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article

Devoted work without limits? Activities and premises of home visit work at the margins of community care

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Community care provided through home visits is an increasingly common way to respond to adult citizens' complex needs due to, for example, mental health and substance abuse problems. This study explores the activities and core premises that this work entails. The data contain six focus group interviews with practitioners in five service settings in Finland and Sweden at the margins of community care. Through a two-stage coding process, 11 activities and three premises – situationality, boundlessness and empathy – were identified. The findings show that home visit work at the margins of community care is comprehensive and flexible, requiring reflexivity.

Key words home visit • community care • adults • complex needs

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Introduction

In many contemporary Western welfare societies, adults with complex service needs are primarily supported and cared for in the community, rather than in institutions. Community care services provided through home visits have become a common way to respond to their intertwined problems and needs, such as mental illnesses, addictions, disabilities, exclusion and isolation (Magnusson et al, 2003; McConkey and Collins, 2010;

Pleace, 2016; Kuluski et al, 2017; Martin et al, 2017; Wahlbeck et al, 2018; Lydahl and Hansen Löfstrand, 2020). These services are supposed to support citizens with 'significant health *and* social care needs' (Kuluski et al, 2017: 2, emphasis in original) to further their inclusion in society, in line with the policy trend over recent decades of emphasising the importance of social inclusion and reducing exclusion (for example, Marlier et al, 2009). They are to be supported so that they can live in their own homes, cope with everyday life and avoid future hospitalisation or other forms of long-term institutional care (England and Dyck, 2011; Martin et al, 2017). Furthermore, care provision through home visits is expected to foster ethically sustainable professional work as citizens with care needs are encountered on their own grounds instead of in clinics and institutions.

However, the goals associated with this policy trend of home care may be difficult to achieve due to a lack of knowledge. A decade ago, it was claimed that research had not addressed 'practitioners' experiences of the work they have to do that goes on beyond the office, on the street and in doing the home visit' (Ferguson, 2010: 1100). Research about the kinds of care provided during home visits is still needed. In this study, we aim to produce knowledge on work at the *margins of community care*, where clients' complex, intertwined needs tend to 'span beyond what the health care system typically provides' (Kuluski et al, 2017: 2). Community care at the margins is a last resort in the sense that its clients have been excluded or are not getting enough help and support from services that only provide care for clearly defined specific illnesses and problems. According to Kuluski et al (2017: 2), there is an urgent need to 'garner the perspectives of experienced health and social care providers, who work with this population, to gain insight into what community supports are needed and what gets in the way of providing them'.

In response to this call for knowledge, we delineate the types of activities that home visit work entails in practice when carried out in the homes of working-age adults with mental health and substance abuse issues, and often accompanied by major challenges in living independently. In addition, we scrutinise in detail how practitioners describe their work orientation in home spaces, which we understand as the premises they connect to their work. Our study makes visible the invisible care done in private and intimate spaces (Pithouse, 1987; Winter and Cree, 2016).

We start by reviewing existing research on the specificities of working in home spaces. Next, we introduce the research settings and discuss our methods and data, which consist of six focus group interviews situated in five service settings. We then move to the results by first depicting the types of activities that home visits entail. The second part of the results provides detailed knowledge about the premises of home visit work, that is, their characteristics, prerequisites and ethical issues.

Home as a place of work

The emphasis on community care means that health and social care practitioners are increasingly doing their work in clients' homes. Homes as a place of work differ considerably from offices and institutions. The spaces of offices and institutions can be defined as 'belonging' to practitioners, with certain institutional rules and codes of behaviour, whereas other people's homes can never be entirely workers' territories (Twigg, 1999: 386). The specificities of professional work conducted in homes have been intensively studied and conceptualised over recent decades. Research has been done in different disciplines covering work among different client groups (for example,

Twigg, 1999; Dyck et al, 2005; Zadoroznyj, 2009; Ferguson, 2010, 2018; Winter and Cree, 2016; Karlsson and Gunnarson, 2018; Muzicant and Peled, 2018). Thus far, the most studied areas from the viewpoint of place are old people's care and home visit work among families with children, whereas work among adults under 65 years with complex service needs has been less studied.

