

Carer Involvement Project:
“Gathering Lived Experience”



Phase I

**Review of Literature & Service Map Concerning
Carer Needs, Peer Support & Mentoring Models**

May 2008

Written by
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Executive Summary

The Carer Involvement Project was initiated by a consultation conducted at ARAFEMI Victoria in 2007. Following service evaluation and carer consultation it was decided to expand the range and format of carer involvement and advocacy programs.

The Carer Involvement Project builds on existing core services (i.e., Helpline, Support Groups & Carer Education) and generates other new service areas (e.g., mental health carers speakers bank & online carer chat room). This report documents the first phase of one of these new carer involvement strategies, peer mentoring, a project of collaboration between ARAFEMI and the Northern Health Alliance.

The purpose of the Peer Mentoring Project is to develop an evidence-based and replicable peer mentoring support service for carers of people with a mental illness. The first phase, reported here, presents a body of knowledge around carer needs, peer support and mentoring models. In light of this review of literature, recommendations are put forward for the prospective program based at ARAFEMI in collaboration with mental health services in the Northern Region of 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 this 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 has generated several design recommendations for a sustainable carer peer mentoring program, facilitated by ARAFEMI and implemented in the Northern Metropolitan communities of Melbourne.



Recommendations in Brief

- (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.



Glossary & Abbreviations

MH – Mental Health

Mutual/Peer support – ‘the shared experience of people affected by mental health conditions underlies services, and promotes mutual support and community connectedness’ (MSSH Agencies Service Development Plan - Department of Human Services, 2004).

Self-help – ‘services are designed to encourage people to be active in their own recovery, and support a holistic approach to improve mental health, emotional well-being and quality of life’ (MSSH Agencies Service Development Plan - Department of Human Services, 2004).

Mentoring – ‘various programs and / or relationships, whether formal or informal, which aim to build the skills or wellbeing of a...person through the input and / or assistance of another person {or peer} who has more skills, experience & knowledge’ (Department of Planning & Community Development, 2007).

Carers - There is no single definition of a carer. For the instance of this report the term mental health ‘carer’ was used to define someone who provides practical and emotional support to someone with a mental health issue including relatives, friends or neighbors. A carer may or may not live with the person they support; nor do they have to be identified by the individual with a mental illness to be their ‘carer’ (Clements, 1996).

Consumer – the term ‘consumer’ is used here as a known and recognised descriptor to refer to a person with a mental illness who requires support and / or services (Carer Life Course Framework - Pagnini, 2005).

Advocacy –The aim is to ensure that the healthcare system delivers the best quality of care for the person with mental illness and the best quality of health care interaction for the carer/s. The process of ensuring beneficial outcomes, experiences and recovery for the consumer, needs to enable the consumer and carer to retain as much control as possible over how it is carried out. Ideally, the recovery process is empowering and healing or positive for the consumer and all carers involved (Commonwealth Department of Health & Community Services, 1998).



Introduction

Background to the Project

In 2007 ARAFEMI carried out a service evaluation and carer consultation to assess the needs of carers of people with a mental illness, service users and the general community. An area of focus for the consultation was assessing carer interest in further service involvement and advocacy.

The consultation / evaluation consisted of a survey and focus groups. Two broad conclusions led to the current project.

- Constructive inclusion and support of carers via peer support models was seen as powerful and positive across the recovery journey.
- Participation in services and advocacy needed to be sensitive to the experiences and needs of the carer along the continuum of caring.

Program Context: The Carer Involvement Project

The Carer Involvement Project, funded by the Scanlon Foundation, incorporates existing core services (i.e., Helpline, Support Groups & Carer Education) and builds on multiple levels of carer involvement. Schemes under this project include:

- A speakers bank of mental health carers
- Media monitoring and media responding
- The development of advocacy networks
- Peer mentoring project
- Supporting and coordinating volunteers
- The use of innovative technologies such as the on-line carer chat room and message board

The **Peer Mentoring Project component** is organised into **3 phases** funded over a 2 year period:

Phase I. Exploration of Peer Support Models

Research and stakeholder review aims to: Develop a body of knowledge around carer needs and peer mentoring models, to inform the organisation to possible future models for carer peer support. This phase would include a research and literature review, service map of existing peer mentor supports throughout Victoria with a comparison evaluation of models, and a stakeholder consultation to further explore the needs for peer support.

It is expected that this report and its recommendations will assist to develop and implement sustainable models of peer support within ARAFEMI's growing suite of services to families and carers.

PHASE II. Pilot Project

Based on the recommendations of phase I, ARAFEMI will develop and implement a peer based project. Opportunity exists for this to occur within the Northern Area Mental Health Service. This project will be based on volunteer peer input, have developed strategies for sustainability, and be rolled out to a target group to be determined by ARAFEMI and Northern Mental Health partners.

PHASE III. Evaluation and Documentation

The project will be evaluated in terms of carer outcomes, sustainability, and its ability to be replicated across other service regions in Victoria.

Peer Mentoring Project Purpose and Objectives

On the whole, the purpose of the peer mentoring project is to develop a sustainable peer mentoring support service for carers of people with a mental illness.

The objectives of the first phase are:

- To develop a literature review of peer support and mentoring models
- To piece together a service map of existing carer peer supports throughout Victoria, and also locate relevant mutual support programs on a national level
- To detail the review findings and service gaps in conjunction with recommendations for future ARAFEMI peer support pathways

Organisational Context

Key Stakeholders in this Project

ARAFEMI stakeholders

Scanlon Foundation

Mental Health Services

Northern Area Mental Health Services

Carer Groups

Northern Health Alliance Reference Group (Carer Sub-Committee)

The peer mentoring project is a partnership between the Northern Mental Health Alliance and ARAFEMI Victoria. Phase I is largely funded by ARAFEMI and Phases II and III will be funded also by the Northern Alliance and piloted in the Northern Metropolitan Region of Melbourne.

The **Northern Alliance Project** is a mental health branch funded initiative aimed at developing the mental health service system through enhanced partnerships between clinical services and the rehabilitation support (PDRS) sector. The focus is working together, sharing information and streamlining referral and assessment processes across regions. The Alliance is a collaboration between Northern Mental Health Service, MIND Australia, NEAMI, North West Regional Office DHS and ARAFEMI.

Alliance project members have identified a need to provide the following in the Northern catchment area (Whittlesea and Darebin):

- Service mapping of carer-specific services and supports
- Strategic regional planning of service responses to carers that are cost effective, sustainable and relevant to a range of settings, clinical and community-based
- To Increase carer peer support mechanisms

ARAFEMI services have a commitment to promote and improve the well being of people experiencing mental illness. ARAFEMI has been an incorporated association, since 1979, and a registered community support service under the Mental Health Act 1986.

Core values held by ARAFEMI include an overarching belief in recovery for both people with mental health issues and their carers. All have the right for respect, dignity and equality of opportunity in society. Central to these values is providing opportunity for family/carer involvement and advocating for family sensitive practice across mental health.

The services provided by ARAFEMI include:

- home-based and intensive outreach support
- flexible respite option for carers and consumers (e.g., Banyan House)
- mutual self-help & support groups
- information provision (e.g., specialised library)
- telephone support for carers

ARAFEMI also works in partnership with Eastern Health to manage a Prevention and Recovery Care service, Linwood House in Mont Albert.

ARAFEMI is the lead statewide provider of support for carers of people with a mental illness. As a grassroots organisation, advocacy and self help have been central to its development. ARAFEMI was a founding member of the advocacy body, Victorian Mental Health Carers Network, and a provider of carer advocacy training. It is in this context that the organisation wished to re-examine and revitalize carer participation as part of its strategic directions.



Methodology

Conducting the Literature Review and Constructing the Service Map

Approximately 500 published empirical works in the area of carer issues and peer support were reviewed, using electronic databases Medline and PsychInfo. These online databases provide a wide coverage of citations and abstracts from psychological, health and medical journals internationally. Keywords used to guide the literature search were:

“peer support model”

“peer support and carers/care-givers”

“self-help and carers/care-givers”

“mentor model/program”

“mentoring and carers/care-givers”

In the cases where these keywords generated hundreds of results, the search was narrowed down to the last 3 or 5 years, to increase time efficiency and relevance to the current socio-historical context. Endnote was used to store and organise the publications.

An internet-based search (using the Google search engine) was conducted into the main carer/family support organisations and advocacy groups in Victoria. For example, MIND Australia, the Mental Health Council of Australia, SANE, VICSERV, The Bouverie Centre, Carers Victoria and beyondblue. This information was used to locate key publications & projects, to map carer services & experiences and to devise evidence-based needs & recommendations. Similar online research was conducted for national and state providers/facilitators of mutual support & self-help (e.g. the Cancer Council, Compassionate Friends). Phone contact was made with coordinators of peer mentoring programs, in order to collect more detailed information on the running of these programs (e.g., Big Brother Big Sister, Compeer).



Findings of the Literature Review

PART I Carer Needs

An aim of this first phase of the Peer Mentoring Project is to paint a picture of the MH carer experience based on academic and other published literature. This body of knowledge will lead to recommendations of peer support services to address carer needs in the community.

Why a carer focus? The Mental Health System, Changes in Structure and Policy

In the current context of, largely, community-based mental health care practices, the carer role and its accompanying political rhetoric (carer/family involvement, carer/family participation, carer/family collaboration) has become a central focus.

