

## **Volunteer and peer support during the perinatal period: A scoping study**

### **Introduction**

The United Kingdom and Republic of Ireland have a long tradition of volunteer support for families, and peer support for specific issues such as breastfeeding. Organised perinatal lay support generally involves the provision of social, emotional informational, and practical support which can be delivered in groups, pairs, one-to-one, by telephone, Short Message Service or social media (Dennis 2003; Thomson et al 2015). Health professionals have sometimes felt concerned about the potential erosion of boundaries between their roles and the roles of non-professional supporters (Thomson et al 2015). However, a recent evidence review identified how volunteer/peer support for pregnant women and families with young children is fundamentally different from, and complementary to, professional support (McLeish et al 2016).

Volunteers and peer supporters can build relationships of trust with parents (including parents who are 'hard to reach') by offering non-judgmental, strengths-based and needs-led support often grounded in their own lived experience of parenthood or adversity. There is evidence that this can contribute to improved outcomes for parents and young children, and also potentially reduce pressure on over-stretched statutory services (McLeish et al 2016). The positive effects of volunteer/peer support may be created through mechanisms of reduced isolation, normalisation, reduced impact of stressors, increased sharing of health and self-management and positive role modelling (Dennis 2003).

Current literature offers little insight into the structure or scope of these projects, the nature and timing of the support, or the recruitment, training, support and supervision of the volunteers/peer supporters (McLeish et al 2016). This creates challenges for using the evidence to inform replication. The aim of this study was to scope the current practice of organisations offering volunteer/peer support to pregnant women and families in the UK and Republic of Ireland.

## Methods

In May to July 2017, we issued an invitation to participate in an online survey to 60 relevant organisations, identified at the Power of Volunteering Conference (2017) and through pre-existing contacts. We asked participants to circulate the invitation to any other relevant organisations. A reminder was sent after four weeks.

The survey comprised open and closed questions about project aims, area covered, target population, funding, timing, types and location of support, number of volunteers/supporters, length and content of training, and evaluation. Data were analysed descriptively using Excel to map and categorise responses.

The Chair of the Science, Technology, Engineering, Medicine and Health (STEMH) ethics sub-committee at the University of Central Lancashire provided approval to undertake this study.

## Findings

We received 28 valid responses. Table 1 provides an overview.

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#### Establishment and funding

The organisations worked in England, Scotland, Northern Ireland, and the Republic of Ireland (Figure 1). Three (10.7%) had a national or regional online presence as well as offering individual support. Nine (32.1%) were active in multiple sites, and the rest served local areas that ranged from a whole county or city, down to a group of four deprived wards. While a few of the projects were long-standing (10+years), three-quarters had been established within the last eight years, and over a quarter within the last four years.

A third of projects relied on funding from a single source: public sector, a charitable trust, or Big Lottery. Eighteen (64.3%) received funding from multiple sources that often included donations and fundraising, and one had no current funding.

## Figure 1: Areas of activity

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#### Aims and focus

All of the projects supported parents during some part of pregnancy and the postnatal period. Eight (28.6%) offered general, needs-led support to parents living in disadvantaged areas or experiencing adversity. The other 20 (71.4%) focused on a particular issue: breastfeeding, perinatal mental health, babies who were preterm or in a Neonatal Intensive Care Unit (NICU), and promoting healthy lifestyles. Three-quarters of respondents said they based their support on a theory of change or logic model.

Some projects offered universal support (within the defined geographical remit), e.g. *‘no specific criteria aside from pregnancy’*; others had more stringent inclusion criteria, e.g. *‘2+ complex social factors (most with 5-10) or tier 3 [safeguarding]’*. A few offered varied levels of service:

*‘Any parent with a mental health condition can access group-based support, with 1-1 targeted support provided to those who are unable to leave the home’ (project\_9)*

When describing their aims, some stated overarching goals, e.g. *‘to improve the lives of families affected by pre and postnatal depression’*, *‘to increase breastfeeding rates’*. Most offered more in-depth consideration of how the support was designed to benefit families (e.g. improve emotional wellbeing, self-esteem and confidence; reduce social isolation; develop confidence in parenting; increase access to healthcare).

#### Timing and types of support

Three-quarters of projects offered support during pregnancy, and all during the postnatal period or early childhood. Half gave weekly support and the other half described a more flexible ‘as and when needed’ approach. Furthermore, while the intended length of support varied, e.g. between 6-8 weeks (17.9%) up to 24 months (10.7%) postnatal; 12 (42.9%) referred to an ethos of needs-based support provision:

*‘One to one email support tends to last 12-18 months, but is continued as long as is needed’ (project\_24).*

All of the projects offered some individual face-to-face support and three-quarters also offered support through groups and/or by phone or text. Other methods of support were social media, email, private messaging, an online forum and video calls.

