Towards a better life

Volunteer work with families who are substance abusing

Lesley Leece

This article presents the findings of a study into the effectiveness of trained volunteers working with families where substance abuse was identified as an issue. The study was initiated by Mater Family Support (now known as Mater Parent Aide Unit), Mater Health Services, Brisbane, and funded by the Commonwealth Department of Family and Community Services (now known as the Department of Families, Community Services and Indigenous Affairs). The goals of the study were to begin to understand the effectiveness of volunteer Parent Aide services that have been provided to myriad client groups over many years. The findings demonstrate that the services are valued by this particular target group. This is summed up in the words of one participant who said, 'Government has to fund this for more people because there are so many people I know who could use it, but haven't been offered the chance'. Replication of the study with other client groups will further enhance understanding of volunteer service provider effectiveness.

ACKNOWLEDGEMENT

I wish to acknowledge the support of Richard Webb, Senior Social Worker, Mater Family Support, whose encouragement, enthusiasm and persistence made this project and the resulting information possible.

Lesley Leece
Community Programs Manager
Lutheran Community Care, Queensland
Email: leece.lesley@qld.lca.org.au

At the time the research project on which this article is based was undertaken, the author was the Coordinator of the Better Life Project, Mater Family Support, Mater Health Services.

Good relationships between parents and their children in the early years of life have been recognised as providing the foundation for a resilient life (Benevolent Society 2002; Commonwealth of Australia 2000; Geggie et al. 2000; Queensland Government 2003). Early intervention with families currently experiencing both the joys and the stresses of early parenthood is a significant step toward preventing child abuse.

Dealing with issues related to substance use while also parenting may warrant additional levels of support (Harmer, Sanderson & Mertin 1999), particularly given that the issues for substance abusing parents may stem back to their own experiences of being parented, the damaging effects of substances taken while pregnant, and the emotional and behavioural adjustment for children coming from such families. While additional support may be warranted, there may also be considerable barriers to taking up that support. These barriers include fear of statutory intervention with children, fear of stigmatisation and being judged, and denial of problems. However, pregnancy can be a powerful motivator for change and, with this in mind, Mater Family Support established the Better Life Project to intervene early with pregnant and parenting women who could see issues for themselves and their families associated with their own drug and alcohol use.

Volunteer Parent Aides have provided an in-home family support service at Mater Family Support for 27 years. In that period, numerous families considered to be 'at risk' due to social circumstances and lack of resources, have been assisted to maintain their family unit during the early years of parenting. It is important to note that there is evidence that home visiting programs linking families to community resources and providing support and education are 'more successful than more narrowly focussed programs' (Drielsma 1998). More narrowly focussed programs can be described as those that do not meet with families in their own environments (that is, are centre-based) and are primarily concerned with a treatment model.

With the broad focus in mind, paid professional staff employed by Mater Family Support trained volunteers for the role of home visitor and supported them in their engagement with families. The roles volunteers engaged in included:

- modelling appropriate parenting behaviour;

- supporting parents' efforts to develop positive relationships with their children;
- helping parents develop an understanding of their child's developmental needs;
- providing information on minimising risks to children;
- helping parents have their rights and entitlements recognised and, at times, advocating on their behalf;
- providing information about community resources;
- providing practical support, such as transport.

The Better Life Project joined the established Mater Family Support team for the period February 2002 - July 2004. Volunteers working with Better Life Project families were clearly instructed that they were to support the family in the parenting of their dependent children. They were not to perform the tasks of a drug and alcohol counsellor (most of the participants were already in touch with such a service), nor a family violence counsellor. However, it was not unusual for the participant to contact their Parent Aide during times of need related to drug taking behaviour and/or violence, and Parent Aides did transport some women and their children to safety. Mater Family Support has always had a strong child protection focus and this was borne out in the interventions that Parent Aides undertook with this target group and their contact with other agencies. There is a strong similarity with other models where 'volunteers and professionals are seen as capable of working together in creative combinations ...' and the role of the volunteer clearly forms a part of the total support plan (Drielsma 1998).

METHODOLOGY

The Better Life Project engaged volunteers in the above activities with the target group and undertook action research in order to evaluate the effectiveness of these services over a 2½ year period. Action research has been defined as a methodology that has the dual aims of action (that is, change) and research (that is, understanding) (Dick 1999, p. 1). Action research tends to be participative and cyclical, leading to change that occurs throughout the life of a project, and is based on feedback from participants.