De-institutionalisation has changed what constitutes mental health care, its settings, delivery, and components of efficacious treatment. For example consider the writings of Minkoff (1987 as cited in Chapman 1997), regarding the moral basis for de-institutionalisation policy: Chapman argues “institutions...are bad for chronic mental patients and should be eliminated. De-institutionalisation is...good...and, if done properly, will make... [lives of patients]... better and easier. Community care and freedom of choice are better...than paternalism and restrictiveness ... and should be encouraged.” These and similar assertions underlie the current MH system. Chapman takes a different point of view, however, asserting that “such simplistic and reductionist promotion of community care as inherently good and institutional care as inherently bad, serves to deny or hide the economic and political pressures...that were the driving force behind the process of institutionalisation...” (Chapman, 1997, p. 149) Chapman’s perspective serves to contextualise pertinent issues for carers tackling difficulties inherent in the MH care structure.

Not only has community care brought a push for consumer/carers inclusion and empowerment, but it has also had detrimental effects upon the quality of care experienced (or not received) by the consumer and impacts on the carer experience of burden. This perspective is portrayed in the Mental Health Council’s report entitled “Out of Hospital. Out of mind” (Groom, Hickie & Davenport, 2003). If mental health care is based in the community and carers are imperative to this system, then potentially isolated / under-resourced carers need specialised support and community-based peer support offers a logical path forward.

Literature Demonstrating Carer Experiences and Needs

There is a growing amount of literature that portrays the difficult experiences of carers of people with mental illness. These range from anecdotal carer stories (collections of ‘lived experience’), support and information booklets and research into the needs of carers. This literature predominantly focuses upon the symptoms and impact of low prevalence disorders (psychotic disorders) and the difficulties in accessing support for someone within the acute phase of illness, also referred to as the ‘burden of care’.

“Providing love and support...valuing and honouring your loved one in a way no one else can.”

“Sometimes we feel we just need a break, for a week or two, but it is hard to find someone to be there to help look after him, who also understands his illness.”

(Carers WA- McKeague, 2003, p 11 & 12)

Caring for a friend or relative who has a mental illness can be felt as a double-edged sword: driven by love and simultaneously weighed down by it. Striving for hope and help, while being flooded by frustrations and disappointments in the face of the illness reality and less than adequate supports and services. SANE (2007) research indicated that up to 40% of carers experience mental health issues themselves as a result of caring.

“At times I feel overwhelmed by sadness for my son...”

“Generally {I experience} a feeling of never being able to be happy and carefree.”

{I'd like} “...that the carers voice would be heard before one has become hoarse from yelling for help”

(Carers WA- McKeague, 2003, p. 13, 40 & 47)

There is clear evidence that carers face ongoing difficulties beyond accessing support and care for their loved one. Carers must come to terms with a range of emotional and coping responses: shock and grief (how can this have happened?) and guilt (could I have prevented it?). It is the eroding frustration and helplessness to cure or assist that impacts the most (Alexander, 1991; Pagnini, 2005). Living with a person with a severe mental illness impacts tremendously upon the family: it can affect relationships, work and finances, one's sense of personal freedom, recreational life and the mental and physical health of the carer as a whole (Baronet, 1999).

Focussing on anxiety, depression and eating disorders, the experience of carers of people with mental illness is well surmised in this following statement. What follows is an excerpt from a paper produced by the Victorian Mental Health Carers Network, High Prevalence Disorders Project Working Group:

“The main findings established by the research were that carers and families experience significant and comprehensive impacts. The research showed that people with these disorders often become highly dependent upon carers (spouses, parents and children) and other family members, leading to a traumatised family system in which crises and tension in relationships are common. The symptoms of the disorders, and accessing treatment, often become the central point around which family life revolves. Physical and emotional exhaustion, chronic stress, depression and grief are commonly experienced by family members and carers may become inextricably involved in compulsive, avoidance and other symptom related behaviours. Social isolation and low self-esteem, economic losses, decreased life opportunities, and difficulties accessing effective treatment and support services all add to the pressures that carers and families experience. Most carers received limited information about their relative's illness, its management and services that can assist themselves or the person they support”.

(I' Anson, 2004)

The Carer Life Course Framework, Carers NSW (Pagnini, 2005), builds on such research and extends carer experiences into a theoretical framework for understanding aspects of caring over a continuum of needs, external factors and timing. This model suggests that support interventions are appropriate to carers dependent on their place in the caring journey, their life stage and relationship with the person with the mental illness. It recognises that caring is not

a linear process, rather a process that changes, is individual and has stages of variant need (see pictorial representation).

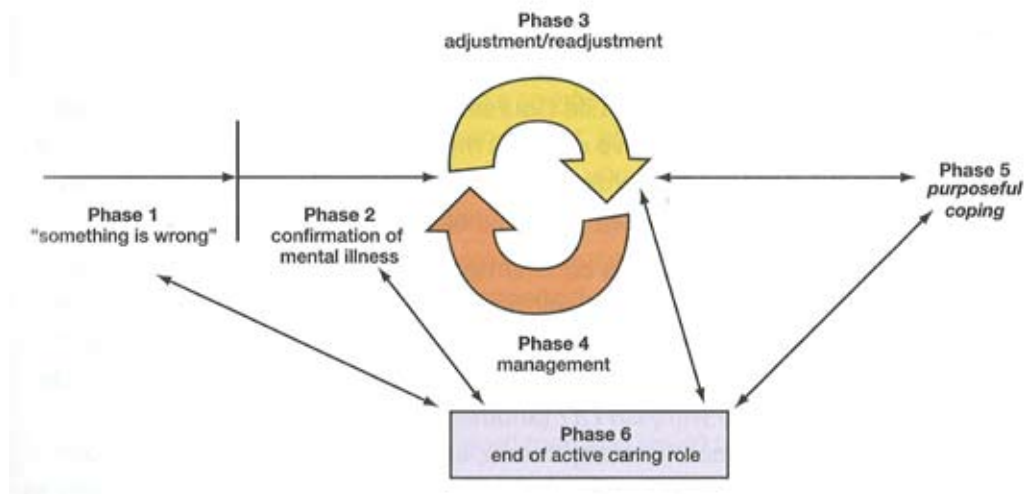


Diagram extracted from Pagnini, 2005, p. 23

The framework uses six distinct phases that many carers go through on their caring journeys. As these are experienced by many carers, they are described as 'constant across phases'. In addition, the framework allows for understanding the different needs and experiences of parents and siblings according to relationship, life course/life stage and resources available. These vary with a carer's experience. The model also explores the impact of the consumer's degree of wellness on the carer's well-being, impact of other relationships on carer well being, ongoing grief and loss, ongoing need for support, impact on financial resources, need for carer input, fear about the consumer's safety and ongoing planning. These aspects are consistent with the research and anecdotal evidence already discussed.

The benefits of mapping of the carer journey are many. For carers, it can help normalise what is often a frightening and isolating journey by providing a map of what other carers have gone through, along with links to relevant information and support services. For *policy and government* organisations, it can be used to construct an evidence-based system of carer support, identify current gaps in those supports, and assign responsibilities for ensuring that carers' needs are met. For *service providers* who work with carers and consumers, it can demystify the carer experience and enable professionals to provide the most effective interventions at the most appropriate time (Carers NSW - Pagnini, 2005).

Much of the literature on caring for people with mental illness particularly discusses the impact on families of poor service delivery, lack of family involvement or inclusion by service providers, fragmentation of services and the lack of access to carer-specific supports. For instance, the research conducted by beyondblue and the Victorian Mental Health Carers Network (2004) identified a set of needs which can be generalised to carers of both high prevalence and low prevalence mental disorders. Their research explored the impact of mental illness from the carers' perspective, over time and in relation to policy / intervention outcomes rather than 'burden of care'. The needs identified by carers were for:

- Increased community **awareness** about signs and symptoms of mental illness to facilitate detection, early intervention and support
- Increased **recognition** of the experiences and needs of carers and provision of **information and referral** for support
- Increased recognition and assistance to **overcome the impact** of living with a person with mental illness (relationships, family dynamics, reduced level of intimacy, social and emotional distancing, restricted social relationships)

- Assistance with significant **financial costs** related to caring (accessing treatment, demands of specific aspects of the illness, time from work and ability to continue employment)
- Increased access to **effective treatment** via better knowledge and awareness, availability of information, **increased awareness and skills among health professionals** and effective early intervention or crisis management
- Better inclusion of carers' needs and concerns – **voice** - and more **inclusive** approaches to treatment and management

"I am wasting my voice, I am constantly being asked what my needs are and then my needs are denied - I have been doing this since my son was early teens- he's in his twenties now."

