The California Home Visiting Program External Evaluation

Challenges Faced by Home Visitors

Karen Moran Finello, PhD, Araksi Terteryan, & Nane Zadouri, MA

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Introduction

This report highlights findings from the California Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program external evaluation conducted by WestEd. The evaluation team conducted a set of site visits in 2014 including interviews with home visiting program directors and managers, home visitors, and reflective supervisors. In addition, home visitors and staff participated in web-based surveys and select reflective supervisors participated in web-based reflective practice support groups. Anecdotal information shared by home visitors during in-person regional workgroup meetings led by the Principal Investigator is also included to paint a richer picture about home visiting. The information in this report presents the significant findings about challenges home visitors face in their line of work according to home visitors themselves and the program administrators who support them.

External Evaluation Methods

The WestEd evaluation team conducted follow-up site visits to examine home visiting programs in distinct regions throughout California. The home visiting programs followed one of two models including the Healthy Families America or the Nurse Family Partnership evidence-based model. The sites that participated were located throughout the state in rural, and small farming communities, isolated communities in the mountains, and urban areas of major metropolitan cities. During the site visits, each home visitor hired to provide MIECHV-funded services was interviewed and the number of home visitors varied at each site. The home visitors and site staff provided detailed information about their background and training, their personal experiences in the work they do, and the challenges faced working in a home-based environment. Responses to interview questions were collected and recorded by the interviewer onto tablet computers at site visits, and process notes were taken during the web-based support calls by an evaluation team member. There were no audio or visual recordings of the interviews, support calls, or workgroup meetings.

Following the site visits, online surveys were used to gather additional data from home visitors and updated program information from site leadership. The online surveys were used to measure work environment, organizational climate, and to capture levels of burnout, compassion fatigue, and compassion satisfaction. In addition, during 2016, reflective supervisors were invited to participate in monthly reflective practice facilitation support groups led by expert mentors. These web-based calls provided support and an outlet for supervisors to discuss challenges faced, provided a sense of community and supported ongoing practice. Qualitative data was gathered through process notes taken during each call.

No identifying information was collected so the data presented refers to only the informant role. Some of the quantitative analysis was done using Excel and SPSS statistical software. Qualitative data analysis was done using ATLAS.ti (qualitative software) through the coding process and by clustering common themes that emerged across multiple responses. Based on the analyses, findings were grouped into themes and subsequently the key topic areas that make up this report.
Sample

The information presented in this report is primarily from the site visits conducted in 2014 throughout California. A total of 45 home visitors (N=45) were interviewed along with 16 (N=16) reflective supervisors, and 12 (N=12) program directors. All of the home visitors who were interviewed in 2014 and still working within their program in 2016 were invited to participate in the online surveys. In addition the sample was expanded to include additional home visiting programs funded by MIECHV in California for participation in online surveys. Some common themes that the 14 reflective supervisors (N=14) discussed during the reflective practice support calls (taken from the process notes) are also included in support of what the home visitors shared.

Background and Demographics of Home Visitors Interviewed in 2014

The home visitors represent a variety of ethnicities and their ages ranged from 25 to 65 years and older, with a median age of 45 years. Over half (60%, n=27) of the 45 home visitors were bilingual, with 18 speaking English only. All but one of the home visitors interviewed was female. The majority of home visitors were either Latino/Hispanic (42%, n=19) or White/Caucasian (34%, n=15) (See Figure 1).

Figure 1. Home Visitor Demographics

Hiring and Recruitment of Home Visitors

Twenty percent (n=9) of the forty-five interviewed home visitors held an Associate's degree, had an LVN license, or earned a certificate in another country. Sixty-four percent of the home visitors held a Bachelor's degree (n=29) in nursing or a related field and 16% (n=7) held a Master's degree. Table 1 shows the home visitors' credentials by program model. Some home visitors reported certificates in homeopathy, accounting, or social work.
Home visitors are reportedly recruited via advertisements on agency websites or the home visiting program model website portal, word of mouth, personal contacts and connections, professional organizations, and job postings at nursing schools. Home visitors may be hired as transfers from other programs, new graduates from educational programs, from a county list, through internal county hiring, promotions of current staff, or through a general county process.

During site visit interviews, thirty-one percent (n=15) of the home visitors reported having home visiting experience with mothers and children prior to being hired in the current MIECHV funded site in programs. They reported previous work in programs such as Adolescent Family Life, Healthy Teen Mothers juvenile justice program, Cal Learn, Healthy Birth Outcomes, Black Infant Health, Early Start, Well Child, High Risk Infant Follow-up for NICU infants, and in the same home visiting program model in another county or under other funding. The remaining 69% (n=31) of the home visitors had backgrounds in other services such as general and pediatric nursing, home health care for the elderly, hospice care, school nursing, preschools, WIC, and medical surgery units.

Upon hire, home visitors are provided various trainings to equip them for their work. Home visitors also attend regional or national training conferences; local workshops; speaker presentations; and individualized trainings and workshops based on team staffing meetings; attend case conferences with colleagues at their sites; and participate in online coursework and webinars. Home visitor training requirements vary by home visiting program model. Some topics addressed during trainings have included: maternal and infant/toddler mental health, perinatal and infant/toddler assessments, family and home, infant/baby physical health, mother prenatal/perinatal health, nutrition, building family relationships, domestic violence, child abuse/CPS involvement, family trauma, extreme poverty, legal/MediCal, unstable environment/neighborhood, cultural competency, client engagement, and home visitor workplace.

