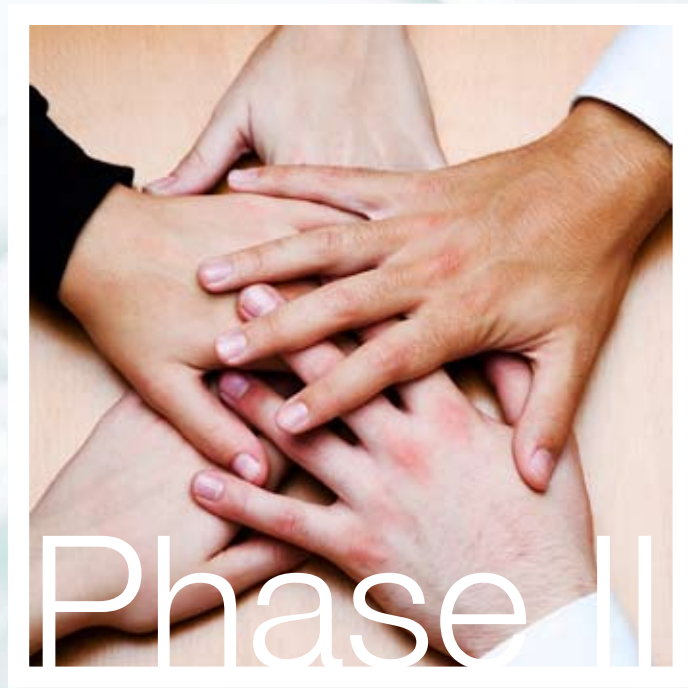


PROJECT EVALUATION:
Gathering Lived Experience Carer Involvement Project



Phase II
Piloting the Peer Support Program
July 2010

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Phase II

Piloting the Peer Support Program

July 2010



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Alliance Members / Specialist Representatives

- Northern Mental Health Service
- MIND Australia
- NEAMI
- North West Regional Office DHS
- ARAFEMI
- ADEC (Action on Disability within Ethnic Communities Incorporated)
- Mental Illness Fellowship Vic
- Carerlink North



The Caring Together Project has been extremely positive for the NAMHS, and the Northern Psychiatric Unit in particular. Although slow to get going, it is now well established and highly valued by staff. It is wonderful to have something so positive and helpful to offer family members and carers at a particularly distressing and difficult time for them. The NAMHS is delighted to be working in partnership with the other Alliance members to offer a range of peer support program for families in the North.

Robyn Humphries

Manager

Northern Area Mental Health Service (NAMHS)



rebuild · reconnect · rediscover life

Carers and family members are recognised as valued partners in the provision of care to Mind clients.

As a carer, and Mind's Carer Consultant, it has been a real privilege to work collaboratively with the Alliance partners on the establishment and delivery of the Caring together program which specifically prioritises meeting the needs of carers.

Michela Cardamone

Carer Consultant

Mind



The important role that carers play in the lives of people who live with mental illness is greatly valued. The Caring Together program has provided an opportunity for services to work together in providing flexible and appropriate support to those carers. In particular the value of the peer support model is recognised in addressing the needs of carers.

Kirra Yates

Service Manager

Neami Regent, Neami Ltd.



In relation to CLN's involvement, we have valued taking part in the development of the pilot and it has certainly provided an opportunity to strengthen relationships with alliance members, with a focus on supporting carers.

In hindsight I have been really heartened by the genuine goodwill and interest in validating and supporting mental health carers. There is/has been such inequity in terms of recognition and support on so many different levels, and the degree of trauma experienced can really be immense. Thank goodness for people who understand and care.

I look forward to reading the final evaluation document.

Claudia Moratto
Team Leader
Mental Health & Older Families Programs
Commonwealth Respite and Carelink Centre /
CarerLinks North



Peer support is highly valued as a means of support by families and carers, having people who can 'walk the walk'. We have valued the opportunity to work collaboratively on a best practice project that builds on sound evidence, and shares around the learning's. The input and support for carers across community and clinical services is heartening – we hope to see more.

Frances Sanders
Service Development Manager
ARAFEMI



The Caring Together, which has operated from ADEC's on Wednesday afternoons has provided an invaluable addition to the agency's services.

A significant number of ADEC's clients have used the service and have found this peer support model very helpful. One comment made by a client illustrates this point very well:

It was very good for me to talk to someone whose frame of reference is her own experiences as a carer, as opposed to someone who may be very empathetic, but may just have a clinical or academic frame of reference. This lived experience represented by the Caring Together person made me feel at ease and not as the family of a 'patient'.

The agency is committed to this project, and will continue to work with the Caring Together staff member in a systematic way.

Rafaela Lopez
Group Activities Manager
ADEC



Mental Illness Fellowship Victoria has valued the partnership established through the Caring Together Program.

The provision of peer support and responsive strategies utilised in the model has improved information, support and referral to services. This has assisted many carers as they negotiate the service system.

By focussing on carer support and information there is a logical empowering process.

Tracey Swadling
Regional Manager East North
Mental Illness Fellowship Victoria



Background to the Project

The purpose of the Caring Together Project is to increase carer support in the North; and develop an evidence-based and replicable peer mentoring support service for carers of people with a mental illness. The project is the result of a collaboration between member of the Northern Area Alliance Group to develop further supports for families and carers.

This report represents an evaluation of the process and outcomes for the first six months of implementation of the Northern Caring Together Peer support project.

Phase I: Surveying the Literature and Designing the Pilot

The first phase of the project allowed the development of a research report, which presents a body of knowledge around carer needs, peer support and mentoring models. In light of this review of literature, recommendations were put forward for prospective program decisions in the alliance project between ARAFEMI and services within Northern Metropolitan Melbourne. To identify service gaps and to assist in the design of a workable model the report also presents a map of Victorian carer peer support programs and relevant mentoring models nationally.

The undertaking of the first phase of the project involved a survey of 500 studies and scholastic articles, furthermore, a research of programs and publications was carried out for all major mental health organisations in Victoria. The report provided a number of recommendations to be incorporated into the development of a peer support pilot project at Phase II:

RECOMMENDATIONS FOR IMPLEMENTING PEER SUPPORT:

- A) Consider a theoretical model for exploring carer peer support and mentoring as part of the broader mental health system framework.
- B) In order to be effective, a carer peer support program needs to have built into its structure and philosophy the dual purpose of learning and support.
- C) It is recommended that a carer peer support program be properly integrated in the organisational context, with well-structured policies and procedures. That is, carer mentors are properly supported by peers and coordinating staff, so that they in turn can properly support the carer mentees.
- D) An area for possible Victorian service growth is one-on-one peer support. It is recommended that a carer peer support program includes structured peer worker selection processes and sufficient peer support worker training.
- E) It is recommended that a carer peer mentoring program is based on national benchmarks for effective development of mentoring programs in order to coincide with existing programs in Victoria. Further, that peer support/mutuality is built into the program framework.



