# Volunteering and early childhood outcomes:
## A review of the evidence

Parents1st

Institute for Voluntary Action Research

**Final report to the Big Lottery Fund**

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# Authorship and acknowledgements

This evidence review was researched and written for the Big Lottery Fund by Parents 1st and IVAR. The evidence review has been written and researched by Jenny McLeish, Leila Baker, Helen Connolly, Houda Davis, Charlotte Pace and Celia Suppiah. An early draft was shared and tested with the five A Better Start partnerships using an implementation science methodology led by Dulcie McBride.

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# Contents

# Summary of key messages from the evidence review

**In 2015, the Big Lottery Fund engaged Parents 1st to carry out an evidence review exploring if and how volunteering, peer support and 'community champions' projects can support child development outcomes. The review was commissioned as part of A Better Start (ABS), a £215million investment, launched in October 2012, which aims to improve the life chances of the most vulnerable babies and children in England. The review is intended to support five voluntary sector-led partnerships to design, develop and implement programmes of science and evidence-based services to improve outcomes in pregnancy and early life for children aged 0-3 (i.e. up to a child's fourth birthday).**

The key messages below summarise the main findings from this review. They are for anyone who works in a volunteer project, whether as a volunteer or staff member; a health or social care professional interested in how volunteer projects fit with what you do; or as a public health or children's services commissioner or a funder thinking about how to support volunteer projects. Each message can be traced back to the evidence in this report, and was judged to be important following workshops with all five ABS partnerships.

Volunteer projects can contribute to ABS outcomes in ways that are distinct from, but complementary to, professional support. They can build relationships of trust and equality with parents; reach and be accepted by parents who do not engage with other services; and help to create the conditions that can lead to change. No two projects will be the same, because it is essential to adapt the volunteer support to local context, to its communities, and to parents. Nonetheless, we can identify some principles and features of volunteer projects that have successfully contributed to the child development outcomes of interest to the ABS partnerships.

## Six principles

- **Strengths-based**: with an emphasis on empowering parents to gain the information, confidence and skills they need to find solutions and become the best parents they can be.
- **Relationship-based**: developing trust between everyone that is involved – parents, volunteers, coordinators and local professionals.
- **Reciprocal**: ensuring that everyone affected by the project feels their voice is heard and that they contribute to and benefit from being a part of the project.
- **Evidence-based but adaptive**: rooted in evidence of what works, based on a theory of change and constantly reflecting, and prepared to innovate and adapt to local context.
- **Collaborative**: aware of the distinctive roles of professional and volunteer support and working cooperatively with local professionals.
- **Clear about parameters**: the aims and the boundaries of the volunteer projects are clearly articulated and understood by parents, professionals and commissioners.

## Six key features of successful projects

- **Understand the key role of the project coordinator**: they will be the lynchpin of a successful volunteer project. Skilled coordinators can:
    - Attract, engage, train, support, supervise and retain volunteers.
    - Facilitate processes that enable volunteers to engage with vulnerable parents.
    - Build relationships with and between professionals and other voluntary sector projects.
- **Fully cost projects so that they can provide a proper operational base**: include staff to coordinate, train and supervise, marketing resources, volunteer expenses such as travel or phone and data systems.
- **Ensure strong organisational leadership**: focus on nurturing grass-roots community involvement.
- **Be realistic about timescales**: they should account for long lead-in time, while a robust implementation design process is carried out with stakeholders, relationships are built with the local community and public sector professionals, and volunteers are recruited and

trained. Initial funding should last for at least three years to allow for meaningful evaluation of impact.

- **'Just enough' data collection**: Tracking impact is important, but data collection can be intrusive and burdensome for volunteers and parents. Consider what impacts can be meaningfully measured and how this data can be collected with as light a touch as possible.
- **Leadership models the principles of the projects**: Leaders in commissioning and provider organisations must model the strengths-based, relational and collaborative working required for successful volunteer projects.

## Messages for volunteer project staff

- **Relationships of mutual respect and trust are key**: Cooperative relationships between volunteers, parents and professionals need to be managed, facilitated, and nurtured.
- **Work in a strengths-based way to empower volunteers to empower parents**: An asset-based approach builds on families' and volunteers' existing strengths and focuses on developing resilience.
    - This means helping volunteers to establish a collaborative way of working with parents that is non-judgemental, avoids dependency and is solution-focused.
- **Invest time to plan the design and implementation of the volunteering project**: This should involve all the key stakeholders, including local professionals, to build relationships and gain buy-in from the outset.
- **Be clear about roles**: Ensure that specific volunteer roles on offer are made explicit and that recruitment processes and criteria reflect the skills and competencies needed.
- **Take time to review and reflect**: Successful projects test ideas, learn from experience and adapt to changing circumstances.
- **Ongoing skilled supervision for volunteers is vital**: this will help to maintain quality, monitor safeguarding issues, and enable reflective practice. Regular training and supervision helps volunteers to develop their skills and confidence.
- **Offer a range of volunteering opportunities and models if possible**: be open to different pathways or routes into volunteering projects in the local area.

## Messages for professionals

- **Volunteers are never a substitute for your professional support**: they can, however, make a valuable and unique contribution to ABS outcomes for families through informal relationships of trust and equality that are built with local parents. Volunteers have the potential to:
    - Achieve intermediary outcomes by supporting parents to articulate their needs and improve their emotional wellbeing and confidence.
    - Reach and gain acceptance from parents who do not engage with services.
    - Create conditions for change through modelling, advocacy and encouraging positive approaches to parenting.
    - Enhance positive social connections with and between parents.
- **Volunteers can assist you to achieve your professional goals**: they can complement your support for individual families and supporting vulnerable families to access your services.
- **Give your support and get involved**: you could raise parents' awareness of the volunteer offer, make referrals, or contribute your knowledge and skills to a volunteering initiative – for example, by participating in training or a steering group. These contributions are invaluable to the volunteer support staff, will help to build positive relationships, and enable you to gain insights into what volunteers can offer.

## Messages for volunteers

- **Volunteers make a valuable and unique contribution to supporting families and achieving ABS outcomes for children**: Volunteers are often able to build trusting relationships and connect families to services they may not otherwise access. As a volunteer, your own life experiences may give parents the assurance that they will not be judged or patronised.
- **Volunteers need easily accessible and consistent support, training and supervision**: This is important in order to feel confident, safe and effective in carrying out the role and to achieve the best possible outcomes for families.
- **Volunteering has lots of benefits for the volunteers**: gaining knowledge, skills and confidence; the satisfaction of helping others; meeting new people and finding out more

about your community.

- **There are different roles for volunteers, needing different amounts of your time**: Check out exactly what the role is and how much time you need to commit – for example, how many hours per week and for how many months.
- **Don't be afraid to come forward to volunteer**: You may not think you have much to offer, but you may be surprised!
- **If you can, make a contribution to the evaluation of your project**: your involvement helps to give families the best possible support.

## Messages for commissioners and funders

Volunteer projects can make a unique and valuable contribution to parenting support for family and early years development through informal relationships of trust and equality that are built with local parents, some of whom may be reluctant to engage directly with support delivered by professionals. However, volunteers are never a substitute for professional support.

**What you can do as a commissioner or a funder**

- **Bring professionals together**: support them to work collaboratively with volunteers, for example, through pathways and referral processes or a community involvement strategy. Include in service specifications for statutory services.
- **Seek out the views of volunteers and the vulnerable parents they support**: they have a valuable contribution to make to how services are designed and delivered.
- **Support success with sufficient time and funding**: set up volunteering projects to succeed by:
  - Ensuring that they are fully costed (see 'Six key features' above).
  - Allowing at least a year for the set-up stage which should include: robust implementation design process, recruitment, training, and building a pool of volunteers.
  - Building relationships with professionals.
  - Providing at least three years of initial funding to achieve meaningful and measurable results.
- **Seek advice**: a volunteering specialist can assist with developing a framework to inform the design, planning and implementation process.
- **Find the right type of lead organisation to operate the volunteering initiative**: they should have a successful track record of implementing grass-roots community volunteering, and developing positive relationships and joint learning between volunteers and professionals.
- **Set realistic goals**: some desired child development outcomes may not show up during the lifetime of a grants programme or contract and may not be evidenced in a short-term evaluation. Build in indicators that can show progress on intermediate steps in a theory of change towards the desired outcomes.
- **Use appropriate indicators and evaluation methods**: use indicators to monitor progress which are appropriate to the stage of implementation. For the first two-three years build in indicators that can show progress on intermediate steps in a theory of change towards the desired outcomes. Developmental and formative evaluation is most appropriate for the first few years of implementation. Summative evaluation and outcome-based indicators are useful once the programme has been delivered consistently for at least two years. All monitoring and evaluation must ensure that data collection does not become burdensome for volunteers.
- **Establish and maintain good local partnerships with organisations that engage volunteers**: keep abreast of working practices across the system and how they meet the relevant needs of communities and of the service.
- **Be an advocate for volunteering**: generate interest and influence partner organisations to gain their support for new projects.
- **Consider the whole system**: Volunteer projects can help achieve a number of outcomes which may be the responsibility of different commissioning and provider organisations. Systems which use joint commissioning arrangements, pooled budgets and new ways of integrating provider organisations are potentially the most useful and cost-effective when commissioning and providing volunteer projects as part of the whole system.

# *Part One:* Introduction

**In this section:**



## 1.1 Background

**In 2015, the Big Lottery Fund engaged Parents 1st to carry out an evidence review exploring if and how volunteering, peer support and 'community champions' projects can support child development outcomes. The review was commissioned as part of "A Better Start" (ABS), a £215million investment, launched in October 2012, to improve the life chances of the most vulnerable babies and children in England. The review is intended to support five voluntary sector-led partnerships (which include local community, public and health services), funded between £36-£49million by Big Lottery over a period of eight to ten years, to design, develop and implement programmes of science and evidence-based services to improve outcomes in pregnancy and early life for children aged 0-3 (i.e. up to a child's fourth birthday). A Better Start has a unique opportunity to add to the evidence base supporting volunteering and the impact on early child development. The five ABS partnerships are shown below:**

### ABS Partnerships:

| | |
|---|---|
| **Site:** | Blackpool |
| **Programme:** | Better Start Blackpool |
| **Lead Org:** | NSPCC |
| **Website:** | www.blackpoolbetterstart.org.uk |

| | |
|---|---|
| **Site:** | Bradford |
| **Programme:** | Better Start Bradford |
| **Lead Org:** | Bradford Trident |
| **Website:** | www.bradfordtrident.co.uk/?page_id=1260 |

| | |
|---|---|
| **Site:** | Nottingham |
| **Programme:** | Small Steps Big Changes |
| **Lead Org:** | Nottingham Citycare Partnership CIC |
| **Website:** | www.nottinghamcitycare.nhs.uk.ssbc/ |

| | |
|---|---|
| **Site:** | Southend-on-Sea |
| **Programme:** | A Better Start Southend |
| **Lead Org:** | Pre-school Learning Alliance |
| **Website:** | www.pre-school.org.uk/better-start-0 |

| | |
|---|---|
| **Site:** | Lambeth |
| **Programme:** | Lambeth Early Action Partnership (LEAP) |
| **Lead Org:** | National Children's Bereau |
| **Website:** | www.leaplambeth.org.uk/ |

In 2015 (when this review was carried out) all five partnerships were still in the set-up and implementation phase of their ABS grants, planning and putting in place the resources and structures that will enable them to implement their local strategies. As part of these local strategies, each partnership had included models of volunteering, peer support and 'community champions' in their portfolio of projects. The Fund wanted to support the grant holders to develop these models further, taking into account considerations such as the availability of suitable models and programmes; expectations regarding outcomes for children; system requirements; governance and safeguarding; and collaboration with the professional workforce and statutory services. The five partnerships had asked for further support and evidence of '**what works, when, for whom and in what circumstances**'. The Fund engaged Parents 1st to carry out this evidence review into which models or methods are successful in contributing, in particular, to three development outcomes:

- Communication and language
- Social and emotional development
- Diet and nutrition

The five ABS partnerships were expected to create full development plans for how their volunteers (or peer supporters) could work alongside their professional workforce and what arrangements would be in place for their supervision, training and support. Each of them was taking a different approach to volunteering and they were at different stages of development. The Fund wanted to avoid being prescriptive about the approach the partnerships should take and recognised that this would need to vary: one size does not fit all. This has been an important steer for our evidence review: we have not sought to arrive at a set of recommendations, but rather a framework for developing a range of approaches to volunteering in different contexts.

Our work and that of the ABS partnerships has taken place in a policy landscape of significant social and economic change affecting families and children as well as the public and voluntary sector services that support them. Here we note three features of that policy landscape that are pertinent to this evidence review. First, government austerity measures have seen cuts to funding and services in the public and voluntary sectors affecting the time available for services to build relationships of trust with vulnerable parents; ABS partnerships by contrast do have the time available to build these relationships. Second, there has been an increased emphasis on professional responsibilities for safeguarding and risk assessment; consequently, some professional services may be less likely to accept that volunteers are safe colleagues to work with. Third, co-production has gained in credibility as an approach to commissioning in recent years and is compatible with the strengths-based approach of the volunteering projects we are discussing in this report. Co-production can be understood as professionals and people working together to shape services, share power over decisions and treat people and communities as assets. The thinking goes that *'Where activities are co-produced in this way, both services and neighborhoods become far more effective agents of change'* (Boyle and Harris 2009).

