resources such as clothes, baby equipment, hygiene products etc. However, at times we are low on resources so it can be difficult to provide families with what they need".* (S)

HVPs also reported assisting and advocating for families by linking them with other agencies/organisations (see below) and/or by, for example, completing forms on their behalf. They indicated that empowering parents (i.e. to enable them to make changes in their own lives) was central to their role, as one Project Coordinator remarked:

> *"Parents need evidence that they're 'good enough' in terms of their motherhood or fatherhood. So as practitioners… we're supporting parents to evolve this sense of self, to develop this positive sense of motherhood, positive sense of fatherhood… we need to kind of feed them back evidence of where they have done well, so it* [home visiting] *needs to be very strengths-based because when they believe that they can achieve, they will achieve."* (O10)

The importance of, and benefits accruing from, the HVP-parent relationship were also highlighted in the smaller observational/shadowing and parent interview element of the study[7] (see *Box 1* below and also *Appendix 5*). The findings here underline the key role of the HVP-parent relationship in the context of the mothers' experience; all of the mothers who were interviewed (mainly in their own homes) reported high levels of positive regard and appreciation for the HVPs:

> *"She* [the HVP] *is a great help to us - she is a friend who looks out for us. She hears me, she knows when I'm sad and helps me feel better. She helps with big and small everyday things. Shebrings brightness to my life; she was with me through very hard days when I had postnatal depression. I would be lost without her."* (M1)

Two mothers reported that the relationship was friendly but fundamentally professional: ***"****The relationship is friendly, but very professional and not overly personal. I like that." (*M5*).* Only one

[7] A brief summary of the homes/settings which we visited, is provided in *Appendix 5*.

mother reported that she did not share an especially close connection with the HVP: *"We get on well. We are not friends, it's professional. It's all about the kids."* (M6). However, it was noted that this mother had begun home visiting only three weeks prior to the shadowing exercise. Six mothers also reported that they felt very isolated particularly with regard to their role as parents and that they relied heavily on the HVP for social support:

> *"She's like a big sister or kind of a mother to me. She gives me the information my mother couldn't. I was reared by my aunt and my family was kind of divided, so I don't have the support. Me and my home visitor have a great relationship - we get on great."* (M10)

(b) Preventing intergenerational impact and reducing stigma

Participating HVPs and other stakeholders frequently described how at-risk families were typically heavily influenced by family and community expectations, as well as intergenerational difficulties. There was a clear recognition of how intergenerational issues and wider environmental factors, such as poverty and long-term unemployment, negatively influenced parenting and infant health and wellbeing:

"…*when we're talking about intergenerational trauma, and we're talking about people carrying on doing what the parents did, maybe going back into homelessness or going back into addiction and stuff like that"*. (O10).

Consequently, HVPs viewed themselves as playing a key role in addressing both the immediate and longer-term needs of families, whilst also being cognisant of family dynamics and the impact of trauma and deprivation on family functioning. The following quotes aptly describe how services strive to deliver support in line with families' needs, circumstances and context:

> *"… we've been made aware that there's young women who are pregnant that we're not getting to and the young age is quite difficult because of their limited experiences. They are protected by their gatekeepers, like mammys and grandmothers, which is fine but we want to be able to give them the space so they can be the parent they want to be."* (O17)

> *"… an understanding of systems theory … how things work, why things stayed the same, why there's intergenerational poverty, what are the factors within and beyond the control of people to move out of poverty or to, you know, disadvantage."* (O20)

> *"In the north of Ireland, we still have very serious intergenerational issues arising from the conflict which have been passed on from one generation to the next and many of the parents and children we work with, have had very difficult childhoods and many just don't have a clue about child rearing. They've had no role model. You know, they never experience positive parenting themselves."* (O14)

Stigma was frequently highlighted as a barrier to engagement with services, particularly amongst at-risk families. Interviewees described the extent to which they felt home visiting support helps to minimise the stigma often associated with engaging with professional services. They shared their experiences of addressing these barriers and felt that being viewed favourably in communities, and establishing trusting relationships with families, helped to reduce stigma and, in turn, fostered greater engagement with families. Participants' perspectives also strongly indicated that home visiting was not a 'one-size-fits all' solution, but rather that a considerable degree of flexibility was needed to adapt to meet the changing and often complex needs of families. To this end, a universal approach to home visiting was widely considered to be instrumental to supporting families regardless of level of need, as one stakeholder commented:

> *"… you know very quickly that services get stigmatised and our families get stigmatised and won't engage in services…this has to be universal so that all families can access it. All families have needs at different times, higher, lower, whatever, but by having it* [home visiting service] *universal, it means everyone will engage."* (O27)

The universal and targeted nature of home visiting services is explored in more detail later in this section.

(c) Child development and infant mental health

One of the most frequently cited benefits of home visiting services/programmes, and one which many participants felt distinguished home visiting from other family support services (e.g Family Support Workers) was the focus on child development and infant mental health: *"[home visiting] is not the same as a family support because they have elements like around child development about promoting maternal health, about health outcomes as well."* (O27). Some programmes were recognised as providing practical support such as household management and budgeting, but for many HVPs, the emphasis during visits was very much on supporting child health and development in addition to improving parenting skills, as these stakeholders and HVPs explained:

> *"The Family Support Workers would look at the issues for the family, and they might be working with the parents or separated parents around various things, and they might be looking at broader things, you know, like budgets and cooking and various things like that. It would be quite broad compared to* [our service]*."* (G5)

> *"So I would have a home visiting role side to my work, but also part of my role would be to build up the capacity of practitioners or social care workers that work in homeless hubs etc. to make use of the interactions they are having, you know with families so that child development is at the forefront of everything that they do."* (O10)

> *"It's looking at every aspect of the child's development from pregnancy up until they start school, so that would involve support for parents, information about child development and getting to know the home and work and in tandem with the parents to support that in whatever way. It's meeting a family where they're at as well".* (G3)

HVPs also emphasised the importance of child development through modelling behaviour with the parent, and allowing the parent to understand how every positive interaction contributes to their child's language and cognitive skills. For example, one HVP spoke of delivering support in homeless hubs and, despite the living conditions, she reinforced the importance of face-to-face communication with the baby to help promote language development:

> *"So even within those spaces* [homeless hubs] *where the practitioners are at, this is their home. And if those interactions are focused on child development … so I'll just give you an example. For example, we know this is evidence based. We know that the more children hear language, the more they are to pick up language and the more they see it face-to-face and there's a certain way you can pause, you can slow down with the language. You can wait your turn and the languages - that interaction that happens with a small baby - we know that this will result in better language [*development*]. If a practitioner is supported to develop those skills themselves and they are continuously modelling those for parents, parents will take that on…"* (O10)

Many HVPs also described the benefits of adopting a holistic approach to addressing child development, which focused on not only the developmental needs of the child, but also on strengthening the parent-child relationship, as two HVPs explained:

"I suppose the whole thing for me and what I would think is going in is just the holistic development all around for the child and enhancing that bond between mam and the child". (G6)

"And we would discuss the holistic approach to support child development with our families and empowering parents. Starting from that strength-based parent child relationship... We bring the information to stimulate and engage - to simulate children and engage parents through different activities that again, are age appropriate." (G2)

(d) Listening and responding to 'the voice' of the parents and children

A number of participants also spoke very positively about the inclusion of service users' (parents and child) voice as part of their programme assessments and evaluations. The voices of both the parent and the child, as well as the HVP, were seen as important for understanding what works best for families and for sustaining positive outcomes for families in the longer term:

"A big part of that [knowing what works best for families] *is capturing the community voice in our programme. One of our core missions or values is to capture child and family voices and practitioner voices. So, to do that, we do research projects throughout the year. We embed that into our work plans around how we're going to capture child and family voices and then we go about doing it and when we get the findings back, we see what we're working with, see what's working well and what's not and how we can be flexible and change to meet the needs of the community and all of that."* (O15)

"...a lot of bad things happen when people aren't listening to the child. And so that's something we have to remind our own staff of. I know you're working with the parent and we've given them, as managers, work with this program, but somebody has to check, you have to check in with the child as well at some point." (O2)

As part of the shadowing element of the study, we also recorded our observations of the interactions between the HVP and both the parent and the child using the Good Practice checklist described earlier in Section Two. The findings are presented in Boxes 1 and 2 below.

Box 1: Summary of Observations of HVP-parent interactions during shadowing home visits

Eight out of the ten parents fully engaged with the HVP during the home visit and had very good (observational) rapport with them. Two parents, both of whom were only recently in receipt of a home visiting service (previous two months), expressed partial rapport with the HVP. Additionally, both fathers who briefly engaged with the HVP, evidenced partially good rapport while the rapportbetween the HPV and the grandmother was very good. The HVP discussed the child's progress with all parents and in 9 of the 10 home visits, this was central to the HVP-parent interaction.

It was evident through observation and discussion, that all HVPs had a good understanding of the family dynamic and contexts. They offered encouragement at all times during each home visit and all were notably strengths-based and positive language-focused in their overall approach. The HVPs encouraged all parents to collaborate and identify strategies for their child's needs.

In over half the visits, the HVPs very much focused on seeking ideas and input from the parent regarding their child's behaviours; in two visits, they partly did this and in the remaining three visits, the HVP relied on the materials provided by their programmes in this regard. Where appropriate, HVPs stepped in to support, or stepped back to facilitate, independent parenting. There was no evidence of HVPs crossing boundaries with parents regarding their parenting role. All supported parents through

modelling, elaboration, commenting and responding to children's behaviour in a positive and meaningful way. They also showed consistently positive interactional approaches that were family-focused and needs-led. All HVPs encouraged, and appeared to value, the parents' opinion, and all parents appeared to value the HVP guidance and input.

All of the nine mothers who agreed to be interviewed as part of the observational and parent interview element of the study, reported that home visiting was a positive, rewarding and supportive experience. Notably, six of the participating mothers said that they were engaging with the service to try to give their child the best start in life. They indicated high levels of satisfaction with the service which they were attending and expressed gratitude that they were in a position to receive such support. One mother commented that *"home visiting is a great initiative for parents…"* (M2) while another stated *"*[home visiting] *is brilliant for the kids to interact with other people."* (M6). The importance of receiving all kinds of support - practical, personal and emotional – was highlighted throughout the interviews. Five mothers reported receiving support from the HVP with regard to feelings of isolation and poor mental health:

> *"The visits are good. They offer a lot of support. I am very alone so they are good because they connect me with* [the HVP] *and I have communication. The visits are good for* [baby's] *development and understanding his growth, but it's great to have someone to talk to. I have no family or friends, only* [the HVP]. *She has saved me."* (M8)

The mothers also discussed how HVPs support them in their role as parents and assist them with, for example, the provision of information relating to child development or supporting them in their role as a parent:

> *"Home visiting is great. She* [the HVP] *shows me lots of ways to be a better parent and supports me and him. I love the home visits, they are really good…I'm learning to play with him* [the baby]*."* (M4)

> *"It's great. It helps me reflect on supporting my daughter. I think you should use all the tools available to you as a parent. I read all child-specific information to be a better parent. It's different to the PHN because she is limited in the visits to what she does – it's clinical.* [The HVP] *is more flexible and supportive. The consistency is great and her advice is for my whole family."* (M7)

All parents said that they would recommend home visiting to others and spoke very positively of their experiences of home visiting. One mother reported that she found home visiting so helpful that her sister also self-referred:

> *"I actually recommended it to my sister. She has a home visitor now too. It's great to get into it. It helps so much."* (M10)

Another parent reported that she engaged with home visiting services only after persistent recommendations from her friends. Even though she admitted to initial apprehension, she commented that:

> *"I always recommend the home visiting services because they are lovely. I was so afraid of myself, but my friend recommended it and I love it now."* (M4)

When asked about possible improvements, mothers referred to increasing the availability, accessibility and/or duration of home visiting services as indicated by the comments below.

> *"Everyone should receive home visits and it is sad this is not the case. Every person needs a* [HVP name]. *She is amazing."* (M8)

"[Home visits] *can be very short. I would like the length of the sessions to be longer…I would love an extra visit per week for more supports."* (M7)

Box 2: Summary of observations of HVP-child interactions during shadowing home visits

In all instances, information, encouragement and support were provided by the HVP regarding the infant's communication both with the HVP and the parent. In all instances, the HVP responded to the child, even in one instance where a child was waking from sleep. All highlighted the child's silence or non-verbal communication to the parent and encouraged the parent to be aware of this. There was a clear focus in all HVP and child interactions to capture observations and to consider what children were trying to communicate to the parent. This was explicitly indicated to parents during all visits except one during which the (only) child was sleeping.

The child's/children's emotional state was also frequently observed and described by the HVP. For instance, the HVPs used terms such as *"what do you think he is trying to tell us"* or *"look at how much he loves you"* throughout the home visits. All appeared to be mindful of how they communicated with the infants and children through non-verbal communication such as verbal tone, facial expression and body language. It was also observed that all HVPs came down to the child's level when communicating or talking with the child (although this was not possible during the cafe visit).

During 7 of the home visits, the children were very much focused on the activity provided by the HVP and two children were partly interested. All but one child was excited when the activities were brought out and all children showed non-verbal expressions of enjoyment at some stage during the home visit. All children's cues were quickly responded to, and their needs met. All children who wereawake at the time of the visit, were engaged in some form of 'conversation' either verbally or non- verbally with the HVP. This was observed through turn taking, mutual eye contact/ facial expression and referential communication. All but one home visit included a child-led activity and all children (excluding one visit where the child was sleeping) displayed positive responsive behaviours towards the parent and in most cases the HVP. This was observed verbally, through laughing, babbling, and non-verbally through leaning or sitting close to the parents.

With regard to the influence of the family on their home visit, it was apparent that the HVPs acknowledged what they were hearing and seeing to the families in all cases. In all but one instance, the HVP ensured that the child's perspective was taken into account regarding future care and intervention. During six visits, there was a mechanism for recording what actions would be taken based on the child's view. This was evidenced by verbal discussion between the HVPs and the parents regarding their post-visit documentation process, or by communicating this with parents via tip sheets and progress discussions. All children were provided with verbal feedback regarding their communications.

(e) Using evidence-based and evidence-informed programmes and practices

The survey findings presented earlier, show that evidence-based or evidence-informed programmes and practices were viewed as central to promoting positive family outcomes and indeed, almost three-quarters of respondents indicated that they had experience of delivering such programmes. Likewise, most of the key informant stakeholders highlighted the importance and benefits of having an appropriate evidence base for home visiting supports. These were also seen as a key element of the commissioning and development of programmes and practices and for sustaining home visiting supports into the future, as explained by one Programme Manager:

"…obviously, evidence bears a certain amount of quality assurance that provides better results, that showcases better outcomes for families, and that goes through a recognised process of randomised control trials…So, we really do want something that can show better outcomes or has evidence of better outcomes for families rather than anecdotal evidence." (O3)

Box 3: Pen Portrait Two (based on shadowing/observation and interview)

Programme: Lifestart Growing Child, Donegal
Referral: PHN (due to poor mental health and isolation)
Duration of engagement with service: 13 months

The family comprised a mother, a 16-year-old son and a 14-month-old baby living in a Direct Provision centre. The HVP (pseudonym 'Mary') carried a food parcel and clothing up six flights of stairs to the third floor. She reported that the lifts in the complex never work and that it is very difficult for families on the upper floors to go out with babies and infants. Mary informed the researcher that the mother had escaped a violent relationship and that there was a threat to her life; hence, the mother was frightened to open her door. She was also living in extreme poverty. On arrival, Mary was welcomed warmly and affectionately hugged by the mother. During the visit, the baby was asleep and the teenage son was at school. The mother gratefully received her food parcel and clothing.

The visit commenced with a discussion relating to financial issues and Mary provided the mother with information relating to financial support services. She also asked about the baby's progress and offered wellbeing and developmental information from the manualised (LGC) programme. She and the mother discussed the information provided in the booklet, including age-appropriate hygiene (teeth brushing), sleep routines and learning through play. Mary also asked about the mother's mental health to which the mother responded that it was very poor. The mother stated that her and her 16-year-old son share the same bed and that this had a negative impact on both of them. She was also feeling very isolated and lonely. Mary suggested speaking to the GP to obtain some help with these feelings. She also recommended that she attend a baby toddler group to meet other mothers in similar situations and made arrangements to meet the mother prior to the toddler group and to accompany her to the location.

Mary used a large number of resources to help the mother and was very focused on the current needs of the family, speaking positively about the mother's parenting and the child's development. She briefly modelled how to use learning materials (toys and flashcards) with her son. The relationship between Mary and the mother was notably very positive and caring throughout. Mary indicated that she often texts the mother to check in on her and assure her that there are people who care for her.

During the subsequent interview with the mother, she reported that she and Mary share a good relationship. The mother stated that Mary is kind and caring and goes above and beyond for them, making sure they have food and other basic necessities, such as clothing and baby supplies. She referred to Mary as her *"guardian angel" (M8)* and how home visiting had changed her life:

"Me and my son escaped a very traumatic situation. We came here to flee and I was pregnant. I gained international protection in Ireland because it was English speaking. We spent 10 days in a hotel and then were taken to live here by taxi. I received no information, I was just dropped here and shown to the apartment. I had to figure everything out - I didn't even know where I was. My mental health was so bad. But 'Mary' helped me so much [after my son was born]. *My neighbour took her own life recently because of how we live as refugees here. That could have been me if I did not have 'Mary'. I would have spent two years with no-one to talk to, no one who cared for me and my family, but I know Mary cares about us"* (M8).

It was noted that the mother became very emotional when discussing the relationship and support she received from Mary. The mother also expressed her belief on a number of occasions that every family should have access to home visiting because it has offered her essential support both practically and psychologically.

