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"I didn't think we'd be dealing with stuff like this": A qualitative study of volunteer support for very disadvantaged pregnant women and new mothers

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ABSTRACT

Objective: to identify the particular issues associated with volunteer support for very disadvantaged mothers (who were young, had insecure immigration status, were recent migrants whose English was poor,misused drugs or alcohol, or were involved in crime), from the perspective of the volunteers.
Design: a qualitative descriptive study, informed by phenomenological social psychology. Semi-structured qualitative interviews were carried out between July 2013 and March 2015. Interview transcripts were analysed using inductive thematic analysis.
Setting: nine volunteer support projects for pregnant women and new mothers, run by third sector organisations in England.
Participants: 38 volunteer supporters.
Measurements and findings: three key themes were identified: 'Meeting challenges', 'Needing support' and 'Identifying successes'. 'Meeting challenges' contained the subthemes 'making the relationship of trust','remaining non-judgemental', 'maintaining boundaries' and 'dealing with child protection'. 'Needing support' contained the subthemes 'feeling prepared', 'feeling supported' and 'staying safe'. 'Identifying successes' contained the subthemes 'celebrating the small wins', 'validation as a mother', and 'supporting access to services'.
Key conclusions: volunteers were able to build strong, empowering relationships with some very disadvantaged women during pregnancy and afterwards, including where the mothers did not readily engage with professionals. However, supporting women with complex needs is emotionally challenging and volunteers need to be carefully selected, realistically trained and robustly supervised and supported during their volunteering.
Implications for practice: third sector organisations offering volunteer support for pregnant women and new mothers can be valuable partners in reaching very disadvantaged women who may find it difficult to engage with services. Volunteers can build up a relationship of trust with vulnerable mothers over time, but need to be well supported to do this safely and effectively.

Background

Disadvantaged pregnant women and their children are affected by significant health inequalities in the United Kingdom: mothers and babies who are Black or Asian or live in poor areas are more likely to die (Knight et al., 2015; Manktelow et al., 2015). Babies are more likely to have a low birthweight and to be born prematurely if their mothers are under 20, from lower socio-economic groups, from some Black and minority ethnic groups or born in Africa or South Asia (Aveyard et al., 2002; Office for National Statistics, 2016). Poor maternal mental health is associated with being poor, a single parent, socially isolated, or a young mother (Liao, 2003; Lancaster et al., 2010).

There are also inequalities in the use of maternity care: mothers are more likely to begin maternity care later than recommended, and to miss appointments, if they have a low socio-economic status, belong to a minority ethnic group, are poorly educated or are very young (Downe et al., 2009). Women who are seeking asylum, homeless, dependent on drugs or alcohol, or who are Gypsy Travellers, may be deterred from

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attending maternity care by fears of being judged or having their children taken into care, chaotic lives, unaffordable transport, or ignorance of an unfamiliar system (Parry et al., 2004; Dartnall et al., 2005; McLeish, 2005; Hall and van Teijlingen, 2006; Knight et al., 2015). The National Institute of Health and Care Excellence identifies pregnant women as having "complex social factors" if they misuse substances, are recent migrants, do not read or speak English, are under 20, or experience domestic abuse (National Institute for Health and Care Excellence, 2010). Their guidance recommends making maternity care and information more accessible and tailored to the needs of vulnerable women.

There is a long tradition in the UK of third sector organisations offering volunteer support to families with young children (McAuley et al., 2004; Suppiah, 2008), and more recently the third sector has begun providing one-to-one volunteer support during pregnancy (Bhavnani et al., 2015; Spiby et al., 2015). Rates of mothers engaging with volunteers or subsequently disengaging are often unreported, but where this has been reported, 47–80% of the mothers referred took up support (Lederer, 2009; Barlow and Coe, 2012; Cupples et al., 2011; Lederer, 2009). Disadvantaged parents are generally less likely to engage than more advantaged parents, and yet once engaged, disadvantaged parents less likely to drop out (Barnes et al., 2006; Suppiah, 2008). However, young mothers may be particularly likely to disengage (Spiby et al., 2015). Projects that specifically target very disadvantaged mothers report more success at engaging with them than projects where the support is less targeted (Lederer, 2009; Barlow and Coe, 2012; Cupples et al., 2011).