# 1.2 Our approach to the evidence review

## Project brief

We were asked to prepare our searches around the following objectives to:

1. Explore the relevant evidence base demonstrating the effectiveness of interventions to ground practice development and delivery.
2. Consolidate relevant evidence from professional networks and organisations across the sector with a view to also supporting practice development and delivery.

## An inclusive approach to the evidence

This has been a rapid review, examining the evidence for whether and how volunteers, peer supporters and community champions can contribute during pregnancy and the first three

years to improving the three ABS outcomes for children:
- Communication and language
- Social and emotional development
- Diet and nutrition

We focused on the following interventions:
- Volunteers
- Peer support
- Community champion models

We concentrated on research published in English from the 1990s onwards. The cultural, social and health service variations between countries can affect parenting practice, access to professional support and developmental outcomes, and are also highly relevant to the acceptability and impact of volunteer projects (Hoddinott 2011). We therefore reviewed the evidence with a wide international lens, but purposefully selected evidence sources from the UK or countries with some similarities to the UK, including Ireland, Australia, and the Netherlands.

We have taken an inclusive approach in three dimensions:
- Including interventions where there is evidence of direct or indirect impact on ABS outcomes.
- Including interventions from both peer reviewed and practitioner ('grey') literature.
- Including studies using a variety of methodologies.

In this report our focus is on volunteering, peer support and community champion models that support the three ABS outcomes outlined above. We are aware that these forms of volunteering sit within a much wider field of people focused volunteering located in adjacent fields such as public health and befriending.

## Indirect impact on ABS outcomes

There is a modest literature evidencing direct and measurable impacts from volunteers on ABS outcomes. There is a much wider literature reporting potential indirect impacts on ABS outcomes, where the volunteer intervention addressed an issue that is causally related to ABS outcomes. An example is maternal mental health, which is known to impact on attachment and thus the child's social/emotional development (NICE 2014). We therefore took the decision also to include studies reporting findings that might relate to an earlier stage of an ABS project's theory of change.

## Sources of evidence

Our review was conducted by researchers working in collaboration with practitioners, and this corroborated our intuition that practitioners will always know more than researchers about how an intervention works, but their detailed knowledge is rarely captured in outcome-focused peer-reviewed papers. We therefore adopted a dual approach to the review: searches of bibliographic databases for peer reviewed papers; and a call for evidence (using our collective professional networks of practitioners and a manual search for relevant organisations) for the practitioner ('grey') literature.

## Methodologies

In seeking to answer questions about whether and how volunteers can impact on ABS outcomes, we undertook a mixed-synthesis of quantitative and qualitative research; we also identified and made use of existing systematic reviews to guide our own review. The quantitative research allowed us largely to address the 'impact' questions of our research, and the qualitative research largely informed the 'process' and experiential questions. We did not, however, create a hierarchy of evidence but instead treated the various forms of quantitative evidence (e.g. quasi-experimental study, before-and-after study, randomised controlled trial, cluster randomised study) and qualitative evidence (e.g. in-depth interviews, focus groups, open text responses to questionnaires) as complementary across both impact and process.

This approach was informed by the wider literature on health promotion and behaviour change interventions. The literature indicates that 'complex and multifaceted' (Nutbeam 1998) health promotion interventions (with their 'long' causal chains) are unsuited to study designs

developed for clinical interventions (with 'short' and 'simple' causal chains) (Cesar 2004, International Union for Health Promotion 2000, Judd et al 2000; Kessler and Glasgow 2011, WHO 2000). These authors have critiqued the use of randomised control trials for measuring health promotion interventions (with their 'long' causal chains) as 'in most cases, inappropriate, misleading, and unnecessarily expensive' (International Union for Health Promotion 2000).

Our inclusive research strategy returned 267 documents including 34 received following our call for evidence. A fuller description of the evidence review methodology can be found in Appendix A.

### The quality of the evidence

The quality of the evidence was very variable, with some interventions being poorly described, and some reported findings based on low response rates. Existing systematic reviews had already screened many of the quantitative and (quasi-) experimental studies for quality. We used an abridged and pragmatic quality appraisal process, using questions that were applicable across both quantitative and qualitative methodologies in order to mitigate any risks to the validity of the research that could arise from the integration of the findings from these different methodologies. As can be seen in Appendix A, these questions were built up around the relevance and transparency of the evidence, its methodological robustness, and data confidence.

Intra-team consistency was checked during weekly meetings about how we were applying our inclusion/exclusion criteria, and a moderation exercise took place, whereby a duplicate search of one of the databases was undertaken in respect of one identified outcome (nutrition). A fuller description of the evidence review methodology can be found in Appendix A.

## 1.3 Terminology

We use 'volunteer' as a generic term that encompasses a wide variety of unpaid roles including those specified by the Fund for this review: volunteers, peer supporters and community champions. This is because, firstly, the evidence that we have reviewed does not always fall neatly into these sub-categories; and second, we found in the literature that a variety of terms are used interchangeably and to mean different things. Where we use the term 'peer support' we mean organised support from a trained peer. Our focus has been on support provided by unpaid volunteers. We briefly examine paid peer support in section 3.4.

We use the term 'professional' to describe individuals who have completed specific qualifications and are registered with a professional body. This includes health, early years and social care professionals (for example doctors, nurses, midwives, psychologists, teachers and social workers).

Volunteer initiatives are variously self-described and described in the literature as 'projects' and 'programmes', so we use these terms interchangeably.

# *Part Two:* Evidence: Impact of volunteer projects and programmes

**In this section:**



## 2.1 Why use volunteers?

**The overall finding from the literature review is that volunteer projects are not a substitute for professional support for parents, but can make a unique and valuable contribution to achieving ABS outcomes:**

- **Volunteers can build a relationship of trust and equality with parents (see section 4.2).**
- **Volunteers may reach and be accepted by parents who do not engage with other services (see section 2.3).**
- **Volunteers help to create the conditions for change (see section 2.4).**
- **Volunteers who are themselves parents from the target community may be beneficiaries as well (see section 2.5).**

**Table 1:**
Summary of the evidence of making effective use of volunteers

| Volunteers are effective when... | Volunteers are not effective when... |
|---|---|
| Their distinctive non-professional contribution is understood and valued. | They are seen as a cheap replacement for health professionals. |
| Their role is to empower the parent with information and support. | They are positioned as expert teachers. |
| There are realistic expectations about what they can achieve and the likely timescales. | They are seen as 'the answer' and there are rigid, short-term targets which require intensive monitoring and data collection. |
| They are supported by local health and social care professionals. | Professionals ignore or obstruct their activities. |

# 2.2 Evidence of impact on ABS outcomes

**There have been many different types of volunteer projects that attempt either to influence the ABS outcomes directly, or to influence them indirectly by affecting an earlier stage on the project's theory of change. The evidence of impact is complex and sometimes contradictory, as well as of variable quality (see Appendix A for an explanation of the quality appraisal process used in the evidence review).**

## Outcome 1: Communication and language

**Evidence of direct impact**
In the **Early Words Together** programme from the National Literacy Trust, trained volunteers delivered a six-week language and literacy intervention in small group sessions, using a structured but flexible toolkit. This significantly improved children's understanding of spoken language (measured using a standardised vocabulary test). Parents reported that it also improved their children's enjoyment of sharing books and joining in with songs and rhymes, increased the amount of parent-child talk, and increased the parents' awareness of the importance of talking and sharing books with their children and their confidence in so doing. Parents who spoke English as an additional language particularly appreciated the programme. Similar benefits were reported from an earlier literacy champion programme where volunteers worked one-to-one with parents (National Literacy Trust 2012, Wood 2015).

In a randomised controlled trial of **Community Mothers** in Ireland, trained volunteers who were experienced mothers from the local community visited first-time mothers monthly to deliver a child health intervention formerly delivered by professionals. Mothers who received the intervention were more likely to report that their children were read to daily and were exposed to more nursery rhymes (Johnson 1993).

In the **Teens and Toddlers** programme, vulnerable teenagers (who were young parents or considered to be at risk of becoming Not in Employment, Education or Training) were paired with preschool children (aged 2-5) who needed extra attention, and worked with them intensively for one afternoon a week during term time. A comparison study found that the children who took part in the programme had significantly increased communication and language skills compared with a control group (Humphrey 2014).

**Evidence of indirect impact**
There is evidence that **Parent Champions** can be effective in promoting uptake of the free childcare offer for 2 year olds in disadvantaged families. Project data from the Family and

Childcare Trust show that almost half of parents took up a place for their child after being given information and encouragement by a Parent Champion (Family and Childcare Trust, 2016). Early years education is likely to promote children's language and communication skills (and social development as well).

## Outcome 2: Social and emotional development

**Evidence of direct impact**

The **Empowering Parents, Empowering Communities (EPEC) programme** offered group parenting support for parents of children aged 2-11, aiming to improve parent-child relationships and interactions, reduce children's behavioural problems, and increase participants' confidence in their parenting abilities. EPEC was a manualised (by 'manualised' we mean that there was some standardisation to the way volunteers delivered the support) eight-week programme delivered to groups of parents by peer facilitators from the local community who had received 60 hours of accredited training. There were significantly greater improvements in positive parenting practices and reduction in child problems for parents (almost all mothers) who attended the group, compared with parents on the waiting list. The majority of those who took part in EPEC were from Black and minority ethnic communities and poorer than the borough average (Day 2012).

**Home Start** offers unstructured one-to-one trained volunteer social support to families with young children (particularly families who are socially and economically vulnerable). Parents who receive Home Start in the UK consistently report that it helps them parent better, manage their children's behaviour better, and be more involved in child development (Kenkre J 2011, McAuley 2004). A randomised controlled trial and a quasi-experimental study in the UK (Barnes 2006a, McAuley 2004) did not find any impact on child outcomes, but a randomised controlled trial of the same model in the Netherlands found that Home Start families had more responsive parenting and fewer child behaviour problems (Hermanns 2013) and these improvements were sustained to age 10 (van Aar 2015), suggesting that measuring impact may be partially dependant on the precise outcome indicators that are chosen and how they are assessed.

**Evidence of indirect impact**

An important factor disrupting children's social and emotional development is the mother's poor mental health both in pregnancy and after birth (NICE 2014). It is highly likely, therefore, that interventions supporting the mother's emotional will have an indirect impact on children's social and emotional development.

There are a number of models of **one-to-one peer/volunteer support** that offer needs-led social and emotional support, often combined with mentoring activities, information about parenting, and support to access services such as children's centres. Although the limited randomised controlled trial evidence demonstrated that receiving unstructured volunteer home visits did not affect the onset of diagnosable maternal depression, mothers consistently report that one-to-one volunteer and peer support reduces their stress and increases their self-esteem, parenting confidence and emotional wellbeing, including reducing feelings of anxiety and depression (Akister 2011, Barlow 2012, Bhavani 2014b, Granville 2012, Kenkre 2011, McAuley 2004, Spiby 2015, Suppiah 2008).

## Outcome 3: Diet and nutrition

**Evidence of direct impact**

Breastfeeding is the healthiest form of nutrition for babies (and helps to prevent obesity), but babies are least likely to be breastfed if their mothers are poor, less educated or young. There are many reasons why mothers do not choose to breastfeed, including bottle-feeding being the social norm for their community and opposition from their partner and family members. Although the majority of mothers start breastfeeding, only around half of mothers continue for six to eight weeks, and only 1% are exclusively breastfeeding at six months (the World Health Organisation recommends six months' exclusive breastfeeding) (McAndrew 2012, World Health Organisation 2001). Many women say that they give up because of a lack of support with breastfeeding problems (McAndrew 2012).

The evidence for the impact of **breastfeeding peer supporters** on increasing breastfeeding is complicated and contested. Systematic review evidence has found that although peer support can increase the length of exclusive breastfeeding in high income countries (with high intensity support being most effective), randomised controlled trial evidence has not shown up specific evidence of impact in the UK (where all mothers have access to some breastfeeding support from midwives and health visitors) (Ingram 2010, Jolly 2012b). On the other hand, some individual projects report that peer support does have an impact on breastfeeding rates in their local area (including in very deprived communities), particularly when delivered in combination with effective health professional support (Alexander 2003, Brown 2011, Tandy 2015). Moreover, breastfeeding mothers who receive peer support often say that it was the peer support that enabled them to continue breastfeeding, either through moral support and encouragement, having breastfeeding role models, or through specific help to overcome problems; and additional benefits such as improved family diet and maternal mental health and parenting skills have been reported by mothers attending breastfeeding peer support groups (Alexander 2003, Battersby 2002, Briant 2005, Brown 2011, Fox 2015, Glass 2015, Hoddinott 2006, Hoddinott 2011, Ingram 2005, Ingram 2013, McInnes 2001, Muller 2009, Raine 2003, Scott 2003, Scott 2005, Tandy 2015, Thomson 2015a, Wade 2009, Whitmore 2015).

One challenge with this evidence is that there are many different models of breastfeeding peer support (e.g. antenatal, postnatal or both; face-to-face or by telephone; on the postnatal ward, community-based, or home-based; one-to-one or in a group; proactive or reactive; universal or targeted; single-contact or repeated contacts; led by health professionals or the voluntary sector) and it appears that there is no 'one size fits all' for all communities or individuals. For example, some mothers value the 'safe space', social support and 'normalisation' provided by breastfeeding groups over the potential 'intrusion' of one-to-one support at home; but other mothers value individual support (e.g. Alexander 2003, Ingram 2013, McInnes 2001, Thomson 2015a). NICE guidance currently recommends that trained breastfeeding peer supporters, working as part of a multi-disciplinary team, should contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth) and offer them ongoing support according to their individual needs, which could be face-to-face, by telephone or in groups (NICE 2008).