The deeply embedded cultural values attached to a home make it a particular place for professional work. It is recognised as a place of intimate relationships, privacy and safety, and where the homeowner has the right to control other persons' access to it (Twigg, 1999; Milligan, 2003). Twigg (1999: 384) writes that these values 'are highly significant in structuring the care encounter from both sides', and continues that 'workers regard their own homes in this way too, so that rules of behaviour are part of taken-for-granted reality of their own social lives'. This creates a challenge for practitioners as they have to follow both the cultural codes of a visiting guest and the roles and norms of a professional actor (Milligan, 2003; Juhila et al, 2016). Furthermore, social and health care work done in private spaces makes it unpredictable. Although home visits usually have certain preset functions and tasks, they need to be modified, for example, if clients do not open the door, if family members and friends participate in home visits, or if some acute crisis is going on in the client's life at that very moment. Unlike standard office spaces, all homes are different and personalised, which further increases their unpredictability.

Research has also shown how homes as places of work make work strongly embodied. The comprehensive interplay between clients and their everyday lives contains bodily movements and experiences (Ferguson, 2010; Karlsson and Gunnarson, 2018; Muzicant and Peled, 2018). According to Muzicant and Peled (2018: 830), who studied social workers' home visits, 'bodily experiences in the client's home involved the senses and bodily actions – sitting, standing up, walking from one room to the next, drinking and eating'. Embodiment also contains sensory experiences in homes – touching, seeing, hearing, tasting and smelling. Work containing these kinds of embodied elements has been characterised as 'body work'. Broadly defined, 'body work' refers to 'all the embodied, interactive work in the consumer service sector that requires co-presence', including 'workers' management of their own bodies and bodily performances, not only their attentions to the bodies of patients, clients and customers' (McDowell, 2009, quoted in Twigg et al, 2011: 174). In some cases, body work has also been described as 'dirty work', in the sense that practitioners occasionally encounter and tackle various kinds of dirtiness in homes (Karlsson and Gunnarson, 2018; Muzicant and Peled, 2018).

Research settings, data and method

The data of this study contain six focus group interviews with health and social care practitioners. The interviews were conducted in five community care services in Finland (three settings) and Sweden (two settings). The Finnish settings are: Supported Housing (SH), targeted at people with mental health problems; the Centre of Housing Services (CHS), targeted at people with substance abuse problems; and Mobile Support (MS), targeted at both mental health and substance abuse rehabilitees. The Swedish settings are the Mental Health Care Unit (MHU) in the context of psychiatric care, and the Special Housing Unit (SHU), targeted at formerly homeless people, many with substance abuse and mental health problems. The research obtained ethical statements

from both the Finnish and Swedish Regional Ethics Boards. We furthermore received informed consent from all practitioners participating in the interviews.

MS and SHU are municipal services, SH and CHS are non-governmental services contracted by and producing services for municipalities, and MHU is part of the activities of a psychiatric ward in a university hospital. All settings are thus publicly funded by welfare states. The health and social care practitioners include nurses, psychiatric nurses, social care workers and social workers, and their educational backgrounds and professional statuses vary both between and within the five settings, though, notably, despite these variations, all practitioners do similar kinds of work and their work has, as will be shown, similar premises. Arguably, this similarity is explained by the following features that all five settings share. First, they are all located at the margins of community care; their clients are adults with complex service needs and who face significant challenges in living independently. Second, the practitioners mainly conduct home visits, rather than meet their clients in offices. Third, the aim of home visit work is to sustain and support clients' everyday lives and housing, and to reduce the risks of evictions and homelessness or hospitalisation. Fourth, practitioners often work in close relationships with clients. They do not (usually) conduct bodily care work that includes bathing, clothing, feeding or housework, but they advise and support clients in these activities and generally in living 'a normal life' in the community.

The six focus group interviews with four to nine practitioners were conducted using the same interview guide, including questions: (1) concerning doing home visits in practice; and (2) reflecting the rationalities, benefits and challenges of working in clients' homes. All practitioners conducting home visits were invited to participate in the interviews, resulting in a total of 42 practitioners. One interview was conducted in every service, with the exception of SHU, where we carried out two interviews because the practitioners worked in two different teams. Taken together, our data contain 473 minutes of recorded interviews, and the average length of the interviews is 68 minutes.

