



A Better Start Evidence Review: Report to Big Lottery Fund

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I V A R Institute for
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Authorship and acknowledgements

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Part One: Introduction

1.1 Background

In October 2012 the Big Lottery Fund (the ‘Fund’) launched A Better Start (‘ABS’), a £215million investment to improve the life chances of some of the most vulnerable babies and children in England. In June 2014 the Fund funded five voluntary sector-led partnerships (which include local community, public and health services) between £36-£49million over 8-10 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). The five partnerships are:

Area	Lead organisation	Region
Nottingham	Nottingham Citycare Partnership CIC	East Midlands
Southend-on-Sea	Pre-school Learning Alliance	East of England
Lambeth	National Children’s Bureau	London
Blackpool	NSPCC	North West
Bradford	Bradford Trident	Yorks & Humber

All five partnerships are currently 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 has included models of volunteering, peer support and ‘community champions’ in their portfolio of projects.

The Fund wishes to support the grant holders to develop these models further, taking into account considerations such as 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 have asked for further support and evidence of ‘what works, when, for whom and in what circumstances’, drawn from evidence and research on existing models, which is why the Fund has engaged Parents 1st to carry out this evidence review.

To support grant holders in the next phase of this investment, Parents 1st will explore the available evidence base and evaluated best practice in using volunteers, peer supporters and community champions during pregnancy and the first few years of life, drawing on experience and evidence from the UK and similar societies internationally.

Through research, Parents 1st will provide understanding of which examples, models or methods were successful in contributing to better outcomes in pregnancy and early life for children, and, in particular, for the three development outcomes areas of:

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

Parents 1st will focus particularly on the following areas during Phase One:

- The benefits of existing volunteer/peer support/community champion initiatives
- Mechanisms that create the benefits

- Implications for ABS Programmes

Throughout the research we have embedded an approach that recognises the value of different perspectives, ideas, knowledge and culture. These perspectives bring great strength to the research and ensure that it reflects the real issues and experiences of the group/groups it is researching.

In addition to the interventions and outcomes above, the 13 indicative questions outlined by the Fund in the invitation to tender also formed part of the broader framework around which the evidence review methodology was grown. The questions were:

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 for 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 or 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?

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

Chris Cuthbert (Head of Development, NSPCC) has been seconded to the Fund as Director of Development, A Better Start. His role is to work with all five sites to optimise implementation of their local programmes. Feedback from this work and a workshop with the sites in February/March 2016 will be a key opportunity to engage the sites in reflecting on and refining their plans in this area; there may be future opportunities too. In addition, we have initiated contact with the University of Warwick who are undertaking the evaluation of A Better Start.

1.2 Our approach to the evidence review in Phase One

This report sets out the evidence that we have collected in Phase One of our A Better Start Evidence Review. This has been a rapid review. In Phase Two we will deepen and focus our searches as well as begin to translate the evidence into a practice framework (in collaboration with the A Better Start sites).

In Phase One, our review of the literature concentrated on research published in English from the 1990s onwards. Given that cultural, social and economic variations bring about different relationships between child care and developmental outcomes, we purposefully selected evidence sources from countries with similarities to the UK, including North America, Ireland, Australia, the Netherlands and Finland, but with a predominant focus on the UK. This is not to suggest that these contexts are homogenous or not without cultural and practice differences, or indeed that the work in small- and medium-sized economies is lacking in richness and/or value. However, for this phase of the research, this rationale was practical and indeed was confirmed by the findings of Hoddinott et al (2011) who highlighted the idiosyncratic cultural and philosophical context of the healthcare system in the UK, and the ways in which these limit the value of evidence beyond the UK context in respect of breastfeeding interventions and outcomes. Going forward into the next phase of the research, the team will reflect on the value of incorporating research from a wider geographical scope into the systematic literature review.

We adopted a dual approach to the review: searches of bibliographic databases and a call for evidence (using our collective professional networks and a manual search for relevant organisations). As our review progressed we also identified and made use of existing systematic reviews to guide our own review.

This dual research strategy returned 267 documents including 34 pieces of potential evidence provided by our call for evidence. Given that this was a rapid review we have drawn largely from electronic sources; it has not been feasible to access sources that are less readily accessible.

A fuller description of the evidence review methodology can be found in Appendix A.

1.3 What we will do in Phase Two

We will undertake some further searches in Phase Two where we, the Fund, together with the ABS sites feel that it is most needed. Our initial suggestions about this are set out in Part Two (Section 2.5).

In Phase Two, we will begin to focus on translating the evidence that we have collected into practice. A framework is already under development and this will be progressed in collaboration with the ABS sites so that it meets their needs.

Based on the findings of the evidence review in Phase One and our own experience of supporting organisations to develop and implement projects, we think that the following might be a suitable process.

The first step would be for sites to clearly define their vision, principles and intended outcomes and then to focus on the best structure for implementation and the local conditions required for the intervention to be delivered well. Therefore, the framework would look at:

Design: We will develop a decision-making tool (in the form of a series of questions) to help sites identify the key elements for a successful intervention. Based on our evidence review, these might include the type of relationship they wish to create between volunteers, parents and professionals and the desired outcomes.

Engagement: At this stage we will consider how volunteers plan to reach a diverse range of groups to gain a fuller picture of how the research outcomes relate to different groups. Specific groups may have very different needs, opinions, values that may be linked to protected characteristics. These characteristics may all affect the needs, views and behaviours of individuals.

Implementation: We will create an 'Active Implementation Framework' that incorporates the key elements identified at the design stage. Each element will be defined using the evidence collected during Phase One. The sites can then tailor this to create an implementation plan for their own intervention without missing any important elements.

Context: Our framework will also help sites to think about the context in which they work and identify important factors, both those which are enabling and those that present more challenges, and how they might approach creating a more enabling context for volunteering programmes. Drawing on the evidence review and our own experience, we have produced a preliminary set of questions (see box below).

We are conscious that separate arrangements are in place to evaluate the ABS programme. When we meet with the five sites we will be interested in how they plan to integrate any new volunteering interventions into their existing projects; and also how they might be able to use the evaluation findings to help them adapt and improve the intervention over time.

Preliminary version of questions that ABS sites might ask themselves about the context in which they work (N.B. This relates to Big Lottery Fund Question 13 and will be explored

further with the sites in Phase Two)

- Looking at the general direction of national policy and local practice, what are the two or three policy issues most relevant to your project; what, if any opportunities or challenges do they present?
- An Equalities Assessment to ascertain local issues and to influence best approaches.
- In particular, what is happening to develop new health structures locally to involve the voluntary sector in the implementation of the Public Services (Social Value) Act; and the Better Care Fund, which emphasises the importance of integrated care.
- Are the right people in the room? Given the policy and practice contexts in which you work, would your project benefit from the knowledge, relationships or experience of any other individuals or local organisations?
- In particular, what are the local commissioning arrangements for early years; how will you engage local commissioners in your project and share what you learn with them?
- What else is happening in your local area that might positively or negatively affect your project, e.g. Children's Centre or other service cuts or closures; other groups or organisations that are using strengths-based approaches to service delivery.

1.4 Report

In Part Two of this report we provide preliminary observations from the evidence. Part Three presents our findings from Phase One of our evidence review. We set out some relevant examples of programmes that we came across in a table in Part Four.

For the purposes of Phase One, we have assembled the evidence under each of the research questions from the Fund apart from Questions 12 and 13 which are about the implications of the evidence and, as such, are addressed in Part Two.

The primary audience for this evidence review is the group of practitioners delivering A Better Start. As such, we have already begun to draft the evidence review in language that 'speaks' to that particular audience. The style may differ therefore from the style of other evidence reviews.

We use 'volunteer' as a generic term that encompasses a wide variety of roles including those specified by the Fund for this review: volunteering, peer support and community champions as well as peer support and befriending. This is because, first, the evidence that we have reviewed does not always fall neatly into these sub-categories, hence our use of 'volunteer'; and, second, in the literature we found that a variety of terms are used interchangeably and to mean different things. An overview of models and outcomes was provided in the original tender from Parents 1st, Appendix A. This will be tested, elaborated and used to underpin the framework that we will develop in collaboration with ABS practitioners in Phase Two.

We found that the literature also used a wide variety of terms to talk about 'collaboration' including co-design and co-production. Where we are directly citing a report then we use the language of that report. Otherwise we use 'collaboration' as a generic term to cover all forms of partnership, formal and informal.

In Part Two we explain how we are beginning to articulate the nature of volunteering in the ABS context.

Part Two: Summary observations from Phase One

In Part Two we provide a narrative about the evidence that we have so far reviewed and the preliminary observations that we can make about the evidence itself; the core principles for volunteering in this context (Big Lottery Fund Question 12); what the evidence tells us about change; some tensions in the evidence; and initial ideas for Phase Two.