Looking beyond projects focused on breastfeeding peer support, there is evidence that **one-to-one volunteer doula** support can affect local breastfeeding rates. Volunteer doulas give mothers (mainly disadvantaged mothers) one-to-one support during pregnancy, at birth and postnatally for six to twelve weeks, and this has been shown to significantly affect both the number of women who start breastfeeding and the number who continue for at least six to eight weeks (when data on doula-supported mothers were statistically analysed against data on all mothers in the local area over six years) (Spiby 2015). The greater measurable breastfeeding impact of volunteer doulas compared with breastfeeding peer supporters may be attributable to the long-term multi-faceted relationship between doulas and the mothers they support.

Apart from breastfeeding, there is little evidence about the benefits of using volunteers to improve children's nutrition. In a randomised controlled trial of **Community Mothers** in Ireland, children whose mothers had received monthly visits from trained volunteers had better diets. NICE guidance recommends that commissioners and managers of children's services should consider training peer supporters to help parents follow professional advice on feeding infants aged 6 months and over (NICE 2008). The only UK randomised controlled trial of **one-to-one volunteer support focused on healthy diet** found some limited aspects of children's diets (such as consuming more of specific fruit and vegetables) improved in the group that received monthly home visits for nine months starting when the child was three months old, but there was no significant impact on vitamin C intake or (when followed up four years later) on BMI (Scheiwe 2010, Watt 2009). **Community Health Champions** and **Parent Champions** have been used to promote healthy eating by 'spreading the word' through informal networks or by leading specific projects to support healthy eating knowledge and skills, but there is no clear evidence of impact on children's nutrition (Ives 2015, Turner 2012).

**Evidence of indirect impact**
It has been suggested that in UK communities with a very limited tradition of breastfeeding, breastfeeding peer supporters may contribute to longer-term change in the local infant feeding culture by championing and normalising breastfeeding as a feeding choice. This understanding argues that the social factors that inhibit women from choosing to breastfeed may need to be addressed at a community rather than individual level (Alexander 2003, Battersby 2002, Briant 2005, Brown 2011, Fox 2015, Glass 2015, Hoddinott 2006, Hoddinott 2011, Ingram 2005, Ingram 2013, McInnes 2001, Muller 2009, Raine 2003, Scott 2003, Scott 2005, Tandy 2015, Thomson 2015a, Wade 2009, Whitmore 2015). **Parent Champions** have been successful at recruiting parents of young children onto a healthy lifestyle group course including nutrition and activity (Ives, 2015).

## 2.3 Reaching the families that other services do not reach

**It has been theorised that volunteers from a specific community may be trusted over outsiders and are therefore able to reach those who are 'hard-to-reach' for services (e.g. Cooper 2009, McInnes 2001), and the core rationale of peer support is the trust and empathetic understanding engendered by common experiences (e.g. Briant 2005, Harris 2015, Jones 2014). The evidence shows that offering peer support from people with 'lived experience' of the parents' own issues could give vulnerable parents the assurance they would be understood and not judged or patronised, and give information from the volunteers more credibility. Some vulnerable parents report being able to talk honestly to a volunteer who has built up a relationship of trust with them over time, when they have not felt able to ask for help from health or social care professionals (Fox 2015, Marden 2014, McInnes 2001, McLeish 2015, Murphy 2008, Schmied 2011, Turner 2012).**

The majority of volunteer projects in this review were delivered in deprived areas, and/or were targeted at groups experiencing particular disadvantages.

- Generally, more **socially, educationally and economically disadvantaged parents** were less likely to engage but, once engaged, parents were least likely to disengage if they were socially isolated, single, facing more complex difficulties, or had mental health problems such as depression (Barnes 2006b, Cox 1991, Suppiah 2008).
- Both group support (e.g. Day 2012) and one-to-one support (e.g. Bhavani 2014a, Lederer 2009, McLeish 2015) have been found to be acceptable and effective for **parents from Black, Asian and minority ethnic (BME) communities,** although the evidence does not distinguish between different BME groups.
- **Parents from BME communities** might access support more readily when it was offered by someone from their own cultural and language background, and they might find information from same-culture volunteers more relevant and credible. Conversely, the support was more acceptable to some parents if the volunteer was not from the same minority community because this was felt to reduce the risk of gossip and stigma (Lederer 2009, McLeish 2015, Muller 2009, Prosman 2014, South 2012, Summerbell 2014).
- One-to-one support has also been shown to be acceptable to and to benefit **very vulnerable families** such as asylum seekers and refugees (Bhavani 2014b, James 2013), Travellers (Fitzpatrick 1997) and families without recourse to public funds (Lederer 2009).
- **Young mothers** may particularly benefit from seeing a health behaviour such as breastfeeding modelled by someone with whom they can identify (Schmied 2011), but many projects found it difficult to engage young parents and one reported that young mothers were the most likely to disengage (Spiby 2015).
- **Mothers experiencing domestic abuse**, and families whose children (of any age) were **at risk of neglect or abuse** have also accepted and valued one-to-one volunteer support (Akister 2011, Prosman 2014a/b, Taggart 2000, Tunstill 2012).

However, given that not all parents who are offered support accept it (see section 4.1),

and that in projects offering universal support the support is disproportionately likely to be used by less disadvantaged parents (Barnes 2006b), it is important not to have simplistic expectations about the ability of volunteers to reach all 'hard-to-reach' parents.

**Into practice: Be realistic about what volunteers can achieve**
**Volunteer projects for marginalised groups do not need to be differently designed, managed or delivered in order to be effective. Although volunteers are often able to connect with disadvantaged parents, either because of peer experience or simply because they are not a professional, disadvantaged families have very diverse needs and not all are able to accept volunteer support. Instead, the evidence indicates that volunteer projects work best when factors such as context, collaboration and resources are taken into account.**

## 2.4 Creating the conditions for change

**As noted in section 2.2 above, not all of the impacts of volunteering on ABS outcomes are direct or easily measured – some are indirect and longer term. Much of this evidence relates to what we have called 'creating the conditions for change'. The evidence suggests that this is happening in four main ways:**

- **Changing the way parents feel about themselves (feeling valued, respected, supported, socially connected) including improved maternal mental health and confidence.**
- **Changing the way parents feel about the services available to them and their ability to engage effectively with services.**
- **Challenging local 'culture' and providing an alternative environment where different approaches to parenting or infant feeding are modelled and encouraged: the 'ripple effect'.**
- **Deepening professionals' understanding of the communities with whom they are working by giving feedback on parents' experiences, enabling services to be delivered more appropriately.**

If we accept that some volunteering interventions create the conditions for change then it follows that some of the desired child development outcomes may not show up during the lifetime of a grants programme and may not be evidenced in a short-term evaluation. These interventions may, nevertheless, lead to improved child outcomes. This is why it is so important for ABS partnerships to develop a t**heory of change** and articulate the assumptions that underpin their theories about how and why volunteers can make a positive contribution to ABS child development outcomes. By specifying intermediate as well as ultimate outcomes, they will be able to assess whether they are moving towards their goals.

This analysis is consistent with a systematic review of health-related lifestyle advice from peers or lay workers, which found that health-related lifestyle advice was only cost-effective when it targeted behaviours likely to have a large impact on **overall health-related quality of life**, rather than narrowly aiming to alter specific health-related knowledge, behaviours or health outcomes (Pennington 2013). Some studies (e.g. South 2012, Thomson 2015a) use the concept of **social capital** (bonding, bridging and linking) to describe some of the ways in which volunteers create the conditions for change through enhancing social connections with and between parents, supporting parents' relationships with health professionals and creating new relationships between volunteers and health professionals.

**Figure 1:**
**Breastfeeding example**

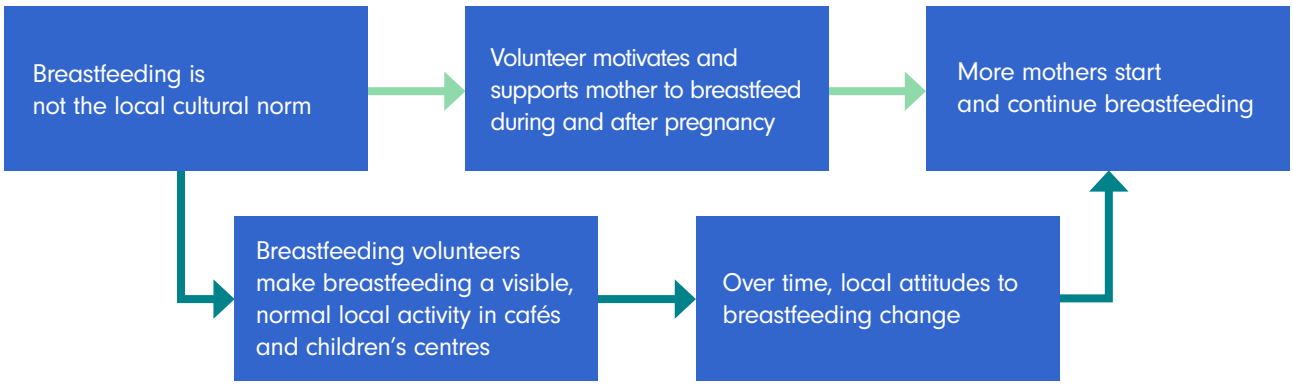
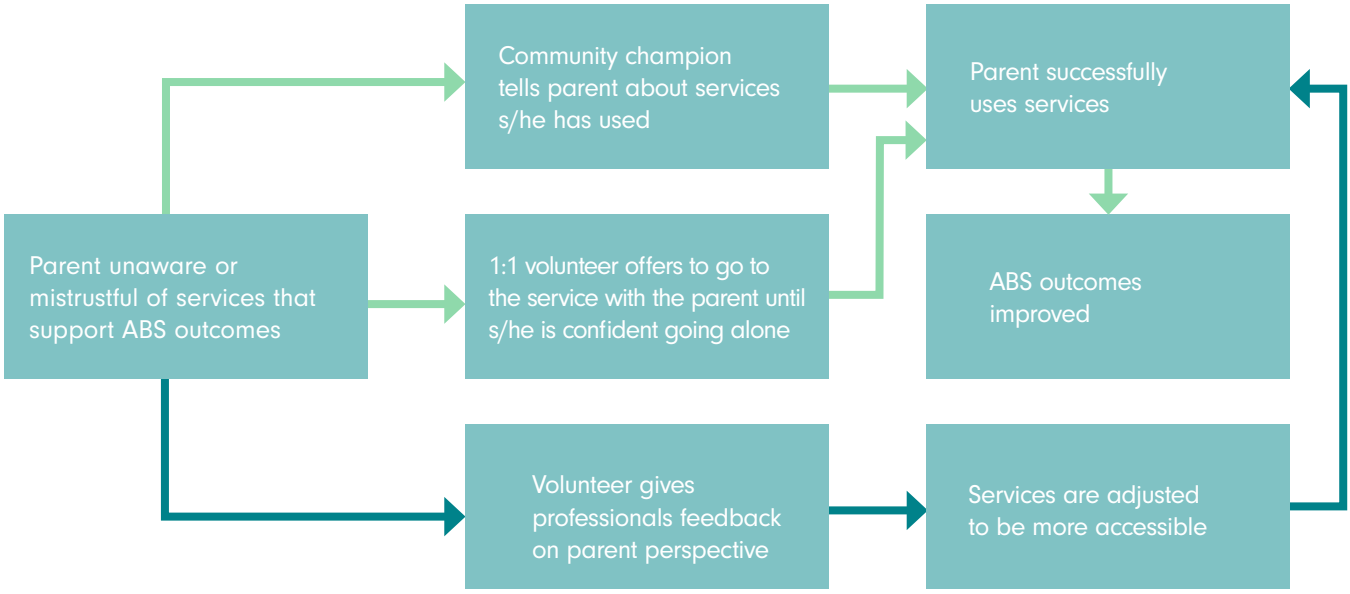



**Figure 2:**
**Social and emotional development and language skills example**


**Figure 3:**
**Engaging with services example**



## 2.5 Volunteers as beneficiaries

The evidence from many of the studies (e.g. Barlow 2012, James 2013, Molloy 2007, Raine 2003, Spiby 2015, Thomson 2015b, Tunstill 2012, Young 2015) points to a number of benefits for volunteers ranging from a profound satisfaction derived from supporting others, to increased social networks, to gaining new skills and knowledge (with a possible pathway into life-long learning) and finding out more about a work sector they are interested in. There is also evidence that ABS outcomes for the volunteers' own children can be positively affected; for example, breastfeeding peer supporters felt more knowledgeable and able to breastfeed for longer than they had planned, and community champions and community parents reported improvements in their own family diets (Briant 2005, Ives 2015, Kempenaar 2013, Suppiah 2008, White 2010). Parents who trained as peer facilitators leading EPEC groups reported positive changes in their own families (Thomson 2015b).

The most consistently reported benefit to volunteers across all types of project was an increase in volunteers' self-confidence. Volunteers had the opportunity to take on an interesting and socially valued role, which gave them a positive additional identity outside parenthood, and to feel they were 'making a difference'; some also developed strong group identities (e.g. McInnes 2001, National Literacy Trust 2012, Suppiah 2008, Spiby 2015, White 2012). The impact on feelings of self-esteem was particularly dramatic for volunteers from vulnerable backgrounds, such as refugees and asylum seekers, who had experienced stigma and enforced dependency (Bhavani 2014a, James 2013).

