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PARAPROFESSIONALS' EXPERIENCES AND UNDERSTANDINGS OF THE MATERNAL INFANT HEALTH OUTREACH WORKER PROGRAM (MIHOW) IN WEST VIRGINIA

A dissertation submitted to
the Graduate College of
Marshall University
In partial fulfillment of
the requirements for the degree of
Doctor of Education
in
Curriculum and Instruction
by
Amy Knell Carlson
Approved by
Dr. Luke E. Lassiter, Committee Chairperson
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Dr. Karen McComas

Marshall University
December 2015

SIGNATURE PAGE

I hereby affirm that the following project meets the high academic standards for original scholarship and creative work established by my discipline, college, and the Graduate College of Marshall University. With my signature, I approve the manuscript for publication.

Project Title: Paraprofessionals' Experiences and Understandings of the Maternal Infant Health Outreach Worker Program (MIHOW) in West Virginia

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DEDICATION

This dissertation is dedicated to the home visitors of the West Virginia Maternal Infant Health Outreach Worker Program. Thank you for sharing your time and stories with me.

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I would first like to thank all of the home visitors who participated in this study. Thanks for every interview, every email, every observation, every phone call, and for every bit of time shared with me. This would not have been possible without their willing participation.

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that her class and her invitation to join the MIHOW qualitative research team were the most influential experiences I had during my time in the doctoral program. I feel so fortunate to have worked with her. Thank you.

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ABSTRACT

MIHOW, the Maternal Infant Health Outreach Worker Program, is a parent-to-parent home visitation program that aims to enhance early childhood development and parent education in economically disadvantaged and geographically isolated families with children birth to three. This qualitative case study conducted in two rural Appalachian counties examined the perceptions and experiences of paraprofessionals who are trained and work as home visitors in the MIHOW Program. Findings were interpreted in relation to extant literature on the use of paraprofessionals in home visitation. Three themes emerged from the data. The first theme related to the use of a strength-based approach and how it was implemented with mothers and with home visitors. The second theme related to the personal and professional support home visitors provided one another. The third theme was related to the training of the home visitors and how it was prescribed but yet customized. The findings provide new evidence that home visitors within the MIHOW program felt their training was effective and adequate to carry out MIHOW's mission, its principles, and its strategies.

CHAPTER 1

INTRODUCTION TO THE PROBLEM

Raising a child has unique challenges no matter life's circumstances. Children and families that come from the most bountiful and supportive environments find that child rearing is often an uncertain process that can be characterized by circumstances that range from difficult to rewarding. This process may even be more uncertain for families and children who come from low socio-economic backgrounds.

Children who come from low socio-economic homes are often raised in more stressful environments with fewer resources. It is no surprise that children brought up in these circumstances are often referred to early intervention or home visitation programs (Deutscher, Fewell, & Gross, 2006). Early intervention and home visitation programs have various goals and purposes, including education, prevention, or direct intervention services. In many cases paraprofessionals are the ones charged with delivering these services to families (Deutscher et.al, 2006).

From a review of the literature, the significance of the growing trend to use home visitation programs as a means of support within the early childhood years is growing. Home visiting has been advocated as a way to improve the outcomes of pregnancy, to reduce the rates of child abuse and neglect, and to help low-income families become economically self-sufficient (Olds, et al., 2002). One way that federal governments and state governments are attempting to support families and children in the early childhood years is by using home visitation programs to educate families about growth and child development (Manning, Homel, & Smith, 2010; Rickards, Walstab, Wright-Rossi, Simpson, & Reddihough, 2009). These programs typically

seek to prevent and/or promote optimal development for infants, toddlers, and/or preschool-age children. The use of paraprofessionals in home visitation programs are one of the most popular and high profile ways to implement prevention models (Tandon, Parillo, Mercer, Keefer, & Duggan, 2008). The training backgrounds of home visitors, however, seem to affect program success (Olds, et al., 2002). With the increased financial and educational interests for home visitation programs, the need to know that programs and paraprofessionals are operating effectively and efficiently has increased.

The literature on the effectiveness of these programs is mixed. Importantly, there is a significant gap in the current knowledge base about issues related to home visitation programs. Findings in the research related to issues such as the characteristics of home visitors and mothers and the differences between professionals and paraprofessionals implementing these services were inconsistent (Azzi-Lessing, 2011). The distinction between the professionals and paraprofessionals working within these programs is marked by an earned degree. Professionals are individuals who hold a degree, such as social workers, nurses, speech-language pathologists, occupational therapists, physical therapists, and early childhood professionals (Harden, Chazan-Cohen, Raikes, & Vogel, 2012). Paraprofessionals are lay individuals, members of a local community, or those individuals without a professional degree (Azzi-Lessing, 2011). This study looked at the paraprofessional side of home visitation as it related to the Maternal Infant Health Outreach Worker Program.

The Maternal Infant Health Outreach Worker (MIHOW) Program is a parent-to-parent home visitation program that originated at Vanderbilt University. The program targets economically disadvantaged and geographically and/or socially isolated families with children

from the ages of birth to three. The program is designed to improve health and child development among these families. MIHOW employs parents from the local community as outreach workers and role models, who educate families about nutrition, child health, childhood development, and positive parenting practices. The paraprofessional outreach workers, or home visitors, provide links to medical, community, and social services.

Statement of the Problem

The MIHOW Program in West Virginia is a home visitation program that targets families who are geographically isolated and economically disadvantaged. Like other home visitation programs, MIHOW focuses on both the parent and the child as part of its mission. Although MIHOW is one of many home visitation programs in existence, there is much that we do not know about the paraprofessional and their experiences related to training and working within these home visitation programs. Furthermore, there is much that we do not know about how those experiences influence their understandings of their roles and the work they do with children and families.

Harden, Chazan-Cohen, Raikes, & Vogel, (2012) showed that there is inconsistent evidence and documentation to suggest how home visitation programs accomplish the outcomes that are reported. The literature was inconsistent in understanding the comparison between service providers with and without degrees and their influences on parent and child outcomes of home visitation programs (Harden et al., 2012; Krysik & Lecroy, 2012). In addition, previous studies suggested that further research was warranted that examined the benefits of home visitation for children and families (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013). Peacock, Konrad, Watson, Nickel, & Muhajarine (2013) called for further studies using a

qualitative research method to better understand the benefits of home visitation and how the relationships between families and paraprofessionals influenced these program processes.

Furthermore, due to the large financial investment in these programs on both the national and state levels, further understanding of home visitation and how it influenced families and children was crucial. It would be unfortunate if the substantial investments of public funds in home visitation programs failed to reach and improve the life chances of these families. An overall study of MIHOW's effectiveness, titled *Evaluation of the WV Maternal Infant Health Outreach Worker (MIHOW) Random Control Trial Study*, administered by Marshall University faculty and students (of which I am a participant), was in part meant to study the effectiveness of the paraprofessionals delivery of services to mothers (Amerikaner, Spatig, Connor-Lockwood, Carlson, Bialk, & Kerbawy, 2015). But no study has been conducted on the effectiveness of paraprofessional training, and how, in turn, it related to this delivery. The problem of the research, then, was to focus on paraprofessional training and how it affected delivery of these home visitation services. In this regard, better understanding of how paraprofessionals experienced and understood their training and home visitation programs, experienced and understood MIHOW's mission, and experienced and understood their roles as individuals who are responsible for promoting language development was critical to apprehending the benefits of home visitation for children and families provided by MIHOW.

Methodical Framework and Research Questions

The methodological framework for this study was phenomenological, meaning that the primary purpose of the research was to understand how home visitors experienced and understood the MIHOW training and the MIHOW program as it related to language development

(Bogdan & Biklen, 2007). For this study I used a variety of data gathering techniques common to qualitative research methods such as interviews, document analysis, and observations (Maxwell, 2013). I interviewed home visitors from two MIHOW locations in rural West Virginia. I completed observations of a home visitor training session for paraprofessionals that enhanced my understanding of home visitation training and how it was experienced by MIHOW home visitors. I accessed written documentation of MIHOW training manuals and MIHOW curriculum guides. Document analysis can raise questions and hunches and thereby shape new directions for observations and interviews (Glesne, 2011).

This methodological approach guided the exploration of the following research questions:

1. How do home visitors experience and understand the mission of MIHOW?
2. How do home visitors experience and understand MIHOW specific strategies and principles learned in their training and preparation?
3. How do home visitors experience and understand the support they receive in their work with the program?
4. How do home visitors experience and understand their roles as paraprofessionals responsible for promoting language development?
5. How and to what extent do home visitors put MIHOW strategies and principles into practice in their home visitations?

Significance of the Study

The literature suggested that home visitation by paraprofessionals was an intervention that held promise for high-risk families with young children; however, further study regarding program fidelity, paraprofessional training and supervision, and how paraprofessionals

understood their roles and their training should be examined (Peacock et al., 2013; Ferguson & Vanderpool, 2013; Azzi-Lessing, 2011). The significance of this study, then, was to contribute to the existing knowledge base regarding home visitation, specifically by gaining knowledge about how MIHOW home visitation program training and support was experienced and understood by home visitors. In addition, the study looked at how MIHOW home visitors experienced and understood the program, how they experienced and understood their training, their support in working with the program, and how they experienced and understood their roles in promoting childhood language development. This study has potential for providing information about effectiveness of paraprofessionals and their roles in home visitation programs. It also has potential to contribute further insights and understandings on home visitation itself and the effectiveness of how services are delivered.

Organization of the Study

Chapter one detailed the introduction of the study. Chapter two will review the relevant literature. I surveyed current knowledge about home visitation and how paraprofessional training was understood and experienced within these programs. I also detailed how this training influenced home visitors' understanding of their role in promoting language development. Chapter three will provide a more detailed description of the methods to be used in this study. It will include a description of the research design, including data collection and data analysis techniques. Chapter four will consist of demographic information about the setting and biographical information about the key participants in the study. Chapter five will address the results of the research questions per the study's qualitative research findings. Chapter six will include an interpretation and analysis of these findings, including discussion of the implications

of the findings for practitioners and policymakers. This chapter will then conclude with suggestions for future research.

CHAPTER 2

LITERATURE REVIEW

For this study I reviewed the available literature on the effectiveness of home visitation programs, the effectiveness of paraprofessionals working in home visitation programs, the effectiveness of home visitation on child outcomes as related to language development, and the impact on-the-job style training and support has on paraprofessionals within home visitation programs.

Three topics, or themes, emerge within the literature as they relate to the issues being explored within the present study. They include: (1) effectiveness of home visitation programs utilizing paraprofessionals; (2) paraprofessional training and support within home visitation programs; and (3) home visitation and language development outcomes. I explore each of these themes in the literature review that follows.

Effectiveness of Home Visitation Programs Utilizing Paraprofessionals

Many studies have considered home visitation program effectiveness to be an essential part of successful home visitation program models. Many studies have also considered paraprofessional effectiveness and paraprofessional characteristics. Several pointed out that further development and evaluation is warranted when it comes to issues such as determining home visitation program effectiveness. Specifically, these studies call for further research on the impact of various factors including service dosage, levels of family engagement, program fidelity, and characteristics of paraprofessional home visitors (Ferguson & Vanderpool, 2013; Azzi-Lessing, 2011; Tandon et al., 2008). Recommendations within each of these studies are made for making improvements in all of these areas, to strengthen home visitation programs and

produce better outcomes for the children and families they serve. I am specifically interested in looking at the fidelity and effectiveness of programs that use paraprofessionals.

Home visiting is not a single service but rather a strategy for delivering services that enhance the health and safety of parents and children. A recent study by Azzi-Lessing (2013) examined the model of home visitation programs. Her research focused on improving the capacity of home-visitation programs to meet the complex and involved needs of highly vulnerable families with young children. She noted three aspects of home-visitation programs that are essential to improving home visitation program effectiveness: family engagement, matching services to families' needs, and finally, the characteristics and competencies of home visitors. Each of these aspects of home visitation programs and their respective roles in improving home visitation effectiveness are key to understanding how home visitation models can be improved. Azzi-Lessing (2013) states, for example, that "family engagement, formation of close relationships between home visitors and families, and employing engagement strategies that emphasize families' strengths and family empowerment are key to developing a successful home visitation program" (p. 379). As Azzi-Lessing points out, the needs of some families may exceed the capacity of paraprofessionals to identify and address factors such as maternal depression and domestic violence. Social workers with a bachelor's and/or master's degree may be the most well-equipped to serve families who display risk factors beyond a paraprofessionals' scope of training. Aziz-Lessing thus concludes with encouraging further research on identifying essential traits and/or experiences of paraprofessional home visitors who may increase their capacity to engage certain types of families.

Other studies that have looked at characteristics of successful and effective home visitors find that the experiences and type and amount of education and training contribute to home visitation effectiveness (Harden, 2010; Huang & Isaacs, 2007; Roggman, Boyce, Cook, & Jump, 2001). Many of the current prominent models of home visitation rely heavily on paraprofessionals. Most of those models have the assumption that families will relate best to service providers with whom they share similarities. There are a few studies within the current literature that support this assumption. Qualitative studies by Brookes et al., (2006) and Raikes and et al., (2006) suggest that similarities in home visitor's and mother's personalities, similarities in personal histories, and similarities in racial/ethnic backgrounds may increase levels of engagement between home visitors and mothers, especially in African American and non-English speaking Latino mothers (Brookes, Summers, Thornburg, Ispa, & Lane, 2006; Raikes, Green, Atwater, Kisker, Constantine, & Chazan-Cohen, 2006). Such studies open up new questions, however: Are high levels of engagement all that is required to qualify for what is deemed to be effective and successful home visitation services? Some of the literature suggests that this may not be entirely true in all situations.

Similarities between home visitors and mothers encompass just one aspect of what is required to deliver effective services to children and families at high levels of risk. Mothers may easily relate to home visitors with whom they share some characteristics, such as being a parent; however, as many studies illustrate, they typically need providers who have the capability to aid them in addressing their problems, as well as mentoring them in promoting healthy child development (Tandon, Mercer, Saylor, & Duggan, 2008; Hebbeler & Gerlach-Downie, 2002; Korfmacher, O'Brien, Hiatt, & Olds, 1999). Indeed, these illustrate that some of the needs of

highly vulnerable families may often fall beyond the capabilities of many paraprofessionals' experiences and trainings.

Following this line of argument, Hebbeler and Gerlach-Downie (2002) offer a longitudinal qualitative study that explores why a home visiting program was not more effective. The study consisted of a sample of twenty-one case study families and nine home visitors and occurred over a period of three years. Interviews with mothers and home visitors and observation of videotapes of home visits and child assessment were used to examine a theory of change for the program. The study found that home visits had a consistent structure and that the home visitors emphasized their social support role and placed little emphasis on changing parenting behavior (Hebbeler & Gerlach-Downie, 2002). Hebbeler and Gerlach-Downie's findings suggest that the need to critically examine the theories that underlie home visiting programs are crucial, and that the need to mentor and guide the day-to-day interactions of home visitors is absolutely essential for successful program implementation.

This study also identified some characteristics that were insightful when looking at the world of paraprofessional development. One interesting finding from home visitor interviews was the lack of willingness of home visitors to identify themselves as experts. Hebbeler and Gerlach-Downie found that home visitors were hesitant to call themselves experts and were uncomfortable as being cast as experts, especially experts on parenting, even though the parents saw them as such (2002). The authors found that "intervention programs that focus on parenting need to accept and support parents while actively helping them to adopt behaviors that have been demonstrated to promote healthy development and that the parents themselves want to learn" (p. 46). The researchers hypothesize that paraprofessionals within this particular program may have

exhibited that hesitancy because of their own confidence in their skills and abilities, or because of a lack of training that made them insufficiently able to recognize potential delays and other problems children and families presented. Regardless of the reason, the hesitancy to take ownership of the skills and expertise required to deliver effective and meaningful home visits could be affected by the paraprofessionals' own beliefs in their skills and abilities to do their jobs.

Studies exploring home visitation program effectiveness have found that the responses of home visitation programs to participants' identified needs varied. For example, needs more closely related to home visiting program goals of providing parenting education and promoting prenatal health were most often met, whereas needs less closely related to program goals (for example, life course needs such as information about job training or education) were less often met (Tandon, Parillo, Mercer, Keefer, & Duggan, 2008). Knowledge and understanding about how paraprofessionals succeeded at promoting maternal and child health outcomes were modest (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Gomby, 2007).

A study by Olds and Kitzman (1990) found that the more effective home visitation programs employed skilled and trained professionals—for example, nurses—who visited families frequently during pregnancy and following delivery of the baby. The authors stress not only an importance on the use of skilled and trained professionals, but also on the importance of dosage frequency. Visiting families frequently strengthened a therapeutic alliance between the mothers and the home visitor. This alliance improved the behavioral and psychosocial factors that influence maternal and child outcomes, such as increased parental responsiveness to the child's emotional needs.

Paraprofessional Training and Support within Home Visitation Programs

Home visiting has been promoted by organizations such as the American Academy of Pediatrics as an important complement to clinical based practices (American Academy of Pediatrics, 1998). The backgrounds of the staff charged with implementing home visitation, however, seems to affect program outcomes and success (Olds, Robinson, Song, & Little, 2000; Gomby, Culross, & Behrman, 1999; Olds & Kitzman, 1993). Reviewed research from randomized trials showed that paraprofessional home visitors have produced small effects that are rarely statistically significant (Olds, et al., 2000). This allows one to pose questions regarding paraprofessional training, personal backgrounds, and support received by the program models they are expected to deliver.

Many researchers have described that mothers may view their home visitors within a broad range of positive attributions. Effective home visitors have been described using characteristics associated with trust, empathy, warmth, conscientiousness, and the ability to nurture friendships (Rossiter, Fowler, McMahon & Kowalenko, 2012; Kirkpatrick, et al., 2007). Beyond the relationship and home visitor characteristics, however, the question of training and support still lingers. With this in mind, this section of the literature review highlights the training of individuals providing services.

Studies comparing the effectiveness of service providers with and without degrees and their influence on parent and child outcomes of home visitation have had inconsistent results (Peacock, et al., 2013; Tandon, Parillo, Mercer, Keefer, & Duggan, 2008). Importantly, David Olds and colleagues have completed extensive research that compares the field of home visitation. Significant portions of the research they conducted were focused on randomized trials

which examined the similarities and differences of programs utilizing professionals (specifically nurses) and paraprofessionals to carry out home visits. One specific study published in 2002 utilized a three-arm randomized trial in which paraprofessionals and nurses were provided well-structured home visit guidelines, training, and supportive supervision in a program model found to be effective when delivered by nurses in earlier trials. Olds and his colleagues hypothesized that if paraprofessionals could produce significant effects it would mean that they have the potential to achieve important effects on maternal and child health if they are trained to transfer proven home visitation models; however, if they produced minimal effects, it would indicate that lack of professional training in some way hampers their effectiveness (Olds, et al., 2002).

In another randomized trial study, by Olds et al. (2002), paraprofessionals improved mother-child interactions in which mothers had low psychological resources, and reduced rates of subsequent pregnancies and births. No other paraprofessional effects approached statistical significance. On the nurse-visited side of the trial, however, there was statistical significance for decreased use of tobacco during pregnancy and following delivery, subsequent pregnancies and births, mother-child responsive interaction, mental development, emotional development, and language development in children born to mothers with low psychological resources. It is important to note that for the majority of the outcomes on which nurses produced beneficial effects, the paraprofessionals' effects were approximately half the size.

This particular research study concluded with the suggestion that consistent evidence from future research studies is needed to support program models that use paraprofessionals in home visiting. In particular, the authors suggest that future research should examine home

visitation programs that use paraprofessionals to deliver services, those that are intended to promote the health and development of pregnant women and children.

The qualitative study mentioned earlier in this chapter—by Hebbeler and Gerlach-Downie (2002)—also cites home visitor training and background as essential elements for successful home visiting programs. Hebbeler and Gerlach-Downie state that home visitor training is critical when it comes to recognizing indicators of atypical development. In their study they found that most of the home visitors lacked the skills necessary to identify and properly refer for intervention services when it was necessary. Findings from this research suggest that it is not enough to have trained staff who understand how to implement a prescribed program. They also need to understand how the program is supposed to work, to understand the goals of the program, to understand the goals for parents, to understand the nature of intervention and/or prevention, and finally, to understand how to monitor effectiveness for each family and for the program overall (Hebbeler & Gerlach-Downie, 2002).

It follows, then, that adequate training is necessary for home visitors to be able to identify and address difficult problems such as developmental risk factors, substance abuse, domestic violence, and depression in the families they service (Damashek, Doughty, Ware, & Silovsky, 2011; Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Hebbeler & Gerlach-Downie, 2002). Possessing ability and knowledge in identifying and assessing these conditions is essential for home visitors to ensure that families receive services critical to their well-being. Home-visitor training should go beyond providing information on these topics and utilize case studies, role playing activities, and other training tools to equip paraprofessional home visitors with the necessary skills to provide effective prevention and intervention services (Tandon et al., 2008).

A powerful example is offered in a 2007 study by Deanna S. Gomby, who found that one aspect paraprofessionals bring to home visitation—one that seems to outweigh those of their professionally trained counterparts—is in the area of community resources. Often paraprofessionals are servicing areas in which they have lived or resided. This can bring about advantages for families who are looking for services and resources to aid them in raising and supporting their children. Gomby's (2007) research concludes that "home visitors who came from the community in which they serve had the necessary skills to navigate the systems and regulations required to assist families in accessing community based resources" (p. 797). This finding is consistent with the earlier qualitative research work of Hebbeler and Gerlach-Downie (2002). In their study, they also note that mothers reported that their home visitors had provided them with information and service referrals within the communities, often with services they never knew existed. In addition to the strength of paraprofessionals' community-based knowledge and experience is also the issue of cultural awareness, or cultural competence.