Table 1. CHVP Home Visitor Educational Background

<table>
<thead>
<tr>
<th>Degree Type</th>
<th>Program Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HFA sites (N=11)</td>
</tr>
<tr>
<td>Associates (AA)</td>
<td>9% (n=1)</td>
</tr>
<tr>
<td>Bachelors (BA/BS)</td>
<td>18% (n=2)</td>
</tr>
<tr>
<td>Masters (MA/MS)</td>
<td>None</td>
</tr>
<tr>
<td>Licensed Vocational Nurse (LVN)</td>
<td>45% (n=5)</td>
</tr>
<tr>
<td>HIGH SCHOOL DIPLOMA</td>
<td></td>
</tr>
<tr>
<td>Other Certificate</td>
<td>27% (n=3)</td>
</tr>
</tbody>
</table>

**Expectations for Average Caseload**

According to Chapin Hall evaluators at the University of Chicago, "NFP model elements [require that] a full-time nurse home visitor ... carry a caseload of no more than 25 active clients
at a time... [while] HFA core standards allow full-time home visitors to serve no more than 15 families at the most intensive service level and no more than 25 families at any combination of service levels" (Spielberger, Gitlow, Winje, Harden, & Banman, 2013).

The 40 full-time home visitors at 100% full-time equivalent (FTE) interviewed during site visits in 2014 indicated similar caseload sizes. Specifically, full-time home visitors reported caseload sizes of eight to 25 clients, with an average of 19 clients each. The five part-time home visitors (28.5% FTE to 80% FTE) reported caseload sizes ranging from four to 18 clients, with an average of 11 clients each. The site with the highest number of clients (101 clients) averaged 17 clients each across the six home visitors interviewed, while the site with the fewest number of clients (60 clients) averaged 20 clients each across the three home visitors. These findings are similar to those of the Chapin Hall evaluators at the University of Chicago, who found that the average caseload size across the three home visiting programs evaluated (HFA, NFP, and PAT) was between 15 and 17 families each year (Spielberger et al., 2013).

**Challenges Around Caseload Expectations According to Reflective Supervisors.** To gain a better understanding of challenges around caseload expectations, reflective supervisors were asked whether they thought the program family caseload expectations were realistic. They expressed that it is a challenge to fulfill expectations given the following factors that make it difficult for home visitors to handle a high caseload:

- Scheduling of home visits
- Periods of enrollment and new births
- Multi-risk clients
- Record-keeping and paperwork
- Acuity level of clients
- Travel time to home visits

One site decided that their staff could not meet the caseload requirements if enrolled families have intense needs because such families require significant time well beyond ordinary expectations and also may require significant collaboration with other agencies. Many supervisors and program directors talked about the need for more mental health training and social work support in order to fully support the complex families being referred for services. Families who are referred to Child Welfare Services are dropped from home visiting caseloads and those with open CPS cases are not enrolled, with the assumption that child welfare workers will be better equipped to provide the intense services needed.

During the web-based reflective supervision facilitation support groups in 2016, reflective supervisors discussed similar concerns about caseload issues. Supervisors described challenges being faced in trying to insure that caseload requirements were met, particularly with the impact of new hires following home visitor attrition. Reflective supervisors report struggling with how to assign challenging referrals when a home visitor is new to the job and building a caseload or when the home visitor is coping with significant stressors. During reflective supervision sessions, supervisors struggle with how to deal with administrative concerns around caseloads while providing the support home visitors need to avoid burnout and dissatisfaction.
Some direct quotes from reflective supervisors about caseload expectations are listed below:

"[Caseload expectations are] about right for an experienced nurse who understands triage... You just don’t need to try to reschedule within the two-week period [for some] stable clients without problems who miss visits. There is no room to reschedule with a full caseload"

"Reporting requirements. Time study in [the program] for home visitors/[staff] appears to be based on health department administration or urban setting – so it falls short for our setting. Travel, for example, isn’t factored in...”

"What is really needed is an acuity scale ([the program] is working on this but it is not that great)."

"When they reach 25, it is overload (combination of mental health clients, probation, DCFS, etc.)... [families are] high-risk, so caseload is too high."

“Staff member has attrition issues with the clients and has struggled to keep active caseload of 25 clients and this has become more of an issue with [the program] over the last six months.”

“Huge challenge with home visitors who have a lot on their caseload, and to make sure they are getting all their assessments done and still listening actively (to them) and taking the time to explore things as they come up.”

“Home visitor says the reason for the caseload and attrition going up over last several months is because of the kinds of clients she is seeing.”

“[I] have had many one-on-ones and as a team [about] what do our caseloads look like as far as full-time versus part-time.”

**Challenges in Serving Families with Multiple Risks**

Home visitors were asked during interviews about the high-risk characteristics that they see in families they are serving. The top five risks that home visitors indicated seeing in their caseload are: 1) mental health issues such as mild and severe mental health conditions, post-partum depression, bipolar mother or father; 2) teen parents as young as 13 years old; 3) substance abuse by the mother or father, alcoholic family members, and possession of illegal drugs; 4) domestic violence (or suspected) in forms of verbal, physical, emotional, sexual abuse; and 5) homelessness/housing issues with safety/health hazards leading to couch surfing or eviction. It is important to note that most of this information is gathered anecdotally or through referral information. A complete risk sheet with questions about issues such as criminal history in the family (e.g., history of parent incarceration) is not utilized in the programs examined and
therefore, some risks are likely underreported. See Table 2 for statistics on the number of risks in families reported by the home visitors.