It is difficult to investigate why some mothers decline home visiting support, because those mothers are often reluctant to speak with researchers (Barlow et al., 2005). Where mothers' reasons for turning down volunteer support have been reported, these included not needing the service, not having time to take on an additional commitment, and unease about the motivation of volunteers and allowing a stranger into their home (Barnes et al., 2006; Spiby et al., 2015), mirroring reasons for turning down professional home visiting (Barlow et al., 2005). The morale of those offering support may be adversely affected where a high proportion of mothers do not want or value it (Murphy et al., 2008).

This study is part of a larger programme of work on peer support during pregnancy and early motherhood in England, for which a previous paper described the different models and perceptions of peer support for mothers from a range of backgrounds (McLeish and Redshaw, 2015). Three core elements were identified in the support: active listening; providing information about pregnancy, birth, parenting, and official systems; and signposting to local services. In many cases the volunteers also offered material and practical support.

This analysis focuses on the issues that arise when offering volunteer support to pregnant women and new mothers who are very disadvantaged, defined in this paper as mothers who are young, have insecure immigration status including seeking asylum, are recent migrants whose English is poor, misuse drugs or alcohol, or are involved in crime. It specifically aims to understand the volunteers' experiences of supporting these very disadvantaged mothers.

Methods

Setting

The research was carried out at nine sites in England (in Bristol, Bradford, Burnley, Halifax, Huddersfield, London and rural North Yorkshire). At each site a third sector organisation ran a project which offered support from unpaid volunteers during pregnancy and the postnatal period. The projects defined their service users in a variety of ways, as mothers who: were from Black and minority ethnic communities, were asylum seekers and refugees, were young, were in prison, had very complex needs, were living with HIV, had mental health problems, or lived in a particular area. The volunteers were generally mothers from the local community, and in some projects were recruited because they had specific peer experiences in common with those they supported. The volunteer support began in pregnancy and continued until the baby was between six weeks and two years old. There was wide variation in the intensity of support, which could comprise weekly visits, rising to daily visits immediately after birth, or visits as little as once a month. One project also offered volunteer 'doula' support during birth.

In the eight projects with a formal training programme, volunteers received initial training of between 8 and 75 contact hours before working with mothers. In all the projects, volunteers received ongoing regular support and supervision from the project co-ordinator. When a mother was referred to the project she was matched to an individual volunteer (in one project, to a small group of volunteers). The volunteer's visits might take place in the mother's home or other settings.

Study design

This was an qualitative descriptive study (Sandelowski, 2000), based on semi-structured, in-depth interviews, theoretically informed by phenomenological social psychology (Landridge, 2008), and underpinned by contextualism (Madill et al., 2000) in which the social and cultural context is emphasised. This "low-inference" (Sandelowski, 2000) design was chosen because the purpose of the study was to explore participants' own perceptions and thus to stay close to their accounts (Landridge, 2008), while acknowledging the role of both participants' understandings and the researchers' interpretations in the production of knowledge (Pidgeon and Henwood, 1997).

The Oxford University Medical Sciences Research Ethics Committee (reference MSD-IDREC-C1-2013-111) approved the study.

The co-ordinator of each volunteer support project (chosen to reflect diversity of location and target population) was contacted to introduce the research. In an initial meeting with each co-ordinator, the researcher (JM) gained an understanding of the project and described the research. The co-ordinator then explained the research to the volunteers using the study information leaflets and invited them to participate. Where a volunteer agreed to participate, the co-ordinator asked her permission for the researcher to contact her, or arranged an interview. The sampling was thus purposive insofar as all participants had experience of giving volunteer support. The researcher did not have any prior contact with participants. One volunteer who had initially agreed to her contact details being passed on, chose not to participate due to childcare commitments.

Data collection

Semi-structured qualitative interviews, which ranged in duration from 20–96 minutes (median 49 minutes), were conducted between July 2013 and March 2015. Each interview took place at a time and place of the participant's choice, after explaining the reasons for the study and obtaining written informed consent (all chose their home, the project base or a café). The topics covered included training, support activities, support received from the project, and the impact on supported women and on the volunteer. After the first six interviews, the topic guide was modified to pursue an emerging theme on specific peer experiences. One participant was interviewed by telephone where it was not possible to arrange such a meeting (oral informed consent was given and recorded in writing), and on two occasions, two participants were interviewed together at their request. No one else was present during the interviews. Each participant was interviewed once, and all interviews were carried out in English, audio-recorded and fully professionally transcribed.