Phase II: From Theory To Practice

In order to lead into phase II of the project, interviews were undertaken with the key stakeholders. Representatives of MIND, the Mental Illness Fellowship, ADEC, ARAFEMI, Darebin Community Mental Health (NAMHS) and Carerlink North provided feedback around peer support needs in the Northern Metropolitan Region, drawing out what services exist, where there are service gaps and feedback from their respective carer cohorts.

The Northern Alliance Reference Committee considered several models of peer support and the following model was adopted:

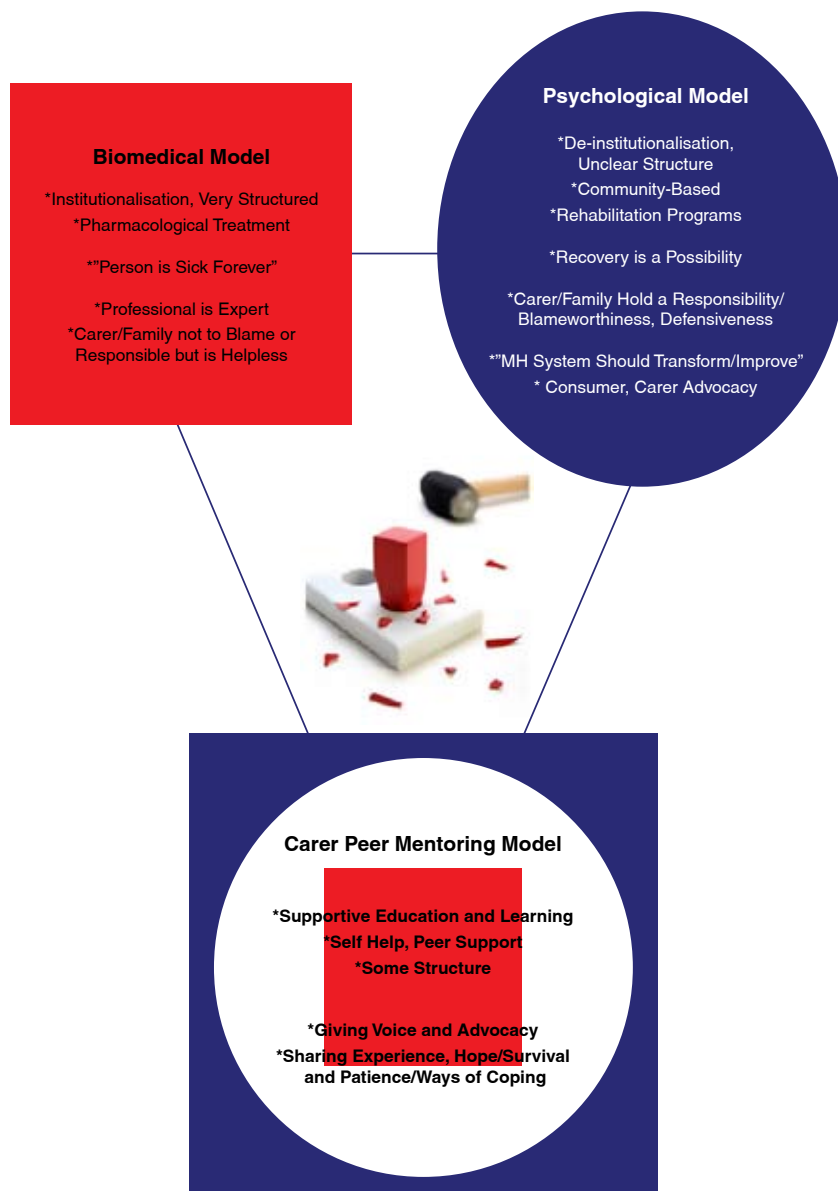
One-on-One Peer Support On-site

- The peer support worker is someone who has personal experience as a carer of someone with a mental illness
- Provision of one on one peer support worker across both a clinical setting and a community based (NGO) setting for two days per week
- Delivery of telephone and face to face support
- Provision of short term support that focuses on carer needs, supportive listening and further information and referral.
- Enhanced support for carers from a CALD or newly emergent / refugee background
- Enhanced ongoing support and supervision to assist carer peer workers in provision of carer support

A theoretical model was also utilised to explore and describe where peer support sits within the broader mental health system.

“The mental health system can be seen as two paradigms existing together, mainly incompatible: 1) the Biomedical Model of mental illness and its coinciding treatment and the 2) Psychological Model of mental illness and its coinciding support services. People with mental illness and their carers mostly encounter both paradigms daily on the road to recovery and professionals also work at this interface. A third service component, 3) Carer Peer Mentoring Model, can provide support, education, learning and empowerment - filling important gaps in traditional mental health services.” (Bartallo–Cassar & Sanders, 2008. p. 31)

Figure 1. Theoretical model for peer support.





Set Up and Implementation

In Phase II of the Caring Together project the focus has been on set up and implementation of a one on one peer support program. The key project goals in this phase were to plan and implement a one on one peer support model that met the following project aims:

- To provide peer support to carers when most at need
- To provide enhanced access to carers for support and information and acute points of access
- To provide enhanced support for carers from CALD and newly emergent communities
- To provide flexible telephone or one on one support in a setting most comfortable for the carer
- Utilised recommendations from Phase I to develop best practice and replicable peer mentor program in the North

In consideration of the project aims, it was decided that the project would operate across two distinct settings to facilitate and support early engagement with carers when most at need. The settings chosen were the:

- Northern Inpatient Unit (acute psychiatric setting)
- ADEC (community disability organisation focussing on carers from a non-English speaking background)

The key performance areas for Phase II are outlined below:

Performance Indicators

- Delivery of detailed Program Plan
- Development of an extended / revised volunteer policy /procedures document and a volunteer peer support training package
- Development of marketing & information tools regarding the new program
- Delivery of marketing / information for key stakeholders (MH service providers, clinical / PDRSS, & carers)
- Setting up 2 program pilot sites
- Delivery of a peer support program operating in the Northern Region of Melbourne
- Delivery of evaluation tools & final report
- Develop project to encompass volunteer peer workers for long term sustainability