(ARAFEMI Consultation- Sanders, 2007, p. 35)

These same or very similar themes of need have been articulated and prioritised and reiterated across a number of small scale and large scale empirical reports over the past 30 odd years (Baker, 1977; Hatfield, 1979; Winefield, 1993; St-Onge & Lavoie, 1997; Knudson & Coyle, 2002; Provencher, Perreault, St-Onge & Rousseau, 2003; Fischer, Kemmler & Meise, 2004; Lloyd & Carson, 2005; Li, Lambert & Lambert, 2007). For example, refer to the following reports by key MH bodies: SANE Australia (2007), Carers NSW (Pagnini, 2005), Victorian Mental Health Carers Network (2001), the Mental Health Council of Australia and the Carers Association of Australia (2000). The findings of these key researches into carer needs are familiar, they include:

- "Targeted **education/mental health promotion** to families and general health and community services." (Victorian Mental Health Carers Network, 2001)
- "When carers are asked about their needs, they often first focus on **services for the person** with the mental illness/mental disorder. They then immediately mention information." (Carers NSW - Pagnini, 2005)
- "Many health professionals still exclude family carers from treatment planning... Health **professionals need training and supervision** to ensure these attitudes to family carers are improved." (SANE, 2007)
- "Some carers reported that additional **financial assistance** would make their lives easier." (Carers WA- McKeague, 2003)
- "**Respect** as a carer from service provider." (Carers WA- McKeague, 2003)
- "The participants wanted structured programs that would **address their needs for information** about the mental illness/mental disorder and its treatment, how to manage symptoms, and how to relate better to the consumer, to other family members, and to health professionals. They also wanted to learn coping strategies, get support from other carers, and have the opportunity to deal with their own issues in a therapeutic environment." (Pagnini, 2005, p. 65)

Findings of the Initial ARAFEMI Consultation into Carer Experiences and Needs

The consultation carried out by ARAFEMI in 2007 was the precursor to the current project. A total of 61 carers participated in focus groups, small group consultations and telephone or in-person interviews. All who attended or gave further information identified themselves as a carer, though some carers also had professional carer support roles.

It is noted that the focus groups varied in composition, but mainly appeared to represent carers who had been engaged with services (general mental health) for some time. As the main hosts of the focus groups were existing support groups for carers, the views may also more heavily

comprise carers who have experience of support groups, some experience of ARAFEMI and also those who may have accessed advocacy training – though there were also carers who identified as not having prior knowledge of ARAFEMI and who were also attending the support group for the first time.

The information from each focus group was written up in detail then viewed as a whole document to identify themes or patterns across ideas and experiences. This analysis is presented below in cluster areas or themes. Carers were requested to work in small groups discussing what they had experienced that had been good for them as carers. There was replication of themes across groups.

A) Characteristics of good service that facilitated caring

Carers described helpful services and interactions in terms of the following attributes:

- **Being Heard:** To be taken seriously, acknowledgement of our skills as people and how those skills can help in this situation
- **Counselling and Support:** Family, couples and individual counselling, sibling support, to have my own counsellor
- **Education:** About the illness in groups with other carers and professionals, information about the effect of the illness on family dynamics, information on services / help groups / where to go for help, accessing literature, getting information about courses and services, and how to deal with the issues related to the Mental Health Act
- **Professional Attitudes and Collaboration:** Connection and trust, someone in the system giving me advice on how to manage the system
- **Service Attributes:** consistency, teamwork, kindness, going the extra step (talking to me on the phone or when I was turning up at the desk), positive experience at the start of caring
- **Support Groups**
- **Financial Support**

B) Key Issues faced along the continuum of caring

Participants in the focus groups identified four major concerns in relation to carers getting assistance:

- The first was a gap in services currently available that could support their loved one. These concerns closely followed those historical factors that led to the formation of ARAFEMI, which are also well documented in anecdotal histories focussing on 'burden of care'. Lack of in-patient support, access to mental health services, accommodation, support and social rehabilitation options
- The second concern related to poor knowledge of how to navigate the treatment system and to gain assistance when it was needed. It was noted that practitioners and professionals appeared to have great limitations of supporting and linking people outside of their own systems
- This was strongly linked to the further theme that carers did not feel acknowledged or listened to in the service system. In fact this was a theme across all groups and in other submissions, including qualitative data accompanying the survey. This lack of voice further compounded carers feeling "lost and left out" at a time of extreme vulnerability
- The final major theme was how carers' could maintain the 'burden of care' to live life beyond caring and the lack of services that support themselves and their families

- A sub-theme of this was carers concerns in how to gain specific support if they were not able to be the mediator and facilitator of treatment or support for their loved one. This was particularly pertinent to those carers that identified themselves as older carers (who will take on the burden of care?)

Call for Carer Advocacy, Involvement & Peer Support

There was also a lot of discussion around individual advocacy and broader systemic advocacy and carer needs for flexible and timely support in both of these areas. The concept that people may need someone to walk beside them at times when they were not able to both care and fight was raised often. In discussing ways that ARAFEMI could better respond at an individual level; the notion of a Carer Advocate was raised. This role was described as providing aid to carers and families to orientate them to the services available and provide encouragement to ensure that the right type of treatment is found, to support them in having their voice heard and to give specific advice in relation to rights and advocacy.

‘There are times when I want to and can go and fight the system... and there are others when I want someone with expert assistance to come and help me’.

(ARAFEMI Consultation- Sanders, 2007, p. 34)

The findings of the ARAFEMI consultation coincide with the broader body of research on carer needs discussed earlier, and lead us into the importance of peer support for carers of people with mental illness.



Findings of the Literature Review PART II Service Responses

This second part of the literature review argues the importance of peer support for MH carers. It examines the effectiveness of existing carer interventions / service models and potential peer support models for the future.

The Case for Carer Peer Support

“Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful...It is about understanding another’s situation empathetically through the shared experience of emotional and psychological pain.”

(Mead, 2003)

Consideration was given to empirical literature regarding support needs and services to:

- parents or caregivers of young children and teenagers
- carers of aged persons
- carers of people with intellectual disabilities
- carers of people with physical illness
- carers of people with mental illness

Empirical evidence demonstrates peer support assists carers to manage well and persevere in their caring role. For example, Smith, Tobin and Sheldon (1993) surveyed 235 carer-parents. They found development of peer support groups among the five essential service initiatives for older parents who care for a developmentally disabled adult-child. Zimmer (1982) found carers of elderly persons sought information, skills training and mutual support from community-based carer groups. Borden (1991) explored the experiences of 51 care-giving spouses of older adults with chronic Dementia and results showed coping strategies and peer support predicted carer well-being. Furthermore, in 2005 Kurz, Hallauer, Jansen and Diehl reviewed literature about carers of people with Dementia. They concluded that peer-led self-help groups have the potential to improve the carer’s emotional support, increase social contact, strengthen control over one’s life and thus facilitate care-giving, lessening psychological burden. Kurz et al. (2005) also found professional assistance for carers, and not peer support group attendance, reduced hospital admissions for the person with Dementia. Perhaps the carer who attends a support group gains information, education and better access to MH services and professionals; which may then indirectly lead to a better recovery for the consumer.

In respect to research and carers of people with mental illness, O’Grady (2004) found self-help groups may promote coping with stigma among families caring for a relative with mental illness. According to a study by Knudson and Coyle (2003) there is a lack of support from social networks for carers of people with schizophrenia. Both informational and emotional support are available through self-help groups. Ferriter and Huband (2003) found self-help groups,

family and police are more helpful than professionals in the mental health field. Based on the experiences of 124 carers of persons with mental illness, Provencher, Perreault, St-Onge, and Rousseau (2003) concluded that diverse networks, including other carers and those who are not carers, are of maximum benefit. Also the quality and not quantity of exchanges are of most importance to carers.

Literature Pertaining to Service Responses to Carer Needs: Review of Peer Support and Mentoring Frameworks

Let us begin by examining carer supports in general before specifying peer support frameworks. A large scale evaluation of carer interventions is that conducted by Carers NSW. The Carers NSW Carers Mental Health Project was initiated in 2001 and completed in 2005. Part of this project was dedicated to evaluating over the long-term a range of group, face-to-face, telephone-based and internet-based support and training programs in place at the time of the project for carers of people with mental illness. The programs assessed are summarised in table 1 and 2 (excerpts taken from Pagnini, 2006, p. 34-35). The range and type, particularly of face-to-face programs, in NSW is representative of those provided in Victoria.

Table 1. Carer Support Programs examined by Carers NSW.

Needs Addressed	Program	Structure
Beginning level knowledge, coping strategies, informal support (adults)	Ken Alexander's <i>Teaching Relatives The 14 Principles of Coping (14P)</i>	2 day workshop 10-25 participants
Age-appropriate education about mental illness and life skills to enhance coping (children)	Erica Pitman's <i>SMILES (Simplifying Mental Illness + Life Enhancement Skills)</i>	3 day workshop 8-10 children (8-12 yr olds or 13-16 yr olds)
Assistance in working through own healing process/counselling	Julie Tallard Johnson's <i>8-Stage Healing Process (8 Stages)</i>	10 week course one 2 hour session/week 8-10 participants
Assistance in dealing with underlying grief and loss issues	<i>Seasons for Growth</i> - adult course adapted to carers of people with a mental illness/disorder	4-5 week course one 2 hour session/week 4-6 participants per companion
Skills in self and systemic advocacy	<i>Carer Advocacy Course</i> - run by the NSW Institute of Psychiatry	3 day course 8-25 participants

Table 1 (cont.) Carer Support Programs examined by Carers NSW.

Needs Addressed	Medium	Program	Structure
Emotional impact of caring and strategies for managing everyday life; reduce social isolation	Telephone Internet	<i>Talk-Link</i> <i>NetConnect</i>	6 carers, 2 facilitators one hour/week 8 weeks group members decide topics
Using the Internet to address needs for information and support, reducing emotional and geographic isolation	Internet	<i>Connecting Carers Online</i>	10 week training program 12 participants, not necessarily online at the same time

According to the findings of Carers NSW, all the programs met objectives in the short and long-term. The respondents were able to apply what they learned in the courses to their own lives, and they reported positive impacts on their wellbeing and relationships. They reported increased levels of knowledge, skills, confidence and abilities directly related to the aims/goals of each program. Of particular relevance to the current peer mentoring project is that one key overlap in what the respondents took away, from whichever course they attended, was that they had benefited from meeting with other carers. The connections made during the program were continued beyond the end of the program: peer networking is a valuable resource for carers of people with mental illness. Even the children's program (for children of families caring for someone with a mental illness) served primarily as a chance to meet other children in similar circumstances. Interesting to note here is the finding of Tse, Doughty and Bristol (2004)- that "informal tea, coffee and biscuits time" was the most commonly used activity to promote social interaction and emotional support among support group members.