Data analysis

Interview transcripts were analysed using inductive thematic analysis (Braun and Clarke, 2006). After checking against the audio recording, each transcript was read and reread, and codes were identified inductively and recorded using NVIVO software. Codes were refined, combined and disaggregated as data collection continued, and emergent themes identified; the technique of constant comparison (Glaser and Strauss, 1967) was used to reconsider earlier codes and emergent themes in the light of subsequent interviews. To ensure the validity of the analysis, the first author analysed all the transcripts and the second author analysed a subset of the transcripts; codes and emerging themes were discussed and agreed. The researchers approached the analysis reflexively, putting aside their existing knowledge as experienced researchers in this field so that the analysis remained close to participants' accounts. They acknowledged the potential impact of their own perspectives as White, UK-born women with children.

In this paper verbatim participant quotations are identified using the participant's unique reference number to protect anonymity. "…" is used to indicate that some non-essential words have been omitted from a quotation in the interest of brevity, and square brackets are used to indicate where a word has been added by the authors to clarify meaning or replace a name.

Findings

Participants

Of the 54 volunteers who took part in the wider study, 38 had supported very disadvantaged women. The findings of this paper are based on interviews with these 38 volunteers, twenty-two of whom were born in the UK and sixteen in Africa, Europe, South Asia, North America and Australasia. Nineteen were White, eleven were Black, seven were Asian, and one was mixed race. They had between one and eight children (median two) and ranged from young mothers (the youngest were 22 years), to women in their fifties with adult children. Sixteen volunteers spoke English as an additional language. Seventeen had specific peer experiences in common with those they supported (for example they were young mothers, were seeking asylum, or were living with HIV).

Thematic findings

The qualitative analysis identified three key themes in the volunteers' experiences: 'Meeting challenges', 'Needing support' and 'Identifying successes' (Table 1).

Theme 1: Meeting challenges

The key theme 'Meeting challenges' considers the difficulties that arise in giving volunteer support to very disadvantaged mothers. It contains four subthemes: '*making the relationship of trust*', '*remaining non-judgemental*', '*maintaining boundaries*' and '*dealing with child protection*'.

Making the relationship of trust

The volunteers had a range of experiences of establishing a trusting relationship with the mothers they supported. Some mothers were willing to disclose intimate details about themselves very quickly: "*We had this amazing conversation the second time I met her where she told me all about her background, she's been trafficked as a minor*" (V014); whereas other volunteers found that it took many visits before the mothers felt able to trust them: "*At the beginning she was really wary, so she was holding back a lot of stuff, and it took a good five, six months…it was just about being patient*" (V035).

Many volunteers described the difficulties the mothers had in trusting professionals, and how as volunteers they could overcome these barriers to engagement. Some asylum seeking mothers were intensely fearful because they did not know who it was safe to talk to; in this situation, volunteers with peer experience could build bridges: *"They don't know the system, so they are just scared of anything around them… they are more open to the other asylum people. They are easier to trust them"* (V040). Non-judgemental volunteers could connect with vulnerable mothers who believed that professionals could not be trusted because they were judging their parenting abilities:

> "*A lot of young mothers especially are a bit scared about…going to your GP or midwife or social services, they're quite official people whereas we're just everyday people….A lot of these mums maybe don't want to say something to a health professional just in case of the repercussions of it all, somebody might feel that you're not coping…they're more open to speaking to 'just a mum'*" (V007).

Many volunteers commented that they had also earned trust through being absolutely reliable in their visits and always following through on promises of practical support, in contrast to statutory services: "*If they've asked me to do something I've done it for them, and that helps as well because they know that they can trust me then"* (V022).

The volunteers also adapted the way that they offered support to meet the needs of very disadvantaged mothers. For example, one described how she took a more motherly role when supporting a young mother: "*Some of the mums need a mum. One of my mums I support has been in and out the care system all her life, so she's never had one role model*" (V023, a mother of adult children). Another felt she needed

Table 1
Themes, subthemes and examples of text from the interviews of volunteers working with very disadvantaged women during pregnancy and afterwards.