### Table 2. Family Risk Characteristics Reported by Home Visitors

<table>
<thead>
<tr>
<th>Risk Order</th>
<th>High-Risk Characteristic</th>
<th>No of Home Visitors experiencing this in their caseload (N=45)</th>
<th>% of HVs who encounter this in their caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mental health issues</td>
<td>35</td>
<td>77.8%</td>
</tr>
<tr>
<td>2.</td>
<td>Teens</td>
<td>27</td>
<td>60%</td>
</tr>
<tr>
<td>3.</td>
<td>Substance abuse</td>
<td>26</td>
<td>57.8%</td>
</tr>
<tr>
<td>4.</td>
<td>Domestic violence</td>
<td>19</td>
<td>42.2%</td>
</tr>
<tr>
<td>5.</td>
<td>Homelessness/Housing</td>
<td>13</td>
<td>28.9%</td>
</tr>
<tr>
<td>6.</td>
<td>Social isolation</td>
<td>13</td>
<td>28.9%</td>
</tr>
<tr>
<td>7.</td>
<td>Other risks</td>
<td>12</td>
<td>26.7%</td>
</tr>
<tr>
<td>8.</td>
<td>Extreme poverty</td>
<td>11</td>
<td>24.4%</td>
</tr>
<tr>
<td>9.</td>
<td>Legal/Medical issues</td>
<td>11</td>
<td>24.4%</td>
</tr>
<tr>
<td>10.</td>
<td>Trauma</td>
<td>10</td>
<td>22.2%</td>
</tr>
<tr>
<td>11.</td>
<td>Lack of family support</td>
<td>9</td>
<td>20%</td>
</tr>
<tr>
<td>12.</td>
<td><em>Depression</em></td>
<td>8</td>
<td>17.8%</td>
</tr>
<tr>
<td>13.</td>
<td>Developmentally disabled mom</td>
<td>8</td>
<td>17.8%</td>
</tr>
<tr>
<td>14.</td>
<td>Low education level</td>
<td>7</td>
<td>15.6%</td>
</tr>
<tr>
<td>15.</td>
<td>Transportation</td>
<td>6</td>
<td>13.3%</td>
</tr>
<tr>
<td>16.</td>
<td>Unstable neighborhood/environment</td>
<td>6</td>
<td>13.3%</td>
</tr>
<tr>
<td>17.</td>
<td>Basic needs</td>
<td>5</td>
<td>11.1%</td>
</tr>
<tr>
<td>18.</td>
<td>Relationship issues</td>
<td>5</td>
<td>11.1%</td>
</tr>
<tr>
<td>19.</td>
<td>Medical conditions</td>
<td>4</td>
<td>8.9%</td>
</tr>
<tr>
<td>20.</td>
<td>Chaotic family</td>
<td>4</td>
<td>8.9%</td>
</tr>
<tr>
<td>21.</td>
<td>Communication barriers</td>
<td>3</td>
<td>6.7%</td>
</tr>
<tr>
<td>22.</td>
<td>CPS involvement or abuse</td>
<td>3</td>
<td>6.7%</td>
</tr>
<tr>
<td>23.</td>
<td>Single mom</td>
<td>2</td>
<td>4.4%</td>
</tr>
<tr>
<td>24.</td>
<td>Mother’s criminal history</td>
<td>2</td>
<td>4.4%</td>
</tr>
<tr>
<td>25.</td>
<td>Partner/family criminal history</td>
<td>1</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

**Client Intensity and Risk Interference with Home Visiting Curriculum.** More than three-quarters (76%) of the home visitors reported that the client risk issues affect the services “a lot” or “moderately.” Home visitors reported during interviews that the majority (38%) of clients being served were classified by home visitors as having moderate needs and moderately intense service provision, while 28% of clients were low in needs and low in service intensity, 25% were
very high needs and require high service intensity, and 9% were reported as being another combination, such as high needs and low in intensity (1%) or low needs and high in intensity (1%) or other/not specified (7%).

Figure 2 and Table 3 present the statistics for the reported caseload composition for both part-time and full-time home visitors.

Figure 2. Average Needs and Service Intensity Level Breakdown for Full-Time and Part-Time Home Visitors

Table 3. Caseload Composition of Part-Time and Full-Time Home Visitors

<table>
<thead>
<tr>
<th>% FTE</th>
<th># of Home Visitors</th>
<th>Average Number of Families in Each Needs/Service Intensity Level</th>
<th>Average # of Clients Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Very high needs &amp; intense</td>
<td>Moderate needs &amp; moderate intensity</td>
</tr>
<tr>
<td>Full-time (100%)</td>
<td>40</td>
<td>$M = 4.64$, $SD = 3.47$</td>
<td>$M = 6.99$, $SD = 4.07$</td>
</tr>
<tr>
<td>Part-time (28.5% - 80% FTE)</td>
<td>5</td>
<td>$M = 3.40$, $SD = 0.89$</td>
<td>$M = 5.20$, $SD = 5.07$</td>
</tr>
<tr>
<td>Total = 45</td>
<td></td>
<td></td>
<td>* $t = 1.59$, $df = 43$, $(p = 0.00)$</td>
</tr>
</tbody>
</table>

The home visitors’ quotes below demonstrate how the reported risks interfere with the home visiting curriculum.
“Absolutely—curriculum is [the] icing on the cake; if cake is there and whole, it is wonderful but often the ingredients are not there and I am working on [resolving] those things and can’t do the curriculum.”

“... [There are] families who just live in awful crisis and welcome the opportunity to escape and talk about something like development –this is so welcomed by them to focus on the baby (ASQ). In order to do this well, we need to constantly be kind to our clients. Just like we want them to put baby first, we need to put her first.”

“If [you are] looking at hierarchy of needs, [families] are going to look at shelter and survival . . . [It is] hard to do more education when you’re always in crisis mode. That’s when [the] supervisor comes into play – [to help] us see the big picture.”

“[Risks interfere] moderately, because with adolescents it is like a roller coaster . . . at times they are doing well and other times they are completely in chaos. The way I see it and teens report [is] that the home visits are an outlet for them.”

