'Supporting Mothers: Issues in a Community Mother's Programme' ,

Introduction

It is widely assumed that women's experience of motherhood is 'naturally positive,' a view which obviates any need for society to provide support for women after the birth of a child. Oakley (1980; 1984) was amongst the first to challenge these ideas, and they have continued to be challenged, with much being made of the way in which the experience of motherhood has been romanticised (Rich, 1977; Richardson, 1993; Nicholson, 1997). A number of studies have shown that child rearing is an extremely demanding, and in some cases a very isolated activity in Western society, with high levels of meaning frequently coexisting with low levels of positive experiences on a day to day basis (Boulton, 1983; O'Connor, 1993); the situation being exacerbated by poverty and lack of support (Fitzgerald and Jeffers 1994; Whelan, Hannan and Creighton, 1991; Nolan and Whelan, 1999). In so far as there has been a concern with children, it has mainly has been with those who are described as being 'at risk': the focus being less on parental support/empowerment and more on the control/removal of the children in these situations (O'Connor, 1992, 1996; Gilligan, 1999). In this context 'normal' married women's 'naturally' positive experience of motherhood has been seen as part and parcel of their 'maternal instinct' (Macintyre, 1991; Hyde, 1997). Hence there has been little recognition of the need to provide direct or indirect support for them in their capacity as mothers.

Ireland has been seen as a strong male breadwinner state in the sense that it is organised on the presumed existence of a male breadwinner and a financially dependent wife who is seen as

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responsible for the care of children (Lewis, 1992). A public nursing service is provided for new mothers, but its focus is very limited. Ireland, with the UK and the Netherlands has the lowest levels of publicly funded child care services for children of all ages (European Commission Network on Child Care, 1996; O'Connor and Shortall, 1999). The stresses faced by many families (financial, social and emotional) have long been highlighted (Task Force Report, 1980). It was not until the 1990s that the Health Boards (i.e. regional service providers) were required to provide family support services. A number of recent initiatives have occurred (including pilot programmes for children and their families in disadvantaged communities: Gilligan 1999); while the Commission on the Family (1998) in one of the few references to support for women recommended the extension of the Community Mother's Programmes to all Health Boards. However, the UN Committee monitoring adherence to the Convention of the Rights of the Child was very critical of the Irish State's performance in relation to children: particularly highlighting the inadequate emphasis on preventative measures (Gilligan, 1999).

High levels of support have been seen as related to a variety of positive outcomes including better physical and mental health; higher levels of resistance to stress; greater ability to deal with life events such as loss etc. (Brown and Harris, 1978; Fleming and Baum, 1986; Hobfall and Stokes, 1988; Brand and Hirsch, 1990; Duck, 1998). Hermanns (1997: 51/52) noted that social support for parents had positive, and hitherto little recognised effects on parenting and hence on child development. Implicitly, such ideas validate a focus on the empowerment of women, since in Ireland (Kiely, 1995), as elsewhere, it is they who are most actively involved in child care. It is not clear to what extent the importance of support lies in its direct effects on health, and/or on its indirect effects as a buffer in various kinds of situations (Thoits, 1982; 1983; 1995; Oakley,

1992). It is also difficult to assess the causal nature of the relationship between support and such outcomes; considerable confusion persisting about the way in which such support works and about the social and psychological factors associated with its existence in the first place. Even insofar as one accepts that support should be provided for mothers, there is still a question as to who should provide this support. Intervention by the State in the family is often viewed as problematic: not least because such intervention (often by women as in the case of social workers) is in fact controlled by male dominated professions and/or bureaucracies (Dale and Foster, 1986; O'Connor, 1992). It also raises issues about the commodification of care and the similarities and differences between support provided by paid and unpaid carers (Lynch, 1989; Sinclair, Crosbie, Vicery and O'Connor 1989; Thomas, 1993; Ungerson, 1995; Lister, 1997; Hodgins and Kelleher, 1998).

Much of the work that has been done on the effects of early intervention programmes has focused on the child rather than on the parent. Programmes that have included a focus on the mother (using teachers or other people with experience of working with young children as home visitors) have found that during the Programme parents became more aware of the child's learning and development and took a more positive attitude in encouraging it (Hirst and Hannon, 1990; Mc Laughlan, 1994). The focus on empowerment was even more explicit in other work, where public health nurses, and later experienced mothers, were used as home visitors sharing knowledge and information with the mother, who remained very much the decision maker in relation to her own child. Such mothers showed an increase in self esteem as well as an increased use of community resources (Barker, 1990). The Community Mother's Programme to be discussed in this article is very much in this tradition. It has some similarities to other

Community Mother's Programmes currently being provided in Ireland - although there are also significant differences (see Sheridan, Roberts, Warner, Coyle and O' Rourke, 1997; Mc Nelis and Kelleher, 1995; Powell, 1998).

Using Thomas (1993) framework it is possible to suggest that the concept of care implicit in the Community Mother's programme is similar to that in other domiciliary care services (such as the home help service) insofar as such care is depicted as non-work; is done in the home in the context of a low paid /volunteering, good neighbourly relationship by economically dependent women: 'This conflation of gender and economic identities and the resultant perpetuation of women's economic dependency by social policies has been identified as a key feature of the patriarchal welfare state' (O'Donovan, 1997:150). Yet on the other hand, the existence of such non- professionalized sources of care potentially offers a challenge to commodification of care- and particularly to male domination through the professions. Thus there is a tension within the Community Mother's Programme insofar as it is concerned with the empowerment of the mothers giving and receiving it but as a paid volunteering relationship it is perpetuating the devaluing of 'women's work'. Thus even insofar as one accepts the desirability of providing support for mothers, the question of who gives that support raises complex issues.