2.1 Appraising the evidence

There is substantial journal literature on breastfeeding peer support, but minimal on diet/nutrition overall, communication or directly on social/emotional development. We took the decision to include studies that address maternal mental health as this is known to impact on attachment and child development. The 'grey' literature offers a richer discussion of some of the study issues, in particular those related to the process questions that we were asked to address about, for example, recruiting and supporting volunteers and of engaging parents.

This (Phase One) was a rapid evidence review rather than a systematic literature one. Nonetheless, we wanted to be systematic and rigorous about screening the literature we uncovered for quality as well as relevance. Piggybacking existing systematic reviews helped us because they had already screened for quality in much of the quantitative and (quasi) experimental research that we came across. But that still left us with the data that we uncovered and that, like the quantitative data, was of variable quality. We had to make a pragmatic choice: include a small number of studies that would fail to address the breadth and depth of our review questions or include a multitude of studies of variable quality but that 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 ABS sites to practically and theoretically reflect on their initiatives and operational and strategic context.

Given that our research questions focussed on impact and non-impact issues, our approach followed a mixed-synthesis of quantitative and qualitative research. The quantitative research we included in the review allowed us largely to address the 'impact' questions of our research and the qualitative research informed the questions we needed answered around the 'non-impact', process, and experience-based questions. In this respect, there was a natural convergence between both paradigms of research within the context of the review. Therefore, the integration of findings using different methodologies was not simply a decision that was derived from our assessment of the nature and comprehensiveness of the existing evidence (see above). In order to mitigate any risks to the validity of the research that could arise from the integration of the findings from these different research methodologies, we took the decision to reduce our quality appraisal questions to those that were comparable across both approaches. These are explicitly given in Appendix A.

Given the practical constraints of this formative/provisional review, such as time and labour, we used an abridged and pragmatic quality appraisal process, the filters of which were derived from the more robust and standardised criteria for assessing quality that we have identified for use in the systematic review of the next phase of the research. As can be seen in Appendix A, these were built-up around the relevance and transparency of the evidence, its methodological robustness and data confidence. The ways in which the research team put these things in the balance was checked for overall consistency and reliability through regular weekly conversations around the ways in which we were applying our

inclusion/exclusion criteria. In addition, a moderation exercise took place, whereby a duplicate search of one of the databases was undertaken in respect of one identified outcome (nutrition) and all identified interventions.

2.2 What we learned about core principles or approaches to volunteering (this section responds to Big Lottery Fund Question 12 and will be elaborated further in Phase Two)

From the evidence that we reviewed, we have identified a number of core principles or approaches that were prominent in the literature; that appeared to be distinctive and important; and that were associated with achieving positive benefits:

- **Strengths-based:** Volunteering in pregnancy and early years contexts is associated with 'strengths' or 'assets' based approaches to supporting parents. In practice, this means operating in ways that empower volunteers, are not judgmental, and enable parents to take control of their situation.
- **Relationships:** To make volunteering work, positive interpersonal relationships need to be developed between everyone that is involved (parents, volunteers, coordinators, local professionals). This is linked to the importance of mutual understanding between all those involved in order to promote positive support by professionals and enable parents to easily access and take up the support offered.
- **Mutuality:** The support is intrinsically different, but can operate alongside support provided by professionals. A strengths-based approach to supporting parents goes hand in hand with the idea of 'mutuality'. There are three main elements to this: first, it is not about the volunteer providing a service to the parent or carrying out delegated tasks for professionals. Second, all three parties (parent, volunteer, professional) are regarded as beneficiaries of the arrangement. Third, all three parties can learn from one another; and the advantages of being linked up alongside a volunteering programme are well understood by expert professionals.
- **Governance:** There is a dearth of evidence about the governance of volunteering in this context. But, in practice, based on the evidence, it is critical to the success of projects that are flexible and built on relationships. In particular, the literature points to the importance of skilled supervision of volunteering and the pivotal role of coordinators in negotiating the boundaries around relationships between volunteers, parents and professionals.

By identifying these core principles we are beginning to be able to articulate how we are thinking about 'volunteering' in this context. This needs further exploration in Phase Two, but we think we can say that it is distinguished by: the type of relationship and where the boundaries around those relationships are set. It is also about desired outcomes and what is the theory behind the programme and why certain boundaries are defined. An appetite for 'integration', understood as placing the child at the centre of programme design and delivery, is a prerequisite.

Successful implementation of the core principles described above is likely to require governance, communications and evaluation (including help with articulating a theory of change) arrangements as well as practical mechanisms for delivery.

2.3 What the evidence can tell us about change

Our review of the evidence has raised questions about where the benefit of volunteer interventions will show up. A Better Start specifies three child development outcomes and there is certainly some evidence of volunteering making a positive contribution to these (see 3.1, Question 1). Much of the evidence, however, relates to what might be characterised as creating the conditions for change. We note four main ways in which this appears to occur:

- Challenging local ‘culture’ and/or providing an alternative environment where different approaches to parenting, for example, are modelled and encouraged.
- Changing the way parents feel about themselves (feeling valued, respected, supported) including improved maternal mental health and confidence.
- Changing the way parents feel about the kinds of support (including statutory) available to them and being able to take control of the way that they engage with this.
- Finding the optimum combination of semi-formal and informal kinds of support for different people in different circumstances.

If we accept that some volunteering interventions are about creating the conditions for change then it may follow that the desired child development outcomes will not show up during the lifetime of a grants programme and may not, therefore, be evidenced in an evaluation. These interventions could, nevertheless, lead to improved child outcomes. First, for example, through processes such as normalising, reframing and emotional support; the informal nature of peer support could assist marginalised parents to overcome the initial stigma, shame, lack of confidence or motivation to attend a group. Second, signposting/advocacy could enable access to, or two-way communication with, a professional. Third, it could take considerable time before the negative social influences impacting breastfeeding rates could be counteracted through a local initiative that gradually built positive social networks to increase breastfeeding.

This is why it is important for projects to develop a theory of change¹ and articulate the assumptions that underpin their theory for how and why the project will make a positive contribution to, in this context, child development outcomes. By articulating a theory of change, A Better Start sites will be better placed to specify intermediate outcomes; this enables them to assess whether they are moving towards their more ambitious goals.

Additionally, because this literature covers a wide variety of volunteering models (and, in some places, uses unspecific language, e.g. peer support can be informal mother to mother, or based on trained peers), we cannot make the assumption that the change mechanisms of interventions in one sphere, e.g. breastfeeding are transferable. Some roles are generic and informal while others are more specific and structured. There is some evidence that the latter can achieve specific measurable child outcomes but the less tangible nature of the former, while more difficult to quantify, would appear to be just as important.

¹ Many of the interventions that we examined in the evidence review do not specify a theory of change; those that do generally feature empowerment.

2.4 Some tensions and issues in the evidence

There are some tensions and complexities in the evidence that we will need to unpick during Phase Two both by deepening our review and by discussing the evidence with the ABS practitioners. Some examples of these tensions are described below.

- **Culture:** Tension between challenging prevailing cultural norms (e.g. related to breastfeeding) by creating a different culture (e.g. through a social parenting group) and creating culturally sensitive volunteer programmes that match volunteers to mothers' culture and experience. Related tension between volunteers working with mothers 'in situ' (home, whole family approach) and deliberately working with them outside the home in order to challenge norms.
- **Structure:** A misnomer in some of the literature is that *unstructured does not mean low quality*. So what is delivered in terms of emotional and/or practical support should vary according to the strengths and challenges of the individual family. However, it is important that provision operates within a clear structure, is well coordinated and ideally theory based.
- **Expectations for outcomes:** There is a message in this about what kinds of outcomes and impact can realistically be expected from programmes of this complexity over the short- and even medium-term. Many of the interventions we have read about for this evidence review have contributed to increased maternal mental health. There is an evidential pathway from improved mental health to improved child outcomes.
- **Expectations for delivery:** It takes time to get a volunteering project up and running both practically (e.g. synchronising the timing of parents wanting support with volunteers trained and DBS checked); and also culturally (e.g. achieving a shared understanding of what 'strengths-based' looks like). All those involved in volunteering projects (as funders, volunteers, etc.) need to understand the need for sensible lead-in times and the importance of ensuring appropriate staff are in place for ongoing recruitment, training, coordination and supervision.