**Into practice: Develop your theory of change to create the right conditions**

**Volunteer interventions can work to support ABS outcomes on multiple levels. when the conditions are right. A clear focus, appropriate timescales and a mix of structured and flexible approaches are needed.**

**Ongoing volunteer training, skilled supervision and coordination are key factors to project success. There is no one model to suit all: it takes time to decide which type of intervention fits best with which child outcome and a community's existing strengths.**

**Developing a theory of change will help your project to identify the different points and ways in which to articulate the assumptions that underpin how and why volunteers can make a positive contribution to ABS child development outcomes, and to value and measure those intermediate as well as ultimate outcomes.**

# *Part Three:* Designing volunteer projects

**In this section:**

- **Models of volunteering**
- **Core principles of successful volunteering projects**
- **Governance arrangements to ensure quality and safety**
- **Paid peer supporters**

## 3.1 Models of volunteering

**There are three broad models of volunteering projects for ABS outcomes: community champions, volunteers leading groups, and volunteers working 1:1 with parents. In some projects (e.g. some versions of breastfeeding peer support) the models were combined.**

### Community champions

In the community champion model (e.g. Ives 2015, Marden 2015, South 2010, Turner 2012, White 2010), volunteers receive some training (which may be very brief), and are expected to cascade information to family, friends and, potentially, to strangers at a specific venue (e.g. a children's centre), and sometimes to organise activities. The evidence suggests that although projects working with community champions may train a large number of volunteers, the impact of their diverse community activities is hard to measure and has not been shown to directly affect ABS outcomes except for the volunteers' own families. Community champions are, however, effective at encouraging other parents to take up local services which are likely to impact indirectly on ABS outcomes, such as childcare and healthy lifestyle groups for families. This type of volunteering may be welcomed by those volunteers who are themselves busy parents with little time to give.

### Volunteers leading groups

Volunteers who are trained in group facilitation have the potential to reach considerable numbers of families, and there is good evidence of impact. Structured groups are normally time-limited and usually focus on a single ABS outcome (e.g. parenting skills, language skills or healthy eating) (Day 2012, Ives 2015, Wood 2015). Other groups have an unstructured drop-in format and may also focus on individual ABS outcomes such as breastfeeding, or may be more generally aimed at enhancing parental wellbeing through social support (e.g. Fox 2015, Bhavani 2014a). Some parents are attracted by the possibility of social support from group members and find this less socially risky than one-to-one support (Bhavani 2014a, Briant 2005, Fox 2015, Hoddinott 2006). However, more vulnerable parents often lack the confidence to attend groups, so those most in need of support may not benefit (Granville 2012, McLeish 2015).

## Volunteers working one-to-one with parents

Where volunteers are trained to work one-to-one with parents, each volunteer normally only works with one family (or a very small number) at a time, often for a period of months. Support may be offered as home-visiting, which can successfully engage parents with chaotic lives who do not always keep appointments, although some parents may perceive this as intrusive (Barnes 2006b, Granville 2012, Spiby 2015). As shown in sections 2.2 and 2.3, this model can have impact across all the ABS outcomes, and can be very effective with vulnerable parents; it is sometimes offered as an initial stage to build up the parents' confidence to attend a group (Bhavani 2014a, Granville 2012, McLeish 2015). This type of volunteering requires a substantial time commitment from volunteers.

One-to-one support takes a variety of forms from structured to unstructured. Unstructured does not mean low quality, but rather support that is tailored flexibly to the individual family's needs (Moran 2013). The impact of structured support (sometimes following a manualised programme) may be easier to measure, as the intervention is more standardised, but the use of set materials may not be acceptable to the most vulnerable families and care must be taken to build relationships first (Suppiah 2008). There is also a risk that peer support projects that are highly structured may professionalise the peers and lose the value of the 'peer' element (Harris 2015).

**Figure 4:**
Impact on different models of volunteering in intensity and reach

**Table 2:**
Strengths and weaknesses of different models of volunteering

| Model | Strengths | Weaknesses |
|---|---|---|
| Community champions | ✔ Large numbers of volunteers.<br>✔ Suitable for volunteers with little time.<br>✔ Effective in passing on information about local services. | ✕ Hard to measure impact.<br>✕ Little evidence of direct impact on ABS outcomes beyond volunteers' own families. |
| Volunteers leading groups | ✔ Parents value social support.<br>✔ May be less 'socially risky' than one to one support.<br>✔ Good evidence of impact. | ✕ Vulnerable parents often lack the confidence to attend groups. |
| One-to-one support | ✔ Can engage most vulnerable parents.<br>✔ Development of long term support relationships.<br>✔ Good evidence of impact. | ✕ Reaches more limited numbers of parents.<br>✕ Significant time commitment required of volunteers.<br>✕ Could be experienced as intrusive. |

## 3.2 Core principles of successful volunteer projects

**The following attributes are associated with 'successful' volunteer projects (these are projects which have elements that contribute positively to direct or indirect ABS outcomes).**

- **Strengths-based:** volunteering in pregnancy and early years is associated with 'strengths-based' or 'assets-based' approaches to supporting parents and the volunteers themselves, with an emphasis on empowering parents with the information, confidence and skills they need to make choices and become the best parents they can be (e.g. McLeish 2015, Suppiah 2008, Spiby 2015, Thomson 2015a).
- **Relationship-based:** positive relationships of trust need to be developed between everyone that is involved – parents, volunteers, coordinators, local professionals (e.g. Suppiah 2008, Tunstill 2012).
- **Clear about purpose and boundaries:** projects need to be able to clearly articulate their aims and their offer in ways that can be clearly understood by parents, professionals and commissioners. They need to be equally clear about the boundaries of their support to avoid inappropriate referrals or disappointed expectations, and to ensure they do not infringe on the work of professionals (e.g. Akister 2011, Spiby 2015).
- **Engaged with local professionals:** professional co-operation is crucial to the success of volunteer projects (this is explored more fully in section 4.7).
- **Reciprocal:** everyone affected by the project (parents, volunteers, coordinators and professionals) needs to feel that their voice is being heard and to understand the mutual benefits that a volunteer project can bring (Suppiah 2008, Granville 2012).
- **Evidence-based but adaptive:** projects should be rooted in evidence of what works,

and based on a theory of change, but at the same time they should constantly reflect on how they are working and be prepared to innovate and adapt in response to local needs. Many of the projects in this evidence review have flexed aspects of their design as they discovered ways to improve on their original plans (e.g. Bhavani 2014a, Francis 2015).

- **Acknowledging the key role of the project coordinator:** the project coordinator is the lynchpin of a volunteer project, and needs to have both inward-facing and outward-facing skills: to attract, support and supervise volunteers effectively; to reach vulnerable parents and match parents with suitable volunteers; and to manage the interface and build relationships with professionals and other voluntary sector projects (e.g. Barlow 2012, Dykes 2005, James 2013, Suppiah 2008, Tunstill 2012).
- **Fully costed:** volunteers may be unpaid but they are not free. Projects need to be realistically funded so that they can pay for costs including an appropriate operational base, staff to train and supervise, tools and resources, travel and telephone expenses, and evaluation (e.g. Spiby 2015).
- **Realistic timescales:** when a project is being set up there is always a long lead-in time while relationships are built with the local community and with health professionals, and volunteers are recruited and trained. Many projects find that funders have unrealistic expectations for achieving results in the first year (e.g. Francis 2015, Turner 2012). It has been suggested that projects should be funded for at least three years to allow for meaningful evaluation of impact (Harris 2015).
- **'Just enough' data collection:** it is important that projects track their impact, but data collection is often experienced as intrusive and burdensome by volunteers and parents (especially if they do not speak English as a first language) and many evaluations are based on extremely incomplete data. Projects should consider how much data they really need and collect it with as light a touch as possible (e.g. Turner 2012, White 2010).

### Into practice: Size matters

**Evidence indicates that a project should not be allowed to develop beyond its means. It should not exceed a size where it can be confident about:**

- **Supporting all the volunteers effectively.**
- **Balancing numbers of trained volunteers with referrals of parents.**
- **Creating a shared understanding of how the project works and its ethos.**
- **Enabling parents and volunteers to build relationships of trust**

**Projects need to work out how their strengths-based support delivered by volunteers complements other support (including from the professional staff) and contributes to positive outcomes for children.**

### Into practice: Universal project elements

**Universal elements of volunteering projects related to early years include:**

- **Making time to build trusting relationships between volunteer, parent and services.**
- **Getting organised to provide flexible volunteer support backed up by structured training, coordination and supervision.**
- **Understanding the way statutory and voluntary sector roles can be integrated.**

**Table 3:**
Illustrative examples of volunteer project design affecting ABS outcomes

| Name | Description | Initial Training | Impact | Type of evidence |
|---|---|---|---|---|
| **One-to-one support** | | | | |
| Community Parents Programme (Parents 1st) | Volunteer one-to-one support. 0–2 model: semi-structured home visiting for vulnerable/ isolated parents enabling them to set and achieve self-identified goals.<br><br>Pregnancy, birth, post-birth model: starting during pregnancy, integrating doula support, and continuing until 3 months after birth. | 75 hours (accredited) | 0–2 model: Parents had improved access to emotional support and information about parenting; felt more confident about handling children's behaviour and what foods are right for children.<br><br>Pregnancy, birth, post-birth model: Mothers had improved confidence and emotional wellbeing and were more likely to continue breastfeeding.<br><br>Volunteers had increased self-confidence and skills, opportunities for work or education. | Mixed methods participatory evaluation involving 10 programmes; project data and qualitative interviews. |
| Family Action (Newpin model) Perinatal Support Project | Volunteer one-to-one befriending for pregnant women or new mothers up to age 1 with mild to moderate mental health difficulties, or vulnerable. | 6 days | Improvements in mothers' anxiety, depression, social support, self-esteem, relationship with baby.<br><br>Volunteers had increased self-confidence; had improved relationship with own family. | Mixed methods based on before/ after project data; qualitative interviews. |
| Goodwin Doula Project | Volunteer one-to-one regular home visiting for vulnerable/isolated women during pregnancy, at birth and up to 6 weeks postnatal. | 75 hours (accredited) | Mothers were more likely to start and continue breastfeeding; felt more knowledgeable, confident and skilled as parents; felt less depressed and had increased emotional wellbeing.<br><br>Volunteers had increased knowledge, self-confidence, parenting skills, opportunities for work or education. | Mixed methods based on project data analysed with comparison data sets; questionnaires; qualitative interviews. |
| Home Start | Volunteer one-to-one weekly home visiting for vulnerable families with a child under 5, offering social and practical support. | 40 hours | Mothers consistently reported feeling less stressed and better able to cope with parenting (although no impact shown when assessed by cluster randomised study). Volunteers have increased self-confidence and skills and improved own parenting skills | Cluster randomised study; quasi-experimental study; studies using before/after project data; qualitative interviews. |
| **Groups** | | | | |
| Empowering Parents, Empowering Communities | Peer facilitators (paid) deliver a structured 8-week parenting course to groups of parents with children aged 2–11. | 60 hours (accredited) | Improved positive parenting and reduced child behavioural problems.<br><br>Peer facilitators had increased knowledge, confidence and skills and improvements in own parenting. | Randomised controlled trial using waiting list as control group; qualitative interviews. |
| Early Words Together from the National Literacy Trust | Volunteers work with parents of children aged 2–5 in small groups for 6 sessions, using a structured but flexible toolkit focusing on supporting parent/ child interaction, play and reading together. | 1–2 days | Children had improved understanding of spoken language and enjoyment of books and songs; parents had more confidence in sharing books, increased parent/child talk. | Mixed methods based on project data; before/after assessment of vocabulary; qualitative interviews/ focus groups. |

| Name | Description | Initial Training | Impact | Type of evidence |
|---|---|---|---|---|
| **Mixed one-to-one groups** | | | | |
| NCT Birth and Beyond Community Supporters | Volunteer one-to-one and group support for vulnerable mothers during pregnancy and up to age 2. Non-directive listening; signposting to services; practical support. | 30 hours (accredited) | Mothers felt more positive and more confident accessing services.<br><br>Volunteers had increased self-confidence and many went on to education/employment. | Mixed methods based on before/after project data; questionnaires; qualitative interviews. |
| Warrington Bosom Buddies | Breastfeeding peer support. Volunteers support by home visits; phone calls; at breastfeeding support groups; speaking to women before birth; attending postnatal ward | Delivered over 8 weeks (based on UNICEF training) | Mothers were more likely to start and to continue breastfeeding, especially mothers from poor areas.<br><br>Some volunteers have gone on to midwifery. | Project data. |
| **Community Champions** | | | | |
| Family and Childcare Trust Parent Champions | Parent Champions talk to other parents about free early years education and other services for families. | 2 days | More children, especially from disadvantaged backgrounds, benefited from early years education and other local services.<br><br>Volunteers had increased self-confidence and opportunities for work. | Mixed methods based on project data; qualitative interviews. |

## 3.3 Governance arrangements to ensure quality and safety

**The evidence on the governance arrangements needed to ensure quality and protect the safety of children, parents and volunteers falls into four main categories:**

- **Clarity about boundaries and safeguarding**
- **Careful recruitment processes for volunteers and background checks**
- **Supervision of volunteers by the project coordinator**
- **Protecting the volunteers**

**The skilled work required to recruit, train, supervise and support volunteers emphasises the crucial importance of the volunteer coordinator having the right skills and time for these tasks (Dykes 2005, Suppiah 2008, Thomson 2015b, Tunstill 2012, Watt 2006). To ensure quality for volunteers and clients, projects need to be realistic about the numbers each coordinator can support, and not grow beyond their means (Taggart 2000).**

### Clarity about boundaries and safeguarding

Many projects reported that safeguarding was an integral part of their initial and ongoing volunteer training (e.g. Day 2012, Suppiah 2008), or had been added as the need became apparent (Ives 2015). Although one-to-one volunteer support was offered on a confidential basis, it was explained to parents that safeguarding concerns would always have to be reported. Some volunteers were actively involved in safeguarding procedures such as case conferences, supported by the project coordinator, and in one project volunteers were

purposefully trained to work with families whose children were judged to be at risk (e.g. Akister 2011, Granville 2012, Spiby 2015, Tunstill 2012).