However, there were mixed views regarding fidelity to evidence-based models. While participants spoke of routinely adhering to programme delivery and implementation protocols/manuals, many also reported adapting programmes to a greater or lesser extent, to better meet the changing and growing needs of families. This is also reflected in the survey which showed that over 80 per cent of the sample frequently adapted their practice to meet family needs, while many attendees at the CARN 'What Works' workshop also felt that services should have more scope to be adaptable, more individualised and led by the needs of families at a programmatic and delivery level and, therefore that a service should be "*bespoke & individualised for each family/ child*", including tailoring the number and frequency of visits in order to meet individual family needs. More generally, it appears that these local adaptations were often undertaken due to financial constraints and to improve outcomes, whilst a more flexible approach was also seen as important in responding sensitively and appropriately to contextual factors and the specific needs of families:

> *"Since the beginning we've stopped doing some things either because they didn't work, or they weren't cost-effective and we've introduced new things as different issues have emerged in the community. But I suppose prevention and early intervention is at the core of what we do, and evidence is at the core of what we do. We always ensure that what we do is appropriately evaluated."* (O11)

> *"If there's early childhood home visiting, it has to be flexible enough to cater for all. It has to be focused on the needs of the parents and the children, not on, I suppose fidelity to the programme; you need the flexibility."* (O4)

> *"Every day is different - you have to be prepared for whatever is there when you pass through that door… working with children who need extra care or have additional needs. You would have to change your entire routine to fit the child's abilities. We have changed the toys and books to address issues, but it all costs money"* (O3)

> *"It is not easy because one family is so different from another and you do have to kind of go with their way of playing and being..."* (O4)

Furthermore, regular research and evaluation activities were widely reported and seen as essential for optimising family outcomes and maintaining evidence- based and evidence-informed practices. This is a key benefit of home visiting services in general, although the nature and scope of evaluation across all programmes varied considerably, ranging from the assessment of ad-hoc family or child-based outcomes and different approaches (based on observation and self-report) to more formal evaluations which were conducted on an internal or external basis (involving repeated data collection using structured measurement tools and evaluation procedures). Further information in this regard, is provided in our national review report.

3.2.2 Micro-level challenges/barriers (including the HVP role)

Participants spoke often of the myriad challenges impacting the day-to-day work and long-term operation of home visiting services and staff. It was frequently noted that these were inextricably linked with the current economic situation and had an ongoing detrimental impact on the capacity of the services to meet existing needs, particularly for high-risk families. For example, issues relating to

mental health, homelessness, addiction, poverty, availability of transport, family commitments, domestic violence, physical disability, and families living in Direct Provision, were all reported as challenges for home visiting services and HVPs across Ireland. A number of subthemes were identified here, as outlined below.

(a) Increasing levels of need and complexity

As mentioned earlier, almost all of the survey respondents described the increasing responsibilities and changes over time of the HVP role, and this was also reported by many interviewees. A number of reasons, some inter-related, were highlighted here, including: higher levels of client need and case complexity; greater family diversity; an influx of issues post-COVID-19; a lack of access to services; increases in both parental and child mental health; the ongoing housing crisis; the increasing number of refugees and asylum seekers (i.e. from Ukraine and elsewhere); higher levels of family stress; and financial difficulties more generally. Some of these are illustrated by the following quotes:

> *"Families are very different now to what they were 20 years ago. Social problems are much greater. Parents are struggling financially."* (S)

> *"I feel that the vulnerability of our families has increased/worsened over recent years due to the severity of the housing/homelessness crisis and the cost-of-living crisis. During the pandemic, we noticed more instances of domestic violence and increased isolation and mental health difficulties.* [With] *the Ukrainian refugee influx, we have also noticed a concerning increase in anti-refugee protests in our catchment area, which prevents proper integration of these families in our community and makes me worry about the safety of refugees in our community."* (S)

> *"I think mental health has become more apparent in children, particularly since COVID. We have had to adapt the way we work with families to meet the needs of the children around their mental health. Often times, this involves referring on to appropriate services."* (S)

There was a strong consensus that the current economic crisis had fuelled an increase in demand for home visiting services across Ireland. HVPs described the higher rates of poverty, homelessness/ insecure living conditions, child protection issues, and rising levels of disability, all of which, in their view, had heavily impacted service provision. Participants also reported that many of these issues had increased significantly post-pandemic and further delays in developmental checks and early detection had resulted in larger numbers of families seeking support to address child developmental problems. HVP responsibilities had also increased due to the large number of Ukrainian and International Protection families seeking support.

On a related note, a number of CARN workshop attendees felt that home visiting services need to be more inclusive and culturally relevant in order to incorporate, and more effectively address, the greater diversity of families in need of home visiting supports. Indeed, the terms *'inclusion'* and '*diversity'* were also mentioned frequently by other participants, although the two appeared to be conflated. These terms were typically spoken about largely in terms of race/nationality, and culture, a perception which may be influenced by the Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education (DCYA, 2016) which are part of many of the education-based modules and training undertaken by HVPs in their current role.

On a related point, both homelessness and/or insecure/inadequate living conditions were an additional major challenge for home visiting services and their staff. Many questioned the extent to which any intervention can be effective when families were living in such precarious and overcrowded accommodation, as the following participants (Programme Managers and Coordinators) explained:

"I suppose the landscape has significantly changed in the last number of years in terms of the number of families… who are experiencing homelessness or if not homelessness, they are in a very precarious temporary living environment and I think it's very hard to offer targeted supports into those types of precarious kind of accommodation … And often actually, it's the space [they need] *to be able to do something nice with their child."* (O7)

"Families that are in emergency accommodation can be a challenge at times as their conditions can be distressing and lives can be quite chaotic". (S)

"We're seeing families really struggling because of the emerging cost-of-living crisis. Another big issue in our community is the waitlists for children with disability services and that actually really affects the home visiting programme as well and how you can support parents in that interim period while they're waiting for developmental assessments or autism assessments - and that's a big, big need we're hearing back from the home visitors as well." (O30)

"… we would question the benefit of, for example, trying to deliver parenting routines to somebody living in one room and how effective that could be, but we have also heard that parents appreciate some supports or some inputs." (O3)

Additional workload pressures appear to have necessitated the prioritisation of more 'at-risk' families in favour of self-referrals or families considered to be categorised as being low risk:

"Currently our programme has become referral-based only; as the referral rate grew, there was not enough room for the 'regular' family. So all our families are of a complex nature, the majority of referrals being for mental health or disabilities or behavioural issues. Rarely are there any referrals to support, for example, a breastfeeding mum." (S)

Programme Managers further reported that many HVPs are in 'crisis-mode', increasingly dealing with cases that are beyond their remit and often unable to implement early intervention supports due to the severity of issues presented by families:

"Many of our family families within the programme are in crisis and are dealing with chaos. It's not like we don't take those families, but we're constantly saying that we are an early intervention programme. We know that if we do stuff early on, we won't have so many more of those children in chaos." (O13)

This crisis way of working is encapsulated by the second subtheme below.

(b) "Holding families": Filling a gap and managing increased responsibilities and workloads

There was considerable frustration among interviewees regarding the increasing numbers of referrals to their services and levels of additional need they encountered on a regular basis, which they felt should be met by other services (which were seen to be experiencing staff shortages and inadequate resources). These challenges had led, in turn, to significant increases in their workload and a requirement to frequently work beyond their remit (and often with families with clinical levels of need).

For instance, some HVPs spoke of the larger numbers of families seeking support from their service for poor speech and language, developmental delays or disability issues, most of which it was felt should be addressed by other services (e.g. Public Health Nurses, SLTs or Social Workers). They also alluded to the increasing number of families presenting with mental health difficulties, often compounded (as mentioned above) by living in chaotic and/or stressful living conditions. Thus, there was a high level of agreement amongst participants that HVPs were 'gatekeeping' or filling a gap in

the absence of more relevant or appropriate specialised supports and services, whilst also having to manage the growing expectations of families:

> *"Home visiting to me is filling a huge gap". (W)*

> *"… we get a lot of referrals from early intervention, primary care and speech and language teams and disability teams, but I would say maybe upwards of 90% of the children on our programme since 2021 are waiting on some form of assessment…We are filling a gap where we're supposed to be providing outcomes for families that need it … The evidence here shows that there's a massive gap here for children who have those unmet needs and they're trying to get anybody to fill in and hold them, to an extent.".* (O3)

> *"I guess we have a position that we are not specialist addiction or mental health or disability. We're getting a huge amount of referrals into internal and external services because of that and the HSE being so stretched, and we have to say 'no' sometimes because we feel what the family, when we go to meet with them, they'll say thank you very much but that isn't what I need. I need a Speech and Language Therapist or I need an OT, so we do sometimes say 'no' on that basis".* (O5)

> *"I would say like 90% of our cases are high need, high complex cases. There's definitely more pressures on the system where you can see in the areas of disability or mental health that there are those clinical services in place and that families are seeking support from them. We're getting referrals from those services and then we're not able to meet the expectations of those families. They are being sent to us in family support but what they're really looking for is the clinical piece for their children, direct work for their children. So there can be a bit of mismatch .. So we're really clear that we're not picking up pieces that we're not capable of."* (G5)

These findings were also reflected in the survey where respondents described their inability to properly support families who were frustrated "…*due to long waitlists for early intervention"* whilst struggling to avoid being *"affected by what you see and hear".* Participants frequently used the term "holding families" to refer to families who required more specialised services and who, for example, were on waiting lists for supports such as SLT, Occupational Therapy (OT), psychology, and mental health, but who were receiving home visiting supports in the interim:

> *"We see the needs in the community and try to fill that need. We recently found a lot of parents frustrated at Children's Disability Network Team (CDNT) wait list times, so we have started to deliver workshops to support parents while on the wait list [i.e.] SLT/verbal/non-verbal, OT/Sensory, toileting for additional needs."* (S)

Worryingly, some HVPs were concerned, in particular, about families where child protection issues were evident, and how such families need more specialised and dedicated levels of support than they could offer. These findings raise important questions about the capacity of home visiting services to continue to provide supports to families who present with more complex needs and especially when there are child safety risks. Indeed, concerns were raised by some HVPs around their ability to adequately promote positive child outcomes when they were working in crisis-mode and the perceived unsustainability of this situation:

> *"The changes I have witnessed over the years in the service engagement, is no longer providing the positive outcomes for child development through the programme, rather filling a gap in day-to-day needs."* (S)

"So what we're finding across the community, we are this holding space and are holding families that do have a lot of complex needs and need a lot of family support and are waiting on assessments and all of those extra things...Our home visitors and our Home Visiting Coordinator are under a lot of pressure to manage these really complex situations especially in places like Direct Provision. We're seeing a lot more issues around domestic violence and a lot more issues around just general mental health, health and wellbeing, plus what's happening with the children as well. So there's a lot of holding and waiting, supporting the family." (O16)

While the results of the survey reflect a generally well-qualified health visiting workforce, the increasing and changing responsibilities of the HVP role were seen to place enormous pressure on them to manage 'crisis' cases for which they felt they did not have the appropriate training or qualifications. For example, the findings suggest some perceived overlap between the duties of the HVPs and that of Social Workers, with both managers and HVPs reporting that HVPs are often required to undertake social work duties due to staffing issues within some areas of the country, to the extent that they feel they are not adequately addressing the needs of some families:

"There's a lack of social work, so we've actually taken on a few social worker duties and are trying to help them with their caseloads a lot more, as well as our own" (G2)

"…we feel like social workers most of the time… we don't have the qualifications to deal with this high end. We're just going with it. We are putting in for the extra support and there is a question around the level that we're dealing with and if we were qualified for that or not, there probably is question around that and so it can be quite a lot dealing with it all." (G1)

"I've been with a family for the last two years. It's been quite hard… over time, more [families] *are coming out at the minute where I see it's at crisis point. I first made a call to Tusla … whereI had concerns for this family… they are very isolated. Mum is an alcoholic,* [with] *young girls, no family around them, things have gotten really bad. Mum has attempted suicide… in the last five months. It's the girls that have found her on the floor and rang an ambulance. It's very traumatic … I have made about six referrals to social work. I have brought it to a 'red meeting' … I've had it to a complex case forum. I have had it to family welfare conference. I brought it everywhere I could, and I kept being left to it all … You know, I would manage a lot of the cases, but when we do face that challenge, we just need more support … "* (G1)

Managers were also keen to clarify the parameters of the HVP roles and to ensure that their services remain committed to the *"ethos and…strength-based perspective so that staff don't see themselves as an extension to social work and go in now thinking that they're doing a different type of job"* (G5). At the same time, however, and despite the concerns expressed by most HVPs in working closely with social services, they did acknowledge the benefits to these families of receiving home visiting supports in terms of reducing the stigma and fear that are often associated with social work and to *"be a listening ear but just really support them too and you're sort of liaising between the family and the social services. You're like the link between."* (G6). This was also seen as reducing the pressure on social work services:

"Social workers are limited to what they can do, so just by having us in, if we're there on a fortnightly basis, it means the social workers don't have to be there every two weeks, they can push theirs out…just kind of takes the workload off them." (G2)

Lastly, the strong relationship building and often intimate connection between HVPs and families demonstrated in the collective findings reported here, coupled with the challenge of heavier and increasingly diverse workloads, suggest a need to emotionally support these practitioners in their role

(as and when required). For instance, one HVP who engaged in an informal conversation with the researcher (but who did not participate in an interview) discussed the death of a client and its impact on her. She had been working with this family for over two years and had a close connection with the mother and children, one of whom was non-verbal; however, she had never met the husband. Following a Christmas break, she returned to the family home to meet with the mother and her children and was informed by the woman's husband that his wife (her client) had passed away over the holidays. She reported feeling devastated at this news, but the husband did not know or wish to engage with her. She reported huge difficulty in walking away when the children were waving at her and calling her from the hallway. Following this, the HVP did not have the opportunity to engage with children she had known and visited weekly for over two years. While these situations may be thankfully rare, they suggest, nonetheless, that HVPs themselves may need (formal/informal) support in their role.

(d) Lack of understanding and awareness of the importance, and impact, of the HVP role

The survey responses demonstrate generally high levels of job satisfaction and likewise, all of the small number of HVPs who agreed to be interviewed as part of the shadowing element of the study, reported enjoying their role and expressed pride in their work: *"it's a great and rewarding job. I love it."* (HVP1). One HVP stated that she *"loves the job because I can empower parents with knowledge and offer a lot of support to those who need it."* (HVP3). Another, who had herself received home visiting prior to becoming employed as a HVP, reported that she loves her job due to her strong belief in – and first-hand knowledge of - the benefits of the role:

> *"…empowering the parents with the knowledge and the confidence in themselves that they are good, that* [they are a] *good enough parent for the child. I think that's the most important part of this."* (HVP4)

Despite this however, a recurring theme and perceived challenge highlighted throughout all of the findings, was a perceived lack of understanding and awareness amongst statutory services, in general, of the value and impact of the HVP role and home visiting services more generally. Many interviewees reported feeling undervalued for the work that they do, particularly with vulnerable and at-risk populations. For example, three of the HVPs who were interviewed as part of the shadowing element of the study, discussed issues such as the perceived lack of respect by other professionals for home visiting and misconceptions that HVPs *"just play with kids"*.

This, coupled with a lack of resources, was a serious and recurring concern, as well as a source of considerable frustration for many. Two interviewees (including a Programme Lead) summarised this well in their comments below:

> *"I think it* [home visiting] *is undervalued. I think there is not sufficient recognition of either the value or the need. It's one of the reasons that this research is absolutely crucial. We are far too focused on 'let's deal with waiting lists downstream'. Let's put in an initiative to resolve something that actually could have been potentially better supported at a much earlier stage."* (O19)

> *"I do believe that* [home visiting] *has the capacity, but it has to be properly resourced and supported and the work has to be valued and recognised…I guess one of the big challenges is … it's just not integrated at the national level in terms of the understanding of it or the rationale for it. And it's under 'First Five', it falls under the Department of Children, you know, I just feel that there's a lack of integration."* (O27)

Likewise, in the survey, HVPs expressed their frustration with the lack of professional recognition of their role:

> *"My input has not been valued and indeed been dismissed by other professionals."* (S)

> *"A lot of the work is underestimated and under-paid, mostly undervalued."* (S)

The perceived lack of awareness and lack of recognition of the value of home visiting services also raised concerns around the need to regulate home visiting supports, similar to that within the ECCE sector, as two interviewees explained:

> *".. so I feel like home visiting overall, there's not enough awareness around it for it to be* [regulated]. *We expect that if someone is going* [into a home]*, if you're sending your child into an early childhood setting, that that would be inspected and everything else,… they're trying to bring it in there with childminders to just have a framework for it."* (O6)

> *"It* [home visiting] *has to be regulated. There has to be governance and there has to be oversight. But to do that, the government needs to take responsibility and they need to actually fund both programme offices in terms of mentoring, support and training, as well as the work on the ground."* (O4)

One home visiting service manager also discussed the (surprising) difficulties regarding the process of obtaining Garda vetting for her staff, as illustrated below by an excerpt from an email provided to the research team where she described her ongoing frustration in resolving this situation:

> *"The Garda Vetting Bureau would not accept* [Name of Home Visiting Service] *for vetting because they stated that we do not work with children on their own. We highlighted the work we do, the levels of complexity and vulnerability, working across the continuum of need, and the one-to-one work we do with children and that many parents are extremely vulnerable adults and we work with many parents under the age of 18 years. Despite all of this, they continued to refuse us access to vetting. This has gone on for 4 years and I reported it to Tusla nationally and they have been working on it also. An agreement was reached only about 6 weeks ago that we apply as an affiliate of Tusla…and they submit to the Garda Vetting Bureau on our behalf."*

While the above comment is from only one participant, it illustrates well the lack of awareness around the HVP role and the extent to which this might also have negative impacts at a practical and operational level. The overall consensus amongst participants was that there should be a greater awareness of the importance and benefits of home visiting coupled with a minimum standard of procedures and practices for HVPs to ensure that families receive quality services. Thus, best practice should focus on *"tight governance, tight supervision* [and that it's] *well structured"* (O12). Nevertheless, there was also a concern that home visiting might become *"too focused on the next HIQA inspection and not on what families actually need"* thereby limiting the *"freedom… to be creative and responsive and innovative…"* (O5). This is discussed later in more detail in Section 3.2.5.