Key Themes		
Meeting challenges	**Needing support**	**Identifying successes**
Making the relationship of trust *"Trust was not a given, it had to be gained"*	**Feeling prepared** *"I didn't think it'd be stuff like the wife being beaten up…we all want to do more training around it"*	**Celebrating small wins** *"Just think how much worse things would have been if we did not get involved"*
Remaining non-judgemental *"You have your own opinions and values on the whole situation"*	**Feeling supported** *"That's the function of [the co-ordinator] to talk you through that as well…And not over-emotionalise and ruminate about it"*	**Validation as a mother** *"We can just focus on the breastfeeding…and all the emotional early stuff and cuddling, and validate all that"*
Maintaining boundaries *"How do we keep it about being a mother when they're in such terrible situations?"*	**Staying safe** *"I felt that she could turn on me… so I left relatively quickly and immediately called the co-ordinator"*	**Supporting access to services** *"If they're frightened of the health visitor, we'll go with them"*
Dealing with child protection *"I did unfortunately have to raise some alarm bells…. And I felt like I'd broken her trust"*		

to avoid being 'motherly' with a young mother because she constructed motherliness as disempowering: *"If she were to become completely dependent on me for things and for me to be very motherly with her, then that doesn't really enable her to make adult decisions herself"* (V016, a mother of young children).

Several volunteers reported encountering mothers who suspected them of ulterior motives and whose suspicions could not be overcome, so no relationship had developed: "S*ome people probably think…'Are [you] from the [government immigration agency]…Are you spying on us?'"* (V042). In other cases, these fears could be allayed through persistence and effective practical and emotional support, even when the concept of volunteering was culturally alien to the mother:

> *"It's a bit of a strange thing, isn't it? A load of people that you don't know, that have no financial gain from doing it, want to come into your home and support you and bring you things and talk to you …Trust was not a given, it had to be gained and earned and so when we did get to the point where that was there, it was all the more rewarding"* (V011).

Remaining non-judgemental

All of the volunteers had received training in non-judgemental active listening, and some said that they genuinely did not judge the mothers they supported. This might be because they had comparable peer experiences: "*You can relate to the person sharing… I am going through what they are going through"* (V047). For others it was because they saw mothers' current situations as constrained by circumstances beyond their control: "*You do meet the saddest people who haven't had many chances… and I think 'There but for the grace of God go I'"* (V009).

However, some described the challenge of being with the mother in a non-judgemental way when they privately *were* judging her: "*You have your own opinions and values on the whole situation"* (V007); *"I had to bite my tongue"* (V008). Some identified issues that would represent an absolute limit for their support: "*For me foetal alcohol syndrome is huge and if I found I was working with a woman who was an alcoholic I don't think I could"* (V004), and one expressed frustration that she was "*wasting my time"* (V015) when a mother did not act on her suggestion. The language used by a few volunteers gave further indication of the challenges of remaining non-judgemental, as they used terms suggestive of negative or infantilising perceptions about some of the mothers they supported or their relationship, for example: *"flaky…dodgy"* (V008),*"some take advantage…they grab whatever they can get"* (V015), *"cling on too much"* (V022), *"wean her off"* (V027).

Many volunteers had experienced vulnerable mothers (especially young mothers) not turning up to planned meetings or responding to their calls. Some found it easy to understand this: *"She just hasn't had time to look at her phone…you understand that anyway because obviously you'd do the same thing"* (V032). Others said they found it *"frustrating"* (V002), *"a bit of a nightmare"* (V007), *"quite irritating"* (V014). Experienced volunteers described how emotional distance was important in coping with mothers' complex and changing lives, while remaining externally non-judgemental: *"They might just disappear. And then they come back on the scene X amount of time later… And you have to resume as though that didn't mean anything"* (V054). Some had found it challenging in this situation to know how best to respect the mother's wishes while not implying that they had lost interest in her: *"It's always this balance in between trying to be helpful but not trying to be intrusive at the same time"* (V010).

Maintaining boundaries

A further challenge the volunteers encountered was maintaining appropriate boundaries in the face of enormous need, which was sometimes unanticipated: *"I didn't think we'd be dealing with stuff like this… I thought it was just going to be mums and dads, happy families…maybe sleep issues or money issues"* (V033). For some, this challenge was framed in terms of keeping their role focused on maternity:

> *"Lots of our volunteers are struggling with, 'How do we keep it about being a mother when they're in such terrible situations?' … We can't fix situations but we can find gaps where we can sneak in…to make that experience more open to appropriate bonding… good early start, good relationship, mother feeling positive about her experience."* (V006).