A demographic profile was obtained on all participants at the outset of service delivery, and interviews with service users were conducted after participants had received services for six months. Parent Aides were also interviewed in order to gain insight into their view of being a part of the project and the unit. Interviews were designed to give participants and volunteers maximum ability to state their point of view and were, therefore, interviewee driven rather than question and answer oriented.

Initial demographic data was obtained by using the *Brisbane Evaluation of Needs Questionnaire (Revised Edition).* The questionnaire was devised for the study of home-based early intervention that resulted in the Family CARE program now used in child health services in Queensland. The questionnaire was revised and used in this study with the permission of the questionnaire's author.

THE RESEARCH GROUP

A total of 104 referrals were made to the service in the period July 2002-March 2004. Of these, 37 families engaged with the service and 27 participated in the research. Some families did not engage with the service for the following reasons:

- family not contactable
- inappropriate referral
- not retaining care of the baby
- outside catchment/transient/homeless
- family had adequate supports
- mother lost the baby during pregnancy
- family not interested in the service.

Some families did receive a service, but did not participate in the research because either the family left the service prior to an interview being conducted, or the mother's mental health condition precluded an interview.

Retention is recognised as problematic in such studies with some of the documented contributing factors being:

- addiction severity level
- involvement with the legal system
- housing problems
- difficulties with interpersonal relationships
- parenting responsibilities
- employment-related issues
- the need for more comprehensive services. (Howard & Beckwith 1996)

It was noted in a study by Daro and Harding (1999, p. 13) that retention rates within services for this target group were improved when initial assessments were carried out with mothers at their clinic appointments. The Mater Family Support study also found that even a limited amount of personal contact at that point made a difference to the willingness of families to consider further contact in their own home, and this contact at clinic appointments therefore became standard practice in the service. It is the quality of that initial contact that is crucial in determining uptake of service (Drielsma 1998, p. 8) and it has also been noted that bonding between participants and home visitors is enhanced by contact during pregnancy (Navaie-Waliser et al. 2000, p.

123). The contact made by Mater Family Support at the clinic appointment did not need to be lengthy, but did give families an idea of what the service could offer, thus smoothing the way for follow-up contact at home.

RESULTS

1. Demographics

All families resided in the southern suburbs of Brisbane, all had issues with drug and alcohol abuse, and all were involved in parenting one or more children. Invariably referrals were received for the mothers and their children. In around 25% of cases the women had an ongoing relationship with a partner.

The women ranged in age from 19 to 47 years. There was an almost even split of women having their first baby and women who already had children. The age range of existing children was from 1 to 9 years, with some of these children being in alternative care. For the majority of the women (74%), the pregnancy was unplanned.

Many women had moderate concerns about the family's level of financial stress and most had completed Year 10 at school. Three of the 27 women identified as Aboriginal.

The mental health issues identified by the women were depression, anxiety, post-traumatic stress disorder, bipolar mood disorder, social phobia, nervous breakdown and grief issues. The mix of drug use encompassed alcohol, benzodiazepines, marijuana, amphetamines, heroin, methadone, tobacco, caffeine, paint, bupronorphine and naltrexone. Poly-drug use was common. The number of women using the drugs is shown in Table 1.

Attempts to either remain abstinent or to reduce and control drug use during pregnancy, and subsequently, were a feature of the target group. In doing so, families were participating in harm minimisation.

Twenty-nine per cent of participants were concerned about violence or threats in the home at this initial interview. Most of these women identified verbal abuse from partners as the prime concern and one was on the receiving end of this from her children. Two said that mutual hitting between partners occurred when angry. Over time, domestic and family violence did come to light in a number of other families as the trusting relationship developed with the Parent Aide.

Table 1: Drug use by participants

DRUG	NUMBER OF PARTICIPANTS USING
Alcohol	21
Benzodiazepines	5
Marijuana	12
Amphetamines	12
Heroin	7
Tobacco	27
Caffeine	27
Paint	3
Bupronorphine	7
Naltrexone	2

2. Themes emerging from the interviews

A positive relationship

The most frequent theme identified in the research was the importance of a positive relationship being developed with the Parent Aide. It has been suggested in other fields of work that workers are seen to be '... helpful when they had built a positive relationship with the person; a relationship often described by participants as one of friendship' (Bloor 2001, p. 1). The results of our study bear this out and confirm the approach that has been taken by Mater Family Support over its 27 year history.