## Careful recruitment processes for volunteers and background checks

Some of the one-to-one projects had an extremely thorough recruitment process with a detailed interview assessing personality, skills, and motivation. This process enabled potential volunteers to eliminate themselves once they had a realistic understanding of the role, and also allowed the project coordinator to assess their suitability. This interview, and getting to know the volunteer through training, enabled the project coordinator to match the volunteer to a family appropriately (e.g. Akister 2011, Granville 2012, Spiby 2015). Many projects specifically reported that volunteers were not allowed to have contact with parents or children until a CRB/DBS check had been carried out (e.g. Day 2012, Muller 2009, National Literacy Trust 2012).

**Into practice: Safeguarding**

**Work with vulnerable families is demanding and it is essential that volunteers understand the issues around safeguarding, including when they need to report concerns. The role of the manager/coordinator is pivotal and they must ensure that volunteers have suitable training, clear boundaries and proactive supervision throughout all their volunteering. It is also vital that coordinators are given regular safeguarding clinical supervision and have appropriate competencies, experience and organisational support to effectively manage their safeguarding responsibilities.**

## Supervision

Almost all projects where there was one-to-one support from volunteers to parents gave their volunteers ongoing supervision, and this was seen as important to maintain quality, monitor safeguarding issues, and enable reflective practice. It also helped the volunteers to develop their skills and confidence by an ongoing focus on building up their strengths, allowing them to talk through successes and problems, and suggesting areas for future development (e.g. Spiby 2015, Thomson 2015b, White 2010). In community champion models where the volunteers where expected to spread health messages after brief one-off training, the volunteers did not normally receive supervision (Turner 2012).

Supervision was normally carried out by the project coordinator in one-to-one sessions of varying frequency (face-to-face and/or by phone), sometimes with the addition of group supervision (which offered ongoing mutual learning and social opportunities with other volunteers) (e.g. Watt 2006, McInnes 2000, White 2010). In one project, group sessions led by the peer facilitators could be videoed and later discussed to enable the peer facilitators to reflect on and develop their practice (Day 2012). In some projects, informal support to debrief challenges or develop practice was also available from the project coordinator and/or other more experienced volunteers (e.g. Spiby 2015, Tandy 2015, Watt 2006).

Lack of effective supervision and support could lead to demoralisation among volunteers (Spiby 2015) but, on the other hand, attendance at group supervision could be poor (Lederer 2009) and arranging sessions was logistically challenging (Thomson 2015b).

**Into practice: Provide strengths-based coordination, training and supervision**

**Strengths-based coordination, training and supervision of volunteers plays a large part in providing a rewarding and empowering journey for each volunteer. Volunteer projects that involve people with 'lived experience' of an issue need sensitive training and coordinators who are readily available to debrief and support volunteers when they need it. Not everyone's volunteering experience will be positive and, while sound recruitment and supervision processes will minimise this, some of the reasons for that will be beyond the project's control.**

## Protecting the volunteers

Where projects offered home visiting, the project coordinator might visit each parent at home first, to assess the safety of the family and the area for home visiting, as well as to understand the parent's needs and personality so that the best match could be offered (e.g. Suppiah 2008, Spiby 2015). One project offering home visits, including potential night working, reported a lone-working system (based on the volunteer phoning in at the start and end of visits and at pre-agreed intervals) to maintain volunteer safety; however, it was also acknowledged that this could be expensive and time-consuming (Spiby 2015). Some projects allowed extensive sharing of personal details between volunteers and parents (e.g. a volunteer might invite a parent to share a meal at her home), while others maintained strict boundaries that prevented any sharing of personal information (McLeish 2015).

**Into practice: Establish a quality improvement process**

**Projects should actively seek feedback from parents, volunteers and professionals about their service, and should regularly reflect on how the service can be improved.**

**If possible, sharing ideas and learning with other volunteer projects can help to evade pitfalls, keep up with emerging practice and avoid reinventing the volunteering wheel.**

**From the evidence, we have been able to identify three sets of factors that projects could use for both establishing new programmes AND reviewing the ones that have already started:**

- **The type of intervention**
- **The way the intervention is implemented**
- **The local context**

**These factors could also be used to develop a quality improvement process that can be applied to any project.**

## Further Reading

**There is a great deal of literature on the management of volunteering. Much of this can be found in the Institute of Volunteering Research Evidence Bank here: http://www.ivr.org.uk/ivr-evidence-bank**

**The Investing in Volunteers standards on governance can be found here: http://iiv.investinginvolunteers.org.uk/images/stories/iiv_standard_revised_jan_2014.pdf**

# 3.4 Paid peer supporters

**Although we are using the term 'volunteer' to include the different types of lay support in this evidence review, there were some schemes that used paid peer supporters – for example, some breastfeeding peer supporters, group facilitators, and home visitors. These roles could be instead of, or alongside, unpaid volunteer roles (Aiken 2013, Cupples 2011, Day 2012). We found mixed opinions on the merits of paid roles.**

**Table 4:**
Advantages and disadvantages of paid peer supporters

| Advantages of paid peer support roles | Disadvantages of paid peer support roles |
|---|---|
| ✔ Creates pathways for progression and retains skills of peer supporters who would otherwise have to leave the project to find paid work.<br>✔ Enables participation by a wider range of people, including those who cannot afford to give their time for free.<br>✔ Recognises the skills and commitment of peer supporters.<br>✔ Increases reliability and availability of peer supporters.<br>✔ Some parents find it difficult to negotiate support from an unpaid volunteer, either because they feel they are imposing on the volunteer's free time, or because they feel unable to assert their own needs (for example visiting times) because they feel under an obligation to the volunteer.<br><br>From: Aiken 2013, MacPherson 2010, Muller 2009, South 2014, Suppiah 2008, White 2010 | ✖ The motivation of peer supporters and the nature of the support relationship may be fundamentally altered.<br>✖ They may lose their independence and have conflicting allegiances (to the parent and the health or social care system that employs them).<br>✖ They become accountable for meeting targets, and the associated time pressure may undermine their availability to be with individual parents and meet their needs.<br>✖ They may be given unwelcome levels of responsibility.<br>✖ Payment may disrupt out-of-work benefit entitlement.<br><br>From: Aiken 2013, South 2014, Spiby 2015 |

We did not find any evidence addressing how unpaid and paid supporters might work together, but one study examined the issues of professionalisation where some previously unpaid volunteer breastfeeding peer supporters became employed as paid peer supporters. The peer supporters who remained volunteers objected to the onerous data collection that was required by the newly commissioned service and were subsequently exempted from this and given their own volunteer coordinator (Aiken 2013).

# *Part Four:* Delivering volunteer projects

**In this section:**

- **Engaging with parents**
- **Retaining parents' engagement**
- **Recruiting volunteers**
- **Training and supporting volunteers**
- **Retaining volunteers**
- **Aligning parent and volunteer expectations**
- **Working with professionals**
- **Using new and emerging technologies in volunteer support**

## 4.1 Engaging with parents

**Projects had varying degrees of success in engaging parents, and these figures were not always reported. For example, home visiting projects reported take up of 64–80% of parents referred (Barlow 2012, Cupples 2011, Lederer 2009), and in a multi-site randomised controlled trial of Home Start home visiting, only 41% of parents referred for support received it, largely due to administrative and capacity issues (Barnes 2006b). Barriers to initial engagement included parents being uninterested in, or not understanding, the support offered; feeling that they already had enough support from friends and family; being concerned at taking on a stressful social obligation; feeling suspicious about the motivation and purpose of the volunteer or experiencing opposition from family members (Barnes 2006b, MacPherson 2010, McLeish 2015, Murphy 2008, Spiby 2015).**

**Effective strategies for initial engagement were:**

- Gaining the **support of local professionals** who actively referred parents into the project, particularly if they understood it and could describe it accurately to parents (e.g. Dykes 2005, Granville 2012, Murphy 2008, National Literacy Trust 2012, Raine 2003, Spiby 2015, Suppiah 2008).
- **Multiple routes** for parents to access the project, For example, through informal opportunities to meet a volunteer face-to-face, word of mouth and self-referral as well as referral by professionals (e.g. Spiby 2015, Suppiah 2008); informal routes were strengthened as a project built up a positive reputation and visible local presence, and could be particularly important for parents who did not trust professionals (Suppiah 2008, Turner 2012).
- **Good administration and timely delivery of the service** – where there was a long delay between being offered the service and being matched with a volunteer, or poor communication, this could lead to parents turning down support (Barnes 2006b, MacPherson 2010).
- **Explaining to parents clearly what the project offered**, without losing the flexibility of personalised support (McLeish 2015).

- **Explaining the volunteer and/or peer nature of the support** – this reassured parents who perceived professionals as focused on parenting deficits, and made them feel they would not be judged or patronised (Fox 2015, Marden 2014, McLeish 2015, Murphy 2008, White 2010).
- **Having a 'brand identity' that was warm, positive and normalising**, and avoided stigmatising language about mental health or parenting deficits; this could include repositioning a targeted programme to imply that it was a universal (and therefore non-stigmatising) offer (Francis 2015, Robinson 2014).
- **Using a venue that was acceptable to the target community** and with an acceptable name, which was not necessarily the local children's centre (Bhavani 2014a, Dykes 2005). Using an alternative venue could also motivate volunteers to reach out to parents who were not currently engaged in children's centres (Marden 2014).
- Offering support from **volunteers who speak the same language** (Lederer 2009, Spiby 2015).
- **Making groups less intimidating** by suggesting the parent attended with a friend or identifying someone at the group with whom the parent could arrive (Hoddinott 2006), or a volunteer accompanying the parent to the group for the first time or meeting the parent at the door (Mcleish 2015, Thomson 2015a).

**Into practice: A tailored approach to engagement**

**There are likely to be a number of different routes to successful engagement and each project needs to tailor its approach to the local context and any sensitive issues that may be present. While the approach should be 'bespoke' it also needs to be well-informed (from the evidence) about what methods are most likely to 'work'. Coordinators need to communicate clearly from the start about how the project will work and what is expected of the parent and volunteer to make the relationship work.**

### Working with fathers

The evidence on engaging with fathers was very weak. Although there were occasional contacts with fathers reported and sometimes particular efforts to reach fathers (e.g. Day 2012, Lederer 2009, Thomson 2015a), in almost all cases the volunteers were working overwhelmingly with mothers. There was no UK evidence of any volunteer projects set up specifically to work with fathers towards ABS outcomes and the limited international evidence of breastfeeding peer support for fathers (in the USA) did not demonstrate any impact (e.g. Lovera 2010, Stremler 2004).

## 4.2 Retaining parents' engagement

**There was very limited reporting of drop-out rates, but it is clear that some disengagement by parents is normal, and can be affected by the length of support offered and the parent's perception of their own needs changing over time. For example, 20% of women disengaged from intensive doula support which was offered during pregnancy, at birth and for six to twelve weeks after birth (Spiby 2015) and, in some areas, 50% of parents dropped out of a five-week literacy programme (National Literacy Trust 2012).**

Effective strategies for sustaining engagement (drawn from one-to-one support projects) were:

- **Building a confidential and empowering relationship of trust.** Volunteers achieved this by being reliable, consistent, non-judgemental, strengths-focused, and generous with their own time; and parents experienced this as being completely different from most professional support (e.g. Barlow 2012, Graffy 2005, Granville 2012, Marden 2013, McLeish 2015, Schmied 2011, Scott 2003, Suppiah 2008, Thomson 2012a). Where volunteers were perceived as unreliable, parents were dissatisfied (MacPherson 2010, Spiby 2015).
- The **careful 'matching'** of volunteers to parents, although this could also raise expectations

about the relationship that were not always met (MacPherson 2010, Spiby 2015, Watt 2006).
- **Continuity** with the same volunteer over the period of support, especially if it began before birth; if the volunteer left the project, the parent might leave too (Ingram 2013, MacPherson 2010, McLeish 2015, Suppiah 2008, Thomson 2015a).
- **Suitably frequent contact** between volunteer and parent – monthly visits may be insufficient to establish the relationship (McLeish 2015, Suppiah 2008).
- **Persistence** in contacting the parent – very disadvantaged parents could be passive about contact and frequently cancelled or missed appointments, even if they valued them (McFarlane 1997, McLeish 2015, Prosman 2014).
- Helping the parent to find **solutions to their pressing practical and emotional problems**, through mentoring and goal setting, or active practical support, even if these were not directly related to their child (Akister 2011, Kenkre 2011, McLeish 2015, Tunstill 2012).