2.5 Initial thoughts about what we focus on in Phase Two

As a team we will be reflecting further on what we have learned in Phase One. We will also want to gather reflections from the Big Lottery Fund and, critically, share and discuss this with the ABS sites. The ideas below are therefore provisional:

- What can the practice-based literature tell us about the role of volunteers during pregnancy and the first few years of life; and how can this literature, when added into the academic and professional literature, enable us to relate the child development outcomes to specific models of volunteering and to say more precisely why and when to use volunteers.
- Which two or three issues might benefit from us looking beyond the early years literature:
 - Governance of volunteering
 - Practical examples of implementing strengths-based approaches
 - Co-production.
- Based on our review of the evidence and our initial insights into the ABS sites, we would recommend linking the sites into the Big Lottery Fund's body of work on replication.

Part Three: Evidence

In this draft report we have organised the evidence under the research questions specified by the Big Lottery Fund. We have clustered the questions into two sections: Benefits (Questions 1-3); Interventions (Questions 4-11). We discuss Questions 12 and 13 earlier in the report because they relate to the wider implications and next steps for the evidence review in Phase Two (see Section 1.3 which addresses Question 13 under sub-heading 'Context'; and Section 2.2 on 'Core principles' which relates to Question 12).

3.1 Benefits of the interventions (Questions 1–3)

Question 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?

Of the 13 questions posed by the ABS sites, this was the one we found most challenging to address. While there was a large volume of evidence that was relevant to this question (compared with some of the other questions), there were tensions and divergence in the evidence as well. With further searches and input from the sites we will be able to refine this section in Phase Two.

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 (particularly girls') 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).

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 behavioural problems in the child, and increase participants' confidence in their parenting abilities. EPEC was a manualised 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 (BME) 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 helped 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), 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). Therefore, it is highly likely that interventions supporting the mother's emotional wellbeing 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 pregnant women and new parents, 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 feelings of anxiety and depression (Barlow 2012, Bhavani 2014b, Granville 2012, Kenkre 2011, McAuley 2004, Spiby 2015, Suppiah 2008).

Outcome 3: Improve children's nutrition and reduce obesity

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 to 6-8 weeks (the World Health Organisation recommends a minimum of six months exclusive breastfeeding). Many women say that they give up because of a lack of support with breastfeeding problems.

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), there is no randomised controlled trial evidence of impact in the UK (where all mothers have access to some breastfeeding support, at least in theory, from midwives and health visitors) (Jolly 2012b). On the other hand, some projects have found that peer support does have an impact on breastfeeding rates in their local area (including in very deprived communities) and 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, or through specific help to overcome problems. It has also 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 (Briant 2005, Fox 2015, Hoddinott 2006, Ingram 2005, Ingram 2013, Muller 2009, Scott 2005, Tandy 2015).

One challenge with this evidence is that there are many different models of breastfeeding peer support (for example, antenatal or postnatal; face-to-face or by telephone; on the postnatal ward in hospital, 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 lack the confidence to attend groups and prefer individual support. 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.

Postnatal breastfeeding support as recommended by NICE will not (in the short-term) affect the number of women who decide to start breastfeeding, but **one-to-one volunteer doula support** can. Volunteer doulas give mothers (mainly disadvantaged mothers) one-to-one support during pregnancy, at birth and postnatally for 6-12 weeks and this has been shown to significantly affect both the number of women who start breastfeeding and who continue to at least 6-8 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 very 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). There is also a study underway to

evaluate the effectiveness of volunteers working one-to-one with vulnerable families to deliver the structured HENRY *Healthy Families* programme. **Community Health 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 (Turner 2012).

More detail on *in what way and what circumstances* can be found in Question 4.

Into Practice ...

Volunteer interventions work and support ABS outcomes, when the conditions are right. A clear focus, timescale and mix of structured and flexible approaches are needed. Ongoing volunteer training, skilled supervision and coordination are key factors in their success and there is no one model to suit all. It takes time to decide which type of intervention fits best with which child outcome, alongside a community's existing strengths.

Question 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?

The majority of the programmes that we reviewed were delivered in deprived areas and were funded to support a particular group.

The evidence supports the idea that collaboration between professional and volunteer workers can contribute to improved health outcomes; and that a strengths (or 'assets') based approach to supporting parents can benefit individuals and communities.

In an IHE review of evidence to inform services in the UK: *'The use of community workers is of interest because there is the potential that community engagement will link to sustained improvement and reach less accessible groups'* (Cooper, 2009) and while it is acknowledged more exploration is needed to support this, the evidence, in particular relating to the benefits brought to parents and volunteers alike, does demonstrate mutual and positive change.

Cultural and other sensitivities that may lead families to resist volunteer support must be considered carefully when designing any intervention programme. If there is no clear messaging and focus for the intervention then it may be feared (too much is unknown) and considered as interfering, without the benefits being fully understood. A Family Action programme in Southwark (2009) for vulnerable pregnant women and mothers focused on attachment and demonstrated reduced maternal anxiety and depression with improved social support. The qualitative results reported that mothers felt more confident as parents and it was observed that 100% service users achieved their target fully or partly to develop good communication and a close bond with their baby, with volunteers saying that they themselves felt more confident as a result of the process. Other programmes such as EPEC (Day, 2012) and National Childbirth Trust's (NCT) Birth and Beyond Community Supporter programme (Bhavani, 2014) demonstrate significant effects (in particular around isolation) for targeted groups such as refugees and asylum seekers. The Refugee Council Health Befriending Network (James, 2013) also stated that clients commonly reported a reduction

in stress and anxiety and improvements in levels of self-care as well as *'reduced depression and having been helped in their healing journey'*.

Factors to consider when planning volunteering interventions:

Intervention

- **Clear messaging and focus:** What is the programme designed to support? How will it do that and who can attend/be part of the scheme?
- **Language:** Will you use interpreters and or recruit same language volunteers? Registration forms and other formal recruitment procedures can be a barrier for potential volunteers who do not read well or do not speak much English. If volunteers do not speak English well the training may need to be adapted (Bhavani, 2014).
- **Recruitment of participants:** Consider participant journeys *into* the programme – what other services will be involved in the recruitment and signposting for a particular scheme? Is outreach work required? Word-of-mouth promotion is popular and gains traction in a community. Are volunteers that reflect the local demography more suitable in supporting the outcome or would parents prefer support from those not from their own community (McLeish, 2015)? Young mothers can feel overwhelmed with services (and this applies to volunteer recruitment also). In culturally and linguistically diverse populations (Robinson, 2014) the stigma and shame attached to some minority ethnic groups' beliefs around mental health and social status can create a barrier, so using acceptable activities to draw people in may work better.
- **Disengagement:** Some parents may take up the support of a volunteer and then later disengage from the relationship, for example, young mothers who hold concerns about 'yet another person to deal with'. The evidence indicates that projects need to recognise that disengagement is a real possibility; decide at the start how they will handle disengagement; and be ready to adapt their project to what they learn about disengagement as they go along.

Implementation

- **Collaboration:** Designing the best operational structure in relation to a well-defined volunteer role and intended outcomes is an important first step. Would close alignment with a professional/statutory team undermine reach to marginalised parents who are wary of professionals?
- **Resources:** Support tools and skilled supervision have also been cited as vital and complementary to the process. For example, in one Chilean project, volunteers kept reflective diaries as a method for embedding learning into their work.
- **Location:** Think about where to locate the support. For example, you may want it co-located with a complementary team of professionals, e.g. midwives, or in a school or other setting where parents go. Think about whether places like council offices or GP surgeries will attract parents or put them off.
- **Inclusive:** Advertise and recruit volunteers using means and places that will reach the kinds of people that you want to attract, e.g. local media and existing community networks. Being inclusive may mean deliberately targeting particular groups and offering them the chance to 'test the water' before they commit to the project as a way to build their confidence to take part.
- **Targets:** *'Adherence to rigid targets and objectives, and judging the 'success' or otherwise of this type of project by such criteria leaves little scope for local innovation and creative approaches to community development'* (Raine 2003).

- **Timelines:** In order to extract learning that will influence future approaches there is a need to avoid limited evaluation timelines and rigid targets/objectives that are used to judge 'success' (counter to community development and innovation approaches).

Context

- **Context:** Consider community, local environment and local infrastructure (support for the programme at all levels)

Into Practice ...

Volunteer programmes for marginalised groups do not need to be differently designed, managed or delivered in order to be effective. Instead, the evidence indicates that volunteer programmes work best when factors such as context, collaboration and resources are taken into account.

Question 3: When is using volunteers, peer supporters and community champions a feasible, effective and acceptable option for achieving ABS outcomes – and when not?

Across the various sources there are numerous 'case study' examples and from those, the main features that best demonstrate the effectiveness of a volunteer scheme have been drawn out, including where the conditions are most conducive to its success and achievement of the ABS outcomes.