Home visitors at the various sites gave similar responses when asked whether they feel equipped to handle the high-risk issues they encounter. The majority of home visitors indicated that despite their training and background, they sometimes feel overwhelmed or ill equipped to handle some issues they come across with the families they serve. Home visitors pointed out that mental health issues, intimate partner violence, family transportation, and acquiring basic needs such as housing and food are often more difficult to deal with due to limited resources or the client's disbelief that there is a problem. Home visitors turn to their peers and supervisors for assistance in handling the issues they face. Home visitors indicated that they value the help from trainings, experience, and knowledge of community resources, but despite their experience, some situations are difficult to handle, as indicated in the direct quotations below.

"At times no, but I come back asking lots of questions to staff and then feel equipped. Might feel overwhelmed during the visit, hearing issues, and sometimes the client doesn’t want the help. My supervisor also helps. Hard for me if the family doesn’t want help – they often want me to listen but don’t necessarily want or be ready to take steps toward help."

"Yes, to a certain extent. I can’t change poverty or substance abuse of the parents, but try to make a difference in the way the new baby is treated and educated. I can give them important information on the best way the baby can grow despite living conditions I cannot change.

"I am resourceful and if I go into a situation, at least I know I don’t know what to do and if I don’t I will get someone who does knows. If I feel empty handed, I can refer her to places [based on my experience] as a public health nurse nurse for 15 years. One big problem was transportation, housing, money beside food stamps etc."
"I don’t think I am ever fully equipped—some of these clients need a team - It would be wonderful to have someone else to help. My background is nursing not social work and there is so much social work needed, [so] I give as much as I can."

"[The] harder [issues] are intimate partner violence—don’t know if I have provided enough resources; what is their safety? Did I do enough?"

"For the most part, because I’m really supported in my job. I talk to my supervisor, and ask what to do. Not a lone ranger. [I feel] equipped to handle the immediate moment, [and the] direction to go afterward I can get from my supervisor when I get back to the office."

"I worked in foster care but it was a desk job and I wasn’t in the field working directly– has been hard to hear and deal with. [It] keeps me up at night sometimes worrying. I feel helpless about their living conditions."

"Sometimes I feel overwhelmed despite my background (working with a team for clients and could work with other team members) but now I can’t focus on ‘nurs-y’ stuff—it’s only me and I have to figure it out with her (the mother). [I] spend so much time putting out little fires!"

"Yes and no. Thankfully I have experience and don’t know how a new grad could come and do it. Bring a lot to the job. Know when to collaborate with our peers and talk to [my supervisor] a lot . . . . I believe going forward and if I had 20 [clients] and five were high acuity . . . I wonder how I would do with that."

**Accessing Community Resources for Families.** Home visitors rely on their training background and experience with multi-risk families to manage the issues they encounter. Home Visitors were asked what kinds of support they have to help manage multi-risk families. They reported connecting with regional centers, drug treatment centers, domestic violence shelters, homeless shelters and food banks, mental health specialists, and other clinics in the community. However, home visitors indicated that there are many challenges they face in accessing services, making it difficult for them to do their work. Home visitors noted the following challenges in accessing family services in the community:

- Limited availability of services in some communities
- Limited accessibility of services in the community (i.e., hours of operation)
- Limited home visitor awareness of resources
- Limited services available to support families with mental health needs or housing needs
- Long wait lists for families to receive services
- Building connections in the community to access resources more easily.
- Finding time to discuss challenges and resources available with peers while in the field
- Unsanitary conditions in local agencies or clinics
Significant comments about challenges in accessing community resources for families are included below:

"Availability does not equal accessibility."

"Resources exist in the community and we can talk to people but I think that the services that are offered are not easily accessible to clients (can call but may not get in) and even food banks have certain hours [of operation]."

"I have had clients call after moving to other counties and say services are much easier to access [in certain counties."

"Home visitors will say [to clients] 'tell them you are a client of ours'."

"I can’t state the value of having a supervisor who understands and gets what it is like out there; having her support is huge."

**Challenges in the Work Environment**

Significant findings about challenges home visitors face in the work environment were gathered through measureable survey data sent to home visitors and supervisors and information from interviews during site visits. During interviews, home visitors shared general challenges they face in their work environment, feelings of isolation, and suggested work accommodations. Home visitors participating in regional focus groups also described numerous challenges being faced in doing the work.

Home visitors from the California Home Visiting Program sites were sent the Survey of Organizational Climate for Early Childhood Settings (SOC-ECS) (Finello and Hampton, 2013) to complete in early 2016. Survey invitations were sent to 143 home visitors in the California MIECHV programs. A total of 82 home visitors completed this survey, a response rate of 57%. (This sample includes 34 competitive-funded and 48 formula-funded home visitors). The SOC-ECS was developed to measure critical components of organization climate important to workers in early childhood field-based settings. The survey consists of 63 items and takes about 20 minutes to complete. Items are measured on a 5-point Likert-scale (1 = strongly disagree, 2= disagree, 3= neither agree nor disagree, 4= agree, 5= strongly agree). The nine subscales on the SOC-ECS include: Physical Setting (10 items); Communication Mechanisms (7 items); Recognition & Respect (6 items); Clarity in Program Protocols (6 items); Clarity in Program Roles & Responsibilities (3 items); Administrative Support (8 items); Internal & External Collaboration (3 items); Decision-making (6 items); and a subscale of Overall Organizational Culture (14 items).

