Volunteer Peer Support Therapy for Abusive and Neglectful Families

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Ms. Upsal's proposal won first prize in the contest for the 1989 Secretary's Award for Innovations in Health Promotion and Disease Prevention. The contest is sponsored by the Department of Health and Human Services and administered by the Health Resources and Services Administration in cooperation with the Federation of Association of the Schools of the Health Professions.

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Synopsis

This project is designed to provide tertiary prevention services to physically abusive and physically neglectful families. The prevention service described, Volunteer Peer Support Therapy, is expected to significantly improve parenting skills and parents' expectations concerning their child, their knowledge about appropriate child behaviors, and coping strategies. The aim of the project is not only to intervene during crises, but also to improve the parent-child relationship on a long-term basis.

In order to accomplish this goal, trained volunteers will be matched to the families being treated for physical abuse or physical neglect. The volunteers will be trained to take on roles traditionally performed by professional therapists and case managers. These roles include matching public and private services to the needs of the clients, investigating employment opportunities, and providing parenting role models. A second purpose of the project is to demonstrate the economic advantage of Volunteer Peer Support Therapy. To achieve that goal, a cost-effectiveness analysis will be performed.

According to the second national incidence study conducted by the Department of Health and Human Services (*1*), the prevalence of physical child abuse is 5.7 per 1,000 children in the United States, and the prevalence of physical neglect is 9.1 per 1,000 children. The proportion of children who suffered demonstrable harm as the result of physical abuse increased by 58 percent from 1980 to 1986. The proportion of children who suffered demonstrable harm as the result of physical neglect increased by 81 percent during the same period. Not only are reports of abuse on the rise, but also the severity of abuse is increasing. From 1980 to 1986, there was a 10 percent increase in child abuse fatalities (*2*).

Literature Survey

There is evidence that paid lay therapists may be equally or slightly more successful at providing services to abusive mothers than professional therapists. Lay therapists differ from professional therapists in that they are expected to be more intimate and nurturing than the professional therapists, and thus they can serve as a parenting role model. The use of lay therapists frees the professional therapist from the strain resulting from providing both nurturance and therapy. It also frees professional therapists from performing tasks unsuitable to their skill level.

In one study, the attrition rate of clients was lower in the group receiving services from both lay therapists and professional therapists than in the group receiving services only from professional therapists. The lay therapists were able to provide more direct client contact than the professional therapists. Additionally, clients in both groups showed similar improvements in nurturance, parental attitudes and beliefs, and parental behavior (*3*). However, using paid lay therapists is very costly. Recommendations for using volunteer lay therapists to offset the financial cost (*3-5*) appear in the literature. The question remains as to whether removing financial compensation reduces the motivation of the lay therapists and thus reduces the effectiveness of the program.

The theory underlining the use of lay therapy for physically abusive families is that the perpetrators of child abuse are themselves victims. They suffer from the inability to meet their own social, emo-

tional, and physical needs (*3,6*). This problem must be addressed before addressing parenting skills and appropriate parent-child interactions (*3*).

This model has not been applied to families in which physical neglect has occurred; however, neglectful mothers are more likely than nonneglectful mothers to have unmet needs. Maternal isolation and confining life situations are characteristic of neglectful mothers (*7*). It stands to reason that perpetrators of physical neglect will respond better to parenting behavior modifications after their own personal needs are met.

After the parental needs are met, the client requires education in child development, typical expectations concerning child behavior, conflict resolution, and appropriate methods of discipline. Additionally, the client needs an appropriate parental role model and help in developing family cohesion and establishing parental responsibility (*3,6,8,9*).

Various lengths of treatment time are reported in the literature (*6,9,10*). Time in treatment is inversely related to the rate of posttreatment reabuse; the longer treatment, the less likely that reabuse occurs. Studies have defined long-term treatment differently; the range has been 6 to 12 months (*10*).

Project Goal and Objectives

The project's goal is to treat effectively and economically families in which a child has been physically abused or physically neglected by means of a model that incorporates peer support volunteers. The project's objectives follow.

1. The use of peer support volunteers will reduce the cost of providing treatment to a maltreating client by 12 percent. This estimate is based on the following:

Category	*Salaries (including 23 percent fringe)*	*Case load*
Volunteer supervisors..	$30,750 per year	30 volunteers
Social workers.....	$27,060 per year	10 clients without peer support volunteers or 20 clients with peer support volunteers

2. After 6 months of treatment, the clients receiving Volunteer Peer Support Therapy will have gains in self-esteem comparable to clients receiving traditional counseling services. Hudson's Index of Self Esteem will be used to measure self-esteem (*11*).

3. After 6 months of treatment, the clients receiving Volunteer Peer Support Therapy will have gains in appropriate expectations for their child comparable to the clients receiving traditional counseling services. Parental expectations will be measured by Bavolek's Adult-Adolescent Parenting Inventory (*12*).