When it IS feasible, effective and acceptable:

With respect to the intervention:

- In areas where families are more economically disadvantaged than the general population (e.g. Empowering Parents, Empowering Communities Day, 2012 – group parenting support in Southwark).
- When there are specific maternal and/or child health outcomes that need to be addressed.

With respect to implementation:

- When operational staff (particularly the coordinator) can be recruited with the necessary competencies and skills (pivotal).
- When managers within the volunteer host organisation are committed to the idea, understand its ethos and will lend it their support.
- When structures and processes within the host organisation can enable an initiative to flourish (community grass roots/respected and embedded in the community served).
- When there are the time, resources and conditions locally to run a successful and well-coordinated (full cost) programme (statutory/VCSE support, etc.) that can provide continuous support (e.g. for childbirth).
- Where there are opportunities for professionals to facilitate access by parents to the volunteer support offered and for parents to easily access the support themselves.

With respect to the context:

- Where there are sufficient resources and long-term investment (to allow time to set-up and embed) and commissioners are prepared to wait for longer-term outcomes (providing process and quality evaluation is positive).
- When it is seen as a support mechanism that sits alongside other interventions and factors, not as one with the sole responsibility for bringing about a change.
- In areas where there is a history of community development approaches and these are integral to addressing local health priorities.

When it IS NOT feasible, effective and acceptable:**With respect to the intervention:**

- In a situation where a peer supporter is being placed in the role of ‘teacher’ and is giving ‘advice’. Peer education is mainly seen as less acceptable/effective as compared with peer support which is generally more acceptable/effective.
- Where there is no clear theory of evidence underpinning a programme.
- When an intervention is seeking to replace a professional role requiring specific/clinical expertise.
- Where there is an expectation that the volunteers will mimic a professional role.
- When there are serious health and safety risks, e.g. likely to compromise a volunteer’s own mental health.
- When a clear safeguarding plan is NOT in place, compromising the safety of volunteers, vulnerable parents and children.
- When a more specialised shorter-term solution is sought (engaging and supporting to instil behaviour change takes time).
- When a wide range of outcomes are sought and a volunteer peer support style intervention is being considered as ‘the solution’, i.e. an over-reliance on the outcome that can be contributed through this route.

With respect to implementation:

- If a programme is seeking to achieve rigid, short-term targets and requires intensive monitoring and data collection by volunteers.
- When external factors do not create the right conditions (lack of resources to deliver effectively, e.g. providing outreach, professional staff on board, limited timescales, etc.).

With respect to context:

- Where a better ‘home’ for the support lies elsewhere, e.g. within a statutory service such as the NHS.

Into practice ...

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 three sets of factors relate to: the intervention itself, the way it is implemented and the local context. These factors could also be translated into a quality improvement process that can be applied to any programme.

3.2 Mechanisms that create these benefits (related to the above) – Questions 4 to 11

Question 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?

We found that reports from volunteering projects and the ‘professional’ literature were the most helpful for addressing this question. So far, elements to consider when creating a core strategy are listed below.

Universal, cross-cutting elements to be included in core strategies:

Intervention

- **Benefits for volunteers can be as important as those to the parents they support:** The impact and benefits for volunteers can also link to ABS outcomes with their own families.
- **Different models of volunteering:** Different issues apply to different models (informal, more structured, group, intensive home visiting, specific to breastfeeding, etc.). And, crucially the level and type of volunteering role should fit with the volunteer recruited and volunteering opportunities matched so that the volunteer is able/has the potential to contribute to ABS outcomes, e.g. motivation, confidence, personal qualities, commitment, time, ability, lived experience.
- **Clear messages and boundaries articulated:** What is the scheme or approach hoping to realistically achieve, how and when by? Family Lives staff communicated well what the service was to both referring practitioners and parents themselves. Both understood that ‘befriending’ was not a practitioner-based service where a professional would make a diagnosis of the situation and use their expertise to advise on a solution. Rather, it was understood as parent-centred support where the parent would be given an opportunity to discuss openly their concerns and be supported in identifying their own solutions. Critically, the service was understood as peer led, non-judgemental and a partnership: (usually) fellow parents helping other parents to talk through difficulties and build confidence in their parenting.
- **Evidence-based approaches:** Project content and design is rooted in evidence of what works, and based on a theory of change.
- **Good quality outreach** creates easy, informal ways for parents to access volunteer support (also applies to volunteer recruitment).
- **Time:** Social support can play an important role (particularly in relation to emotional support and postnatal depression): often what volunteers have and professionals do not, is time to listen and discuss things that parents perceive to be ‘trivial’ to a professional. **The need to build trust:** The ‘initial ‘getting to know each other’ stage of the volunteer/parent relationship requires social skills, confidence, empathy and a non-judgmental approach. Parents with few or no qualifications may fear that they would be made to feel insecure in the presence of the trained volunteer, possibly expecting that most are middle class (Barnes 2006b). For example, in a study where two mothers reported feeling uneasy about having a stranger in their house and

with their baby, the unease was linked with input from friends, who felt that the volunteers must simply be 'nosey parkers'. One mother reported that she did not get on with the organiser at the initial visit and that she felt she was being judged. However the benefits of lived experience can mitigate some of these challenges and provide a good cultural understanding of a particular situation (e.g. pre-term baby).

- **Timing, nature and intensity:** Carefully considering these factors before an intervention begins. When does it start? How often is it available? How many sessions in total or overall time period? Is it a group, is it one-to-one? In a centre or in the home?
- **The flexibility of programmes and coordinators being open to potential changes to the model of delivery in order to achieve child outcomes:** This can mean flexibility in terms of volunteers working at different stages with different families or in terms of the way volunteers work with families one-to-one or in pairs or small groups (Francis, 2015).

Implementation

- **Empowerment:** We know that the idea of empowerment is relevant to volunteering and the ABS outcomes but we need to understand more about what empowerment looks like in this kind of project and what role it plays (Brunton 2014).
- **Skilled supervision/opportunities to reflect/reinforce fidelity:** There is a need to delve deeper into what is meant by 'skilled supervision', e.g. processes, knowledge and skills required for reviewing/monitoring the ongoing quality of volunteer support being delivered and achievement of child outcomes, the nature of the supervisor/volunteer relationship (linked with empowerment mechanisms above), governance requirements, personal development of the volunteer, etc.
- **Training and accreditation:** This needs to be well planned, not onerous, and responsive to the specific volunteer role so as to enhance the personal journey for the volunteer (a continuous process) and equip volunteers to confidently carry out the role. A mutually supportive, enjoyable, informal group learning experience for volunteers is important – generating a sense of joint purpose and social friendships (Also impacts on volunteer retention). Offering opportunities to gain a qualification can impact on new career progression opportunities for volunteers (both within and outside the project).
- **Infrastructure:** From the evidence, we learned that projects need skilled coordination, efficient administration, sound arrangements for training and supervision, and good relationships with partner agencies. To have all of these in place, and to adapt them to the local (changing) context will require considerable time, skills, knowledge and tenacity. We found that this kind of 'infrastructure' was missing from some Home-Start schemes, and from projects operating on limited budgets; these projects sometimes struggle with volunteer recruitment and retention as well.
- **Pathways that enable access:** The evidence tells us that a significant number of referrals are not progressed and that professionals can have difficulty explaining programmes to the parent. This may result in support being declined because the parent misunderstands or feels 'needy' when referred. This has important implications for testing out non-stigmatising pathways to support. Practitioners should be instrumental in their acceptance and development of peer support, ensuring these networks are valued, nurtured and encouraged (Jones, 2014).
- **Evaluation:** Evaluation design and methods need to be appropriate to a community development ethos and avoid undermining the volunteer/parent relationship; and they need to be proportionate to the project's aims and timeframe. *'Self-evaluation*

is challenging and a lesson learned is the importance of proportionality – do not be too ambitious in what you ask of projects’ (Turner, 2012).

- **Promoting inclusivity:** This is about delivering volunteer training in local venues, paying out of pocket expenses for volunteers (this may need to be offered upfront in ABS communities due to volunteers being on low incomes).
- **Full cost recovery:** Programmes need to be fully funded so that they can pay for travel expenses, operational base, staff to deliver and supervise, accreditation and training, tools and resources, evaluation, etc.
- **Data collection, why and for whom:** *‘Less data well collected is more useful than large amounts collected inconsistently’ (Turner 2012).*

Context

- **Awareness:** Projects will need to raise and then maintain awareness of the project so that local partner agencies are familiar with the project team and so that volunteers and supported parents learn more about the project. It may help if local agencies, volunteers and some parents are engaged at the design stage of the project.
- **Fostering mutual respect for complementary roles:** Evidence tells us that distancing volunteering from statutory services can be important because professionals can be seen as threatening by some vulnerable and excluded families (Bhavani 2014a). Professional resistance is inevitable and an important consideration: *‘The most persistently challenging aspect of engagement has been in relation to partner organisations, and in particular those which it was hoped would refer families into the programme. Just under half of survey respondents (47%) thought that the programme had increased the number of partner agencies who understood the importance of home learning environments. In some areas the programme was a mechanism to build relationships’ (Francis 2015).* It is important to facilitate joint learning and get the power relationships right (hence the important role of the coordinator). It is important to ensure that particular roles are interlinked where they need to be, e.g. postnatal depression, cooking groups, play and expert professional support.