Detailing The Steps

1. Publication and launch of report from phase I, also publicising the upcoming program
2. Consultation with peer support program coordinators in and around the region (e.g., the COPES program, the peer family/carer program at Orygen Youth Health, ADEC programs)
3. Consultation with Alliance and Northern area services about service model/needs
4. Detailed planning of pilot model
5. Consultation and negotiation with stakeholders regarding pilot sites, contribution to training and support for peer volunteers (Phase 3 – building sustainability beyond the pilot)
6. Writing policy, planning referral processes, putting together a training package and marketing material to facilitate the pilot program, evaluation design
7. Resourcing and setting up the work space at pilot sites (clinical and community)
8. Conducting information sessions and training for peer support worker
9. Identification and development of site based Champions
10. Engaging and informing clinicians and PDRSS staff at each pilot site (included facilitating staff visits to other peer programs)
11. Program Launch – public event celebrating start and raising awareness
12. The Pilot: beginning the program – tackling practical matters, e.g., rosters, security (at acute setting), working across 3 sites, phone calls and back up
13. The Pilot: continuing the program – Supporting the worker (individual debriefing sessions weekly, onsite support via champion; peer group supervision monthly, reference group monthly); making appointments and seeing carers. ongoing marketing, promotion and liaison with services
14. Commencement of data collation and write-up
15. Pilot report







Pro's and Con's – Peer Support Worker Perspective

The following section provides in-depth feedback from the perspective of the Peer Support Worker. It is based on learning's from reflective practice used as part of the post service analysis and supervision.

It provides a refreshingly frank and honest insight into the benefits and drawbacks from a peer worker perspective and allows us to briefly step into the role. Her thoughts provide us with some valuable feedback on how this role may be experienced and supported. For presentation it is divided into pro's (benefits) and con's (disadvantages) of the role as experienced by the worker.

PRO'S

- Offering people the opportunity to 'air' feelings in a safe environment. Words such as anger, guilt, helplessness, blame, walking on eggs shells, when is the next wave going to happen, exhaustion, nothing I can do helps, fear for the future, fear for their safety, fear for their loved ones safety, fear of the affect on other siblings, break down of family due to illness, drugs, lose of friends, isolation, depression, just don't have the strength, financial burden, can't go back to work, constant worry, black cloud over my life, housing, can't sleep, dealing with suicidal loved ones, not coping, need a break, no one understands, feel isolated from the family, don't know who to talk with, don't want to worry other family members, why, no one understands what I'm going through, feeling overwhelmed, traumatic, confused, shutdown/numbness, no energy, feeling disorientated, regressing socially, feeling like there is no one else to help and soooooo many more...
- I get a tremendous sense of community, caring and offering empathy to someone I don't know gives me a feeling of self-worth. When one hurts we seek to heal. I have also experienced and felt the pain of the emotions that are mentioned above. It gives my journey a sense of purpose, meaning and justification.
- Having a connection with the carer that is unique to the doctor, nurse, social worker through the lived experience.
- The feedback from careers – even if sometimes I feel as if I hardly spoke they seem to feel relieved that they were able to off load their concerns.

- Being able to give them the opportunity to be heard and speak freely. Not judge or give them the 20 questions that the health professionals usually ask about their loved one. But ask; How are they feeling? Often this question alone has never been asked and it opens a flood of emotions. You see the facial expression change, the body relax and it's almost as if they haven't given this a thought, it has just dawned on them the stress and worry they have been harvesting. Their focus has been on their loved one and just the fact that someone has enquired about them is a wake up call to the emotions they have pushed aside.
- Empowering carers to ask questions about their loved ones treatment, medication and future.
- Offering carers respite that they previously didn't know about.
- Encouraging carers to seek information and education about their loved ones illness. Through education carers are more informed to assist with their loved ones on the road to recovery and adjustment for both of them.
- Providing referrals to range of services through the Northern Alliance Team.
- Sometimes it feels as if you are offering a life-line to the carer who feels so isolated.
- Holding the 'hope' for them when it eludes their horizon. Just as the sunsets each night nothing does stay the same. There is a sunrise tomorrow.
- Reaching out to the multi cultural community carers. I have a tremendous amount of empathy towards them. Especially the older female long-term carers that seem to have resilience on the outside but are holding so much inside. Just being able to off load that gives them a feeling that someone cares, someone is listening to them. They often have had many traumas in their lives and are juggling other issues of finance, grandchildren, and relationships plus on top of that care for a son/daughter with a long-term mental illness. Their cultural background and values often implies for them to not talk about the illness or even acknowledge that it exists. Only when they are admitted into hospital does it finally hit them that they need assistance.
- Feeling like you have been able to help someone in time of need is very humbling.
- The people I have met, nurses, staff, co-workers, colleagues and the carers themselves.
- I have done many jobs but never, have I learnt so much as a peer support worker. This has come through the carers themselves and co-workers. It is a two-way affect. They teach me.... I feel privileged to be invited into their space. To give them a chance to learn, an opportunity to grow and assist there loved ones with their choices to heal.
- Regular supervision – This has been a great source of support and guidance.
- Linking in with other peer support workers and the professional development and training that is offered through ARAFEMI.
- Focussing on the positive actions and hope for their loved ones is often difficult. Feeling compassion and forgiveness over actions during their illness is not easy for them. But for them and their loved ones to move forward it is necessary – understanding it is the illness and not the person helps them to deal with situations with some kind of logic in a moment of confusion.

CON'S

- A sense that sometimes you just can't change the carers situation. It is not in your control. Sitting with that is difficult when they are after answers. I can be responsive to their suffering but not responsible for their lives.
- Frustration with the mental health system from situations explained by the carers.
- Listening to someone's pain and suffering takes more energy than running around the block..... Some days it can be easier than others it just depends on my own situation and where I'm sitting in my own personal role. Through experience and education that ARAFEMI has supplied I'm learning to deal with this dilemma.
- I feel some counselling for myself externally would assist and for some reason I haven't yet done this.....not good at following my own advice! but it is on the agenda. I understand prevention is better than cure....I take time out to exercise, eat, read, educate myself but feel I need a more holistic approach which needs to include counselling. This I feel will balance my professional role as a peer support worker if I don't focus on my personal needs. How can I assist others if I don't assist myself?
- The travelling from venue to venue is often time consuming and eats in to my limited time available but it is part of the job and I have adapted.
- At the moment I'm managing with the referral load but feel with the expansion of the hospital it will increase. Cross that bridge when we get to it!
- I still find it difficult to bring up my own story whilst seeing carers, I have only ever done it two –three times when it just came out naturally. I feel it is more about my loved ones confidentiality than anything else. Plus the fact that it is a contentious subject between us. Although I focus my story on more about how it made me feel, not about my loved one. Carers open up to me and touch my soul - I strive to be mindful, compassionate and show empathy but understand to be effective I need to work on self-care for myself.
- I was drawn to the role due to my own situation, you can truly empathize with other carers as you have also walked in their shoes and want to assist them not to go through some of the issues that you needed to go through. But I'm also mindful that I was drawn to it sub- consciously as I'm seeking to heal myself. I understand there are areas of vulnerability that I need to work through.
- Understanding that not all cases of carers are the same, some will not need what I needed.....giving them the options and asking 'what do they need' then sourcing the material or resources. Finding these resources is becoming easier through my peers and knowledge but the magic wand would come in handy!
- Recognizing and understanding when I'm feeling a fatigue 'moment' becoming more self aware of this so that it doesn't impair on my role.
- Prioritising my work load, working two days you need to be extremely disciplined in your planning or your time. I appreciate all the education that is offered in my role and would like to take more but at the end of the day I just can't fit it all in.