Peer Support Models

Peer support can be looked at in terms of informal peer networks or more formalised peer support groups: this review focuses upon the latter. This section of the report is an overview of peer support models tested empirically with carers of people with health issues, parents and families.

It is useful to get a broad sense of the functions of peer support groups for individuals. A paper by Munn-Giddings and McVicar (2007) presents findings from a doctoral study with two self-help/mutual aid groups for carers in England. Interviews with 15 active members explored reasons for joining, benefits derived from membership, and perceived differences between support gained by membership and their relationship with professionals (excerpt over leaf).

"Most group members had prior experience of voluntary work/activity, which influenced their decision to join, often prompted by a failure of the 'usual' support network of family/friends to cope or adjust to the carer's needs. Members reported personal gains of empathy, emotional information, experiential knowledge and practical information, based on a core value of reciprocity through peer support. It is this latter benefit that sets apart membership of self-help groups from groups supported by professionals who may not appreciate the scope and breadth of carers' responsibilities, or of the importance of their relationship with the person for whom they care. In this way, self-help groups offered additional, but not alternative, 'space' that enabled members to transcend their traditional role as a 'carer'.

It is concluded that self-help/mutual aid groups, based on reciprocal peer support, offer a valuable type of resource in the community that is not replicable in professional-client relations.” (p. 26)

Peer Support and Empirical Findings

Research into peer support groups has been undertaken with a range of caring groups, including parents, grandparents and mothers in prison; carers of people with physical, psychiatric and intellectual disabilities; and carers of aged persons. Note that it is beyond the scope of this project to examine the value of peer support in the recovery of people who themselves are living with mental illness. A detailed overview of empirical findings and corresponding publications are represented in table form in the section entitled “Tabulating the Literature Review Part II: Review of Peer Support Models”. The overall findings are summarised here.

Results illustrate multiple benefits of peer support programs for carers and parent/grandparent care-givers. They include more knowledge about the illness, more confidence, reduced caregiver burden, better management of difficult feelings, better family relationships, increased contact with family/friends and better physical health in the long-term.

An important finding of research is that benefits stretch beyond the carer to include benefits for the consumer. For example, Heller and Cadwell (2006) carried out a study with aging carers of people with developmental disabilities. The program included five small group workshops and a legal/financial training session. In addition to program benefits for the carer, Heller and Cadwell found an increase in daily choices of the individual with a disability.

Empirical research represents an even spread of effective programs co-led by professionals or solely peer-led. Generally this component makes little difference to the impact of the program on participants.

Findings demonstrate effective models include two key aspects of peer support, i.e., learning and support:

- 1) **LEARNING AND INFORMATION SHARING:** Can encompass informal networking / resourcing or a structured education program / information session
- 2) **SUPPORT AND SHARING EXPERIENCES:** Can encompass informal sharing of stories or a structured psycho-education program about ways of coping / facilitated problem solving

The evidence suggests that peer support without an explicit education-focus can work well for carers, probably because informal learning between members can still take place. For example Winter and Glitin’s (2007) telephone support group model for carers of people with Alzheimer’s, or Henrikson and Andershed’s (2007) support group program for informal palliative carers. However, psycho-education without a focus on peer support may be less effective, suggested by Chien, Chan and Thompson (2006). They found families who cared for a relative with mental illness attending a support group showed greater improvement in family functioning and less carer burden than participants who attended family group workshops regarding coping strategies.

Adding a **3rd** component to learning and support, “services” (i.e., home-visiting or counselling) creates another level of care to a peer support program. However, whether there are additional benefits is unclear according to this literature review. Mittelman, Roth, Clay and Heley (2007) developed a program for spouse-carers of people with Alzheimer’s disease. It included 6 sessions of individual/family counselling, a support group and long-term ad-hoc telephone support. Mittelman et al., (2007) found spouses who attended the (learning-support-services) program reported better health 2 years later. A service-component was also added to Mohide, Pringle, Streiner, Gilbert et al., 1990.

Conclusions and Recommendations in respect to Peer Support Models

A carer peer support program needs to have built into its structure and philosophy the dual purpose of learning and support in order to be effective.

Peer support programs can have multiple benefits for carers in terms of their own well being and facilitating their role as care givers. As opposed to social support, peer support is based on a notion of mutual sharing. Sharing experiential knowledge and stories; sharing information and pooling resources; connection, sharing identity and networking.

It is recommended that a carer peer support program incorporate an education element and an element of emotional / practical support. For example:

Education / Learning features: peer support group with accompanying lecture series, a course, regular presentations or facilitated exchange of resources / information / strategies.

Emotional / Practical Support features: as well as facilitating communication/meetings between peers to create a setting (group rules, mission, training for peer support workers), based on values such as trust, belonging, safety, rest, encouragement, affirmation, listening and expressiveness.

Mentoring Models

Mentoring with carers is relatively under-researched. Mentoring is a relevant pathway for future carer services. In line with the previous recommendation, mentoring models foster both learning and support. This part of the review is an overview of mentoring models tested empirically. This cannot be a comprehensive review of the literature pertaining to mentoring models as that literature covers a vast range of work, particularly in the areas of business and professional development. Instead, this review outlines the core areas of mentoring with young people, carers, parents and professional caregivers, students and employees. Young people included in mentoring research are considered to be most at risk of social exclusion, tackling issues such as disability, mental health problems, drug misuse and limited participation in education / employment / community life. These issues are also relevant to the experience of carers. Mentoring with professionals or business employees focuses on less relevant issues, such as motivation and vocational competencies. A more detailed overview of publications in this area is represented in section entitled “Tabulating the Literature Review Part II: Review of Mentoring Models”. The overall findings are summarised here.

A case for Mentoring

Mentoring is a holistic approach with benefits for the individual mentee, the mentor, the organisation and the community (Department of Planning & Community Development, 2007, p. 17-18). For example, the young person (or carer-mentee) can benefit in terms of emotional and social development or wellbeing, academic/work performance and reduction in high risk behaviour (drug misuse, criminal activities, aggressive behaviour). The mentor can benefit in terms of satisfaction from making a positive contribution to the lives of others, generating meaning about their own life experiences and building new skills and networks. For the organisation, mentoring encompasses positive client (carer mentee/mentor) involvement and input that is empowering to the client. For communities, mentoring makes for increased collaborative partnerships, community-based activity and a sense of connectedness.

Developing a Mentoring Program: Evidence-based Practice with Young People

Here we will examine two documents that outline evidence-based mentoring practice based on programs with young people. These guidelines coincide nicely with the findings of this literature review, which examined mentoring across broader groups (e.g., carers, parents, adults). This discussion will assist in developing recommendations for the prospective peer mentoring program for carers.

The Victorian state Department of Planning and Community Development, through the Office of Youth, assembled a guide to supporting good practice for mentoring young people. This guide presents benchmarks based on national and international research and programs. The characteristics of effective mentoring identified were:

- 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)

The second guide was commissioned by The University of Glasgow (UK). It is a thorough review of academic papers on mentoring and young people published between 1995 and 2003 in America and the United Kingdom (Hall, 2003). The key questions were: *What works to make a youth mentoring program and what doesn't work effectively?* The conclusions are represented in the table below.

What works?	What doesn't work?
<p>The US literature has identified a number of key features which help to make mentoring schemes successful. These include:</p> <ul style="list-style-type: none"> • monitoring of program implementation • screening of prospective mentors • matching of mentors and youth on relevant criteria • structured activities for mentors and youth <p>The UK literature reminds us that:</p> <ul style="list-style-type: none"> • mentoring needs to be properly integrated into its organisational context and establish links with other services and opportunities <p>There are mixed views on whether mentors should be matched with mentees and, if so, on what basis the matching should be made</p>	<p>Mentoring is in danger of being unsuccessful if any of the following conditions apply:</p> <ul style="list-style-type: none"> • social distance and mismatch between the values of the mentor and mentee • inexpert or untrained mentors • mismatch between the aims of the mentoring scheme and the needs of the person being mentored • conflict of roles such that it is unclear whether the mentor is to act on the behalf of the person being mentored or of 'authority'

(Adapted from Hall, 2003, pp 20 & 24)

Mentoring and Empirical Findings

There is a strong parallel between these youth mentoring practice guidelines and findings regarding mentoring with broader groups (caregivers, parents, youth students and professionals). According to the present extensive literature review the components of effective mentor programs with various target groups include:

- The agency having structures and procedures to support the mentor program, e.g., agency support for the coordinator; regular monitoring / reinforcing agency guidelines by coordinator for mentor (being a role model for the mentor by demonstrating consistency, reliability, interest, engagement, availability and responsiveness)
- Mentor and mentee are matched on the basis of shared experience, e.g., caregiver status; gender and relationship to care recipient; language, culture and ethnicity; or characteristics of the person cared for
- The mentor is selected for the program and paired with a mentee based upon having more experience than the mentee
- There are various group formats that can be used: where there are multiple mentors (e.g., business models), multiple mentees (e.g., education) or where a group of mentor-mentee dyads meet regularly (e.g., school context)
- The act of mentoring can be that of supporter, consultant, trainer, a reflective process, observing and giving feedback, buddy and tutor, listener
- Meetings between mentor and mentee can be face-to-face, telephone-based, in-home, involve structured activities, tailored to individual needs, mentee following mentor doing normal day-to-day activities
- The program includes a resource library, website of mentor/mentee participants. A dedicated meeting place provided by the agency where they can feel safe, welcome and understood

Conclusions and Recommendations in respect to Mentoring Models

Mentoring programs for carers of people with psychiatric or physical disabilities can have benefits at multiple levels, for the individual, the organisation and local community. It enhances the mentor's existing skills and knowledge, and encourages learning of new skills / knowledge for the mentee. The limited amount of empirical evidence available for mentoring with mental health carers suggests this type of program will be of great assistance: reducing stress, offering support from people with similar experiences and increasing carer satisfaction with support services. Given the vast amount of mentoring research demonstrates success with young people and professional groups, taken along side the mounting evidence demonstrating a need / request for peer support among carers, a peer mentoring program with mental health carers is relevant and will be helpful.