Into Practice ...

Universal elements of volunteering programmes related to early years include: making time to build trust and to get the relationships between volunteer, parent and services right for everyone; getting organised – flexible volunteer support backed up by structured training, coordination and supervision; and understanding the way statutory and voluntary sector roles can be integrated.

Question 5: What are effective strategies for the recruitment, training, accreditation and supervision for 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?

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 leave. Projects reported a wide variety of successful strategies for recruiting volunteers including:

- Advertising through local media (newspaper/radio) and online
- Notices and leaflets in community spaces, e.g. children's centres, GP surgeries, schools
- Outreach by recruited volunteers, e.g. 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 (Battye 2012, Bhavani 2014a, James 2013, Marden 2013, McInnes 2000, Spiby 2015, Watt 2006, White 2010, Young 2015).

It was important to clearly define the volunteer role in advance: what it was and what it was not, so that potential volunteers understood the scope of the commitment. Some projects offered taster courses to explore suitability by both potential volunteers and programme staff (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 be more robust and include one-to-one interviews which include an assessment of skills and understanding of the role and motivations for applying, to ensure quality, suitability and increase retention (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 (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'). There were also some marked differences in practical and philosophical approach. In service-focused projects where volunteers were not seen as equal 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 recruiting 'the usual suspects' (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 (Bhavani 2014a, Francis 2015, James 2013).

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 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 and project staff 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 (Granville 2012, Watt 2006, White 2010)
- Training that was fun, suited to adult learners, was 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 may also give professionals confidence in the quality and consistency of the training (Tandy 2015, Turner 2012)
- Offering vocational qualifications where evidence of learning can be derived from the natural volunteer setting
- Adaption 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)
- Providing childcare alongside training if needed (having children in the room disrupts learning), and paying travel expenses (Bhavani 2014a, Muller 2009, Turner 2012, Watt 2006)
- Using a local, easily accessible or familiar venue for training (Turner 2012)
- Involving local health or social care professionals in the training, which assists them to 'buy in' to the project (Bhavani 2014a)
- Ensuring some active volunteering took place early on in tandem with the training plus staged assessment and mentoring to minimise wastage (Day 2012, Spiby 2015).

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, enable reflective practice and empower the volunteers 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, White 2010). 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 was also available from the project coordinator (e.g. Tandy 2015, Watt 2006) and/or other more experienced volunteers (e.g. Spiby 2015). In community champion models where the volunteers were expected to spread health messages after brief one-off training, the volunteers did not normally receive supervision and were less active and effective (Turner 2012). Lack of effective supervision and support could lead to demoralisation among volunteers (Spiby 2015).

The skilled work required to recruit, train, supervise and support volunteers emphasises the importance of the volunteer coordinator having the right skills and time for these tasks (Suppiah 2008, 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).

Motivation

Motivations for joining projects were varied and mixed, but the motivations consistently reported across all the projects were:

- Altruistic – 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.
- 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’.
- Career orientated – 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.
- Social – hoping to meet interesting people.

Additional motivations for remaining involved developed over time and these are explored under Question 6.

Projects can connect with these different motivations by offering a high quality volunteering experience, including:

- For altruistic motivation: opportunities to receive feedback from clients about the impact of support; emotional support for volunteers who have experienced similar issues.

- For personal development motivation: strengths focused training; supervision that supports reflective practice and personal growth.
- For career orientated motivation: offering accredited training that leads to a recognised qualification, and ongoing training opportunities.
- For employment motivation: offering employment opportunities within the project to experienced and skilled volunteers as projects expanded.
- For social motivation: 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).

Into Practice ...

Volunteering projects need a decent lead-in time to find the 'right' volunteers for the project 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. Programme evidence suggests that it is crucial to match volunteers to the programme 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.

Question 6: What are effective strategies in the retention of volunteers, peer supporters and community champions? Are there any key barriers?

On exploring the various evaluations and reports of trials, initiatives and more established programmes, the most effective strategies for the retention of volunteers are set out below:

- Good organisation, including administration systems, and arrangements for prompt payment of volunteer expenses.
- Recruitment that mentors people into roles that are right for them; makes time to explore their aspirations and motivations with them; and then, where feasible and appropriate, identifies employment pathways within the programme (e.g. within the Community Parent Programme to retain experienced and skilled volunteers and build local sustainability).
- Avoid lengthy training programmes that don't offer any experience of volunteering until the end. Use the training to begin to build a relationship between volunteers and coordinators.
- Arrangements for ongoing training and supervision are explained to volunteers when they first become involved so that they understand the commitment.
- Skilled supervision that offers regular opportunities for volunteers and managers to review progress, e.g. how relationships are developing with the parents being supported. Group supervision can be useful for helping volunteers to feel they are part of a team, facilitating peer-to-peer learning and a shared sense of purpose.
- Credibility of the volunteering role and contribution within the project and among other health and social care professionals.

Three barriers were also identified:

- An unwelcoming attitude by some professionals
- The volunteer's own family issues/life events

- Anxieties and frustration when projects are poorly organised.

Evidence of the importance of volunteer support and supervision is provided by Marden 2013, Spiby 2015 and Suppiah 2008 who all highlight the need to avoid a delay between a volunteer finishing their training and having their first volunteer opportunity (a key barrier being CRB/DBS checks). Spiby reports a specific strategy of not awarding the training qualification until the volunteer had supported some mothers. So there is an interesting question of community development (you want volunteers to become empowered and move on) versus service delivery (you want to maximise retention) and the importance of recruiting volunteers with a range of motivations, as motivation and retention may be correlated.

The EPEC programme went beyond this to create a collective and shared ethos within the programme including peer facilitators in promoting the programme, the equivalent of 'continuing professional development', positively incorporating facilitators' experience and ideas to improve the programme. This was a partnership between the varied knowledge and expertise across the EPEC programme irrespective of role/position based on a shared ethos/group identity.

Into Practice ...

The need for high quality supervision stands out. It is the most critical element in the retention of volunteers. More structured and formal practice, making provision for reflective opportunities and peer-to-peer support, as well as personal development and ongoing training are all pivotal in developing skills and maintaining commitment. Building confidence and feeling valued and respected by local professionals is also important.

Question 7: What is effective in achieving positive impact and better outcomes for volunteers, peer supporters and community champions themselves?

The evidence from many of the studies (e.g. Barlow 2012, James 2013, Molloy 2007, Spiby 2015, and 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 and finding out more about an area they are interested in (with a possible pathway into life-long learning). The most consistently reported benefit 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 outside motherhood, which gave them a positive additional identity, and to feel they were 'making a difference'. The impact on feelings of self-worth 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). It was also strikingly apparent where a small group of breastfeeding peer supporters, volunteering in a deprived community where breastfeeding was a counter-cultural activity, developed a strong and positive group identity centred on their volunteering, creating a logo and branded T shirts for their public activities (McInnes 2001). In other projects, volunteers who did not have the opportunity to meet up with other volunteers often said that they would have liked to do this, in order to build on supportive relationships formed during training.

The empowerment of volunteers began with the training course – gaining knowledge, skills and confidence in a group situation that valued and built on volunteers’ existing skills, strengths and experiences. This was then expanded by succeeding at volunteering and reinforced by strengths-based feedback from the coordinator. Programmes with a community development focus actively supported their volunteers to access more education and other opportunities, and some created employment paths within the programme. Participating as a volunteer could also lead to education, employment and career opportunities outside the programme.

There is also evidence that training and volunteering in health-related projects has a positive impact on the health and wellbeing of the volunteers and their children, for example, breastfeeding peer supporters felt able to breastfeed for longer than they had planned, and community health champions and community parents reported improvements in their own family diets (Briant 2005, Ives 2015, Suppiah 2008, White 2010).