This article will first briefly describe the aims of the Programme and its establishment; secondly it will explore the whole question of women's need for support after the birth of a child; thirdly it will look at its effectiveness in the context of the aims of the Programme; fourthly it will look at its implications for other projects.

Aims and establishment of the programme

The programme started from the assumption of a need for parental support, and the usefulness of providing such support, within a context that recognised the importance of child care and the potential effectiveness of support being provided by an experienced parent. The Mission Statement defined the Programme:

> 'as a structured programme aimed at enabling parents to enjoy and participate more fully in their child's development and supporting them in their role by encouragement, sharing experiences and information with other parents.

The aims were more extensively stated as

> (a) 'to improve the parents capacity to rear, educate and provide emotional support to their children by enhancing the self esteem and confidence of parents;
> (b) to recruit visiting parents in the target areas and provide them with training and support through a community based resource unit
> (c) to establish appropriate and sustainable co-operation between the community, the voluntary and statutory sectors for longer development and resourcing of the programme'(Powell, 1998:4)

A number of factors came together in the early 1990s which led to the involvement of the Mid-Western Health Board with the Bernard Van Leer Foundation in the establishment of a Community Mother's programme on a pilot basis in Limerick Social Services Centre (Sheridan, Roberts, Warner, Coyle and O' Rourke, 1997). Firstly, the Irish Child Care Act 1991 placed a statutory duty on Health Boards (i.e. regional dispensers of health services) to promote the welfare of children in their area and it strengthened their powers to provide child care and family support services. Secondly, the Mid-Western Health Board has been to the fore in the initiation of partnerships with voluntary agencies inside and outside the Health Services (Duffy, 1993). Thirdly, in Limerick City, and indeed nationally, there was an increasing concern about the adequacy of traditional supports for parenting in the face of a dramatic rise in married women's participation in (largely full time) paid employment; dramatic increases in marital separation and an increasing awareness of domestic violence and familial sexual abuse (O'Connor, 1998).

Receptivity to the Community Mother's Programme was heightened by the fact that it had been shown to have been very effective in terms of its impact on the health and well being of both mothers and children in the Eastern Health Board area (See Johnson, Howell, and Molloy, 1993; Mc Nelis and Kelleher, 1995; Molloy, 1997). A Public Health Nurse had initially been used there but later an experienced mother was substituted, thus increasing both its attractiveness in terms of cost and its compatibility with the 'good neighbour' model of care which has been identified as a feature of patriarchal welfare states (Paterman, 1992; O'Donovan, 1997).

The Steering Group to establish the Programme in the Limerick City area consisted of an interdisciplinary team from the Statutory and Voluntary sectors (led by a Community Worker attached to the Mid-Western Health Board). They received training under the direction of the Early Child Development Unit (ECDU) in Bristol. The Steering Group decided to concentrate on estates built by the Local Authority in Limerick since these had the highest levels of poverty and the least resources to purchase child care on the open market. It was decided that the Programme would be offered to all parents with new babies within these target areas (such births were to be identified from the list provided by the Public Health Nursing Service). Initially the families were offered one visit per month for approximately a year. (At a later stage visits were provided at different frequencies to take account of variation in the needs of those receiving the service). The Programme was provided free of charge to the recipients. The providers were recruited from same communities as the recipients and were given a nominal fee -£3 per visit. Two local community activists became the (paid) co-ordinators of the Programme. The overwhelming majority of both providers and recipients were women, and so it became known

as the Community Mother's Programme although at times, for various reasons, 'parent' was used.

Based on the training provided by ECDU, and reflecting the inclusion in the Steering Group of a Public Health Nurse and a parenting co-ordinator attached to the Health Education Team, the programme included a focus on child development and health related practices and on advice concerning parenting. Thus the Community Mothers were introduced to a revised version of the form used at Bristol ECDU to map the child's development and to record the mother's diet (the 'green forms'). They were encouraged to complete these forms during the visit. Each Community Mother was also provided with a pack of cartoons through which discrete parental advice was provided as regards children's health; diet; safety etc. These elements were seen as differentially important by different members of the Steering Group during the start up phase, but as the project continued they became subordinate to the overall establishment of a supportive relationship between providers and recipients; with the documentary analysis showing that the 'green forms' and the educational cartoons were differentially used by various Community Mothers (O'Connor, 1999).

Evaluation of the Programme

An evaluation element, as an ongoing feature of the programme from its inception, was required by the Bernard Van Leer Foundation and it existed from 1993 up to 1997 (O'Connor 1999). My own position at that time was Course Director in Women's Studies at the local University. My interest and support for women oriented projects was known. My role was seen as largely one of supportive clarification (through direct contact with the Steering Group as a whole and/or through the leader of the Programme (with whom I had previously worked) as well as through

documentary analysis). From my perspective, validating the importance of mothers' work as mothers, by mothers, seemed worthwhile. My hope was that the Programme would recognise that the period after the birth of a baby could be difficult for any mother (and not simply for those whose social situations were seen as problematic); and that it would adopt what has been called a 'social support' home visitation model (Thompson, 1995). As a programme involving women supporting women, it appeared deceptively easy (Powell, 1998).