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.

Such a program would include the following components:

- monitoring of program implementation and during the running of the program (keeping in touch with mentors and mentees)
- screening of prospective mentors (expectations, place in one's caring journey)
- matching of mentor-mentee pairs (gender, residential area, relationship to person with the mental illness and type of illness)
- mentor training (initially and ongoing) in mental health issues and peer support training
- offering peer support for carer mentors (mentor peer support group, for debriefing, for training refresher/updates)



Service Mapping and Comparison of Peer Support and Mentoring Models

The second task of this report is to present a service map of peer support programs across Victoria, relevant mentoring programs nationally and to identify service needs to make recommendations.

Snapshot of Existing Peer Support Programs and Frameworks in Victoria

There is an absence of documented service mapping for the MH sector carer-specific services in Victoria, especially the mapping of state peer support models and mentor programs. The only relevant report is that commissioned by Carelinks North (2008) which investigated mental health respite services for the Northern Metropolitan Region of Melbourne. Consultation with service providers and carer support groups in the Northern region resulted in this recommendation for:

“Direct Carer Support

The mental health respite program should also have the capacity to directly respond to carer needs. This can be achieved through the provision of resources to the carer in order for them to continue in their caring role. The guiding principles underpinning this approach are flexibility and responsiveness....Carer education and conferences to enhance an understanding of mental illness and the mental health system, enhance carer coping capacity and knowledge of self care...”

(Carerlinks North, 2008, p. 9)

The discussion here gives an overview of the section entitled “Service Map of Peer Support Programs”. It is important to note from the outset that this map of services is not exhaustive. It is a broad sweep of the major structured peer support models (e.g., with peer support worker training) utilised in the state of Victoria - focussing on carers of people with mental/physical conditions. Peer supports for consumers have not been reviewed and standard self help group models have been excluded. There are a plethora of those standard peer support groups for carers of people with mental illness in Victoria (e.g., see the Victorian Mental Health Carers Network support group Directory at: <http://www.carersnetwork.org.au/csg.shtml>).

All of the existing Victorian peer support programs covered in this report have as their focus both learning and support. Many of the peer led programs have established selection processes and provide training for the peer support workers in issues related to the illness, service / treatment issues and topics related to carrying out a support role. The MS Society and Family Drug Help programs are particularly comprehensive in this regard. Cancerconnect / Family Cancerconnect is unique in that its telephone-based program involves matching processes.

ARAFEMI Victoria already has extensive training packages for carers in advocacy and peer support. Its family education programs provide very appropriate avenues for further training and networking between peer support workers. And it is clear from the consultation that flexible one-on-one support is an area of need and service growth.

Recommendations in respect to Mapping Peer Support Programs

Based on this service map, it is recommended that a carer peer support program include structured peer worker selection processes and sufficient peer support worker training. An area for possible Victorian service growth is one-on-one peer support.

Map of Relevant Mentorship Programs and Frameworks Australia-Wide

The discussion here gives an overview of the section entitled “Service Map of Mentoring Programs”. This service map is a broad sweep of the major mentor models utilised nationally. However, the carer mentor programs shown here are, most probably, the only models implemented in Australia with carers of people with mental illness. It is important to note from the outset that this map of mentoring programs is not exhaustive. Mentoring is a fast growing phenomenon, particularly in youth services. An extensive directory is available online at Youth Mentoring Network: <http://www.youthmentoring.org.au/programs.php>

Conclusions and Recommendations in respect to Mapping Mentoring Programs

There is a strong case for mentoring, particularly in the Youth, education and business sector. Consequently, most of the mentoring programs mapped here adhere to the practice guidelines (e.g., formalised selection, matching, training) discussed in the literature review.

Three important points need to be made in relation to mental health carer support. First, there is a need for more peer mentoring programs in Australia and at a state level for carers of people with mental illness. Second, the most relevant models are Carerconnect (Carers Queensland) and the Young Carers Peer Mentoring Project (Carers Victoria). Both seem to have inherent in the design the established mentoring benchmarks. Third, the most useful contribution came from the model adopted by Uniting Care, Parents Mentoring Project, whereby coordinating staff are consumers and parents themselves, and a peer mentor support group is held monthly.

It is recommended that a carer peer mentoring program is based on national benchmarks guiding 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 – e.g., staff have lived experience as a mental health carer themselves and mentors have access to peer support in their mentoring role.

A Theoretical Proposal

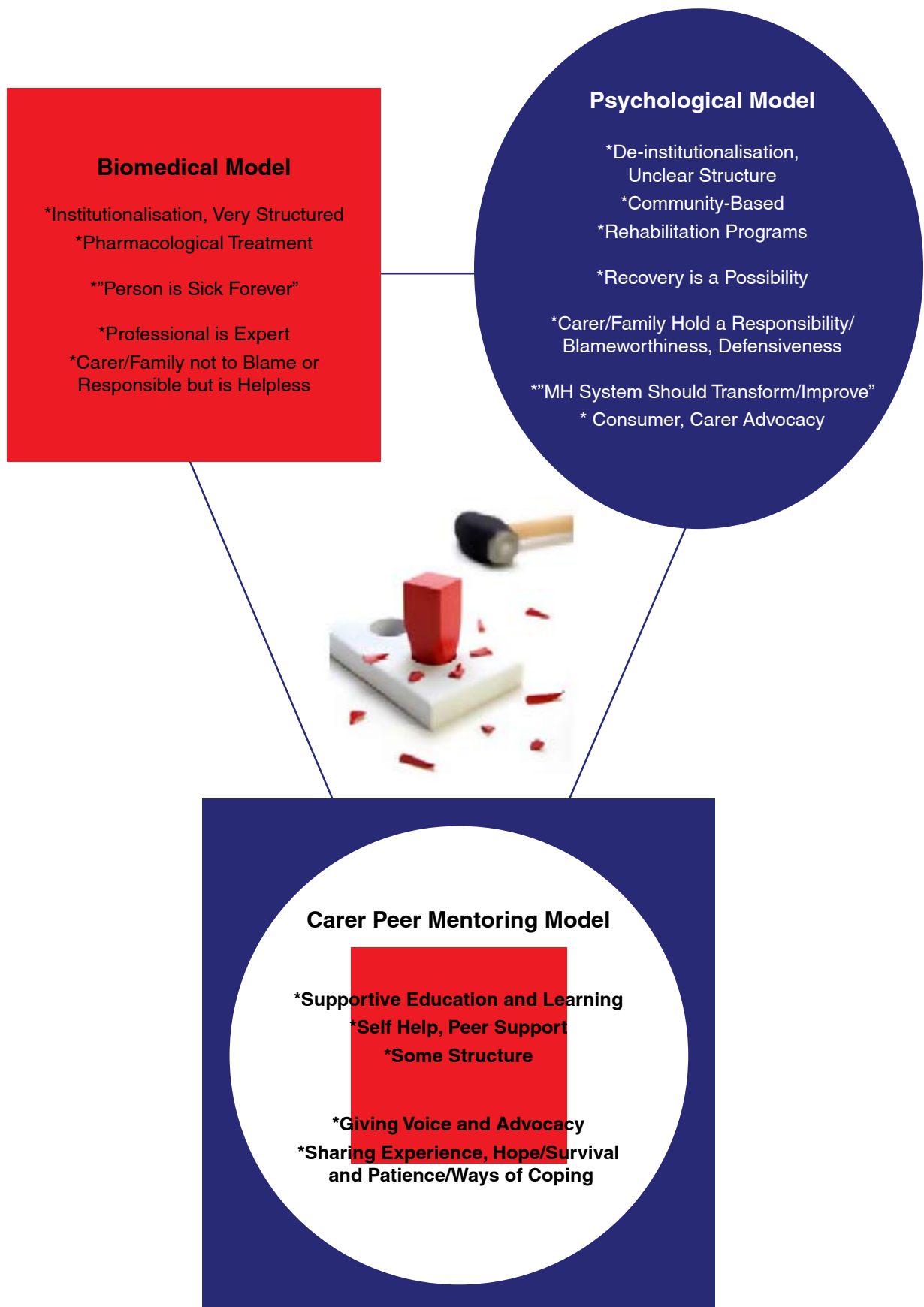
In the course of bringing together the literature and service mapping, a theoretical framework began to emerge. This section puts forward a theory for structuring MH services to include carers- carers who occupy a productive position and a supported role.