4. After 6 months of treatment, the clients receiving Volunteer Peer Support Therapy will have gains in their perception of their child's behavior comparable to the clients receiving traditional counseling services. This change will be measured with the Eyberg Child Behavior Inventory (*13*).

5. After 6 months of treatment, the clients receiving Volunteer Peer Support Therapy will show reductions in dysfunctional behavior similar to those of clients receiving traditional counseling. This will be measured by pre- and post-needs assessments of the client's ability to provide appropriate and sanitary housing, clothing, food, and medical care to their families.

6. At the time of assessment (6 months after treatment onset), the clients receiving Volunteer Peer Support Therapy will show less attrition from therapy than the clients receiving traditional counseling.

7. After 6 months of treatment, the clients receiving Volunteer Peer Support Therapy will be as successful at forming a support network as clients receiving traditional counseling services. Their success will be measured by a log of contacts made by the client. Contacts can include Parents Anonymous meetings, telephone or personal contact with the extended family, friends, and neighbors.

Methods

Treatment plan. Subjects ($N=120$) will be randomly assigned to either the peer support treatment group ($N_1=60$) or to the traditional treatment group ($N_2=60$), which will serve as a comparison group. Subjects receiving Volunteer Peer Support Therapy will have limited contact with trained social workers. The trained social workers will spend approximately half as much time with clients receiving Volunteer Peer Support Therapy as they will spend with clients receiving traditional therapy.

Volunteer Peer Support Therapy. Clients receiving Volunteer Peer Support Therapy progress through three stages. In the first stage, dependency, a trusting relationship is formed. During this stage, the peer support volunteer plays the role of a "nur-

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turant parent," and the concentration of the relationship is on meeting the needs of the client (*4*).

The second stage is interdependency. At this time, the peer support volunteer changes the focus of the relationship to parenting skills. This change is accomplished by introducing discipline alternatives to abuse, discouraging impulsive behavior, and discussing appropriate child behavior expectations and appropriate parent-child interaction. This stage may coincide with a family crisis. If a crisis occurs, the peer support volunteer resumes stage one contact (*4*).

The third stage, independence, is characterized by stability in the client's family. The client's contact with the peer support volunteer is reduced to every few months or to stressful situations, such as holidays (*4*).

Volunteer-client relationship. The clients and the peer support volunteers will be introduced to each other by the volunteer supervisor. The volunteer supervisor will act as a liaison in arranging the introduction. This meeting will usually occur at the agency. If transportation is a problem, arrangements to meet at the client's home will be made. After the introduction, the matched pair will be encouraged to begin their relationship immediately with a nonstressful activity. The client and the peer support volunteer will exchange phone numbers, and the volunteer will encourage the client to call at any time. After the introduction, all meetings will be arranged by the client and the peer support volunteer.

Volunteer-client activities. The client and the peer support volunteer together determine their activities. However, priority is placed on activities that will help the client function in day-to-day life. Initially, the volunteer will provide transportation, babysitting, or other services if needed. Later, the volunteer will work with the client in finding other alternatives for these services. A peer support volunteer can also accompany the client to appointments, help the client find and use community resources, help the client obtain employment information, provide guidance in household tasks, educate the client in terms of child development and child nurturing needs, encourage and role model problem-solving techniques, and engage in enjoyable activities, such as going out for coffee or a movie.

Peer and supervisor relationship. The peer support volunteer will have regular telephone and personal contact with both the social worker assigned to the case and the volunteer supervisor. The volunteer supervisor will supervise all peer support volunteers and will be in charge of training. Peer support volunteers will be encouraged to contact the volunteer supervisor whenever they deem necessary. The peer support volunteers will participate in monthly 2-hour meetings supervised by the volunteer supervisor. The purpose of these meetings is to provide support and ongoing training to the peer support volunteers.

The peer support volunteers will also be responsible for bringing to the meeting a monthly report of progress, a personal log of contacts, and the client's contact log. The form for the progress report will show the client's name, date, name of the peer support volunteer, and a summary of the relationship to date. The form for telephone and personal contacts will have space for recording the date, hours, and activity. The form for the client's contact log will have a list of the telephone and personal support contacts that the client initiated by date, hours, and activity. Clients will be encouraged to attend meetings of Parents Anonymous regularly.

Discussion

This project has both economic and humanitarian significance. With today's concern over the national budget deficit, the emphasis is on eliminating new programs and cutting back on old ones. Not only does Volunteer Peer Support Therapy provide a mechanism for cutting costs, it also provides a method for effectively treating abusive and neglectful families that is theoretically sound and supported in the literature (*3–5*). Furthermore, Volunteer Peer Support Therapy may actually prove to provide more effective treatment than the traditional therapy (*3*). Researchers have described the qualities of similar projects (*4,5*), and in one study analyzed the cost effectiveness of the paid lay

therapist (*3*). However, this project is the first to evaluate systematically and quantitatively Volunteer Peer Support Therapy.