Dr. Gomby's work suggests that paraprofessionals and their supervisors can have a "culturally competent expertise when servicing families in communities in which they reside" (p. 795). Research by Roberts (1990) confirms Gomby's findings. Roberts found that community based home visitors have an ingrained expertise in culturally competent service delivery that supports families' cultural traditions, values, and beliefs. Roberts defines cultural competence as "a program's ability to honor and respect those beliefs, interpersonal styles, attitudes and behaviors both of families who are clients and the multicultural staff who are providing services" (p. 4). If paraprofessionals are familiar with the communities they service, then they would be more likely to have the necessary knowledge to link families to the available resources and

services within those communities. Roberts thus concludes that “a home visitor who is recognized as someone who shares similar values and traditions of the family can have positive outcomes on all areas of development” and that “early referral leads to early intervention, which leads to greater gains in development within the critical years of early childhood” (p. 5).

As previously mentioned, an awareness of family resources and community services are one of the believed pros of using paraprofessionals who reside within the community they serve. In addition to being more acquainted with possible resources, there is also the belief that paraprofessionals are sometimes more relatable to mothers who reside within rural and isolated areas. For example, in one three-year study by Heinicke, Fineman, Ponce, and Guthrie (2001) and Heinicke, Fineman, Becchia, Guthrie, and Rodning (1999), researchers looked at rural mothers and professional versus paraprofessional home visitation. The study targeted low-income, first time mothers, who received weekly and biweekly visits from a home visitor. This work yielded results that demonstrated improvement in maternal parenting behaviors when the home visitors were mental health professionals with a master’s degree in social work and trained in child development. Specifically, children in the intervention group were more likely to be securely attached, and the maternal parenting behaviors such as responsiveness and encouragement to succeed at tasks with their children were more positive with the intervention mothers than with control mothers (Heinicke et al., 2001; Heinicke et al., 1999). These studies further point out that while programs that employed mental health specialists had positive effects on the mothers and children they served, there was no evidence to conclude that home visitors from any one trained discipline are better than those of another. Given this, however, the researchers also suggested that the complexity of the issues faced within home visitation

demanded that home visitors need something beyond a high school diploma (Heinicke et al., 2001; Gomby et al., 1999).

Along these same lines, A.M. Culp and colleagues completed an experimental study that explored how first time mothers from rural counties in Oklahoma received home visitation services. The mothers in the experimental group received home visitation services and the mothers in the control group only received standard health department services without home visitation. Home visitors were all trained by the home visitation program using a curriculum that taught child development and parenting, that taught child and maternal health, and taught modeling parenting skills (Culp et al., 2004). The supervisors of the paraprofessionals held master's or doctoral degrees in child development and two years of supervisory experience. In general, the study revealed that intervention mothers utilized more community services, had safer homes, had a better understanding of parenting knowledge regarding child developmental expectations and were more accepting and respectful to their children (Culp et al., 2004).

Home Visitation and Language Development

Earlier analyses in the child development field have emphasized the importance of intensive, enduring home visitation, and of early education programs for young children (especially those deemed vulnerable or at-risk). Promotion of healthy and typical child development is often one of the reasons cited for the importance of early prevention services and programs like home visitation. One specific area of development that is of particular interest to my research interests, and to this study, is language development. Ample evidence suggests that home visitation positively affects outcomes of development—particularly cognitive and physical development, as well as mental health and, importantly, safety of the child (Peacock, Konrad,

Watson, Nickel, & Muhajarine, 2013; Gomby, 2007; Lagerberg, 2000; Gomby, Culross, & Berhman, 1999). But evidence supporting how language development impacts children similarly is lacking. For the purposes of this study, I am thus interested in how paraprofessionals view their roles in the promotion of language development within the context of home visitation. The remainder of this literature review focuses specifically on this research problem.

Various studies by Olds and colleagues reviewed randomized trials of prenatal and infancy home-visitation programs for socially disadvantaged women and children. Beginning with research from 1990, Olds and Kitzman (1990) found that home visitation programs were a promising means to pursue and promote the outcomes of parental caregiving associated with positive child health and development outcomes. But they found that language development was not viewed as being an area of development as advanced as the gains in other areas of development such as social and emotional development.

Following in this vein, Olds, Kitzman, Cole, and Robinson (1997) explored the theoretical foundations of home visitation programs that used both professional and paraprofessional staff to carry out services. These studies found that while both professional and paraprofessional home-visitation programs were effective in improving women's health-related behaviors during pregnancy—such as low birth weight—no definitive findings could support developmental outcomes specifically related to language development as major influencers in either type of program. In fact, Olds et al. (1997) conclude that “when trained within a model program of prenatal and infancy home visiting, paraprofessionals produced small effects that rarely achieved statistical or clinical significance” (p. 486).

Another study conducted by Dr. Olds and his colleagues, in 2002, also examined the effectiveness of home visiting by paraprofessionals and by nurses as separate means of improving maternal and child health outcomes. Olds and colleagues conducted a randomized, controlled trial study of home visiting by paraprofessionals and by nurses. When comparing families who received services from nurses and families who received services from paraprofessionals, results showed that childhood language development for nurse-visited families yielded superior language scores on testing than those scores from paraprofessional visited families (Olds et al., 2002).

A related study by Westerlund and Lagerberg, which analyzes expressive vocabulary in eighteen month-old children from low socioeconomic backgrounds (2008). The researchers found that the communication style of the primary caregiver, specifically the mother, to be the core factor in promoting language development within children. We know that a child's language is enriched when parents are consistent with labeling, commenting, and identifying within the presence of their child and their environment. This knowledge is one reason support for home-visitation parent education programs exist. Westerlund and Lagerberg (2008) found that contrary to demographic factors, communication styles can be influenced and improved in parent and child interaction. In fact they state that "We strongly recommend organizations working with parents and children to develop methods for encouraging parents to communicate positively with their children" (p. 265).

Westerlund and Lagerberg are just one example of many studies that have illuminated the strong link between socioeconomic status and children's expressive language output. Some of these many studies, including ones by Locke, Ginsborg, and Peers in 2002, Bornstein, Haynes,

and Painter, in 1998, and Hoff-Ginsberg in 1998, found that a key factor in improving expressive language skills in children is the amount and complexity of verbal communication accessible to the child. This is not new information, of course, but it should be noted just the same to serve as a reminder of the importance of parental language and communication styles in language development.

Communication styles that invite the child to take part in conversations, that describe and explain what is in their immediate environment, are likely to expand concept formation and linguistic capacity (Manolson, 1992). Mothers that come from low socioeconomic backgrounds tend to demonstrate directive communication styles according to a study by Hoff-Ginsberg. A directive communication style is one where language is not linked to the child's current attention or interest. Instead, it is language in the form of requesting and expecting a desired response (Hoff-Ginsberg, 1991). Language in the form of requesting and asking questions has not been linked to expand a child's understanding and use of any of the five parts of language development. Furthermore, research supports that mothers from low socioeconomic backgrounds are more likely to use what is called "empty-language" with their children, using terms such as "this" or "that" instead of complex and specific language (Landry, Smith, & Swank, 2002). Westerlund and Lagerberg found that children from high-risk backgrounds can achieve greater gains in expressive vocabulary when mothers are taught and encouraged to use descriptive language and highly verbal communication styles with their children (2008). One measure they cite as to how to encourage and teach this style of communication to mothers from low socioeconomic backgrounds is through the use of home visitation programs.

> Contrary to age, education, gender and birth order, reading and communication style are open to influence and change. Parents of young children are highly motivated to receive information that may benefit their child's development. Stimulating parents to observe, comment upon and encourage the child's talking appears to be a highly relevant task for professionals in early childhood education, healthcare services and home visitation settings. (Westerlund & Lagerberg, 2008, p. 265)

Given the role of language development in a child's development, many studies on paraprofessionals, perhaps paradoxically, did not focus specifically on the child; instead they examined the influence of home visitation on the mother or the family (Harden, Chazan-Cohen, Raikes, & Vogel, 2012). Within these particular publications, results and findings stated an association between home visitation and improved health outcomes related to birth weight, social-emotional development, and cognitive development (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013; Ferguson & Vanderpool, 2013). It should not come as a surprise, then, that the outcomes for language development are mixed.

Many researchers suggest that further and specific research is needed in the areas of language development outcomes and home visitation. Peacock et al. (2013), for example, found that while home visitation by paraprofessionals is an intervention that holds promise for high-risk families, it has shown little improvement in the domain of language development. It may be related to improvements in cognition and a reduction in problem behaviors. This, of course, leaves questions of language development unclear. Related to this, Ferguson and Vanderpool (2013) also found that there is a research disparity pertaining to the influence of home visitation on child outcomes, including language development, following birth.

Summary

The extensive body of current research that examines home visitation services effectiveness, the use of paraprofessionals within these programs, paraprofessional training and support, and the role of paraprofessionals in language development illustrates the importance of intervening early in the lives of vulnerable children and families. The literature demonstrates and advocates home visitation as a way to improve the outcomes for pregnancy, to reduce the rates of abuse, to reduce neglect, to educate families on childhood development, and to reach positive developmental outcomes for children.

What remains unclear is who, if anyone, is better at providing these services — professionals who hold a degree in a field related to childhood development and/or health care, or program based trained paraprofessionals who hold no formal degree? This question is not one that will be specifically addressed, *per se*, in this research study. But I raise it because I believe it underlines the questions I do want to explore. How do paraprofessionals experience and understand their own training and support? What are their experiences and beliefs with training, with home visitation, and with providing support for a child's language development?

The literature clearly illustrates the potential benefits of home visitation but the degree to which prominent models of home visitation have the capacity to meet the needs of children and families they serve warrants further research. By knowing more about the paraprofessionals' experiences and understandings we can better identify the potential strengths and potential weaknesses for programs utilizing paraprofessionals as home visitors. Further study is needed to help policy makers, educators, and program planners understand why there are mixed results

from studies that simultaneously show the benefits and pitfalls of using paraprofessionals to implement home visitation curriculum and program models.

CHAPTER 3

RESEARCH METHODS

The proposed study used qualitative research methods to gather and analyze the collected data. Qualitative research approaches focus on firsthand experience and meaning, and because I was most interested in how home visitors experienced and understood their roles as paraprofessionals, these methods were most appropriate for this particular study (Azzi-Lessing, 2011). Qualitative research methods, of course, include formal and informal forms of interviewing, collection and analysis of various kinds of documents and artifacts, and participant observation. I focused this qualitative approach, however, via a research strategy known as a collective case study, also called "case-based research design." As suggested by Yin (2002), a case study/case-based research design is often utilized when the researcher seeks to answer specific how or why questions about the experiences and meanings of programs and practices, such as that I sought to address herein (see chapter one). Using this framework as my guide, I used direct participant observation, face to face and telephone interviews, and document analysis to examine the experiences and understandings of home visitors related to their training, the support they receive, and the implementation of MIHOW language development curriculum.

Research Context and Study Design

This study was part of a larger mixed methods program evaluation study titled the *Evaluation of the WV Maternal Infant Health Outreach Worker (MIHOW) Random Control Trial Study,* led by Dr. Marty Amerikaner and Dr. Linda Spatig. I have participated as part of the qualitative research team over the past three years. The larger team conducted a randomized control trial mixed methods evaluation study of the West Virginia MIHOW program, under a

contractual agreement with the West Virginia Department of Health and Human Resources (DHHR). The purpose of the qualitative component of the West Virginia MIHOW research was to understand how the program was experienced and perceived by the people who are involved in the program on a day-to-day basis, namely participating families and MIHOW staff. The goals of the study's qualitative component were to provide information and insights into what was helpful in explaining quantitative research findings, as well as what was helpful to program designers and implementers in their efforts to make the program as effective as possible. The qualitative research team carefully and systematically analyzed data and found themes that reflected the experiences of the people intimately involved with the MIHOW program.

The research design for my study expanded on this program evaluation. My study was a phenomenological, collective case study. According to Glesne (2011), a collective case study is one where the researcher examines multiple cases to investigate a phenomenon or a general condition of a specific population. The phenomenon of interest in this study was participants' perceptions and experiences with paraprofessional training and support within the MIHOW Home Visitation Program, and how they viewed their role in promoting childhood language development. Extant data from the larger study was utilized to provide larger context and analysis.

Settings

The settings for the study were two MIHOW Home Visitation Programs located in rural West Virginia. The West Virginia DHHR chose the selected MIHOW sites from five of the state's MIHOW centers. At the time of this study the two selected sites were the only sites in West Virginia which had received accreditation from the MIHOW center located at Vanderbilt

University. In addition to accreditation status, the two selected sites were also the most established and longest running sites in West Virginia. The "Blue Lake" program was located near Beckley, West Virginia. The "Mountain Ridge" program was located in a small town in northern Mingo County. Both sites are rural, economically disadvantaged, and socially isolated areas of West Virginia.

Sampling/Participants

Participants in the study included home visitors who worked in one of the two West Virginia MIHOW locations selected for this study. The sample consisted of six home visitors who worked as home visitors for a minimum of two years at one of the two designated sites. I ensured equal representation of both sites in the sampling of participants. Purposeful sampling practices were used to select home visitors for interviewing. It should be noted that the emerging design of the research required flexibility because the home visitors sampled could have quit their jobs at any time during the course of the research and therefore be unavailable for follow-up interviews.

Data Collection and Analysis

As previously mentioned, I implemented a phenomenological qualitative research study via the framework of collective case study to explore the proposed research questions. I collected data from home visitors via multiple collection methods, including (1) face to face and telephone interviews, (2) document analysis, and (3) participant observation of home visitor training sessions and of a MIHOW home visit. This section expands on how I utilized these methods in the research study.

A critical component of a collective phenomenological case study is interviewing (Bogdan & Biklen, 2007). Interviews, then, took a central role in this study, and were completed with home visitors from both West Virginia MIHOW sites. As they related to my research questions, interviews served as valuable ways to collect data and gain descriptions of actions, feelings, events, and/or situations that I was not be able to access via observations alone.

I completed both face to face and phone interviews. Interviews were semi-structured, in that they were designed to prompt both closed and open-ended responses from participants. Importantly, however, unstructured, open-ended questions were the primary focus of my interview guides and questions. The typical in-depth, unstructured interview aims to elicit stories of experiences. Interviews are one data collection method that aims to gain direct access to an interviewee's experiences and understandings through stories.

As important as interviews were to this study, multiple data collection methods were also critical to this particular qualitative study. Joseph Maxwell (2013) argues that the use of multiple collection methods allows researchers to regularly check, support, and identify the different strengths and/or limitations of data and drawn conclusions. One method that allowed me to do just this was document analysis, procedures involved in analyzing and interpreting data generated from the examination of documents, records, and other forms of written materials that were relevant to a study. For the purposes of my study, document analysis was useful as a means of examining the established MIHOW paraprofessional training protocol, and the MIHOW curriculum as it related specifically to language development.

Another data collection method I used was participant observation. Participant observations in qualitative studies, of course, are critical because they allow a researcher to

carefully observe, systematically experience, and consciously record in detail the many aspects of a situation, especially as it relates to other data collection methods such as interviews and document collection and analysis (Glesne, 2011).

In this study, extant data generalized as a result of observation of training sessions and of home visits was utilized. I observed multiple home visitor training sessions and one home visit at each of the two selected West Virginia MIHOW sites. I also observed an annual initial training session. Each observation was documented with field notes, which, along with data generated by interviews and document analysis, provided the necessary data needed to conduct the final data analysis of the collected materials.

Analysis of the data—in this case, of interviews, observations, and documents—was the activity of making sense of, interpreting, and finally theorizing about. It was a process that required me to organize and reduce data into meaningful parts. Accordingly, I broke down the interview transcripts and the data from field, observation, and document notes by coding and categorizing the data to establish patterns.

My plan for data analysis followed Bogdan and Biklen's (2007) process of qualitative data analysis, which they describe as consisting of several steps. The first step is ordering the data chronologically and keeping similar forms of data together. In this study, this was done by organizing the interviews and observations chronologically and keeping them organized throughout the data collection and analysis process.

The second step is reading through data using observer comments and memos simultaneously to gain deeper understandings of the data. In this case, I sought to understand how the participants perceived their training, support and the MIHOW Program. This included

systematically reviewing and coding interview transcripts and participant observation notes. This step required the comparing, contrasting, and labeling of the data. This was necessary to bringing some order to the undifferentiated quantity of data that was collected.

The third step was developing coding categories or themes, using specific words or phrases to capture ideas and issues in the data. Coding is an inductive procedure that breaks the data into manageable parts, or segments, and identifies or names those parts. In this step, constant comparison and contrasting various segments of data and then naming the data using a code or a category was completed. For this study I implemented a thematic analysis to label the data and identify themes and patterns. Thematic analysis requires the researcher to work with the actual language of the interviewees to generate the themes and categories. The researcher must also work back and forth between the data segments and the themes and categories to refine their meanings as they decipher and work through the data (Maxwell, 2013).

The fourth step involved sorting units of data from field notes and interviews into the established coding categories. This step yielded fully categorized sets of data that were treated and manipulated for analysis and interpretation. In this step I recognized the established codes. But I allowed for emergence and organic changing of the categories of the data analysis as is practice in qualitative research.

This study used prior and on-going analysis of data from the larger study by examining home visitors' perceptions and understandings of the MIHOW Program. My analysis built on what we learned from findings from the evaluation research study. This study examined different questions than the mixed methods study, therefore different themes unfolded from the collected data during the analysis process.

The final step consisted of data interpretation. Interpretation is the process of relating findings to extant literature and applying findings to other concepts and issues (Bogdan & Biklen, 2007). I interpreted the findings in relation to what has been documented in previous research about the use of paraprofessionals in implementing home visitation programs.

My findings contributed to the larger evaluation mixed methods study by providing insight into the perspectives of the home visitors. The larger study looked at both mothers' and home visitors' perceptions of the MIHOW program. But this study took a more extensive look into the home visitors and their experiences and understandings with the program - specifically, their perceptions as related to their training, their ongoing support, and their roles in the promotion of language development.

Methodological Strengths and Weaknesses

There were several strengths and weaknesses of which I was cognizant during my study. The strengths were related to my MIHOW affiliations, use of qualitative research, and my extended time in the field. The weaknesses were related to participant accessibility.

The first strength of the study was based on my current affiliation as a MIHOW research team member. I have spoken with and met many of the home visitors over the past three years as a member of the evaluation research team. I had access to all of the home visitors from both West Virginia sites. I also had opportunities to attend MIHOW sponsored training events, which were found to be essential for my data collection. In addition, because of my affiliation with the MIHOW research team, I had Institutional Review Board approval.

The use of qualitative research methods for this collective case study were a second strength of the study. Qualitative research methods enabled me to apprehend how the home

visitors perceived their training and roles in the MIHOW program. Glogowska, Young, and Lockyer (2011) discussed the practicality of using qualitative research methods and telephone interviewing. They determined that the advantages of using telephone interviewing outweighed the disadvantages. They noted that this type of interviewing allowed for open-ended questions with interviewees who might otherwise go unheard. Phone interviewing allowed researchers to gain access to participants who may have difficulty participating in face to face interviews due to geographic isolation. Many of the home visitors who were included in this study lived in rural and socially isolated areas of Appalachia. Phone interviewing was not only practical for access, it was often the only way I could reach these women.

A third strength of the study was that I had participated on the MIHOW research team for an extended period of time. I had been on the MIHOW research team since June of 2012. My affiliation with the MIHOW evaluation research team allowed me to better understand how home visitation worked and how the MIHOW program instituted home visitation as a service for its curriculum and its mission. I met many of the home visitors and spent time becoming acquainted with them at MIHOW trainings. This allowed me to build a rapport with these women, which, as in many qualitative studies, was essential to this study.

The weaknesses and limitations of this study included continued and ongoing access to home visitors. The home visitors did not leave the program frequently; however, it was a possible issue that could have arisen during my research. Home visitors did have difficulty with phone reception given the rural locations they live and work in. This made getting in touch with them to schedule and set up interviews and observations difficult at times. The difficulty with participant access could have inhibited the study because the home visitors could have been

unavailable for follow-up interviews, which could have made identifying patterns difficult and subsequently affected the study's findings. But it should be noted that over the course of the past three years of participating in the mixed methods evaluation study, no home visitors who had been interviewed had quit their jobs or dropped out of the larger study. To help ensure their participation, we sent the home visitors a ten dollar Walmart gift card for each interview they participated in. These gift cards were provided by the research grant received from the West Virginia Department of Health and Human Resources. It was our hope that this would help motivate home visitors to continue to participate in the study.

There are, of course, issues of trust and mutuality in the interview process. Interviewing itself is a process that serves as a means of gaining direct access to an interviewee's experiences but it can also be a limiting factor and a possible weakness without constant critical reflection on the process. The interview event were a cultural phenomenon, where the interviewee can be regarded, as Schwandt (2015) points out, as a "passive vessel of answers for the kind of factual and experiential questions put to her or him by the interviewer" (p.605). Because of the cultural expectations surrounding "stimulus-response" type interviews, the interviewer must be conscious of how not all interviews unfold in exactly the same way, and that other forms of knowledge exchange can transpire during an interview event. As Briggs (1986) points out, interviews are often structured in such a way that preclude the flow of information rather than encourage it, and may end up limiting studies significantly. It was thus my goal to structure and frame my interviews in a manner that was an active process for the interviewees. This framework allowed the interviewee's meaning to be constructed in their own answers, stories, and examples.