# 4.3 Recruiting volunteers

## Recruitment

**A recurrent theme was the (often unanticipated) need for sufficient lead-in time at the beginning of a project for recruiting volunteers. Recruiting volunteers was also an ongoing process throughout the life of projects, as new volunteers were needed to replace those who moved on. Projects reported a wide variety of successful strategies for recruiting volunteers (Battye 2012, Bhavani 2014a, James 2013, Marden 2013, McInnes 2000, Spiby 2015, Watt 2006, White 2010, Young 2015), including:**

- **Advertising through notices and leaflets in community spaces, local media and online.**
- **Outreach by recruited volunteers, for example running a stall at community events.**
- **Word-of-mouth from recruited volunteers through their own social networks.**
- **Parents who had previously received support becoming volunteers.**
- **Networking with community groups.**
- **Using pre-existing local pools of volunteers (e.g. those attached to children's centres).**

**Most projects used a combination of methods and those involving personal contact were often reported to be most successful.**

It was important to clearly define the volunteer role in advance so that potential volunteers understood the scope of the commitment. Some projects offered taster courses to explore applicants' suitability (Turner 2012, Spiby 2015). It was also important to recruit people with particular qualities, for example, empathy, enthusiasm, and an ability to communicate. In some communities it was particularly important to recruit volunteers who spoke a range of community languages. In more intense interventions, the recruitment process could include one-to-one interviews to ensure quality and suitability, and increase retention (Akister 2011, Bhavani 2014a, James 2013, Spiby 2015, Suppiah 2008, White 2012). Projects that offer a range of roles of varying intensity and commitment may attract a wider range of volunteers (Thomson 2015a, Turner 2012) and this may be especially helpful in enabling busy parents of young children to volunteer.

Some projects found it very challenging to recruit enough volunteers at first, and responded by widening their criteria for who could volunteer (e.g. from 'peer' to 'general'); this did not appear to undermine their credibility with their target community (Bhavani 2014a, James 2013). There were also some marked differences in practical and philosophical approaches. In projects where volunteers were not seen as beneficiaries, or where staff believed that the complexity of the volunteer role required confident and professionally experienced volunteers, the emphasis could be on simply getting the planned numbers of volunteers, even if this meant mainly recruiting people already engaged in volunteering. In projects with a community-development or peer-support approach, one aim was to recruit more intensively within the same disadvantaged communities and offer opportunities for personal development through volunteering, and to recruit volunteers who would have similar life-experiences to the parents supported. These projects had to work much harder to recruit people who were new to volunteering, in particular to recruit peer volunteers with 'lived experience' of a specific issue

(e.g. the asylum process), but who might lack confidence and literacy skills; effective strategies were a personal approach from the coordinator, or recruiting formerly-supported parents as volunteers (Battye 2012, Bhavani 2014a, Francis 2015, James 2013).

**Into practice: Recruiting the right people**

**Volunteering projects need a decent lead-in time to find the 'right' volunteers for the project, with the values and personal qualities that fit the project's aims and ethos as well as the necessary commitment. Careful recruitment is needed because it takes time to work out what the volunteer role will be and what kinds of skills will be needed to carry it out. Project coordinators often build up these recruitment skills over time. Evidence suggests that it is crucial to match volunteers to the project aims and ethos as well as the way it will be delivered. This is just as important as thinking about how, practically, to organise quality training and support to make it a positive experience for the volunteer.**

# 4.4 Training and supporting volunteers

## Training and accreditation

**Having recruited people with the right qualities, all projects recognised the need to support them to develop their skills through training. However, the nature and extent of this training was enormously variable, depending on the intensity and skill of the volunteering role (for example, it could be as little as half a day, or up to 75 hours of highly structured face-to-face training with a similar amount of home study); and in much of the literature the training is not described in any detail.**

Aspects of training that were valued by volunteers included:

- **Strengths-based** training that built up volunteer confidence (Granville 2012, Spiby 2015, Turner 2012).
- Training that focused on the **skills for the role** (e.g. non-judgemental active listening), not just knowledge (Dykes 2005, Granville 2012, Watt 2006, White 2010).
- Training that was fun, **suited to adult learners**, provided a safe space for sharing ideas and debriefing about their own experiences, included **opportunities for reflection**, and offered **social opportunities** (Turner 2012, Watt 2006, White 2010).
- Training that gave **clear guidance about the boundaries** and ground rules of the volunteer-parent relationship, confidentiality and safeguarding (Spiby 2015, Watt 2006, White 2010).
- Training that was **accredited** – this was important for some volunteers in opening a pathway to future education or employment and could also give professionals confidence in the quality and consistency of the training (Tandy 2015, Turner 2012).
- Providing **childcare** alongside training if needed, and paying travel expenses (Bhavani 2014a, Muller 2009, Turner 2012, Watt 2006).
- Using a local, easily accessible or familiar venue for training (Turner 2012).
- Adapting to volunteers who had **English as a second language** (e.g. fewer written assessments) (Bhavani 2014a).
- **Regular ongoing training opportunities** to sustain and reaffirm the model, skills and knowledge for carrying out the volunteer role (Bhavani 2014a, Spiby 2015, Turner 2012).

In the context of peer support it has been claimed that skills training is essential as 'peer' similarities alone are not enough to build non-judgemental relationships of trust (Harris 2015), and also that too much training may shift peers' allegiances to the health care system and professionalise them as 'paraprofessionals', although the amount of training which might undermine the 'peer' quality is unknown (Dennis, 2003). In this review, there were many examples of projects giving their volunteers very substantial training without their allegiances transferring to the health or social care system (e.g. Akister 2011, McLeish 2015, Spiby 2015).

# 4.5 Retaining volunteers

**Motivations for joining projects were varied and mixed, but the motivations consistently reported across all the projects were in four main categories (see Table 6). Projects could retain volunteers by offering a high quality volunteering experience that connected with these motivations (e.g. Granville 2012, Spiby 2015, Suppiah 2008, Watt 2006, Thomson 2015a). This again reflects the crucial roles of the coordinator and volunteer support staff.**

**Table 5:**
Four categories of volunteer motivation and strategies to support retention

| Motivation | Strategies supporting retention |
|---|---|
| Altruism – wanting to 'give something back' and help others in the community, which could often include those with 'lived experience' wanting to help others avoid distressing circumstances they had experienced themselves. | Opportunities to receive feedback from clients about the impact of support; emotional support for volunteers who have experienced similar issues; supervision that enables volunteers to deal with feelings of rejection and failure if parents withdraw from support. |
| Personal development – wanting to use or develop existing skills; gain information relevant to their own parenting or health; find a sense of purpose by 'making a difference'; gain an identity beyond being 'just a parent'. | Strengths-focused training; supervision that supports reflective practice and personal growth. |
| Career development – seeking the skills, qualifications and experience to explore or progress pathways into education or employment, particularly after a period out of work while looking after children. | Ongoing training; offering employment opportunities within the project to volunteers as projects expanded. |
| Social reasons – hoping to meet interesting people. | Opportunities to sustain social relationships formed during training, for example, through organising social events; regular group meetings; opportunities to volunteer in pairs (e.g. for outreach). |

Projects reported a variety of barriers to retention and strategies to overcome them (e.g. Marden 2013, Raine 2003, Spiby 2015, Suppiah 2008).

**Table 6:**
Nine barriers to volunteer retention and strategies to overcome them

| Barriers to retention | Solutions |
|---|---|
| Poor administration. | Good communication, prompt payment of expenses. |
| Delays between finishing training and starting volunteering (e.g. because of CRB/ DBS checks or lack of parents referred). | Ensure recruitment of parents aligns with training of volunteers. |
| Volunteers perceive an unfair distribution of volunteering opportunities or parents to support. | Good communication and transparent policy on volunteering opportunities or matching volunteers with parents. |
| Volunteers are primarily interested in the qualification for their own career aspirations. | Specify the expectation of a minimum amount of volunteering in return for the free training; or incorporate some volunteering into the training qualification. |
| The volunteer's own family issues/life events (e.g. work, pregnancy). | Recruit volunteers at a range of life stages (e.g. including retired people as well as younger people). |
| Volunteers experience negative attitudes from some professionals. | Relationship building facilitated by both the volunteer coordinator and public sector managers. |
| Volunteers feel out of their depth. | Strong reflective supervision, clear boundaries, opportunities for volunteers to learn from each other. |
| Volunteers do not feel valued. | Promote a team ethos; support volunteers with an empowerment model that values their personal development; give positive feedback. |
| Volunteers underestimate the time commitment. | Offer a range of volunteer roles; be clear about time commitment (e.g. hours per week and total months of volunteering expected) during recruitment. |

**Into practice: Supervision, support and retaining volunteers**

**The need for high quality supervision and support stands out in the evidence. It is one of the most critical elements in the retention of volunteers. This includes:**

- **Providing opportunities for personal development and ongoing training to ensure volunteers are able to develop skills and confidence.**
- **Making time for more informal opportunities, such as provision for individual reflection and personal development, mutual support among volunteers and peer-to-peer support.**

**Building confidence and feeling valued and respected by local professionals is also important, so there may be value in involving professionals in volunteer training and vice versa.**

## 4.6 Aligning parent and volunteer expectations

**The biggest area of potential tension between parent and volunteer goals and expectations in the one-to-one projects was the nature and purpose of the support relationship. Although these projects took a wide variety of approaches (often not clearly articulated), many volunteers identified their role as a temporary '*professional friendship*' (time limited, purposeful and with clear boundaries) whereas many supported mothers had feelings of actual friendship and some suffered feelings of considerable emotional loss when the support was withdrawn (e.g. McLeish 2015, Spiby 2015).**

The strategies used to manage this included (Granville 2012, James 2013, McLeish 2015, Suppiah 2008, Watt 2006):

- Clear statements of project boundaries (e.g. about sharing personal information).
- Specific recruitment, training and supervision processes to ensure volunteers were able to use an empowering, strengths-based approach that built resilience so that parents did not become dependent on their volunteers.
- Flexibility about the timing of the end of the support, based on the parent's individual situation and reflection and review during volunteer supervision sessions.
- Managing the end of the support with reminders as to when this would be, phasing it out, and ensuring that the parent was linked to community services or groups before the support ended.
- Providing support to extremely vulnerable women in small teams, to prevent the development of strong one-to-one relationships.
- Not matching people who lived very close or already knew one another, to maintain boundaries and the possibility of closure.
- Some projects required a total cessation of contact after the end of the support relationship; others allowed ongoing social contact if both volunteer and parent chose this.

A second challenge in aligning goals and expectations was negotiating the timing and frequency of one-to-one support. Because their supporter was a volunteer, parents could feel inhibited about asking for the amount of support they felt they really needed. For their part, volunteers were usually parents who might want or need to take extended periods off volunteering (e.g. school holidays). Clear guidelines from the project were reported to help, plus back-up from the project staff (MacPherson 2010, McLeish, 2015).

## 4.7 Working with professionals

**Good relationships with local professionals are key to the success and sustainability of volunteer projects. Many volunteer projects experienced tension with professionals, leading to restrictive 'gatekeeping', poor communication and a lack of referrals (e.g. Aiken 2013, Suppiah 2008, Curtis 2007, Dykes 2005, Ingram 2013, Thomson 2015). Other professionals were reported to see volunteers as a key resource, complementing and enhancing their professional support for families, and reaching families who were 'hard-to-reach' (e.g. Curtis 2007, Ingram 2013, Lea 2015, Spiby 2015, Thomson 2015a, Tunstill 2012). Many projects found it challenging to publicise their work effectively to the wide range of professionals whose support they needed, and this required ongoing networking from project coordinators (e.g. Barlow 2012, Bhavani 2014a, Spiby 2015).**

Tensions usually arise because (e.g. Akister 2011, Curtis 2007, Ingram 2013, Thomson 2015, Tunstill 2012):

- The volunteers are seen as a **threat** to professional jobs.
- The volunteer role is poorly understood and/or seen as **challenging professional competencies**.

- There are concerns that volunteers will **transgress project boundaries**, for example by giving parents advice.
- Professionals are concerned that peer supporters will give parents **misleading or contradictory information.**
- Professionals are **unaware of the scope and rigour of volunteer training** and supervision.
- The project does not yet have a t**rack record.**

Successful strategies for promoting co-operation between volunteer projects and professionals include (Barlow 2012, Bhavani 2014a, Curtis 2007, Lederer 2009, Raine 2003, Spiby 2015, Thomson 2015a, Tunstill 2012):

- Professionals are **involved at the earliest stage** of the development of the project, and are involved in the steering group and as champions for the project.
- Projects demonstrate how the volunteers can contribute to the **shared endeavour** of improved outcomes for children, complementing professional support.
- Projects **articulate their clear boundaries**, training and supervision.
- Professionals are **involved in volunteer training** and sometimes volunteers become involved in professionals' training.
- Volunteers **use training that is also used and/or understood** by professionals (for example on breastfeeding).
- The project budget costs in the ongoing time the coordinator needs to spend **networking** with professionals.
- There are **clear referral guidelines** and a simple referral process into the project.
- Projects are **co-located** with a professional service, or at an existing voluntary sector organisation with pre-existing referral links (but co-location may deter vulnerable families).

## 4.8 Using new and emerging technologies in volunteer support

There is very little evidence about how volunteers use new and emerging technologies to support parents in achieving improved ABS outcomes for children. There are many internet forums offering parents either generic support through 'chatting' anonymously to other parents online (e.g. Mumsnet, Netmums), or support focused on a specific issue such as mental health (e.g. Action on Postpartum Psychosis). However, the impact of these social media platforms is very difficult to measure and international studies have found no evidence of impact on ABS outcomes, whether or not the discussions are moderated by trained peers (Cowie 2011, Niela–Vilén 2014).

Many one-to-one volunteers use a combination of face to face visits, phone calls and texting to keep in touch with the parents they support (e.g. McLeish 2015), but there is no UK evidence about the impact of telephone-only volunteer support, although a trial of the impact of structured telephone peer-support for women experiencing postnatal depression is underway (Caramlau 2011).