3.2.3 Partnerships and interagency collaboration

Partnerships and interagency collaboration, a third recurring and stand-alone theme throughout the findings, was identified as crucial to effective service coordination and the promotion of positive family outcomes across services and programmes. These partnerships were both formal and informal in nature and, as indicated in both the survey responses and interviews, covered a large number of health and social care agencies and organisations including: Tusla social work; the CYPSEs; keyworkers; maternity hospitals; GPs; PHNs; local family services (including domestic violence services)

and resource centres; primary care and disability teams; ECCE services; schools; local libraries; food banks; and An Garda Siochana. Health and disability agencies and organisations (e.g. PHNs, SLTs, primary care, mental health services) were considered to be particularly important in terms of the early identification and support of children with Special Educational Needs (SEN).

Box 4: Pen Portrait Three (based on shadowing/observation and interview)

Programme: Preparing for Life (Dublin)
Referral: Self-referral (for parenting support)
Duration of engagement with service: 3 years

This meeting took place in a café. The HVP (pseudonym 'Anne') met with the researcher prior to the mother's arrival and advised the researcher that the mother was a teen parent and had moved home halfway through the programme. She reported that the home visiting service had accommodated the family by meeting them outside of the catchment area and that the café suited the mother because she had weekly errands to run in the location.

When the mother arrived, she was very casual and friendly with Anne. The child, a two-year-old boy, smiled happily when seeing Anne. The mother tended to the needs of the child, ordering and cutting up food for him while she and Anne briefly talked about life in general and the mother's current wellbeing, family and relationships. Progressively, Anne transitioned into a conversation about the child's progression and development. She was very complimentary about the mothers parenting skills while discussing the child's positive sleep pattern. She provided, and verbally described, the content of some tip sheets regarding the child's development in the coming months and discussed the child's language skills and how to prevent and identify common winter illness.

There was considerable evidence of Anne's strengths-based support and she praised the mother throughout the session. However, the environment was not conducive to observing the interaction between Anne and the child, and it was apparent at times, that the child was bored and frustrated. The mother tried to appease him while chatting to Anne, and some information was left for the mother to review at home later. Toward the end of the visit, the child was placed in his pram and fellasleep. Anne and the mother then discussed the mother's upcoming birth and the mother expressedsome sadness that Anne would not be her HVP going forward. Likewise, Anne stated that she will be sad to say 'goodbye' to the mother and child.

The relationship between Anne and the mother was positive and friendly, but also very professional. The parent was provided with information in a friendly and supportive manner. During the research interview with the mother, she reported that her home life had been quite chaotic and that she had not been raised by her own mother. She reported that she was seeking parenting support because she wanted to provide her child with a better life. The mother also stated that when she moved fromthe PFL catchment area, she signed up with another home visiting service but that she preferred PFL due to its more personal approach and more regular contact:

"I Like PFL. I love the chat. It's like I can escape for an hour. It's all about parenting advice but it's in a way that suits me. It's great. They give me so much information and I am aware it's a professional relationship, but it's comfortable. When I moved, I had a different home visitor. I didn't like it because it was not personal. It was a half-hour twice a week - no TV on, not personal, no chat, just showing me how to play with the toys and then she was gone. I like how we can have a chat about how me and the baby are getting on." (M10).

Overall, home visiting was seen as a strongly collaborative endeavour and it was clear from the findings that considerable efforts are being made to build and maintain relationships with other services; participants also recognised the wider benefits of interagency working in terms of ensuring greater access to family supports and more coordinated efforts to enhance family outcomes, as well as opportunities for shared learning and practice. For example, referral processes across agencies and organisations are a key part of their role, and many HVPs also reported attending CYPSC and Meitheal meetings, or engaging with disability teams and networks, as illustrated by the comments below.

> *"And for us it's about working with the other agencies. We're one agency and we're a small, relatively small agency so we have child and family support networks across the two counties, and that's where the professionals are coming together once every two months within their local community. But at some point, they have links with the school principals, the Community welfare officer. So, all that connectivity happens for the more vulnerable families."* (O2)

> *"The other thing I think that's important for all of us is that interagency work that's now going on. I mean, no service can achieve anything on their own. We need all the services on the ground, and we need to be working together. So, I think that's important for me."* (G5)

For some programmes, collaboration is a key part of their work:

"Interagency work is written into our programme. It's explicitly outlined as an element of the programme and we expect our home visitors to be referral points of information and resources, referral facilitators and advocates." (O13).

However, some of the participants felt that more work was needed in this regard at a cross-disciplinary level. It was also thought by some, that home visiting services need to be more visible and accessible to those who need them. Building strong connections and relationships with the local community was also seen as requiring a considerable investment of time and resources, as well as a physical and online presence (e.g. a good website), which were not always available:

> *"I think if you look across policies, there's huge calls for collaboration and integrated services and that, but actually the disciplines all stay very separate."* (O22)

A recurring theme throughout the CARN 'What Works' workshop and one that was mentioned earlier in the context of home visiting services 'filling a gap', was the existence of multiple barriers and the lack of cross-agency working for families with a child presenting with developmental delays, and/or a potential disability. The attendees indicated that these expanding gaps in service provision negatively impact their capacity to provide adequate services and, in turn, outcomes for families. Issues related to the non-availability or lack of joined-up working with disability services, *"concerns about waiting lists"*, linguistic and developmental barriers, and limited intergenerational and parental family-based supports, were all highlighted throughout the discussion:

> *"…*[regarding] *HSE Disability services…many of these vulnerable adults go on to have children and they may not come to the attention of services until the child is school going age and there are queries around child's development etc. Turnaround between services is too slow, lots of services can link in with families but it's tooooo slow." (W)*

> *"Better support for EAL families* [language barriers] [is needed] *when providing home visiting to children with additional needs …how do we ensure that complex needs are met?" (W)*

Arguably, the challenges within the home visiting sector may mean that children with disabilities will be denied access to available, affordable and quality support and intervention, a source of considerable concern given the particular importance of early intervention for all children with disabilities.

Lastly, the opportunity for home visiting services to collaborate both amongst themselves and with other early intervention services, was also suggested during the CARN 'What Works' workshop as an area worthy of consideration. A need to *"… expand the potential for networking between HV services"* was highlighted, while attendees felt that there was an opportunity to enhance outcomes for families through needs-based collaboration among services, as well as providing links to existing services/agencies that would help children and families beyond the scope of any one service. Attendees felt that coordinated networking would be entirely feasible and would provide a more cohesive service for families and children by, for example, *"linking in with the child's preschool for information on how the child is developing and if there is any areas, we could work on together."*

3.2.4 Qualifications, training and supervision

The survey results presented earlier, point toward a generally well-qualified workforce whose staff typically engage in regular and ongoing training/CPD and reflective practice. For example, all of the HPVs who participated in the shadowing element of the study had a Third Level qualification and took part in regular CPD/training (e.g. baby massage, Circle of Security). However, the experience and qualifications vary considerably in their nature, breadth and depth and an extensive range of courses and training programmes was mentioned by participants, particularly in the area of Special Educational Needs and ECCE (see *Appendix 8*). Those most widely mentioned, include social care, closely followed by childcare, psychology, education, early education, childcare, nursing, and youth and community work.

All interviewees had also engaged in some form of CPD within their various roles (and regardless of their previous qualifications), both as a means of enhancing their skillset and gaining additional expertise, particularly when working with marginalised or more vulnerable groups. For instance, the vast majority of participants had received training either in-house or through micro credentials (i.e. short, accredited learning experiences that are designed to meet the demands of learners and organisations) through external organisations such as the National College of Ireland (NCI). Indeed, many home visiting services were offering, and/or were supportive of, additional CPD/training:

> *"I think it's really important that if we are being allowed into people's homes, that there is a minimum amount of training"* (G6).
>
> *"We would offer core training, which is your very generic bits like health and safety-related training, but then we would have role specific training… there would be Meitheal training as well that we would source for everybody. We offer a promoting positive behaviour training to all of our staff. We offer Partnership with Parents training [and] there have been times where we've Circle of Security offered or programmes in partnership with other organisations."* (O7)

Most HVPs indicated that they were also required to undertake regular CPD to meet the increasingly diverse and changing needs of families and some also felt that the training sometimes does not equip them to manage all aspects of their changing role. For instance, three practitioners who were interviewed as part of the shadowing element of the study, felt that there is limited training regarding autism and speech and language issues despite an increasing number of referrals in this regard. At the same time, it was noted by other interviewees that working with diverse families becomes easier over time as the knowledge, learning and skills they accumulate are transferable to a range of contexts:

"… because I work with diverse families every day so what I learn from one I take with me to another". (S)

A need for cultural diversity training was also increasingly recognised by programme managers:

"[We provide] *cultural diversity training for our home visiting team and for all of the staff that we work with, and we also have a number of home visitors who are not Irish themselves or where English is not their first language."* (O6)

There was also considerable diversity of opinion regarding minimum qualifications, as illustrated by, for example, comments from the CARN workshop attendees:

"In relation to qualification/training, I think it's so much more important to have the ability/skills to build a warm trusting and non-judgmental relationship with parents/caregivers as without this, there will be no opportunity to look at child development etc." (W)

"…at least Level 5 – our HV service is not universal – it is a therapeutic HV service dealing with very complex needs – our staff have extensive training and experience…" (W)

"… having a standard level of education and experience will support them [HVPs] *to navigate their way through such complexity…"* (W)

Notably, some participants/service representatives who took part in the one-to-one interviews felt that their HVPs did not require any formal qualifications as such and were deliberatively recruited as peer workers (i.e. paraprofessionals) who had previously received home visiting supports:

"So a qualification is one thing and then all the other attributes and competencies would come on top of that. So you could make it level 4, for example and if that person didn't have some of the other basic skills, they wouldn't get panelled, but I would ideally not exclude anyone based on qualifications." (O5).

"So I never want to be seen as someone who is just is only hiring if you have a third level degree, because if the whole purpose of us is trying to change the community, we need to people to have access to education at every level. So we don't. We're not hiring for qualifications. We do expect you to get your level 5 once you come in the door, but we're very happy to support that and pay for that for people…" .(O6)

On a related point, there were questions raised by some participants about the possible professionalisation of HVPs and the extent to which this might be helpful in terms of role recognition (and attendant salaries) and enhanced service provision. Overall, there were mixed views in this regard perhaps, in large part, because it was felt by many that the personal characteristics and qualities of HVPs were as, if not more, important than qualifications (or professionalisation) when supporting parents and families and that 'learning by doing' was key:

"Would registration in the early years similar to the Social Care Workers registration, support the importance of HV or would it make it too clinical?" (W)

" … to have a degree? I don't know would I be a better or worse practitioner if I didn't have it? Do you know there are things that I suppose I do, take with me, because we're getting so many people with mental health, and with a psychology degree - I am able to bring little bits in there. I mean, all the stuff that I do on a day-to-day basis. I learn on the job. You know, I learned how to be a home visitor through training; I did Parent Plus training. That was all through work and learning about how to actually do the job was from my colleagues, my peers, my supervisor. And

so, I don't see why someone else, if they had the right temperament and the right personality, couldn't do that." (G6)

"I suppose we require a level of professional training in terms of being able to engage with the processes around the work if that makes sense. You know the report writing the critical thinking, the assessment skills. The piece where that really plays out is in our interactions with the interagency network and, you know, being able to have the professional confidence and competence to be able to present your work in." (O7)

"The level of qualification is increasing because our services are becoming more professionalised and I think that's common across the board in this whole sector because we are working with children and families who are vulnerable and at risk. Increasingly we are asking for some qualification, third level qualification, either a degree or equivalent." (O14)

Despite mixed views on the minimum level of qualifications, all participants highlighted the importance of personal attributes and qualities. For instance, 'soft skills' were widely valued and an individual's personality or background were seen as essential to the role. Qualities such as the ability to be non-judgemental and having the capacity to build and maintain relationships with diverse and marginalised populations, were considered to be of vital importance. Additionally, it was felt that prospective HVPs should have local or cultural knowledge and life or work experience in the context of home visiting:

"I think where a person may not have the full social care qualifications or whatever is deemed necessary for the role, but could be a very active member in the community, might have been a mother themselves, a grandmother. They just naturally possess the skills necessary to be a home visitor … Yes, you have to have a level, whatever it is, 7 or 8, you know, to enter this, but then I think it's nice to know that people have their qualifications as well." (G4)

"And there was a home visitor, but some say the PHN and the HSE were reluctant to refer because they [the HVP] *was a volunteer, that they wanted the professional going into the home so that's their point of view. I suppose my point of view would be if they're well trained, they have good governance, tight governance, tight supervision, and they have good will around that. It's well structured, I would be open to the volunteers or someone going in. I don't see the qualification as really important. It's more the qualities."* (O12)

All of these comments reflect the perceived importance, and increasing diversity, of the HVP role when engaging with families in a uniquely personal way and in their private space. Some CARN workshop attendees also felt that, in addition to a baseline qualifications, HVPs themselves should be aware of how they might bring their own biases and personal perceptions into a client's home:

"Home visitors wear so many hats. They can often be presented with very complex issues, so having a standard level of education and experience will support them to navigate their way through such complexity and support/empower parents to be the best they can be (whatever that happens to look like for that parent) for their child to be the best. For the home visitor [it's also important] *to have the ability to be aware of their own histories, biases etc. becauseat times, these will play out in ways we are often not even aware of".* (W)

On a related point and reassuringly, there was a recognition that HVPs should also be supported in their role, and weekly supervision, access to employee mental health supports (EAP), self-care, reflective practice, community of practice days, and monthly Infant Mental Health network group

meetings, were all reported as ways in which this might be achieved. Indeed, a number of participants highlighted the importance of both formal and informal support for practitioners:

> *“Agreed - we have a policy that all those working with children 0-3 receive Reflective Supervision as a support." (W)*

> *"I think it's critical that all HVs engage in Continuous Professional Development - capacity building that is inclusive of coaching, reflective supervision, action learning, and peer support."* (W)

3.2.5 Macro-level and sector-wide challenges/barriers

There was robust discussion and comment throughout all elements of the study about more macro-level organisational and structural barriers to the effective and sustainable delivery/implementation of home visiting services and programmes in Ireland. These relate primarily to funding/resources and attendant staff workload and pay (and retention) issues, as well as the standardisation, regulation and nature (i.e. universal versus targeted) of home visiting provision. Each of these is discussed below in the context of four separate but inter-related sub-themes.

(a) Funding and resource constraints

There was a strong consensus throughout the findings, relating to a need for adequate funding streams to enhance service provision and improve outcomes for children and families. Almost all participants expressed frustration regarding the short-term nature of funding and the increasing workload of staff working within home visiting services, particularly in view of (as mentioned earlier) the perceived low levels of role recognition and increasing levels of need and complexity within families. The funding mechanisms of home visiting services were commonly described by stakeholders as precarious and dependent on a system of ad-hoc annual grants which were considered to stifle forward planning whilst also negatively impacting staff recruitment and retention:

> *“*[you’re] *projecting forward for five years, it's very hard to do it when you really don't know exactly whether you have funds. … it isn't a great way to move forward, especially if you want to grow and expand and, stay relevant.”* (O15)

> *“Funding streams need to be longer than 12 months so organisations can plan ahead; 3 year funding streams would be much more realistic in relation to staff retention and strategic planning."* (W)

While some managers (and services) reported secure funding streams, most participants commented on the significant time invested in pursuing funding and completing numerous annual and multi-annual funding applications. The generally fragmented funding supports also raised serious concerns regarding the expansion and longer-term security and sustainability of service provision as well as a lack of resources to support more vulnerable families:

> *“There's no real long-term security in this and few opportunities for further development or expansion, but then we're community and voluntary sector people, so there generally isn't security in what we do.”* (O14)

> *"I suppose that would come back to sustainability of funding because that's an issue, you know. So while our institution has to kind of guarantee, you know, all your terms and conditions, we don't have sustainable funding. You know yourself with the multi annual fund and with government, if the ABC programme was gone in the morning … then we're in trouble.”* (O6)

A number of participants suggested that funding difficulties were also inextricably linked to the lack of awareness/recognition of the HVP role, especially in light of the patchy service provision within the early years sector more generally. Indeed, several interviewees commented on a perceived short-sightedness among some statutory agencies in terms of their failure to recognise the benefits of home visiting programmes (as outlined earlier) and their perceived limited support:

> *"It's actually just utterly disrespectful to the service…you know, if this has been worth doing for the last number of years and if there's sufficient impact, and even without objective reviews like the research that you guys are doing or others are doing, and without new outcomes, frameworks etc, there still is enough feedback and enough of an ask to say, 'well actually. we've provided this service year in year out so why the hell can't we take a leap of faith and say absolutely we have a defined ongoing service, not begging and borrowing'., I mean, I've a real thing that it is utterly, and I keep saying this, but it's a lack of recognition and it's disrespectful to the service and the providers."* (O19)

> *"And if you look at those families that have very intense, complex needs, then you're looking at visits that are taking place at least weekly that puts a huge pressure on the service. We have to have two members of staff going into a lot of visits. So, all of those add-ons that we're looking at put severe pressure on services on the ground, you know, so we do need statutory agencies to come behind us and stop giving us piecemeal funding and fund the projects properly."* (G5)

The fragmented nature of funding was also seen as impacting negatively on staff salaries/ remuneration. The long-term sustainability of home visiting services was frequently called into question due to concerns about low salary levels and short-term contracts especially in light of the current socio-economic climate. There was also widespread agreement among participants that HVP salary levels were not commensurate with their level of responsibilities and expertise, particularly in view of their increasing and changing client caseloads. Furthermore, as one Programme Director indicated, the demanding and increasingly specialised nature of their work is often deeply undervalued and therefore, also undercompensated:

> *" I would see home visiting as a very fitting part of the early childhood sector ... it's disgustingly underpaid and I always feel that the further you are away from the child, the more you get paid and it doesn't make any sense, you know, and they're* [the HVPs] *the people doing the work, you know, so they're the people that are actually improving the lives of the children, and then we think 12 or 13 euro* [per hour[8]] *is acceptable?"* (O6)

Survey responses similarly reflect the considerable frustration felt by many HVPs regarding their pay and working conditions and the challenges involved in meeting the requirements of their role within existing resources, despite as mentioned earlier, their typically high levels of job satisfaction and their considerable commitment to, and investment in, their roles:

> *"While pay and conditions are not reflective of the role I have, it is the purpose of the role and the needs of the families being supported that supersedes these elements. That said, it is hard to continue to give over and above when there are definite stretches on home visitors."* (S)

Staff retention was an attendant key concern, especially amongst Tusla staff and programme managers. Several participants expressed concerns about the sustainability of home visiting services

[8] The information available to us at the time of writing, based on a review of the Community Mothers (soon to be Community Families) programme (Brocklesby, 2019), indicates that the typical rate ranges from €11-€16.5 per hour. However, it should be noted that salaries can vary considerably within and between programmes as they are dictated by the host organisations which have their own salary structure guidelines.

especially in light of the current economic climate and funding constraints. The instability of funding, low salaries and excessive workloads were widely considered to have contributed to poor staff morale and, in turn, negatively affecting staff retention. Overall, the findings indicate that the successful recruitment and retention of staff were seen as crucially important in ensuring the consistency and continuity of care for families, but remain a key challenge across the sector:

> *"At the moment it's difficult to attract and retain staff and people want to move into the statutory sector so that they can get a better pension and so you're trying to compete with that and we are very limited."* (O29)

Without appropriate funding, employers appeared to be increasingly considering alternative approaches for retaining staff such as introducing more flexible working hours and providing more team building and reflective supervision, to ensure that their wellbeing remained a priority:

> *"I think we need to be always looking to make sure we're as competitive as possible, but I suppose in terms of one part of that, but within the organisation, we're really like taking a real look at how we invest in staff well-being and investing in staff* [generally] *and that's a real focus for us at the moment. Looking at well-being initiatives and self-care and support structures outside of the day-to-day supervision, which is really important."* (O7)

> *"It* [salary] *impacts well-being. I mean, if you see somebody else doing the same work, getting more money, you kind of wonder about that. So we have to kind of make up* [for that] *by allowing and giving more training opportunities or, you know, being more flexible around hours, but obviously everybody wants to get paid according to the job they do."* (O23)

> *"The increased cost of living is further impacting on the pay divide meaning that it is necessary to keep an eye on other job avenues despite preferring this role. The impact of staff turnover on our service is also increasing as colleagues feel there is no choice but to move to another service that can offer better pay and conditions and permanency."* (S)

(b) Potential standardisation and regulation of home visiting provision

The collective findings highlight mixed views regarding any potential standardisation or regulation of home visiting services and how this might be achieved, albeit with a slight majority broadly in favour. It was felt by this group that greater oversight and stronger governance and regulation around home visiting were necessary in order to enhance the quality of services, improve outcomes and provide value for money:

> *"I agree there should be regulation and I agree home visiting organisations should be inspected like any service working with children"* (O14).

> *"I'd like to see more standardisation of what's happening rather than just what's feasible. Because everybody puts in different parts of money and then doing whatever they can with it. I think there's an onus on the government to look at home visiting and say that it's either universal, targeted or something else."* (O3)

> *"It* [home visiting] *definitely needs regulation. Because there's loads of different home visitors. They're all doing different things. It would be lovely to see a national one being rolled out, that everybody's singing from the same hymn sheet because then families, I think, would get a better service and children would get better outcomes from that."* (O25)

Despite the fact that many participants advocated for stronger governance, others argued, equally, that standardisation in terms of greater regulation, inspection and evaluation may negatively impact

programme delivery, particularly due to the variation in the delivery of programmes and the differing needs of the population served in any given area:

> "*My concern would be how do you evaluate it* [a service] *in a universal manner? If you think of Jack and Jill, there's significant regulations there …How do you create a system that values every single one of those pieces and doesn't look for the higher professional people going in?"* (O12)

There was also some concern as to whether approaches to governance will take into account the more personalised nature of the work and the flexibility of delivery or whether services would *"lose the ability to be creative, to be responsive, because often it brings up prescriptiveness … and it becomes about the process as opposed to the work."* This concern was reiterated by a number of other key stakeholders:

> *"If, I think that it would mean the death of kind of personalised service and having families want to work with us…and you don't want it to get to that point where this happens, to just kill what is a very natural and important service … Like, just let it not die out as a result of some kind of regulation.* (O12)

> *"I think maybe if it was standardised you could lose something … I think there's something very special about the home visitor role and the fact that it is so different across different services ... I think one of the advantages that we discussed was the flexibility and I wonder, would you lose a little bit of that if it was completely standardised?"* (G6)

However, amongst those in favour of greater regulation (in principle), a number of caveats were highlighted. Some stakeholders remarked on the need for either an independent, or State, body to regulate the home visiting sector, but at the same time allowing services sufficient autonomy to manage their own planning and delivery at a local level:

> *"I see that there could be a governance and oversight piece that is State, but the day-to-day management should be in the community voluntary sector… I think the model we have in the* [programme] *could work really well if you have HSE and Tusla working together in overseeing the programme, but that the people who are co-ordinating the day-to-day work on the programme are based in the community and voluntary sector and then the delivery mechanism is the community and voluntary sector."* (O27)

> *"Regulation and inspection, I think we have paralysed services, personally speaking. Obviously, you have to have all the appropriate checks and balances around people being appropriately cleared and having appropriate clearances, etc, but you also need to devolve your governance structures in as much as you possibly can."* (O19)

Where services were provided and commissioned by governing bodies (e.g. ABC programmes), there appeared to be little or no consistency in terms of routine evaluation and fidelity monitoring, with some services devising their own internal questionnaires to collect data. For example, one Programme Manager spoke of the lack of standardised evaluation approaches and how providers are required to assess outcomes without any advice or support from the funder:

> *"[the agency] in fairness to them are not the strictest in terms of data collection or quality assurance…They don't ask for any performance indicators, but that is changing. I've been asked to gather a lot more data on each of our programmes and whether they would be evaluated pre- and post- depending on the programme. For instance, we have been trying to devise a questionnaire for one programme and we would also have a questionnaire for another*

> *programme. So, we have a range of different assessment tools for each programme essentially but we review that ourselves…"* (O3)

Notably, the SLAs examined as part of the national review presented in our first report (Hickey et al., 2023) reflect some potential challenges with regard to standardisation and regulation. For example, there is substantial variation in the objectives and targets outlined therein. Some services/providers indicate only a small number of objectives focused specifically on programme delivery targets while others provide numerous objectives that focus on targets pertaining to, for example, the training needs of staff, the service recipients, development of inter-agency partnerships, service outcomes, and improvements to service provision. Thus, it is difficult to make comparisons across SLAs and to implement a standardised monitoring tool.

In addition, many of the Key Performance Indicators (KPIs) or metrics included within the SLAs are used to evaluate (short-term) effectiveness. Arguably however, they are not easily measured (e.g. in 'SMART' terms) due to the nature of the services on offer, while the SLAs do not allude to any method of reviewing or evaluating KPIs; quite limited information is available, therefore, on how the effectiveness of services or standards of delivery are routinely assessed. For example, how might we measure whether the home environment becomes a more "*stable, safe, secure, caring and holistic learning environment*" as a result of service delivery? This reflects, perhaps more than anything else, the complexities of the work of home visiting programmes (and services) and how they should be broken down into their component parts and assessed and monitored more effectively in order to help evaluate their overall effectiveness.

(c) Universal and Targeted Service Provision

With regard to the nature of programme provision (i.e. universal, targeted or both), the benefits of a universal approach to delivery were broadly recognised, but it was also acknowledged that families with more complex needs require a more targeted approach *"so they start universal, they try and see all parents and then and then offer extra to those parents who need extra work."* (O5). Thus, there was a broad consensus amongst participants (i.e. from both the survey and the interviews) that home visiting should be based on the notion of 'progressive universalism', '*a perspective that combines universalism with the targeting of resources on those that have special needs for support or protection; in other words, help to all and extra help for those who need it most'* (HSE, 2015). This was seen as crucial in terms of maximising service accessibility/reach, engagement and impact, whilst also reducing stigma:

> *"On a broader level, if it* [progressive universalism] *was something that was rolled out further countrywide, that would reduce the stigma and I suppose looking at it being a broader thing around the country, if there was more public information about it, maybe from Tusla and the likes, and that it just became normalised for families. That… it's a home visiting service and that it was just something that you're offered with no stigma attached."* (G3)

> *"…*[Having a universal service] *means that you've got two mums in the chipper who are arguing over who has the better home visitor because there is no stigma, there's no shame...So I think that the part of there being a universal tilt is essential in a home visiting programme."* (G4)

> *"Targeted interventions alone will miss a large proportion of the population presenting with delays due to poverty… and coming from a more affluent area is no guarantee that you are coping with the transition to parenthood or have a support network around you".* (S)

"I think from an HSE perspective, we talk a lot about universality and everything is universal. And then when you drill down, do people really know the core child health programme is basedon the principle of progressive universalism. That's always kind of been the foundation." (O19)

At the same time, however, almost one in five of the survey respondents were in favour of a universal-only approach, most probably due to the perceived limited geographical spread and national availability of home visiting services for families. It was suggested at a number of junctures that more flexibility is also needed in terms of those who are offered services and/or who can avail of them.

"Home visiting is important as a universal provision but it's more important for children in Direct Provision, emergency accommodation, [and with] *additional needs,* [who are] *isolated, who need EAI [English as an Additional Language]*[and those] *affected by trauma." (W)*

As indicated earlier, a number of participants also indicated that home visiting services need to be more inclusive, to incorporate greater diversity, and to be more culturally relevant. This is an important point in the context of the growing ethnic minority population in Ireland, as well as the need to address the health and wellbeing of children and families amongst Ireland's much increased refugee and asylum seeker population (e.g. Murphy, 2021). There was also the view that home visitingservices need to be more gender inclusive. It was noted that there were only two references to provision for fathers in the responses collected during the initial stakeholder workshop at the CARN conference, indicating, amidst all of the references to the "mother" and "maternal capacity", that gender is not always considered in terms of home visiting services.

Furthermore, there was substantial discussion and concern during the CARN 'What Works' workshop about the eligibility criteria for families accessing home visiting services. For example, some attendees highlighted the importance of *"age cohorts of children for home visiting"*, referring to the age-based criteria for inclusion/exclusion whereby services typically have different targeted age profiles. For example, some programmes offer services from pregnancy to school going age while others target the parents of children aged 0-2 years. However, these kind of eligibility criteria (whilst perhaps necessary due to limited resources and/or programme materials) were considered by some, to be too restrictive and ultimately counterproductive, thereby illustrating the tension that can sometimes exist between the perceived need or desire to provide services on a universal or targeted basis.

"I think obviously the evidence is there that it [the use of age-related criteria] *is better ultimately, but for me, if a parent… realises they need a service, to turn them away post-natal? It's cruel. If a parent really needs that service and hasn't signed up pre-birth and you're saying 'no, I'm sorry, you can't have us' , it's very hard … I don't agree with that in any kind of business. You can't judge parents like that."* (O25)

(d) Perceived policy-related influences

Key informant stakeholders were also asked about how existing policy influenced or informed their programme/service. Many referred to numerous child- and family-related national policies such as 'First Five' and 'Better Outcomes for Brighter Futures', as well as the Children and Family Act, Healthy Families, Slainte Care, the Meitheal process, and relevant child protection policies and legislation (e.g. Children First). However, there was some uncertainty with regard to the impact of these policies on home visiting services and whether supports were aligned to existing policies. For example, a small number of interviewees questioned whether home visiting is explicitly referenced within existing government policy and the extent to which it is considered important/valued:

"I suppose the Children and Family Act, all the pieces of legislation, the Children First. I don't think we actually have a home visiting policy now that I'm just trying to think, we don't do we?" (O24).

"I'm not that switched on to the policy stuff nationally and it doesn't help that it's all gone a bit vague in recent years and look, obviously what guides us is the national policy framework for Meitheal, but even nationally within Tusla, that's kind've gone off the agenda". (O21)

There was also some limited discussion of the role of the Home Visiting Alliance (HVA) in Ireland, one of the aims of which is to provide a forum for shared learning and collaboration among services and links to policy makers, as one key stakeholder remarked:

"Home visiting has been going on for years in Ireland and I suppose in some ways, there was a competition, but there was also, because we all had very different histories, there also was collaboration …The landscape was changing, and we felt it was important that we influenced that landscape somehow." (O4)

However, there was a perception from a small number of participants, that the HVA is not sufficiently inclusive and that the full range of home visiting services and programmes currently exist across Ireland should be accommodated/recognised in some way:

"… personally I think home visiting between the ages of 0 to 6 is little bit restrictive. I think there's other types of home visiting that could be included from cradle to grave. There is the Home Visiting Alliance and I look at it sometimes and go 'hold on a second. What about these guys?' "So that's a bit of an issue for me… I think we probably do need everybody to get together, not just one alliance and look at a strategic role and review what's happening in the area." (O3)

"… some of the family support workers and Tusla would say - and some of the PPFS [Prevention, Partnership and Family Support programe developed by Tusla] *managers - that they do home visiting as part of their role and that they were kind of excluded from the Home Visiting Alliance …"* (O22)

Overall, the findings indicate a perceived need for a greater commitment to home visiting through policy development which explicitly recognises the value of home visiting in terms of early intervention and prevention.

SECTION 4: DISCUSSION (AND FUTURE DIRECTIONS)

The collective findings reported here, reflect the attitudes, views and experiences of over 100 (approximately) stakeholder participants who, at the time of the study, were involved largely in delivering, managing, or coordinating home visiting programmes and other support services across Ireland. A small number of families in receipt of home visiting programmes also agreed to take part in some in-home observation and interviews. The results are presented and discussed here across a number of thematic domains and contextualised with reference to both our national review (Report Number One) (Hickey et al., 2023) and a broader overarching review of the international literature, both of which were conducted as important elements of the UNITES project.

4.1 The benefits and acceptability of home visiting in Ireland

The results highlight, firstly, the numerous perceived benefits and acceptability of home visiting programmes and services in Ireland. Participants reported that home visiting offers a holistic, family-focused and strong relationship- and trust-building approach to promoting positive parenting skills and capacity within the home and to promoting positive child health and development (including child mental health), as well as preventing intergenerational impacts and reducing stigma. The strong 'relational' component of home visiting, also seen in research conducted elsewhere (e.g. Cowley et al. 2015; Shaw, Mendelsohn and Morris, 2021; McKean et al., 2022), was considered central to the HVP role, and crucial in terms of enabling them to engage effectively with typically at-risk (or high risk) families. This was also highlighted by the, albeit small, sample of mothers who took part in the in-home observation and interviews and who found home visiting to be a positive, supportive and rewarding experience.

The perceived positive family outcomes highlighted by stakeholders in the current study, are broadly consistent with those reported both internationally (e.g. Duffee et al., 2017; Eckenrode et al., 2017) and as part of our national review (Hickey et al., 2023). For example, all of the evaluations conducted in an Irish context report many positive outcomes for parents, including for example: reductions in parenting related stress (Miller et al., 2015; 2023); improvements in parenting practices and in parent knowledge of child development (Connolly, Adams and Fleming, 2019; Leckey et al., 2022; Miller et al., 2023); and enhanced parent-child relationships (Connolly et al., 2019; Johnson et al., 1993). While improvements in child outcomes, such as gains in cognitive functioning, language development and literacy (Doyle et al., 2016) and changes in child development and behaviour (Hayes et al., 2013) are also reported, the findings in relation to child outcomes are generally more mixed (Hickey et al., 2023), while economic evaluations are rare. There was also considerable variation across programmes in terms of theoretical underpinnings, content, eligibility criteria and staff qualifications, although this also reflects the kind of diversity seen in the international literature (Filene et al., 2013; Haroz et al., 2022).

Our combined findings point to numerous reported benefits for families who receive home visiting programmes and reassuringly, all services also have capacity-building procedures and processes (e.g. careful staff recruitment, provision and support of staff training and supervision) in place to support

staff in maintaining the quality and delivery of programmes/services. The vast majority of Irish programmes are also either evidence-informed or evidence-based, albeit a need for more rigorous up-to-date evaluation has been identified.

However, the findings also highlight a number of important, often inter-related, organisational and structural challenges and barriers in addressing families' needs including, for example: increasing workloads; low levels of HVP role recognition; appropriate staff training and qualifications; the increasingly diverse and complex needs of families (including inter-agency collaboration); the low and unpredictable levels of funding (and low salary levels); and the need to ensure appropriate and ongoing monitoring and evaluation. These are discussed in more detail below.

4.2 The role of the HVP (including managers)

The HVPs whom we interviewed as part of this study are entrusted with the critical task of providing support, guidance, and resources to vulnerable families during crucial stages of child development and often within limited resources. However, it is clear from the findings reported here, that there is a wide and diverse range of home visiting roles (and programmes) in Ireland. For example, the Community Mothers (soon to be 'Community Families') programme involves mainly (paid) 'paraprofessionals' (previously a volunteer role) who focus on providing maternal support for first time mothers.[9] The Preparing for Life (PFL) programme, on the other hand, focuses on enhancing child development through the delivery of a set curriculum designed to enhance school readiness via parental knowledge and investment (Doyle et al., 2017). Other HVPs (e.g. who work with the Jack and Jill Foundation) provide parental support and respite in order to enhance a child's quality of life and with a focus on family-focused care (Revill et al., 2013).