Schwandt (2015) refers to this more flexible interview structure as a way of interviewing that required focus to be not only on what is said, but how the process unfolded.

Validity

Maxwell (2013) indicates that researcher bias and reactivity are two primary threats to validity in qualitative research. As a speech-language pathologist who has a history of working in early intervention, I had some preconceived notions about ways to influence and elicit language development in children in the birth-to-three age range. Being aware of my own biases made me more vigilant in not unduly imposing my own views onto the data that I collected. I was aware of these biases as this helped inform me of my own personal feelings and perceptions as I completed the study.

As a researcher and an evaluator whom the participants did not know I could, to a certain degree, have affected participant responses in interviews or behavior during observations. Reactivity is typically regarded as a threat to validity and it is often thought that it can be prevented through unobtrusive observation. But in reality, reactivity is something that can never be completely eliminated, meaning that there are always effects of the audience and the context on what people say and do (Schwandt, 2015). As Schwandt (2015) notes, "because of this reality, the best a researcher can do is to acknowledge the existence of reactivity, and recognize that all accounts researchers produce must be interpreted within the context in which they were collected" (p. 890). Be that as it may, as the researcher I, to the best of my ability, critically evaluated each point in the study and how my presence helped to shape the collected data.

In addition, participants may have been aware that the research was part of a larger evaluation study. To take into account this issue, I identified myself as a graduate student prior to each interaction with participants. I also explained confidentiality to the research participants prior to any interview or observation and assured them that their confidentiality would be honored throughout the entire study. Because of potential threats caused by reactivity issues and personal bias, I needed to employ some common validity techniques that worked to ensure that the findings of the study were as true to the actual experiences and perceptions of participants as possible. The specific techniques I employed included the following: triangulation, long term involvement, and multiple reviewers.

Triangulation

Triangulation is a procedure used to establish that criteria for validity have been met, and for checking the integrity of inferences made from data. Maxwell (2013) describes triangulation as a process that has a goal of examining the drawn conclusions from more than one perspective or viewpoint. Triangulation can involve the use of multiple data sources, multiple investigators, multiple theoretical perspectives, or multiple methods.

Within the context of this study, I had access to interviews with home visitors and mothers who participated in the MIHOW Program. I also had access to written documents, such as curriculum, handouts, and training manuals, which were designed and distributed to paraprofessionals trained by MIHOW regional coordinators and staff. Content analysis of these materials allowed for another source- in addition to data I collected in interviews. I also had the ability to observe home visits with a family and a home visitor, as well as training sessions where

home visitors were participants. These observations helped provide me with more confidence regarding my findings.

Long Term Involvement

Another way validity can be enhanced is by participating with research participants long enough to get complete and authentic data (Maxwell, 2013). I have been involved in an evaluation study of the MIHOW Program since May of 2012. This study dovetailed with the pre-existing evaluation research project. I continued to follow the home visitors with whom I had established relationships over the past three years, as well as establish new relationships with additional home visitors from both sites. I hoped that my involvement over the past few years would help generate a more authentic understanding of their experiences and make the participants feel more comfortable with sharing their experiences and understandings with me.

Multiple Reviewers

Interviews I conducted with mothers and home visitors were recorded using a digital tape recorder. The interviews were recorded for transcription purposes and for my own reflective notes and memo writing. To further the process of triangulation, I utilized multiple reviewers by checking in with other members of my evaluation research team. The other members of the evaluation research team reviewed my data and my coding categories as they developed. This ongoing process helped strengthen data accuracy as well as helped me check and compare themes, patterns, and interpretations as they emerged. In addition to this, the process of using multiple reviewers allowed for active collaboration and cooperation between myself and the other researchers who completed the reviews.

Conclusion

Through the use of multiple methods—participant observation, interviews, and document analysis—I hoped to provide valuable information and insights that were helpful to MIHOW as an organization working to provide quality prenatal and early childhood care to the children and families they served. I wanted this research study and its findings to aid program designers and program implementers in their efforts to best develop, serve, and train the home visitors who carried out MIHOW's mission through their work.

I used extant data I and my other research team members collected over the past three years as well as the data I continued to collect as part of the evaluation research study. I collected data in the form of interviews and in participant observations for MIHOW trainings and home visits.

My expectations of findings, in general terms, were that I planned to better understand how home visitors perceived their training and support and what they viewed as critical and necessary components of successful home visitation. I also anticipated that I would find that the relationship between home visitors and mothers was a strong connection and bond that aided the success of the MIHOW program. Findings from the evaluation research study supported these notions. I hoped to find that home visitors had obtained a significant amount of learning via their MIHOW training and experiences. In interpreting the results of the study, I explored how my findings could be used to help policy makers, program designers, and MIHOW staff determine what roles paraprofessionals should have in home visitation and how they could be best trained and supported within their work as home visitors.

CHAPTER 4

DESCRIPTION OF SETTINGS AND PARTICIPANTS

In order to address my research questions, I have interviewed six home visitors at two different West Virginia MIHOW sites. This fourth chapter contains a description of the national MIHOW program, housed at Vanderbilt University, and the two local West Virginia accredited MIHOW settings. It describes sites located near Fayette County, and northern Mingo County, West Virginia. Biographical information about all six selected home visitors from the two West Virginia sites was also included. To maintain confidentiality, I have used the same pseudonyms for the two site names and for all of the research participants as used in the larger study described in chapter three and, further, below. I have done so to maintain consistency across both of the studies and to keep confidentiality of participants intact.

National Maternal Infant Health Outreach Worker Program

For my study I interviewed home visitors who are employees of the Maternal Infant Health Outreach Worker (MIHOW) program. MIHOW is a national home visitation program that serves "economically disadvantaged and geographically and/or socially isolated families with children birth to age three" (MIHOW Program: Vanderbilt University Medical Center, 2014, para.1). The MIHOW program was developed from an initiative in 1982 by the Vanderbilt Center for Health Services. The program was developed in order to improve early child development and health in Appalachia (MIHOW Program, 2014). The Vanderbilt Center for Health Services created peer outreach programs for pregnant women using lay women—paraprofessionals—from the community as the home visitors. Since its inception, MIHOW has grown nationally to serve parts of Appalachia and the Mississippi Delta region. West Virginia is

one of the Appalachian states that has MIHOW programs in existence. The local MIHOW programs use the training and technical support provided by the Vanderbilt Center for Community Health and individual community agencies. Two of the five West Virginia MIHOW programs are accredited by Vanderbilt University. These two programs served as the settings for my study.

The national MIHOW program was initially funded by the Ford and Robert Wood Johnson Foundations for sites located in rural areas of Tennessee, Kentucky, and West Virginia between 1982-1987 (Elkins, Aquinaga, Clinton-Selin, Clinton, & Gotterer, 2013). Outreach workers were hired at six agencies in Tennessee, West Virginia, and Kentucky. This program was developed to promote prenatal care, good nutrition and eating habits, and education about what to expect during and after pregnancy (MIHOW Program: Vanderbilt University Medical Center, 2014).

The Vanderbilt MIHOW staff serve as the base of operations for all of the MIHOW programs. To bolster effective services, as well as the long-term financial sustainability of the programs, Vanderbilt offers extensive, high quality training and technical support to all regionally located staff. Each year, site leaders and home visitors come together for trainings, workshops, networking opportunities, and team building activities at an annual conference held in Nashville, Tennessee. Regional coordinators are responsible for three annual trainings per region, and provide individual site consultation on program management as needed. Site-based trainings are also conducted twelve times a year. These trainings are at the discretion of site based leaders and program coordinators.

Thirty years and 15 sites later, MIHOW has served 15,000 families located in the Appalachian and Mississippi Delta areas of Kentucky, Mississippi, Tennessee, and West Virginia (Elkins et al., 2013). Many of the families served by the MIHOW program and its staff struggle with issues relating to poverty, transportation, education, safety, and health. MIHOW aims to impact mothers by improving birthing and parenting outcomes. Although program services are often customized to meet an individual family's needs, the main components of the program are focused around a strengths-based approach that trains mothers from the community through monthly home visits, community linkages, and monitored program fidelity (Elkins et al., 2013).

West Virginia MIHOW

As previously mentioned in Chapter One, a larger study examining the West Virginia MIHOW program's effectiveness, titled *Evaluation of the WV Maternal Infant Health Outreach Worker (MIHOW) Random Control Trial Study*, administered by Marshall University faculty and students (of which I am a participant), was being conducted along with this study (Amerikaner, et al., 2015). The larger study examined MIHOW's overall effectiveness from the viewpoint of home visitors and from mothers enrolled in the program. My part of the study examined different questions than the larger evaluation study, in particular, those that addressed the effectiveness of paraprofessional training, and how, in turn, it related to home visitation.

The central problem of my research was to focus on paraprofessional training and how it affects delivery of MIHOW home visitation. In this regard, a better understanding of how paraprofessionals experienced and understood their training, experienced and understood MIHOW's mission, and experienced and understood their roles as individuals who were

responsible for promoting language development, was critical to finding the benefits of home visitation services for children and families provided by MIHOW.

MIHOW recognized that paraprofessionals and program participants are equal members of the community and have a mutual interest in making the lives of participants better. Paraprofessional home visitors visit families in their own homes. They utilize peer-to-peer mentoring to develop the relationships necessary for what they believe to be productive home visiting. MIHOW home visitors receive extensive and ongoing training about pregnancy, childbirth, infant feeding, strength-based teaching, child development, and positive parenting (MIHOW Program: Vanderbilt University Medical Center, 2014). With regional mentors and a MIHOW research-based curriculum to guide them, home visitors are trained to respond to each family's unique strengths—as well as their needs. According to MIHOW's expressed mission, paraprofessional home visitors serve several roles to the families they serve: these include a helpful resource to referral services and community based programs, a confidant, and a powerful role model (MIHOW Program: Vanderbilt University Medical Center, 2014).

As previously mentioned, there are two accredited MIHOW programs within the state of West Virginia. These two locations were chosen as the settings for this study. Accreditation is provided by the national MIHOW program at Vanderbilt University. The accreditation process for each site occurs every four years. All MIHOW programs hire mothers from the community they serve to become home visitors. The workers share the culture and language of the families and regions they serve. Home visitors collect data from the families they serve, including demographics, financial/housing, nutrition, health assessment, birth weight, breastfeeding,

development, and formula feeding practices, just to name a few (MIHOW Program: Vanderbilt University Medical Center, 2014).

For the purposes of this study, the first of the two West Virginia sites will be referred to as the Blue Lake Program. Blue Lake is located in Raleigh County, West Virginia. The second site, located in northern Mingo County, will be referred to as the Mountain Ridge Program. Both sites' programs, which are located in economically disadvantaged and geographically isolated areas, operate under the direction of the national MIHOW program at Vanderbilt University. Three home visitors from each of these two MIHOW locations were participants in this study. Each of these participants will be introduced and described in the following section of this chapter.

Setting One: Blue Lake

The Blue Lake site, located in Raleigh County, West Virginia, was the second national MIHOW site to be identified. At the time of this study, the Blue Lake program, located beside a community medical health clinic, served the rural counties of Fayette, Raleigh, Nicholas, Greenbrier, and Montgomery. In 2013, Fayette County had an estimated population of 45,5999 (United States Census Bureau, 2013). As of 2008-2012 19.8% of the population lived below the poverty line. The annual income in Fayette County from 2008-2012 was $34,891. In 2012, nearby Raleigh County had a population of 79,021 (United States Census Bureau, 2013). Raleigh county had a median household income from 2008-2012 of $39,325 (United States Census Bureau, 2013). From 2009-2013, 17.1% were living below the poverty line in Raleigh County, compared to the overall state average of 17.9 %.

In the MIHOW program, the Blue Lake site had 111 participant mothers and seven home visitors (Amerikaner, Spatig, Conner-Lockwood, Carlson, Bialk, & Kebawy, 2013). More recent MIHOW demographic information from Blue Lake, as of March 2015, indicated that the Blue Lake site served 68 families, and conducted 82 home visits in March 2015.

Setting Two: Mountain Ridge

The second MIHOW setting, the Mountain Ridge program, is located in northern Mingo County. The Mountain Ridge program is connected to a food and clothes pantry that provides services to the surrounding communities. This program connected families with local community-based services which provided donations related to clothes, food, and other miscellaneous items. The median county household income was $34,518 (United States Census Bureau, 2013). In 2008-2012, Mingo County had 22.9% of the population living below the poverty line. The West Virginia state average of individuals living below the poverty line was 17.6% in 2013 (United States Census Bureau, 2013).

Mountain Ridge is the smaller of the two West Virginia programs with 60 participant mothers and six home visitors (Amerikaner, et al., 2013). Most of these mothers reside in Mingo County which has a population of 26,103 (United States Census Bureau, 2013). More recent surveys, as of September 2014, and reported by the Mountain Ridge regional site coordinator, identified that the program served 89 adults, which were defined as mothers and fathers. During the month of September, Mountain Ridge served 86 children, 49 families, and home visitors conducted 52 visits.

According to the site coordinator at Mountain Ridge, the program also served around 25 to 30 children per day in an after-school program. A site coordinator and three other individuals

worked at the after-school program. The program also had an additional employee who worked on life skills. They had an adult education employee on staff who helped people obtain their General Educational Development (GED), assist with college readiness, and apply for jobs. The Mountain Ridge program also had an outreach program that worked with mothers in a local prison and with teenage mothers in a local high school.

Similarities and Differences across Settings and Programs

The Blue Lake and Mountain Ridge Programs shared some similarities and differences which may influence overall program impact. The similarities across the two sites related to the type and frequency of training home visitors received, attrition rates, and the income of participants. (Amerikaner, et al., 2013). For example, an equal number of participants from both sites discontinued participation in the program in the past year. Related to this were economics. Although initial indicators point to economic variability within the Blue Lake program, there was really no difference between the two program sites regarding participants' income (Amerikaner et al., 2013). In other words, both programs were serving economically disadvantaged rurally isolated individuals with high unemployment, low monthly income, and high numbers receiving food stamps.

Differences between the two programs related to number of participants and program goals. Blue Lake had 111 participants and Mountain Ridge had 89 (Amerikaner et al., 2013). As of September/October 2014, Blue Lake reported having 72 participants, and Mountain Ridge reported having 49. Blue Lake had eight home visitors and Mountain Ridge had six. Both programs conducted community outreach outside of home visits, but in different ways. Blue Ridge had an adult education coordinator on staff who guided people in obtaining GEDs, getting

prepared for college, and applying for jobs. Blue Lake used their curriculum to teach about parenting methods at the Day Report Center once a week, and at the Raleigh County Substance Abuse Center twice a month. Overall, Blue Lake had more participants and home visitors, and participated with more community organizations for parent learning. Another difference between the two sites related to those mothers who work and those who remain at home. Mountain Ridge mothers indicated that more of them remain at home than do the mothers located at the Blue Lake setting.

Blue Lake Home Visitors

Three home visitors from the Blue Lake program participated in this study. Each was interviewed twice. One participant observation of a home visit was also completed at the Blue Lake setting. The home visitor profiles featured below provide information related to how long they had been a home visitor, their educational background, employment background, and any other information related to their understanding of the program. In addition, excerpts from interviews are provided to give further insight into who these women are both within and outside the framework of being home visitors in the MIHOW program.

Laura. Laura was a home visitor who has been with the program for 22 years. She was first interviewed on July 17, 2012. A follow-up interview was conducted on June 23, 2014. Having been with MIHOW for 22 years, Laura described herself as "an older home visitor." Her experience was only one facet of who Laura was in both the personal and professional aspects of her life. Laura had a pleasant and easy-going personality and she was very easy to talk to. Laura reported that she had lived in the Fayetteville area of West Virginia for most of her life. Although it is not required for home visitors, Laura did attend college at West Virginia

University. She obtained a bachelor's degree in Editorial Journalism. She stated that although she had a degree, she "knew absolutely nothing about prenatal care and child development, outside of raising my own kids" (Laura, personal communication, July 17, 2012). Laura's degree in an outside field made her a lay person in relation to the scope of what she did as a home visitor in MIHOW.

Laura often spoke of her family during our interviews. She had a husband and three grown sons. In addition to completing two interviews with Laura, I also completed a participant observation of Laura conducting a home visit. During this participant observation of a home visit, she mentioned that her youngest son was 18 and getting ready to leave to begin college in a week or so, an event that seemed bittersweet to her. She mentioned having the "empty nest syndrome," and admitted that she was apprehensive about his departure. She seemed to value family and her role as a mother. Her rapport with the mother she was visiting was very at ease and natural. Laura appeared to be very "at home" as a home visitor, interacting in someone else's environment. She spoke about this during her second interview:

> Probably what sets this job apart from just your typical job description, is just to really enter into what it is and MIHOW of course it's the acronym for Maternal Infant Health Outreach Worker program and that it is a strength-based approach and workers know you know, this is just not, at least to us, it's not just another job. It is a job where you go into somebody's home. You enter their world. (Laura, personal communication, July 17, 2012)

Laura worked several jobs before beginning her time with MIHOW as a home visitor. She initially worked for a newspaper in Beckley, and owned and operated a jewelry store for 14 years. She, like other home visitors with whom I spoke, had a diverse vocational background before coming to MIHOW. Laura came to MIHOW somewhat by chance. She stated that she

“kind of came through the back door” when she initially started working as a home visitor. Laura reflected on her early experience at a MIHOW meeting during one of our interviews:

> I didn’t know a whole lot about what it was, what kind of meeting I was going to, but I went to a meeting of this wonderful group of women that were working with the MIHOW program, and identified me as a good resource for breastfeeding, and she identified me as a person that might work as a MIHOW home visitor. (Laura, personal communication, July 17, 2012)

Laura said one of the reasons she was interested in working for MIHOW was her desire to be a midwife. In addition to labor and delivery, Laura reported that she was also interested in child development. Laura was one of the first local MIHOW home visitors to collaborate with the national MIHOW program at Vanderbilt University on the development of the MIHOW curriculum, which included the child development norms MIHOW uses. Collaboratively with several women at Vanderbilt, she worked to help Blue Lake become an accredited MIHOW program. The Blue Lake site received accreditation through the national MIHOW site housed in the School of Nursing at Vanderbilt University in Nashville, Tennessee. She developed the specific curriculum for the prenatal period through age three.

During her interviews, she reflected on many of the changes she had witnessed in her 22 years with the MIHOW program. She discussed, for instance, the increased number of trainings that MIHOW provided home visitors, explaining that “I feel like we have just gotten more and more training over the years. Many of the trainings were held at local, state, and national MIHOW conferences and they continue to grow each year” (Laura, personal communication, June 23, 2014). Some of the specific trainings she identified related to breast feeding, child development, childhood neurological development, child safety, and smoking, among others.

Laura recalled that in her early years with MIHOW she had less paperwork than she has to do now in the program, saying, "We don't like it, but we understand the importance of it" (Laura, personal communication, June 23, 2014). The increase in paperwork for many home visitors was related to developmental screenings. The home visitors complete them, score them, determine what the scores mean, and look at what to do after the screening and scoring for the mom and child. She noted that MIHOW is nationally recognized and that they network with other state agencies which eliminates the duplication of services among agencies. Laura described some of the remote areas where she goes to visit, mothers, some homes that are not accessible by car, and others that are only accessible by foot.

Tammy. Tammy has worked as a MIHOW home visitor for 25 years. She was well-informed, outspoken, confident, and frank during her telephone interviews. Tammy was knowledgeable regarding MIHOW's mission and she was able to convey her thoughts and feelings effectively during both of our interviews. Tammy stated many examples of how MIHOW's curriculum had been shaped and had changed over her years as a home visitor. Tammy was a lay member of the community because she held no college degree. My first impression of Tammy was that she was a very confident and independent woman who loved being a mother. Tammy spoke about her own children briefly during our first interview and then again in more length in the second interview. The first interview with Tammy was conducted on July 16, 2012. Her follow-up interview was conducted on October 30, 2014. She has been with the MIHOW program as a home visitor since 1990.

Tammy's previous work history was varied. It included being a stay-at-home mom and working as a preschool teacher at a daycare before she became a MIHOW home visitor. During

her first interview Tammy described how she became a MIHOW home visitor while being pregnant herself: “The woman who, like on the board of the preschool, pretty much invited me to become a MIHOW home visitor. So right from there after I had my baby I became a visitor” (Tammy, personal communication, July 16, 2012).

Tammy described working for MIHOW as something that she “liked to do.” When asked why she liked home visiting, she talked about the flexibility and independence it gave her as a mother and as a provider for her children. Tammy gave an example of that independence home visiting gave her as a mother when it came to deciding about her own children’s education. “MIHOW allowed me to keep my kids with me and educate them all while still earning a paycheck and I am still doing this today, now with my daughter” (Tammy, personal communication, July 16, 2012). Tammy went on to express that she was able to homeschool her children and take them on home visits with her during the time she worked.