Evaluation Design

The evaluation process sought to gather information around the following areas:

- To detail the steps taken in the implementation of the research recommendations – from Phase 1 of the Caring Together Project.
- To evaluate the Caring Together Project against the key project goals
- To provide evaluation of the experience of services from a carer / service user perspective
- To evaluate the impact of the service within mental health services in the Northern region - attitudes and experience
- To provide statistical information on service usage in the first 6 months of operation

The evaluation design had a three pronged approach to data collection to assist in making recommendations for further use of peer support frameworks within a northern context:

Area	Method
To detail and inform others about the implementation of a peer support program for carers utilising the research on peer mentor models	<ul style="list-style-type: none"> • Analysis of work practice against recommendations • Capturing the process of set up and implementation / roles / structures / training and evidence
To provide information and evidence about the service usage and needs of carers	<ul style="list-style-type: none"> • Quantitative service usage data • carer post intervention survey
To provide feedback about collaborative processes – how did partners experience the caring together project – did they believe the service was good / easy to access / useful	<ul style="list-style-type: none"> • In-depth interviews (project champions, peer worker) • service provider survey (monkey survey)



Method inDetail

Analysis of work practice against recommendations:

We conducted an 'in time' review of the program against the recommendation using a descriptive format and illustrations of how we had met the recommendations. Data was derived from in-depth work interviews, work practice review and document audit. It seeks to provide a description of how we put into practice the recommendations made within the research phase of the peer involvement project.

Capturing the process of set up and implementation / roles / structures / training

We provided detailed information on how we have set up the project – to inform and evidence practice protocols. Evidence was collected using document review and interview of key staff.

Quantitative service usage data

Data collection method was developed prior to project implementation. Service statistics are collected by the peer worker and reported to the Project Manager and reference subcommittee for program quality and tracking. Quantitative service usage data was tabulated and presented as part of overall results.

Carer post intervention survey

A post intervention survey was developed and implemented as part of the project design. Carers are provided with a short survey following the provision of peer support. The evaluation asks the carer to rate their feelings in relation to being heard, understood and respected by the worker as well as usefulness of support. In addition, carers are asked to identify if they would recommend the program to others and how we could improve services. A copy of the carer post intervention survey is in Appendix 1. Surveys are given with a stamped addressed envelope and returned to the Manager of Family Services (ARAFEMI). Surveys do not ask for identifying information and are anonymous.

Service provider survey

To gain information about service take up and expectations from alliance partners and the broader field of service providers a brief online survey was designed utilising monkey survey. The survey was emailed to stakeholders via members of the project reference group to reach staff of the participating alliance agencies. The intention was to find out how the project had been received by the field, perceived usefulness for carers, feedback about use and referral processes and recommendations for change. Surveys were distributed and collected over a one month period. The survey did not request any identifying information and all responses were anonymous.

Stakeholder interview

In-depth interviews with project 'Champions' were conducted by an external research volunteer to gain additional feedback about the set – up and implementation of the caring together project and needs for the future, and to gain specific insight into how the collaborative partnership could potentially support the project.





Results

Review of outcomes against key research recommendations

Data for the following section was derived from in-depth work interviews, work practice review and document audit. It seeks to provide a description of how we put into practice the recommendations made within the research phase of the peer involvement project.

- A) Consider a theoretical model for exploring carer peer support and mentoring as part of the broader mental health system framework.

The project utilised the model proposed in the initial research paper: Carer Involvement Project: "Gathering Lived Experience" (2008 p. 28). The project is conceptualised as a carer specific support that sits within and between clinical mental health services and the community (PDRS) sector. Its aims are to provide carer specific information, support, education and referral to enhance self care, empowerment, knowledge and ability to navigate between systems of care.

By basing the project within an acute clinical setting and in a community setting, we hoped to make explicit that peer support was a supportive process that sits alongside and within the two broader systems of care.

- B) In order to be effective, a carer peer support program needs to have built into its structure and philosophy the dual purpose of learning and support.

Learning and support are central to the peer support model developed. This is explicit in its aims, program materials, resources available, setting and its support structures (links to Northern services, use of Champions, positioning of employee within broader family / carer support services).

"Caring Together peer support program provides opportunities for carers to talk to another carer about their needs and get support with finding services available."

– service brochure 2009/10

The peer support workers are employed on the basis of their lived experience as a carer of someone with a mental illness, and are provided with enhanced training and supervision in delivering support via peer mechanisms. In addition, formal training in service systems, mental illness, dual diagnosis, recovery models and carer specific topics (compassion fatigue, grief and loss etc) is structured as part of induction and ongoing developmental processes.

In addition, formal induction training and observations was undertaken within a mutual support self help setting that operated a specialist mental health carer Helpline, peer support programs and peer support groups. Induction was structured to provide opportunity for peer support workers to be guided through the process of delivering peer support and education with experienced workers, prior to commencement of the Caring Together model.

The collaboration between the alliance members and specialist services through the reference group, provides an enhanced link for the worker to gain more specific information and input into services and carer supports within the region. It both allows the worker to develop key resources needed and to have clear pathways to seek further information when needed.

C) It is recommended that a carer peer support program be properly integrated in the organisational context, with well-structured policies and procedures. That is, carer mentors are properly supported by peers and coordinating staff, so that they in turn can properly support the carer mentees.

Prior to commencement and delivery of the Caring Together program, resources were focused on the development of key documents that would guide services and support the peer worker. Though the program is a collaborative partnership, it was essential that staff had clear pathways for employment, employment support and policy and procedure. ARAFEMI, as a Statewide carer peer support organisation, took the lead project role as the employer, providing ongoing support and supervision to peer workers.