Documentary analysis showed that by January 1997 thirty three Community Mothers had made a total of 1390 visits to 368 families since the inception of the Programme. Each Community Mother on average offered the Programme to eleven new mothers: a figure which is very similar to the 12 family maximum suggested in guidelines for Programmes such as Head- Start (Meleen, Love and Nauta, 1988). The analysis also highlighted some of the difficulties in the Programme (including the turnover of providers; the high proportion of recipients turning it down on the first visit and the low proportion who received the entire programme: O'Connor, 1999). Nevertheless there was a strong feeling in the Steering Group that the Programme was having an impact. In this context it was felt that a formal evaluation should be undertaken. Various models were considered, including an evaluation of the impact of the programme on the children. However in the light of Mc Nelis and Kelleher's observations (1995: 81) that 'parents' recollection of children achieving milestones ....are generally earlier than those suggested for normal children by textbooks' it was decided to focus mainly at the summative level, looking at the perceived impact of the Programme on both recipients and providers (excluding those who had not been involved and who, hence, had experienced no such impact).

In consultation with the Steering Group it was decided to interview a random sample of those recipients who had at least a minimal input from the Programme (this was defined as having received three or more visits); in addition to all of those who had been involved in its delivery. The inclusion of both recipients and providers made sense in view of the objectives of the Programme, and the expectation that over time there would be movement between the two groups (see Mc Nelis and Kelleher, 1995). It was decided that interview schedules would be used for data collection. Initially so as to facilitate comparison, it was proposed to use the schedule developed by Mc Nelis and Kelleher. However this was rejected by the Steering Group and a revised schedule was agreed in consultation with them and the Community Mothers. Predominantly open-ended questions were favoured with only a small number of rating scales being included (e.g. on attitudes to training). As of January 1997, 98 families who had received three or more visits were identified by the main co-ordinator. Using a random one in three sample of 37 families (seven of whom had moved) 26 mothers were interviewed (response rate of 84%, with two respondents refusing to be interviewed and two being contacted but not obtained). Excluding very recently recruited Community Mothers, 28 women who had been involved in the Programme at various stages since its inception were identified by the co-ordinator, and 96% of these were interviewed. Interviewing of both groups was done by a post graduate student who was herself a mother. The data was subsequently analysed using the SPSS data package.(See O'Connor, 1999 for a more detailed description of the methodology).

Experience of motherhood on going home after the birth of last child

In so far as attention has been paid to the mother's experiences, the focus in Ireland, as elsewhere, has been on lone parents, with their experiences being very much more likely to be

problematised than their married counterparts (Macintyre; 1991; Mc Cashin, 1996; Hyde, 1997).

Yet it seems very possible that in a society which makes it very difficult for men to share the care

of a new baby; and where the availability of relatives or friends to share that care cannot be

guaranteed, a mother's arrival home from hospital with a new baby may pose considerable

challenges (Oakley, 1992). It was decided to explore not only the recipients' experiences and

feelings when they came home from hospital with the new baby, but also to ask the similar

questions of the providers, asking them to focus on the birth of their last child. Obviously since

the providers were older (the majority were aged at least 36 years whereas the majority of the

recipients were under 30 years: O'Connor, 1999) their experiences can be seen as reflecting

those of an earlier era. However since a key element in the Programme was the validation of the

shared experience of motherhood, it seemed important to include the experiences of an older

generation who might be seen as embedded in traditional support structures.

When the recipients of the Community Mother's Programme were asked what things were like

when they came home from hospital with the new baby 50% of them used a variety of graphic

negative phrases. They said that it was 'terrible' 'very hard, very stressful'; 'it was hectic. I felt

smothered, fit to kill someone'. In some cases they explicitly linked these feelings to the

absence of support: 'I had no-one to turn to as my husband did not understand'. Interestingly,

such statements were made by an even larger proportion of the providers (81%) than the

recipients (50%) although the tone of both was very similar. Thus when the providers were

asked what things were like when they came home from hospital with their last baby they said

that they felt 'tense, unsure, panic'; 'lonely, tired, nervous, unsure of myself'; 'difficult, my

husband had to go to work so I was alone.' The higher proportion of the providers expressing such negative feelings implicitly challenges the assumed existence of traditional support structures. It may reflect their age and the longer (paid) working days of their generation. Alternatively it may be that those whose own experiences were negative were disproportionately attracted to the programme in an altruistic attempt to protect younger women from these experiences. There was some indirect support for this interpretation insofar as two thirds of the providers said that they had no expectation that getting involved in the programme would lead anywhere. There was a striking level of altruism in their replies: 'I just saw a need and wanted to help'.

INSERT TABLE 1

Broadly similar trends emerged when the recipients and providers were specifically asked how they felt when they came home from hospital with the new baby. Thus 46% of the recipients described their feelings in negative terms. They said that they felt 'very stressed out, couldn't cope, couldn't get anything done;' 'how am I going to cope with four children. I was a nervous wreck.' Again these feelings were more common amongst the providers than the recipients (70% versus 46% respectively). The intensity of the negative feelings expressed by the providers many years after the birth of their last child was striking: 'very insecure, nervous, thinking that I couldn't cope;' ' tired, terrified, worried.'

It is important to stress that some people had positive experiences and feelings. Thus 38% of the recipients (and 11% of the providers) described the situation when they came home from hospital in positive terms as: 'wonderful a different life'; with others describing it positively but less enthusiastically: 'O.K.-my husband took a weeks holiday'. Similarly a sizeable minority

(23% of the recipients and 11% of the providers) described positive feelings when they were asked how they felt when they came home from hospital with the new baby. They said they felt 'great;' 'I felt supported;' 'delighted with myself'; 'excited, relieved and looking forward to the future.' In both situations a minority of both the recipients and the providers had mixed feelings, describing their situation as 'hard but I was supported well.' Overall however the prominence of fear and anxiety about coping was particularly striking in a context where a belief in maternal instincts has conveniently obviated any need for support for 'normal' women.