All the projects offered emotional support, and all except one provided information. Twenty-five (89.3%) provided social support and 26 (92.9%) signposted or referred parents to other sources of support. Almost two-thirds gave some form of practical support. Other forms of support included doula support during birth, a crèche, accompanying to appointments and creative sessions.

The healthy lifestyle project and one of the breastfeeding peer support projects described their approach as ‘highly structured’. The others gave support that was either ‘completely spontaneous’ (35.7%), e.g. *‘our volunteers approach mums and dads and simply just chat and answer any questions that they may have’* (project\_4); or ‘had elements of structure’ (57.1%), e.g. *‘we use a range of home visiting materials to enable structure, focus and purpose to the one-to-one peer support’* (project\_13).

### Numbers supported

The projects varied greatly in size and scope. As would be expected, those offering 1:1 support (typically the most intensive) tended to work with fewer parents per year (20-200) than those offering support through groups or outreach (150-1000).

### Number, criteria and training of volunteers/peer supporters

The projects reported between two and over 250 active volunteers/peer supporters; the majority (n=17, 60.7%) had 2-30. Half of the projects required that their supporters had similar specific lived experiences to the parents they supported, e.g. breastfeeding, perinatal mental illness, or social adversity:

*‘They must be able to demonstrate that they have withstood the circumstances and experiences they have in common with the parents they will support’* (project\_19).

Other projects accepted volunteers without specific peer experiences and referred to other desirable qualities, e.g. having relevant professional experience and/or the ability to offer empathetic, relational emotional support:

*'Most have similar experiences to the target population but their ability/potential to provide effective relational support is our key consideration' (project\_13)*

Twenty-seven (96.4%) projects had a formal training programme for their volunteers/peer supporters, of which 18 (64.3%) led to an accredited qualification. The remaining project upskilled its volunteers through prolonged work-shadowing. The length of initial training varied across the projects, with half providing between 20-29 hours. In free text responses, most described their training as a mixture of skill development (e.g. active listening, group hosting) and knowledge (e.g. pregnancy, birth, infant feeding, parenting, prematurity, mental health, safeguarding, the volunteer role and its boundaries).

Twenty-five (89.3%) projects also provided ongoing training through supervision, study days, mandatory updates (e.g. safeguarding), debriefing sessions, and virtual online communities.

### Assessing and measuring impact

All projects gathered feedback and measured their impact on families (such as through validated scales and bespoke questionnaires) and most used multiple methods. While there were disparities in the outcomes measured, the most commonly collected outcomes were emotional wellbeing/mental health, and confidence.

## **Discussion**

While the findings illustrate the uneven spread of projects across the country, they also highlight the diversity and creativity of volunteer/peer support projects working with families during the perinatal period. The relative youth of most projects may be related to an increasing recognition by commissioners and funders of the value of this form of support, in line with the National Institute for Health and Care Excellence's (NICE) endorsement of breastfeeding peer support (NICE 2017) and the role of voluntary organisations in the support of pregnant women with complex social needs (NICE 2010). Alternatively, it may reflect the preference of some funders to fund innovation, rather than sustaining proven work. Although the focus of the projects varied considerably, emotional support was a central tenet. All projects provided

emotional support to parents, and the impact of the service on emotional wellbeing was the most commonly reported outcome. This focus aligns with the current NHS agenda to improve perinatal mental health.

The projects demonstrated a supportive infrastructure for service-users and for volunteers/peer supporters. All provided face-to-face contact and associated opportunities for relationship building, and the majority offered flexible support, with the frequency, content and length often determined by service-users. In the majority of projects, volunteers/peer supporters were able to attain an accredited qualification, and provided with ongoing opportunities for training and development.

Although most projects gave substantial training, there was wide variation in the length of training provided (some of which may be related to the focus of the projects and the complexity of service-users' needs). There were also differences as to whether projects recruited supporters who shared specific characteristics or experiences with those they supported. However, it may be, as identified within a recent realist review into one-to-one breastfeeding peer support, that a context of socially similar peers and level of expertise may be less important than the qualities and types of support provided (Trickey et al 2018).

While different outcomes were measured by different projects, it is positive to note that 75% of projects had an underpinning theory of change/logic model. Realist-informed (Pawson 2017) research to 'test' the theoretical models in practice – to assess how certain mechanisms 'fire' in particular contexts to create intended (and unintended) outcomes - would be beneficial for commissioning and service development purposes.

While this is the first study of its kind, we were unable to capture insights from all projects across the UK and Ireland, and our findings are limited by the varying level of detail provided. Future research should use qualitative methods to gain a deeper understanding.

### **Implications for Midwifery Practice**

While perinatal volunteer and peer support projects vary in focus and scope, they all see emotional support as the heart of their work and almost all give their volunteers/peer supporters extensive training for their defined role. Maternity professionals should see local projects as a resource that is complementary to professional care, and refer women who could benefit from

their support. There is scope to develop better midwife engagement with such projects to enhance women's experience of childbearing and new motherhood as well as to identify funding streams and ways to signpost volunteers into particular projects.

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