The most important ways of achieving these good outcomes for volunteers were high quality training; a relationship of trust, rapport and respect between coordinator and volunteer; good communication from the project; and high quality supervision and support. In a study of five volunteer doula projects (Spiby 2015), volunteers who experienced poor communication, disorganised administration and no support became frustrated and demoralised. Where the volunteer had personal ‘lived experience’ of a particular issue (for example, a traumatic birth, difficulties breastfeeding, or mental health problems), it was important that both training and supervision sensitively offered the volunteer opportunities to debrief and reflect on their own experiences and to manage feelings and memories which might be evoked by supporting parents going through similar experiences. Easy access to the coordinator was very important when volunteers were supporting highly vulnerable families who might experience crisis issues where the volunteer felt out of their depth, but this could be problematic where the coordinator worked part-time (James 2013).

There were inevitably some negative impacts for volunteers that could arise in some projects, although these are much more rarely reported. These impacts were principally the stress of managing other time commitments such as work and family alongside supported parents’ desire for flexible support arrangements; and the frustration and disappointment that could arise when parents rejected the offer of help, refused to open the door, didn’t turn up to appointments or were uninterested in forming a relationship with the volunteer (McInnes 2001, Murphy 2008, National Literacy Trust, 2012). Some volunteers referred to the stress of being exposed to traumatic experiences, or feelings of loss when their volunteering relationship with a parent came to an end, but noted that these feelings could be managed through timely support from the project coordinator (Spiby 2015).

Into practice ...

Strengths-based coordination, training and supervision of volunteers play a large part in providing a rewarding and empowering journey for each volunteer. Volunteer programmes that involve people with ‘lived experience’ of an issue need sensitive training programmes and coordinators who are readily available to debrief and support volunteers when they need it. Programmes need to anticipate that not everyone’s volunteering experience will be positive and some of the reasons for that will be beyond the programme’s control.

Question 8: What evidence is there for how new emerging technologies might be used to support volunteers, peer supporters and community champions?

We did not find any examples of specifically *new* emerging technologies in the domestic evidence that we reviewed. However, volunteers and parents supported in one-to-one programmes generally use mobile phones, which makes it easier to contact each other and, in some programmes, means that the person they are supporting can text/call any time of the day. Technology is also used for health and safety reasons, for example, when on home visits or out of hours when volunteers have to phone in every hour to confirm they are okay – this can be outsourced to a professional company (Spiby 2015).

There is anecdotal evidence that volunteers and supported parents look at on-line videos together as a means of finding out information and learning together. Use of other technologies, such as Google hangouts or blogging, may have potential for offering peer support in different ways.

There are national support mechanisms available through social media groups such as Mumsnet and Netmums (e.g. Action on Postpartum Psychosis) that illustrate self-help gained through mutual support via ‘chatting’ to other parents online. Steps are taken to ensure safety, for example, Mumsnet has a policy to keep their intervention to a minimum and ‘let the conversation flow’. However, they will remove postings that are obscene, contain personal attacks or break the law – so quality moderation is in place.

While this is not formal volunteering, this method can link mothers up with anonymous on-line peer support and has the benefit of being able to provide instant and timely access to information and perhaps reduce social isolation or postnatal depression as a result, even, for example, providing early help to prevent problems such as postnatal depression escalating (although a reliable study has not confirmed this). Another key feature is that these websites provide valuable signposting to services in a particular area/locality. This way of providing support may be suitable for a range of situations as a reference point, even as a resource that sits alongside a peer-led intervention, or introduces/follows it, rather than as a standalone ‘service’ or intervention in its own right.

The Parents Informal Network for Early Childhood Learning (PINECL) brings together a number of technical and pedagogic elements that can be utilised to support the development of children. The PINECL project seeks to improve existing practices where early childhood development and learning is concerned, especially in rural areas, with an ultimate goal of impacting policy which governs the delivery of key early childhood development services. The project supports parents in rural communities providing them with a range of early childhood development resources as well as providing an online platform to help connect parents from disadvantaged rural areas with key professionals and service providers. As ICT and social media are extremely important elements of modern society the PINECL project promotes the development of key digital competences to enable parents and service providers to engage through micro social networks like the ‘*Parents Academy*’ online resource that the consortium have developed.

The pregnancy to 6 months Baby Buddy phone app is approved by professional bodies representing midwives and health visitors, the Department of Health, etc., and, in some areas, is part of the maternity care pathway for pregnant women and new mothers. Peer supporters have started to use this app in a positive way with the parents they support:

'Feedback has been extremely positive. Peer supporters have frequently commented on how useful the breastfeeding videos are as well as infant feeding messages that are pushed through "Today's Information". Furthermore, the inclusion of localised information about support groups that are run by peer supporters, into the "Bump/Baby Around" function is seen to be of real benefit to local new and expectant mums. It is viewed as a valuable resource to support their work' [<http://www.bestbeginnings.org.uk/babybuddy>] [Last accessed 23 November 2015].

Into practice ...

Many schemes have found that Facebook and mobile phones are useful for volunteer recruitment and keeping in touch. And some programmes thought that they could gather evaluation data via, for example, tablets or mobilephones. 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!

Question 9: What are effective strategies for engaging parents and aligning volunteer and parent goals and expectations?

Projects reported varying success in engaging parents, both in making the initial contact and in subsequently maintaining the engagement. 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 opposition from family members (MacPherson 2010, McLeish 2015, Murphy 2008).

Effective strategies for initial engagement were:

- 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. Granville 2012, Murphy 2008, National Literacy Trust 2012, Spiby 2015, Suppiah 2008).
- 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 frustration and disengagement (McPherson 2010).
- Multiple routes for parents to access the project, e.g. 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).
- Building up a positive reputation and visible local presence (Suppiah 2008, Turner 2012).
- Making the informal and non-professional nature of the support explicit, i.e. not health or social care professionals – this was experienced as unthreatening, particularly for parents who perceived professionals as focused on parenting deficits and potentially looking for reasons to take their children into care (McLeish 2015, White 2010).

- Offering services based at a community hub that was separate from health and local authority services – these were seen as threatening by some vulnerable or excluded families (Bhavani 2014a).
- Offering peer support from people with ‘lived experience’ of the parents’ own issues – this could give parents the assurance they would be understood and not judged or patronised, and was felt to give information from the volunteers more credibility (Fox 2015, Marden 2014, McLeish 2015, Murphy 2008, Turner 2012).
- Parents who were from BME communities might access support when it was offered by someone from their own cultural and language background; conversely, offering volunteers who were not from the same minority community made the support acceptable to some parents who were worried about community gossip and stigma (Lederer 2009, McLeish 2015, Muller 2009).
- Offering support in a group – some parents were attracted by the possibility of social support from group members and found this less socially risky than a one-to-one support (Bhavani 2014a, Briant 2005, Fox 2015, Hoddinott 2006). However, offering one-to-one support was very important for parents who lacked the confidence to attend groups, and was sometimes offered as a phase before group support (Bhavani 2014a, Granville 2012, McLeish 2015).
- Offering support at home – this could engage parents with chaotic lives who do not always keep appointments, although some parents could potentially perceive this as intrusive (Barnes 2006b, Granville 2012, Spiby 2015).
- Having a ‘brand identity’ that was warm, positive and normalising, and avoided stigmatising language (e.g. did not prominently reference problems such as mental health) (Robinson 2014).
- Projects needed to explain clearly to parents what they could offer, without losing the flexibility of personalised support (McLeish 2015).
- For breastfeeding support, face-to-face contact while the mother was still in hospital after birth (e.g. Western Health and Social Care Trust 2015).

Effective strategies for ongoing 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, focused on strengths not deficits, and generous with their own time; and parents experienced this as being completely different from professional support (Barlow 2012, Granville 2012, Marden 2013, McLeish 2015, Suppiah 2008). Where volunteers were perceived as unreliable, parents were dissatisfied (MacPherson 2010, Spiby 2015).
- The careful ‘matching’ of volunteers to individual clients, although this could also raise expectations about the relationship that were not always met (MacPherson 2010, Spiby 2015).
- 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).
- Helping the parent to find solutions to their pressing practical and emotional problems, through mentoring, goal setting and review, or active practical support, even if these were not directly related to their child (Kenkre 2011, McLeish 2015).

Studies have found that more socially, educationally and economically disadvantaged parents were less likely to engage, but that 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).

Aligning parent and volunteer goals and expectations

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

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

- Clear statements of project boundaries (for example, 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 and might want or need to take extended periods off volunteering (e.g. school holidays). Clear guidelines from the project may help plus back-up from the project staff (MacPherson 2010, McLeish, 2015).

Into Practice ...

There are many different routes to successful engagement and each programme needs to tailor their 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'; and communicate clearly and from the start how the programme will work, what is likely to be involved, and what is expected of the parent and of the volunteer to make the relationship work.

Question 10: What systems (i.e. funding, accountability, governance, structures and communications) promote good relationships, cooperation and trust between volunteers and professionals/paid staff?