With reference to the figure on page 32, this diagram is not a representation of mental health history: it is a new perspective or window on the current ‘dual’ reality of mental health care. The mental health system can be seen as two paradigms existing together. Both are essential to service provision, but the two have inherent conflicts: 1) the Biomedical Model of mental illness and its coinciding treatment and 2) the Psychological Model of mental illness and its coinciding support services. Such theoretical issues are imperative to designing effective mental health services and support. This is because people with mental illness and their carers mostly encounter both paradigms daily on the road to recovery. Professionals also work at this interface.

The purpose of this diagram is not to extensively critique the proposed theory, no doubt there are many valid questions and modifications. However, the purposes of this theoretical framework are:

- to place in the mind of the reader a picture, a snippet, of what it is like to live with mental illness as a carer encountering contradictory beliefs daily in the care of a loved one. Confusions and contradictions regarding key questions: e.g., why is my relative/friend unwell? Is it my fault? what is my role as a carer? and what should I do to help my friend/relative? As a carer or as a MH professional the lived experience of MH care can feel as though one is forcing a square peg into a round hole constantly.
- A second purpose of this proposed model is to argue that carer peer mentoring provides a way of bringing together, in a positive way, the Medical and Psychological Model; by shifting the basis of carer services more toward a paradigm of supportive learning and education.

Empowerment and support through education is not a new idea: advocacy bodies in MH (e.g., ARAFEMI) have education and support as their core business. Moreover, mentoring was founded on the business and learning sectors. However, looking at mental health care explicitly in this way functions to highlight clearly the strengths of a mentoring approach for carer support.





Recommendations and Ways Forward into Phase II of the Peer Mentoring Project

Recommendation (A)

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

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 2) the 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 major finding of this project was that a third service component, 3) Carer Peer Mentoring Model, can provide support, education, learning and empowerment - filling important gaps in traditional mental health services. Such theoretical issues are imperative to designing effective MH services and carer support.

Recommendation (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.

It is recommended that a carer peer support program incorporate an education element and an element of emotional / practical support. For example: *Education / Learning features:* peer support group with accompanying lecture series, a course, regular presentations or facilitated exchange of resources / information / strategies. *Emotional / Practical Support features:* as well as facilitating communication/meetings between peers, to create a setting (group rules, mission, training for peer support workers) based on values such as trust, belonging, safety, rest, encouragement, affirmation, listening and expressiveness.

Recommendation (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.

Such a program would include the following components:

- monitoring of program implementation and during the running of the program (keeping in touch with mentors and mentees)
- screening of prospective mentors (expectations, place in caring journey)
- matching of mentor-mentee pairs (gender, residential area, relationship to person with the mental illness & type of illness)
- mentor training (initially and ongoing) in mental health issues and peer support training

- offering peer support for carer mentors (mentor peer support group, for debriefing, for training refresher/updates)

Recommendation (D)

An area for possible Victorian service growth is one-on-one peer support. Based on this service map, it is recommended that a carer peer support program includes structured peer worker selection processes and sufficient peer support worker training.

All of the existing peer support programs covered in the current service map focus on the two key areas of learning and support. Many of the peer led programs have established selection processes. Cancerconnect / Family Cancerconnect is unique in that its telephone-based program involves matching processes (for pairing people with appropriate peer support workers).

ARAFEMI Victoria already has extensive training packages for carers in advocacy and peer support. Its family education programs provide very appropriate avenues for further training and networking between peer support workers. Furthermore, flexible one-on-one support is an area of need and service growth.

Recommendation (E)

It is recommended that a carer peer mentoring program is based on national benchmarks regarding effective development of mentoring programs to coincide with existing programs in Victoria. Further, that peer support/mutuality is built into the program framework – e.g., staff have lived experience as a mental health carer themselves and that mentors have access to peer support in their mentoring role.



Tabulating the Literature Review:
Peer Support & Mentoring Research

Findings in Respect to Peer Support

Tabulating the Literature Review Part II Review of Peer Support Models

(see reference list for more specific details for each of the articles)

Carers of People with Mental Illness		
Program Description	Findings	Publications
<p>Family-to-Family Education Program is a 12-week course for family members of adults with serious mental illness.</p>	<ul style="list-style-type: none"> * Reduced subjective burden and increased empowerment without changes in objective burden * Knowledge about mental illness and understanding the mental health system and self-care also improved * There was no significant decay at 6-month follow-up 	<p>Dixon, Lucksted, Stewart, Burland, Brown, Postrado, McGuire & Hoffman, 2004</p>
<p>Mutual support group - principles include:</p> <ul style="list-style-type: none"> * trust to disclose information * discuss taboos * recognise common plights * mutual support * individual problem solving (practice and discuss) * Consider Chinese culture <p>Provided over 6-months</p>	<p>At 18-month follow-up:</p> <ul style="list-style-type: none"> * greater improvement in patient and family functioning and less caregiver burden * support group worked best compared to standard care and psycho-education regarding caring/coping via family group workshops 	<p>Chien, Chan & Thompson, 2006</p>
<p>Peer support program for young carers with a structured activity program – The Lulus Model</p> <p>Eight Sessions:</p> <ol style="list-style-type: none"> 1. 'Getting to know you' –group name, rights, responsibilities 2. Sharing games and activities they enjoy. To talk about things they would like to do as a group 3. See DVD about young carers and start to discuss their own experiences 4. Creating a group mural about dealing with stress 5. Watching movie about caring (What's eating Gilbert Grape) 6. Rewarding yourself when you get through a tough day- discuss how 7. Discuss feelings they experience and situations that evoke them 8. Conclusion and celebration 	<ul style="list-style-type: none"> * participants enjoyed positive respite with other young carers and the celebration afterwards * being able to talk about feelings often for the first time * being understood * talking with other carers * managing life in a more positive way * better communication with family members * not feeling alone * increased confidence * not being as scared and anxious 	<p>Carers Victoria, 2008</p>

Carers of Aged Persons		
Program Description	Findings	Publications
A comparison of peer led and professionally led support groups for caregivers of frail older persons living in the community	<p>Demonstrates that both types of groups are effective.</p> <ul style="list-style-type: none"> * opportunity to ventilate pent-up feelings and emotions * validation of caregiving experiences * affirmation of coping abilities * encouragement for continuing to provide care and cope with the situation * exploration of alternative caregiving arrangements * mutual support & sharing of information about community resources & coping strategies appeared most helpful of both types of groups 	Toseland, Rossiter, Peak & Hill, 1990
African-American daughters caring for aging parents who attended support groups	<ul style="list-style-type: none"> * women who attended support groups had increased family involvement, were religious and coped better with caregiving 	Jones-Cannon & Davis, 2005

Carers of People with Dementia or Alzheimer's Disease		
Program Description	Findings	Publications
Support groups for caregivers of family members with dementia	<ul style="list-style-type: none"> * attenders engaged in more help-seeking * well-being was the same whether attended or not * Carers unable to attend due to logistic barriers had more caregiving hassles and lower positive affect than those who chose not to attend these groups 	Gage & Kinney, 1997
6-month Peer Telephone Support Network & Lecture Series for Carers of people with Alzheimer's	<ul style="list-style-type: none"> * increased contact with family & friends * provided information & emotional support 	Goodman, 1990
Combined education about dementia & caregiving, assistance with problem solving, regularly scheduled in-home respite, & a self-help family caregiver support group	<ul style="list-style-type: none"> * improved quality of life, found the caregiver role less problematic and had greater satisfaction with nursing care 	Mohide, Pringle, Streiner, Gilbert et al., 1990
Telephone support groups for English-speaking & Spanish-speaking caregivers of persons with dementia	Participants found the group valuable, largely because of the social & emotional support & useful information obtained from other members	Bank, Arguelles, Rubert, Eisdorfer & Czaja, 2006
6 sessions of individual & family counselling, support group and continuous availability of ad-hoc telephone counselling for caregiving spouses of people with Alzheimer's	Significantly better self-rated health which was maintained for 2 years after	Mittelman, Roth, Clay & Haley, 2007
Telephone support groups, 5 carers of people with Alzheimer's per group, had weekly 1-hour sessions conducted by a trained social worker	In contrast with carers who didn't participate in a telephone support group, older carers reported reduced depression at 6 months follow-up	Winter & Gitlin, 2007

Carers of People with Physical Conditions		
Program Description	Findings	Publications
Multi-professional informal teaching is combined with peer support for carers of home-based <u>palliative care</u> patients	Valuable outcomes for carers include: <ul style="list-style-type: none"> * Identifying with other carers of home-based palliative care patients * validating feelings * asking questions of professionals * providing each other with support and encouragement 	Harding, Leam, Pearce, Taylor, Higginson, & Irene, 2002
Support group program during the late <u>palliative care</u> phase of their family member	Relative's experience in the group: <ul style="list-style-type: none"> * confirmation * insight into the gravity of the illness * sense of belonging created by similar experiences * participation in the care system * being able to rest * strength to provide support for the patient * sense of safety in relation to the patient, the illness, the nursing staff and the care unit 	Henriksson & Andershed 2007
Online psychotherapeutic support group intervention for family caregivers of persons with <u>neurodegenerative diseases</u> . Website including: <ul style="list-style-type: none"> * video conferencing in two formats one-on-one and a group format with up to 6 participants and a facilitator Following ten professionally-facilitated sessions, each group evolved into a web-based self-help support group facilitated online by a group member	Positive participant responses in each of the following areas: <p>learning to use computers, negotiating the web site links, obtaining disease-specific information from the website, using technology to communicate, bonding with group members, providing mutual guidance and support, and benefiting in terms of coping with the stresses of caregiving</p>	Marziali, Damianakis & Donahue, 2006