Our approach to analysing the data has been explorative, meaning that our first phase of analysis was guided by an open question: 'What activities does home visit work entail in practice, according to the practitioners themselves?' The aim was to get an overall view of the tasks involved in home visit work at the margins of community care (see McConkey and Collins, 2010). All instances in the interviews that included descriptions of work tasks were coded using the ATLAS.ti program (on the practices of coding, see Charmaz, 2014). Then, the instances were compared and similar activities were grouped and named. We delineated 11 different types of work activities, which are presented in the first results section of this article. In this first phase of the analysis, the two Finnish authors of the article coded the interviews conducted in the Finnish settings and the Swedish author coded the Swedish interviews.

The overall finding from the first phase of analysis was the comprehensiveness and heterogeneous nature of home visit work, which led us to a second research question: 'What are the core premises of the comprehensive home visit work at the margins of community care?' Our objective was to develop an understanding of the practitioners' work orientation. By core premises, we mean the characteristics, prerequisites and ethics that the practitioners connect to their work. We coded the interviews a second time by concentrating on talk containing practitioners' accounts and reflections of the premises of home visit work. In this phase, we did the analysis jointly by reading and discussing data extracts from each setting translated into English. Through this

analysis – which resulted in such codes as 'respecting private space', 'close relationships', 'flexibility', 'unpredictability', 'risks/insecurity' and 'last-resort responsibility' – and after comparing our codes, we produced empirically grounded conceptualisations of three premises of home visit work: situationality, boundlessness and empathy. These premises are presented in the second results section.

Home visit activities

As an outcome of our explorative approach to home visit work at the margins of community care, we present here what such work entails in the form of 11 types of activities that the practitioners attended to:

1. *Making and revising individual care plans, putting them into practice, and evaluating the ups and downs in recovery processes.* This is a basic activity as home visit work is based on written care plans that are often prepared, discussed and evaluated in home visits.
2. *Strengthening and ensuring the life skills for living independently by giving advice, supervising and helping with everyday tasks at home.* This activity includes, for example, advising clients about when and how to pay the rent, clean their home, prepare food or perform an exercise programme at home. Sometimes, the practitioners do this by showing in practice and by jointly conducting these tasks.
3. *Doing basic medical measures.* This activity includes, for example, administering medication and measuring blood pressure or sugar levels.
4. *Checking in with clients to see how they are doing at the moment*. This includes, for example, to check how stable the clients seem or whether they have enough food at home.
5. *Managing acute crises* This activity includes, for example, if clients seem to need urgent hospital treatment or if they run out of money.
6. *Having therapeutic and motivational conversations with clients that cover numerous issues relevant in human life.* The practitioners and clients talk a lot and, occasionally, this talk becomes therapeutic and motivational in nature. It is done in an ad hoc way and covers sensitive topics concerning the clients' lives, such as having fears and anxieties, troubles with intimate relationships, or problems with substance use.
7. *Being positioned as a friend*. Apart from actually being a friend, this means taking the role of a guest and making small talk with clients. It also includes examples of practitioners showing appreciation when the client shows affection, for example, hugs, or acts with consideration, such as offering the practitioner coffee.
8. *Doing advocacy work in regard to social and health care services and benefits*. This includes sorting out clients' entitlements to certain benefits or services. It is done by reading official decisions on services, filling out forms and making phone calls for the services in question.
9. *Going along with clients to take care of social and health care matters.* This means accompanying clients to meet other practitioners, such as social workers or doctors, if clients wish to have support on these visits.
10. *Participating with clients in everyday activities outside the home.* This activity includes, for example, shopping, going to the gym or library, or taking a walk in the park.
11. *Being available (on the phone) for clients in-between scheduled home visits.* This is done in cases of both acute needs and questions pertaining to everyday life.

In addition to the aforementioned activities, the practitioners described that they regularly participate in meetings with other professional workers, either together with or on behalf of the clients. Furthermore, they participate in staff meetings with colleagues to discuss individual clients, and they prepare a large amount of documentation on their clients. Taken together, it is evident that home visit work at the margins of community care is comprehensive and entails many heterogeneous types of activities.