There is considerable tension with health professionals detected (Suppiah 2008, Curtis 2007), but perhaps this is inevitable and highlights the need to promote a greater understanding of the parallel and complementary roles of volunteers and professionals. A poor understanding of the offer from volunteer programmes is likely to lead to non-referral, in spite of best efforts to bridge gaps, promote the approaches and emphasise the value. So, it would seem important to be aware that some professional resistance is inevitable and to put in place plans to mitigate this. Within any local area key partners should be engaged at the outset enabling a more holistic, cross sector and multi-agency route to the support being offered. Systems that promote collaborative working but also ensure the integrity of the project should be integral to the design of a programme. The altruistic desire of parents to support other parents should be acknowledged and valued. The 'gatekeeping' nature of professional resistance that is often experienced can be reduced by articulating to professionals the clear boundaries, ground rules, robust training and supervision and showing that their professional authority/status/competence is not being challenged. Showing how the volunteers can contribute to the shared endeavour of improved outcomes for children and how they can alleviate pressure on professionals can also be reassuring. It is also important to engage influential local professional as champions for programmes (for example, on a steering group) and some programmes have professionals buy-in to the programme by contributing to volunteer training; or by having volunteers/service users contribute to professional training.

One factor that seems noteworthy is that large impersonal programmes are less likely to engage with those they need to, and therefore develop those necessary relationships that bring about change – *'a project should not be allowed to develop beyond its means'*. Expertise and experience of community development is frequently referred to (Bhavani 2014a, Suppiah 2008, Turner 2012). Ensuring this is a project component will help secure a strong and authentic value base at the centre of a programme that brings with it knowledge of the best methods and pathways into communities and those 'beneficiaries' the initiative is seeking to support. These sorts of skills can provide benefits beyond the programme itself. For professionals it was commented that there was the associated 'credibility' of being connected to an experienced community organiser (or similar) who understands the best ways to engage with women in a particular locality (Raine 2003).

Establishing quality standards is also crucial, especially with respect to coordination (Taggart 2000). So across the programme delivery there need to be clear procedures and guiding principles. Communication arrangements need to be embedded into organisational systems with clear lines of responsibility at each level. These need to facilitate adequate training, ongoing education, and skilled supervision of volunteers, which are vital to the success of the project. There are benefits to volunteers and professionals alike from investing time in regular communication (Schmied 2011).

There are limited examples of the governance of relationships between volunteers and professionals. Here we identify some programme elements that contribute to governance:

- Volunteer coordinator provides a bridge between volunteers and professionals; and protects the integrity of the initiative, for example, by avoiding professionalising the volunteer role.
- Projects concentrate on making themselves easy to access and recognise that referrals by professionals aren't key.
- Funding is proportionate to the size, complexity and intensity of the programme.
- Ensure development of both volunteers and professionals is ongoing (Curtis 2007).
- Recognise the potential of volunteers to articulate parents' experiences of using services – they need to be free to share, to be heard and for this to influence how services are delivered.
- Manage and vet referrals – ensure professionals don't pass over inappropriate responsibility to a volunteer; the systems need to be in place to protect against misuse.
- Importance of safeguarding and information sharing procedures and protocols.
- Professionals are more confident when reassured by boundaries, training and strong supervision.

Into Practice ...

The 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: setting boundaries; creating a shared understanding of how the project works and the ideas that underpin it; enabling parents and volunteers to build an equal relationship. 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.

Question 11: What governance arrangements are needed to ensure the safety of children, service users and volunteers and maintain high quality support?

There is limited evidence available from the searches to date that inform us about effective governance arrangements around safety and high quality support however there is sufficient proof to support the fact that the role of the manager and/or coordinator is pivotal and that repeated underfunding can jeopardise safe and effective practice. To add, the evidence around building relationships between paid staff and volunteers and the necessary structures is fairly well documented so the 'building blocks' are there but a more targeted approach to the research is likely to be required.

At a practice level, EPEC, for example, has strict governance arrangements that require DBS status, regular observation of practice, attendance at supervision, etc., for EPEC facilitators. Core elements of Community Parent Programme ongoing training and supervision processes aim to ensure safe practice is adhered to, i.e. emphasising and reinforcing the boundaries and responsibilities of the peer support role; safeguarding processes for vulnerable adults and children; and programme values, standards and procedures (Suppiah 2008). Parents 1st staff '*support the volunteers with child protection and safeguarding issues, offering guidance to the volunteer, reaffirming their role and attending case reviews with them ... volunteers feel confident carrying out their work with more vulnerable families because of the level of support that is provided*' (Granville 2012, p. 48). And, in the Doula Project, there are examples of governance in relation to the safety of volunteers with respect to lone working

(see, for example, Spiby, 2015). A need was identified for a system to monitor volunteer safety when on visits/night working, e.g. phoning in at pre-agreed intervals, but it was also acknowledged that this can be expensive and time-consuming.

Some key components therefore are summarised as:

- Clear volunteering policies and procedures, particularly in relation to safeguarding vulnerable children and adults, lone working, health and safety, confidentiality, information sharing and duty of care.
- Ensuring volunteer coordinators and trainers have the necessary competencies, knowledge and experience to ensure safe practice as well as strengths-based supervision.
- Adhering to national standards of best practice, e.g. Investing in Volunteers standards.
- Process and quality evaluation should be built in and appropriate to the initiative.

Currently, there is nothing further to add to this question due to the lack of evidence that was available through the research. The Investing in Volunteers standards however are a key source of support and guidance and will be flagged to those sites not already referring to them:

http://iiv.investinginvolunteers.org.uk/images/stories/iiv_standard_revised_jan_2014.pdf.

Into Practice ...

Work with vulnerable families is demanding and safeguarding is important; the role of the manager/coordinator is pivotal and they must ensure that volunteers have suitable training, clear boundaries and proactive supervision throughout any programme (Bhavani 2014a).

Part Four: Examples of relevant programmes

Name	Type of evidence	Description	Training	Impact
NCT Birth and Beyond Community Supporters	Mixed methods based on before/after project data; parent & volunteer questionnaires; qualitative interviews with participants and stakeholders	Volunteer/peer 1:1 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. Volunteers had increased self-confidence and self-worth and many went on to education/employment.
Family Action (Newpin model) Perinatal Support Project	Mixed methods based on before/after project data; qualitative interviews with participants and stakeholders	Volunteer 1:1 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. Volunteers felt empowered and more confident; had improved relationship with own family.
Home Start	Cluster randomised study; quasi-experimental study; studies using before/after project data; qualitative interviews with parents & volunteers	Volunteer 1:1 weekly home visiting for vulnerable families with a child under 5; offering social and practical support.	40 hours	In the UK the model has not been shown to have an impact when assessed by cluster randomised study, but mothers consistently report that they value the support, are less stressed and better able to cope. Volunteers have increased self-confidence and skills and improve own parenting skills.
Goodwin Doula Project	Mixed methods based on project data analysed with comparison data sets; parent & volunteer questionnaires; qualitative interviews with stakeholders	Volunteer 1:1 regular home visiting for vulnerable/isolated women during pregnancy and up to 6 weeks postnatal, plus support during birth.	75 hours (accredited)	Mothers are more likely to start and continue breastfeeding; they feel more knowledgeable, confident and skilled as parents; they feel less depressed and have increased emotional wellbeing. Volunteers have increased knowledge, confidence, sense of achievement, parenting skills, opportunities for work or education.
Warrington Bosom Buddies	Project data	Breastfeeding peer support. Volunteers support by home visits, phone calls, at breastfeeding support groups, speak to women before birth, work on postnatal ward.	Delivered over 8 weeks (based on UNICEF training)	Mothers are more likely to start and to continue breastfeeding, especially mothers from poor areas. Some volunteers have gone on to midwifery.
Empowering Parents, Empowering Communities	Randomised controlled trial using waiting list as control group	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, although no impact on parental stress.