The recipients were not, for the most part, young inexperienced mothers. Thus, in the case of only just over a quarter (27%) of the recipients was this baby their first child. Overall however, they were at a very demanding stage of their child rearing, with all of them having at least one child under five years old, and almost two fifths having at least two children under five years old. Only a small group (8%) of the recipients (and none of the providers) were under 20 years old. There was also no suggestion that such feelings reflected the absence of a partner and/or local kin ties. Thus 81% of the recipients (and 96% of the providers) had a partner at the time the last baby was born. However the existence of a partner did not guarantee his support. Of those who had a partner, 38% of the recipients (and 46% of the providers) said their partner had been little or no help at that time: 'he didn't help at all.' It was striking that the recipients were more likely than the providers to offer excuses for their partner's low level of help. Those who were separated (who were most likely to be providers) were disproportionately represented amongst those who described him as having been no help: it is impossible to know to what extent this reflected his low level of help and/or the current status of their relationship.

However 62% of the recipients who had a partner (and 54% of the providers who had one) said that he was a help at that time. Nevertheless only roughly two fifths of both the recipients and providers said that he was the person who gave them most support after they came home from hospital with the new baby. The extent and nature of the kind of support given varied within both groups- ranging from those who stressed practical help: 'My husband. He did everything- cooking, shopping, cleaning, looking after the baby;' to those who said that 'My husband. He was not much help but emotionally he was there'.

Roughly two fifths of the recipients and the providers said their mother/family/parents were living nearby when their last child was born. As one might expect their mother was the person who was mentioned second most often as having given most support when they came home from hospital with the new baby. Nevertheless only 30% of the recipients and 22% of the providers referred specifically to her: 'my mother- she'd take the baby and give me a break and she gave me my dinner.' There were occasional hints of tension in the relationship: 'My mother. She advised me well, but then she got too overbearing and I had to ask her to stop.' The majority of the recipients and of the providers (77% and 56% respectively) identified specific friends by name, and the majority of them said that they were a help at that time (90% and 69% respectively). As one might expect from studies of the nature of the friendship (O'Connor, 1992) only 6% of the total sample referred to friends as providing most support.

Thus quite clearly although the majority of both providers and recipients had partners, parents and friends around when their last child was born; and although they identified traditional sources of support, such as partners and mothers, as those giving them most support, it was clear

that the sheer existence of such relationships by no means guaranteed their support. Furthermore roughly half of the recipients, and roughly three quarters of the providers were fearful and anxious when they came home from hospital with the new baby.

Aim 1:Impact of the programme on self esteem and perceived confidence and capacity to parent

Relationships with home visitors vary in terms of the extent to which they are conventional professional-client relationships or more or less collaborative partnerships where the focus is on facilitating and empowering parents: with most being of the former kind (Cochran, 1988; Powell, 1990). The present Programme adopted a broadly collaborative mode of working with parents within the context of the first aim of the programme: namely to enhance parents' self esteem and confidence so as to improve their capacity to rear their children.

It is difficult to disentangle the effect of support on psychological well-being within close ties since both may reflect an underlying psychological reality. Such contamination is obviously much less likely to occur when support is provided (as in this case) by some kind of outside agency. When the recipients and the providers were asked whether, overall, the programme had any effect on them, the overwhelming majority of both said that it had. Thus 70% of those who said that they had received the Programme and 82% of the providers said that it had a positive effect. When both were asked to identify three positive effects of the Programme, 82% of the recipients and all of the providers were able to do this (See Table 2). Their replies were categorised into three groups: its effects on their emotional well-being (as reflected in its effect on their confidence, self esteem/security and calmness/relaxation); on their social well being (in terms of social contacts and social skills) and on their knowledge (as regards parenting and

community information).   In this section attention is focused on its general and specific perceived effects on their emotional well- being and on their perceived parenting ability.

INSERT TABLE 2

Overall, the effect which was mentioned most often was increased confidence, with 50% of the total sample referring to this. Increased confidence was very much more likely to be referred to by the providers than the recipients (67% and 24% respectively: see Table 2). Similarly in reply to a direct question, 81% of the providers and 53% of those who said they had received the Programme said that participation in the programme had affected their confidence positively. These trends may well reflect the fact that, inevitably, the providers met a wider range of people. However many of the recipients specifically referred to its effect on their confidence as a mother: 'It boosted me. I was worried about coping and the Community Mother made me feel better.' This pattern of course makes sense in view of the salience of this identity in their lives at this point in time. Only one person in the total sample said that participation in the Programme had affected their confidence negatively.

In contrast to the trends emerging as regards confidence the recipients were more likely than the providers to spontaneously refer to its impact on their sense of self esteem/security as well as on their sense of calm /ability to relax (41% and 26% respectively and 35% and 26% respectively: See Table 2). Thus for example they said their 'self esteem rose'; 'I felt better about myself'; that it had 'made me feel more relaxed'. This implicitly supports the idea that the impact of motherhood, in a society which provides few supports for mothers, was to challenge many of the women's ability to cope and their positive evaluation of themselves.   In this context the

programme played an important part in re-establishing their self esteem and their ability to cope in a calm relaxed way with their increased responsibilities.