Premises of home visit work: situationality, boundlessness and empathy

In this second results section, we present the core premises, that is, the key characteristics, prerequisites and ethics, of home visit work at the margins of community care. Our empirically grounded conceptualisations of the premises and, thus, the work orientation of the practitioners are situationality, boundlessness and empathy.

Situationality

When practitioners meet clients in private homes, encounters are not as routinised and predictable as they are in institutions and offices. Homes are the arenas of people's everyday lives, which become visible and are taken into consideration during home visits. All homes and their everyday practices differ from each other, which means that practitioners' work environments are constantly changing (see England and Dyck, 2011: 211). Furthermore, the visits to one and the same home can be very different, depending on the client's current situation. For example, if the practitioner faces an acute crisis or an unexpected source of joy when entering the home, pre-planned discussion topics and activities need to be revised and unexpected issues attended to instead.

By the concept of situationality, we refer to three features of the practitioners' work. The first feature is the practitioners' *respect for the clients' ownership of their home spaces*. The practitioners are aware that they are not able to conduct their work in clients' homes in the same way as they do in institutional arenas. At the same time, they point out the benefits of doing home visits as visits enable them to see aspects of clients' lives that are not visible in institutional encounters. However, entering clients' homes and observing their surroundings always needs to be done with respect (I in the extracts refers to an interviewer and P1, P2 to practitioners):

I: 'It is, indeed, interesting that you do your work at people's homes.'
P1: 'Well, the first thing is that it is that person's home. We kind of respect it, that we can't do all kinds of things in there.'
I: 'What do you think you can do in there and what can you not do?'
P1: 'Well, for instance, we cannot go directly to a cupboard, this kind of thing.'
P2: 'And we cannot go to flats just like that.'
P1: 'No.'
P2: 'We always ring the doorbell.' (SH)

To some extent, every home visit is about looking around and checking up on the client and the apartment, "to check if the place is in order" (SH). Whether or not

the practitioners actually express their evaluations of the condition of apartments to individual clients, and comment on, for example, the cleanliness of the home, depends on the situation and the mental condition of the client at the specific moment. It also varies between clients: "some clients do not care about it at all; they can, for example, go to another room when I am looking around or go to have a smoke", explained one practitioner; whereas other clients would become very anxious, so "you always have to go there with respect" (SH).

A second feature of situationality is the *unpredictability of work*, implying the need to be oriented on a 'here and now' basis. The practitioners need to adjust what they do to the current situation. Sometimes, unpredictability is connected to insecurity and possible risks for the practitioners. The following excerpt illustrates this, as well as the safety routines and precautions of the practitioners:

> 'Those support visits that we carry out outside the unit [in the homes of clients] are a bit different in the sense that you always need to go there with a co-worker. Well, not to every place. It needs to be carefully planned how to enter a flat. So, security issues are very different.... There are, indeed, those [clients] who use substances, and although their flats or at least some persons' flats are in very bad shape with trash on the floor, they still quickly and intensively blow up if you, for instance, step on some piece of paper crumpled on the floor. So, a person can feel like "you come to my flat and step on my papers", although you have not done it on purpose.... So, indeed, it is always planned with a co-worker in advance how to enter a flat, who goes first, and how to be seated and so on.' (SH)

As highlighted in the preceding example, security routines (like going to clients' homes in pairs) are stressed as crucial for entering homes. However, such routines tend to be ignored when the practitioners and clients have established a kind of trustful relationship (see the section on empathy later), which enables the practitioners to make home visits alone. The issues of how to move around in the home and how to be seated also need to be managed, as mentioned in the preceding excerpt. Seating arrangements are further illustrated in the following example, which sheds more light on how safety routines can be sidestepped in favour of adjusting flexibly to the client's wants and accepting a kind gesture made by the client:

P1: 'You sit where the patient wants you to sit. There are things that you are supposed to take into account, like that you have a free passage out for security reasons, but when it comes down to it, it's ultimately the patient's decision where you sit...'