Carers of People with Physical Conditions (cont.)		
Program Description	Findings	Publications
Comparison of group support program & home visiting program for family caregivers of stroke patients	<ul style="list-style-type: none"> * The group program participants showed more benefit especially with respect to informational and emotional components * Home visit participants missed peer contact * Caregivers' preference for type of intervention revealed that both types of intervention had its supporters. * Follow-up contacts were missed in both interventions * Those that preferred the group program could be clearly characterised: they were burdened, lived with a more psychologically handicapped relative 	Schure, van den Heuvel, Stewart, Sanderman, de Witte & Meyboom-de Jong, 2007
In-home adjunctive and supportive services to persons with traumatic <u>brain injury</u> and their families via a web site	The on-line support group was the most used and valued module. Helped meet their needs for social support, information, and guidance following the return home of persons with traumatic brain injury	Rotondi, Sinkule & Spring, 2005

Carers of People with Intellectual Disabilities		
Program Description	Findings	Publications
Peer support intervention for aging caregivers of adults with developmental disabilities <ul style="list-style-type: none"> * a legal/financial training session * five additional small-group workshops 	<ul style="list-style-type: none"> * Contributed to families completing a letter of intent, taking action on residential planning and developing a special needs trust * Caregiving burden significantly decreased * Daily choice-making of individuals with disabilities increased 	Heller & Cadwell, 2006

Parents and Grandparents		
Program Description	Findings	Publications
Parents peer support group with parent and professional co-leaders	<p>Benefits:</p> <ul style="list-style-type: none"> * connection with peers, resources * Build confidence * Learning about child development, parenting and coping * Empowerment and influencing peers and community 	Gay, 2005
Peer support group for <u>mothers</u> in a correctional facility, co-facilitated by mother and professional	<ul style="list-style-type: none"> * Showed strengths of the peer support model * mother worked on her own emotional issues and this improved her ability to parent, kept the child's needs in the forefront 	Boudin, 1998
"Graniators" support group for Aboriginal <u>Grandmothers</u>	<ul style="list-style-type: none"> * initially worked to support each other * the group extended to address social issues, around youth and children * the "Graniators" partnered with other organisations in the community (police, the municipal council, the state government's department of housing, the local primary school and a special youth service group) * a positive formula for driving change at a grass roots level 	Sullivan, Blignault, Duncan, Pulver, 2007

Findings in Respect to Mentoring

Tabulating the Literature Review Part II Review of Mentor Models

(see reference list for more specific details for each of the articles)

Carers		
Program Description	Findings	Publications
Peer mentoring intervention for carers of <u>aged persons</u> having just admitted a loved one to a long-term care	At 3-month follow-up carers had decreased stress in both groups & depression levels remained unchanged	Lichtenberg, 2007
<p>Dyadic peer support for <u>parents of technology-assisted children with chronic lung disease</u></p> <ul style="list-style-type: none"> * matching parents with similar caregiving responsibilities 	<ul style="list-style-type: none"> * parents favoured peer support * it offers opportunity for mutual sharing, understanding the unique realities * sharing daily experiences reduces isolation, increase knowledge & sense of feelings * Challenges of peer support included scheduling difficulties & personality incompatibility 	Nicholas & Keilty, 2007
<p>“Families Helping Families” program at ORYGEN Youth Health trains family peer-support workers, who are employed to provide information and support to families new to the service</p> <ul style="list-style-type: none"> * Family carers of people with mental illness receive from the peer support worker: shared experience, hope, how to navigate MH system, details about information sessions, they are encouraged to document difficulties and to follow-up concerns with professionals <p>Training for peer support workers includes:</p> <ul style="list-style-type: none"> * Using lived experience * Interpreters * emotional distance management * managing illness behaviour * mental health services * boundaries/roles <ul style="list-style-type: none"> * Peer workers use telephone and meetings face to face * families are welcomed in the resource library <p>No evaluative results are available, but the program continues and seems to be working for the organisation. When I phoned reception the person was more than willing to recommend the 2 current peer support workers</p>		Leggatt, 2007

Carers (cont.)		
Program Description	Findings	Publications
<p>Dyadic Peer support for <u>carers of people with Alzheimer's</u></p> <p>Matched on similar age, marital status, gender, education, appraisal of caregiver experience, personality, self-esteem and depression</p>	<ul style="list-style-type: none"> * such extensive matching criteria are unnecessary. Only shared experience, caregiver status, was important: sharing stressful, rewarding experience 	<p>Sabir, Pillemer, Suito & Patterson, 2003</p>
<p>Peer mentoring for carers of people with Alzheimer's disease, 8 weekly sessions for 2 hours (so it wasn't too long for volunteers)</p> <ul style="list-style-type: none"> * Pairs matched on gender and relationship to care recipient * Volunteer visitors were provided with intensive training in understanding their own carer experience, providing social support (communication, active listening, engaged in role playing to learn these skills) and received a toolkit of exercises/activities to do with the caregiver – activities to discuss their situations, to obtain better support from peer network in the program * Program coordinator calls volunteers weekly 	<ul style="list-style-type: none"> * No differences were apparent in self esteem or depression between carers who participated and those who didn't * But carers in the program were highly satisfied with the program, especially the element of common experience between their situation and that of the mentor * It was concluded that social support alone is not enough support for carers 	<p>Pillemer & Suito, 2002</p>

Parents		
Program Description	Findings	Publications
<p>Peer-support intervention for mothers of very preterm infants</p> <p>* pairs matched on language, culture, ethnicity, and characteristics of their infant to a volunteer, trained support giver with experience of preterm birth</p>	<p>* mentored mothers feel more confident in their parenting, understand the medical condition of their infants and experience greater quality of their listening support than mothers without mentoring</p>	<p>Preyde, 2007</p>
<p>Obesity prevention intervention for American Indian families called “Healthy Children, Strong Families” (home-based and tailored to individual family needs)</p> <p>Involved academic researchers, tribal wellness staff and “American Indian community mentors”- older peers, experienced older parents teaching life skills to next generation parents / children</p> <p>Mentors trained in child development, nutrition and physical activity, lessons/topics presented to families by staff and mentors in collaboration</p>	<p>* successfully received by families and what didn’t work well was subsequently adapted</p>	<p>LaRowe, Wubben, Cronin, Vannatter, Adams, 2007</p>

Professional Carers		
Program Description	Findings	Publications
<p>Note: not a program</p> <p><u>Employees of eldercare program</u> identified whether they had a mentor in their life, someone with more experience who provided support and guidance to them</p>	<p>Participants with a mentor had:</p> <ul style="list-style-type: none"> * stronger motives to help others (e.g., boosting self-esteem, understanding of social problems & reflection of one’s values) * stronger beliefs in a common mission & a desire to be supportive of peers * less caregiver stress in helping older adults 	<p>Sanchez & Ferrari, 2005</p>
<p>Mentor training program for <u>child care workers</u>:</p> <ul style="list-style-type: none"> * 4-months long intervention * paired with an early childhood educator of 5-7 years of experience * problem solving approach. Mentor just observed in the beginning to develop a trusting relationship and then their suggestions could be entertained by the mentor 	<ul style="list-style-type: none"> * very effective in improving the overall quality of the classroom, as well as making caregivers more sensitive to infants’ needs 	<p>Fiene, 2002</p>
<p>Note: Not a program:</p> <p>Reviewing <u>nursing</u> literature, much of it is based on a formal model of “orchestrated” mentoring, rather than the spontaneous and very effective mentoring style of academic leaders. This paper examines scope and type of established mentoring relationships</p>	<ul style="list-style-type: none"> * mentoring should be expanded to include 3 types of relationships: * direct (traditional) mentoring “Teaching embedded in friendship” * collegial mentoring “Closer to peer friendship” * indirect mentoring e.g., writing to an audience, an element of friendship remains with the envisioned reader * These mentoring relationships have made a profound impact on a large number of students and emerging academics * Mentee needs to make commitment, open to mutuality, have positive identity * Mentor needs confidence, generosity, kindness, open to mutuality * Mentoring fosters more than satisfaction - growth 	<p>Morse, 2006</p>