The Programme is intended to provide support to mothers although it recognizes that providing such support may have an effect on the way they handle their children (Hermanns, 1997). Other work (such as Mc Nelis and Kelleher, 1995) would suggest that this effect is likely to be experienced by both the providers and the recipients. In reply to the general question about the positive effects of the Programme, the recipients were more likely than the providers to refer spontaneously to effects on their parenting abilities (to say that 'they learned more about being a good parent' or 'that they became a better parent': 41% versus 19% respectively: see Table 2). However, in reply to a specific question about its effect on the way they handled their children, roughly three fifths of both said that participation in the Programme had changed this (63% of those who said that they had received the Programme and 59% of the providers). Thus there were frequent references to the fact that it had made them more understanding of, and more informed about, their children's needs: 'I look at things differently now. I see the good now in the kids;' 'I listen more now and I encourage them to do more things around the house now'; 'I use better wording now when I correct them.' The similarity in the trends amongst the providers and the recipients in reply to the direct question was particularly striking given the different ages of the mothers and children in the two groups. The greater tendency for the recipients to mention this effect spontaneously arguably reflected their greater anxiety about their current ability to parent and hence the greater salience of this issue in their minds. Broadly similar trends have emerged in other studies. Thus for example Mc Nelis and Kelleher (1995) noted that the overwhelming majority (89%) of the recipients in their Community Mothers Programme said

that they felt more comfortable in their role as parents as a result of participation in the programme: with greater understanding, patience and information being most frequently mentioned. As in the present study the providers also saw themselves as benefiting: with increased awareness of children's development, social awareness and contacts, and being able to help somebody being mentioned equally frequently. Thus effects on both recipients and providers were not peculiar to this Programme.

Overall then participation in the Programme was widely perceived by those receiving and providing it as having positive effects on their confidence; their sense of sense of self esteem and their parenting skills. Thus in terms of the first aim there was evidence of its success of the Programme in the case of at least a half to two thirds of the recipients and providers.

Aim 2: Recruitment, training, support of visiting parents through community resource unit
In this Programme local people were recruited and trained as providers, and local activists were recruited as (paid) co-ordinators. Potential Community Mothers were identified primarily through contacts known to members of the Steering Group. All those invited to become Community Mothers went through an induction programme involving at least six sessions in Limerick Social Services Centre. The Programme focused on their own valuable experiences as parents and sensitised them to valuing the skills and talents of the parents they were visiting, placing considerable stress on developing listening skills and encouraging the development of their own self esteem. Information was also given about a wide range of services in their community and on how to access them. These were broadly similar to those provided in other projects.

Since the focus was on validating their skills and knowledge as parents there was ambivalence about the use of the word 'training'. However, when the Community Mothers were asked what they thought about the 'training' the overwhelming majority (89%) of the comments were very

positive. The overwhelming majority of them were happy with the time (89%) and venue (85%) More than three quarters (77%) of them assessed the 'training' on the five point scale as 'very helpful' (top point) and all but one assessed it as helpful (point 2). They stressed that 'the tutors were very good;' 'brilliant training really;' 'they asked our advice. they listened to us;' 'it made us think back to when we were mothers ourselves and this made us more aware of how the new mother felt.'   Role playing (44%), especially in relation to knocking on doors, and communication skills (26%), including ' getting us to open up;' 'expressing ourselves in a group' were seen as the most useful elements. Nevertheless the overwhelming majority of the providers (85%) found knocking on people's doors to offer the programme very difficult: 'terrible; embarrassed;' 'sick, very nervous'; 'I hated it'. Almost two thirds said that they found it easier as time went on. However, roughly one in three said that they still felt the same as they did at the beginning:- 'I hated it and still do;' 'nerve-wracking and now it is the same.'

Visiting skills and communication skills were also addressed in other 'training' programmes (Mc Nelis and Kelleher, 1995) with a great deal of attention being paid in both projects to building in structures to support the providers. In the present Programme all the Community Mothers met with one of the co-ordinators on a monthly basis for support and supervision in both individual and group feedback sessions. As a group, the Community Mothers met at least six times per year for peer support and, when required, for an additional 'training' type input. The two co-ordinators (who also visited families in their capacity as Community Mothers) met with the Manager once a month for their own support and supervision. The overwhelming majority (85%) of the providers were very positive about the individual and group feedback sessions.

Powell (1998) and Barker (1997) have noted that there is no publicly accepted role into which an individual Community Mother can slip. They are different to Public Health Nurses and Social

Workers. Thus their role must be negotiated on an individual basis; within a context where many of the new mothers are in an emotional whirlwind; where there is frequently a certain suspicion about any kind of intervention in family life and where many of the providers find great difficulty in approaching strangers. Hence it is perhaps not surprising that there were difficulties retaining providers. In part this turnover can be related to the low level of payment (£3 per visit) and the increase in the demand for workers in the service sector during the 1990s (O' Connor, 1998). An attempt was made to deal with this by targeting providers from different age groups. The group who appeared most willing to stay with the programme were older women (aged 41 or older), with those aged 20-30 being particularly unlikely to do so. A similar pattern emerged in Scallan, Farrelly Sorensen and Webster's (1998) study of the characteristics of those providing family support services (where the mean age was 44 years). It is impossible to know to what extent this reflects the attractiveness of the Programme to older women; their greater ability to deal with refusals or the difficulties they face in re-entering the labour market (having left it before 1973 when the Marriage Bar was still in existence: O'Connor, 1998).