P2: 'I have a patient who has two chairs, and he actually makes a conscious choice every time, who will sit in the armchair and who will sit on the wooden chair.... Before, I always sat on the wooden chair, and I have made home visits to him many times, and then, one day, he said, "Now you can sit here." Well, then you have established a relationship.' (MHU)

The preceding example also illustrates a third feature of situationality, namely, *embodiment*. Practitioners move their own bodies around in clients' homes, and, as shown, this can be a delicate issue. Home visit work is 'embodied, interactive work',

and apart from being attentive to the clients' bodies, practitioners need to manage their own bodily performances (McDowell, 2009, quoted in Twigg et al, 2011: 174). An important premise of home visit work is, thus, a specific form of self-consciousness: 'a critical bodily awareness and a critical emotional awareness' (Peile, 1998: 54). Therefore, taken together, being in the homes creates a specific practitioner–client relationship and interaction, as highlighted in the following excerpt:

> 'It is very good for a client that we go to the home. It is not a neutral ground, but it is the client's own environment, and this immediately changes the way of conversations. It is very different from having an appointment with a nurse or visiting some office, a really different thing. In that sense, it is good from the point of view of this work. You see the home and the environment, and it reveals many additional issues than encounters in offices do.' (CHS)

The practitioners therefore regard home visits as particularly useful as they reveal much about both the homes and the needs of the clients themselves: the client becomes "more of a person" in their home (MHU). For practitioners to be able to carry out their work, adjusting and adapting flexibly to the individual client is seen as a necessity. This, in turn, means coming up with individual solutions and suggestions to the extent that "it's almost like, well, the foundation [of our work]" (MHU).

Boundlessness

The comprehensiveness of activities involved in home visit work, combined with the situationality of work, brings us to our next concept: boundlessness. The practitioners need to attend to a wide variety of matters. The main feature of boundlessness is that *work is generalist, including almost any aspect of human life*. Practitioners do not only focus on health or social matters in their clients' lives, or on just certain specific and clearly delimited tasks during home visits. This sometimes creates problems for practitioners: how to cope with everything, *what to prioritise and where to draw a boundary* if a workload proves to be impossible to manage. This second feature of boundlessness is illustrated in the following example:

> 'Some of our clients are a bit challenging. They have a terribly lot of everything. Especially in the beginning of the clienthood, when it is revealed that there have been so many mixed-up issues that you need to prioritise what is the most relevant issue, what is best to do now, to have a discussion about what would help the most at this moment and what matters to attend to first. Sometimes, when you leave a client's home, you feel like you have a big backpack on your back, and you worry and think about how all these issues will be sorted out, but they will settle.' (MS)

The practitioners therefore put a lot of thought into what is the best way to help and support their clients, which issues should be attended to quickly, and which issues can wait. Adjusting to the client's 'here and now' needs and wishes may also mean having to flexibly reorient to the situation at hand:

> 'There is flexibility, so that if the client says "Couldn't we go and have a coffee instead?", well, of course we do, or we only go out for a drive in the car. We've done that. But at the same time, if there is a crisis, we can come several times a week, if we have an agreement with the client. We have some clients who have really very heavy drinking periods, and then it may be that we go there every day until we see that either he's getting better or we have to take him to the hospital. We have talked about that; if you are to work here, you need to be flexible. We've got a framework, but if we were to stay inside that framework, it wouldn't work; there has to be a little bit outside of the box as well.' (SHU)

Whatever the clients need in their everyday lives, the practitioners try to help. This may mean helping clients with a fitness programme or accompanying them on walks "to help them get out of the home" (MS). It can also mean going with them to an appointment with their lawyer, doctor or hairdresser. One of the practitioners summed up this prerequisite of their work with the statement that "only creativity is the limit" (MS). At the same time, the practitioners stressed the importance of carefully reflecting on what they do with or for individual clients so as not to hamper clients' independence. They "also encourage them [clients] to do things independently, that it strengthens them, that she or he is capable of taking care of their own matters" (SH). The practitioners recurrently talked about this two-sided aspect of their work: on the one hand, they attend to any matter that needs attending to; on the other hand, they state that "we put as much as we can on the clients; they should govern their own life and, well, run their own life, but when they cannot, we need to support them" (SHU).