Volunteers in projects with clear boundaries of this kind nonetheless recognised their responsibility to help the mother deal with her wider problems through careful referrals: *"It's not like you can just say like, 'We can't [help you with that issue].' You have to think of, 'Okay, can I pass that on to another organisation?'"* (V046). However, some found these limitations frustrating and naive:

> *"I've gone in allegedly to give information…and it's just not breastfeeding. It*'s housing, it's drug problems, it's massive… I don't understand how you could go in and say, 'Actually stop, I don't want to know, let's just talk about breastfeeding'" (V023).

Some volunteers admitted they had been strongly tempted to stray outside the strict project boundaries to help women in desperate situations: *"There's part of you thinking, 'I could just carry on, on a private scale, just going and doing a bit'"* (V045).

In other projects, volunteers were allowed or encouraged to become involved in all aspects of vulnerable mothers' lives, seeing this as a prerequisite for them to have a safe and positive pregnancy: *"There was a woman in full-blown crisis… my role for her was sort of more a facilitator finding other services to help support her, rather than just being a peer maternity support person"* (V004). This open-ended role could, however, create additional burdens for volunteers who had busy lives of their own: *"She literally needed somebody every day to do something…[but] my time was limited"* (V041).

Dealing with child protection

Understanding child protection responsibilities was a core part of volunteer training. Many volunteers had worked with families who were involved with social care services because of domestic violence, mental health problems or child welfare. Some felt out of their depth in these challenging situations: *"They confide in you and you don't know what to say because you don't want to say the wrong thing"* (V015). Others were confident that they could support mothers effectively while knowing when they would have to escalate an issue to professionals: *"She's not had the crisis team to come out to her. She's rang me [instead]… But [the services] always know that if I feel that this isn't helping, she's not responding, I will ring up the team"* (V023).

All the volunteers were aware that confidentiality would have to be broken if there was a child protection concern. Only one had been in a position where, reluctantly, she had to report a serious incident, and she described how this had led to a total breakdown in the support relationship:

> *"I did unfortunately have to raise some alarm bells… The whole thing is relationship and trust. And I felt like I'd broken her trust…* She didn't want to speak to me; she didn't want to know me…she doesn't trust us." (V042)

Theme 2: Needing support

The key theme 'Needing support' considers the ways in which projects adapted to working with very disadvantaged women and supporting their volunteers to carry out their role safely and effectively. It contains three subthemes: '*feeling prepared*', '*feeling supported*' and

'*staying safe*'.

Feeling prepared

All of the volunteers had been trained for their role supporting pregnant women, and some projects prepared them realistically for the distressing social circumstances they would encounter: *"They'll have never been in some of those homes… filthy accommodation that's provided by statutory agencies …no heating or light… so there is some training around that"* (V006). Other projects had initially underestimated the complexity of mothers' lives, leaving their volunteers underprepared: *"I didn't think it'd be stuff like the wife being beaten up…we all want to do more training around it"* (V030). These projects had gone on to develop or access local training on issues such as domestic abuse and mental illness.

Almost all the volunteers praised the active listening skills they had learnt in preparation for their volunteering. Although there was substantial variation in the length of the training they received, this did not appear to be correlated with their perceptions of readiness for work with very disadvantaged women. For example, one volunteer who had received the longest training (72 hours) said that at the end of it "*I was still nervous, I was still very unsure*" (V011). By contrast, none of the volunteers who received the shortest training (8 hours) described feeling nervous or unprepared, although they did report the highest incidence of very disadvantaged women dropping out of contact.

Feeling supported

Being exposed to mothers' suffering caused many volunteers real distress, particularly if they had comparable peer experiences: *"When people talk about their stories, I can feel the tears coming"* (V033). Almost all of the volunteers emphasised the value of not having to deal with mothers' difficulties on their own, citing the regular supervision and access to the project co-ordinator as key to coping:

> *"I'm so worried about [the mother]'s situation because of what she's told me, and I'm calling [the co-ordinator] at ten o'clock at night to say, 'What shall I do?' She was…really supportive, saying that I really shouldn't bear this kind of responsibility because that's* her job" (V015).

This supervision combined supporting the volunteer to work through her feelings, and help in planning what could be done to help the mother resolve her problems: *"That's the function of [the co-ordinator] to talk you through…processing it and then thinking, "How can I practically help and what can we do?" And not over-emotionalise and ruminate about it"* (V014).