This also allowed opportunity for the project to harness their existing knowledge in setting up and delivering peer support projects, seamless integration within a broader organisational context and use of policies and documentation particularly around peer support and volunteer management.

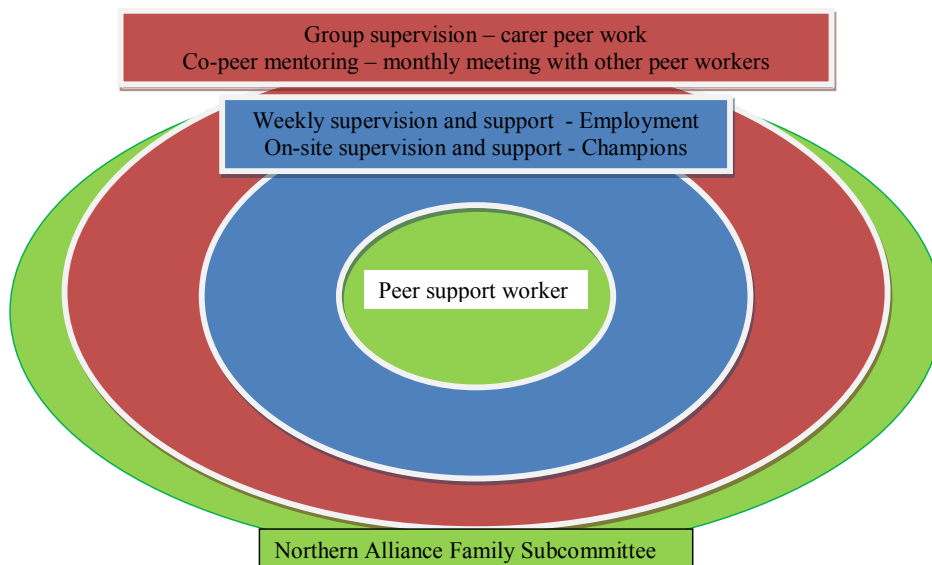
Work completed in this early stage included the development of:

- Detailed project briefs using project management principles to guide and inform the developmental and pilot phase.
- Program name and project descriptors
- Position description and KPI's for peer workers
- Marketing materials and marketing plans
- Detailed program manual which linked back to broader organisational frameworks and policy (i.e. this document provides a day to day guide for information and practice ie. what and how information is collected; with links to guiding policy on privacy, confidentiality and information collection).
- Referral forms and pathways
- Development of supervision and support structures

As a collaborative project it was essential that all partners engaged in this early process. For example; each organisation identifying strengths and barriers to referral models; explicit articulation of support structures; shared understanding of project goals.

In terms of support structures the project utilises a range of mechanisms to provide ongoing support to the worker. These are represented diagrammatically in Figure 1.

Figure 1. Support structure for workers



- D) An area for possible Victorian service growth is one-on-one peer support. It is recommended that a carer peer support program includes structured peer worker selection processes and sufficient peer support worker training.

As outlined, the project pilot focussed on one on one support which provides a supportive environment for shared listening, information and referral by a paid and trained carer peer worker. The worker was recruited utilising a structured selection process which focussed on the skills necessary to fulfil the position and also lived experience: see position description attached. Although the project is a collaborative partnership the position was placed with one employer selected on the basis of its carer – peer support skills and structures. However the selection process was conducted collaboratively as were components of the induction and training ie. alliance involvement in interviews, site visits with each alliance member organisation, access to shared alliance member training, identification of key contact people for resourcing the employee, allocation of direct supervisory and support roles.

- E) It is recommended that a carer peer mentoring program is based on national benchmarks for effective development of mentoring programs in order to coincide with existing programs in Victoria. Further, that peer support/mutuality is built into the program framework.

Based on comparable National benchmarks from youth and educational mentoring programs we utilised the following indicators for program development:

- Clear vision, purpose and value
- Collaboration with relevant agencies / schools / community groups
- Policies and procedures
- Screening / selection criteria for mentors
- Orientation and training for mentors and mentees
- Matching processes
- Ongoing support and supervision
- Managed closure
- Evaluation process

(Department of Planning & Community Development, 2007, pp. 21-23)

As outlined in C) and D) extensive peer support was built into training and peer support structures.

“It was incredibly useful knowing that I had the carer consultant from NAMHS and regular meetings with the COPES workers and family service team – it helped to put the peer role into perspective.

– Peer support worker”

Service Usage Data

The service usage data is based on a six month pilot period post commencement.

There were a total of 126 support contacts in the pilot period with 51 carers. The number of contacts ranged between 2-5 contacts with an average of 3 contacts per carer.

Type of Contact

Figure 1: Percentage of contacts by contact type

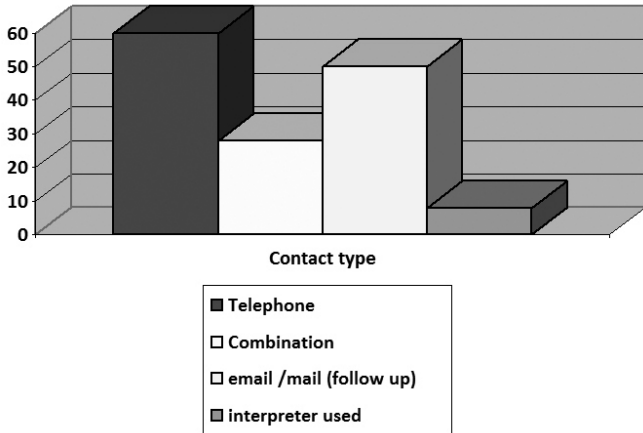


Figure 1 illustrates the percentage of contacts by contact type. It also identifies the usage of interpreters in contacts (column 5). Of the service contacts that were made 35% contacts face to face, 28% of combined telephone contact and face to face contact, 60% telephone (may include combination) and 50% had follow up email or mail out of information. Interpreters were used for 7% of contacts.

CALD Carer

Figure 2: Total number of cald carers / interpreter usage

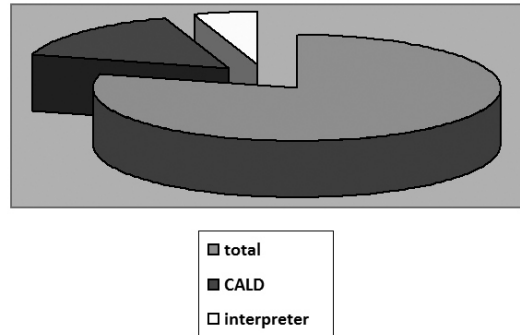


Figure 2 shows the total number of carers who attended the program who identified as CALD carers (26% CALD). In addition the number of carers who utilised interpreters is identified (8).