Means and standard deviations for each subscale and the overall scale are provided in Table 4. Home visitors reported high levels of satisfaction with subscale items measuring Communication Mechanisms, Clarity in Program Protocols, Internal and External Collaborations, and Physical Setting.
### Table 4. Means and Standard Deviations of the SOC-ECS Subscales

<table>
<thead>
<tr>
<th>SOC-ECS Subscale</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical setting</td>
<td>82</td>
<td>3.73</td>
<td>0.51</td>
</tr>
<tr>
<td>Communication mechanisms</td>
<td>82</td>
<td>4.22</td>
<td>0.54</td>
</tr>
<tr>
<td>Recognition and respect</td>
<td>82</td>
<td>3.34</td>
<td>0.78</td>
</tr>
<tr>
<td>Clarity in program protocols</td>
<td>82</td>
<td>3.87</td>
<td>0.66</td>
</tr>
<tr>
<td>Clarity in program roles and responsibilities</td>
<td>81</td>
<td>2.40</td>
<td>0.75</td>
</tr>
<tr>
<td>Administrative support</td>
<td>82</td>
<td>3.26</td>
<td>0.66</td>
</tr>
<tr>
<td>Internal and external collaborations</td>
<td>82</td>
<td>3.85</td>
<td>0.77</td>
</tr>
<tr>
<td>Decision making</td>
<td>82</td>
<td>3.22</td>
<td>0.57</td>
</tr>
<tr>
<td>Overall organizational culture</td>
<td>81</td>
<td>3.34</td>
<td>0.60</td>
</tr>
<tr>
<td>Total of subscales</td>
<td>82</td>
<td>3.51</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Scores ranged from 1 (strongly disagree) to 5 (strongly agree).

Some examples of specific items within the subscales with high ratings of agreement are described in the following sections.

**Communication Mechanisms**
- Clear systems are in place to indicate the daily visits scheduled by home visitors \((M=4.52, SD=.63, n=82)\)
- Our program promotes the use of current communication, including cell phones, text messaging, and/or emails \((M=4.51, SD=.85, n=82)\)

**Clarity in Program Protocols**
- There are clearly written and common sense safety rules that everyone follows \((M=4.20, SD=.90, n=82)\)
- There is clear, written communication to support boundaries between home visitors and families and within the program (includes guidelines re participation in family events, hospital visits, etc.) \((M=4.05, SD=1.10, n=80)\)
- Clear policies and procedures help me in my daily work \((M=4.09, SD=.94, n=81)\)
Physical Setting
- I have been issued a cell phone for my use in the home visiting program ($M=4.54$, $SD=1.06$, $n=82$)
- I have a personal computer that only I can access ($M=4.52$, $SD=.82$, $n=82$)
- I have individual space to work allocated only to me ($M=4.38$, $SD=1.01$, $n=82$)

Overall Organizational Culture
- Program staff has considerable autonomy in determining workday schedules ($M=4.30$, $SD=.84$, $n=82$)
- There is a clear mechanism to assist home visitors with data collection, data entry, or other paperwork ($M=4.13$, $SD=.97$, $n=80$)
- Collaboration is promoted both within the home visiting program and outside of the program (with other agency priorities and programs) ($M=4.15$, $SD=.76$, $n=81$)
- I feel valued by all members of our home visiting program ($M=4.06$, $SD=.95$, $n=80$)

Lower ratings on specific items indicate possible challenges the home visitors encounter in their work environments. These areas should be explored further to address home visitors’ concerns and needs in the programs in which they are working.

Items with Low Levels of Agreement:
- I have office space that insures privacy when I am on the phone with clients ($M=2.68$, $SD=1.33$, $n=80$)
- A newsletter or other written tool is used to praise and recognize team and individual contributions ($M=2.68$, $SD=1.21$, $n=81$)
- Program management contacts staff members who have been responsible for program recognition in the community to personally thank them ($M=3.01$, $SD=1.31$, $n=79$)
- Workloads are monitored and management works to insure that staffs are not overburdened ($M=3.26$, $SD=1.22$, $n=80$)
- All program personnel are involved in making decisions that impact the entire program ($M=3.09$, $SD=1.11$, $n=82$)
- There is little turnover or staff attrition within our agency/organization ($M=3.09$, $SD=1.41$, $n=78$)

General Challenges in the Work Environment. Home visitors are frequently working in isolation and have limited interactions with peers due to the nature of fieldwork. To explore these issues, home visitors were asked, "Does your work environment (office space) provide you with support for your field work or do you frequently feel isolated and alone?" Most home visitors feel peer support is there and that office space is adequate. However, some home visitors noted the following as challenges they face in the work environment:
- Limited internet technology for documentation in remote locations
- Inadequate office work space
- Inadequate office storage space
- Outdated cell-phones making it difficult to communicate with clients
- Difficulties in carrying paperwork and visitation materials (including laptops and iPads) to and from the home
- Difficulty accessing supplies and returning them (e.g., keys) and knowing what supplies are available
- Limited funding in some programs for supplies

Quotes from home visitors about their work environment are listed below:

"My only issue is not having easy access to some supplies (most places probably have it much worse); it is just a hassle in terms of getting keys, getting supplies, giving key back—[I] don’t know what supplies are available."

"We each have our own cubicle that locks; we don’t have enough space for our materials (facilitator sheets, additional paperwork) and don’t have storage area for our materials (personal client info is in our locked cubicles)"

"We have laptops with air cards to access the Internet through the county, but I try not to take it with me because it is hard to lug around and I worry about leaving it [at the client's home]."

"In general, things are very conducive to doing work well. Could use phones that accept text messaging better (have old phones that flip and don’t work well)."

**Feelings of Isolation.** According to the home visitors, isolation in the work environment may be related to the number of clients in their caseload and where clients live. Some direct quotes about challenges in the home visiting work environment are included below:

"My clients are within 20 minutes so I don’t feel so isolated"

"[I] don’t feel as isolated because we call in at the end of the day, but I do feel that it could be an isolating job. If I’m in the field all the time, it can be hard and feel isolated. Right now [I have a] smaller caseload so not as much of an issue."