In addition to the independence, Tammy also mentioned the flexibility being a home visitor afforded her as a paraprofessional. She stated several times that this was an important feature of her work with MIHOW. Tammy said that after her husband passed away a few years ago she was forced to take another job that would allow her to provide for her family. But, even after taking on an additional job, Tammy chose to continue to work as a home visitor in more of a part-time manner. Because MIHOW is flexible regarding when home visits can occur, Tammy was able to conduct her home visits for MIHOW on the weekends. Tammy was grateful for this aspect of the program. She said that the families she worked with were “fine with her coming on weekends” and this allowed her to support her own family while continuing to do work she enjoyed (Tammy, personal communication, July 16, 2012). This topic of the support MIHOW

provides the home visitors in their own personal lives is one that appeared over and over in the collected data. When asked if she felt she had a support system to do her job effectively, Tammy quickly answered by saying,

> Definitely, definitely. Our team's been together for so many years. We just know each other and we know who knows what and who has got what information. I tell you what, that's what what has kept me at this job for 25 years, the people I work with and the support that they give you. It's like no other place that I've ever been to. (Tammy, personal communication, October 30, 2014)

Tammy said that she currently has a MIHOW caseload of approximately 14 families. Like Laura, Tammy spoke with an obvious and great affection for the MIHOW program. She mentioned what the MIHOW trainings did for her early on in her career as a home visitor and what it continues to do for her today:

> I think that all the support and knowing that there's so many other people who have done this for a while, makes you benefit from their wisdom. Support like that is a major thing when you first start and even now this many years in. To lose your baggage and your own stuff at the door and to go in and be there for that individual that you're visiting is a huge thing and it is something you have to learn to do. The trainings, especially the initial training, does that. And all the information you get. I mean if you went into this an you didn't have any background in development or any kind of medical anything it would be very beneficial because there's so much information during initial training that's given out. (Tammy, personal communication, October 30, 2014)

Olivia. Olivia is a home visitor who lives in Oak Hill, West Virginia, and has been with the MIHOW program for three years serving as a home visitor. Olivia has approximately 15 families she serves as a home visitor in the Raleigh and Fayette County regions. She was a mother of two children. My impressions and feelings regarding Olivia were that she was committed to growing and learning as a home visitor. She was nice and pleasant to speak with over the phone. Olivia demonstrated a great excitement and love for the MIHOW program in her

interviews. In one of her interviews she discussed the MIHOW curriculum and how she felt about it:

> I actually love the MIHOW curriculum. It keeps you focused on what you need to cover and I love it because it does baby steps and it pretty much goes month by month but it can be altered so that we can go back a month or forward a few or we can pull from other areas. You know, you kind of fit it to whatever the child and the family needs. Our curriculum is awesome. (Olivia, personal communication, June 5, 2015)

Her first interview was conducted on June 5, 2015. A follow-up interview was conducted on August 8, 2015. Olivia is a lay member of the community. She has obtained no formal degree post high school. Before joining MIHOW as a home visitor she was a stay-at-home mother of two kids. When asked about her own training within the MIHOW program she stated how the trainings were as beneficial to her as they were to the families she served. She gave an example of this at the end of our first interview. Olivia said, “MIHOW trainings are as much for me as a home visitor as they are for the families. I’ve never walked away from a training not feeling like I haven’t learned something new, each and every time” (Olivia, personal communication, June 5, 2015). She specifically spoke with affection about the initial home visitor trainings. She felt she came away from each initial training with something new. Olivia stated that “I’ve attended three initial trainings and I think they are the most beneficial trainings” (Olivia, personal communication, June 5, 2015). Olivia felt that the initial trainings allowed her to network and learn from more experienced home visitors. She believed this to be especially beneficial the first time she attended the initial training three years ago.

Olivia, like many of the other participants in the study, discussed language development as a key component of the MIHOW curriculum. Although MIHOW focused on promotion of all of the domains of child development, language development was the only developmental domain

of focus in this study. Language development was discussed in all 12 of the home visitor interviews. When asked if she felt she influenced language development she adamantly answered:

> Of course we do, yes absolutely. This is one of the biggest things I push and I think all the girls push. We really encourage language through reading and print. We teach them to model by being models ourselves. This is something I kind of did naturally as a mother, but not all mothers do this. So with MIHOW they teach us how to model good language practices around the mothers and then around the kids. Then we hope that these moms will do this with their kids once we leave. Putting labels all over the house and things like that are just a few things we do. (Olivia, personal communication, June 5, 2012)

Like Olivia, other home visitors gave examples of how language development was targeted during home visits. I found these practices to be consistent across both sites. As I will return to in the next chapter, it appeared from the data that both sites were training their home visitors to use modeling and early literacy as key ways to influence language development. One way home visitors were trained to promote language development was through the use of print materials. Olivia used print to help promote early literacy, and thus early language skills with the children who were about to exit the program. She stated that she will "teach moms to write words out and label items around their house and to put them at the level where the child can see them" (Olivia, personal communication, August 8, 2015). When asked if MIHOW trainings prepared her to promote language development, and if so, how, Olivia answered by saying:

> I think a little bit of both honestly. When you are in the field working, you pick up on things just naturally. But the modeling, and the rate of speaking, and how to speak to the kids came from my MIHOW trainings. I think natural experiences and being a mom prepare you for some of this stuff naturally. But the more formal stuff, like language development in a younger child who has an older sibling is different than an only child, that is something I learned from a monthly training we had a year or so back. I think it really is a bit of both MIHOW and experiences you bring in with you and you gain along the way by making visits. (Olivia, personal communication, June 5, 2015)

Olivia's comments regarding language development and MIHOW trainings was consistent with literature found in MIHOW's *Home Visitor Training Notebook*. MIHOW's training breaks language development down into stages from birth to five years of age (note that MIHOW services cease once the child turns three). Home visitors are trained using Ages and Stages protocols developed by MIHOW (Roberts & Withrow, 2014). Home visitors are provided an initial training that teaches home visitors that long before children can speak they are active language learners. This was the focus of the language development training portion of the home visitor initial training session I attended. Language development and how home visitors experience and understand their roles in promoting it will be explored in the data results and findings discussed in Chapter Five.

Mountain Ridge Home Visitors

Just as with the Blue Lake program, three home visitors from the Mountain Ridge program were also interviewed. Each of these participants were interviewed two times. One participant observation of a home visit was completed at the Mountain Ridge setting. The following home visitor profiles relate to how long they had been a home visitor, their educational background, employment history, and any other information related to their understanding of the program. In addition, excerpts from interviews are provided to give further insight into who these women are both within and outside the framework of being home visitors in the MIHOW program.

Trisha. Trisha was the first home visitor I interviewed from the Mountain Ridge program in Mingo County, West Virginia. Trisha had obtained no formal degree post high school. Trisha demonstrated confidence, spunk, and enthusiasm in her role as a home visitor. A

first interview was conducted on January 21, 2013. A follow-up interview was conducted on December 7, 2014, and an observation of her completing a home visit was conducted on August 12, 2014. Trisha had also served as key informant for clarification of information. I contacted her several times outside of our interviews to make sure I had correct information regarding details related to the program protocols and materials.

At the time of our last interview in December, Trisha had been with MIHOW for three years. She worked for a community action council for 18 years before getting a job with MIHOW. Trisha frequently mentioned her past trainings and the certificates and the licenses she had obtained during her time with the community action council. For example, she stated she had received “a food handler’s card, a child development license, and a license to drive children” (Trisha, personal communication, January 21, 2013) while she worked at the community action council. She strongly believed that these trainings, credentials, and her previous experiences with the community action council made her a strong candidate for being an effective home visitor. Trisha stated these sentiments to me during her initial interview.

> I think daycare workers and MIHOW people should have an education. Even if they would just have a two-year degree that would help. I’ve taken all kinds of classes with the community action council and I applied to be a home visitor with MIHOW twice before they hired me. I know they send you to what they call an initial training, their MIHOW training, and I understand all of that, but if I give you the background of what I’ve done for the past 18 years I think you would’ve put me on the payroll a little bit faster. (Trisha, personal communication, January 21, 2013)

Trisha discussed differences in the expectations for a position with MIHOW compared with the community action council where she previously worked, noting differences between programs that required degrees and those that did not. She was outspoken, direct, and passionate about issues related to MIHOW. She frequently expressed concerns about the fact that MIHOW

did not require their home visitors to have a degree: "All you have to do is go through their trainings and be a mom, you know, be a mother" (Trisha, personal communication, January 21, 2013). Trisha reflected on what she believed to be the importance of having a degree in order to teach children and mothers appropriately: "Anybody can be a teacher but it takes someone that has got the degree that can really teach and understand the teaching that they give" (Trisha, personal communication, January 21, 2013). This was ironic, in that Trisha herself does not hold a formal degree.

Trisha also identified another difference in the expectations of MIHOW compared to her previous employment. One of those differences was in the frequency of home visits. Trisha was of the mind-set that MIHOW should increase the frequency in which they see mothers and families. One specific area she felt the frequency should be increased was during the prenatal period. She discussed the importance of seeing pregnant moms more often for home visits:

> I think that home visiting should be, well if they don't want to do it because of the once of the month, and there's a lot needed, you know, if they're pregnant women they're going to need you more than once a month. They're going to need you at least three times a month, because there's things that comes up that you won't know until the next time you go see her the following next month. The MIHOW home visitors are only required to see the moms once a month. (Trisha, personal communication, December 7, 2014)

Trisha was an excellent informant. She was incredibly open and frank during both of our interviews. I found her to be incredibly charming and direct. She exhibited an authenticity and spirit that one could easily see influenced her work as a home visitor. She wanted and expected a lot of the families she served. Nora, her boss, described her as "a fantastic home visitor who gets passionate about her families and what she wants us to do for them" (Nora, personal communication, June 26, 2015). This passion was evident early on in our conversations.

Trisha saw herself as an advocate for the children she served. She was one of the first home visitors who used this term during an interview. When asked if she was making referrals for the children who appeared to be developmentally delayed Trisha answered, “I do advocate for babies and for them with help for therapy services or whatever they need like Birth to Three and also for everyday life stuff. Like stuff they need to help them survive just day to day” (Trisha, personal communication, December 7, 2014). Trisha spoke about making phone calls to people and services she knew within the community to provide the families with services and materials they needed.

Trisha, like all of the home visitors, appeared to use community services as a frequent resource for families. Trisha stated that because she had worked with young children for 18 years prior to coming to MIHOW, she was well informed, knowledgable, and well connected with services in the Mingo County area. For example, Trisha spoke of a few churches that would consistently provide products like car seats or formula for families in need. Being a member of the community in which they serve was one requirement of MIHOW’s hiring practices for home visitors. In addition to being a mother, home visitors must reside within the regions they serve. This was based on the idea that if home visitors are members of that community themselves, then they are more aware and capable to help families make connections to community based services that can continue to help them, if needed, after they have exited the MIHOW program (MIHOW Program, 2014).

Rachel. Rachel is the second home visitor I interviewed from the Mountain Ridge program. I first spoke with her via a phone interview on June 24, 2015. Like Trisha, Rachel was a lay member of the community. She had no formal degree, but she had worked in several

different job settings. Before becoming a home visitor almost three years ago, Rachel was a stay-at-home mom. Prior to that she was employed as a census worker, a home health worker who cared for elderly patients, and a beautician. Like many of the other paraprofessionals, Rachel came to MIHOW with a diverse work history.

> I did different jobs from census to in-home healthcare giver, and I just was a stay at home mom for a while, plus raised my own two kids with no help. And then my sister was working with a girl in the MIHOW program and she just informed me that they was looking for another employee, I mean looking for another client to work the job and she explained her job and I was very interested in it so I went and did an interview and got the position and I've been there ever since. (Rachel, personal communication, June 24, 2015)

A follow-up interview with Rachel was conducted on August 18, 2015. During both of our interviews Rachel was pleasant and accommodating. Of all the home visitors interviewed, Rachel appeared to be the most reserved. She had a quieter personality as compared to other participants. Rachel's personality could be described as somewhat reserved and perhaps "laid-back" in comparison to the other home visitors interviewed.

Rachel lives in Justice, West Virginia, and has worked as a home visitor at the Mountain Ridge program since December of 2012. Her supervisor, who I also interviewed and will discuss next, described Rachel as "hard-working, dedicated, open-minded, and strong willed" (Nora, personal communication, June 26, 2015). My impressions of Rachel were consistent with the comments made by her supervisor. I could sense her dedication to her families and to the community she lived in and served as a home visitor. I felt a strong sense of pride from Rachel in regard to her work. She exhibited a good example of this pride during our first interview:

> You help them learn their strengths that they don't really know or you bring it out in them or you help them build from their strengths and they go from there and that's what I liked most about it. It's a strength-based program, it's non-profit, it's not got nobody to judge

on one for their living conditions or circumstances. You're helping them and you can see that help in their confidence and in their actions. That makes me happy and proud of what I do. (Rachel, personal communication, June 24, 2015)

Rachel served as a home visitor to 15 families in the Mingo County area. She was a single mother of two children. As mentioned earlier in this chapter Rachel said she raised her own children, "with no help" (Rachel, personal communication, June 24, 2015). Rachel's oldest child was about to graduate with a master's degree and her teenage son attended high school. I could sense how proud Rachel was that her oldest child had earned a college degree and that her youngest child planned to attend college. Rachel said, "I didn't have the chance to go to college, but I knew I wanted to give my kids that chance if they wanted it, and they have thank the Lord" (Rachel, personal communication, August 18, 2015).

During our first interview Rachel spoke with a fondness about MIHOW and what it has done for her own life, specifically in regard to being a single mom, as well as what she believes it has done for the families she visited. She spoke about what the support of her supervisors and coworkers has meant to her.

> I have a wonderful support system with MIHOW. I mean if you've got a problem you go in, you've got your other ladies there you can talk to. And my boss, to have someone as wonderful as her, to go in and talk to her one-on-one, is a blessing. She'll just be there for you. I mean she always has been, and she'll help us no matter what we need. If we need something we can text or call her and she's there no matter what it. And she understands that you have a family and that things come up and you can't suddenly be there or something, to understand that takes a lot of stress off of you, especially as a single mom. (Rachel, personal communication, June 24, 2015)

When asked about what she loved most about MIHOW Rachel replied that MIHOW was a program where "mothers help mothers and it's a strength based approach" (Rachel, personal communication, June 24, 2015). My belief was that Rachel valued the concept of "mothers helping mothers" and the strength-based approach. She had personal experiences to draw upon,

some of those experiences were similar to the challenges facing some of the mothers and families she visited. Rachel said that she believed that this strength-based approach, was the greatest and most important aspect of the MIHOW mission and that, at its heart, MIHOW was "at its best when home visitors can help mothers realize their own strengths, and teach them how to use those strengths to help their kids and themselves" (Rachel, personal communication, June 24, 2015). When Rachel was asked to give an example of how she has seen a strength-based approach change the trajectory for a mother, she replied by telling me a story. She said:

> You know it's all to do with strengths and how to help someone. I mean it's just all to do with strengths. You've got to find the strengths. You've got to have the strength to even want to do this job, and you've got to have the willpower and the openness, the open heart, because this job can get to you, you've got to find their strengths and your own strengths. Like this one girl I'm seeing, her baby came five months early and she's really living on the strength of love and passion and hard work and determination, cause she has to take her baby every two weeks to Morgantown and she's constantly doing something. There's constantly someone in the house and I try to just get her to take deep breaths and to realize that without her, her baby wouldn't be doing as well, and that builds up her confidence. And that baby's doing wonderful and she's handling it really well. She's surprised me with how she's handling it with all the strength that came with that situation. (Rachel, personal communication, June 24, 2015)

Rachel recalled many stories over her two interviews that gave examples of how her training with the strength-based approach translated into action. The strength-based approach was a key component to home visiting for all of this study's participants. They all spoke of it during their interviews and how they had observed the strength-based approach influence learning and change. For example, Rachel spoke about her own training with the strength-based approach.

> You have to start by learning what a strength is. Saying it is one thing but you know you've got to know what the meaning for it is. That's one thing we've learned that my boss, Nora, has really stressed with us to learn is what strengths really mean. Cause when we all started this thing we wasn't really doing it. We was writing things down on

> paper but we really wasn't, we was going at it all backwards, and then after our boss explained it to us in a training then we'd start thinking about it and then you really, you get deeper into it. We started to see how to pick out strengths, like you're doing this good, or you're so good at calming that baby, or you're so strong-willed to get your family to stop smoking. You may not think those being are strengths but they are. (Rachel, personal communication, August 18, 2015)

This theme and idea of MIHOW being a strength-based curriculum appeared over and over again in the collected data. MIHOW believes in helping people recognize their own values and how their perceptions of others are often viewed through the lens of their personal value system. MIHOW trained its home visitors to recognize their own values so that they do not allow that to impose on someone else as they are working with families. MIHOW's training curriculum states that "It is easier to see the strengths in a person if home visitors aren't looking at it from their own value system" (MIHOW Initial Training Conference, 2014). This will be explored in detail in the following chapter.

Nora. Nora was the third home visitor from Mountain Ridge that I had the pleasure of interviewing on two separate occasions. I completed her first interview on June 26, 2015. A follow-up interview was completed on July 22, 2015. Nora was incredibly knowledgeable about MIHOW's curriculum, its training requirements and protocols, and its overall mission to serve mothers and families in rurally isolated areas. Nora was a unique informant,in that she started the MIHOW program enrolled as a mother, then became a home visitor after exiting the program when her child turned three, and then within the past six months was promoted to a MIHOW supervisory position. When she recalled how she initially became involved in the program Nora said:

> I had just moved to Mingo County and I was at a baseball game and one of the MIHOW women approached me and asked me if I had heard of the program and if I would be

> interested in being in it. And I was like sure. I thought it would be a good way to kind of meet people, meet other moms, and just learn more about our area. So then I completed the program and then after I completed the program there was a opening with a job position and they asked me if I would be interested in being a MIHOW home visitor since I knew the program, and so I did. And since then I just moved into new positions as they came open until now I'm the site leader. (Nora, personal communication, July 22, 2015)

Nora, a mother of three, has lived in Kermit, West Virginia for approximately 16 years. She was enrolled as a mother in the MIHOW program for three years and then served as a home visitor for seven years. As stated, she was promoted to MIHOW Site Leader six months ago when she was asked to do so by the then director of the Mountain Ridge Program. Nora explained that she was content being a home visitor but the position was open and her boss, "saw something in me that she thought would make me a good supervisor" (Nora, personal communication, July 22, 2015). I first met Nora when I observed an initial MIHOW training in August of 2014. Immediately, I felt a rapport with her. We spent time together that day just chatting and becoming acquainted with one another during one of the training breaks. When I called her in June she remembered me and we quickly picked up with the initial rapport we had established the prior year. It should be noted that Nora continued to do some home visiting, but the majority of her time was now spent as a site supervisor for the Mountain Ridge location.

Nora had a Certified Nursing Assistant (CNA) certificate. Nora had no formal educational degree post high school, but she was enrolled part-time in college and was working towards obtaining her bachelor's degree in social work. Previous employment prior to MIHOW included working as a CNA in a nursing home and working privately as someone who cared for people who are elderly and/or ill. During our first interview, Nora shared with me the fact that

she was a teen mom herself. This was an interesting segue way into her opening up about her passion for working with teen mothers in the MIHOW program. She said:

> There's certain things that are just near to my heart like the teen moms. I was a teen mom myself, so I've been there. I have a daughter who is almost 20 right now, and so I had her like five days before my senior year in high school. So I still go and see the teenaged moms in the high schools. There are two high schools in the county and I have not given that up yet. Even though I'm a site leader, I still like that piece of it, so I still go to the high school teen night groups with the teen moms. I know how hard it is, so I know how judged teenage moms can be, and how that can seem to be. (Nora, personal communication, June 26, 2015)

Family, and being a mother, seemed to be a very important part of Nora's life. She spoke openly about her own three children and often referenced how MIHOW changed the way she interacted with them, even now that they are older. Like all of the home visitors, Nora spoke about the strength-based approach with great affection. She told me about how the strength-based thinking flowed over into her own life, outside of home visiting.

> I'm a fairly positive person anyway, but there will be days I'm talking to my own kids, and they know I'm using my strength-based work stuff. And I'm like yeah I am, but that's ok, and they will look at me like, mom please. But it really does kind of change your whole life, you know. In our training they are constantly talking about, you know, the strength-based approach and it truly does spill over into your whole life. (Nora, personal communication, July 26, 2015)

Nora spoke with great passion about the MIHOW program and what she believes it has done for her own life and what it has done for the families she has served. Nora appeared to be an extremely open-minded, caring, and compassionate person. Many of stories she shared with me during our conversations reinforced my belief and feelings about this. When asked about how being a home visitor was different from what she had expected, she said that at first she could influence change by simply wanting to see the change occur. She said that "I would get a file put in front of me, and I would think when I'm done with them this is what their life will be

like." She went on to discuss how her expectations changed over time. She credited the MIHOW training she received for this change.

> Early on during my time as a home visitor I would get frustrated with my moms because I thought, if they knew better, they'd do better. But I found out quickly that wasn't always the case. I just thought if I showed people how, they'd want something more. Then through my trainings I saw how to approach each case with a nonjudgmental, open-mind, and that if I met them where they were then the best outcomes would be met. Maybe they weren't the outcomes I thought the moms should want, but it was what they wanted that mattered. That's what MIHOW training showed me. It's not what I want as a home visitor, it's what these moms and families want. Training showed me that is how change can happen. (Nora, personal communication, July 26, 2015)

Nora was the only home visitor with whom I spoke that was a student. Nora was a non-traditional student who was working part-time on a bachelor's degree in social work while still maintaining full-time hours as a MIHOW Site Leader. She credited Mountain Ridge's former Site Leader for inspiring her to go back to school. It was this conversation in our first interview that led to Nora telling me a story about the time her former boss approached her about going back to school.

Nora said that her former boss "one day, out of the blue, she just looked at me and asked me, why did you never go to college?" (Nora, personal communication, June 26, 2015). Nora then preceded to tell me about that interaction and how her former boss believed that she could and should get a college degree. "She didn't make me," Nora said, "but she made it possible for me to take classes every semester for the last two years" (Nora, personal communication, June 26, 2015). She then finished the story by saying "I could've never worked anywhere else and been able to get hours I need and go back to school" (Nora, personal communication, June 26, 2015). It is my belief that MIHOW has perhaps meant more to Nora than any other participant

in this study. She certainly credits it as the catalyst that has allowed her to make changes in both her personal and professional lives.