Referral Source

Figure 3. Referral source

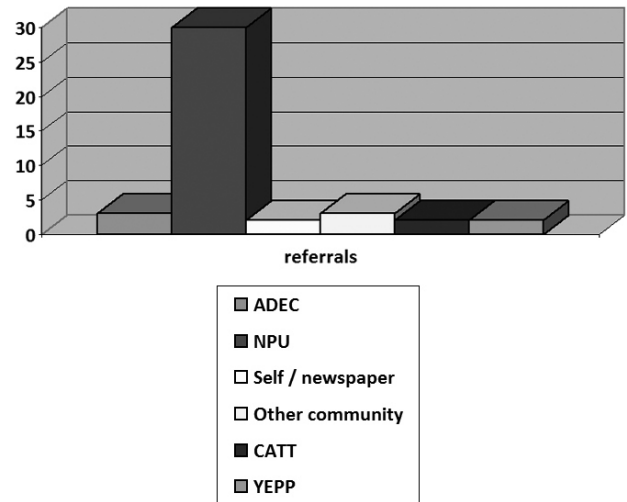


Figure 3 identifies in number, the referral source for carers who were provided with support through the caring together project.

Referral sources included:

Adec (3), Newspaper Article – Leader, Community Justice, Carers Link North, COPES, NPU (30), CATT, YEPP, Self

Carer Post Intervention Survey

Six (6) evaluation forms were returned at the data analysis stage. Further evaluation forms received (as part of ongoing evaluation processes) have not been captured in this report. The carer post intervention survey utilised a series of rating scales as well as qualitative questions to capture the experience of support and usefulness of the intervention. The results are presented by question below:

Q1: I did / did not feel understood and respected

100% of respondents provided a strong positive rating that they felt understood and respected.

Q2: I was able / not able to talk about what was important for me.

100% of respondents provided a strong positive rating that they able to talk about what was important to them.

Q3: The approach was a good fit / not a good fit for me.

100% of respondents provided a strong positive rating that the approach was a good fit for them.

Q4: The peer support was useful / not useful for me.

100% of respondents provided a strong positive rating that peer support was useful for them.

Q5: The session has helped me understand my situation more clearly. (1-5 rating scale)

4 respondents rated (5) yes the session helped them understand their situation more clearly. One rated 4 (positive) and one rated 3 (midline).

Q6: I feel more confident in dealing with my situation in the future (1-5 rating scale)

4 respondents rated (5) yes they felt more confident in dealing with their situation in the future. One rated 4 (positive) and one rated 3 (midline).

Q7: Was it easy to get access to the caring Together Program? (rating 1-5)

5 people rated (5 yes) the caring together program was easy to access. One respondent rated 3 (midline)

Q8: One thing I liked (open question):

- Your calm manner and understanding
- A feeling of being understood and with meaningful advice
- All is fantastic, and especially the fact that I'm able to speak freely and have support
- The attitude (kindness), the well mannered and respect shown by staff. The treatment, the fact of clearing up the situation by looking at means of support, fact sheets, insisting on looking after ourselves first, so that we can manage caring for others.
- Gillian was very understanding and you knew she spoke from experience

Q9: Comments

- A lifeline to what to do – very helpful
- All good
- As a first timer I am extremely impressed and I was made to feel very comfortable - however my real concern is my son who has the condition rather than me.
- I would recommend the program that I think need some help – thank you

In-depth Interviews – Champions

Interviews were conducted by a research assistant supported by Neami as an Alliance member. Interviews were conducted in person – at worksites for approximately one hour each. The following is a transcript of the interviews.

The Champions and place of location were:

NORTHERN PSYCHIATRIC UNIT AT NORTHERN HOSPITAL – SOCIAL WORKER (DREW)

ADEC - TRANSCULTURAL MENTAL HEALTH ACCESS PROGRAM COORDINATOR (NADINE)

(Highlight indicates which person is responding)

TRANSCRIPT

1. How did you feel as a champion?

Fine, mainly due to the focus of my role in family work at NPU, appeared to link well with the caring together project.

Initially, expected challenges and was a bit complicated however, ended up being ok, believed this was due to the alliance group and support from Gillian (carer co-ordinator) who made the process smooth.

2. What was it like for you hosting it?

Fine, as in any project initially it was difficulty to start on the ground. Prior work in sourcing room the physical space proved a challenge but once managed, the rest of the project resulted ok.

Very good given the character Gillian is – open, comforting, easily adapted to an environment, clear about limitations and challenges especially in the CALD community with needing to be flexible due to support needs.

(**Note - this could have been different if change of staff member in the carer co-ordinator role**)

3. What has it been like for you to be a champion? Process reflected in scale (1 - not so good to 5 – good)

On the scale I would say 4.

On the scale I would say between 4-5 as it increased partnerships with other services and the organisational tasks meant implementation was hands on due to pilot site.

4. Do you believe the project met its initially key project goals?

I believe in some ways it did - due to Gillian's work and how she managed it.

Not really sure, however there was other evidence from other peer support projects that helped with feedback from carers

5. Do you believe the service was good, easy to access, useful etc?

I believe the service has been useful in our work, there are always teething issues initially on how it can be accessed, worked well due to Gillian commitment at NPU – i.e. attending clinical meetings, carer evenings.

Not sure due to mainly not hearing the evaluation from carers themselves, however appears Yes as most are believed to of been satisfied.

6. Process – What do you think is needed?

I think what is needed like in any project is - continued funding especially can see how this project could be incorporated into NPU new unit and the 'new model of care'.

I believe what is needed is clearer responsibilities outlined for the Champions. Just a question of thought - Is the alliance group just a reference group, or should it be more of a supportive active group, where all members are active?

7. Recommendations – What is missing, that you would like to recommend?

In the guidelines to practice – clearer aims in how long to work with the carer(s).

I would recommend:

- More advertisement and promotion strategy work.
- More of a checklist to allow for accountability of stakeholders.
- Volunteers – need to assess for the future – how to engage, recruit, length of commitment
- CALD communities, how to increase access by CALD backgrounds, link more in with other workers in CALD services i.e. - Group Facilitator role i.e. at ADEC
- Review alliance roles – is it a reference group? Or an active group role? Need for more ongoing promotion.
- View how different sites pick up what role, i.e.: NPU – carer times, work hours need to be at a time that suits the carers (more accessibility or project).