"Part of being a home visitor is that you are on your own a lot, but we have a good team"

"I do not feel isolated at all. Coming from where I came from, I feel I am taking care of myself."
Work Accommodations. Home visitors at one site were pleased with the environmental support they receive since they use Skype (online video conferencing program) when they are not able to go to the office for staff meetings, and to meet with site mental health specialist. One home visitor was very pleased with the office administrative support she receives at her site (organizing files, inputting data, tracking office supplies). Two home visitors at one site indicated they would like a "drop-in" workspace.

Home Visitor Burnout and Compassion Fatigue

Statistical information measuring home visitor burnout in the workforce was gathered using the standardized and published Professional Quality of Life Scale (ProQOL Version 5, Stamm, 2009). The ProQOL was used to measure compassion satisfaction and compassion fatigue in the home visiting program staff and was part of a package of surveys that home visitors at participating evaluation sites received during 2013 and in 2016. During site visits in 2014, home visitors shared anecdotal information about factors that contribute to burnout and mechanisms that they use to cope with burnout, vicarious trauma, and safety concerns.

Professional Quality of Life Scale (ProQOL) Information from 2016. The standardized and published Professional Quality of Life Scale (ProQOL Version 5, Stamm, 2009) was used to measure compassion satisfaction and compassion fatigue in the home visiting program staff. The ProQOL is a widely used measure of the effects on professionals of their work with individuals suffering from extreme traumas and stresses (Stamm, 2010). The current version of the ProQOL consists of 30 questions, uses a 5-point Likert scale (1=never to 5=very often), takes 5-10 minutes to complete, and includes three subscales: Compassion Satisfaction (10 items); Burnout (10 items); and Secondary Traumatic Stress (10 items) (ProQOL, Version 5, Stamm, 2009). The California home visitors (from both competitive and formula-funded sites) were sent this online survey in early 2016 to complete. A total of 82 home visitors completed this survey, including 34 competitive-funded and 48 formula-funded home visitors.

The ProQOL manual was used for converting raw scores into Z scores and t-scores, calculating the subscale scores, and interpreting the results for this group of home visitors compared to the published norms. (Note, the ProQOL is only used for exploratory description; it is not a diagnostic tool). Following directions in the manual, labels were assigned based on the scores to indicate the level of each subscale as Low, Average, or High (Stamm, 2010). The published Average scores for each of the three subscales is $M=50$ ($SD=10$) with about 25% of people scoring High and about 25% of people scoring Low (Stamm, 2010). We compared subscale scores from our sample of home visitors to the group norms and found them to be comparable to those in the ProQOL manual. Figures 3-5 below depict the distribution of our home visiting sample in California compared to the published norms for each subscale.
Figure 3. Compassion Satisfaction Level

Figure 4. Burnout Levels

Figure 5. Secondary Traumatic Stress Level
For this group of home visitors \((n=82)\), the individual scoring worksheet was used to calculate the level of each subscale and overall frequencies were run for this sample. The results indicate that across all three subscales, the majority of home visitors fall into the Average level for each subscale. Frequency analyses indicated that 52.4\% \((n=43)\) of home visitors scored Average for Compassion Satisfaction; 52.4\% \((n=43)\) scored Average for Burnout; and 73.2\% \((n=60)\) scored Average for Secondary Traumatic Stress. Twenty-nine percent of the sample \((n=24)\) scored High on levels of Compassion Satisfaction. According to the ProQOL manual higher scores on this represent a greater satisfaction in one’s abilities to be an effective caregiver and those in the higher range derive a good deal of professional satisfaction from their position (Stamm, 2010). Table 5 provides the scores for compassion satisfaction.

### Table 5. Compassion Satisfaction Subscale

<table>
<thead>
<tr>
<th>Compassion Satisfaction Level:</th>
<th>Home Visitors ((n))</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>15</td>
<td>18.3%</td>
</tr>
<tr>
<td>Average</td>
<td>43</td>
<td>52.4%</td>
</tr>
<tr>
<td>High</td>
<td>24</td>
<td>29.3%</td>
</tr>
<tr>
<td>Total (N= 82)</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

**Burnout & Secondary Traumatic Stress Scores.** In terms of level of Burnout, 18 home visitors \((22\%)\) scored High on this subscale while 21 home visitors \((25.6\%)\) scored Low on the Burnout subscale. This is in line with the published norms, which state that, “about 25\% of people score above 57 and about 25\% of people score below 43,” (Stamm, 2010).

For the Secondary Traumatic Stress subscale, 15 home visitors \((18.3\%)\) scored high while only 7 home visitors \((8.5\%)\) scored Low on this subscale. For this subscale, there were more home visitors with Average scores. See Tables 6 and 7 for details.