Summary

Over the past three years I have interviewed and observed these home visitors during home visits and during trainings. As a result, I have gained a deeper understanding of the MIHOW program, its training structure, its training approach, and its mission. But in addition to MIHOW I also learned a lot about these participants as home visitors and as people. Each of the participants were kind, open, honest, caring, and knowledgable about the things they believed to be MIHOW's strengths and, in some cases, MIHOW's weaknesses. Each time I talked with these women or observed them doing their work I gained further insight into MIHOW myself. It was their words, stories, and examples that gave me a deeper understanding of what it is like to be a home visitor. Through observing their actions in trainings and in home visits, I was able to see their experience put to work.

Emerging themes that address the research questions of this study appeared throughout the interviews and observations conducted with these home visitors. Those themes and their analysis will be discussed at length in the following chapter. Overall, this research study highlighted the perceptions and experiences of how home visitors perceived their training and how they felt supported by local, state, and national MIHOW programs and how that support translated into their own lives.

Some home visitors felt that the training and support they received from MIHOW equipped them for carrying out MIHOW's mission, while others felt it would be beneficial for families, and for them, if MIHOW required more background information regarding child

development prior to starting as a home visitor. Themes that looked at ongoing training and support also emerged throughout the data. These themes looked specifically at the support home visitors felt from the MIHOW program and from fellow staff members. All of these women talked about how MIHOW changed their own lives with the support it provided them as wives, as mothers, as women.

Discussion and themes related to ongoing trainings that dealt with current issues within their work (e.g. prescription drug abuse), language development and making appropriate referrals and recommendations when necessary, and the importance of utilizing a strength-based approach in home visitation were consistent across all observations and interviews with the home visitors who participated in this study. The following chapter will detail those themes and will compare those themes, via document analysis, to MIHOW's mission and its training protocols for home visitors.

CHAPTER 5

RESULTS

Thus far, I have introduced the two settings of my study and have introduced its participants by examining their experiences and understandings within the contexts of MIHOW's mission, its home visitor training, its ongoing support of home visitors, its possible role in promoting language development, and its practice of putting training and skills into practice. I also described the home visitors' narratives to construct their experiences and their understandings of the MIHOW program. In this chapter, I return to my research questions to report on my findings. Specifically, I analyzed the interviews, observations, and documents associated with MIHOW training and curriculum to generate responses to my five research questions. These questions include:

1. How do home visitors experience and understand the mission of MIHOW?
2. How do home visitors experience and understand MIHOW specific strategies and principles learned in their training and preparation?
3. How do home visitors experience and understand the support they receive in their work with the program?
4. How do home visitors experience and understand their roles as paraprofessionals responsible for promoting language development?
5. How and to what extent do home visitors put MIHOW strategies and principles into practice in their home visitations?

Findings

The findings from this study have been grouped for organizational purposes into categories that align with each of the above research questions. Each research question will be represented in its own category and section within this chapter. The answers to the research questions are presented based upon the collected data that explored the experiences and understandings of the six home visitors.

Question One

"That's the kind of magic of MIHOW." MIHOW's mission is clear and easily accessible to any outsider looking to find it. It is even more evident when one attends a MIHOW training or speaks to MIHOW home visitors. Home visitor trainings cover everything from the history of the MIHOW program to the mission of the program to the curriculum that guides the mission. The mission of MIHOW was founded on the recognition that regardless of living conditions or circumstances every family has strengths. Helping the MIHOW staff and participants acknowledge and build on these strengths is the heart of the program. Therefore, MIHOW's mission states that identifying strengths of families is the fuel that drives each program; and that self-discovery, encouragement, and action begin with the selection and training of home visitors and continues throughout their MIHOW careers. The home visitors, in turn, apply the same skills to home visiting, focusing on the needs identified by the family members and using the family's strengths to address those needs. In simpler terms, MIHOW's mission could be summed up in the words of some of its home visitors. One home visitor from Blue Lake said that "it's a support program for families. It's to go in and listen, observe, and help that family use their strengths, that do exist in every family, to the best of their needs, that's the kind of

magic of MIHOW" (Laura, personal communication, July 16, 2012). Or maybe even more simply put by a home visitor from the Mountain Ridge site who said the mission of MIHOW was, "A program where mothers help mothers" (Rachel, personal communication, June 24, 2015).

After examining the data collected from interviews and observations of home visits and trainings, it was clear that these participants understood MIHOW's mission to be based upon three principles they identified throughout their interviews. The first was the strength-based approach, the second was the MIHOW curriculum and how it influenced their work, and the third was the importance of being nonjudgmental regarding any of the families they worked with. All three of these findings will be broken down to better organize and answer the first research question.

Strength-Based Approach "It's our job to go into the home, point out those strengths and help them use those strengths." Home visitors in this study found the ideas, principles, and application of the strength-based approach as the most important feature of MIHOW's mission. The strength-based approach appeared over and over again throughout the collected data. It was spoken about in all of the home visitor interviews, it was observed in the MIHOW trainings, and it was observed being carried out in the observation of home visits. A strength-based approach is a teaching approach that emerged through a social work perspective that shifted thinking from deficits to strengths (Lietz, 2009). It takes the focus away from deficits and focuses instead on capabilities, knowledge, interests, goals, and objectives of an individual. The strengths perspective demands a different way of looking at individuals,

families, and communities (McMillen, Morris, & Sherraden, 2004). This shift in perspective is the lens through which MIHOW trains home visitors.

MIHOW cites the foundation of all of its services as the recognition that regardless of circumstances every family has strengths. Home visitors are charged with helping families identify their strengths and using those strengths to meet their needs. One home visitor stated that it (MHOW) "was all about the strengths, it's just all about the strengths" (Rachel, personal communication, August 8, 2015). In her first interview she described the program this way:

> Before I started it the way I understood it [MIHOW] was mothers helping mothers and it's all a strength-based approach. Which is what the program really is. That's what I liked about it. You build off of their strengths. You help them learn their strengths that they don't really know or you bring it out in them or you help them build from their strengths and they go from there and that's what I liked about it. It's a strength-based program, it's non-profit, it's not got nobody to judge no one for their living conditions or circumstances. (Rachel, personal communication, June 24, 2015)

Another home visitor described her home visitor job as "going into the home, pointing out strengths that maybe no one has ever pointed out to them, help them use those strengths to make them better people and to be able to step up and be better parents" (Nora, personal communication, July 22, 2015). Home visitors were aware that their responsibility as home visitors was to use the strength-based approach as a teaching tool and as a way to encourage learning and change.

At the end of each visit, home visitors are required to write "a strength" of the mothers on the form they fill out following each visit. This form is then taken back to the MIHOW site and filed to help chart progress and growth. The home visitors talked about how sometimes finding such a strength could be a struggle. But the home visitors stated that their trainings on the use of

the strength-based approach helped them understand how to identify strengths even in the most difficult of cases. One home visitor commented on this during her interview.

> I don't care if you've worked for MIHOW for fifteen years you're continually trained on the strength-based approach because it's just the core of what we do. So we have to have trainings on ways to find strengths. So then we'll bring out new words that maybe people haven't really thought of as being strengths and we're constantly giving the girls lists of words to kind of jog their mind." (Nora, personal communication, June 26, 2015)

I obtained a copy of an example of these lists Nora spoke about during her interview. The document was given out to home visitors at one of the trainings I observed. On this piece of paper home visitors are given two separate lists. One category of list was called "skills and competencies" and one category of list was called "characteristics." These two lists were given to home visitors to help them come up with ideas for strengths in case they were faced with a situation where identifying a strength was difficult. Some examples of the skills/competencies list included: organizes, leads, invents, problem-solves, spots details, and demonstrates commitment to tackle difficult issues. Some examples of the characteristics list included: resourceful, patient, content, calm, creative, curious, dedicated, and willing to make adjustments to benefit family (Roberts & Withrow, 2014).

As data was collected the team of researchers on the larger evaluation study became aware of some possible confusion between distinguishing between what constitutes "a strength" and what constitutes "a behavior." During two of the follow-up interviews with home visitors from Blue Lake and Mountain Ridge I asked them about the differences and how they were trained to understand those. Rachel, a home visitor from Mountain Ridge, gave this answer :

> Well "a behavior" could be anything they do really. But "a strength" is something they do that will help their life or their baby's life. "A strength" come from within. And I

> think “an action” is something someone does in a moment, but “a strength” can change their life. (Rachel, personal communication, August 8, 2015)

A follow-up question was then asked to Rachel. I wanted to know if she could give me an example of a “strength” she had seen in a mother versus a “behavior.” She then recalled a story about a mother she was currently seeing who had a premature baby. Rachel said that caring for the baby would be a “behavior.” She said that the mother did a good job of keeping up with medical visits and keeping the baby healthy. But she said this mother’s “strengths” were determination and not giving up. Rachel felt that, “Bringing that strength to their [mothers] eyes gives them confidence and helps them so they can help the baby.”

The second home visitor, this time from Blue Lake, who was asked about distinguishing the differences between a “strength” and a “behavior” gave a similar answer. She also said that a “strength” comes from within the mother and that a “behavior” could be a positive or a negative. For example, she stated that a behavior could be that a mother was a smoker. But she went on to say that she would encourage that mother through other “strengths” she would identify. She said that, “maybe that mother was very willing to make changes to benefit her family in other areas.” If so, she would point those out to the mother and then use that example to “encourage the mother to stop the behavior of smoking” (Olivia, personal communication, August 8, 2015).

All of the home visitors found the strength-based approach to be the backbone of the MIHOW mission and the MIHOW program. The collected interview data illustrated this point over and over again. Laura, a veteran home visitor from the Blue Lake location, summed up what she believed to be the most beneficial parts of the MIHOW program in her follow-up interview on June 23, 2014.

> We've been doing it a long time. It has always been the premise of our program and being that despite circumstance or education of the family there are strengths, and when you walk into their world the idea of identifying their strengths and sharing those with the family is very powerful. MIHOW is a strength-based approach and for workers to know this is important and this is just not another job. (Laura, personal communication, June 23, 2014).

Curriculum "It's pretty much led by the mom, but we have the curriculum." The home visitors interviewed in this study viewed the MIHOW curriculum, based on monthly development, as the foundation of the MIHOW program, although not always the focus of the home visits. Often the curriculum was customized based on the current needs of the families. Home visitors were trained to prioritize each of their home visits by always putting the family's needs above their own plan for that visit. One home visitor explained how the mother's needs could set the tone for the home visit. "You know it's pretty much led by the mom, but we have the curriculum" (Tammy, personal communication, October 30, 2014). Tammy described the curriculum and how it was used:

> We have these curriculum guides that kind of guide us through the information that we need to cover. But I like to go there [to the home] and see what they [the parents] know because I'm a teacher at heart. I don't want to re-teach if someone already knows things. (Tammy, personal communication, October 30, 2014)

The curriculum was originally written at one of the West Virginia sites by Linda Stein, a former MIHOW home visitor and site leader, who eventually submitted it to the national MIHOW site. Vanderbilt University took the submissions and created the national curriculum. A home visitor described the content of the curriculum as it related to monthly development:

> We had specific curriculums for prenatal each month during the prenatal period, like a big three-ring binder curriculum for. . . each month during the prenatal period. We have a curriculum for the first year for each month. We have a curriculum for the second year for each month, and then we have a curriculum for the third year, which doesn't go so much by each month of the third year but very important topics, be it dental or safety or just a

> lot of great information for parents. So that is our curriculum and we base every home visit we do from our curriculum. We take information or go with intentions to cover those things as well as whatever the family needs covered and what is the most important, but we do have a curriculum and use that to design our visits. (Laura, personal communication, July 17, 2012)

Home visitors conducted a home visit with each family for approximately an hour and a half one time a month. Home visitors reported that they planned home visits related to methods and materials based upon where the mother was in her pregnancy or where the child was in their developmental process. As one home visitor described:

> It's a program that is volunteering and is free and one that home visitors visit about once a month, for about an hour and a half … I would prepare my visit. I have a folder and a file for each family I visit…What are the plans for this visit? And I gather my materials that I need for the visit, which might be a handout. It might be a visual to demonstrate something that I'm trying to get across like how do you figure how many teaspoons of sugar are in that little can of root beer you are drinking… And when you show them that. It just sends a greater impact than telling them. (Laura, personal communication, July 17, 2012)

Echoing that home visitor, another home visitor explained that her typical curriculum-focused home visit only lasted about an hour. But the additional time that she spent with the mothers during the visits varied based on the mothers' needs: "I don't even use a watch." She said it usually takes her over an hour and a half and that she allows for more time during the home visits based on where the moms are in their pregnancy and depending on their intellect. "Sometimes if you move too fast and they're a little slow it is hard for them to retain everything and understand it" (Tammy, personal communication, October 30, 2014).

Many of the home visitors spoke about the accessibility of the MIHOW curriculum. They understood the curriculum to be a resource for practical help for the mothers. One home visitor described how the curriculum was helpful: "Because they've got a curriculum they go by

and it helps mothers who just don't know what to do." This same home visitor described the content of the curriculum and how it focused on the development of the child:

> A home visit … consists of one piece of paper. It is based on whatever month of pregnancy you are in, what the baby's development is, and what is developed on the child. Then whatever stage you're in we talk to you about that, and then write down if there were any concerns or anything like that. (Tammy, personal communication, July 16, 2012)

She provided another example of the content of the curriculum and how it focused on the development of the child:

> You go exactly where the child, even if it's a new one or say that I've got a six month old. I'm seeing her this month and it's turned six months. I'm going to look up the six months lesson plan and I'm going to pull out of there mostly the activities I need to see the child doing. (Tammy, personal communication, July 16, 2012)

As stated in MIHOW's mission, the curriculum was also customized to fit the needs of individual mothers depending on what they needed at the time of the visit. One home visitor provided a strong example of how the content of the curriculum could be customized:

> She [the mom] had two kids in the program. She had everything ready for the children, and when I got to the door the husband met me at the door. He said, "Look where she stabbed me with an ink pen." You know you can't just fly off. You've got to see what the surroundings is like a little bit before you do anything. I said, "Come on let's see where mommy's at." And we walked on in there and she was picking glass out of her head. (Trisha, personal communication, January 21, 2013)

The home visitor changed her plans for the visit based on the need of the family at that time. Another home visitor spoke about the customization of visits and the need to build flexibility into the visits. Home visitors have what are called Home Visit Guides. These guides are somewhat like a lesson plan in that they help a home visitor know what targets the mother and/or the baby should be on or what topics should be discussed during that visit. But MIHOW's mission is first and foremost about meeting the mother and the family where they are in that

moment. The flexibility to forego the Home Visit Guide, or to modify the guide, was mentioned by each home visitor. One home visitor explained what that type of flexibility entailed during one of our discussions:

> You can go in and you've got to focus on the family where they're at, and you don't push stuff on them, because you've got to know your families. You can't push stuff on them that they're not ready for no matter what you prepared. (Trisha, personal communication, January 21, 2013)

Home visitors in this study expressed their experiences and understandings of the MIHOW curriculum by illustrating that they knew how to create a plan and how to achieve the objectives of that plan based upon the mother's needs. Home visitors believed that they were there to provide information, to model and teach the curriculum, and to provide support by listening to the mothers' needs, thoughts, feelings, and concerns. Home visitors prepare for home visits using Home Visit Guides so that they are well equipped to share information through everyday conversation, to recognize and use teachable moments, to modify the information and plan when necessary, and to speak the language of the community so that mothers can access the MIHOW curriculum to the best of their ability.

Nonjudgmental Approach "If people are content they're probably happier than you are." The initial home visitor MIHOW training sessions discussed the importance of nonjudgmental help and teaching. Home visitors are taught to listen attentively and without judgment. I observed home visitors from both of this study's settings participate in this portion of the initial training in August of 2014. The training coordinators told the MIHOW home visitors that an essential part of providing support was to approach each visit with an open mind. It was not the job of the home visitor to impress their own thoughts or beliefs upon a family.

Home visitors were taught how to use active listening strategies, how to be sensitive to non-verbal communication, how to recognize unvoiced needs, and how to respond appropriately to those needs.

The participants in the study conveyed their own understandings of a nonjudgmental, or open-minded, approach to teaching during the interviews. It should be noted that all three home visitors interviewed from the Mountain Ridge location mentioned this characteristic of the MIHOW mission numerous times in their interviews. They believed it to be an important part of the MIHOW program. All three home visitors interviewed at the Blue Lake location also discussed their beliefs and understandings of the program's mission as it related to being nonjudgmental. They too cited it as an important and distinguishing feature of the MIHOW program and its mission.

One of the reasons MIHOW holds the nonjudgmental aspects of its home visitor training paramount has to do with the relationship between a home visitor and a mother. Home visitors are taught that while the home visitor-mother relationship is not a reciprocal one, it should be a safe and trusted one. Teaching home visitors how to serve as a confidant was something that I observed during the training I attended. Home visitors were taught that often they were the only person that was trusted enough for mothers to ask sensitive or embarrassing questions. This was why listening without judgment and helping without judgment were essential to the success of the home visitor and mother relationship. A home visitor from Mountain Ridge spoke about the importance of being open-minded:

> When you go to training they teach you these roles, I mean these scenarios and stuff and you've got to learn what you're going to do in that scenario and how you're going to handle it, and yeah that's where you learn how you can't, you've got to go in with an

> open mind. You can't go in with closed shutters or anything or thinking it's going to be this and it's not. I mean everybody's lifestyle is different and everybody has different ways. (Rachel, personal communication, June 24, 2015)

Rachel then went on to give an example of a time when she had to put those skills to practice in terms of being nonjudgmental and open-minded about living conditions with one of the families she saw. She said:

> I've gone into a house that's infested with cockroaches. And you've got to learn you know, just keep your mouth shut and figure out how to do it and say thank you and stay positive and be strength wise, give them strength and then go on. But you are not there to change them so you can't judge what they think is ok as long as it don't harm the baby. (Rachel, personal communication, June 24, 2015)

Open-minded home visiting goes beyond living conditions. Some of the home visitors spoke about intense situations related to domestic violence and safety issues. Trisha, a home visitor from Mountain Ridge, spoke candidly about a case where Child Protective Services (CPS) became involved with one of her mothers without her knowledge. She just happened to be coming for a scheduled visit the day CPS came to remove a child from the family home. She described the day to me:

> I went to see her and she was pregnant at the time and when I went in her mom answered the door and said she's in the room. I asked if I could go in there. She was crying when I opened up the door. She had another kid and she was crying because they [CPS] were coming to take that child away. I sat with her and I let her tell me, I listened. I listened to what she said. I said is there anything else you want me to know? I didn't feel like it was my place to say anything at that time. And I wanted her to tell me what she wanted me to know. (Trisha, personal communication, December 12, 2014)

As mentioned earlier home visitors are trained in the skills associated with active listening. Trisha gave an example of active listening that matched what I observed during the home visitor training that I observed. Role-playing was used to help home visitors practice active listening skills such as attending, acknowledging, displaying eye contact, being quiet, and

supporting all while listening to what the speaker is saying. One home visitor from Blue Lake said "Being quiet is sometimes the hardest thing to do, but it often can be the most important" (Olivia, personal communication, August 8, 2015). During the initial home visitor training seminar the three steps home visitors were told to complete in each situation were as follows: 1.) Stop before you speak 2.) Look at the nonverbal signs 3.) Listen to the words.

Olivia spoke about empathy when she was discussing being nonjudgmental as long as no harm was being imposed on the child or the family. Olivia reported that she liked using the active listening skills of interpreting and restating with families she saw. "I will find myself saying, let's see if I'm clear about this, or let's see if I understand this correctly." She also stated that she finds that tentatively offering your perspective about the feelings or meanings expressed was a useful tool to getting mothers to express their thoughts, fears, or concerns more openly. "If I say what I think and don't let them speak, then I've lost them. But if I listen and wait for them, I will speak and give advice or help" (Olivia, personal communication, June 5, 2015).

Tammy spoke about her training within the MIHOW program as it related to learning to be nonjudgmental with the families she saw. "That's like a really big thing for a home visitor to go through. To lose your baggage and your own stuff at the door and go in and be there for that individual that you're visiting" (Tammy, personal communication, July 16, 2012). All of the home visitors believed that nonjudgmental mentoring was an important feature of the MIHOW program.