Many volunteers also felt supported by other volunteers. This could be through informal relationships developed during their volunteering: *"I certainly know three or four people that I could call and wake them up and say, 'I can't believe what's just happened'"* (V012). It might also be through organised buddying or mentoring: *"I can always ring [a buddy volunteer] and just say, 'Oh my God, I feel awful'"* (V036). In some projects there were regular group meetings, which were also a forum to share ideas on how to deal with challenging situations: *"You're maybe dealing with a very hard case and somebody will share their own…and you find that you've actually moved over the hurdle"* (V047). One project actively tried to avoid 1:1 support for women with extremely complex needs, to avoid the risk of a dependency relationship forming and an individual carrying excessive responsibility, and instead supported women as an organisation with a small group of volunteers sharing the visiting: "*To take it all on yourself would be too much…the relationship is with the charity, rather than with a specific volunteer"* (V011).

Some volunteers experienced feelings of guilt knowing the magnitude of the women's needs but being unable to help: "*I did feel quite guilty that there wasn't more that I could do… she needed so much more than what I could give"* (V011). They might have feelings of inadequacy if the mother did not continue with the support relationship: *"It felt like I failed her*" (V046). The project co-ordinators had supported these volunteers to deal resiliently with their feelings: *"The advice I got was that sometimes happens and you just have to bear with it… it didn't mean that I was mucking it up*" (V014).

Staying safe

Some of the mothers had serious mental health problems, or were living with someone who could pose a risk to the volunteer. The projects had safety procedures such as the co-ordinator carrying out a risk assessment before matching volunteer to mother, or the volunteer reporting in by telephone before and after a visit. One project did not allow home visiting. One volunteer described how safety procedures could evolve as the projects gained experience of supporting very vulnerable mothers:

> *"I felt that [the mother] could turn on me… so I left relatively quickly and immediately called the co-ordinator ….[I thought] if we know that somebody's got a history of violence we should go in twos, you know? So I sort of feel as if it's* developing as we go along." (V009)

Theme 3: Identifying successes

The impact on mothers of volunteer peer support during pregnancy and early motherhood has been explored more generally in other papers from this study (McLeish and Redshaw, 2015, 2016). Within the key theme of 'Identifying successes' there were, however, specific subthemes which emerged in relation to volunteers' experiences of supporting very disadvantaged mothers: *'celebrating the small wins', 'validation as a mother',* and *'supporting access to services'*.

Celebrating the small wins

Some of the volunteers had the personally rewarding experience of seeing a very disadvantaged mother transformed through their support: "*She's an absolutely different person, and when she first smiled and laughed I could have wept because I'd realised I hadn't seen that before…and she laughs all the time now"* (V027). Some had also seen serious problems avoided with their support: *"For her other two children [she had] severe postnatal depression, suicidal, self-harm, drug abuse, alcohol abuse, and this time…we haven't gone down that road"* (V023).

However, other volunteers had worked with mothers who had such intractable problems (*"You see women who are just going to get worse and worse"* (V009)) that the volunteer's impact could only be limited. The volunteers nonetheless remained motivated by focusing on whatever their involvement had achieved: "*We did some good, if not as much as we would have liked"* (V010). It was important for volunteers to accept that they could not 'rescue' a mother: *"What's possible, but not in a stupid, single person riding over the horizon [way], like a cowboy"* (V009). Project co-ordinators helped them to see and celebrate their contribution to a mother's wellbeing even though they could not resolve her difficult situation: *"Just think how much worse things would have been if we did not get involved"* (V011).

Several volunteers felt they had an empowering role simply in offering choice to mothers who had minimal personal autonomy, even if that was just control over how they used the support: *"You take what you need and we'll give all we can"* (V007). It could even be as basic as having control over taking up the support: "*Your impact is in that they get the choice of whether to accept it or not, and they're not used to choices"* (V012).

Validation as a mother

Volunteers said that mothers who had very chaotic lives, with issues of substance misuse, prostitution or involvement with the criminal justice system, "*have never been treated as a woman or…as a mother-to-be*" (V011), and *"really don't feel like they're being looked at"* (V009). The volunteers enabled these mothers to feel noticed: *"[The mother in prison] said, 'Thank you for coming to see me'. It was really important that she was remembered*" (V009). They also created space for the mothers to focus on motherhood: *"We can always bring it back at some stage to something to do with recognising that she's pregnant"* (V006). This could be practical, for example supporting a woman to think through getting to hospital in labour if she had no money; or it could framed in terms of validating the woman as a mother in the midst of difficult circumstances: *"[It's] about her being special…We can just focus on the breastfeeding… and all the emotional early stuff and cuddling, and validate all that"* (V006).