### Table 6. Burnout Subscale

<table>
<thead>
<tr>
<th>Burnout Level:</th>
<th>Home Visitors ((n))</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>21</td>
<td>25.6%</td>
</tr>
<tr>
<td>Average</td>
<td>43</td>
<td>52.4%</td>
</tr>
<tr>
<td>High</td>
<td>18</td>
<td>22.0%</td>
</tr>
<tr>
<td>Total (N= 82)</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 7. Secondary Traumatic Stress Subscale

<table>
<thead>
<tr>
<th>Secondary Traumatic Stress Level:</th>
<th>Home Visitors (n)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>7</td>
<td>8.5 %</td>
</tr>
<tr>
<td>Average</td>
<td>60</td>
<td>73.2 %</td>
</tr>
<tr>
<td>High</td>
<td>15</td>
<td>18.3 %</td>
</tr>
<tr>
<td>Total N= 82</td>
<td></td>
<td>100 %</td>
</tr>
</tbody>
</table>

Reflective Supervisors’ Reports of Home Visitor Burnout. Reflective supervisors shared their concerns about home visitors experiencing burnout during the web-based support calls. Supervisors notice burnout and compassion fatigue in some staff members and reported that home visitors often bring their own histories and then experience vicarious trauma from situations they encounter. Supervisors are also concerned for their staff because of ongoing paperwork demands and data collection requirements within programs. Supervisors themselves expressed frustration with requirements, new tools being implemented, and the time paperwork takes away from home visiting sessions. The supervisors’ concerns about vicarious trauma and paperwork demands leading to burnout are expressed in the quotes taken from the reflective supervisor mentor call process notes below:

“Experiencing similar issues with nurses and forms for [the program], funder’s data, CHVP, and county data. What needs to get done first? [These are] big issue for nurses.”

“My opinion is that home visitors miss when the nurse connection was primary and data was NOT the focus...desire for a better way to collect data that’s not a 25-page form.”

“The problem is that new staff are excited about the program and the older staff in the program over two years are burned out and being introduced to new tools and data forms.”

“Her attrition was being affected. Supervisor went out doing observational assessment and several times noticed that first impressions are lasting impressions, the nurse’s drive and motivation weren’t there. Families were picking up on that and we were taking a look at performance, staff development goals.”

“A member of staff [experienced burnout] because of tragedy. I gave her time and she went on leave. She came back half time and did not get back completely before she had to leave after one year.”

Ongoing Need to Address Burnout & Reduce Vicarious Trauma. Based on this data, it is clear that some of the home visitors in the California MIECHV programs are experiencing high levels of and high levels of secondary traumatic stress. Even though these figures are in line
with the published norms (25% score High on each subscale), there is a need to address these concerns to reduce attrition and improve job satisfaction in the workforce by putting systems in place to reduce burnout and vicarious trauma. The following sections indicate what home visitors and reflective supervisors and managers report as activities going on within their programs to reduce burnout and vicarious trauma.

To manage burnout, home visitors report that they talk to their supervisors during one-to-one reflective supervision sessions or approach them outside of appointed times about charting progress or talking about things they are experiencing (n=19), talk to their peers casually or during team case management sessions (n=11), and refer to trainings and seminars focused on topics such as compassion fatigue, trauma, safety, crisis management, workplace violence, self-care, and stress management (n=10). Home visitors indicated they would like staff retreats not centered around work, lunch meetings with peers, and trainings on "de-stressing".

Group management strategies include:
- Staff retreats
- Emotional refueling group activities

Personal burnout management strategies include:
- Not rescheduling cancelations in order to do paperwork and waiting for the next cycle
- Doing charting or paperwork at nearby cafes
- Ensuring a clear mind before plunging into next home visit
- Taking time off
- Practicing self-care through exercise and hobbies
- Utilizing Employee Assistance Program
- Leaving work at work
- Practicing self-talk
- Taking hour-long lunch breaks

Supervisors and program managers reported other mechanisms that are implemented to help manage staff burnout including exercise, such as light yoga, walking to converse with peers, and Zumba, as well as group activities such as a staff development retreat and holiday celebrations.

**Personal Safety.** According to home visitors, safety mechanisms are acquired through a combination of "common sense", program policies, supervisor mandates, peer suggestions, and personal experience in the field. Because home visits often occur in high-risk neighborhoods or homes, personal safety was a concern reported across all sites that participated in the evaluation. Vicious dogs and fear of dog bites was widely reported, particularly in rural areas. A worry about cars breaking down in remote or unsafe neighborhoods was a recurring theme, particularly for those relying on old and poorly maintained county vehicles. Home visitors also reported concerns about weapons in homes, gangs in the community, violent partners, and mental instability in family members. Home visitors reported that they manage safety according to their home visiting program's policies, the guidance of their reflective supervisor, and through self-taught mechanisms. Confidence in home visitor safety depends on the environment or
neighborhood of the home visit, the time of day, and preparedness before the visit. Home visitors are advised of the following to maximize safety during home visits:

- Pay attention to email updates and safety tips
- Refer to trainings on safety and crisis management
- Be vigilant of surroundings
- Devise a plan for quick exits
- Leave a situation that feels unsafe
- Schedule a visit outside of the home
- Bring a co-worker to the visit
- Pay attention to tips home visitors share during case conferences
- Call-in at the end of the day to check in

Common concerns expressed by the home visitors about their safety are presented in Figure 6.

**Figure 6. Home Visitor Safety Concerns**

- Being provided cell phones that do not work in isolated areas with poor reception
- A lack of home visiting safety protocol *(union issue)*
- Some areas increasingly becoming more dangerous
- Limited training on safety
- Unsafe county cars without auto-locks and non-secure windows
- Untamed animals in the home
Discussion

Numerous gaps remain in our scientific understanding of workforce issues in home visiting yet successful implementation, family retention, and child and family outcomes in home visiting programs hinge upon the expertise and retention of frontline home visiting staff. The literature and anecdotal information from the field clearly indicate that it is critical to measure job satisfaction, along with supervision support, overall work environment, and burnout as key infrastructure issues important to retention of home visitors and their supervisors. The characteristics of home visitors and reflective supervisors that we have explored in California include: demographic information (e.g., languages spoken, race/ethnicity/culture of origin, age range, gender), educational backgrounds, length of experience in comprehensive home visiting programs for infants/toddlers/families, discipline, and part-time/full-time equivalence. We have also gathered information about service delivery intensity, training, challenges encountered, paperwork intensity, job satisfaction, stress management strategies used in the program, program flexibility, organizational climate, supports for both supervisors and staff, career goals, understanding of organizational support for further educational attainment and promotions, plans to remain in home visiting services, and overload/burnout related to service delivery. Finally, we have been gathering detailed information from program directors through interviews and online surveys about staff recruitment, hiring processes, staff trainings, infrastructure support, attrition (& reasons for attrition), client risk factors, caseload size, and initial and ongoing support and training for home visitors and reflective supervisors.