There was one reported example of volunteers using a phone application to support mothers. The Baby Buddy phone app, which covers pregnancy to six months, is endorsed by professional bodies representing midwives and health visitors, and in some areas is part of the maternity care pathway for pregnant women and new mothers. Breastfeeding peer supporters have been using this app with mothers to enhance their face-to-face work, commenting positively on how useful they find the breastfeeding videos, the infant feeding messages that are pushed to the user as daily notifications, and the function enabling users to find their nearest group run by peer supporters (Best Beginnings, 2015).

### Into practice: New technology vs face-to-face interaction

Many projects have found that Facebook and mobile phones and other types of online presence are useful for volunteer recruitment and enabling volunteers and parents to get in touch with each other. Some projects also thought that they could gather evaluation data via using tablets or mobile phones.

Mobile phones are often provided to volunteers to keep in touch with the parents they are supporting in between face-to-face visits, and this can strengthen the support relationship.

While 'emerging technologies' have the potential to be applied in other ways, the evidence sounds a word of caution – face-to-face contact and relationships are key!

# *Part Five:* Three case studies of volunteer projects

**We have provided three case studies of current or recent volunteer programmes that illustrate and elaborate some of the points raised in Parts Two to Four. These case studies are based on desk review of project documents and evaluation reports that include parents' own views and experiences; and telephone interviews with key personnel in each of the projects. Report references are included as part of the bibliography at the end of this report.**

**The three case studies are:**

- **Bradford Volunteer Doula Service**
- **HENRY Parent Champions**
- **Volunteers Supporting Families, Southend**

## Case study: Bradford Volunteer Doula Service

**Host organisation:** Action For Community Limited
**Date started:** 2012
**Funder:** Bradford City Clinical Commissioning Group
**Members of staff:** Project Coordinator: 30hrs; Administrator: 1 day per week
**Current number of active volunteers:** 26
**Length of initial volunteer training:** 90+ hours over 13 weeks
**Number of families supported per year:** average 53 families
**Location:** Manningham in Bradford

### What the volunteers do

The volunteer doulas work one-to-one with pregnant women for the last six weeks of pregnancy, are with them when they give birth, and continue one-to-one support until six weeks after birth. All the mothers are isolated, and many have mental health issues, have experienced domestic abuse, or are recent migrants who do not speak English and do not understand the UK maternity system. The volunteers typically visit each mother for an hour a week and are available by phone between visits. The content of the visits varies according to the mother's needs, but typically includes information about pregnancy, birth, baby care and infant feeding, emotional support, and support to access health and community services. The volunteers are 'on call' 24 hours a day around the expected date of birth, and when a mother goes into labour the volunteer remains with her until her baby is born, giving her support and encouragement. If the labour lasts so long that the volunteer is unable to stay, a back-up volunteer will take over from her. If the mother's partner is present, the volunteer works with the couple.

## What is known about the impact?

Mixed methods evaluation (Spiby 2015) of this volunteer model (including Bradford alongside four other sites) showed that mothers were more likely to start breastfeeding and to continue breastfeeding for at least six to eight weeks; they felt more knowledgeable, confident and skilled as parents; and they felt less depressed and had increased emotional wellbeing.

## Key learning about working with volunteers

- Recruiting the right volunteers takes skill. In the first round of recruitment they were inexperienced and about half of those trained were more interested in the training than the volunteering. In subsequent rounds they had gained the experience needed to ask potential volunteers the right questions and to make the necessary time commitment clear to them (including the need for them to have childcare support so they can attend births in the middle of the night). They also recruited a much wider range of volunteers, including from the local south Asian community, by marketing the opportunity better – they talked to local health professionals, advertised in children's centres, had a Facebook page, and the original volunteers brought others in.
- Build a relationship of trust with volunteers. It is essential that volunteers feel able to be open with the project coordinator about any problems, and it is easier to build this relationship if the coordinator takes part in their initial training.
- Retaining volunteers takes a lot of investment. The volunteers work on their own so the project coordinator works hard to keep them connected to one another and to the project, and to show them how much they are valued. They have monthly meetings for the volunteers, and use a Facebook page. If personal circumstances mean that a volunteer doesn't currently have time to volunteer, they invite her to take a break rather than leaving, and encourage her to stay involved by coming to volunteer meetings and staying in the Facebook group.

## Challenges of running a volunteer doula project

- Resources - the size of the team has limited what they can do. The project manager has multiple roles including strategic meetings, networking with professionals, initial interviews with mothers referred, matching of mothers to volunteers, support and supervision of the volunteers, and is also a back-up doula where needed. She doesn't have enough time for fundraising or to do these many roles as comprehensively as she would like.
- Getting professionals to understand what the volunteer doula role is and how it's different from an independent doula (privately hired by mothers), and making sure the volunteers know and respect their own boundaries.
- Balancing referrals with volunteer capacity – particularly when they have not had funds to train more volunteers.
- Combining a friendly relationship with volunteers and effective supervision. Friendliness helps volunteer retention and trust (the volunteer feels able to phone in the middle of the night if they don't know what to do), but it also makes it more difficult to challenge a volunteer who has underperformed. If necessary, they can bring in the CEO of the host social enterprise to do a difficult supervision.

## Building relationships with health professionals

They knew from the start that this project could only work with the full support of the local maternity hospital. Some midwives were initially suspicious because of previous experience of assertive and sometimes confrontational independent doulas. They built relationships from the beginning by:

- Having a champion for the project in a leadership role in the maternity services – the local consultant midwife. She took part in the volunteer training and created opportunities for the project manager to explain the project to midwives, for example by attending the 6am shift change meeting at the hospital, and doing a presentation to student midwives.
- Clarifying the volunteers' boundaries – that they have no medical role and will not

interfere with the midwives' role. Midwives are reassured by the rigorous training and supervision.
- Establishing a track record – over time, the midwives have come to see the volunteers as an asset to their service as it reduces the pressure on the midwives if a mother has someone with her all the time during labour.

However, with constant staff changes and excessive workloads, it takes a lot of work to keep the momentum going. The project coordinator keeps the doula project visible to busy professionals by:
- Doing quick talks at GP practice meetings, to remind community professionals how to refer.
- Attending a range of local strategic maternity meetings and the local Maternity Services Liaison Committee.

**Tips for success**
- **Do the groundwork with professionals before you start, and keep it going.**
- **Create diverse roles for volunteers to maintain the involvement of those who are on a break from the one-to-one role. For example, volunteers were involved in running a 'Happy Birthday' community event which also enabled volunteers and mothers to see each other again.**
- **Ensure a structured referral process that is easy for professionals to use but also clear for the project to follow up.**

# Case study: HENRY Parent Champions

**Date:** 2012–15
**Funder:** Big Lottery Fund: Reaching Communities
**Members of staff:** Project Coordinator: 0.6 fte, Volunteer Coordinator in each site: 0.4 fte
**Total volunteers trained:** 49
**Length of initial volunteer training:** 25 hours over 5 days
**Number of families supported per year:** 128
**Locations:** Leeds and Telford & Wrekin

## What the volunteers do

The volunteers are recruited from 'graduates' of HENRY group programmes (an eight-session programme for parents of under 5s, focused on improving parenting confidence, healthy eating and activity). They offer a variety of peer support and community activities to help families adopt and sustain healthier and more active lifestyles after their HENRY parent group has ended. They also help to engage families who have not joined a HENRY group in community-level activities such as buggy-walks, fruit & veg tasting sessions, and 'healthy cooking on a budget' groups. They act as enthusiastic recruiters for HENRY group programmes, helping to increase access for more isolated families.

## What is known about the impact on ABS outcomes?

Although the HENRY group programme has been shown to increase family activity and healthy eating, there is limited evidence for the added value of Parent Champions on family lifestyle and eating habits. As with other community champions projects, it is extremely difficult to demonstrate a causal link between volunteer support and behaviour change, in part because the informal and sometimes one-off nature of the support makes it difficult to follow up parents later, and in part because many of the parents receiving volunteer support had also attended a professionally-led group programme encouraging behaviour change (so it would be impossible to disentangle the specific contribution of the volunteers).

However, small scale qualitative research (Ives, 2015) indicated that parents valued receiving healthy-living messages and doing activities led by non-judgemental peers: peer recruitment was an effective means of engaging parents in HENRY groups and other children's centre activities, and the Parent Champions themselves became passionate and committed advocates of a healthy lifestyle. Children's centre managers were confident enough about the benefits to parents and their children to mainstream the volunteering after the project funding ended.

## Challenges of running a parent champion project

- The project was originally designed with the expectation that trained volunteers would run peer support groups as a follow-on from a HENRY course, but this was not in fact what most parents wanted. As the project evolved, its primary focus changed to informal community activities and parent engagement, alongside some peer one-to-one and group support.
- Initially the project envisaged that volunteers would consult parents and organise activities in response to their needs and interests. This proved too daunting and open-ended for most volunteers, who needed a more structured role. Volunteers therefore worked with the project coordinators to develop a menu of activities from which parents could choose.
- The simple data collection system designed to measure the impact of peer support groups (a booklet for parents to track changes) was not suitable for one-off events, so was abandoned in favour of gathering parents' contact details so they could be asked about impact later (this also had limited success).
- During the project, public health was transferred from health to local authority

responsibility, causing great instability for one of the project coordinators who was funded by the charity but employed by public health.

## Key learning about working with volunteers

- Volunteers have a range of skills and bring with them different levels of confidence and ability, so it is important to offer a range of volunteer activities to suit them. Some did outreach for the group programme in their own social networks or at stalls at community events. Others took part in one-off community activities that were organised with the volunteer coordinator, such as a street play event. The most confident volunteers organised groups and activities in children's centres or other community venues, on their own or working in pairs, such as cooking sessions and a Zumba class requested by parents.
- Volunteers are most likely to stay involved when they are nurtured – the role of the volunteer coordinator is key to maintaining motivation (and quality control). The project worked hard to develop a team spirit for mutual support, with monthly meetings, a buddy system for experienced/recent volunteers, offering the chance to volunteer in pairs, and creating a strong project identity to which volunteers were proud to belong.

### Tips for success

- **Identify the win-win for professionals – where a volunteer can add value by reinforcing messages, complementing the work professionals are doing, and reaching parents who aren't currently using services – and work in partnership from the beginning.**
- **Be responsive and flexible, building in reactive learning as you go – match what parents want, what children's centres want and what volunteers are willing and able to offer.**
- **Accept that tracking outcomes is very hard for unstructured projects – design realistic methods for capturing feedback, don't overpromise outcome data, resource properly what you are collecting, and make data collection from parents an explicit volunteer coordinator responsibility.**
- **Offer diverse flexible roles that suit volunteers of different skills, abilities and confidence.**

# Case study: Volunteers Supporting Families (VsF), Southend

**Host organisation:** Volunteering Matters (formerly CSV)
**Project started:** 2009
**Funder:** Southend Borough Council
**Staff:** Project Manager: full time, Project Coordinator: full time, Project Administrator: 20 hours
**Current number of active volunteers:** 30 active and in the process of training 6 more
**Length of initial volunteer training:** 18 hours over 3 days. Further training is provided
**Number of families supported per year:** 50+
**Location:** Southend, Essex

## What the volunteers do

One-to-one support for families involved with social care services and subject to a Child Protection Plan, Child in Need Plan or Early Help Assessment (Stage 3 – complex needs or Stage 4 – acute needs). The volunteer visits weekly for one to two hours and gives emotional and practical support to help parents achieve the goals on their plan, for example by helping them to set routines, learn how to tidy their home, and attend appointments; and also by role modelling consistent positive parenting including playing and reading with children.
The volunteer may visit for up to a year if needed.

## What is known about the impact on ABS outcomes?

A mixed methods evaluation (Akister, 2011) found that in almost nine out of ten cases, the family had moved to a lower level of safeguarding concern. Parents felt emotionally supported and had learnt positive parenting skills, including playing with their children. Although the project works with families with children of all ages, it is clear that empowering parents with improved confidence and parenting skills could be an important step towards all three ABS outcomes for young children.

## Key learning about working with volunteers in safeguarding

- It is essential to recruit volunteers with the right attitude and the ability to commit for a year. It took time for the team to develop skills to identify who is suitable for the role, and at first there was high volunteer drop-out, but they have developed a robust process which welcomes volunteers from a wide range of backgrounds but also enables people to eliminate themselves at any stage if they feel they can't progress into the role.
- The project needs to be able to do skilful risk assessment of volunteers who may themselves have a social care background, experience of domestic abuse, or other challenging issues, and to support them appropriately.
- The project needs to keep volunteers safe by doing careful risk and needs assessments of families referred for support. The training gives volunteers knowledge about keeping safe.
- The role can be frustrating as families may not engage immediately. The volunteers are offered regular supervision which enables the volunteer and the manager to reflect on progress and amend the plan if need be. This also helps the volunteer to understand the pace the family may need to work at and any positive steps that may have already been made, no matter how small they may seem to the volunteer.
- Volunteers were originally asked for a commitment of two to six hours per week, but this was reduced to one to two hours per week as families were feeling overwhelmed with their plan.