It is difficult to know what actually happens during home visits of any kind (Powell, 1993, 1998). However, more than four fifths (82%) of the recipients said that they felt comfortable with the Community Mother who visited them and a similar proportion were happy about the kinds of things that were talked about; with 71% of the recipients said that what they liked most was: 'Being able to talk to someone who understands me.' The small number of recipients (18%) who were less happy 'wanted more chat about me and my baby...more about my problems rather than hers.' Thus it was clear that in a small number of cases the Community Mothers were offering a more reciprocal kind of relationship than the recipients needed or wanted (see

Powell, 1990). The educational cartoons were very popular with the providers*: 85% of them seeing them as 'the best invention ever'. They were seen as particularly useful for those who could not read: with children as well as parents enjoying them. There was some suggestion that Community Mothers picked out cartoons which seemed particularly appropriate for particular mothers. Reaction to the forms monitoring the child's development and the mother's diet (the 'green forms') was very different. Thus 93% of the providers did not like these forms: 'it looked like you were checking up on them' (although over half of the recipients did not mind them, seeing them as reflecting a kind of concern: ' At least someone was thinking about me anyway.').

Roughly half (52%) of the providers felt comfortable with the families who were allocated to them without exception and said that they found it easy or very easy to talk to them; with the majority of the remainder being comfortable with most of those allocated to them. In general the crucial factor seemed to be the extent to which the potential recipients made them feel welcome-again reflecting a degree of personal sensitivity that is perhaps inevitable given the paid volunteering character of the Programme.

Home visiting is unusual insofar as it inverts the usual power relationship between providers and recipients. Thus interaction is on the recipient's 'home turf'; they are the people who lay down the ground rules and it is the home visitor who must adjust- a situation which is very different to what occurs in situations where the interaction occurs in the provider's office. Roughly four fifths both of the providers and of those who said that they had received the Programme felt it was all right seeing the Community Mother in their own home. However when specific

alternatives were offered, the majority of the providers favoured parent group sessions (82%) and/or parent and child group sessions (85%). There was less interest in various kinds of group sessions amongst the recipients: 41% of them saying that if they had a choice they would prefer parent group sessions; and 47% preferring prefer parent and child sessions.

Overall, training and support provided was very positively evaluated. There were issues around the turnover of the providers: an issue that is returned to later in the article.

Aim 3:Sustainable co-operation between community, voluntary and statutory sectors

The strengthening of existing links within and between the community, the voluntary and statutory sectors was one of the aims of the Programme. In part this reflected a recognition of the importance of local community leadership in disadvantaged communities, and the need for close ties to exist between this and the voluntary and statutory services.

The majority of the providers were chosen because they were well established in their communities and so were in a position to facilitate the development of such links: 70% of them having lived in their present community for at least 10 years and over four fifths of them describing themselves as very well known in the area. At the time of interview more than half (56%) of the providers were involved in a wide range of community based organisations or activities (apart from the Community Mothers programme. Perhaps even more strikingly, at the time of interview, 96% of the providers had attended classes of various kinds including parenting; child care; sewing; cookery; sex education; assertiveness; money management; welfare rights; computers; aerobics; personal development; pottery; aromatherapy; maths and

creative writing. It was striking how often they said 'I enjoy learning new things.' Such high levels of participation in adult education may be unrelated to their participation in the Programme, although this seems implausible given its stress on respecting their skills, knowledge and resources (Powell 1998; Sheridan, Roberts, Warner, Coyle and O'Rourke 1997).

Roughly one third of the providers and the recipients spontaneously referred to the effect of the programme in terms of increasing their social contacts (37% and 35% respectively: Table 2); with the providers being more likely to refer to the positive effect of the programme on their social skills (30% and 6% respectively: Table 2). Both the providers and the recipients also spontaneously referred to the impact of the programme on their knowledge about the wider community (saying that they were 'more informed about the community;' 'were more aware of what was going on': 33% and 41% respectively: Table 2). It does not seen unrealistic to see these effects as the beginning of the development of community leadership.

In reply to a specific question, the majority (78%) of the providers said that participation in the programme had affected the nature and depth of their links with the local community ('I started a support group for lone parents'; 'I got more involved in the Committees;' 'I know people better now and I chat to people more now.)' Roughly half (48%) of the providers felt that participation in the programme had opened up new contacts for them in a variety of classes, organisations and groups. An even larger proportion (81%) of the providers said that it had increased their information about the local community: about doctors' times, mother/toddler groups; support groups; classes; social events; money advice and social welfare. Thus the majority of providers, who were selected on the basis of their actual or potential community leadership, became more

knowledgeable about and/or more involved in the community as a result of their involvement in the Community Mothers Programme. No information was collected on the impact of this or indeed other aspects of the Programme on partners, siblings or other family members. However it is difficult to see how such increased knowledge about and involvement in the community would not have impacted on them.

The recipients had been living in the area for a shorter period of time than the providers with the majority (62%) of them having lived there between one and ten years (only a very small minority were virtually new arrivals). Just over half (53%) of those who said that they had received the Programme also said that it had increased their information about what was going on in the community; with 29% saying that it had an effect on them in terms of making new contacts in classes, groups or organisations; while (12%) said that it had improved their links with others in the community (the overwhelming majority of these having received the Community Mother's Programme at least three years ago). Perhaps not surprisingly in view of the fact that they had just had a new baby, only a small proportion (7%) were currently involved in community organisations or activities. However half of those who were not currently involved said that they would like to be in the future (naming specific activities and/or groups).