Service Provider Survey

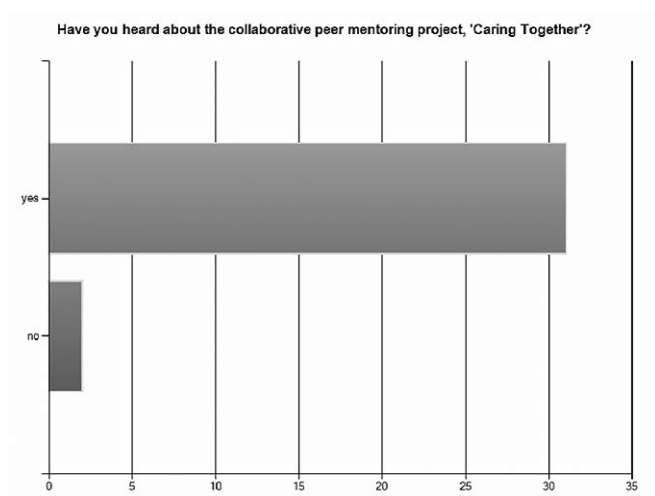


Table 1. Program knowledge

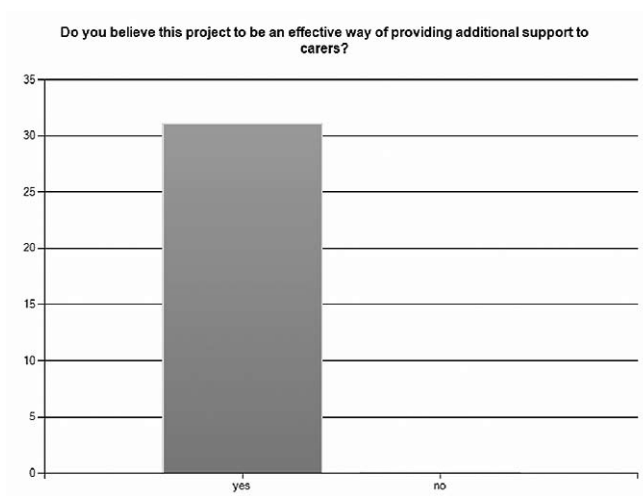


Table 2. Program effectiveness

Q1a Have you heard about the collaborative peer mentoring project, 'Caring Together'?

33 people responded to this question. The results are shown in table 1 in percentage. 31 (93.9%) of people had heard of the program. 2 (6.1%) had not heard of the program.

Q1b If no, would you like more information / consultation. Explain what may be helpful.

We received three responses to this question. Comments included:

- Yes, however I have only heard of the initiative. I would like to know the hours of operation, resources available, length of time carers can use the program for
- I regard it as an Individual Peer Support Program
- Not prior to receiving this email.

Q2 Do you believe this project to be an effective way of providing additional support to carers?

The responses for question 2 are displayed in Table 2. 31 people responded to this question and 100% of respondents believed that yes, this project is an effective way of providing additional support to carers.

Q2a If yes, How do you feel the support is effective?

This question asked for a qualitative response to identifying project effectiveness. 17 (54.8%) of respondents provided additional detailed responses. These are presented in order below.

1. It provides carers with somebody to talk to who has lived experience caring for a loved one with a mental illness rather than just talking to professionals who may not have the same level of understanding
2. DON'T KNOW
3. based where carers have identified they need support - early intervention, kindness and listening, carers can say more to another carer
4. It is important for carers to have support from other carers. It can be helpful to talk with people who have similar experiences.
5. Carers often respond best to peers and good link between peers and services.

6. Has the potential for earlier intervention through meeting carers at the Inpatient unit.
7. For carers to know that they are not the only ones. That there is support out there. It also provides carers further opportunities to know how to navigate the system more effectively
8. It allows for a different style of support for carers that was previously not available
9. By the feed back I have received in the past from carers I believe it's effective and useful to carers and their families.
10. I don't know what the objectives for the program are, hours of operation , financial support? information provision?.
11. My impression is that it provides an early access point to peer support which can then facilitate additional professional linkage and intervention.
12. Complements other carer support and family intervention work and meets a gap in relation to families who are not referred on to specialist MH services.
13. By being available to families and carers, and also educating the professionals.
14. Peer support is important and provides a "lived experience" perspective to the carer and family rather than just a clinical one. The program can also link carers and families in with other relevant or required community services. The fact that it is open to Mental Health service carers as well as those out in the community is also powerful in creating links for carers. The fact that the support can be provided through interpreters enables access to the CALD community.
15. Don't really know enough about it: would have ticked "unsure" if that was an option
16. Taking pressure off family members-freeing up their time/head space, to lead a relatively normal life.
17. Support is valuable when it is received from someone with similar experiences.

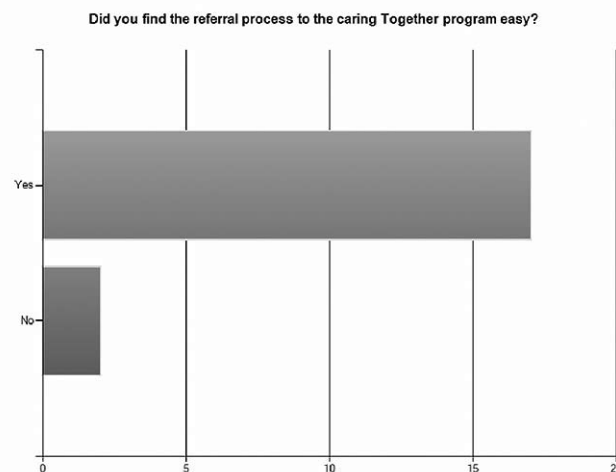


Table 3. Referral process

Q3a Did you find the referral process to the Caring Together program easy?

Table three depicts the referral process to the Caring Together program. 19 people responded to question 3 about referral processes. 17 (89.5%) said yes they found the referral process easy. 2 10.5% said no they did not find the process easy.

Q3b Please comment

21 people provided further comment to the question. Their comments are detailed below.

1. Very easy!
2. DON'T KNOW.
3. Haven't referred to it yet.
4. I have not made a referral to the program.
5. Have not referred as of yet so do not have experience of the referral process.
6. Have not used referral process yet.
7. Not Sure about the program right now.
8. Have not referred as I am involved in little clinical work with NAMHS. However, I have been informing other clinicians re: project.
9. It is not overly detailed and very easy to complete as limited information is required.
10. Have not made a referral.
11. N/A
12. Simple form, non intrusive.

- 13. Has not been applicable to my work in the community care unit.
- 14. N/A - Haven't referred myself - involved in supporting the program development
- 15. Haven't referred as this does not fit my role.
- 16. Yes once you have the referral form or contact phone number.
- 17. Again, don't know, as I haven't done a referral
- 18. Haven't referred.
- 19. I find it OK however I find I really need to encourage the carers to contact carers support services as they feel they do not have time and would not get any benefit from it.
- 20. Have not done a referral.
- 21. N/A

- Improve distribution of pamphlets and referral form to staff. Increase profile of project to staff. Increase no. of peer support workers.
- I have not accessed program.