The rapport between the mothers and home visitors was important to establishing and maintaining their relationships. Being nonjudgmental is one key that is necessary to establishing that bond. One home visitor said that it was not difficult for her to gain rapport with the mothers:

“They tell me everything” (Trisha, personal communication, December 12, 2014). She then explained that often she was the only person coming around the house regularly to see mothers:

> Some of them tell me too much but…I realize I’m the only person that probably comes in the home once a month and talking about her and her baby and the family, you know. I’m also the only person these moms see on a regular basis. (Trisha, personal communication, December 12, 2014)

Personal experiences of the home visitors also seemed to influence the work and the relationships they had with mothers. All of the home visitors came from different and unique backgrounds that influenced their work within MIHOW. Nora, a home visitor and now the MIHOW site leader for Mountain Ridge, spoke about her own life when asked about why she continued to do some home visiting, even though she was in a leadership position. “There’s certain things that are just near to my heart like the teens, I was a teen mom myself” (Nora, personal communication, June 26, 2015). I followed up by asking her what that meant to her, she responded:

> I’ve been there and I just really, I know how hard it is, so I know how judged teenage moms seem to be. And I’ve always said like sometimes I run across teenage moms who are better moms than some of the older moms cause I think they just try really hard you know to prove people wrong. (Nora, personal communication, June 26, 2015)

Nora spoke about how she learned how to be more open-minded and how her views changed about situations over the course of the seven years she had spent as a home visitor. She talked about how with each new family she would see, she would change her views about what families wanted, or what she believed they should want. This disconnect between personal beliefs and the beliefs of the families spoke to the importance of home visitors understanding MIHOW’s mission as it related to the nonjudgmental approach to home visiting. Nora recalled

one story when she realized that “wanting something more for somebody than they wanted for themselves” could be a frustrating part of the job. She went on to say:

> One family that really kind of made me change my views of the way I looked at families was a family that lived, in you know, like, low-income apartments, and they had four kids. Their dad would walk to work every day. A good family, but just seemed to struggle all the time. And I was always giving them plans to get out of the housing place they were in. Like, I wanted them to have something more than what they had. But they were so content. They were just completely content. And all their needs were met. Their kids were healthy. They had a roof over their heads, all that stuff, and they were just so content, and it was so hard for me to understand why they wouldn’t want to grow and do better, and one day I was talking to this woman about making some changes and improving where they lived and she was just kind of like, we’re fine. Like, they were just completely fine with where they were. And you know, it taught me how sometimes being content is worth more than anything, I mean, you know as long as everybody’s needs are met. (Nora, personal communication, June 26, 2015)

Throughout the years she learned from experiences, like the one mentioned above, about what being a home visitor required. She also learned how to let go of her own personal belief systems and goals. This was a key to being successful in carrying out MIHOW’s mission. Following what the family needed or deemed important, as long as all of their needs were being met, is what MIHOW asked home visitors to do. As Nora said in her first interview, “if people are content they’re probably happier than you are. So then why would you try to change something that’s not broken even though it may not be what your plan is for their life” (Nora, personal communication, June 26, 2015).

Question Two

“The training I have received over the years has been varied, lots and lots of different types of training.” MIHOW recognizes that outreach workers and mothers have a mutual interest in making life better for all community members. MIHOW believes that trained community workers, home visitors that come from the same communities as program participants,

understand how to present and personalize information that best educates and meets the needs of the parent while giving the program a local face. Home visitors are trained paraprofessionals that visit families in their own homes. MIHOW states that home visitors serve several roles including being a helpful resource, a confidant, and a powerful role model (Roberts & Withrow, 2014).

Home visitors must shadow a veteran home visitor on a home visit and complete 40 hours of initial training before they begin to serve families. Initial training orients home visitors to the MIHOW model and instructs them in the following areas: recognizing and building on mothers' strengths, developing active listening skills, use of the MIHOW curriculum, understanding home visitor safety, record keeping, nonjudgmental mentoring, recognizing and accessing community resources, how to conduct home visits, and balancing work and home. The MIHOW program's training manual, *The MIHOW Way,* states that "because home visitors are paraprofessionals, monthly training is a requirement of the program" (Roberts & Withrow, 2014).

Trainings for home visitors exist on three levels within the MIHOW structure. First, national MIHOW conferences occur one time a year at the home of MIHOW, Vanderbilt University. Secondly, a state-level conference is held every year that provides education and training for home visitors from all state MIHOW agencies. And thirdly, site based trainings occur twelve times a year. These trainings are usually held one time a month and cover a variety of topics. Home visitors that participated in this study stated that site based trainings covered topics that were important or vital to the needs of home visitors at that time. For example, one site based training recently covered the topic of prescription drug abuse because of its rise within

that community. Another recent site based training covered the topic of how to properly use a new software system to complete monthly paperwork following home visits. In addition to these different training levels, an initial home visitor training is also conducted each year on the state-level. All home visitors, no matter if they are new to the job or not, are required to attend this training. All three levels of MIHOW training are required for accreditation through the national MIHOW organization.

Each home visitor was asked about the kinds of training they received through MIHOW, what they had learned through their trainings, what types of things they would like to see included in the trainings, and what they believed to be the most beneficial parts of their MIHOW trainings. Each home visitor answered each of these questions and gave examples of experiences and stories related to each of these questions.

Laura was the first home visitor interviewed during the data collection process. When asked if she could tell us about the trainings she had received over her years as a home visitor she said:

> To start off we learn about what skills does a MIHOW home visitor need to be effective. And the idea of being a good listener, the idea of being positive and sharing the strengths of the family, we would be there to support mom. That is our primary goal is to be there to support that family and that can be a lot of different things. Not to be judgmental. I mean we learn at these initial trainings the skills that are important to be a good effective home visitor, the approach we use being strength-based, also the importance of being able to keep up with paperwork. (Laura, personal communication, June 23,2014)

MIHOW's training covers the broad categories that help define MIHOW's mission and its goals as a program. Understanding the strength-based approach, how to develop rapport and appropriate relationships with mothers, and learning to be nonjudgmental no matter the living conditions or circumstances were all mentioned by the home visitors as being components of

many of MIHOW"s training seminars and sessions. Specifically though, home visitors broke down other parts of their training that covered topics from breast feeding, to neurological development, to a self-defense class.

"The training I have received over the years has been varied and different" (Olivia, personal communication, August 8, 2015). Home visitors gave examples of the different topics that were covered at the site based trainings they attended each month. Tammy, Olivia, and Laura spoke about the monthly trainings they received at Blue Lake. "These monthly trainings could be anything from information about WIC, to inviting someone in to speak about child development or even brain development" (Laura, personal communication, June 23, 2014).

Home visitors at both sites spoke about how MIHOW site leaders would often ask home visitors for a wish list or a needs list of what they would like to learn more about. Tammy mentioned that she wanted to learn more about autism while Trisha, a home visitor from Mountain Ridge, had wanted to learn more about infant massage. Both of these women were given financial support to attend conferences that covered those two topics. Rachel, another home visitor from Mountain Ridge, told her supervisor that she would like to learn some basic self-defense tactics and strategies. The following year the state MIHOW conference held a session on women's self-defense conducted by the West Virginia State Police.

While monthly trainings varied and were often based upon home visitors' wants and needs, the initial training seminar did not vary from year. Home visitor initial training seminars occur one time a year and take place over three days. Home visitors are required to attend each year regardless of how many years they have been working as a home visitor. Rachel recalled what she learned during her first time attending the home visitor initial training.

> We learn a lot in the first ones. It's almost a week full of classes and we learn about what MIHOW is and where it started and the history. And then I remember in the first one I learned things about breastfeeding that I didn't know and all about the different stages of a baby's life. It's got a lot of good stuff in it that teaches you things that I didn't even know. (Rachel, personal communication, June 24, 2015)

The presentation of the *MIHOW Home Visitor Training Notebook* by Roberts and Withrow (2014), the home visitors interviews, and the observation of the initial home visitor training seminar in 2014 revealed that during the initial training session the following topics were covered: MIHOW's history, its approach, pregnancy, birth, child development, how to complete MIHOW home visit guides, record keeping, paperwork, professionalism, confidentiality, nutritional information, healthy living habits, and how to use screening tools.

The state conferences are usually one or two day workshops and/or trainings that cover topics pertinent to home visiting. Sometimes these conferences cover topics that are personalized to the home visitors. The state conference for 2015 covered the strength-based approach and how to implement it effectively. Olivia, a home visitor who attended this conference, spoke about the importance of revisiting the strength-based training.

> I feel like it is always good to go back to the strengths. It really doesn't matter how often you hear about the strengths and how to help mothers realize their strengths. I find that just hearing stories and examples from the more experienced home visitors gives me ideas and helps me look at my families differently sometimes. It's like a refresher and I know I need it. I think we probably do from time to time. (Olivia, personal communication, August 8, 2015)

The home visitors did not talk as specifically about the national home visitors training conference that was held each year at Vanderbilt. They all stated that they had attended the conference each year that they had been a home visitor and that the conference was held every April. A few of the home visitors spoke about how nice it was to visit Nashville each year and

that they enjoyed seeing the home base of the MIHOW program and meeting home visitors from other states.

Trisha did recall some specific types of training that they received at the national conference. “You go to the conference for like three or four days and you’re in there for like eight hours a day” (Trisha, personal communication, January 21, 2013). She stated that there was usually a portion of the opening day of the conference that covered MIHOW’s history. She also stated that the national conference would usually announce any new program-wide changes that would be occurring in the coming year. For example, this past year they were told about the switching of their monthly home visit paperwork. They were in the process of moving all of their monthly paperwork from a hand written copy to a digital format. The home visitors at both of the study’s locations were recently trained on the new software program.

Trisha went on to say that the national conference was geared directly towards the home visiting process and practice. “It’s mostly geared towards home visiting guides, you know just different stuff and they kind of bring in some stuff that’s new and new things you can try with your moms or with your kids.” When I asked Trisha if MIHOW had new presenters each year she responded by saying, “Yeah, they’ll have new speakers coming in and doing different trainings just for home visitors. Things like child safety, domestic violence, child development, breastfeeding and stuff like that. That’s what we talked about most this past year” (Trisha, personal communication, December, 12, 2014).

Laura also spoke about some of the training topics she had remembered the MIHOW national conference teaching over the years. “Trainings go anywhere from labor and delivery, STDs, contraception, and just how to help moms identify resources” (Laura, personal

communication, June 23, 2014). She went on to say that many of the same topics covered at the national conference may be reviewed during a state or site based monthly training.

One aspect of the MIHOW program that is unique is the use of paraprofessionals as home visitors. MIHOW does all of its own training, therefore, they feel that women who are mothers themselves and who reside in the communities they work can be taught the skills and strategies to become effective home visitors. Of the six participants in this study, five of them are lay members of the communities they serve. Laura was the only home visitor who had obtained a bachelor's degree, in Editorial Journalism. All of the other home visitors had obtained a high school diploma and various training post high school, but none had obtained a bachelor's degree.

Two of the home visitors had differing opinions on the topic of using paraprofessionals as home visitors. Trisha, a paraprofessional herself, believed that MIHOW would be a stronger program if home visitors were required to hold a degree. Trisha believed that home visitors should have a degree in a child development or teaching field. She recalled the surprise she had when learning the requirements for being a home visitor. "Through this program you don't have to have no education. You don't have to have an education to go up there and be a MIHOW worker. All you have to do is go through their trainings and be a mom" (Trisha, personal communication, January 21, 2013). I asked Trisha how she felt about that and she said that "I think you need education, I'm sorry but I think daycare workers and MIHOW people should have an education" (Trisha, personal communication, January 21, 2013). When I asked her why she felt this way she responded by saying:

> Even if they have a degree, a two year degree. I don't mean to sound mean or nothing but you need to be able to go in these homes and teach what you should be teaching on the child's level. Anybody can be a teacher but it takes someone that has got the degree

> that can really teach and understand the teaching they give. (Trisha, personal communication, January 21, 2013)

On the opposite side of this belief was Trisha's site leader, Nora. Nora was also a lay member of the community but she had recently begun working towards obtaining her bachelor's degree in social work. Nora goes to school part-time and works at MIHOW full-time. Nora brought up the topic of paraprofessionals in MIHOW without prompting. She was referring to the idea of what she called the "power of mothers helping mothers." I asked her about why she felt there was "power" in this relationship between mothers and home visitors and she replied by stating the following:

> I mean I have three of my girls who have degrees in other things, and four don't you know maybe not necessarily like social work or whatever but they have degrees. It's not required for the girls, you know women to have degrees, but I just think that, well I mean we've had other people who have been on the program and then they become a visitor. I don't think it matters if you have a degree or not. Because the program trains you to do what we do and they keep up with it and then you really do learn by doing it. And of course, everyone is a mother themselves too. I just think, even through just me working here I didn't have a degree. I'd never been to college and I have worked up to being a supervisor or site leader. (Nora, personal communication, June 26, 2015)

The two differing views on this idea of training and education were interesting. Nora, a site leader who was once a mother in the MIHOW program and who is now working towards a degree in social work, felt MIHOW's trainings and being a mother were enough to make the program effective regardless of a degree. But, Trisha, a home visitor who had years of experience working with Head Start and MIHOW, felt that having a degree would be beneficial to the children in the MIHOW program. Trisha believed that if a home visitor had a knowledge base about child development or teaching models and strategies then she would be more effective at her job. Both women stated their beliefs and experiences as home visitors who had

attended the same MIHOW trainings as home visitors. The other home visitors fell on the side of Nora and did not feel a degree was necessary for home visitors. They all felt that their past and ongoing trainings within the MIHOW program had made them prepared to conduct home visits and help the mothers and children they served.

Question Three

"You feel like somebody's got your back." How do home visitors experience and understand the support they receive in their work with the program? This question was asked of each of the participants in this study. In addition, each home visitor was asked to give examples of ways they felt supported, or if there were ways they felt the program could be more supportive. The home visitors spoke about support in a few different ways. They spoke about the unity of the home visitors and how they felt supported by one another. They spoke about the process of reflective supervision and what that meant to them. They spoke about the continuing education parts of MIHOW, and finally they all spoke about a few ways in which they believed they could be supported more in terms of their own reimbursement and use of resources.

The data revealed that all of the home visitors felt supported by one another. As one home visitor put it, "having someone that's there for you, knowing that they're there for you is a big support, you feel like somebody's got your back" (Rachel, personal communication, June 24, 2015). Home visitors stated that they felt supported by one another in the areas of mentoring, collaboration, and even beyond the parameters of work into their personal lives.

Some of the home visitors mentioned that they felt the biggest component of support from MIHOW came from knowing that you "always had someone there to bounce ideas off of" (Tammy, personal communication, July 16, 2012). She stated that within her location they

all had areas where they excelled. So for her personally, when she did not feel comfortable with some areas of breastfeeding education, she knew she had a colleague that she referred to as a "breastfeeding guru." She spoke about going to her for help and how that home visitor came to her aid.

> Let's say I have a girl who is having trouble with breastfeeding. Well I don't know a whole bunch about that so I would call [Laura] and she is like our breastfeeding guru. She would go with me and we would go in there together and visit that girl. I would watch and try and learn from observing her." (Tammy, personal communication, July 16, 2012)

Tammy went on to explain that having the support of other home visitors was crucial to the job for all of the home visitors.   I asked her if she felt she had a support system to do her job effectively. She answered quickly and confidently, "Definitely, definitely. Our team's been together for so many years." I asked her why she thought that was important and she said:

> We just know each other and we know who knows what and who has got what information. I tell you what, that's what has kept me at this job for twenty-five years, the people I work with and the support they give you. (Tammy, personal communication, October 30, 2014)

Both of Tammy's colleagues at the Blue Lake location echoed these sentiments. One of the home visitors there stated that when she first started she "never would have made it long without the support of her other home visitors" (Olivia, personal communication, June 5, 2015). She talked about how her own confidence grew because she knew that she had "resources and help whenever I needed them." The other home visitor from this location went on to describe the support she felt they had created within the MIHOW structure. She stated that she felt "like our program is respected and valued and that we all work together. It's a network that is more

effective because we're connected" (Laura, personal communication, June 23, 2014). She then went on to give an example of that "connected" feeling:

> Every time we meet we have a positive check in. We do our business. We have appreciations at the end of our meetings. It's just a lovely way to work, lovely coworkers, and since we have been doing this we have a program that is becoming more recognized. (Laura, personal communication, June 23, 2014)

These meetings or, "positive check-in" activities, are completed at both sites. MIHOW believes so strongly in the strength-based approach that the program uses this model with home visitors as well. The home visitors spoke about how they enjoyed this part of their own support structure and how it made them feel as women asked to complete what is sometimes difficult work under difficult situations.

> We have our own strengths and this job has helped me to learn some of mine. My boss [Nora] has helped me to focus on what I have that helps me be a good home visitor. I speak my mind, you know if you ask me I'll tell you, cause you shouldn't of asked you know. I like that I can be myself cause they have told me that is a strength I can use in this job. And [Nora] will tell me things that I can do and she knows I'm creative, crafty. I build things and my strength is I will advocate for my parents. That is my own personality but the job brings out the good parts of that. I did it myself but my boss made me realize I did it. (Trisha, personal communication, December 14, 2014)

Trisha went on to say that hearing someone else identify your own strengths "gave you a confidence, it makes you feel good." She said you could "get ideas of how to make things work for you and then if it doesn't work then someone will offer to go with you" (Trisha, personal communication, December 14, 2012). Just like at the Blue Lake site, mentoring and observing one another were brought up as positive forms of support.

Monthly staff meetings and one-on-one with MIHOW Site Leaders provided home visitors opportunities to hear their own strengths and to hear how they could use those strengths to improve areas they needed to work on. One home visitor believed the monthly staff meetings

were important because these were times when everyone's voice was heard and everyone talked about their problems. She felt this was a powerful part of MIHOW's support not just for the home visitor doing the speaking, but also for the home visitors who were listening. She judged this interaction to demonstrate to all of the home visitors that everyone has families that have challenges and that working with one another they could tackle those challenges.

The one-on-one meetings with the MIHOW Site Leaders are called reflective supervision meetings. During these meetings site leaders talk and listen to home visitors, their concerns, their challenges, and their triumphs. Reflective supervision meetings take place one time a month and last for approximately two hours. One home visitor described this time as "a chance to rant and rave about what we all have problems with, what's going on, what we need help with, anything like that" (Rachel, personal communication, June 24, 2015).

All of the home visitors treasured these reflective supervision meetings.   They cited these exchanges as ways to learn more about themselves and to learn more about effective home visitation. Rachel described what reflective supervision meant to her:

> We all have this one-on-one thing with her [Nora], and it's just, to have someone as wonderful as Nora be your boss and to go in and she's always there for you and to help you that's one bonus that I have with this job. I've went through quite a few jobs and bosses, but Nora does so well with helping you get to your strengths and she'll talk to you no matter how long it takes. She'll just be there for you. I mean she always has been, and she'll help us no matter what we need. (Rachel, personal communication, June 24, 2015)

Continuing education opportunities were another way home visitors experienced and understood the support they received from MIHOW. As mentioned in the answer to the second research question that examined the home visitor training, many of the home visitors gave examples of times when they had asked for further training on topics both by MIHOW and by

outside agencies. All of the home visitors reported that if MIHOW could not find a specialist to come in and provide the training then they would support the home visitors to seek out the training from an outside agency, as long as the budget supported it.

Some of the outside trainings that home visitors mentioned included topics such as infant massage, sign language, car seat safety, autism training, fetal alcohol syndrome, drug abuse and pregnancy, and tobacco use prevention. One of the home visitors discussed a recent continuing education workshop she attended on tobacco use prevention and how the workshop lead to her connection to other resources within her community.

> Most recently I attended a tobacco prevention workshop and it was just amazing. We learned what to talk about to parents and how West Virginia has a quit line that will help support people when they are trying to quit smoking. And in addition to the state-level person who was providing this training we also had an OB/GYN doctor who was there to really qualify how bad it is to smoke during pregnancy and what she sees. We had kind of a total medical experience with this state agency where we could all talk and get materials. (Laura, personal communication, June 23, 2014)

The only topics that were mentioned when home visitors were asked about ways they could be more supported were related to monetary resources. Home visitors all mentioned that they wished they were compensated a little more and wished they received benefits like retirement and healthcare. One of the home visitors also mentioned that she would like to have MIHOW provide vehicles for them to complete visits. She explained that the maintenance and wear and tear on her car was something that was concerning due to the “kind of roads and places we have to travel to.” One home visitor said, “As far as personal support we have that. We have a network of support within our group, but it would be nice to have a retirement plan and benefits like that.” It should be noted that home visitors were questioned and even asked to name

“pie in the sky” ways they could be better supported. No other topics outside of pay and vehicle maintenance were ever mentioned.

One area that home visitors expressed support from MIHOW went beyond the parameters of their jobs as home visitors. Three of the home visitors mentioned ways that MIHOW and their fellow coworkers had supported them in their own lives. These situations included the death of a spouse and the support to go back to school.

One home visitor from the Blue Lake site spoke about a time when she lost her husband and how during those times her fellow home visitors and bosses were there for her. “I tell you when my husband died twelve years ago in 2002, they were there for me just on a personal level” (Tammy, personal communication, July 16, 2012). Although the subject was personal, I did follow up by asking her how her colleagues were there for her. “They gave me time to grieve without the pressure of jumping back to work. They helped me and my kids and let me work around my kids’ schedules since I was now a single parent” (Tammy, personal communication, July 16, 2012).

Another home visitor, this time from Mountain Ridge, spoke about how her former boss at MIHOW was responsible for her return to school. Nora stated that she did not feel like it was a reasonable time for her to be pursuing her own education.

> One day my boss asked me why I never went to school. I told her I didn’t have any, like, family, both of my parents died when I was younger. I just had no real help. So when she approached me about going to school it was about the same time that my husband lost his job in the coal mines where he worked for thirteen years and my daughter was leaving for college too and I was just like I need my hours here. I need to work. And she said to not worry about it like she would work it out where I had enough hours and could go to school too. I could’ve never worked anywhere else. (Nora, personal communication, June 26, 2015)

Each of these home visitors came from unique backgrounds where they have experiences that shaped who they are as women as well as who they are as home visitors working for MIHOW. The women in this study told stories and gave examples of how they felt MIHOW was working for them in their lives as women who are supporting themselves, their families, and their MIHOW. The women described MIHOW as a network of support over and over again in their interviews. The home visitors viewed this network as a fundamental part of their success and effectiveness as home visitors.

Question Four

"Teaching them how to talk to their baby to learning how to talk for themselves." When asked if MIHOW influenced language development and if so, how each of the home visitors described their own experiences with working with families and how they understood their roles in teaching and identifying language behaviors. Home visitors also spoke candidly about their language training and where their knowledge about the subject came from. I also attended a conferences where the required *MIHOW Home Visitor Training Notebook* was presented. In addition, I also completed a participant observation of the first day of the initial home visitor training seminar that was held in August of 2014.