Importantly, the duties and responsibilities of HVPs were not unanimously articulated across all services and it is difficult, therefore, to make like-with-like comparisons across programmes in this regard. However, there were strong broad commonalities, in the sense that the remit of the role appears to largely complement rather than duplicate other formal more clearly defined roles, such as Family Support Workers (FSWs) or Social Workers within Tusla. For example, FSWs (also referred to as Family Support Practitioners) tend to support parents and families in terms of addressing basic day-to-day living needs (e.g. meals, budgeting) whereas the HVP may be seen to provide a more generic and peer mentoring role which helps to address parenting and child behaviour/needs and to signpost families to relevant services.

Furthermore, as outlined in our companion report (Hickey et al., 2023), a number of approaches and processes are common to the delivery of all programmes, including the central role of the HVP and the interactive processes and mechanisms with families, such as discussion, problem solving, role playing, modelling and relationship building. Several core principles and objectives identified as underpinning these programmes and demonstrating, therefore, how they broadly work in practice, are also outlined in our first report.

Notably, HVPs were also described in different ways during our data collection in the present study, including 'home visitors', 'practitioners', 'professionals', and 'programmers'. Interestingly however,

[9] This programme is now more family-focused, following a recent review and subsequent recommendations for a 'community families' model (Brocklesby, 2021).

many studies in the international literature conducted in, for example, the UK, France and America, use the term *'Home Visitors'* (e.g. Gomby, 2005; Peacock et al., 2013; Saïas et al., 2015; Duffee et al. 2017; Condon, 2019; Duggan et al., 2022), although other descriptors such as '*Home Visiting Practitioner*' or *'Home Visiting Provider'* (Sweet & Applebaum, 2004; Kelley et al., 2022) are also used. As indicated earlier, we have used the term 'Home Visiting Practitioner (HVP)' throughout both of our reports, but the lack of clarity and consistency on an agreed term highlights the need, at a minimum, for a clear and definitive title and role description for HVPs in an Irish context (and attendant basic Terms and Conditions of employment) (also highlighted by Brocklesby (2023) in a report on the five Health Visiting Alliance (HVA) programmes). This is especially important in view of their increasing responsibilities and the often-challenging family situations in which they are involved. It is also important therein, to clearly distinguish their role from other (largely complementary) roles undertaken by FSWs.

The specifics of the role also appear to vary considerably depending on the programme/service being delivered and it is not entirely clear how programmes are tailored to the needs of different communities, although the Hardiker model (Hardiker et al., 1991) provides a broadly useful tool in this regard. Very little is known, either nationally or internationally, about the extent to which HVPs go beyond their role, remit, or capacity, but the largely crisis-oriented approach evident in our findings, stands in stark contrast to the traditional preventative model of care typically undertaken by home visitors internationally (Cowley et al., 2013; Russell et al., 2014; Whittaker et al., 2016) and extends far beyond the scope of addressing solely parenting challenges. HVPs also reported high levels of frustration in having to prioritise families with more complex needs in preference to other families who were also considered important, albeit lower risk.

The above findings are also corroborated by the survey results which indicate that just over two-thirds of respondents agreed they were increasingly 'filling a gap'. Collectively, our findings suggest that these 'gap-filling' responsibilities are required *over and above* routine service provision and the 'normal' day-to-day duties and activities of HVPs. This increasingly demanding and more specialised HVP role may be due to a number of factors, including the growing complexity of their caseloads, changing demographics, increasing levels of population need, the HSE recruitment embargo and lengthy waiting lists for other supports and services. Perhaps unsurprisingly, therefore, HVP narratives indicate that many are struggling in this regard. This, in turn, raises important questions on a number of fronts, including: (a) safeguarding issues; (b) HVP capacity (or suitability of the role) to effectively manage, in the longer-term, high-risk families with often multiple complex needs; and (c) the continuing capacity of home visiting providers to preserve their original role/remit in terms of the critical supports which they provide to parents and children.

Relatedly, many of the HVPs working 'at the coalface' of service provision also reported considerable frustration with their current salary levels and excessive workloads. While strong relationships were identified as central to effective health visiting practice, the heavier workloads, coupled with a general lack of resources, were reported to be key factors in limiting their ability to meet the needs of all families. Indeed, there appears to be a convergence or 'perfect storm' of factors in terms of the considerable pressures on under-resourced HVPs as they grapple with the challenges of managing larger numbers of families during the crucial stages of a child's development against a backdrop of increasing socioeconomic disparities (as demonstrated by the most recent Pobal HP Deprivation Index (Pobal, 2023)).[10] Mental health difficulties and domestic abuse within families add another layer of complexity, requiring that HVPs become proficient at identifying and responding to a multiplicity of

[10] https://www.pobal.ie/pobal-hp-deprivation-index/

issues and often without formal protocols or mechanisms to facilitate referrals to other agencies (see below). Additionally, shifting family dynamics, including the prevalence of lone parent households and the increasing number of families from diverse ethnic backgrounds (including refugees and asylum seekers), necessitate cultural and other adaptations to service delivery.

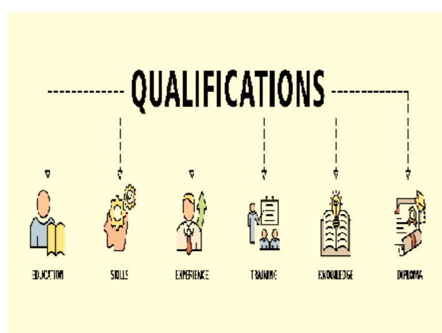
Despite these challenges, the HVPs reported high levels of job satisfaction and were hugely invested in their families, appearing highly motivated to support and advocate for families and to build long-term relationships to meet their needs. The vocational nature of the role was abundantly clear from our findings and further corroborated by our, albeit small, in-home observational work and interviews undertaken with both HVPs and parents. These findings underscore the importance of, amongst other things, developing formal referral structures and mechanisms to support the HVP role, whilst also providing HVPs with the opportunity to upskill and obtain relevant professional qualifications in order to enhance their role and sense of professional identity. These may also help to address the frustration expressed by many HVPs in our study regarding the lack of understanding and recognition, both of their role and of the significant perceived contribution of home visiting services within the early years sector and public health service context more broadly.

There was also a strong indication from our findings, and one also reported elsewhere (e.g. Barak, Spielberger and Gitlow, 2014), that existing government policy does not appropriately or explicitly recognise the role and impact of home visiting on family and child outcomes in the earliest years, and that a national policy coupled with ongoing ringfenced funding, would be important in promoting and supporting the HVP role and the sustainable delivery of home visiting services and programmes across Ireland.

4.2.1 Training and qualifications

On a related point, the findings reported here, demonstrate considerable breadth and depth in the qualifications of HVPs which are typically supplemented with ongoing and extensive upskilling and training (see *Appendix 8*). These, coupled with the wide experience and skill sets of HVPs, also described within our findings, clearly reflect a need for a combination of relevant qualifications, skills, and experience to effectively address the increasingly diverse and complex needs of families in Ireland. Likewise, a recent US report on home visiting career trajectories highlights the wide range of qualifications held by HVPs, many of which surpass minimum requirements, but also identifies challenges in recruiting and retaining staff (Sandstrom et al., 2020). International evidence further indicates that training and supervision can significantly impact home visiting programme outcomes (e.g. Casillas et. al, 2016; Richer et al., 2018).

However, there is little consensus across the international literature on the qualifications required by HVPs as these can vary considerably depending on the specific requirements of the role, the programme(s) being delivered, the population served, the available funding/resources and policies of the employer/service provider (Mackenzie, 2006; Peters, Benatar and Sandstrom, 2021). This is also reflected in an Irish context, with mixed views on the requirement for a minimum qualification(s) and relatedly, the possible professionalisation of the HVP role within services. This appears to reflect a tension, on the one hand, between a desire for greater role recognition (and attendant salaries to match) and a more recognisable and supportive professional structure/ethos, and a perceived need on the other hand, to have a service that



recognises the importance of ‘soft skills’ and that is relatable for families, particularly those from different socio-economic or cultural backgrounds.

Thus, steps toward professionalisation or a more robust professionalisation structure were considered by some, to pose a potential risk to the building of trust and rapport which, as mentioned above (and consistent with the international literature (e.g. Correll, West and Duggan, 2023), was repeatedly highlighted in our findings as crucial to the successful delivery of home visiting programmes. Likewise, many studies within the international literature highlight the requirement for strong interpersonal qualities and a caring, sensitive disposition over and above any formal qualifications (Elicker et al. 2013; Aston et al., 2015; Roggman et al., 2016; Leer & Lopez-Boo, 2019; Ispa et al., 2000).

In a recent report on the professional development of home visitors in the US, Peters and colleagues (2021) suggest that the varying educational and professional backgrounds of home visitors reflect the wide range, and staffing needs, of home visiting programmes and that no existing university or higher education institution provides standardised pre-service preparation for home visitors. The authors recognise that the vastly different knowledge and skills across the sector pose considerable challenges and they recommend the use of ‘non-model-specific tools’ such as staff self-assessments, supervisors’ observations, reflective supervision, and core competency frameworks to support quality improvement activities and to identify individual staff training needs (Peters, Benatar & Sandstrom, 2021). This wide variation also highlights a challenge in preparing people for home visiting as a profession. On this basis, therefore, greater professionalisation in terms of a minimum standard of qualifications and training should be encouraged, but not to the exclusion, or detriment, of the kind of local, community-based knowledge, skills (including language skills) and rich situated expertise that are intrinsic to many frontline HVP roles and to the effective delivery of programmes within local communities.

Two micro-credentials on home visiting are currently offered by the National College of Ireland (NCI) at Levels 6 and 7 on the National Framework of Qualifications (e.g. focusing specifically on the delivery of early intervention programmes in the home). It may be that an additional specialist qualification(s) is needed to reflect the increasing responsibilities of the HVP role and the range of challenging issues and circumstances which they encounter, including poor mental health, disability, domestic violence, abuse and/or addiction. Additionally, while a requirement for a baseline professional qualification(s) would, arguably, help to formalise, and provide greater recognition of, the HVP role (perhaps within the context of other improvements to professional standards and protocols), it is also important to recognise and reward the kind of local ‘grassroots’ knowledge and experience that are seen as vital to enabling HVPs to effectively build relationships with, and support, families in their own homes.

Therefore, an apprenticeship model similar to that currently used by, for example, Community Mothers, may provide a useful option in terms of recognising the ‘soft skills’ of newly recruited HVPs, whilst also providing them with appropriate (and necessary) ‘on-the-job’ training and supervision as well as opportunities for reflective practice. The benefits of reflective practice for practitioners has also gained increasing attention in the early years sector, not only for enhancing practitioner competence, but also for promoting awareness of children’s emotional experiences and the quality of HVP-child interactions (Dyer & Taylor, 2012; Bleach, 2014). More recently, Virmani and colleagues (2020) found that greater reflective practice was associated with more developmentally supportive responses among pre-service Early Childhood Practitioners and can enhance the quality of care for young children in ECCE settings (Virmani et al., 2020).

Our findings also raise some questions about the demanding (and again variable) role of home visiting managers and co-ordinators who are involved, on a full- or part-time basis, in training, supporting,

coordinating and supervising HVPs, and/or overseeing the implementation of home visiting programmes. For instance, our previous research demonstrates that strategic leadership from key local stakeholders, coupled with the provision of appropriate training, education and supervision for programme providers, are important implementation strategies for successful programme delivery (Hickey et al., 2021). It is important, therefore, to ensure that home visiting managers and co-ordinators also have the core competencies and qualifications required to: (a) provide appropriate support and supervision to frontline staff (including coaching/mentoring and opportunities for reflective practice); (b) deliver appropriate leadership; (c) monitor quality and safety; (d) deal with HR and finance issues; and (e) contribute to ongoing service development. Indeed, international research indicates that capacity building for managers, including appropriate qualifications in coaching and supervision for service development, is vital in fostering effective leadership skills, creating an appropriate and supportive organisational climate, and promoting effective service development (Paulsell et al., 2014; Duggan et al., 2018).

4.3 External collaborations and partnerships

Our findings further indicate that home visiting services and practitioners need, and have an ability and capacity, to work in partnership with a wide range of statutory and voluntary services and agencies and indeed, interagency and multi-agency working is a feature of all of the home visiting programmes and other services reviewed in our companion report (Hickey et al., 2023). Multi-agencyworking and cross-agency collaboration were seen as essential for facilitating referrals, and providingseamless access, to a range of community-based services in order to meet the increasingly diverse andcomplex needs of families within the wider community.

International evidence indicates that coordination between home visiting and other services has clear benefits for families in terms of improving parent and child outcomes and linking them to appropriate health and social care services (e.g. Milbourne, 2009; Paradis et al. 2018), while community resources and linkages are also key facilitators of successful programme implementation (Menser et al., 2020). Indeed, there is evidence from some countries, such as Australia, France, and parts of the United States, that home visits are (and should be) seen as part of a comprehensive intersectoral approach, particularly in preventing family violence, abuse, and neglect (Evans et al. 2014).

However, it was indicated by some participants in the current study, that building strong connections and relationships with other services in the local community, while seen as crucial to the HVP's role, can require considerable time and resources as well as a strong physical (and online) presence. Linked to this was a perception that HVPs need to be more visible and accessible to those who need them. This is also reflected in the national literature in which there is a strong sense that home visiting services are often not considered 'primary' services and are not always directly accessible to communities other than by means of referrals from, for example, Tusla, PHNs, the HSE or other government agencies (Connolly, Devaney & Crosse, 2017; Jack and Jill Children's Foundation, 2017; Brocklesby, 2021; Ní Dhiorbháin et al., 2021; Darmody et al., 2022).

Many participants in the current study also described their frustration with regard to a lack of *formal* collaborative arrangements and facilitative structures/mechanisms which, in turn, pose challenges to effective interagency collaboration and service delivery. For example, we could find no evidence of any formal protocols or templates that are being used to monitor or guide the engagement of home visiting services with other organisations and agencies and which might encourage some level of shared ownership or support (where feasible) joint commissioning/funding arrangements. However, this gap has also been identified in international research which suggests that formal coordination mechanisms such as memoranda of understanding, or communication networks and protocols are

typically absent from home visiting service provision (Paradis et al. 2018; West et al., 2018; Brentani et al., 2021; Joshi et al., 2023).

There was a further indication from our findings, that HVPs are frequently acting as *key* points of referral and, as mentioned earlier, are providing services well beyond their remit and professional capacity, due largely to perceived (or actual) shortcomings and gaps in some non-home visiting services (and against a changing socioeconomic context). For instance, the sharing of workloads with other departments such as SLT, OT and social work was not uncommon and deemed necessary in order to 'hold' families until such time as specialised supports become available. Some stakeholders alluded, in particular, to the existence of multiple barriers and a lack of cross-agency working (and service gaps) for families with a child with a developmental delay and/or a potential disability. These findings, in line with a recent report commissioned on behalf of the Ombudsman for Children (Moloney et al. 2021), raise concerns about the impact on families and their children with disabilities, of delays in accessing both an Assessment of Need (AON) and subsequent appropriate services and supports.

Importantly, and on a related point, our findings also demonstrate a desire amongst some stakeholders for more networking opportunities between services within the home visiting sector (as well as externally) in order to create, for example, a peer-led community of practice. Indeed, research suggests that such organisational networking may enhance services for families and children where there is also a need for additional supports provided by a home visiting service (i.e. education needs-based/parental support) or other organisations (e.g. mental health/addiction/child protection service) (Paradis et al., 2018; Brentani, et al.,2021; Hosseinnejad et al., 2022). Currently, there is no national body which advocates for, brings together, or supports, *all* home visiting programmes/services at a national level. This is something that might be worth exploring in an Irish context and which may provide a useful structure and mechanism to lead on addressing some of the kinds of micro- and macro-level challenges and barriers identified here.

4.4 The use of evidence-based programmes

Reassuringly, there was a strong consensus from our findings on the importance and value ofdelivering evidence-informed and evidence-based programmes in order to promote positive family outcomes and to provide a useful basis for securing and justifying funding. However, participants were keen to emphasise the need for flexibility, and frequently modified their practice to better address families' needs. Overall, it would seem that while home visiting services, as they are currentlyconfigured and delivered in Ireland, are largely informed by, or based on, evidence, they also need tobe adaptable at point of delivery, including freedom to be needs-led. This also means, amongst otherthings, that children should not necessarily have to be of a certain age or socioeconomic status to qualify for eligibility, or to live in a particular geographical location.

A number of international studies (e.g. Aarons et al., 2019; Wiltsey Sterman, Baumann & Miller, 2019) have shown, likewise, that adaptations to EBPs are commonplace in real-world settings and are increasingly viewed as necessary to ensure that interventions meet the needs of specific population groups. Indeed, some home visiting services in Ireland are using 'plug in' materials based on family need and adjusting their provision (e.g. number of visits) depending on progress and family feedback (Connolly, Adams & Fleming, 2019). Moreover, when it comes to the needs of the most marginalised

families (including migrant families), the evidence clearly suggests that services need to be adaptable in order to make a meaningful difference (Bäckström, 2021).

4.5 Funding: viability, accessibility, VfM and long-term service planning

4.5.1 Key barriers to funding

The nature and extent of collaboration and partnerships within the home visiting sector, and the changing role and extended remit of the HPV as outlined earlier, highlight a pressing need, not only for formal collaborative structures/mechanisms, but also an urgent requirement for appropriate funding and resources. A key recurring sector-wide challenge identified by numerous participants throughout all elements of this project and also highlighted as a key theme in our companion report, was the typically short-term, fragmented, unpredictable and inflexible nature of funding and funding arrangements (or lack thereof) in the home visiting sector, and generally low salary levels, despite increasing and more demanding staff workloads. For example, many 'high-level' stakeholders (including programme directors, managers and coordinators) reported organisational and funding constraints to be key barriers to programme expansion, staff retention and wider reach/service accessibility, all of which have also been identified in both the national and international literature. For example, Bower and colleagues (2020) in an integrative review of the home visiting literature from 2007-2018, found that staff turnover was a significant obstacle to parental involvement and engagement, whilst adequate and secure funding has also been identified in an international context, as a key factor in successful programme implementation and outcomes (Buccini et al., 2024; Deshmukh et al., 2022).