The relationships that developed over the period of the project, and which have now extended beyond that time, were based on a partnership approach. Participants talked about the following elements of a positive relationship.

Communication

Again and again participants talked about the value of someone who listens:

> Someone to talk to, someone who listens.
>
> If I do want to discuss something with her then she's a good ear to do that and a good sounding board for my ideas, or whatever, because she's got kids herself.
>
> She was a good sounding board for me. I used to talk to her a lot and she was a really good listener. I knew she was listening ... she'd look at it from my angle and give me a couple of different suggestions.
>
> She is easy to talk to.
>
> ... just having coffees and talking.
>
> I got to talk about things about the baby.
>
> [I was] feeling like I might have a panic attack or something like that and she was just wonderful to me – talking it through.
>
> I know it's time when I can just relax and also have a talk about things.
>
> ... someone to talk to as well. Like a female companion.

Positive reinforcement

> She praises me and keeps my self-esteem up ... tells me how good I've been, a good job I'm doing.
>
> She's been there for support to help me through it ... and keeps me smiling instead of being down and morbid and moping around the house.

Becoming a friend

There is a widely held belief among paid professionals that working relationships with families and friendships do not mix. As paid professionals and members of organisations, we are all mindful of the importance of insurance, confidentiality and boundaries, but we must also take into account that participants of this study did mention the importance of friendship.

> I think she is a lovely lady. I really hope if the Parent Aiding finishes off, I still want her to come and visit. I'm hoping that we end up great friends. I don't ever look at her from the Parent Aiding [role], she's more of a friend now.
>
> ... someone to talk to as well. Like a female companion.
>
> I was having trouble with money and stuff, and sometimes she brings me morning tea and we'd have coffee. She's just the best, really good friend.
>
> [Parent Aide] has known her [the baby] since she was a few weeks old and now [the baby] really recognises her and they have actually developed a friendship themselves.
>
> She's like my sister ... I love the conversation. I like the time and I feel like a woman.
>
> I don't want to lose her. She's a very big support. She's easy to talk to.

Doing more than required

Participants recognised that Parent Aides did go beyond the role that they took on. For instance:

> ... all my expectations have been met and better.
>
> She's always here whenever I need her.
>
> She's gone above and beyond everything that I'm sure she had to do as a Parent Aide.

However, it is not always the case that the families' expectations and the role taken on by the service are well matched, despite there being discussions at the beginning of contact about what is possible and what is not. In addition, Parent Aides make decisions while in the field about service delivery that may not always match well with the case plan developed with the case manager in the office. One mother, who had a lengthy antenatal contact and felt the involvement changed to be less supportive after the birth of the baby, commented:

> I did expect a bit more involvement and I thought there would be more involvement after the baby was born than when I was pregnant.

The case manager also expressed concern that this situation was somewhat the reverse of that anticipated at the outset of service delivery, and this had to be discussed with the Parent Aide.

The service deliberately did not structure interventions in a standardised way, but instead took the approach of negotiating between the parties according to need. The basis of this approach is a strengths perspective in which it is assumed that 'clients are experts about their own lives and can work with health professionals to co-create solutions to problems confronting them' (O'Brien & Baca 1997, p. 49). In order to achieve this, a higher level of negotiation is required and this may be ongoing if the service does not immediately match with client needs, or if client needs change over time. Matching client expectations of what a service has to offer them, volunteer views of their role, and what the organisation reasonably feels it can offer, requires careful negotiation and flexibility. It is possible that 'grey areas' could emerge and these may have been reflected in the comments participants made about friendships with their Parent Aides.

Emotional support

For some families, emotional support had been scant in their lives and a person who was reliable and available, despite the presence of an array of social problems, was a special experience. Although the project has been disbanded due to a lack of ongoing funding, it is to be hoped that families will look back positively on this experience of human interaction and be able to transfer that positive experience to future relationships.

> Having someone here ... that I knew was coming and supportive and understanding – it really helped me ...
>
> It's having the emotional support ... I guess I still feel like it would be lovely to have that extra strength.
>
> Just having the comfort of having someone around ...

Belief in the participants' ability, particularly in their ability to stay off drugs, was important and, as Gruber, Fleetwood and Herring (2001, p.1) state:

> Many substance-affected parents are faced with hard choices in managing their recovery efforts and meeting their family responsibilities.