Home visitors at both sites spoke about the MIHOW training they received regarding typical language development. The MIHOW home visitor training that pertained to language development also consisted of providing home visitors with developmental norms and guidelines for developmental language milestones. Within these guidelines some language behaviors were listed. For example, in the one to two year timeframe the *MIHOW Home Visitor Training Notebook* states that, "Children begin to learn many new words and begin to use simple phrases

between year one and year two" (Roberts & Withrow, 2014). The *MIHOW Home Visitor Training Notebook* then goes on to list seven different behaviors that MIHOW considers key characteristics of language development during this time (Roberts & Withrow, 2014). These language behaviors include: following multi-step related directions, responding correctly to "where" questions, understanding many words and phrases, using some pronouns, using some prepositions, using words to describe an event, and denoting that beginning at 18 months the child should be learning on average nine new words a day (Roberts & Withrow, 2014). MIHOW training provides each home visitor with handouts listing the key language behaviors and skills of children from birth to three years of age.

Other training activities home visitors spoke of regarding language development included role-playing activities. I observed one of these role-playing activities when I observed the Initial MIHOW Home Visitor Training on August 25, 2014. During the home visitor training I observed an activity where home visitors were asked to role-play with one another the practice of modeling. In this activity the home visitors divided themselves into groups of two and worked on modeling language while participating in an activity. These activities included labeling parts of various objects and commenting on what the home visitor was doing within the activity. When the home visitor was pretending to be a "child," the other home visitor would comment on what the "child" was doing. This style of modeling was described in a second interview with Rachel, a home visitor from Mountain Ridge. Rachel said, "You know once that baby comes we start trying to teach the mom how to talk to that baby and how to point stuff out that they are doing" (Rachel, personal communication, August 18, 2015).

The home visitors spoke about how they assessed language development and how they taught moms methods to improve language for their babies using talking, reading, and other activities. The amount of time spent working with mothers on language was also an issue mentioned by one home visitor.

One home visitor identified speech delays as one of the most common areas in which home visitors see developmental delays: “We see lots of speech delays which can usually be taken care of pretty well” (Olivia, personal communication, June 5, 2015). One of the ways home visitors addressed possible speech delays was with the use of the Ages and Stages developmental screenings. As one home visitor explained, “They are really just good indicators for children that aren’t meeting their milestones” (Laura, personal communication, June 23, 2014). The monthly screenings followed a format with six questions in five different developmental areas: communication, gross motor, fine motor skills, problems solving, and personal-social. Three of the home visitors spoke about making referrals to outside services if they were concerned about language development.

One home visitor brought up the way she had used Birth to Three services. “They [Birth to Three] are usually very helpful. They’ll work with us and that’s great. If somebody needs, say, speech therapy they can go in and do more intensive things with the children and parents that we can’t do” (Tammy, personal communication, July 16, 2012). This home visitor went on to report that she had made referrals to West Virginia Birth to Three over the years for child development issues related to language, speech, swallowing, and physical growth.

Another issue related to the kinds of strategies and methods that the home visitors used with the mothers related to language development for the babies. As one home visitor put it: “I

do a lot that focuses on how to teach mothers good language habits" (Olivia, personal communication, August 8, 2015). Talking and reading were two methods that were mentioned multiple times by home visitors as ways to teach mothers how to promote language development. One home visitor described how talking and reading to the baby was used to help the baby meet language milestones through face-to-face listening between the baby and mom:

> [If] you're not hearing those little cooing sounds, that's going to be something that before I leave you know I'm going to say, "Okay this will really help you, to help baby meet those milestones you know, talking to the baby, reading to the baby, face-to-face, whole face listening. (Trisha, personal communication, December 12, 2014)

Another home visitor described how she used modeling: "That's my biggie, just encouraging reading and modeling, the necessity of speech and words" (Laura, personal communication, July 17, 2012). The same home visitor explained in that interview that "we talk about speech and how babies can see your lips and doing things deliberately."

In addition to modeling, one home visitor from Blue Lake explained, "There's so many different language activities we are taught to do with the kids and then of course you start getting experience and you come up with new ones on your own" (Laura, personal communication, October 30, 2014). She then identified activities such as puppet play, magnets for the refrigerator, making books, writing labels on objects, and singing songs. She said she promoted activities so that the babies had fun while they were learning.

MIHOW trains home visitors to work with the mothers and to teach them how to interact with their children. This is key to how MIHOW approaches language development. It is also key to understanding how home visitors view their own roles as paraprofessionals charged with

instilling these practices in the families they serve. Rachel spoke of a recent example of how she indirectly taught the mother how to keep track of the new words her daughter was learning.

> I have been working with this family and the baby is the first baby they have had. Mom and Dad are new to all of this and Mom is real worried because that baby was premature and so we watch real close and she writes down the words or the sounds she hears that baby use. And she did that on her own because one time after I was filling out the Ages and Stages form with her she couldn't think of any words that baby was using, so next time when we did one the next month she pulled out a list. And she did that on her own because she knew I would ask again and she wanted to get it right to make sure her little baby was growing like she should. (Rachel, personal communication, August 18, 2015)

According to one home visitor, the MIHOW program had a strong focus on language. This home visitor explained difficulties she was having with the push for language development with mothers for their babies: "They're not doing too good right now but I push it, I am trying to get them to repeat what they are doing and to talk about it" (Laura, personal communication, June 23, 2014). She explained that since language and reading were two major components of education, she may be working with a parent that is lacking in education, "So when I visit with her she is learning to repeat, because she never had, you know, a good education. So I help her" (Laura, personal communication, June 23, 2014).

The home visitor described how she conversed with one mom about how to use conversation to encourage language development: "I always explain what she's [the baby is] doing. She [mom] said, "That's a lot of talking." I said, "Yes, but who's learning?" She said, "Me." And then she said, "Oh, is that what you want me to do?" I said, "Yeah" (Laura, personal communication, June 23, 2014).

All of the home visitors spoke about how their roles in teaching language really relied on teaching the mothers first and foremost. Home visitors did report working directly with children

during language activities but it was found that they worked on language development so that mothers would see their modeling of the language behaviors and then carry those behaviors over when they were gone. This was a MIHOW strategy that was mentioned in the training I observed as well as in the home visitor training manual. Home visitors are taught that focusing on the needs of the family and using the family's strengths to address those needs will lead to healthy living, lasting motivations, and self-sufficiency. This self-sufficiency is the ultimate goal the home visitors are working towards for each of the families they serve. As one home visitor said during her first interview, "I want these mothers to learn how to do for themselves and for their kids, and that is in everything from teaching them how to talk to their baby to learning how to talk for themselves." (Nora, personal communication, July 22, 2015)

Question Five

"We gave her a sense of importance, like I can do this." How and to what extent do home visitors put MIHOW strategies and principles into practice in their home visitations? Home visitors have explained how they understand and experience MIHOW's mission but how do they go beyond the principles of MIHOW and put them into place? Home visitors talked again about how the strength-based approach was the focus of implementing MIHOW's principles. They also talked about another component of MIHOW, its principle of connecting families to community resources. And finally, the home visitors talked about implementing MIHOW's curriculum and what that process looked like in terms of home visits, development, and filling out a screening tool known as the ASQ form, Ages and Stages Questionnaire.

According to home visitors they connected mothers to available services and resources in their community. This is one of MIHOW's strategies. MIHOW believes that one job of a home

visitor is to connect families to resources that can help them long after the family has exited the MIHOW program. Both the Mountain Ridge and Blue Lake identified a large number of resources for their families, and services were suggested to the mothers and families based on their individualized needs. "There's a million resources. We kind of just tailor it to the family's needs. We may use WIC a lot but it doesn't mean we do it for every family" (Laura, personal communication, July 16, 2012). The customization of the MIHOW curriculum was evident across both of the West Virginia MIHOW locations.

Another resource specifically mentioned was the use of a tobacco use prevention specialist because, "we see a lot of smoking" (Laura, personal communication, July 16, 2012). Some of the other resources identified by the home visitors from Blue Lake and Mountain Ridge were DHHR food stamps, smoking cessation clinics, Right from the Start, West Virginia Birth to Three, WV Quit-Line, food pantries, churches, and playgroups.

Often the home visitors were affiliated with community services or resources and knew of them before becoming home visitors. This affiliation was one of the reasons MIHOW required home visitors to reside in the communities they served. One home visitor from Mountain Ridge explained that MIHOW encouraged home visitors to use resources close to families. This home visitor conducted car seat safety trainings and trainings on home safety for the baby in which they gave away items such as car seats, wall plug-ins, safety doorknobs, and door latches. She described how she was a resource for her families related to car seat safety:

> I'm a car safety tech…. I'll check the car seats that are given to them [the moms]… and you know tell them that you really don't want to do that [accept car seats from others] because you don't know if that car seat has been in a wreck. It may look good but it may have lost its strength once it is in a wreck. So we have bought some car seats for our programs. (Trisha, personal communication, January 21, 2013)

Another community resource that home visitors at the Mountain Ridge location mentioned in all of their interviews was the GED program. The home visitors from Mountain Ridge utilized this program with many of the mothers they saw. One home visitor described the importance of helping mothers obtain this degree while MIHOW was involved to help mentor them through the program.

> They want them to come to GED classes. I have explained to my moms that there's a need that you are going to want to get done and that's why I'm helping you get this finished. I said GED is there to help. I said you're going to learn and they can help you if you want to do it. (Trisha, personal communication, January 21, 2013)

Nora, also from the Mountain Ridge location, recalled a story about a mother who had been linked to the GED program via MIHOW and how when that mother finished the program she had no one in her family to attend the ceremony with her. This mother called Nora and told her she would not be attending the ceremony because "it wasn't a big deal and she didn't have childcare" (Nora, personal communication, June 26, 2015). Nora took it upon herself to make sure this mother was recognized for her work.

> She had five siblings, none of them finished high school. The parents made them all quit. They believed that education was of no importance to anybody in the family. We had been working with her and she got her GED and then the day came and she was supposed to go for her graduation and she stopped by the office and said she wasn't going because nobody wanted to go with her and she didn't have a babysitter. Her husband, her sisters, nobody. I called a couple of my girls and they babysat her kids, and then I went to her ceremony with her. During the ceremony when they asked the mother of the graduate to stand she just looked over at me like, stand up. And then on the way home I was talking to her and I just told her she really had a lot to feel proud of. And she said it's not that big of a deal. And I told her yes it was because now your kids will understand that as for me and my kids, we don't quit school. You won't even leave it as an option for your kids. And, like, none of her family supported her, but, yet, through our program I feel like we just gave her that sense of importance, like I can do this. (Nora, personal communication, June 26, 2015)

This type of story illustrates the manner in which MIHOW's home visitors can influence their families. MIHOW home visitors are taught that if they can change the lives of a mother then they are likely to change the trajectory of the child's life as well. MIHOW believes that they can do this by using a strength-based approach operating under the model of prevention.

Prevention can be categorized in three ways: primary, secondary and tertiary. The findings from this study show that primary and secondary prevention are being implemented by home visitors within MIHOW. Prevention is aimed to reduce risk and/or concerns as related to health. Primary prevention aims to prevent health concerns or injuries before they occur. This level of prevention is carried out by altering unhealthy or unsafe behaviors. MIHOW practices this level of prevention in each home visit through education. Secondary prevention looks to reduce the impact of a delay or concern that has already occurred. This is done by identifying and treating the concern as soon as possible. Secondary prevention strives to slow, stop, or prevent recurrences. One way MIHOW practices this level of prevention is through the use of the ASQs.

MIHOW believes that using primary and secondary prevention will help ensure that families will receive the education and services they need to grow and change. Specifically, MIHOW's goal is to influence what one home visitor identified as "generational change." This type of change was found in a small gesture the mother from the previous story exhibited. Nora, the home visitor for that mother, went on to say:

> One day one of the visitors went to her house. And we take books, you know, we'll take in books and give to the kids and one day she had like a plastic tote to store things in turned sideways and had made a little library for her kids out of it. And that was like ah, one of the moments for me, like, she's really getting a grip of this education thing and seeing how important the early reading and all that is. . . It's people like that on the days

> you feel like nobody's listening and they're not just changing for themselves they could be changing generations. (Nora, personal communication, June 26, 2015)

The MIHOW curriculum was another way the home visitors discussed how principles and strategies were put into place during home visits. According to home visitors, child development was addressed often, and in many ways, with the visitors using a uniform curriculum all while still tailoring the needs of the mothers first and foremost.

Home visitors from both of the study's locations addressed child development using the MIHOW curriculum. The content of the curriculum, according to one home visitor, covered topics related to parenting, nutrition, health, and development. She explained: "Visitor guides address everything during the prenatal period, which covers everything from conception up through having this baby, and that goes into nutrition, and child development in utero, and every month of pregnancy" (Olivia, personal communication, August 8, 2015). Based on these home visitors' guides, they provided information related to topics such as potty training, activities, and discipline. The home visitors conducted monthly developmental screenings, known as ASQ's, and did many activities with the children to help assess the development of the children.

The curriculum was also customized for the mothers. In one home visitor's words, "anything that's on a parent's mind, we have it covered" (Laura, personal communication, June 23, 2014). The curriculum was customized related to child development.

The MIHOW curriculum was practical help for the mothers and that is the way MIHOW wants it to be. "Because they've got a curriculum they go by and it helps moms who just don't know what to do" (Trisha, personal communication, January 21, 2013). The home visitor described the content of the curriculum and how it focused on the development of the child:

> A home visit. . . consists of one piece of paper. . . It is based on whatever month of pregnancy you are in, what the baby's development is, and what is developed on the child. Then whatever stage you're in we talk to you about that, and then write down if there were any concerns, or anything like that. (Trisha, personal communication, January 21, 2013)

She provided another example of the content of the curriculum and how it focused on the development of the child:

> You go exactly where the child [leads], even if it's a new one or say that I've got a six month old. I'm seeing her this month and it's turned six months. I'm going to look up the six months lesson plan and I'm going to pull out of there mostly the activities I need to see the child doing. (Trisha, personal communication, January, 21, 2013)

Home visitors described the curricular content for the MIHOW program as based on the month-to-month development of the child. The curriculum in practice focused on what to expect and not expect for that month. In addition to monthly pre and post-natal development, home visitors talked about the content of the curriculum and how it related to topics such as gestational diabetes, morning sickness, weight of the baby, what to eat, emotions, breastfeeding, drugs, and alcohol/tobacco use.

Finally, one MIHOW strategy that makes it a unique program as compared to other early intervention and prevention programs is its principle that it will not demand or require certain actions from their families as long as no safety issues are involved. Olivia, a home visitor from Blue Lake, stated that she felt it was important to keep this principle in place. She said, "I think we are dealing with sensitive situations here a lot of the time and we want to keep these families, not cause them to shut us out. MIHOW is protective and safe" (Olivia, personal communication, June 5, 2015). Laura, another Blue Lake home visitor, described this principle in her first interview as well.

> I just look at some programs that go in homes and they're very demanding and they semi-threaten and degrade families in ways, like you've got to clean this place up. You've got to paint these walls. You can't do this, you know, they do it with that approach, and it really alienates and pisses off families and it also hurts their feelings and it degrades them. At MIHOW we just don't do that. It's just not like that. They seem to go in and point out everything that's wrong and tell them to fix it and we seem to go in and try to identify all the things that are right and build on that. (Laura, personal communication, July 16, 2012)

Home visitors recognize the challenge and difficulty of the balancing act of maintaining MIHOW's principles, strategies, and its mission all while following the lead and needs of the family. The realization that sometimes priorities must be set can be an obstacle for home visitors. MIHOW addresses this balancing act in its initial home visitor training seminar. Ultimately, home visitors are taught that "a woman must consider her own well-being as well as the needs of others in her life. This is true of home visitors as much as it is for the families they serve" (Roberts & Withrow, 2014). MIHOW trains home visitors to finish every day and be done with it and to remember if they are following the curriculum, and implementing the strategies they have been trained to do then they have done all that they could and tomorrow is another chance to do it again.

CHAPTER 6

ANALYSIS AND INTERPRETATION

This study was conducted to explore the experiences and understandings of the home visitors' perceptions of the MIHOW home visitation program from two West Virginia MIHOW sites. Chapter four contained the descriptive information about the two sites and the home visitors. Chapter five featured findings based on the interviews with home visitors from the Mountain Ridge and Blue Lake sites, as well as information obtained from participant observations of home visitor training sessions, document analysis of MIHOW curriculum, and document analysis of home visitor training manuals. Results in this chapter were organized around the study's five research questions. In this chapter, I will present the analysis and interpretation of the research data in relation to relevant prior research. Additionally, implications of the findings for practitioners and policymakers will be discussed. This chapter will also provide suggestions for future research and some thoughts on final conclusions and significance.

Based on the research questions, three key themes emerged from the findings. The first theme was related to the strength-based approach utilized by home visitors. This theme highlighted the approach in terms of how it was used with mothers and how it was experienced by home visitors both in their work and in their interactions during reflective supervision. It was described by one home visitor as "the core of what we do" (Laura, personal communication, July 17, 2012). The second theme related to how home visitors felt supported by MIHOW and by one another, "having each other around." The third theme was related to the training of the home visitors. This theme looked at how training came from MIHOW and came from the

requests, needs, and wishes of the home visitors. This idea of a uniform yet customized training style was explored in the third theme.

Theme One: *"The core of what we do."*

The strength-based approach came up over and over again during the participant interviews. The theme of using strengths as part of the program experience was evident from talking with the home visitors. Home visitors liked using the strengths-based approach with their mothers and they liked having their site leaders use the strength-based approach within their own development as home visitors. As a veteran home visitor put it, "it's the core of what we do" (Tammy, personal communication, October 30, 2014).

A home visitor explained the importance of emphasizing mothers' strengths as part of the home visits. "The idea is that we are going to acknowledge her strengths," she said, "We're going to go in there [the home], we're going to listen; we're going to observe. Some moms may have very little education but they may have just the most amazing patience you've ever seen with their children. And I'm going to tell her that. I'm going to say, 'You are so patient and loving to your children. And . . . no one's maybe ever told her that" (Trisha, personal communication, January 21, 2013).

This same home visitor went on to explain how they were required to identify at least one strength on every visit, describing a variety of types of strengths that might be named including: "they really work well under pressure;" "they always get their bills paid;" "they always have everything in on time, so they're punctual;" "they always read to their kids;" and "they always listen well to suggestions from others." Home visitors believed that by calling attention to these positive qualities or actions, the home visitor was affirming the mothers' strengths and, therefore,

influencing growth and change within the family. Home visitors reported that they witnessed an increased sense of competence and confidence with the mothers. A home visitor from Mountain Ridge, Nora, provided a terrific example of this increased confidence with one of the mothers she served.

> We met a mom who the first time I met her was in a hospital room. She was beaten within an inch of her life by her husband. I went there to meet her and then we started visits with her, and she's since moved out of the area and got out of the relationship, and moved back to the area. When she was pregnant again she called us wanting the program again. When I met her she wouldn't even make eye contact with you. She was so beaten down physically, mentally, everything. And she's been to the capitol with us. She went to the capitol and she got up and gave a speech. (Nora, personal communication, June 26, 2015)

Home visitors also highlighted the importance of the strength-based approach in their development as home visitors and what it has done for them in their own lives. Home visitors meet with site leaders one time a month to complete reflective supervision meetings. During these meetings home visitors are given the freedom to talk about whatever they wish. The site leader from Mountain Ridge described what was entailed in a session during one of her interviews. "They can talk about the families they see in the program, they can vent, they can rave, or they can even talk about personal stuff from their own life."

MIHOW believes so strongly in identifying strengths that they implement that strategy with their home visitors. Home visitors reported that reflective supervision sessions always ended with the site leader identifying a strength of the home visitor. One home visitor simply said, "It just makes you feel good." The strength-based approach is practiced across all levels within the MIHOW framework. Home visitors' strengths are identified by site leaders, site leaders' strengths are identified by the regional coordinators, and the regional coordinators hear

their strengths from Vanderbilt. Some examples of strengths home visitors named as things site leaders had told them included: “dedicated,” “passionate and hard working,” “warm-hearted,” “crafty and creative,” and “positive role model for families.”

Finally, home visitors expressed how the strength-based approach had made its way into their personal lives outside of MIHOW. Home visitors reported that by using the strengths they knew that they had changed their outlook on some of the challenges and obstacles they faced in their lives. “Even my kids notice it in me” said one home visitor. One home visitor talked about the use of the strength-based approach in her own life.

> I think sometimes this area we live in is such a negative area, beaten down, you just feel that way sometimes like you’re not doing any good. But I just know that MIHOW is as much for the worker as it is the people that we’re serving. Like when you go to those strength-based trainings they just give you that little extra push and encouragement and just that strength-based approach, how that has to be the center of every decision you make with families….you just need that positive pushed into you as much you can get. (Nora, personal communication, July 22, 2015)

The findings of this study are consistent with previous literature regarding the use of strength-based approaches in teaching and learning. Current findings have shown that strength-based approaches can have a positive influence on change (Alvord & Grados, 2005; Donnon & Hammond, 2007). Alvord & Grados completed a study in 2005 that found that the strength-based approach was not just a model for practice, but instead an approach that relied on values and attitudes. Values and attitudes were the primary keys to the strength-based approach and the outcomes of the approach relied more on values and attitudes than skills or knowledge (Alvord & Grados, 2005). The current study found new knowledge that the strength-based approach was not only a philosophy of practice but also a philosophy for the home visitors outside of MIHOW.