Our national review (Hickey et al., 2023) demonstrates the diverse and wide-ranging nature of home visiting programmes and supports across Ireland, straddling health, education, welfare and wellbeing spaces (see *Appendix 1*) and delivered through a range of services or 'host organisations' including the ABC programme, Tusla, the HSE and FRCs. While these kinds of support structures have been identified as crucial in ensuring the quality of programme implementation and in supporting the scaling and sustainability of home visiting programmes in an Irish context, the diversity within the sector has led to a wide range of funding and governance mechanisms. Despite some services receiving core funding (e.g. from Tusla), this suggests an overall lack of cohesion and a very competitive funding landscape more generally within the sector.

Furthermore, the reported fragmented or absent funding sources, as well as multiple funding mechanisms, were identified as significant barriers to capacity building and strategic planning for long-term service provision, whilst also negatively impacting the ability to recruit and retain HVP staff. For example, annual funding does not typically take into account the costs associated with programme development or implementation (including training). Likewise, Brocklesby (2023) highlighted insecure and insufficient funding to be a significant barrier to recruitment, programme planning, delivery and sustainability for the five services within the HVA. Indeed, there is no national infrastructure for the commissioning and implementation of home visiting programmes more generally (Brocklesby, 2023), posing considerable challenges for the expansion and optimal functioning of programmes nationally.

Furthermore, as part of that review (Hickey et al., 2023) and as indicated earlier, we were provided with, and reviewed, 8 SLAs which were set up between Tusla and a number of home visiting service providers. These contain funding details such as the total funding requested and allocated, overhead and staffing costs, programme costs and details of any unspent funds from the previous year. They also incorporate information on for example, total salary and hours contracted per week, as well as relevant service categories (e.g. 'family and community support' or 'early years'). It was evident from

these SLAs that posts were mainly funded on an hourly basis, reflecting and reinforcing the findings reported here, which highlight the mainly short-term and precarious working conditions of most HVPs across the sector. Furthermore, according to our findings, salary levels appear to be generally considered to be below acceptable rates for the nature and extent of work involved. This is compounded by the fact that salaries can vary considerably within and between programmes as they are dictated by the host organisations, which have their own salary structure guidelines.

These sector-wide funding issues, coupled with the typically low salary levels, increasingly complex caseloads, and challenging work conditions (e.g. short contracts and non-traditional working hours), appear to have had a detrimental impact on staff morale which, evidence suggests, can lead, to job dissatisfaction and greater turnover among staff as well as negatively affecting the overall quality of services and supports provided (e.g. Begic, Weaver and McDonald, 2019). For instance, our survey findings show that only around half of HVPs were in full-time employment, while almost two-thirds felt that their salary did not reflect their level of responsibility and experience. This is consistent with some work in the international literature; for instance, Spoth et al. (2007) and more recently Finello et al. (2016) indicate that time-limited funding directly affects recruitment and is not conducive, therefore, to the successful and sustained implementation of services.

According to Revill et al. in their 2013 paper, 'non statutory-funded' home visiting models in Ireland were "*developed in an effort to fill gaps in the provision of care*" (p. 262). Clearly, these gaps are still in evidence 10 years later, suggesting perhaps, a longer-term change in the role of the HVP and, therefore, the need to re-consider funding arrangements and models. Furthermore, national research indicates that HVPs are providing services to the most vulnerable and at-risk families across the country, but typically (and as mentioned earlier) without any universal referral pathway (Doyle et al, 2016; Jack and Jill Children's Foundation, 2017; Brocklesby, 2021; Darmody et al. 2022), albeit with considerable variation across services in this regard. For example, the Community Mothers programme which is funded mainly by Tusla (Brocklesby, 2021), has successfully "*embedded themselves in local early years' service infrastructures*" across all of their sites, thereby reflecting the importance of, amongst other things, an appropriate level of governance. Nonetheless, the need for appropriate referral pathways across the sector is indicated and was one of a number of suggested improvements highlighted at our Stakeholder Engagement workshop in late 2023.

4.5.2 Monitoring and evaluation

A wealth of research evidence exists to show that ongoing monitoring and evaluation of programme implementation and outcomes are critical to overall programme success and to quality assurance and service improvement (e.g. Casillas et al., 2016; Hickey et al., 2018a; Hickey et al., 2020). Furthermore, continuous refinement and evaluation are necessary to ensure the sustainability of services and programmes (Supplee & Duggan, 2019). Thus, programmes which are based on theories of change and which undertake regular monitoring and evaluation, are more likely to involve continuous improvement than those without such mechanisms (Perrin, 2012). Equally, well-designed programmes are insufficient in and of themselves if not accompanied by robust evaluation (and preferably including economic appraisals).

As mentioned in our companion report and national review (Hickey et al., 2023), ongoing evaluative and data monitoring processes have been implemented by a number of services delivering home visiting programmes in Ireland (e.g. Community Mothers, Homemaker, CDI, Preparing for Life, Partnership with Parents and Parent-Child+) in order to enhance programme quality and impact (e.g. through practitioner and parental feedback mechanisms and data collection tools). A considerable body of knowledge, experience and expertise has also accumulated across the sector over the years. However, only a small number of the 10 home visiting programmes included in our review, have been rigorously evaluated (i.e. through RCTs) in an Irish context, although in the case of two 'imported' parenting-focused programmes (Let's Grow Together - Infant Mental Health and Parent-Child+), there is strong evidence from evaluations conducted elsewhere. Some of the existing evidence is also now quite dated, while longer-term evaluations are limited and economic evaluations almost non-existent, with the exception of the Incredible Years evaluation led by McGilloway and colleagues (which included a home coaching element) (O'Neill et al., 2013).

The availability of longer-term sustained funding has been highlighted nationally as critical in terms of facilitating appropriate research and evaluation (Curtin et al., 2015; Hickey, C. et al., 2018; Brocklesby, 2023). It would also appear that the organisations affiliated with the HVA are in a stronger position than others to seek funding for, and conduct, research to help inform programme effectiveness and to generate evidenced outcomes. For example, as outlined in our national review (and companion report) (Hickey et al., 2023), the Preparing For Life and Community Mothers programmes have been extensively researched by means of, for example, longitudinal studies, a number of randomised control trials (RCTs) and internal reviews, all of which demonstrate a strong and ongoing commitment to evidence-based practice (e.g. Doyle et al, 2009, 2016, 2017, 2018, 2020; Brocklesby, 2021; Darmody et al., 2022).

Less is known about some of the other home visiting programmes, but it should be noted that the absence, or limited evidence, of effectiveness of programmes should not be considered equivalent to ineffectiveness, and to ignore the potential of such programmes/services may therefore "*inadvertently put greater numbers of children at risk*" (Edwards et al., 2021; p.28). Nonetheless, there is a clear need for more rigorous mixed method evaluations and attendant funding support across the home visiting sector in order to provide evidence on short- medium- and longer-term effectiveness/impact and implementation.

Data collection and monitoring infrastructure

The availability of longer-term funding has also been repeatedly highlighted as crucially important in facilitating evidence-based planning, local needs analyses and ongoing data monitoring within the home visiting sector in Ireland (Curtin et al., 2015; Hickey, C. et al., 2018; Brocklesby, 2023). Indeed, anecdotal evidence points toward the existence of large amounts of routinely collected (but not publicly available) data within, for example, the five HVA programmes and relating mainly to programme performance and implementation (e.g. end-of-year reports, monthly feedback forms on, for example, number of families referred, assessments conducted etc). Furthermore, the ABC Outcomes Framework provides a useful structured approach/tool to facilitate the collection of relevant outcome and background data across ABC sites in order to assess the quality and impact of their programmes (e.g. Hickey et al., 2018), while a number of logic models developed by individual programmes may also be helpful in this regard (see Report Number One, Appendix B).

Nonetheless, each of the 10 home visiting programmes service, at present, appears to have its own data collection and monitoring tools, which may be important in terms of their autonomy, but might suggest some duplication of effort and resources. Moreover, our review of the Service Level Agreements (SLAs) that were provided to us as part of our national review, indicates that protocols designed to monitor programme performance are often ad-hoc in nature and, overall, there is a marked lack of standardised measurement frameworks and routine monitoring systems. Furthermore, many of the Key Performance Indicators (KPIs) or metrics included within the SLAs are not easily measured and limited information is available, therefore, on how the effectiveness of services or standards of delivery are routinely assessed. The need for a re-think in this regard, was identified as one of several key priorities at our Stakeholder Engagement event (in November, 2023).

While most routinely available data do not appear to be in the public domain, or collected in a necessarily systematic or uniform fashion, some or all of these data could be usefully standardised, de-identified and aggregated (alongside similar data from elsewhere if available) to help inform service planning, funding and policy decisions at national level. For example, linked administrative data (e.g. on health and social care characteristics, service utilisation , child outcomes) , based typicallyon large sample sizes, have been used successfully in observational studies to support evaluations of the Family Nurse Partnership in the UK (Cavallaro et al., 2020; Lugg-Widger et al., 2020). According toCavallaro et al. (2023), these offer a potentially useful *"cost- and time-saving alternative to RCTs…andexciting opportunities for ongoing evaluation of existing population health interventions"* (p.2).

From our informal conversations with stakeholders, we also understand that the Community Mothers (soon to be known as 'Community Families') service staff have been designing and planning, and are currently involved in implementing across 5 of their 7 sites, a sophisticated Customer Relationship Management (CRM) system. This kind of technology/system, traditionally used for marketing and customer relations purposes, has been employed increasingly in recent years within the non-profit sector to help capture data on service-related activity, knowledge and outcomes which can be better organised, managed and shared in order to inform decision making and investment decisions (e.g. Rathi and Given, 2017). The Community Mothers CRM is based on the INCLUDE model used in the domestic violence sector in Ireland and involves HVPs collecting 'in-the-moment' data using tablets in the home. Based on the work completed by Community Mothers to date, the set-up costs per site for such a system (excluding any insurance costs), amount to approximately €10k, and with a small annual licence and technical support subscription thereafter of €1500 p.a. This represents a very small investment in view of the many possibilities and potential impacts that such a system would offer.

Factors identified as critical to the successful implementation of these kinds of information management systems, include the need to: create a clear strategy prior to implementation and separate to the system itself; allocate resources judiciously; and secure buy-in from staff at all levels (Kristoffersen & Singh, 2004). While focusing only on a single service at this early stage, this work could generate important learning for other home visiting programmes in Ireland, thereby building knowledge, capacity, quality and innovation across the entire sector, all of which are crucial for the ultimate sustainability of home visiting services. While this may pose challenges in an Irish context, in terms of the complexity and wide variability of home visiting programmes, services, settings, and parent and child outcomes, it could, if successful, be transformative in terms of providing a novel, standardised, sector-wide approach and important support infrastructure (resources permitting). If successfully implemented, this would also be an important step and paradigm shift toward a culture of "*embedded, near real-time evaluation supporting evidence-based policy-making*" (Cavallaro et al., 2023; p.9) within the home visiting sector.

It is also important to note at this juncture, that the HVA has just begun a new project entitled 'A collaborative exploratory study of data definitions, knowledge frameworks and practices', the aim of which is to learn "*…how to use data to identify gaps in home visiting service delivery, both locally and nationally, to track and review data, and to share evidence-informed evaluation of services and approaches used across the 5 early childhood home visiting programmes"* (HVA, 2024, p.1). This will involve, primarily, a review of existing practices (and commonalities therein) in relation to different aspects of routine data collection, monitoring, management, analysis and utilisation as well as ongoing evaluation. The results of this work should be very helpful in terms of supporting commissioning and programme delivery and facilitating the sharing of data, knowledge and learning across the home visiting service sector.

4.5.3 Demonstrating Value for Money

Internationally, there is considerable evidence to demonstrate the positive longer-term cost benefits and returns of intervening early in a child's life (Cunha and Heckman, 2007). There is also a small but growing body of evidence to show that home visiting can be a cost-effective strategy when compared to other interventions (Michalopoulos et al., 2017; Leer & Lopez-Boo, 2019; Kelley et al., 2022), albeit with mixed findings in this regard.

As outlined in our national review (Report Number One, Hickey et al., 2023), we could find no evidence of economic evaluations for any of the home visiting programmes or services in Ireland, with the notable exception of the national evaluation of the Incredible Years parenting programme (for children aged 3-6 years) and the ENRICH research programme led by McGilloway and colleagues (O'Neill et al., 2013; Crealey et al., 2024), both of which involve an element of home coaching. It is difficult, therefore, to determine the wider intersectoral cost benefits or Value for Money (VfM) of these kinds of supports. Likewise however, the international literature contains relatively few economic evaluations of home visiting interventions despite a need to better understand the costs and benefits associated with early help and intervention programmes more generally.

Economic evaluations are typically based on a cost-effectiveness (CEA) or cost-benefit analysis (CBA) which involve the calculation/estimation of a range of costs which are then examined in the context of (parent and child) outcomes typically assessed as part of a pre-post evaluation (e.g. O'Neill et al., 2013; Crealey et al., 2024). Doyle (2024) provides a useful summary of the international evidence on economic evaluations of home visiting based on several reviews of the literature; she concludes that the findings from CEA and CBA studies vary widely and it is not clear to what extent, therefore, they can be attributed to programme effectiveness or methodological differences.

Indeed, as indicated in our previous report, there are many methodological and other challenges involved more generally in assessing the cost-effectiveness of early intervention and prevention programmes for young children and their families (Bailey et al., 2021). It is also important, yet challenging, to capture both health-related and wider societal costs (Cox et al., 2022). Furthermore, according to recent work involving some members of the UNITES team, costs and outcomes may also fall across multiple sectors while intervention benefits may not yet have materialised within the time frame of an evaluation or indeed, may extend well beyond it (Crealey et al. 2024).

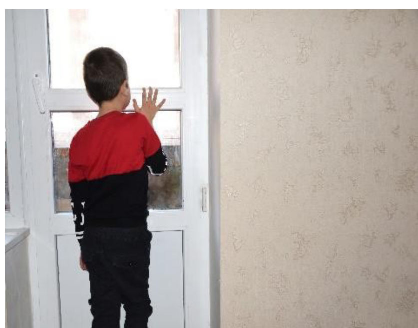
While it is difficult, in the notable absence of economic evaluations, to identify the wider intersectoral cost benefits or Value for Money (VfM) of these programmes (an important policy making consideration), some national work may be useful in this regard. For example, Brocklesby (2023) provides some approximate indicative cost indications (i.e. cost per child per year) of running a small project in a Community Mothers/Families area (including travel and associated costs). However, these kinds of exercises, whilst laudable, should be interpreted with caution because, as described by Brocklesby, costs can vary considerably from one programme to the next in terms of, for example: levels of administrative support; number of home visits per family (e.g. weekly versus monthly); number of interagency meetings and interagency working involved; number of high-need families; staff qualifications/length of service; travel (e.g. in rural areas); and IT support. Indeed, in a recent US study of four evidence-based home visiting programmes (Corso, Ingels and Walcott, 2022), the average costs (which ranged from $2568 to $5351 per family) differed due to staff salaries (typically the largest cost element), number of home visits and programme-specific allocation of resources.

Doyle (2024) provides a more detailed analysis of the likely return on investment and cost benefits of home visiting programmes in Ireland, using the Washington State Institute for Public Policy (WSIPP) Benefit-Cost Model (Beuchert and Verner, 2019). The conclusion from that work, based on a small number of US programmes considered to be most similar to those identified in our national review, is that home visiting generates a positive return on investment. However, a major caveat, as highlighted by the author, is the extent to which findings from the US translate to an Irish context. This lack of robust economic data remains a key knowledge gap in both an Irish and international context (see also Hickey et al., 2023) and a need for further work in this regard is indicated, both in terms of a larger number of economic appraisals, and the use therein of more appropriate, robust and standardised economic evaluation frameworks and approaches.

4.5.4 Programme availability/reach

The mix or appropriate balance of universal and targeted provision is a key question in an early intervention and prevention context and one that merits careful consideration. As outlined in our companion report (Hickey et al., 2023), the vast majority of home visiting programmes available across the country may be best described as targeted interventions which operate at either an individual level (i.e. where services are delivered to children-parents/families with particular/specified needs), or at a community/group level, supporting targeted populations, such as disadvantaged communities or marginalised groups (e.g. ethnic minorities, homeless families). Several programmes may be described as 'targeted universal' in the sense that they are available to all community members living in an area of recognised socioeconomic disadvantage (e.g. Community Mothers, Parent-Child+, Preparing for Life, and Let's Grow Together! Infant Mental Health). Others are targeted and cater for families with specific experiences/identified risks (e.g. parenting challenges) or particular needs such as Down Syndrome, physical disability, or life limiting conditions (e.g. the Parent Child+ 'Home from Home Transition Programme', Jack and Jill Foundation and Laura Lynn). Overall, however, programme availability tends to be delimited by service catchment areas, although a small number of programmes (e.g. Community Mothers, PwP) are delivered across multiple sites.

While there were some differences of opinion as to the extent to which home visiting programmes in Ireland should be provided on a universal and/or targeted basis, a broad consensus emerged amongst participants (i.e. from the survey, interviews and stakeholder workshops) that home visiting should, ideally, be based on a 'progressive universalism' approach that provides good quality services for all, but with additional supports for the most vulnerable and marginalised families. This is consistent with the HSE's Universal Child Health Programme (HSE, 2015) and the First 5 Strategy (DCEDIY, 2019), whilst also reflecting the international literature (Oberklaid et al., 2013; Klinkhammer & Berth, 2019).