The third feature of boundlessness is the specific position of the practitioners and home visit work in social and health care services, which is their *last-resort responsibility for clients*. Whereas other services and professions tend to delineate and define their areas of work more strictly, home visit practitioners at the margins of community care experience being delegated all kinds of tasks:

> P2: 'There are new demands from somewhere that they shall submit account statements [from their bank] every month [to the social services], and this has stirred up things.'
> P1: 'It is every application [to the social services office to receive welfare relief].'
> P2: 'Every application to the social services, even though they have had it for, well, it's totally insane and everyone [all clients] gets very jumpy and our workload increases very much [laughter]. Well, I don't know. No. To put it frankly, I think that the social services delegate their job to us. They say it's our job, "Can you see to it that the bills are paid?", but it is not my job, or it then becomes my job.' (SHU)

The practitioners complained of having to help clients with tasks that are actually the responsibility of other services and professional groups in the welfare state. However, if they did not attend to these matters, such as helping clients with paying bills or submitting applications to social service authorities, it would put the clients in vulnerable situations (with no money, risk of eviction and so on). Hence, the practitioners do attend to these matters.

Empathy

The third premise of home visit work – empathy – is linked to the other two premises. Doing situational work in homes and having a boundless workload in regard to clients' needs forge relationships between the practitioners and clients. This closeness creates and requires empathy. Sennett (2013: 21) writes that empathy means attending to a person 'on his or her own terms'. It also means alignment and affiliation with clients, and a relationship based on trust, respect and reciprocity. The practitioners described that by doing home visits, they develop "a relationship of trust" that "becomes really different and deeper" (MS) compared to work in institutional spaces. This feature of work is characterised as "walking alongside [the client] in everyday life":

> 'Well, I kind of think that it is somehow like walking alongside in everyday life. So, as a worker, I have somehow always seen my role not like a person who just meets a client momentarily. Instead, I somehow live comprehensively in clients' everyday lives. When I come to work, those clients who I know, they know that they can call and ask. So, they are living normal everyday lives and getting help when they need it.… And that might help [them] to overcome some situation, so that maybe there will be no need for heavy hospital treatment or something else if you are able to go there and be strongly present for some time in their everyday lives. And then there are times when there is no need and a client manages well. And then there comes a time again when there is a need to meet even many times per week. So, it is based on a client's needs, what everyone needs in this very moment.' (MS)

This 'walking alongside' example further illustrates boundlessness, the almost limitless responsibilities of the practitioners, including preventing the need for institutional care and treatment (Brodwin, 2013: 1). It also speaks to situationality as the practitioners have to adapt to the current needs of individual clients and acknowledge that, at times, clients need a lot of support, whereas at other times, they manage well in their everyday lives: "We are adaptable in order to find a good way of working with each person" (MHU). Regardless of the type of support needed, at the core of home visit interactions should be "a warm-hearted encounter from human to human", the idea of "aiming for genuine presence" (CHS). Empathy as 'walking alongside' also includes aligning with clients, so that instead of making a difference between 'I' as the practitioner and 'you' as the client, the emphasis is on 'we orientation': "We do things together with clients, together we make mistakes and try new things" (MS).

Furthermore, the practitioners acknowledged that they commonly become important persons in clients' lives: "We are on their territory, in their homes and in their lives; we become important" (MS). Moreover, some recounted experiences of having been positioned as 'friends' by clients:

> 'Many of our patients have a small social network, and they think it is nice that someone is coming and that they get to show their home to someone.… I have several patients who, if they get a telephone call when I'm there, they say "I'm sitting here with my friend", because that's almost how they perceive us, because we see each other at home. If you see each other in a room at a hospital, it is more difficult to feel that you have such a relationship. You become so important.' (MHU)

The practitioners can therefore be positioned on the boundary between informal caregivers and professional health and social care workers (Zadoroznyj, 2009). This *liminal position of the practitioners, as somewhere between a professional and a close relationship with clients*, is another feature of relationships based on empathy. It is precisely this feature of work that is often manifested by clients offering 'gifts' to the practitioners in the form of, for example, a cup of coffee or tobacco. The practitioners reflected on the importance of accepting such offers to strengthen the relationship:

> 'I have several patients where I accept their offer of a cup of coffee [laughter], and I know that it is important for the person to treat me to a cup of coffee. I've made mistakes and accepted the offer in places where I should have said "No" and where I say "No" now.… They can accept a "No" if I say "Yes" occasionally. You have to get a feeling about how important it is for the relationship to accept an offer. Because it is something about this, when they offer something and you decline.' (MUH)

The preceding example also illustrates well the *non-judgemental attitude* towards clients (see Karlsson and Gunnarson, 2018), which is the third feature of empathy. In some sense, home visit work can be understood as 'dirty work' (Hughes, 1962; Emerson and Pollner, 1976). At times, work involves physical dirt, for example, when the practitioners need to deal with dirty matters or bodily fluids. It could also be described as socially and morally tainted dirty work in the sense that the practitioners work with people who are stigmatised in society. However, the practitioners did not depict their work as socially or morally questionable. On the contrary, they regarded their home visit work as essential in society, important for clients and ethically sustainable work among stigmatised and vulnerable people (see Morriss, 2016).

Conclusion and discussion

In this article, we first studied the concrete home visit activities in five service settings targeted at adults with complex service needs and situated at the margins of community care. In the focus group interviews, the practitioners produced a respectable list of 11 types of activities they attach to home visit work. Managing such a wide variety of activities demands a particular work orientation. Hence, we identified three intertwined premises of the practitioners' work orientation: situationality, boundlessness and empathy. Taken together, both findings – activities and premises – create a picture of home visit work as comprehensive and flexible, requiring constant reflexivity.

Comprehensiveness and flexibility do not necessarily apply to all practitioners who make home visits in social and health care services. Some of them have more specialised roles and duties. Community care at the margins seems to be different in this sense. Brodwin (2013: 1–3, 67), who studied the practices of front-line community psychiatry in the US, argues that workers have 'limitless responsibilities in the post-asylum area', and that it is 'a near impossible task: to safeguard their clients' lives so they will not return to the hospital, the shelter, the street, or the jail'. Our results show that the practitioners in our research settings have to manage similar kinds of limitless responsibilities and almost impossible expectations.

Limitless responsibilities are clearly linked to homes as places of work, where the richness and complexity of clients' lives are present and encountered. This is typical to all such professional care provision that is done close to people's everyday lives in their homes (Kamp and Hvid, 2012). Limitlessness is also linked to practitioners' generalist work orientation, covering both social and health issues, with the aim to safeguard the dignity of human life by promoting clients' safe and meaningful living in communities. In addition, limitless responsibilities indicate the last-resort position of the studied services in the welfare state; they are often regarded as the ultimate safety net for adults with complex needs and problems. It is difficult to share this kind of comprehensive work with more specialised professions.

Integrated care is a concept that has been developed and used a lot over recent decades to drive major policy- and practice-level changes in Western social and health care systems (Kodner, 2009). It commonly refers to inter-professional work and service integration aimed at client-centredness by holistically addressing clients with multiple needs (Kodner and Spreeuwenberg, 2002). However, community care practitioners at the margins go beyond that. They do not just collaborate with other professionals; rather, their work itself is 'integrated care', covering both social and health issues, and all other kinds of issues in clients' everyday lives. Hence, in this sense, home visit work at the margins of community care can be described as a 'hybrid' practice that requires expertise in multiple areas without being specialised in only certain activities.

Integrated and 'hybrid' home visit work has some obvious strengths. Clients are encountered, supported and respected as 'whole persons' in their own territories. Their strengths and difficulties can be noticed and assessed better in their everyday living environments than in institutional spaces. Clients can get wide-ranging, long-lasting and, if needed, instant help and support from one service provider and in one place – in their own homes – which can be seen as the opposite of specialised social and health professions and services (Axelsson and Axelsson, 2006) and the 'revolving door' phenomenon. Furthermore, practitioners' embodied presence in clients' homes enables them to assume more varied positions, such as having coffee as a 'guest' or taking part in cleaning as a 'practical helper', compared to just having a limited role as a professional in an institutional encounter. In this way, clients can be empowered and 'walked along with' at the grass-roots level. Home as a place of work can also equalise power relations between practitioners and clients as interactions occur in the clients' own territories.