Right from the start good relationships were formed between professionals within the statutory sector and between them and those in the voluntary and community sectors. Key players from each of these areas had been included in the Steering Group which consisted of a Community Worker on the Social Work team of the Health Board; a Public Health Nurse from the Health Board; a member of the Health Boards' Health Education team who was also an adult education

tutor and local community activists who became the (paid) co-ordinators of the Programme. Links were also successfully created and maintained with other local agencies and with the Social Work Services in the Regional Maternity Hospital. There was no professional opposition to the use of 'inexperienced parents'; no difficulties in contacting new mothers or liasing with other services- problems which have affected other Programmes (Sheridan, Roberts, Warner, Coyle and O'Rourke, 1997; Powell, 1998)

Pilot funding by the Bernard Van Leer Foundation has been replaced by mainstream funding from the statutory sector. The focus has been extended to include teenage mothers: effectively teenage lone mothers. This latter focus is very much in tune with current public concern with such pregnancies. Insofar as it becomes the main focus of the Programme it can be seen as reflecting and reinforcing the idea that motherhood in a context where there is a partner is unproblematic: a highly questionable assumption. There are questions too around young lone mothers need for the Programme as originally envisaged since many of them are effectively co-parenting with their own mother. Such young lone mothers do have problems :but what evidence we have suggests that these derive from the public arena (because of the low level of social welfare payments; the difficulty of reconciling child care with work/education etc: Mc Cashin, 1996; Finlay, Whittington, Shaw and Mc Williams, 1997). Indeed an attempt is being made to tackle the latter problems through the establishment of a support group for lone mothers facilitated by a Community Mother in a variety of community based facilities including a school and a youth service context.

The local community activists who acted as the co-ordinators of the project have been replaced by a qualified community worker employed by Limerick Social Services who has experience of working with women's groups and by a person who has been involved in a voluntary capacity in parenting and sexual health programmes in disadvantaged areas for a number of years. A third co-ordinator is still to be appointed: and it remains to be seen if this post will be filled by a local activist. All three posts are being paid for at a level above the industrial wage and do not exemplify what O'Donovan (1997) has called the 'conflation of gender and economic identities.' The payment per visit remains low, but has been increased to £4 per visit.

Thus clearly the Programme has strengthened ties within the community; has developed the capacity for community leadership; has consolidated existing ties between the community, the voluntary and statutory sectors and has successfully negotiated mainstream funding for the continuance of an extended Programme with a specific focus on teenage lone mothers. In the latter context it is concerned with issues which perhaps could best be described as education for parenting. It remains to be seen whether such concerns will overshadow the initial focus, and whether the presence of trained /experienced people from the voluntary sector (as co-ordinators) will increase or diminish its embedded ness in local communities.

Implications for other projects

In terms of its aims it is clear that the Programme was successful. However there were a number of difficulties which have implications for other studies. Firstly then getting mothers to take the Programme was difficult. The majority (74%) of the providers indicated that they had at least some difficulty getting people to do this. The most common explanations offered were lack of

knowledge about it; and being perceived as 'spying' and being 'from the authorities'. It is not surprising that in disadvantaged areas intervention by caring agencies in family life is frequently seen as stigmatising and a prelude to the removal of children into care, the withdrawal of social welfare etc. Some of the Community Mothers perceptively noted that: 'usually support doesn't GO to people's houses. They wondered about me and what were my motives.' The boundaries implicit in kinship were also adverted to: young mothers who were living with their parents were seen as particularly likely to turn down the Programme; and the 'tough areas they need it but they don't want it...they are ashamed of their homes.' Up to January 1997, 40% of those who had been offered the Programme turned it down on the first visit. These difficulties were not peculiar to this Health Board (Powell, 1998). In the Community Mother's Programme in Ballymun in Dublin, 41% of those who were offered the Programme turned it down in 1991, although by 1993 this had fallen to 22% (Mc Nelis and Kelleher, 1995). Clearly, it takes time for acceptance and trust to be built up within such disadvantaged communities.

Secondly, there were issues around the turnover in Community Mothers. Thus just over half of those who had been recruited as Community Mothers at the beginning were no longer Community Mothers at the time of interview, so that the majority of them had been involved in the programme for a relatively short period of time (i.e. 67% being involved for less than one year). One would expect some turnover because of moving house; sickness; entering paid employment; their own pregnancy etc. This also occurred in other Programmes: Mc Nelis and Kelleher (1995) found that the average length of time their Community Mother's stayed with that Programme was 16-18 months. However, the documentary evidence suggested that those who had difficulties getting families beyond the second visit were disproportionately likely to

leave (O'Connor, 1999).   This is not unrelated to the difficulties Community Mothers experienced approaching new mothers for the first time (and the terror one third of them continued to feel 'knocking on strange doors' despite role playing etc.).   Such experiences throw into sharp relief the whole issue of the difficulties involved in a 'paid volunteering' Programmes of this kind.

Thirdly, there appeared to be some administrative difficulties in the Programme.   Thus more than a third (35%) of those who said that they had received the programme also said that the ending of their own programme of visits had not been well handled.   As they saw it the Community Mother had simply left and not come back; got sick and was not replaced etc.   This was not helpful for these recipients or for the overall image of the Programme.   There were also some other minor administrative difficulties, which were reflected in the fact that almost one third of those on what purported to be a list of families who had received at least three visits did not appear to have done so (see O'Connor, 1999).   Again this is arguably related to the attempt to ground the Programme in the local area through the appointment of local activists as (paid) co-ordinators.

Fourthly, as previously mentioned the 'standard' package of visits in the Programme was 13 visits over 13 months.   Although there was no consensus as to the appropriate frequency, this frequency was unpopular with roughly three quarters of the recipients and the providers. Roughly a third (35%) of the recipients and half of the providers felt that the visits should be more often than once a month.   Two fifths (41%) of the recipients and roughly a quarter (23%) of the providers suggested that frequency should vary for different groups (such as the ' more

isolated' and 'first time parents'- a practice which was adopted by the Programme at a later stage). Thus quite clearly there was no consensus as regards the appropriate frequency of visits although there was very little support for the 'standard package' of once a month.