This approach, based on social justice principles, suggests that home visiting services need the freedom to adapt as necessary to family needs at a local level, whilst striving to ensure equality of access and outcomes for all. Arguably however, this represents an ideal which may not be attainable or sustainable at present in a context of continuing financial constraints and with many services not operating at full capacity. Furthermore, as noted in our national review (Report Number One), it is also important to question the extent to which specific groups, such as first-time mothers or traveller families, may be best served by the home visiting programme/model available within a community, requiring instead, more targeted and tailored approaches to address their unique needs. Families with multiple and complex needs may also benefit from home visiting programmes, but it is important that home visiting is not seen as a "gap filler" that can adequately address *all* the needs of families in crisis even with additional supports. The integration of home visiting services into a well-resourced child health and development-focused system, as well as effective interagency working across services, is critical in order to meet the needs of all families.

As outlined in our national review, the research literature suggests that Implementation Teams (also used with some of the ABC initiatives) may be used to guide programme implementation and, in particular, to align programmes to community needs/interests and the desired goals of core stakeholders (Hurlburt et al., 2014; Barnes et al., 2017; Hickey et al., 2018b; Hickey et al., 2020); thus, these could be very helpful in terms of designing and implementing more universal approaches, supported by appropriate strategic leadership, training, education and supervision for programme providers.

4.6 Strengths and limitations of the study

This study is the first of its kind, conducted in a national context, to examine and review all of the home visiting programmes and other support services that are currently being delivered in Ireland. The findings from all elements of this study, including our national review (presented in Report Number One), provide important and useful insights into the views and experiences of a large number, and wide range, of stakeholders who work in the home visiting sector in Ireland. These include, not only the many frontline practitioners, but also those occupying managerial/co-ordinator, research and other support/advocacy roles.

The response rate from the online survey was disappointingly low (perhaps because many prospective respondents had already taken part in one or more other elements of the study) and, therefore, generated less representative findings than originally anticipated. However, the findings are broadly consistent with, and are amplified and supplemented by, the qualitative findings from the larger sample of stakeholders who took part in the one-to-one interviews (including a small sample of

mothers), focus groups, group discussions, the CARN 'What Works' workshop, the in-home observational work and the Stakeholder Engagement workshop.

The CARN 'What Works' workshop presented the research team with an initial, unique and once-off opportunity to assess the views and experiences of a large and diverse cohort of staff working in, or associated with, the home visiting sector, ranging from CEOs and policy makers to HVPs affiliated with a wide range of organisations. An initial review of the international literature (based on some scoping review principles) was used to inform the development of a number of questions which were used to guide the discussion (and to later contextualise the findings). However, it should be noted that the group-based and informal nature of the discussion and the hybrid model of interaction may have impacted the responses provided by attendees and inhibited their sense of freedom to engage openly. Furthermore, whilst an anonymised Vevox option was provided online for this option, those attendees who participated in-person may have felt inhibited in their responses due to, for example, issues such as confidentiality, groupthink or perceived possible negative repercussions.

Furthermore, while the observational and HVP shadowing study was small-scale in nature, it was based on a heterogeneous sample in terms of geographical location, family composition, programmes, and types of setting, and provided some interesting insights into the day-to-day activities and realities of the work of frontline HVPs and the varying needs of the diverse families whom they support. The inclusion of the service user voice is important and could be incorporated on a larger scale, into future research.

The triangulation of the findings across the various elements of the study, suggests that the findings may be considered broadly generalisable even though we may not have accurately or adequately captured all of the key 'voices' in our data collection. When conducting our national review, little information was publicly available on the development, governance and funding of some programmes, while our review of the SLAs also yielded very little useful information. Our review also indicates a marked lack of information on programme implementation (e.g. the resources being used to deliver programmes), as well as considerable variation in terms of programme components and delivery, thus making it difficult (and perhaps not appropriate) to make like-with-like comparisons. The lack of rigorous evaluations in an Irish context also limits our understanding of the influence of the local context and wider constraints on programme replication and roll-out. Furthermore, it was not within the remit of this study to collect or review any routinely held data which may have helped to fill some of the knowledge gaps identified here, although our findings may be helpful in terms of highlighting avenues for future exploration in this regard.

Lastly, a number of key learnings for policy and practice, contextualised with reference to our review of the international literature, were identified from the findings reported across all elements of the project (as outlined in both of our reports), although this is not necessarily an exhaustive list. For example, at a strategic level, these include: the longer-term investment needed to develop, deliver and evaluate home visiting programmes; a need for *both* universal and targeted supports (given the heavy emphasis on the latter); the importance of the local context when addressing families' needs; and the role of programme monitoring and routine data collection. A number of gaps were also identified, including the fragmentation of service delivery, limited data on programme implementation, and the lack of an evidence-base to guide or support the work of some programmes.

4.7 A national vision for the future: Key learnings and directions for the future development and optimal effectiveness of home visiting in Ireland

All of the findings reported here, highlight a need to consider whether or not home visiting programmes/services (and the role of staff therein), should be more cohesive or standardised at a national level. Most participants in our study were broadly in favour of greater regulation and standardisation and stronger governance within the home visiting sector in the form of minimum standard policies, procedures and practices that support and enhance the quality of their work. At the same time, however, this was tempered with concerns about how this might be best achieved and accommodated within the considerable diversity across the sector. For example, there was a broad consensus that this should not be at the expense of restricting adaptation and innovation of home visiting programmes, practices and services which were considered essential to meeting the many diverse needs of families across Ireland.

Furthermore, while regulation and standardisation can often be beneficial for maintaining quality, there is also a risk of over-regulation which can stifle flexibility and adaptability in meeting diverse family needs in a timely and effective manner (Azzi-Lessing, 2011). Arguably therefore, it is important to strike a balance between ensuring a high-quality, professional and broadly standardised service, and maintaining the flexibility and community connection that are key to the success of earlychildhood interventions more generally (Britto et al., 2018; Yousafzai et al., 2018). Both should be front-and-centre when considering any new proposed national model of home visiting.

There is no 'one size fits all' approach to home visiting programmes in Ireland, or indeed elsewhere (Morrison, Hughes & Doi, 2022), but this does not preclude the development of a national approach in order to strengthen and possibly standardise critical elements or aspects of home visiting provision. The combined findings reported here and in our companion report provide, for the first time in a national context, an important basis to inform the identification of some proposed actions/goals that can (and should) be used as key stepping stones toward a more standardised and optimally effective 'model' of home visiting service delivery, ultimately with a view to maximising reach, ensuring sustainability and enhancing outcomes for vulnerable children and their families in Ireland.

These are presented below as a (largely stakeholder-informed) 'menu' of options which may be implemented on a short-, medium- or longer-term basis and with the support of variable funding or other resource requirements, as well as appropriate and effective leadership and commitment. They are contextualised and supported, where applicable, with reference to both the national and international research literature. As outlined below, these suggested options/actions straddle four broad topic areas including: (a) the HVP role (including training and qualifications); (b) funding and its relationship to the viability, accessibility and sustainability of services; (c) interagency, cross-disciplinary and multi-sector working and collaboration; and (d) the implementation of collaborative intra-sector mechanisms and structures. As indicated above, this is not designed to be an exhaustive list, but rather highlights a number of critical areas and specific actions/ goals that should be prioritised for the future development, optimal effectiveness and sustainability of the home visiting sector in Ireland.

4.7.1 The HVP role

Definitions and visibility

- Establish and agree a clear definition of ‘home visiting’ in an Irish context.
- Agree a clear and definitive title and role description(s) for staff working in the home visiting sector in Ireland.
- Appoint all staff on a contract basis rather than occasional/casualised employment.
- Develop, agree and implement a standard job description for home visiting managers and co-ordinators across services (but allowing for some cross-site variability).
- Develop and agree some basic employment Terms and Conditions across services and, in tandem, a salary range that reflects the appropriate expertise and length of service of many HVPs (e.g. based on the Tusla Family Support Practitioner scale).
- Recognise and value the important role and impact of home visiting providers within the wider service landscape (and possibly as part of a dedicated Child Health Workforce[11]) through service planning documents and strategies and in the medium to longer term, a national policy.

Qualifications and training

- Establish a minimum NFQ Level 5 baseline qualification for all HVPs and/or implement an apprenticeship/training model, during which time a newly appointed HVP can acquire the necessary qualifications and additional training required to undertake their role (and as determined by their employer).
- Ensure that minimum levels of training and soft skills are tailored to the responsibilities of the role and the specific needs of families.
- Encourage all staff to engage in ongoing training, education and CPD activities.
- Ensure that home visiting managers and co-ordinators have minimum core competencies and qualifications required to: (a) provide appropriate support and supervision to frontline staff (including coaching/mentoring and opportunities for reflective practice); (b) deliver appropriate leadership; (c) monitor quality and safety; (d) deal with HR and finance issues; and (e) contribute to ongoing service development (Paulsell et al., 2014; Duggan et al., 2018).
- Ensure that the HPV workforce is sufficiently culturally competent and diverse to effectively serve the needs of a wide range of communities (e.g. through the provision of modules/courses on cultural sensitivity, inclusivity, language skills and working with diverse populations).

Supporting staff

- Ensure that HVP salaries are commensurate with experience, expertise, level of qualifications and overall level of responsibility, especially within the context of increasing workloads and the need to manage greater complexity and diversity.
- Develop and implement a system-wide recruitment and retention strategy aimed at addressing staff shortages and minimising staff turnover; both of these factors have been

[11] The concept of a "Dedicated Child Health Workforce" is part of the *First 5* strategy in Ireland (2019-2028). This workforce is intended to enhance child health services, especially in areas with high population density and disadvantage, by increasing service capacity (in collaboration with the HSE) in the fields of health promotion, prevention, and early intervention.

shown, internationally, to be detrimental to the continuity and quality of care provision, while also leading to low morale/staff burnout.
- Encourage an organisational culture and ethos that values and supports staff health and wellbeing and open communication. This should include consideration of caseload size (and contact hours) and some 'light-touch' regulation/oversight.
- Foster a supportive work environment through regular supervision, mentoring, peer support and opportunities for reflective practice,
- Establish feedback mechanisms for both families and service providers.

4.7.2 Funding: viability, accessibility and sustainability

Sustainable funding

- Make available longer-term, more sustainable, multi-annual and preferably cross-Departmental funding to address the reported chronic under-funding and attendant uncertainties across the sector, while enabling existing services to operate to a sufficient standard.
- Establish realistic funding timeframes and targets
- Include consideration of the costs associated with programme development and implementation (including training).
- Consider establishing, if feasible, an agreed national approach(es) to service commissioning.
- Strive to implement, prioritise and fund, as a longer term (e.g. 5-year) goal, a progressive universalism approach to home visiting. The current funding stability in the sector poses a major challenge in this regard.

Economic (VfM) considerations

- Develop an economic case for home visiting in Ireland (see Doyle, 2024)
- Make more funding available for economic evaluations. These could include 'non-traditional' approaches, such as Social Return on Investment models (e.g. Lawlor & McGilloway, 2012) or newly developed methods such as Realistic Economic Evaluation (e.g. the REEM project in Northumbria University) to evaluate and properly capture and contextualise the costs and outcomes of home visiting programmes and to "establish what works, for whom, in which circumstances, why, and with what related resource impacts and opportunity costs" (https://www.realist-economic.co.uk/).

Research and evaluation

- Provide appropriate dedicated funding to enable programmes, as part of their ongoing research and development, to access sufficient funding to continue to evaluate and monitor the outcomes/impact of their work and of programme implementation and to address some of the gaps identified in our national review (Hickey et al., 2023).
- Harness the collective and considerable expertise of the research community across Ireland (and internationally where applicable) to work collaboratively and collegially with home visiting sector colleagues in ways that are more efficient and more accessible than previously.

Routine monitoring and service evaluation

- Set and monitor (realistic) targets for programme delivery (e.g. this could be informed by key policy frameworks such as the Children and Young People's indicator set[12]).
- Capitalise on, and exploit, opportunities for the extensive use and sharing of routinely collected data at national level (underpinned by appropriate funding support).
- Identify, agree and appropriately resource through annual dedicated funding, a standardised data monitoring and evaluation system for each of the programmes/services in order to inform service planning and development at local level (e.g. by helping to set realistic desirable targets and eligibility criteria for programme selection and delivery) while, crucially, helping to identify what works, where, and for whom.
- Provide (and fund) appropriate administrative and training support for any new system
- Consider modelling the new system or framework on the Community Mothers (soon to be Community Families) CRM (see above), on which a considerable amount of work has been completed to date (with the support of significant philanthropic funding).
- Agree a minimum set of outcomes for inclusion in the system (e.g. maternal and child mental health and wellbeing, parental self-efficacy, parental perceptions and experiences and social support/isolation).[13]
- Consider collecting/recording additional 'activity data' on, for example, breastfeeding rates, the nature and duration of each home visit/contact, parental attrition/engagement and inter-agency referrals.
- Set up and agree data sharing agreements based on a standard template.
- Consider over time, using this system to facilitate online referrals to other services while capturing data on, for example, number of children entering care, service utilisation (e.g. GP and hospital visits), staff training and supervision, and family satisfaction/experiences.

4.7.3 Interagency, cross-disciplinary and multi-sector working and collaboration

- Recognise, support and increase the 'visibility' and accessibility of the home visiting sector by developing and resourcing (where applicable) stronger partnerships with statutory and community service providers and especially in terms of equipping services to meet the increasingly diverse and complex needs of families.
- Consider involving national and international experts to help guide and support this comprehensive intersectoral approach [in line with guidance from the international literature (e.g. Aarons et al., 2014; Palinkas et al., 2015; Green et al., 2016)].
- Develop a standard protocol(s)/template(s) (e.g. Memoranda of Understanding) to help monitor, guide and formalise (where appropriate) cross-agency and interdisciplinary working (e.g. by clearly defining key roles and responsibilities)
- Develop and agree formal or semi-formal referral structures/mechanisms to support the inter-agency aspect of the HVP role and to facilitate rapid referrals, or create appropriate pathways, to a range of integrated child-development focused and needs-led services.
- Encourage some level of shared ownership or joint commissioning if desirable or feasible.

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[12] This is a comprehensive framework aligned with national policy (e.g First Five) and designed to help monitor and evaluate the well-being and outcomes of children and young people across the country. "

[13] Specifically, the Community Mothers CRM incorporates: the *Warwick-Edinburgh* scale (maternal depression); the *Strengths and Difficulties Questionnaire (SDQ)* (conduct problems in children); the *TOPSE* parental self-efficacy); the *What Being the Parent of a New Baby Is Like (WPL)* (parents' perceptions and experiences of parenting); and the *OSLO Social Support Scale (OSSS-3)* to measure social support.

- Consider revising and standardising the current SLAs (e.g. by including realistic SMART goals).
- Provide networking opportunities for staff within the home visiting sector and also with other agencies with a view to sharing learning and good practice.

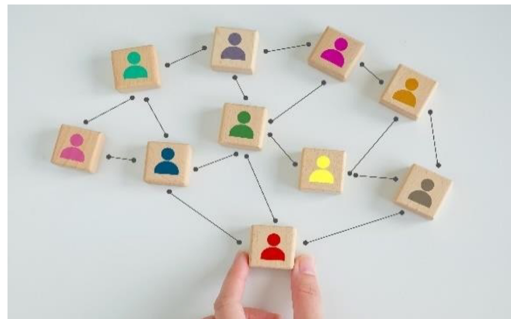
4.7.4 'Embracing unity within diversity' - implementing collaborative mechanisms/structures

All of the above should be attainable in the short, medium or longer term and will, of course, require differing levels of time, effort, funding, leadership, commitment and creativity. Potential challenges/risks include mainly, increased operational costs, resource availability, budget/funding re-allocation and a competitive funding landscape. Important facilitators include appropriate leadership and co-ordination, capacity building (including training), and timely and effective information sharing, including attendant systems to facilitate monitoring and evaluation. Ongoing ringfenced or dedicated funding across Government departments and agencies (e.g. Department of Children, Equality, Disability, Integration and Youth, Department of Health and the Department of Education, Tusla, HSE), coupled with strong leadership, collaboration and co-ordination, have been identified within the international literature, to be particularly critical facilitators in this regard (Reichenpfader, Carlfjord & Nilsen, 2015; Green et al., 2016).

The options outlined here, present challenges which, it is suggested, can only be overcome through meaningful collective efforts by all stakeholders, including the research community. We propose two ways, below, which might be helpful in this regard, both of which are based on national and international evidence.

- Firstly, an Implementation Team could be established (e.g. at programme level) to help guide service delivery/programme implementation and, in particular, to align programmes to community needs/interests and the desired goals of core stakeholders (Hurlburt et al., 2014; Barnes et al., 2017). These have been used effectively as part of the ABC initiative (Hickey et al., 2018b; Hickey et al., 2020) and could be very helpful, in the longer term and amongst other things, in terms of designing and implementing more progressive universal approaches, supported by appropriate funding, strategic leadership, training, education and supervision for programme providers.

- A collaborative and inclusive 'Home Visiting Network of Excellence' comprising all 10 home visiting programmes, could be established at national level and aligned with (and expanded within) emerging inter-agency structures such as the HVA. For example, the HVA currently provides an excellent cross-service model for 5 of the 10 home visiting programmes in Ireland (included in our national review (see Hickey et al., 2023)).



This kind of network-based approach has been used successfully in New Zealand (the 'New Zealand Kindergarten Network') based on the premise of 'no association left behind', and underpinned by principles of trust, transparency, inclusiveness, innovation, empowerment, holistic development and stewardship (Bond, 2023). This is also a model which was used, with some success, by The Atlantic Philanthropies in Ireland, in terms of bringing organisations together and promoting more effective stakeholder networking co-operation (e.g. within the ageing sector) (Cochrane et al., 2013).

The initial work of the Network could involve developing a Network Strategic Plan, a suite of agreed policies and procedures, and implementation of a staff culture survey. Membership criteria/terms could be agreed with a view to encouraging all home visiting programmes across Ireland to be involved (e.g. via an Implementation Team representative(s)) and including funder and policy maker representatives across relevant government departments (including the HSE).