Our work has reinforced prior findings and new questions being raised around the home visiting workforce. Although we know that effective program implementation is contingent upon staff retention in order to keep families in the program, most early childhood programs continue to report high rates of staff attrition. Limited research in home visiting programs indicates that attrition rates commonly reported in infant/family and early childhood programs range from 12-13% in EHS programs (Schmit & Ewen, 2012) to 25-50% in preschool programs (Zinsser & Curby, 2014) to 30% for child care staff in the United States (Porter, 2012) to 40% and higher in child welfare service settings (Claiborne et al., 2011). Limited work has been done to explore attrition in home visitors, but anecdotal information indicates that it typically ranges between 10% and 35% when aggregated across sites. However, individual agencies within California have reported home visitor attrition as high as 80%, depending on program location and model (Rogers, personal communication, May 6, 2015). In turn, staff turnover impacts client attrition from program services and subsequent program outcomes (Glisson & Hemmelgarn, 1998; Wagner, Van Reyk, & Spence, 2001; Zeitlin Schudrich et al., 2013). Most research in this arena has been focused on child welfare settings, but Van Berckelaer (2011) reported that mid-cycle attrition of home visiting nurses can lead to 50-75% attrition of clients.

Workforce attrition can be attributed to several factors, including the absence of supportive organizational policies and practices and the lack of direct practitioner supports of specialized training and reflective supervision (Figley, 1995). There are numerous stressors for home visitors serving high risk families that lead to attrition, including “the emotional burden of listening repeatedly to difficult family stories and trying to engage and establish trust with many burdened clients affecting personal life and reawakening personal trauma histories; concerns about personal safety being alone in the home with families; the risk of liability and lawsuits in situations that place a child or parent at risk for harm; and inadequate training and support for the
difficult work” (p. 10) (Infant Mental Health Promotion Project, 2004, rev 2011b). All of these challenging stressors were raised by home visitors and reflective supervisors during site interviews, regional meetings, and through on-line survey reports in the California MIECHV external evaluation.

In addition, home visitors are often dealing with high caseloads of extremely high risk families living under adverse conditions who may be resistant to interventions, are frequently in crisis, and may only demonstrate very small changes over time (IMHP, 2004b). Both clinical and non-clinical staff working with such families may undergo burnout, compassion fatigue, vicarious traumatization, and heavy staff turnovers (Mor Barak, Nissly & Levin, 2001; Woltman, et al., 2008). The impact on programs can be diminished job performance, poor morale, stressed personal relationships and increased absenteeism (Lookabill, 2008).

Although researchers (Jones Harden, Denmark, & Saul, 2010; Lee et al., 2013) have noted the paucity of research examining issues related to the home visiting workforce itself, Lee and colleagues (2013) point to a few studies illustrating a link between burnout in home visitors and overall service quality (Burrell et al., 2009; Sharp, Ispa, Thornburg, & Lane, 2003). Stress, compassion fatigue, and burnout also may lead to high rates of turnover in professionals providing services to very young children and their families (Biglan, Layton, Jones, Hankins, & Rusby, 2011; Burrell et al., 2009; Shirom, 2005). The McCormick Center for Early Childhood Leadership (2014) noted an association between work environment and burnout and attrition in early childhood programs, and Billingsley (2004) reported this connection in her review of research on attrition in special education settings in the United States. Job satisfaction, in turn, is inversely associated with burnout and staff attrition (Burrell et al., 2009; Shirom, 2005; Xanthopoulou et al., 2007), impacting client attrition and program outcomes (Glisson & Hemmelgarn, 1998; Zeitlin Schudrich et al., 2013).

The external evaluation in California examined factors contributing to attrition in families, including attrition of home visitors, which families reported led them to refuse further services. Burnout and compassion fatigue are strongly associated with job satisfaction; therefore, all of these factors were examined in the California home visiting workforce. The intent is not only to illustrate factors that contribute to loss of program staff, but also to provide ideas for the organizations in which home visiting programs operate about how they might better support the workforce. We also believe that it is critical to examine the work climate within early childhood organizations that rely upon field based work. Home visitors are frequently working in isolation, engaged with families with multiple crises and chaotic living environments, and coping with long drives, unsafe neighborhoods, and lack of day to day peer/collegial support seen in center based service delivery. Further, their sense of obligation in meeting the complicated and high levels of needs seen in the families served often lead to increasing levels of burnout. Xanthopoulou and colleagues (2007) point to the need for organizations to limit job demands in order to reduce burnout, while noting that when this is not possible, provision of sufficient resources (e.g., support, autonomy and opportunities for professional development) may help to “offset the negative effect of job demands on burnout” (p. 782).

Early childhood service delivery can be extremely stressful for direct service providers. Providing specialized support and training for staff would better equip them to better serve the many high acuity clients being referred for home visiting services and enable programs to retain home visitors. In addition, creative approaches such as diverting funds previously used to retrain new staff in organizations with high attrition to enhance team building, to develop better conditions within the program, and to create a better climate may lead to improved long-term
health of an organization, stronger program outcomes, and a more satisfied workforce. Creating organizations with climates that are supportive for home visitors would be expected to help with management of stress and job satisfaction, leading to improved rates of staff retention and improved program outcomes.
References