In meeting these responsibilities, it helped to know someone who visited regularly had faith in their ability.

> I really need people around me like [Parent Aide] who believed I could stay clean and believed that I could do the right thing ... it's really good that she's had that kind of faith in me ...
>
> [Client] has come so far – she was on illicit drugs, but she's not doing that now. She listens and tries hard and she usually succeeds.

Parent Aides demonstrated their ability to work within a strengths framework and in so doing helped to:

> ... build mothers' and other family members' confidence in their role as parents and provide incentives for their acquiring

> new caregiver skills (Olds, Kitzman, Cole & Robinson 1997, p. 11).

In their interviews, Parent Aides reiterated the elements of a positive relationship cited here by participants and identified this as the vehicle by which to support and effect change in families. They emphasised communication skills, particularly active listening; starting where the client is; empathy; reinforcing the positives; empowerment; and a sense of humour.

A non-judgemental attitude

The second important theme was the ability of the Parent Aide to refrain from judgement of participants, particularly in relation to their use of substances and the resulting social implications. The target group had experienced the marginalisation and consequences of substance use and, understandably, these women were frequently wary of services perceived to be authoritarian.

> Judgemental and punitive attitudes of care providers towards addicted people (pregnant women in particular) are not unusual (Corse, McHugh & Gordon 1994, p. 4).

It is therefore imperative for anyone working with this group – and in the case of this study, for volunteers – to demonstrate acceptance without condoning the behaviour that is harmful to the women and their families.

In this study both participants and Parent Aides identified a non-judgemental attitude as important. One of the lessons learnt from the research has been the fragility of a relationship if there is any hint of a judgemental attitude displayed, as demonstrated in the following quotes from participants.

> I know that she can't appear to be judgemental. I really feel she is quite judgemental of my managing of the situation, so I find it a bit difficult at the moment.
>
> I was worried about being judged on my abilities as a parent.
>
> She is not trying to understand how it is for my family.
>
> I've found her a tiny bit condescending, which I don't worry about because I know she has the best intentions in the world and a really good heart.
>
> I understand why she would disapprove, but still it's my choice.
>
> She assumes things about the people in my life.

While Parent Aides identified judgemental attitudes as problematic for their work, they did not always recognise when they were being judgemental. The following are some of their comments on the subject:

> We ... have to just take people as they come.
>
> I just want to be there to be a good listener, be somebody who won't judge her.
>
> They soon pick up on whether you are there to hear their story and to help them and you are not trying to say you should be doing it this way or that.
>
> I want them to see that there are positive role models out there that really do want to help them, who won't judge them and are not spies or won't go back and report them to somebody, won't tell them how they should live their lives.
>
> They think that any type of authority talks down to them, government departments, hospitals.

While it is clear that Parent Aides recognised the importance of being non-judgemental, it is equally clear that at times they were, and this was communicated to participants unconsciously, as evidenced by the comments of the participants above. Since these findings, Mater Family Support has reviewed its training for Parent Aides to give greater emphasis to the many ways in which judgemental attitudes can be communicated. However, it is important to note that while training may address philosophies underpinning service delivery, entrenched attitudes may not always be as easy to shift. In some cases, the most appropriate result will be that a trainee or an experienced volunteer decides this particular type of service delivery is not suited to them. For example, a Parent Aide who had attempted to work in the Better Life Project, but who had left a client feeling judged about her behaviour and its affect on her family, later commented on what had been an eye-opening experience:

> I wasn't totally comfortable dealing in the drug area to be honest with you. The people I have come across who have been involved in it didn't enhance my ideas of life.

Practical help

Participants rated practical help very highly, identifying the following areas as important:

- transport
- baby-sitting or, more accurately, respite care in the home
- attending appointments
- linking with resources
- helping with supply of baby needs – loan equipment is available through MFS
- advocacy
- cleaning.

Participants commented in the following way:

> I'm hoping that [Parent Aide] should be able to baby-sit a little bit and give me a bit more freedom.
>
> If I need to get her to the doctor or something like that on short notice I can do that.
>
> She took [baby] while I did the dishes and had a shower.