## Challenges of working with volunteers in safeguarding

- The project has found recruiting volunteers demanding, and 50% of the project coordinator role is recruitment. To promote the project, they give talks at local events, groups and colleges (social work and counselling), advertise online and in newspapers.
- The training provides volunteers with the resources to write a report after each visit, with the parents' knowledge, but some volunteers need reminding to do this. The volunteer's

relationship of trust with the family enables them to report both positives and negatives to professionals.
- Gaining the trust of vulnerable families can, in some cases, take several months. Volunteers need support to remain patient and not give up, and to understand that reliability and continuity does build trust over time.
- There is a risk that a volunteer could appear to be 'colluding' with parents, having heard only their version of events. Volunteers are invited to meetings of the multi-agency team working with the parents to better understand the broader picture. Reflective supervision also reinforces the importance of avoiding collusion.

## Establishing good relationships with professionals in safeguarding

The VsF team in Southend has built a strong relationship with professionals:

- Co-location – the VsF team is situated within the social care team. Staff explain the project to all new social workers, and remind existing staff about what they do by holding 'doughnut days' in the communal kitchen (free doughnut in return for a chat about the project).
- Several of the project's volunteers have qualified as social workers and are champions for the project within the social care team.
- Establishing a track record of success – social workers and health visitors see the benefits to families and feel supported in meeting their own professional targets.
- Positioning the service as complementary to statutory support and defining clear boundaries – working with other agencies to identify steps for parents to take (the 'what' of change). Volunteers are able to give the time and persistence to support parents to take those steps over the long term (the 'how' of change). The volunteer support may be written into a Child Protection Plan (as a second phase following an intensive period of professional support) to help the parent to maintain their progress towards desired changes.
- Robust training, reporting and supervision – professionals are reassured that volunteers will report any safeguarding concerns at once to their project coordinator, and some see the volunteers as an extra pair of eyes and ears in the family's home.
- Encouraging families to trust statutory services – volunteers, who are more acceptable to some families precisely because they are volunteers, use their relationship with families to promote the benefits of engaging with statutory services.

**Tips for success**

- **To recruit the right volunteers, you need good administration and paperwork, prompt responses to enquiries, and willingness to turn people down.**
- **The relationship between the volunteers and the project coordinator is key to keeping the volunteer motivated and involved – keep trying different ways to make volunteers feel valued and to bring volunteers together for mutual support.**
- **Give volunteers working with vulnerable families skilful, regular supervision and access to immediate support at any time if there's a crisis.**
- **Diversity of volunteers allows for more flexible matching of volunteers to parents. For example, the project has two male volunteers, one of whom has been matched to a single parent father, and the other to a single parent mother who wanted a male role model for her sons.**
- **Attend the local voluntary sector forum for advice on recruiting and retaining volunteers.**

# *Part Six:* Concluding remarks

**The purpose of our evidence review was to furnish practitioners with practically useful, well-informed guidance to help them design and deliver volunteer projects that would have an impact on the lives of parents and their children. For that reason, we have provided, at the front of this report, a substantial set of key messages derived from the evidence. But the evidence review has also provided us with the chance to test and elaborate some critical ideas and arguments about this field. We set out some of these here.**

## Valuable and unique role

This evidence review has helped us to specify the distinctive role and contribution that volunteers make alongside professionals. We think that this could help professionals and commissioners to see where and how they might want to tap into this, and help volunteer projects to articulate and communicate their role to commissioners. We have summarised the contribution of volunteering projects as follows: they can initiate a different kind of relationship with parents based on trust and equality and can reach and be accepted by parents who do not engage with professional services. They do this by concentrating on parents' strengths, building relationships, and working collaboratively with the people and agencies that offer professional support to parents and children.

## One size does not fit all

The Big Lottery Fund wanted to avoid being prescriptive about the approach ABS partnerships take to designing and implementing volunteering programmes, because of a belief that 'one size does not fit all'. Our findings support this belief: it is not possible to say that there is a 'best' way for volunteers to improve ABS outcomes, because a project model that works in one place may not work in another.

However, by providing a description of what the evidence has shown about the impact of different models of volunteering and about the core principles that underlie all successful projects, we hope that those who are developing projects will be able to select a model that fits with their aims and other activities, and then (keeping the core principles) adapt it to their local situation, testing and learning as they go.

## Laying the foundations for change

As well as directly improving child outcomes, volunteer support can lay the foundations for changes in child development outcomes that may only show up some years later, well after the grant (and any evaluation) have come to an end. This has two implications for those who fund, initiate and design volunteering projects: first, a theory of change can help to identify and understand the kinds of 'conditions' that a project can create, that will eventually lead to improved child development outcomes; second, impact evaluations and expectations for what can be achieved within the lifetime of a grant need to be proportionate and appropriate.

## Focus on meaningful data

In order to understand the distinctive role and contribution of volunteering, it has been important to take an inclusive approach to the evidence. Academic studies may measure outcomes but rarely capture the detail of processes, for which project reports can be a richer source. A hierarchical approach to ranking different methodologies was inappropriate

because the relationship-based behaviour change interventions cannot usually be meaningfully measured with traditional experimental study designs. This is because of their complex and personalised nature, with different potential impacts at different stages of a theory of change contributing to intermediate as well as to ultimate outcomes. Instead we have used quantitative and qualitative data from a range of methodologies (all subject to a quality appraisal process) to illuminate the impact, outcomes and processes of volunteering projects.

It was striking that many of the volunteering projects in this review had attempted to demonstrate their impact with over-ambitious data collection plans. These had often failed, either because the parents or volunteers did not cooperate with the data collection, or because data were being collected too early in the project's lifecycle to show any real impact. In other cases, quantitative data were reported with claims of attribution that could not necessarily be justified by the evidence (e.g. it was not known what other support besides volunteer support the parent was receiving).

We hope that going forward, commissioners, funders and projects will understand that a small amount of well-collected, meaningful data is better than a large amount of inconsistently collected data.

## Fund for the long term

We came across many examples of short-term funding (less than two years) where a project's impact was measured at a point where all of the set-up costs had been incurred, but little volunteering had taken place. Measured in this way, these projects would naturally appear rather poor value for money. It typically takes at least a year for a project to establish itself, build relationships with professionals, recruit and train volunteers, and begin to gain referrals, so the first year is often a 'sunk cost'. Once a group of volunteers has been trained, the longer each volunteer continues volunteering, the more cost-effective the training and support invested in that volunteer become. Thus projects that are stopped after a short period of funding are likely to be less cost-effective than projects that are funded for the long term.

## Beyond the evidence review… the economic benefits of volunteering as part of a system

In this report, and our concluding remarks, we have argued that volunteering makes a unique and valuable contribution alongside other important forms of support. It is part of a system of support to parents and their children, and it is extremely hard to meaningfully measure the economic impact of any individual part of that system in isolation. We have also argued that volunteering projects need funding over longer periods so that they can be established, trusted, and embedded. We know that governments, commissioners and policy decision makers will continue to be interested in the economic, as well as the social, benefits of their funding. ABS partnerships offer an excellent opportunity to assess economic benefit in terms of collective impact across a broad early prevention 'system'.

# *Appendix A:* Evidence review methodology

## 1. Scope of the Review

**We were asked to prepare our searches around the following objectives to:**

1. Explore the relevant evidence base demonstrating the effectiveness of interventions to ground practice development and delivery.
2. Consolidate relevant evidence from professional networks and organisations across the sector with a view to also supporting practice development and delivery.

The following interventions and developmental outcomes formed the heart of our searches:

**Interventions**

- Volunteers
- Peer support
- Community champion models

**Developmental outcomes**

- Communication and language
- Social and emotional development
- Diet and nutrition

In addition to these interventions and outcomes, Big Lottery posed 13 indicative questions for the evidence review:

1. What evidence exists on the benefits of using volunteers, peer supporters and community champions to deliver ABS outcomes during pregnancy to age 3 (up to their 4th birthday). To include who benefits, in what way and under what circumstances?
2. What is the learning from evaluations of different delivery programmes/models (successful and unsuccessful) and their effectiveness across different ethnic groups and with very deprived areas? How should these programmes/models be adapted within these areas?
3. When is using volunteers, peer supporters and community champions a feasible, effective and acceptable option for achieving ABS outcomes – and when not?
4. Are there universal or cross-cutting elements (including but not limited to engagement, selection, training and accreditation or integration within an existing workforce) which can be applied across different delivery models, which should be at the core of any strategy which uses volunteers, peer supporters and community champions?
5. What are effective strategies for the recruitment, training, accreditation and supervision of volunteers, peer supporters and community champions? What motivates volunteers, peer supporters and community champions and how best to connect with these? Are there any key barriers?
6. What are effective strategies in the retention of volunteers, peer supporters and community champions? Are there any key barriers?
7. What is effective in achieving positive impact and better outcomes for volunteers, peer supporters and community champions themselves?
8. What evidence is there for how new emerging technologies might be used to support volunteers, peer supporters and community champions?
9. What are effective strategies for engaging parents and aligning volunteer and parent goals and expectations?
10. What systems (i.e. funding, accountability, governance, structures and communications) promote

good relationships, cooperation and trust between volunteers and professionals/paid staff?

11. What governance arrangements are needed to ensure the safety of children, service users and volunteers and maintain high quality support?
12. What conclusions on successful modes or core principles can be drawn from this evidence which can be applied for the replication by other organisations and partnerships delivering services for families during pregnancy and the first years?
13. In addition, and based on the findings, what considerations does the current and impending policy landscape create for organisations using volunteers, peer supporters and community champions in pregnancy and early years? What opportunities or challenges does this present?

# 2. Search Strategy

## 2.1 Databases used

We searched the following bibliographic databases:

- CINAHL
- ASSIA
- PUBMED
- MEDLINE
- PSYCHINFO
- Social Services Abstracts
- IBSS (International Bibliography of the Social Sciences)
- Cochrane Library
- SCOPUS

## 2.2 Key search terms

| | **Families** **AND** | **Intervention** **AND** | **Outcomes** **AND** |
|---|---|---|---|
| OR | Family | Volunteer | Nutrition |
| OR | Mother | Volunteers | Nutrient |
| OR | Mothers | Lay support | Breastmilk |
| OR | Birth | Paraprofessional | Breast milk |
| OR | Early years | Community parent | Breastmilk substitute |
| OR | Babies | Peer support | Breast milk substitute |
| OR | Baby | Peer supporters | Infant formula |
| OR | Antenatal | Peer counselling | Well-being |
| OR | Postnatal | Peer counsellors | Social |
| OR | Natal | Community champions | Emotional |
| OR | Childbirth | Better start | Child protection |
| OR | Infant | Buddies | Safeguarding |
| OR | Infancy | Pals | Child welfare |
| OR | Perinatal | Befriender | Affect |
| OR | Child | Befrienders | Cognitive |
| OR | Children | Mentor | Motor skills |
| OR | Pregnancy | Mentors | School readiness |
| OR | Maternity | Parent champions | Infant learning |
| OR | New mother | Unpaid workers | Reading |
| OR | Maternal | Unpaid staff | Early education |
| OR | Pregnant | Peer educators | Child development |
| OR | Early parenthood | | Brain |
| OR | Early parenting | | Psychosocial |
| OR | Neonatal | | Behavioural |
| OR | Post-partum | | Communication |
| OR | Postpartum | | Language |
| OR | Caregiver | | Vocabulary |
| OR | Toddler | | Phonology |
| OR | Newborn | | Speech development |
| OR | Post-birth | | Attachment |
| OR | Prenatal | | Relationship |
| OR | Pre-natal | | Security |
| OR | Intrapartum | | Interaction |
| OR | Father | | Dyad |
| OR | Fathers | | Depression |
| OR | Early life | | Mental health |
| OR | Pre-birth | | Obesity |
| OR | Pre-school | | |
| OR | Parent | | |
| OR | Parents | | |
| OR | Low income | | |
| OR | Expectant mothers | | |
| OR | First years | | |
| OR | Early childhood | | |

## 2.3 Call for evidence

Our call for evidence was sent out electronically via email to over 120 practitioners and professional organisations, requesting that they send us any published or unpublished material they had that was relevant to our research questions.

## 2.4 Search Results

After screening over 25,000 documents, our dual search strategy returned a total of 269 documents that were relevant to the review, including 36 reports identified through the call for evidence or already known to the project team.

# 3. Quality Review

Because this was a rapid evidence review with a very broad scope, a full critical appraisal of all the evidence was beyond the resources and commissioned time of the small review team. We therefore worked pragmatically with abbreviated filters and processes for quality appraisal, built around the relevance and transparency of the evidence, its methodological robustness and data confidence. We used the following key criteria:

- Whether the aims and objectives of the paper were explicitly outlined and questions and hypotheses addressed.
- Whether interventions were clearly defined.
- Whether the research design was clearly described and appropriate to the research question, aims and objectives.
- The degree to which existing research and theories were considered.
- To what extent the approach to sampling was clearly stated and explained and allowed for broader comparisons to be made.
- How appropriate the methods of measurement were.
- How clear the methods of analysis were.
- The extent to which the methodology mitigated against bias.
- How transparent the researchers were in explaining the research process and its relationship to their findings and conclusions.
- Whether the research addressed limitations and quality.
- Whether there was clarity in terms of the position of the researcher(s) vis a vis the research subject.

We also drew on the quality appraisals of some of the quantitative evidence already performed by existing systematic reviews.

Much of the relevant evidence, across all methodologies, was of low quality. We therefore had to make a pragmatic choice around whether to choose to include a small number of studies that would fail to address the breadth and depth of our review questions, or a larger number of studies of variable and largely low (but acceptable) quality but which had relevance to our review. We made the decision that the latter approach would be most useful in this context and would be a starting point, albeit a tentative one, for the A Better Start sites to practically and theoretically reflect on their initiatives and operational and strategic context.

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