Budget Justification

The project is designed to be established in a public agency that already provides counseling services to abusive and neglectful families. Specifics of the budget for the project are given in the table.

The salaries of the social workers are financed from other sources. The project director will be responsible for coordinating, monitoring, and evaluating the project. He or she will have a master's degree in health planning and will have at least 5 years of experience in health planning.

Two supervisors of the volunteers will be hired to recruit, train, organize, motivate, and otherwise supervise the volunteers. Each supervisor will oversee 30 volunteers, will be educated at the master's level in social work, and will have at least 1 year of experience in recruiting and organizing volunteers.

The sum of $250 has been allocated to cover the costs of office supplies. The $75 postage allocation includes $60 for mailing and the return of followup questionnaires and $15 for miscellaneous postage. Copying costs include copying evaluation forms (described earlier), copying followup questionnaires, and miscellaneous copying.

The contractual services have been allocated in order to provide for data collection and statistical analysis. Three hours of statistical consultation will occur before the project to ensure that appropriate data are collected in an efficient manner, thus expediting data coding. Funds for an additional 5 hours of statistical consultation have been appropriated for the analysis of the data.

The data coding will be done by students from a nearby university. One hour will be needed to code the data on each of the 120 subjects. Indirect costs include rent, heat, electricity, and telephone.

Budget

Position and title	*Annual salary rate*	*Fringe 23 percent*	*Percent time*	*Total*
Personnel				
Project director	$32,000	$7,360	35	$13,776
Supervisors of volunteers (2)	25,000	5,750	100	61,500
Social workers	22,000	5,060	100	...
Subtotal	...	...	...	75,276
Supplies				
Postage	...	...	...	75
Copying	...	...	...	120
General office supplies	...	...	...	55
Subtotal	...	...	...	250
Contractual				
Data coding ($6 per hour)	...	...	...	720
Statistical consultation ($30 per hour)	...	...	...	240
Subtotal	...	...	...	960
Total	...	...	...	$76,486

Evaluation

The following demographic data will be collected on subjects in both groups: sex of perpetrator, age of perpetrator, relationship of perpetrator to the target child, income level of perpetrator, type of maltreatment, and age of target child. These data will be used to describe the population that the sample group represents and to examine the sample's homogeneity. Volunteer Peer Support Therapy will be evaluated in terms of cost and effectiveness. The cost of treating a client with traditional services will be compared to the cost of treating a client with Volunteer Peer Support Therapy. Data will be collected on the time the clients spend with social workers and peer support volunteers.

The effectiveness of volunteer support therapy will be evaluated in terms of improvements in parental self-esteem, parental expectations concerning the child, parental perception of child behavior problems, and parental dysfunctional behavior. A pre-post statistical comparison will be performed on these four aspects. Additionally, clients receiving peer support therapy will be compared statistically to clients receiving traditional services on these four parental aspects.

Self-esteem will be measured with the Index of Self-Esteem (*11*). Parental expectations regarding the child will be measured with the Adult-Adolescent Parenting Inventory (*12*). The Eyberg Child Behavior Inventory will be used to measure parental perception of child behavior (*13*). In order to evaluate improvements in dysfunctional behavior by the client, an intake needs assessment will be conducted during the initial client interview. The client's ability to provide her or his family with adequate nutrition, clothing, shelter, and medical care will be assessed. Also, the client's ability to budget household finances and provide a clean, safe environment for the children will be assessed.

Six months after onset of treatment, a followup needs assessment will be completed on each client. The percent decrease of problems will be calcu-

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lated. Additionally, new problems that were not present during the initial interview will be reported. The average percent decrease and the average number of new problems per client for the clients receiving Volunteer Peer Support Therapy will be compared statistically to the same figures for the clients receiving traditional services. Also, attrition from treatment will be examined in each group.

The clients and the peer support volunteers will complete logs of their contacts. Each client will keep track of all types of telephone and personal support contacts made, including those with their peer support volunteer, friends, neighbors, extended family, and Parents Anonymous. The peer support volunteers will keep track of all telephone and personal contacts with their clients. The peer support volunteers' logs will be used to verify the accuracy of the clients' logs.

The clients' logs will be reviewed to ascertain the clients' ability to form a support network. Initially, there should be a preponderance of contacts with the peer support volunteers. Over time, the dependency on the peer support volunteers should diminish, and the clients' logs should reveal a strong support system to replace the client-peer support volunteer relationship. The number of clients who successfully made this transition of support in the Volunteer Peer Support Therapy group will be compared statistically to those in the group receiving traditional services.

Lastly, a posttreatment followup will be conducted 6 months after client termination. An anonymous response form will be mailed to each client. The clients will be asked to report any incidents of abuse or neglect that occurred in the 6 months following treatment termination. Additionally, the clients' records at the agency will be reviewed for any reported incidents of abuse or neglect.

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