Early Words Together (built on Literacy Champions) National Literacy Trust	Mixed methods based on project data; before/after standardised assessment of vocabulary; qualitative interviews/focus groups with parents	Parent champions. 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 have improved understanding of spoken language and enjoyment of books and songs, parents have more confidence in sharing books, increased parent/child talk.
Community Parents Programme (Parents 1 st)	Collective multi-faceted participatory evaluation involving 10 programmes including before/after data (parents with children post birth to aged 2); Pregnancy, birth, post birth model: study using mixed methods based on project data; qualitative interviews with parents, volunteers and stakeholders	Volunteer 1:1 support. Regular, fairly structured home visiting for vulnerable/isolated parents enabling them to set and achieve self-identified ongoing goals; 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; mothers had more time in their day to eat properly and for meeting others in their community. (Pregnancy, birth, post birth model): Mothers had improved confidence and emotional wellbeing and were more likely to continue breastfeeding. Volunteers had increased self-confidence and skills, opportunities for work or education.
Altogether Better Community Health Champions	Mixed methods based on project data; case studies; qualitative interviews with stakeholders	Community Health Champions (Not parent-focused). Volunteers either spread health messages among own social networks, or started up healthy group activities.	Between 0.5 and 14 days	Volunteers had increased self-confidence and skills, opportunities for work or education. Limited evidence for impact on others.
HENRY Parent Champions	Qualitative interviews with parents, volunteers and stakeholders (incomplete project report seen in draft)	Volunteer-led activities in the community to support a healthy family lifestyle, e.g. play sessions in the park, cooking sessions, fruit and vegetable tasting, Zumba sessions, etc., as well as recruiting and buddying local parents to attend HENRY group programme.	18 hours (accredited)	Parents engaged in a range of accessible activities in the community that support a healthy lifestyle. Volunteers had increased self-confidence and skills, opportunities for work or education. Volunteers made improvements to own family eating habits.
HENRY Healthy Start Mentors	External evaluation still underway	Structured volunteer-led delivery of HENRY evidence-based <i>Healthy Families</i> programme – working 1:1 with vulnerable families in the home over 8-10 weeks – especially focused on parents from diverse ethnic backgrounds and/or for whom English is an additional language	30 hours (accredited)	Anecdotal findings to date: <ul style="list-style-type: none"> • Parents value being supported in own language/by someone from within community. • Positive changes to family lifestyle habits, eating and activity – as well as parenting efficacy.

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

- Diet and Nutrition
- Communication and language
- Social and emotional.

In addition to the interventions and outcomes above, the 13 indicative questions outlined by the Big Lottery in the invitation to tender also formed part of the broader framework around which the evidence review methodology was grown. The questions were:

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 for 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. Criteria for Inclusion

Our review of the literature concentrated on research published in English from the 1990s onwards. Given that cultural, social and economic variations bring about different relationships between child care and developmental outcomes, we purposefully selected evidence sources from countries with similarities to the UK. These included North America, Ireland, Australia, the Netherlands and Finland.²

Given that our research questions were grown around the broader question of ‘what works’, we used the hierarchy of evidence schema to guide our understanding of the standards of evidence of the various practices and projects of the research literature (Nutley et al, 2013). In this respect, different levels and types of evidence have been engaged for the purposes of this review. Randomised control trials and non-randomised controlled studies were recognised by the research team as producing interventions that can be evaluated in usual conditions, that are more generalisable, and, as such, as being sources of evidence normally regarded as ‘strong scientific evidence’ (see Section 3 below which describes the quality review process). ‘Highly processed evidence’, such as systematic reviews, that do not rely on primary outcomes and reduce bias by consolidating the findings of a number of studies, were also recognised and integrated as examples of robust evidence. The research team acknowledged that there were limits to the ‘strong scientific evidence’ within the literature body and that much of the research evidence was in fact qualitative (examples of strong and weak qualitative evidence were found) or descriptive in nature. Therefore, the review also included any research, irrespective of the methodological approaches used, that related to the research questions, and that met our quality and value criteria as ‘good enough’ evidence. A total of 267 studies were included following our quality review process.

Given that there is a lack of clarity in the literature around how an intervention is defined and, as an extension of this, what an intervention does, and at what time points, we adopted a wide definition of intervention throughout the review process. We included

² However, that is not to suggest that these are easily transferable. Indeed, it is unclear, and there is no existing evidence in the literature, to demonstrate the extent to which evidence from these contexts can be directly applied to the UK. They therefore have to be considered with a degree of caution and as indicative rather than definitive.

preventative interventions, interventions at the development of a potential problem, and those designed to support children and families once a problem has been identified.

2.1 Search Strategy

Before the review began, our expert advisory group recommended that we adopt a dual approach to our review strategy, entailing both searches of bibliographic databases and a call for evidence using our collective professional networks and a manual search for relevant organisations. Our call for information was sent out electronically via email and requested that organisations and individuals send us any published or unpublished material they had that was relevant to our research questions. We circulated our call for evidence to over 120 practitioners and professional organisations and received 34 pieces of potential evidence (see Appendix B for a list of organisations that we approached).

In Phase One of the review we directed a good deal of our attention towards the academic literature. We searched the bibliographic databases below. As we enter into Phase Two, these searches will be supplemented by reviewing the reference list of the sources we have so far included as a way of identifying any other relevant papers:

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

Given that this phase of the research required evidence to be collated in such a compacted time frame, we also made use of existing systematic reviews to guide our own review. Identifying the key sources of evidence from these accelerated the speed and efficiency of our searches.

An emergent finding from Phase One of this review has been that the grey literature is a valuable source for data relating to the 'process' questions of this review. In Phase Two, we will therefore continue to build on our searches of this grey literature by using the following electronic databases:

- COPAC Library Catalogue
- OPENSigle/Opengrey
- EU bookshop
- WHO
- UNICEF
- Social Care Online
- Social Science Research Network
- UK Institutional Repository Search
- www.gov.uk
- Department of Health <https://www.gov.uk/government/publications>
- Government Departmental papers from 2010

- Older Official Government Documents at the National Archives
<http://www.nationalarchives.gov.uk>
- Health Management Information Consortium
- NHS Evidence
- Childlink
- Google and Google scholar

2.2 Key Search Terms

The search terms used for the bibliographic databases were as follows.

	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		

Search Results

Our dual search strategy returned a total of 267 documents that were relevant to the review after screening over 25,000 documents including largely academic articles, but also systematic reviews, which were filtered for relevance and quality, using our search terms.

Of these, 236 were academic papers identified through our bibliographic searches and 31 were reports identified through our call for evidence or already known to the project team as being relevant to the evidence review aims and questions.

As is evident throughout the course of this Phase One report, the review has drawn largely from electronic sources. Given that this is a rapid evidence review, this has been a practical strategy as it has not been feasible to access sources that are less easily/readily accessible.

3. The Process of Quality Review

When we designed our search and quality protocol at the beginning of the review, we decided to use reliable quality assessment tools to appraise the methodological quality of the quantitative and qualitative research. The tools we identified were *Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence* (Spencer et al, 2003) and the NICE Quality Appraisal Checklists for quantitative approaches, such as those devised for intervention studies, correlations and associations and systematic reviews and meta-analyses. However, given that this review was a rapid evidence review with a very broad scope, it quickly became apparent that a full critical appraisal of all the evidence would be a time consuming and challenging/complex process. Indeed, we are a very small review team and had limited commissioned time to complete the work. We had to therefore find a suitable compromise between what was achievable and what was desirable. In this respect, we agreed to work with simplified/abbreviated filters and processes for appraising the evidence that we built up around the relevance and transparency of the evidence, its methodological robustness and data confidence. For example, we considered the following key criteria:

- Whether the aims and objectives of the paper were explicitly outlined and questions and hypotheses addressed
- Were interventions clearly defined
- If 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 conclusion
- Did the research address limitations and quality
- Whether there was clarity in terms of the position of the researcher(s) *vis a vis* the research subject.

Given that much of the quantitative research we found had already been appraised and included/excluded by the systematic reviews we also identified during our search a considerable amount of quality appraisal that had already happened. Much of the evidence base that we were reviewing tended to be of low quality and this is something that also

consistently appears as a finding in the systematic reviews. We found that this characteristic was also true of the nature of the qualitative research. The research team 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 multitude of studies of variable and largely low quality but that 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 sites to practically and theoretically reflect on their initiatives and operational and strategic context.

Appendix B: Organisations contacted in call for evidence

4Children
Barnardo's
Befriending and Mentoring Foundation
The Communications Trust
Early Education
Family Lives
Family & Childcare Trust
Health, Exercise, Nutrition for the Really Young (HENRY)
Institute of Health Equity (IHE)
Institute of Health Visiting (circulated to networks)
Locality
Maternal Mental Health Alliance
National Association for Voluntary & Community Associations (NAVCA)
National Childbirth Trust (NCT)
National Children's Bureau (NCB)
National Day Nurseries Association (NDNA)
National Early Years Trainers & Consultants (NEYTCO)
National Institute of Clinical Excellence (NICE)
National Society for the Prevention of Cruelty to Children (NSPCC)
NCIA
NESTA
Pen Green Research Centre
Pre-School Learning Alliance (PLA)
Professional Association for Childcare and Early Years (PACEY)
Queen's Nursing Institute
Royal College of Midwives (circulated to networks)
Royal College of Paediatrics and Child Health
Royal College of Speech and Language Therapists
UNICEF Baby Friendly Initiative (circulated to networks)
Volunteering England (as part of NCVO)

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