Fifthly, statutory services are sometimes reluctant to offer non-stigmatising support to married mothers on the grounds that it would 'open the floodgates' as regards the demand for such support. This study suggested that the recipients' need for a Community Mothers Programme was for the most part a time limited one. For more than half of them a combination of a reduction in the intensity of child care demands because the children were older, as well as the availability of help from others created a context where they felt that they no longer needed it: 'I'm on my feet now: I'm OK.' Furthermore this was in a situation where only just over a quarter of the recipients received at least five visits. Only roughly a quarter (27%) of the recipients felt any need for ongoing support, whether from the Community Mothers programme, a mother and toddler group, or an available crèche, mostly so that they could do part-time (paid) work. Effectively what most of these were looking for were 'family friendly' (Lewis, 1997) initiatives which would help them to reconcile work and family. Thus, when they were offered the choice of a standard range of services that they would like to see in place for new parents, 89% of the total sample indicated that they saw a need for day care; 75% for after school care; 92% for some kind of a drop in centre; and 98% for access to adult/continuing education. For most the need for support from a Community Mother was a very time specific one.

Thus it is clear that providing what appears to be a very simple Programme consisting of mothers supporting mothers raised fundamental issues that are relevant to other similar projects.

Summary

The Programme described in this article questioned the assumption that the existence of a partner and local kin obviated a need for support for women in certain situations. Roughly half of the recipients and just under three quarters of the providers graphically described strong negative feelings when they came home from hospital with their last new baby. The intensity of these feelings was striking. Implicit in the Programme was the idea that support for the mother was important both in its own right and as one way of facilitating the child's development- a perspective that is only now being recognised in child development studies (Hermanns, 1997; Thompson, 1995).

Untypically in a world where there is an increasing reliance on professional workers, the Programme 'builds on the idea that experienced mothers in the community have skills and knowledge, developed through parenting and life experiences that are crucial to pass along to the next generation of parents' (Powell, 1998:9). The qualitative material clearly illustrates the nature and impact of the Programme on women and their lives. In terms of its first aim, the majority of those who said that they had received the Programme (72%) and of those who provided it (82%) said that it had a positive effect. Two thirds of the providers spontaneously referred to its effect on their confidence; two fifths of the recipients spontaneously referred to its effect on their self esteem/security and more than one third of the recipients referred to its impact on their sense of calm/ability to relax. Furthermore, in reply to a direct question, roughly three fifths of both the providers and the recipients said that it had impacted on their parenting abilities. Many of the quotations vividly illustrate the nature and depth of its impact: 'I see the

good now in the kids'; 'I use better wording when I correct them.' The Programme provided training and support for the providers and this was overwhelmingly positively evaluated: its second aim. In line with the third aim, links within the community, and between the community and statutory and voluntary sectors were strengthened. There were difficulties in the Programme including those related to attracting recipients and holding on to providers- the former being partly seen as reflecting the absence of a clear positive image of a Community Mother and the alienated nature of the community; and the latter, as partly reflecting the difficulties of preparing paid volunteers for what they see as rejection on the door step; and partly reflecting the difficulties of providing support through paid volunteering relationships. It is possible to see the Programme's attempt to validate the work of mothers by mothers as perpetuating the equation of caring with unskilled and undervalued work.

The Programme, which was funded on a pilot basis by the Bernard Van Leer Foundation, has been mainstreamed and will continue to be funded by statutory services. It now includes a focus on lone teenage mothers. The main (paid) local co-ordinator has been replaced by a community worker from Limerick Social Services. It is arguable that it is being mainstreamed because it fits well with the model of care which has been identified as a key feature of what has been called a patriarchal welfare state (O'Donovan, 1997:150). Insofar as it becomes targeted at teenage lone mothers who are already effectively co-parenting with their own mothers, it is possible to see it as constituting another attempt by a (male) State to erode female control. On the other hand however, in so far as it remains a pro-active programme that attempts to facilitate women supporting women; and which is outside the regulatory ambit of statutory health and social services, it can be seen in a rather different light. It is unclear how the balance of these elements

will change as it moves from being a pilot programme funded by the Bernard Van Leer Foundation to one financed by the statutory services. The issue of supporting mothers is clearly a highly complex and ambiguous area.

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Table 1 Proportion of recipients and providers reporting different feelings on coming home from hospital with new baby?

Feelings	Recipients	Providers	Total
	N=26	N=27	N=53
	%	%	%
Very Positive/Positive	23%	11%	17%
Mixed Feelings	27%	11%	19%
Very Negative/Negative	46%	70%	58%
Other	4%	7%	6%
Total	100%	99%	100%

Table 2 Proportion of recipients and providers identifying different positive effects of the Programme

Positive effects	Recipients N=17	Providers N=27	Total N=44
Emotional well being			
Greater confidence	24%	67%	50%
Self esteem/security	41%	26%	32%
Calmer/more relaxed	35%	26%	30%
Being needed/useful	6%	22%	16%
Social well being			
Social contacts	35%	37%	36%
Social skills	6%	30%	20%
Knowledge			
More knowledge	41%	33%	36%
Improved parenting	41%	19%	27%
Job/Job Prep	0%	7%	5%
Other	18%	26%	23%
No Positive effects	18%	0%	7%

Note: Percentages do not add up to 100% since most respondents mentioned more than one

One third of those who were listed as having at least three visits did not appear to have received the Programme.

Hence N in this case is 17 not 26