Specifically, the benefits of such a network would include:

- Connecting local managers
- Retaining local identity and autonomy
- Learning from individual and shared history and experiences
- Promoting local decision-making supported by a national network
- Facilitating professional and community connections and contributions/input
- Providing an opportunity for local people to support home visiting services locally
- Developing some level of shared funding arrangements
- Sharing innovation, expertise and problem-solving.

The new Network of Excellence would lead on developing a new national model of home visiting that incorporates and progresses some or all of the actions/options/goals identified here. This should tap into the collective skills and extensive expertise within the home visiting sector, while addressing fragmentation and possible duplication, and ensuring the sharing of data, learning and best practice approaches. Broadly, this could, if properly and sensitively implemented and resourced, promote excellence in governance, sector leadership, advocacy, interagency collaboration and capacity building, thereby contributing significantly to the longer-term effectiveness and sustainability of the sector.

4.8 Conclusion

All children have a right to be protected and supported under European law (United Nations Convention on the Rights of the Child (UNCRC, 1989) and, therefore, to have access to early intervention and prevention services that are grounded in principles of health, education, inclusion, participation, protection, and family support. For example, under Article 6 of the Convention, children have the right to the highest attainable standard of health, whilst Article 19 confers rights upon children to protection from all forms of physical and psychological harm, abuse, neglect, or maltreatment. These rights are also enshrined in key policy developments in Ireland, such as *Better Outcomes, Brighter Futures (2015), First 5 – A Whole of Government Strategy for Parents and Babies (2019)*, and *Supporting Parents: A National Model of Parenting Support (2022)*, all of which reflect a strong and enduring commitment to supporting early childhood development and wellbeing through the provision of accessible, high quality and evidence-led parenting and other supports. However, our findings suggest that there remains a disconnect between policy and practice in the home visiting space in Ireland. Whilst the landscape of broader policies has moved toward equality, raising hopes for many vulnerable children and families, arguably, there still exists a contested space between the rights conferred upon vulnerable children and their families and their lived realities.

The UNITES project team conducted, for the first time, an extensive national review of home visiting service provision in Ireland and, in tandem, elicited the views and experiences of a wide and diverse range of key stakeholders who provide (or receive) home visiting supports across the country. The collective findings provide important and useful insights into the benefits of home visiting and a number of best practice approaches and principles. However, they also highlight the many challenges facing HVPs and programme providers and funders within the home visiting sector in Ireland today (as also seen in previous work (e.g. Brocklesby, 2023)).

Despite the widely reported benefits of home visiting, there is considerable variation across the sector in terms of overall governance and funding streams which pose a significant barrier to optimal effectiveness, impact and sustainability. There has been an increasing focus internationally on the sustainability of interventions particularly as the full effects of programmes may not be evident in the short-term. It is important, therefore, to be mindful that any possible discontinuation or underfunding of programmes may be counterproductive and pose obstacles to future health promotion efforts at local and population level (Scheirer & Dearing, 2011; Walugembe et al., 2019).

There was also a clear message from our findings that HVPs and their services view themselves as positive change agents and see value and direct impact from their day-to-day work in supporting and fostering the health and wellbeing and development of vulnerable young children and families. However, they clearly need additional support and clarification of their role and responsibilities to help them manage their increasing and more diverse and complex workloads (and needs) and an attendant shift toward more specialised provision. At the same time, this raises important questions as to whether HVPs should be taking on (or have the capacity to take on) additional and more specialised health and social care duties/responsibilities whilst maintaining their 'regular' roles and responsibilities, and especially if such support needs to be delivered (in the medium to longer term) on a progressive universal basis.

The lack of a national home visiting infrastructure and appropriate governance and policy, coupled with continuing funding instability and uncertainty - fuelled by a reliance on fluctuating public funds and other socioeconomic factors - are significant barriers to the successful delivery/implementation, effectiveness, impact, availability and sustainability of home visiting programmes/services. These challenges appear to have been compounded by the COVID-19 pandemic and the cost-of-living crisis, both of which have added to the vulnerability of many families and intensified the demand for home visiting services, while requiring HVPs and services to adapt rapidly to many new challenges.

The evidence presented both here and in our companion report (Hickey et al., 2023), indicates that home visiting providers continue to play a critical role in supporting vulnerable families in Ireland. However, their full potential and impact can only be realised by developing a more standardised, sustainable, and ideally, progressive universal, national model of service delivery based on the suggested options/goals outlined here and informed by a diverse and committed collective of stakeholders at all levels. By addressing these critical needs and requirements, home visiting providers can be empowered and supported to more effectively meet the needs of increasing numbers of vulnerable children and families in Ireland, ultimately improving their outcomes and promoting healthier and more resilient communities in the longer term.

"A child is a treasure, to be nurtured, to grow, to flourish"

(Te Whariki Early Childhood Curriculum report, New Zealand Ministry of Education, 2017)

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Appendix 1

Home visiting provision in Ireland

Table A Home visiting programmes and wider sector supports currently available in Ireland

Type of programme	**Name of programme**
State and community/voluntary sector supports	• ABC Programme • Home Visiting Alliance • Infant Mental Health Networks • Tusla Child and Family Agency

Parent/Family-focused programmes
 	
Early Childhood Home Visiting Programmes
	• Homemaker
	• Incredible Years Home Coaching Programme
	• Partnership with Parents
	
	• Community Mothers*
	• Home-Start
	• Let's Grow Together Infant Mental Health Home visiting programme
	• Lifestart
	  - Growing Child Programme
	  - Lifestart At home in Transition Programme
	• ParentChild+
	  - ParentChild+ Home from Home Transition Programme
	• Powerful Parenting
	• Preparing for Life

*Soon to be re-named 'Community Families'

Table B: Other education- and disability-focused home visiting support services currently available in Ireland

Type of home visiting support	**Name of support**
Education-focused supports	• Early Intervention Home Teacher Programme (Down Syndrome Ireland) • National Council for Special Education Visiting Teacher Programme for children who are Deaf/Hard of Hearing or Blind/Visually Impaired
Disability-focused supports (profound cognitive delay or life limiting conditions)	• Enable Ireland • Jack & Jill Foundation • Laura Lynn

Appendix 2

Focus Group Recruitment Poster

Focus Groups for Home Visiting Practitioners

The UNITES team would like to invite

All Home Visitors to join **online** focus groups to discuss their experiences and perceptions of Home Visiting in Ireland on:

Tuesday May 30th @ 10am & 1pm

Thursday 1st June@ 10am &1pm

Friday 2nd June @10am & 1pm

If you are interested or would like more information, please email:

PATRICE.MCCORMACK.2019@mumail.ie

Or call 0873313330

Appendix 3

Sample one-to-one interview schedule

Questions for Home Visiting Local area Manager/Coordinator

1. Can you tell me your name and your role in the organisation in which you work?
2. Can you tell me a little bit about your organisation?
3. What geographical area does your service cover?
4. What sort of programme/service do you deliver?
5. How do you find the parents and families who need your services?
6. How do you cater for diverse families and homes?
7. Do you work in partnership with any external agencies, if so are these arrangements formal / informal?
8. How would you describe the role of a Home Visitor?
9. How do you recruit Home Visitors?
10. Do you use a paraprofessional or professional model?
11. What are the qualification(s) (formal or otherwise) you look for in a Home Visitor? What are the qualities you look for?
12. What qualifications (if any) should a HVP hold, ideally, in your opinion?
13. Do you offer inhouse training? If so, what does it entail?
14. How many HV's would you have responsibility for?
15. How many families would they work with?
16. How are HV's supported?
17. How secure are the positions the HV's hold?
18. In your opinion, are Home Visitors paid comparative to the responsibilities they hold?
19. How do you evaluate how the HV's are performing?
20. Do you evaluate the outcomes of the families with whom your HV's work? If so, how?
21. Do you use a rating scale or evaluation framework? If so, which one?
22. Do you think that the HV sector needs to be regulated, inspected, evaluated in a universal manner?
23. Is there anything you would like to add that I haven't considered in relation to Home Visiting Services in Ireland

Appendix 4

Focus group interview schedule

Can you explain your definition of home visiting

Minimum qualifications / training requirements for HVPs?

- Undergraduate qualification / postgraduate qualification plus additional training
- Paraprofessionals; minimum requirement and what add-on training is necessary?
- What kind of hard skills and soft skills do you consider essential for your role?

Benefits of home visiting?
Discuss HVP – Parent relationship

How can home visiting services be improved?

- Are there gaps in services?
- What works/doesn't work?
- What would make a HVP's life easier? (e.g. better antenatal supports/info, greater collaboration)?

Barriers *prompt for …*

- Daily difficulties/challenges?
- Precarity of contracts?
- Psychosocial wellbeing – what support is offered? Is the support adequate?

Should home visiting be standardised?

- Flexibility allows for differing needs of families?
- Bespoke service

Universal vs targeted prevention – any thoughts?

- When should support become more targeted?

Importance of evidence-based programmes?
Managing diversity

- Is it important / necessary to 'match' a HVP's background and skills with that of the family?
- Does it facilitate engagement?
- Is it beneficial?

Referrals

- What are the ideal referral pathways to services within existing structures/systems?
- Importance of signposting to other services and the timely provision of support?
- Waiting times -an issue?
- Is there an urban/rural divide?

Interagency collaboration

- What is the 'ideal' collaboration? How would this work?
- Should this be more formalised; and if so, who should be included - HSE / Tusla etc

Appendix 5

In-home observation of families/shadowing of HVPs and interviews

Observational comments on the environment

All but two settings were fully or partly baby friendly, safe for the infant to move around, free from distractions and were suitably decorated for infants. Two environments were not child friendly because one was a cafe where the child was seated at a window between a table and chair as a means of keeping him safe. The other was a home where a family had furniture stacked against a wall and window, closed curtains and it was a notably dark and damp environment. Neither of these environments were conducive to positive engagement or interaction with young children and did not provide a safe environment for the children in which they could move around. For example, in the café, the child was not physically comfortable, and he became overstimulated and frustrated during the visit. He wanted to get down from his seat to a point where he was placed in his buggy to rest while provided with a phone on which to watch cartoons. It was difficult, therefore, for the mother and the HVP to adequately respond to the needs of the child during this visit.

All environments, with the exception of the café, had appropriate sleeping/resting facilities available to the children. In all but two homes (and the café), there were age age-appropriate toys available. It was noted that in the two homes where toys were not observed, the mothers indicated they were experiencing mental health difficulties; however, the homes were clean and clutter free. All children excluding two who were sleeping and one newborn, were either presented with toys by the HVP or had toys available in their environment and they were very interested in playing during the visits. (The child who attended the cafe visit played with cutlery and his food during the visit.) All children were provided with sufficient time and space to ensure that their communications were listened to and reflected upon by the HVP, excluding two children who were sleeping at the time of the home visits.

Appendix 6

Interview Schedule - Home Visitor Practitioner and Parent/Caregiver (during shadowing/home observation)

Interview Schedule - Home Visitor Practitioner

1. Tell me about your job as a home visitor practitioner?
2. How long have you been working as a home visitor practitioner?
3. Can you tell me about any training that you have received?
4. What do you think is the most effective part of your role?
5. How might your role be improved (if at all)?
6. What are the biggest challenges you face in your role?
7. To what extent have you made any changes to the programme based on the home you are entering?
8. Can you provide an example?
9. To what extent do you feel supported in your role?
10. In your own words, what do you consider to be a home visiting service?

Interview Schedule – Parent/Caregiver in receipt of home visits

1. Why did you decide to engage with the home visiting service?
2. Can you tell me about the home visits you receive?
3. How long have you been having home visits from [name of service]?
4. How did you get in touch with [the Home Visiting Service name] or did they contact you?
5. What do you think of the home visits?
6. Is there anything that could improve the visits?
7. What are the biggest challenges you face?
8. To what extent do you think that any changes could be made to make home visits better?
9. What are these changes and why do you think they are needed? Can you provide an example?
10. How do you feel about someone coming into your home?
11. Can you tell me about your relationship with your home visitor?
12. If you had to talk to other parents/guardians about home visits, what would you say?

Appendix 7

Feedback Survey for Co-Participatory Stakeholder Meeting

Instructions: Please take a few minutes to provide us with your valuable feedback about the co-participatory stakeholder meeting. Your input is important to help us ensure we captured your expertise.

1. Overall Evaluation: On a scale of 1 to 5, where 1 is very poor and 5 is excellent, how would you rate the overall effectiveness of the meeting?

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

2. Content and Agenda: a. Were the topics and content relevant to your interests and needs?

☐ Yes

☐ No

b. Were the speakers/presenters knowledgeable and engaging?

☐ Yes

☐ No

3. Facilitation: a. Were the facilitator(s) approachable and responsive to questions and concerns?

☐ Yes

☐ No

4. Participation and Engagement: a. Were you encouraged to actively participate and share your insights during the meeting?

☐ Yes

☐ No

b. How would you rate the level of engagement among the participants?

☐ High

☐ Moderate

☐ Low

5. Suggestions for Improvement: Please provide any suggestions or specific feedback on how we can improve future co-participatory stakeholder meetings:

7. Additional Comments: Is there anything other feedback or insights you would like to share?

Thank you for taking the time to complete this feedback survey. Your input is greatly appreciated and will help us enhance our future co-participatory stakeholder meetings.

Appendix 8

List of qualifications / training undertaken by HVPs

• Action Learning Coaching Perry Support and Capacity Building Training • Addiction Training • AsIAm/ Autism Training • Baby Massage • Barnardo's TLC program • Breastfeeding Support Training • Children's First • Circle of Security • Common Sense Parenting • Cultural diversity training • Disability training • Domestic Violence program • Early childhood degree • FAN – Facilitated Attuned Interactions Training for Home Visitors and Supervisors • First Aid • Health and Safety training • Healthy Families Programmes • Home makers • Incredible Years Programmes • Infant Mental Health master classes • Infant Mental Health Training • Infant reflexology • Lámh • Level 5 Early Childcare • Level 6 Home Visiting Microcredential • Level 7 in Leadership • Lifestart Training • Logic model training • MABS discussions • Marte Meo training	• Meitheal Training • Mentoring staff training • Monitoring and evaluation training • Motivational Interviewing • Parent and Baby Programme • Parent Child Plus Home Visitor training • Parental Engagement and Relationships training • Parenting when Separated • Parents Plus Programmes • Parents Stay and Play Programme • Parents Under Pressure • Partnership with Parents • Peep Learning Together Programme • Peer Coaching • PFL HV training • Promoting Positive Behaviour • Restorative practise • Seasons for growth • Self-image psychology/ understanding mindsets • Sensory Attachment Intervention training • Storm Skill training(Self Harm/ Suicide prevention) • Triple P Programmes • The Suicide Prevention Program • Toddler yoga • Tony Morrison Supervision Training • Touch Points • Training and CPD funded and provided for HVP • Trauma informed practice

Appendix 9

Additional Pen Portraits from shadowing/observation of home visits

Pen Portrait Four

Name of programme: Parent Child Plus, Galway.
Referral source: Self-referral (but initial referral from social worker
Duration of engagement with service: Approximately 6 weeks

The family in receipt of the service, consisted of a mother and a young boy (aged two years). The mother was very welcoming, and the child was very excited to see the HVP (pseudonym 'Anne'). Anne chatted to him while repeating words and phrases. She also sat on the floor and chatted with the mother asking several questions about the child's milestones and progress since the last visit. When the mother expressed concerns regarding her son banging his head when frustrated, Anne reassured her that her son was just trying to communicate. She produced a new developmental toy (coloured stacking rings) and she and the mother and child then played with the toy while repeating colours and stacking in accordance with ring sizes. The child was initially very engaged but became distracted by the researcher as well as by his other toys.

Anne then discussed and modelled the benefits of the toy with the mother. She encouraged her to show the child how to stack and repeat colours. The mother re-engaged the child with Anne's support and all three sang songs and played together for 15 minutes. Anne offered very positive, strength-based reinforcement to both the mother and child and repeatedly said 'look how much he loves you' to the mother. She gave the mother space to play with her son while modelling and supporting the interaction. She consistently emphasised to the mother how well she and her child were doing.

During the interview, the mother reported that she had been initially fearful of home visits stating:

"I was afraid to join [home visiting] because I thought they were like social workers and might take my son off me. But my friends kept telling me it was great and not to be worried, so I gave it a try."(M4).

She also indicated that she wished she had engaged with home visiting services earlier, particularly as Anne was so supportive and non-judgmental. She reported that as a result of the home visits, she is learning to more effectively communicate with, and better understand, her son through play and feels she is a better parent**.** Following the home visit, Anne explained to the researcher that the mother has three older children who are all in state care or living with family members. She further explained that the mother has suffered from chronic addiction issues and had experienced extensive domestic violence in the past.

Pen Portrait Five

Name of programme: Parent Child Plus, Galway. **Referral source:** Self-referral **Duration of engagement with service:** Approximately 3 weeks
This family consisted of a mother and two children (a boy aged two years and a girl almost four years). The mother welcomed the HVP (pseudonym 'Laura') into her home, and the children were happy to see her. Laura instantly began chatting with the children and invited the mother to sit with them. She sat on the floor with the children while the mother sat on a chair beside them. Laura had brought some farmyard toys for the children to play with. They focused on making the animals a home out of items they had at their disposal (e.g. paper and tissue) and feeding them with cereal. Laura focused throughout on the children learning to share with each other through play. She provided considerable positive strengths-based support for both the mother and her children. For example, she consistently praised, and described, the positive interactions between various members of the family. She also encouraged the mother to play with the children independently and stated on a number of occasions *"look how they love to play with you mammy".* The little girl engaged with the researcher independently and was very interested in why she was attending the home visit. The researcher chatted with the child and asked her if she enjoyed having Laura coming to her house. She said she loved Laura because she plays with her and brings them fun toys which she can keep.

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