The analysis of our data verified Kuluski et al's (2017: 2) notion that responding to clients' complex needs tends to 'span beyond' what social and health care systems normally provide. Also in line with the research by Kuluski et al (2017: 8), we find that giving clients room to decide what kind of care they need and want to receive, adjusting to clients own goals, and allowing time for their own processes are essential for successful home visit work at the margins of community care. Practitioners need to be able to retain a degree of discretion in order to establish responsive, trustful and respectful relationships with individual clients. Furthermore, we acknowledge that this kind of work orientation would not fit a care system 'which prioritizes short episodes of care delivery, provider driven care decisions, and rewards efficiency and cost-effectiveness in service utilization' (Kuluski et al, 2017: 8). In contrast to such priorities, home visit work practitioners go beyond what can be professionally expected (Denton et al, 2002: 4). However, in times of strong societal discourses emphasising evidence-based practices (Winter and Cree, 2016), this kind of work orientation is

in danger as it is not easy to translate into specific, time-limited and pre-directed interventions that produce certain results. There is always the risk of an 'increasing bureaucratic utility', meaning more regulation and oversight of practitioners' work (see Holbrook, 1983), such as stipulating the number of home visits to be carried out by practitioners each working day, or the maximum time allotted for each visit.

We held workshops for the practitioners in all five settings to share and validate our overall findings. Their responses were positive, specifically concerning our depiction of their work as comprehensive and entailing many different tasks and responsibilities, as well as regarding the work orientation needed. The unpredictability of their work, its generalist character and their last-resort responsibility, in combination with their empathy for their clients, are key to work at the margins of community care. It means that the practitioners cannot regulate their workload but (still) need to prioritise. This aspect of their work is characteristic of many types of interactive service work (for example, Forseth, 2001) and needs to be acknowledged. Rather than increasing managerial oversight and work regulation, it is important that managers and policymakers enable space for collective and reflective meaning-making of the dilemmas and prioritisations that the provision of care in home spaces seems to unavoidably involve (for example, Bottrup and Bruhn, 2012).

The work orientation at the margins of community care, as described by the practitioners in this study, has some inherent risks. From the practitioners' points of view, there is an obvious risk of becoming burdened with boundless work in private spaces (see Forseth, 2001; Denton et al, 2002). Thus, practitioners do not necessarily have enough time to do everything that needs to be done, which poses difficult ethical questions. Furthermore, the situational nature of the work means that practitioners have to encounter unexpected situations and crises in home spaces, which can be very stressful. Also, close, empathic relationships with clients may increase emotional stress and moral pressure in situations where the practitioners are not able to support clients according to their wishes and needs. It may also be a burden to manage empathic relationships with clients as there are potential risks in these, such as failing to build trustful client relationships or failing to keep an appropriate distance from clients, that is, becoming too intimate with clients and too important in their lives.

A limitation of this study is that the focus group discussions may present too positive an image of home visit work, to the extent that the practitioners might have idealised their work in the interview context. It is possible that if the interviews had included participants from many more service settings, the results would have been different. The interviews, however, as shown in this study, also contained critical descriptions of home visit interactions and criticisms of workloads that were too difficult to manage at times. Furthermore, according to our previous studies based on 'naturally occurring' home visit interactions in similar settings (Juhila et al, 2016; Raitakari et al, 2018; Juhila et al, 2020), the work activities and premises appear rather similar to those described by the practitioners in the focus group interviews.

From the clients' points of view, they risk losing autonomy as the practitioners enter their lives and intimate home spaces with such broad and all-encompassing agendas. In extreme cases, there is even a threat of colonisation of clients' lives and institutionalisation of their homes (Hall, 2011; Healey-Ogden, 2014). The practitioners were aware of this potential risk and recurrently reflected on the thin line between doing things on behalf of or *for* the client when needed and, at the same time, always striving to support clients' independence. Further consideration of the clients'

experiences and their assessments of home visit work at the margins of community care is much needed in future research.

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Conflict of interest
The authors declare that there is no conflict of interest.

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