Q4 Do you have any recommendations / comments to improve the project?

13 people responded with additional recommendations or comments to improve the project. The qualitative data is listed in order of response below.

- More people on your team as the referrals are going to keep coming and increase in 2010!
- Keep it up.
- More promotion of the program.
- Keep going! Very needed.
- To continue to keep it alive. Having a presence. More posters that are visible.
- A wider suite of staff referring would be beneficial to the project, perhaps some more inservices?
- Not at this stage, I would like feedback from carers in particular to ascertain its perceived value.
- Feedback from referrals as to whether the carer is going to get the support and perhaps when it stops.
- Need to extend to include Young Carer Peer Support.
- Project still developing, and doing well for the timespan.
- An extension.

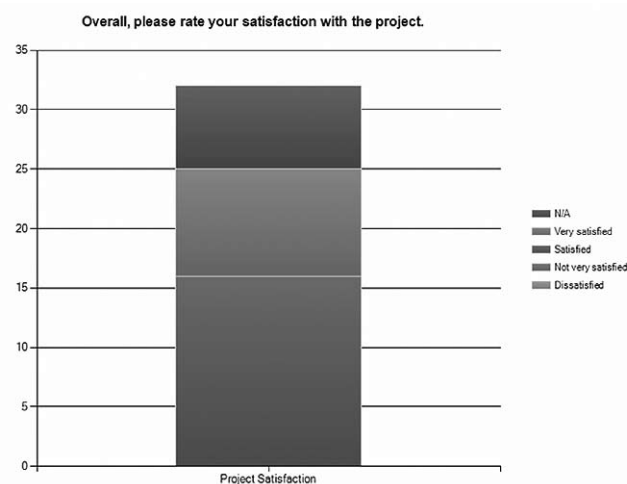


Table 5. Project satisfaction

Q5 Overall, please rate your satisfaction with the project.

Finally respondents were asked to rate their satisfaction with the program utilizing a 5 value rating scale (Dissatisfied, Not very satisfied, Satisfied, Very satisfied, N/A)

32 people responded to this question. 50% (16) people rated that they were satisfied with the program,

28.1% (9) reacted that they were very satisfied with the program and 21.9% (7) felt that a rating did not apply (N/A).



Discussion

Support for the peer support project:

The results highlight that varied stakeholders feel that peer support is a valued and valuable addition to services for carers in the northern region. There was a strong positive response to the program from service users (carers) and stakeholders. It is noted that the response from stakeholders is not based on actual service usage rather the philosophy that peer support is a welcome and human response to carer need.

It was clear in the results that lived experience and knowledge of carers was valued and respected and that this is integral to the peer support project. The use of collaborative partnerships, community delivery and the service mix of information and support from an experienced carer appeared to positively impact during the pilot phase.

Results also highlighted the strength of relationship, presence and attitude of the peer support worker as being vital in both getting the program going (gaining acceptance from staff / stakeholders) and also of value to carers as a relationship based program. The report was extremely complimentary of the work of the peer support worker as an individual.

Referrals:

The referrals indicate that the project has, in the pilot phase, been successful in implementing and providing one on one peer support in the Northern region.

Referrals have primarily come via the clinical setting, with few referrals from alliance partners. This may be in part that the projects stated aims are to support carers early in episode / early in care – and the acute unit is well positioned to support this goal. It was evident in the set up process, that the planning and collaboration was greater in this setting – due to the nature and type of the setting.

Referrals have reflected a diverse community in this pilot period, having a high number of CALD carers and representative proportion of carers who used interpreters. The indications in this early stage are that the project seems well positioned to meet its stated aims in regards to CALD and newly emergent carers. The positioning of the program within a CALD service, has had some impact on the CALD referrals, though it is noted that primary referrals of CALD carers has come from the acute unit as the primary referrer.

The types of contacts and number of contacts reveal that carers may utilise a telephone contact, face to face or a combination of these two supports across a number of contacts. It is important therefore that the program continues to facilitate time and space for the peer support worker to complete follow up telephone calls in addition to being available for face to face appointments. Given that the main referral source was the in-patient unit, face to face may be difficult at times for carers as they juggled multiple demands and challenges – however survey data reflects that these carers may follow up with a face to face after a number of telephone interventions. The results from the in-depth interviews also reveal the usefulness of having the champion based in family work so that support surrounds both the peer support worker and the carers that they see.

Program Promotion:

The most overwhelming finding is that the success of the program will be determined by its ability to market itself and develop referral relationships. It was interesting that the majority of the stakeholder survey respondents had not referred to the project, and knew little about the project – but thought it was a great initiative. It is possible that the project can harness this positive response to further enhance project outcomes. Further marketing and promotion is indicated in the post pilot phase.

Outcomes against project aims:

The evaluation indicates that the project has met key project goals in the pilot phase:

The key project goals in this phase were to plan and implement a one on one peer support model. This has been implemented.

The aims are referenced against key evidence in the evaluation:

AIM	EVIDENCE AREA (Results)
To provide peer support to carers when most at need.	High referrals from the in-patient unit and feedback on access (survey).
To provide enhanced access to carers for support and information and acute points of access.	High referrals from the in-patient unit and feedback on access.
To provide enhanced support for carers from CALD and newly emergent communities.	Housing within CALD service. Service statistics / referrals.
To provide flexible telephone or one on one support in a setting most comfortable for the carer.	Service statistics on 1:1 telephone or in person support. Carer feedback – survey.
Utilised recommendations from Phase I to develop best practice and replicable peer mentor program in the North.	Review of outcomes against key research recommendations.



Recommendations

1. Based on initial project uptake and stakeholder support, it is recommended that the Alliance group consider extending the project timeframes and explore long term implementation of the program.
2. That further attention and resources be provided to the marketing, promotion and dissemination of project materials.
3. That consideration is given to the role and input of the Alliance Subcommittee post pilot – and that further mechanisms for collaborative referral be made.
4. To enhance supervision, training, support and continuity of champion and supervisory roles as keys to the program implementation. In addition, to develop succession and handover plans to allow continuity of mentor support across organisational transitions.
5. To provide further definition in process and policy to enhance support to staff and supporters of the project.
6. To continue to evaluate and collect data to inform ongoing development of the project and impact on carers.
7. To consider volunteer involvement post pilot to enhance outputs and benefits to carers.