A few of the volunteers had experience of supporting mothers who knew that their baby was going to be removed from their care shortly after birth, and these volunteers emphasised the importance of *"optimising the situation"* (V009) by acknowledging and celebrating the women as mothers:

> *"[We] do everything that [we] can to facilitate them being a mum in a non-judgmental fashion. 'We are here to support you, no matter what you have done in the past or what might be happening with baby after the birth.'"* (V011).

Even in less extreme circumstances, volunteers felt they had a role in building up vulnerable women's self-belief as mothers: "*Getting them to feel better about themselves, making them believe that they are good enough"* (V022). One volunteer described the emotional impact that she believed volunteer support, focused around motherhood, could have:

> *"I think it's a huge relief for the women to feel that at that this moment in their lives when things are terrible, they're separated from their other kids, they don't know what*'s going to happen in the future, where their home's going to be, and everything's disrupted and every stress you can imagine, that they have somebody who's just being really gentle with them and giving them lots of praise as well." (V009).

Supporting access to services

Some of the volunteers' successes related to supporting vulnerable mothers to access essential maternity and child health services they had not been using. They encouraged mothers by helping them to overcome their fear and mistrust of professionals: *"You can explain things more and tell them what them services are about… We'll help them fight their corner as well, like if they're frightened of the health visitor, we'll go with them"* (V031). Mothers were more likely to trust information about their right to use services from someone who shared their uncertain immigration status: *"If they have got no papers they are scared to go to hospital…I feel the same when I came [to the UK]. So after I know, I said, 'You are not supposed to feel fearful of hospitals or GPs, you need to go'"* (V029).

Volunteers also gave mothers practical support to access services, for example giving a lift by car to a mother who lacked transport, or helping a mother unfamiliar with maps or public transport to find her way. Although this was not officially part of what projects offered, some volunteers also informally interpreted for migrant mothers at appointments, enabling meaningful access to care for the first time:

> *"Some women were failing to attend their antenatal appointment 'cause they didn't understand… they just said, 'We don't go because what's the point of going*…and not understanding a thing?'… I serve the purpose of accompanying them." (V005).

Discussion

Volunteer projects working with pregnant women and new mothers have diverse aims and structures (Suppiah, 2008; Barlow and Coe, 2012; Spiby et al., 2015), and this diversity was reflected in the nine projects where this research was carried out. Some focused exclusively on very disadvantaged women and for others, very disadvantaged women were part of a wider group of clients. As well as a volunteer relationship being qualitatively different from professional support (Granville and Sugarman, 2012; McLeish and Redshaw, 2015), it has been suggested that local volunteers may be able to connect with mothers who professionals find it hard to reach (McInnes and Stone, 2001). The findings of this study support the contention that where a volunteer has peer experiences in common with the supported mother, she may be able to offer a uniquely empathetic understanding (Mead and MacNeil, 2006; Sokol and Fisher, 2016).

Volunteer support in England is usually aimed at disadvantaged mothers, but the definition of disadvantage is very wide and can include mothers who are poor but have support from family and friends (Barnes et al., 2006) or more socially and economically advantaged mothers who identify themselves as needing additional support (Moran and Ghate, 2013). Thus the specific issues associated with volunteers supporting very disadvantaged mothers have not been reported separately, except rates of engagement and disengagement (Barnes et al., 2006; Spiby et al., 2015; Suppiah, 2008). More generally, peer support has been reported to have greater salience for more disadvantaged people (Sokol and Fisher, 2016). It is, however, not known to what extent the impact of volunteer support and the dynamics of the relationship between volunteer and mother may vary according to the severity of the mother's circumstances and needs.

Successful volunteer support for mothers has been consistently found to be grounded in an empowering relationship of trust, which enables the mother to build up her self-confidence and to make informed choices about maternity care and parenting (Suppiah, 2008; Akister et al., 2011; Barlow and Coe, 2012; Granville and Sugarman, 2012; Spiby et al., 2015). This paper illustrates some of the challenges associated with making that relationship of trust with very disadvantaged mothers who often found it hard to trust others.