Theme Two: ***"Having each other around."***

Home visitors stated that they felt supported by one another in the areas of mentoring, collaboration, and in their personal lives. Home visitors reported that they felt support from one another. Participation in MIHOW encourages healthy, positive relationships between mothers and their children. What is not as apparent when looking at MIHOW on the surface is that it also encourages those relationships between home visitors. In this theme, the connections that are being forged between the home visitors will be explored.

Interviews and observations provided evidence that home visitors relied on one another. During the observation of the home visitor training I saw that the trust between home visitors and their supervisors was evident. As one of the training instructors said, "we are the support system for each other." Trusting relationships are important in any work environment. Home visitors valued having each other. It is nice to have "somebody to talk to," and "to have each other around, people who can help you figure it out."

Having "each other around" was the key to the support home visitors felt from one another. Seeing one another at monthly meetings and during trainings provided opportunities for home visitors to meet and network with one another. One home visitor said that their training on active listening carried over into how they communicated with one another as well. "I find myself asking, "so you're saying," or, "you mean this," and that helps." Another home visitor described her relationship with her fellow home visitors by saying, "We are just available to one another to help each other in any way."

Home visitors felt that support from MIHOW could be stronger in two areas: pay and benefits. These issues were not the focus of home visitors but they were the only topics that

were brought up when it came to inadequate support from MIHOW. Home visitors mentioned that sometimes they wished they could have more hours to work and therefore have more money. One home visitor said, “I’m seeing about 19 families a month but I’d like to see more or at least see those families more.” She stated that it would help her out if she could get more hours from the MIHOW program. Another home visitor reported that “it would be nice” if benefits or a retirement plan were part of MIHOW employment.

Current literature regarding home visitor relationships between one another as colleagues was limited. Most of the studies have looked at what characteristics make a successful and effective home visitor. Studies have also looked specifically at what makes a successful relationship between a home visitor and a mother. These studies found that experiences, type, and amount of education and training contributed to home visitation effectiveness (Harden, 2010; Huang & Isaacs, 2007; Roggman, Boyce, Cook, & Jump, 2001). In terms of relationships between mothers and home visitors, qualitative studies by Brookes and colleagues (2006) and Raikes and colleagues (2006) suggested that similarities in personalities, similarities in personal histories, and similarities in racial/ethnic backgrounds may increase levels of engagement between home visitors and mothers. The current study adds new knowledge that home visitors valued the relationships they had with one another as much as they valued the relationships they had with the families they served. Furthermore, home visitors felt that their own learning and their own success came partly from the support they received from one another.

Theme Three: *“Training comes from MIHOW, but it also comes from us.”*

MIHOW’s training curriculum and manuals are prescribed and detailed. Each home visitor knows what is expected of them because it is laid out clearly by the MIHOW training

manuals and by the training coordinators who complete the initial MIHOW trainings. MIHOW training is based on evidence obtained over the 30 years the home visitation curriculum has existed. Over that time curriculum and trainings have grown and developed into what home visitors and families want and need. This collaboration on the state and national level has emerged to give life to trainings that are what one home visitor called, "perfect and everything I need to do my job well." While trainings are mandated and prescribed from the national organization, the ongoing continuing education and training of home visitors is customized to meet home visitors' current needs at the local level. As one home visitor put it, the "training comes from MIHOW, but it also comes from us."

As I learned from observing an initial training session for home visitors and speaking with home visitors in individual interviews, this uniform yet personalized experience is by design. As one home visitor explained:

> We have to do the initial trainings and the national trainings each year. You know, it's pretty much what we have to do, but we like it because they are always covering things we need and we have the freedom to do things at our own places that give us the day to day stuff we need. . . the kind of stuff we see as a community, like right now prescription drug abuse is a big problem in our area so we have asked for help with that. (Rachel, personal communication, June 24, 2015)

During observation of the initial home visitor training session in 2014, I learned that even the standard MIHOW home visitation curriculum was developed initially in a way that prioritized local community needs. Home visitors from the Blue Lake location were an integral part of the development of the home visitation guides and home visitation curriculum. One of the initial training presenters, who had been a home visitor before being promoted within the program to regional coordinator, described the process with great pride: "We did it . . . from the

grass roots up, not from the top down, and we did it by developing our own curriculum as it emerged from what families wanted, what people were asking for."

Interviews with home visitors also shed light on the extent to which home visitor training was customized "for us." A home visitor with considerable experience with the program described the training as "varied with lots of different types of training." She went on to explain how the nature of the training is determined in light of home visitors' expressed needs and interests. I heard about training on a multitude of topics including WIC guidelines, the use of a strength-based approaches, child development, tobacco use prevention, how to use the MIHOW curriculum, breastfeeding, developmental screenings, drug abuse and prevention, and domestic violence. Interview data suggested that the quality of the trainings is high, often making use of regional and/or national experts. As one home visitor put it, "I don't know if it could be any better at this point. All the knowledge, we're pretty much getting it at our site. We really do, and we really know [about] current [thinking about] breastfeeding. We really have it covered." This home visitor went on to say the following:

> All of the MIHOW groups come together and we have several days of workshops, again, what we feel, we all have input and have been on the planning committee for the national and state conferences. We decide what is needed. (Laura, personal communication, June 23, 2014)

One home visitor went on to explain the process of deciding from year to year at the state conference. "If we have a lot of new home visitors we do need to talk about the basics and go beyond and expand on our knowledge of this and that." Home visitors liked that they had input regarding their training. MIHOW requires monthly home visitor trainings because of the paraprofessional aspect of home visiting. But they do not mandate what trainings occur, as long

as each regional location holds 12 site-based trainings a year. Home visitors felt that training requirements from MIHOW were adequate. They did not feel MIHOW required too many trainings and they did not feel MIHOW required too few. As one home visitor said, "We want to keep current on all issues so getting together and talking and networking in our trainings is how we do that."

The findings of this study are consistent with previous literature regarding the curriculum content used in home visitation programs (Westerlund & Lagerberg, 2008; Krysik & Lecroy, 2012). Many current models of home visitation use curricula that are based on the babies' monthly and yearly child development. This current study adds more specific information related to home visitors' understanding of curriculum development in relation to the standards and practices set forth by MIHOW. The curriculum comes from the headquarters located at Vanderbilt University. This study specifically looked at how home visitors experienced and understood their roles as people responsible for promoting language development.

For home visitors in the program, the curriculum and training were effective in providing knowledge and guidance as it related to activities that helped encourage positive language development. Ferguson and Vanderpool (2013) found that there was a research disparity pertaining to the influence of home visitation on child outcomes, including language development. This study did not look directly at the effects home visitation had on language development. But it did yield information that found that home visitors within West Virginia's MIHOW Program felt that they had the necessary skills to promote language development and to make necessary referrals if language was not progressing at the rate it should.

Implications for Future Research

The current study explored two home visitation programs in rural Appalachia to examine the experiences and understandings of home visitors regarding MIHOW's mission, MIHOW's training of home visitors, MIHOW's support of home visitors, home visitors' understanding of their role in promoting language development, and the implementation of MIHOW's principles and strategies. Three themes emerged from the study. One theme related to how the home visitors understood the strength-based approach and what that meant to them and to the families they served. Few research studies have focused specifically on the use of a strength-based approach carried out by paraprofessionals in home visitation programs. A future qualitative research study might observe how paraprofessional home visitors are using the strength-based approach to influence parenting behaviors or to influence adult learning.

A second theme was related to the importance of support between home visitors and their relationships. The current study explored how home visitors' developed relationships and what those relationships meant to their work as home visitors. The current study also looked at how these relationships influenced the development and growth of home visitors. Home visitors also stated that they would like it if they would receive more pay and/or benefits as a MIHOW employee. A future qualitative study might feature the "having each other around" theme more fully and explicitly. This could produce new knowledge about the nature of peer relationships between home visitors, and how, if in any way, the relationships affect home visitation services. In addition to interviewing, observing the relationships between home visitors during meetings and reflective supervision style interactions may demonstrate how those relationships are

developed. In addition, a future qualitative study may also look at home visitor turnover rate, why it is occurring, and if monetary issues are somehow related to these job turnovers.

The final theme in this study was related to the area of home visitor training. The training of MIHOW home visitors was uniform and had mandatory dimensions to its structure. Home visitors liked and trusted the trainings that they received, but they also liked that the trainings were customized to their needs and wishes. Monthly trainings were based upon the requests of the home visitors, as long as there were no budgetary constraints. A future qualitative research study might investigate the customized versus uniform training styles with paraprofessionals working within home visitation programs and why each is successful, or not successful, depending on the outcome of the research.

Significance and Conclusions

The findings of this study add to the limited research on home visitation and the use of paraprofessionals within home visitation programs. Home visitors understand their mission as it correlated with MIHOW's mission. They experienced their training within MIHOW to not only understand what the MIHOW program expected from them as workers but also what their families needed from them as home visitors. Issues associated with training and previous knowledge bases were raised by one of the home visitors, but most of the home visitors felt their training and support was more than adequate to carry out their jobs and MIHOW's mission. This is new information as compared to current literature that suggests paraprofessionals may not receive adequate training to carry out home visitation services as compared to professionals who hold a minimum of a four year degree. The study also highlighted the importance of the strength-based approach and what that meant to home visitors. Home visitors believed strongly

in the power of using a strength-based approach with their families and within their own growth as home visitors. Home visitors provided examples of how the strength-based approach was addressed within the MIHOW program and how they believed it was the foundation for their learning and the pathway to change for the mothers and children they served.

Based on previous research, we know that early intervention is beneficial to young children and their families. The results of this study show that participants believed that home visitation has an influence on mothers' understanding of the monthly growth and development of language development and that the home visitors understand their roles as women who are present to encourage and promote healthy language habits by assisting and guiding mothers in the way they interact with their children. The ability of the program to intervene when development is not progressing as it should was also a way in which home visitors understood their role in home visitation. Five of the six home visitors believed that their MIHOW training made them capable and effective at identifying and referring for appropriate services if a concern was raised regarding language development. The home visitors suggested methods and materials, including the MIHOW ASQ screening tool, that they could do with families. Home visitors also described working closely with West Virginia Birth to Three in order to assist families with referrals as needed.

The findings from this study will provide practitioners and policymakers more information regarding home visitation programs, like MIHOW, which use a prevention model focused on using strength-based theories and practice to implement strategies that promote healthy prenatal care and development. It will also provide programs that complete their own training of paraprofessionals with helpful information on training styles, models, and practices.

This study will provide program supervisors and policymakers with knowledge about the types and styles of training requirements necessary to equip practitioners with the skills to become effective home visitation workers. Since early prevention and intervention programs have received increased funding through the Affordable Health Care Act and President Obama's Universal Preschool Act, this study will help policymakers to better understand what services and information were most beneficial for mothers and families. Finally, this study identified the methods and the resources that home visitation programs should be focusing their attention on in order to help home visitors effectively implement the goals, objectives, and mission of the home visitation program they work for. My study is evidence that the training home visitors received through the MIHOW program made them effective at carrying out the mission, strategies, and principles of the program.

As stated in the findings and in the themes found within the research data, the strength-based approach to teaching and learning was the essential element of the MIHOW program for home visitors. The "magic" or "power" of the strength-based approach was credited for what home visitors saw as the greatest asset of the MIHOW program. More specifically, home visitors reported that the strength of the program itself, the strength and confidence within mothers, and the strength and success of home visitors resulted from the collaborative use of the strength-based approach.

The strength-based approach operates under the belief that inherent strengths of individuals, families, and/or groups can aid in teaching, learning, and in empowerment, thus leading to change. In essence, MIHOW focuses on the strengths of its mothers, its families, and its home visitors to embrace and promote positive change and growth. I believe my research

shows that this positive change and growth occurs within the home visitors who participate in MIHOW training and who practice the strength-based approach with the families they serve.

Furthermore, it is my view that MIHOW uses the strength-based approach as a way to influence and create the culture of their program; they are successfully doing so with their home visitors. By training home visitors to shift the focus from deficiencies to instead focus on possibilities and solutions they are in effect creating and supporting the families in the program to do the same. MIHOW home visitors make it their goal to develop services that are focused on prevention and ultimately on independence. My view is that this research provides evidence that MIHOW creates a culture where it is believed that strength does not come from a physical or economic capacity, but instead from an indomitable will and belief in oneself. MIHOW is convinced that this will and belief can be nurtured and honed within the women who participate in the program, both as mothers and as home visitors. My perspective is that MIHOW's "magic" lies in the idea that focusing on strengths can create a positive spirit, or "power," that can be shared with one another, with mothers, and with families.

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APPENDIX A: Letter from Institutional Research Board

This dissertation research was part of a larger study titled Evaluation of the WV Maternal Infant Health Outreach Worker (MIHOW) Random Control Trial Study, administered by Marshall University faculty and students (of which I am a participant). The original IRB approval, which included my own research detailed herein, follows. Note the date of 2013-2014 was the date participants were no longer enrolled in the study. The study itself had approval through 2015.

Office of Research Integrity
Institutional Review Board
401 11th St., Suite 1300
Huntington, WV 25701

FWA 00002704

IRB1 #00002205
IRB2 #00003206

October 25, 2012

Martin Amerikaner, Ph. D.
Psychology Department

RE: IRBNet ID# 283395-3
At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Amerikaner:

Protocol Title:	[283395-3] Randomized Control Group Evaluation of the Maternal Infant Health Outreach Worker (MIHOW) In-Home Visitation Program
Expiration Date:	October 25, 2013
Site Location:	MU
Submission Type:	Continuing Review/Progress Report APPROVED
Review Type:	Expedited Review

The above study and informed consent were approved for an additional 12 months by the Marshall University Institutional Review Board #2 (Social/Behavioral) Chair. The approval will expire October 25, 2013. This continuing review also includes the addition of Amy (Knell) Carlson and Debra Lockwood as research staff. Continuing review materials should be submitted no later than 30 days prior to the expiration date.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral/Educational) Coordinator Michelle Woomer, B.A., M.S at (304) 696-4308 or woomer3@marshall.edu. Please include your study title and reference number in all correspondence with this office.

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APPENDIX B: Interview Guides

Home Visitor Interview Guide #1

Ethnographic Explanations: Well first I want to thank you for taking your time to talk with me today. As we spoke about before, the purpose of this study is to look at the MIHOW program and get a better understanding of how it works, especially from the point of view of someone who is directly involved in it like you are. We just really want to "pick your brain" about the program. This information you give us will help us understand the program, how it works, what works well and what can be better. This and all interviews will be confidential and no information will be shared with anyone, including your supervisor, other staff, or the mothers you work with. All information you give us and any personal information about you will be kept completely confidential. This process is voluntary and you can stop participating in this interview or any other portion of this study at any time. We are tape recording this interview just to make sure we get an accurate account of what you say. Is this okay with you? Do you have any questions for me before I start recording?

Don't forget to ask for **EXAMPLES** throughout the interview!!!
Remember to exhaust all categories (Anything Else?)

- Tell me a how you got involved with the MIHOW program.
- After you decided to work with the program, what did you expect the program to be like before you started?
  - How is the program different than what you expected?
  - How is the program similar to what you expected?
- How would you explain the program to someone who has never heard of it before?
  - How does it work?
  - What services have you provided so far, if any?
- What types of training do you receive as a home vistor?
- I've never been on a MIHOW home visit. Walk me through what that is like. (could also open the door for asking about observing home visit at some point)
  - General questions about home visitor if this information isn't provided
    - I haven't met the women you meet with, what are they like?

        - How well they get along?
        - Development of rapport?
        - Social bonding/support?
- What kind of information does the mother provide you with?
    - How do you use this information?
    - What of this information do you agree with?
    - What do you disagree with?
- Do you think you have learned anything new from being involved with MIHOW?
    - Tell me more about that?
- Do you have any sense of what the mothers are learning or getting out of the program?
- What are some things you would like to see the MIHOW program include?
- What is your favorite part of the program so far?
- What is your least favorite part of the program so far?
- Have you had any experience since you've been involved with the MIHOW program that really stands out? If yes, what was it?
- Would you recommend the program to others?
- Anything you would like to add that I didn't ask?

Home Visitor Interview #2 Guide

(For HV's that have had a 1st interview, review transcript and open with something that lets them know you recall what they have said about their experiences with MIHOW already.)

1. Tell me about the training you've received as a home visitor? (Examples)
2. What do you think are the most beneficial parts of the initial MIHOW training?
3. What parts of your training (initial or continuing) do you think could have been better? (Examples)

4. Can you talk to me about any new information you've learned from participating in the MIHOW trainings? (Tell more about that, can you give me an example?)

5. Tell me about the continuing education you receive as a MIHOW home visitor.

6. The training literature talks about Home Visitors (Outreach Workers) recognizing and building on mothers' strengths. Would you explain how you may recognize moms' strengths and how you work with them to build upon them?
7. Would you be able to provide examples of ways in which moms have used their strengths to work toward their life goals?
8. Based on understanding moms' goals for themselves now and in the future, what kind of community resources have they been referred to?
   a. What kind of experiences have they had with accessing community resources?
9. The training literature also talks about home visitor's helping moms with balancing home and work. Could you tell me how you help moms with this? (Get examples)
10. Could you tell me your thoughts about the MIHOW curriculum? (How is it used)?
11. Do you feel you have the support you need to do your job effectively? (Get examples of how they do or do not get the support they need AND get examples of what kinds of support do they believe are needed)
12. Do you see the MIHOW program as having any influence on child development? If so, how? (If they respond yes, probe further asking how it relates to the areas of cognition, social-emotional, and physical development.)
13. Do you see MIHOW having any influence on language development? If so, how? (GET EXAMPLES)
14. Do you feel MIHOW's training prepared you to work on promoting language development? If so, how? If not, were you prepared in other ways? Tell me about those ways.)
15. How would you describe your relationship with moms? What do you think makes a difference in your relationships with them? (successful versus unsuccessful)
16. What do you see as the most beneficial information you discuss with the mothers? The least? Why?

APPENDIX C: Home Visitor Consent Forms

Informed Consent to Participate in a Research Study

Randomized Control Group Evaluation of the Maternal Infant Health Outreach Worker (MIHOW) In-Home Visitation Program

Marty Amerikaner, Ph.D. Principal Investigator

Introduction

You are invited to be in a research study. Research studies are designed to gain scientific knowledge that may help other people in the future. You may or may not receive any benefit from being part of the study. Your participation is voluntary. Please take your time to make your decision, and ask your research investigator or research staff to explain any words or information that you do not understand.

Why Is This Study Being Done?

The purpose of this study is to help determine the value of an in-home visitation program and to better understand the experiences of MIHOW staff, home visitors, and administrators.

How Many People Will Take Part In The Study?

Approximately 30 people will take part in this study. A total of 30 subjects are the most that would be able to enter the study.

What Is Involved In This Research Study?

In this study, all participants will be contacted up to 3 times. Each contact will either be by phone or in person at a time and place that is convenient for the participant. Participants will be interviewed about topics such as their own training, their experiences with MIHOW as a home visitor, their interaction with families, the support they receive from MIHOW, and how they experience and understand MIHOW's goals and mission.

Participants will be from one of the two selected WV Maternal Infant Health Outreach Worker (MIHOW) program sites. Participants will include MIHOW staff, home visitors, and administrators. By agreeing to be interviewed you are agreeing to being a part of the study.

How Long Will You Be In The Study?

You will be in the study until just after your final round of interviews.

You can decide to stop participating at any time. If you decide to stop participating in the study we encourage you to talk to the study investigator or study staff as soon as possible.

The study investigator may stop you from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What Are The Risks Of The Study?

There are no known risks to those who take part in this study.

What About Confidentiality?

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way.

What Are The Costs Of Taking Part In This Study?

There are no costs to you for taking part in this study. All the study costs, including any study tests, supplies and procedures related directly to the study, will be paid for by the study.

Will You Be Paid For Participating?

You will receive no payment or other compensation for taking part in this study, other than the "thank you" gifts provided to all participants.

Who Is Sponsoring This Study?

This study is being sponsored by the West Virginia Office of Maternal, Child and Family Health. The sponsor is providing money or other support to help conduct this study. The researchers do not, however, hold a direct financial interest in the sponsor and have no financial interests in the outcome of the study.

What Are Your Rights As A Research Study Participant?

Taking part in this study is voluntary. You may choose not to take part or you may leave the study at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to stop participating in the study we encourage you to talk to the investigators or study staff first.

Whom Do You Call If You Have Questions Or Problems?

For questions about the study or in the event of a research-related injury, contact the study investigator, Dr. Marty Amerikaner at (304) 696-2783. You should also call the investigator if you have a concern or complaint about the research.

For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Stephen Cooper or ORI at (304) 696-4303. You may also call this number if:

- You have concerns or complaints about the research.
- The research staff cannot be reached.
- You want to talk to someone other than the research staff.

You will be given a signed and dated copy of this consent form.

SIGNATURES

You agree to take part in this study and confirm that you are 18 years of age or older. You have had a chance to ask questions about being in this study and have had those questions answered. By signing this consent form you are not giving up any legal rights to which you are entitled.

____

Subject Name (Printed)

____ _________________

Subject Signature Date

____

Person Obtaining Consent (Printed)

____ _________________

Person Obtaining Consent Signature Date

VITA

Amy Knell Carlson

Education

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Publications

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Knell, A. (2011). A look at understanding schemas and emotion in early childhood. [Review of the book *Understanding schemas and emotions in early childhood,* by C. Arnold]. *West Virginia Early Childhood Provider* 12(2), 16-17.