> She went out of her way to think about helpful advice she could give me and was happy to do any kind of cleaning.
>
> She went out and got me some teats as the ones I had were flowing too fast.
>
> She's been to meetings with me and appointments.
>
> Whatever I've got to do here, there and everywhere ... [Parent Aide] is there to help look after bub while I'm busy.
>
> I have no transport at all and it enabled me to do anything, to pay any bill that I had ... there's no pressure and it made me feel good.
>
> Whenever I want to go out or anything she's got the car and we can go anywhere. I don't have access to anything except public transport and it's so difficult with two prams.

Parent Aides did not mention this practical assistance and may be inclined to see it as secondary to the emotional support and modelling of parenting behaviour. However, much of this practical support can assist in building rapport with families as the home visitor provides a service that begins where the greatest need is. No doubt paid professionals will also be familiar with the rapport that can be built while driving to and from appointments, for instance. It is important, in learning from this study, that we understand it is through undertaking these tasks that a huge difference can be made with a family, which may lead to the 'better life' we champion.

CONCLUSION

The Better Life Project set out to study the effectiveness of volunteer home visiting in supporting the parenting of families where substance abuse is an issue. The qualitative data collected during the study demonstrates that this group has valued the relationship with the Parent Aides. However, there are notes of caution about possibly damaging the relationship if the families perceive judgemental attitudes underpinning the work being done.

The project has worked with families in a partnership framework. The challenge faced by human service professionals and volunteers alike is to:

> ...provide what people want and need ... Listening to people's stories and understanding the meaning they attribute to them is fundamental to such an endeavour (Bloor 2001, p. 1).

This study has begun a process of listening to the stories of this particular group receiving service. Mater Family Support now seeks to further enhance this process by continuing to explore service delivery with other groups. By doing so, the partnership model will move from strength to strength within Mater Family Support. ■

REFERENCES

Benevolent Society (2002) *Nurture or Nightmare*, Sydney: Author.

Bloor, M. (2001) 'What helps people recover from schizophrenia?', *ARAFMI News*, Nov 2000-Jan 2001, 1.

Commonwealth of Australia (2000) *Pathways to Prevention: Developmental and Early Intervention Approaches to Crime in Australia*, Canberra: Author.

Corse, S., McHugh, M. & Gordon, S. (1994) 'Enhancing provider effectiveness in treating pregnant women with addictions', *Journal of Substance Abuse Treatment*, 12, 3-12.

Daro, D. & Harding, K. (1999) 'Healthy Families America: Using research to enhance practice', *The Future of Children*, 9(1), 1-18.

Dick, B. (1999) 'Sources of Rigour in Action Research: Addressing the issues of trustworthiness and credibility', a paper presented at the Association for Qualitative Research Conference *Issues of Rigour in Qualitative Research*, July 1999.

Drielsma, P. (1998) 'Early intervention home visiting: A preventative model to strengthen isolated families', *Children Australia*, 23(1), 4-11.

Harmer, A., Sanderson, J. & Mertin, P. (1999) 'Influence of negative childhood experiences on psychological functioning, social support and parenting for mothers recovering from addiction', *Child Abuse and Neglect*, 23(5), 421-433.

Howard, J. & Beckwith, L. (1996) 'Issues in subject recruitment and retention with pregnant and parenting substance-abusing women', in *Treatment for drug exposed women and their children*, NIDA Research Monograph No. 166, 68-86, available at: http://www.nida.nih.gov/pdf/monographs/monograph166/068_086.pdf

Geggie, J., DeFrain, J., Hitchcock, S. & Silberberg, S. (2000) *Family Strengths Research Project*, Family Action Centre, University of Newcastle.

Gruber, K., Fleetwood, T. & Herring, M. (2001) 'In-home continuing care services for substance-affected families: The Bridges Program', *Social Work*, 46(3), 267-278.

Navaie-Waliser, M., Tessaro, I., Martin, S., Kotelchuck, M., Campbell, M. & Cross, A. (2000) 'Factors predicting completion of a home visitation program by high risk pregnant women: The North Carolina maternal outreach worker program', *American Journal of Public Health*, 90(1), 121-132.

O'Brien, R. & Baca, R. (1997) 'Application of solution-focused interventions to nurse home visitation for pregnant women and parents of young children', *Journal of Community Psychology*, 25(1), 47-57.

Olds, D., Kitzman, H., Cole, R. & Robinson, J. (1997) 'Theoretical foundations of a program of home visitation for pregnant women and parents of young children', *Journal of Community Psychology*, 25(1), 9-25.

Queensland Government (2003) *Strategic Framework for Child Protection 2003-06*, Queensland Government, Brisbane.