The key factor was that the relationship was experienced by volunteers and mothers as different from the professional support they had experienced. The volunteers were consistent, persistent and patient, accepting that the relationship would take time. Persistence and consistency over time have been highlighted before, for example as qualities in a keyworker valued by families with anti-social behaviour issues (White et al., 2008), or qualities in the practitioners from a third sector organisation valued by vulnerable families (Crowther and Cowen, 2011). However, the volunteer support differed from practitioner and professional models, in that volunteers were perceived as non-judgemental and non-threatening, *'just a mum'*. For some mothers, particularly some asylum seekers who were fearful of official systems, the peer nature of the support was instrumental in enabling trust to build (Sokol and Fisher, 2016).

From the volunteer perspective, it could take a conscious effort to maintain a non-judgemental demeanour in their interactions with very disadvantaged women whose choices they privately condemned, but this non-judgemental stance is known to be profoundly important for the success of the relationship (Granville and Sugarman, 2012; Small et al., 2011), comparable to the concept of Unconditional Positive Regard in client-centred therapy (Rogers, 1956). The pivotal role of being able to suspend judgement and show respect during each encounter emphasises the importance of selecting volunteers with values and attitudes that are consistent with the goals of the volunteer project, and having a training programme that builds their skills of

active listening and gives them realistic expectations of the scope of the role and the nature of the issues they will come across in supporting very disadvantaged mothers (Suppiah, 2008; Akister et al., 2011; Bhavnani et al., 2015).

All volunteer projects establish boundaries for the relationship, although there is no consensus about where these boundaries should lie and they may vary from the volunteer being allowed to disclose only minimal personal details, to the volunteer being free to involve the woman she is supporting in her own family's social life (McLeish and Redshaw, 2015; NCVO, 2016) When the person being supported has very complex needs and feels they have no one else to turn to, it can be challenging for volunteers to keep to these boundaries (James, 2013). This study found that volunteers framed the boundaries variously as: helpful to retain focus; limiting, with a temptation to transgress; or insufficient, when their own capacity as a supporter was limited. Feelings of distress at a mother's situation could be combined with feelings of guilt at not being able to do more to help. Volunteers had to accept that they could not come "*riding over the horizon, like a cowboy"* or *"fix situations*". Consistent with other studies, our findings highlighted the vital role of the project co-ordinator, and to a lesser extent the other volunteers, in providing support and supervision to enable volunteers to process and manage their emotional reactions and identify practical steps to help those they were supporting (Barlow and Coe, 2012; Granville and Sugarman, 2012; Bhavnani et al., 2015; Spiby et al., 2015).

Research on volunteer support for mothers has tended to focus on what impact it has on those who receive and give it, without considering how it may impact differently on women with different degrees of complexity and disadvantage in their lives (Johnson et al., 1993; McInnes and Stone, 2001; Barnet et al., 2002; Barnes et al., 2009; Barlow and Coe, 2012; Granville and Sugarman, 2012). This study found that volunteers experienced some extremely vulnerable women's wellbeing being transformed through their support, but for other women the gains were more subtle – the support gave women some autonomy by enabling them to exercise small choices, affirmed them in their role as mothers when others could not see past their circumstances or choices, and helped them to make use of maternity and child health services that they were not otherwise able to use.

It was a strength of this research that it involved in depth qualitative interviews with 38 volunteers who had supported very disadvantaged pregnant women and new mothers, from a range of volunteer projects in England, enabling diverse experiences to be analysed together. It was a limitation that because volunteers generally supported only one mother at a time for a long period, and some of the projects had only been operating for a short time, many of the volunteers had only supported a few very disadvantaged mothers.

Conclusion

Volunteers are able to build strong, empowering relationships with very disadvantaged women during pregnancy and afterwards, including in situations where the mothers do not readily engage with professionals. However, supporting women with complex needs is emotionally challenging and volunteers need to be carefully selected, realistically trained and robustly supervised and supported during their volunteering. Further research could explore whether the dynamics and impact of volunteer support during pregnancy and early motherhood vary according to the severity of the mother's needs and circumstances.

Competing interests

None declared.

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Author Contributions

This study is part of a programme of work, the research questions for which were developed by MR and JM. MR and JM conceived and developed the outline for this study. JM undertook the data collection and JM and MR both took part in data analysis. JM drafted the manuscript. Both authors were involved in interpretation, review and revision of the draft manuscript and approval of the final version.

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