Professional Carers (cont.)		
Program Description	Findings	Publications
<p>Mentors trained in clinical psychology or social work to support <u>infant mental health services workers</u></p> <p>* Mentors (supporter, consultant) observed and trained worker during home visits to parents/child; they provided referrals to parents and provided a resource library for parents and workers</p>	<p>* Reflective listening and reflective consultation process (including video-taping visitor-parent-child interactions) was most useful – at all levels, for clients, the mentees and the infant health organisation</p>	<p>Summers, Funk, Twombly, Waddell & Squires, 2007</p>
<p>Peer mentoring program for <u>nurses</u> “helping another grow”</p> <p>* For mentoring to be a transformative/growth experience the relationship needs to be reflective and meaningful</p> <p>* Mentoring involves communication, knowing, process, skills, practice and support</p>	<p>Mentor attributes: commitment to supporting another, respectful/liking of self, belief in others’ capabilities, personal ethics, energy / creativity / vision, expertise / networks / competent, flexible / open / available</p> <p>Mentee attributes: commitment to relationship, respectful/liking of self, respect of others, personal ethics, energy / creativity, initiative, willing to learn</p> <p>Mentoring effectively requires:</p> <ul style="list-style-type: none"> * time together face-to-face * communication skills * freedom to leave * mentor monthly support meetings, ongoing learning environment * match mentoring pairs on location and personal interests * group celebrations between mentors-mentees and between mentors-coordinators 	<p>Wagner & Seymour, 2007</p>
<p>Note: not a program</p> <p>Mentoring for <u>trainee surgeons</u></p>	<p>* Failed mentorship are common in our medical centers and, specifically, in surgical training programs</p> <p>* Behavioral adaptation that supports surgical decision-making (incomplete data and unusual stress) often devalues succession planning and satisfaction from the success of other members of the team. So, fostering effective mentoring relationships in academic surgery will require a “concerted effort” to develop appropriate behaviors conducive to the mentoring process</p>	<p>Pellegrini, 2006</p>

Professional Carers (cont.)		
Program Description	Findings	Publications
Mentors trained in clinical Mentor program for new graduate nurses	<ul style="list-style-type: none"> * For participants who met with their mentors on a regular basis (54%), the mentor provided guidance and support for more than 90% and facilitated stress reduction for the majority * lack of connection between mentor and mentee occurred due to lack of commitment and time and scheduling * inadequate roles was also apparent, especially in relation to socialisation/career advice * Educational level, age and choice of nursing unit added to or decreased stress & influenced the mentoring relationship 	Beecroft, Santner, Lacy, Kunzman, Dorey, 2006

Employees / Professionals		
Program Description	Findings	Publications
<p>Note: not a program</p> <p><u>African American college administrators</u> identified whether they had a mentor in their professional life</p>	<ul style="list-style-type: none"> * Participants recognised the importance of communicating in writing and speaking, setting goals, and developing / strengthening self-confidence. A mentoring relationship played an important role in professional development and career achievement 	Bridges, 1996
<p>Note: Not a program</p> <p>Goal of this study was to determine the factors of the mentoring relationship that <u>professional women</u> contribute to their success</p>	<p>Found positive correlation between mentoring and career advancement</p>	Newbold-Coco, 2006
<p>Touchstone mentoring program for <u>women in the workplace</u>, extending mentoring to include empowerment</p> <ul style="list-style-type: none"> * multiple-mentor model 	<ul style="list-style-type: none"> * Among African-Americans, satisfaction with mentoring relationships was linked to career functions of mentoring, e.g., coaching, sponsorship & challenging assignments * For Caucasians satisfaction related to provision of psychosocial functions, e.g., counselling, role modeling, acceptance, confirmation and empowerment * multiple-mentor model facilitates empowerment for females to enhance their personal and career development 	Eggeman, 1997
<p>Star II Peer Mentor program for <u>teachers</u></p>	<ul style="list-style-type: none"> * positive effect on emotional exhaustion and accomplishment * reduces burnout * improvement in efficacy for student engagement, instructional strategies and classroom management 	Davis, 2004
<p>1-year formal mentoring for newly employed <u>mechanical and electrical engineers</u></p>	<ul style="list-style-type: none"> * higher levels of job satisfaction * no effect on work-role stress or self esteem 	Seibert, 1999

Employees / Professionals (cont.)		
Program Description	Findings	Publications
<p>Senior staff mentoring junior Medical Academics</p> <ul style="list-style-type: none"> * Focused on independence, initiative, improved thinking, skills, and self-reflection * mentor's methods included extensive and varied use of questioning, active listening, standard setting, and frequent feedback 	<ul style="list-style-type: none"> * The mentee evolved as a teacher, enhanced the creativity in his teaching, and matured as a person * safety, intimacy, honesty, setting of high standards, praxis and detailed planning and feedback was associated with mentee excitement, personal and professional growth, concrete accomplishments and a commitment to teaching 	<p>Rabatin, Lipkin, Rubin, Schachter, Nathan & Kalet, 2004</p>

Youth		
Program Description	Findings	Publications
Cultural / Spirituality-centered group mentoring intervention with <u>African-American boys at-risk</u>	A slight increase in spiritual orientation among the youth and improved school and home behavior	Washington, Johnson, Jones, Langs, 2007
Behavioral mentoring program aimed at serving <u>youth with psychiatric disorders</u>	Mentoring services was related to higher family functioning across a number of domains: <ul style="list-style-type: none"> * child behavior * parenting stress * perceived parent social support * quality of parent-child relationship 	Jent & Niec, 2006
<p>Big Brother Big Sister Program</p> <ul style="list-style-type: none"> * Supportive older adult volunteer paired with <u>youth living in high-risk circumstances</u> (no more than one parent actively engaged in their lives, 9 to 15 years) * Long-term program – meeting with mentor at least 3 times a week. With same mentor for several months or over a year * The study looked at youth-mentor relationship 	<ul style="list-style-type: none"> * According to the literature review, mentoring has academic and personal adjustment benefits * Results showed that successful mentoring was defined in terms of absence of disappointment and negative feelings regarding the mentor 	Rhodes, Reddy, Roffman & Grossman, 2005
<p>Big Sisters Program for <u>female youth</u> grades 3 to final year of high school</p> <p>Aimed at enhancing youth development: e.g., confidence, self esteem, leadership, problem solving, life skills, health/positive relationships</p> <p>Group format (7/8 girls), in respective grades (e.g., grades 3-4), co-led by 2 female workers/mentors</p> <p>Combined peer support/adult mentor approach</p> <p>Session planned with activities to develop skills, knowledge & relationship skills appropriate to age. 6 to 8 weeks long</p>	<ul style="list-style-type: none"> * improved self esteem, made new friends and learnt new things * no difference found in empathy, trust, communication or alienation from parents 	Westhues, Clarke, Watton, St Claire-Smith, 2001

Youth (cont.)		
Program Description	Findings	Publications
<p>Systemic model of mentoring <u>children engaged in welfare agency</u>. Mentored by a non-parental adult.</p> <ul style="list-style-type: none"> * The mentor-child relationship involves parent (information) and case worker (consultation) * The case worker meets with the mentor regularly, monitoring / reinforcing agency guidelines. Being a role model for the mentor – demonstrating consistency, reliability, interest, engagement, availability and responsiveness * Agency provides structure and support for coordinator 	<p>This network of relationships facilitates or inhibits the mentoring</p>	<p>Keller, 2005</p>

Youth - Students		
Program Description	Findings	Publications
<p>Head Start Mentoring between Graduate student mentors and at risk, preschool aged children</p>	<p>All the children, control/mentoring group, were found to form positive relationships with classroom teachers, and for the mentored children with their mentors.</p> <ul style="list-style-type: none"> * A positive relationship with a mentor didn't improve performance on behavioral ratings. No differences were found within the mentored group based upon quality of the mentor-child relationship * But mentoring was able to foster stabilisation in problem behaviors among mentored children * children serving as controls demonstrated increased ratings on aggression and externalising behaviors 	<p>Moffatt, 2000</p>
<p>Big Buddies Program for school-age children</p> <ul style="list-style-type: none"> * met twice weekly for 45 minutes at school * the mentor is a buddy and tutor (in academic-deficit subjects) * Mentor training (daily for 3 weeks) regarding aims/rules/procedures of the program. Sessions include warm-up exercises, encourages feedback/questions/concerns from mentors to trainer. Covers listening, child development, anger management, conflict resolution skills, communication, youth issues and troubleshooting * Mentor receives a kit-plans and materials (tasks sheets to guide beginning, continuing a relationship) to use to plan/organise buddy time * Planning is the key to an effective mentor program-identification/referral of mentees, selecting mentors, time/frequency/content of mentoring sessions, location of mentoring, coordination of program, mentor training and program evaluation 	<ul style="list-style-type: none"> * Young students demonstrated a more positive attitude to school, appeared as less needy children & appeared to be enjoying school more by the year's end * Grades improved * Mentors reported increased motivation and interest in doing future volunteering * There is an added benefit in providing at risk children with both a mentor and tutor, support and education. Simultaneously building a positive relationship while addressing some of the youngster's learning issues: empowerment via support and knowledge * Training mentors is imperative to work with at-risk youth 	<p>Dennison, 2000</p>

Youth - Students (cont.)		
Program Description	Findings	Publications
<p>Teen-Mentor Program that involves high-school students as role models and friends to younger children who have been identified as at risk or needing additional emotional support and adult attention at school</p>	<p>Parents (of mentee children) and mentors reported that mentoring positively impacted the mentees' self-esteem, attitude toward school and behavior at school.</p> <ul style="list-style-type: none"> * Impacted mentee students' academic performance * The teen-mentor training prepared teen mentors to be successful mentors 	<p>Finckler, 2003</p>
<p>Students at risk of academic under-achievement mentored by caring influential adult</p>	<p>Better grades, language and reading among mentored students</p>	<p>Starks, 2002</p>
<p>College students serve as mentors for at-risk children in an elementary school</p> <ul style="list-style-type: none"> * met weekly 	<ul style="list-style-type: none"> * 10 weeks of mentoring led to benefits for self-esteem, social competence, general competence and less delinquent behavior * a few of the positive trends appeared to reverse after the mentor relationships had been terminated 	<p>Matzenbacher, 1999</p>
<p>Mentoring intervention with characteristics of "will" (support) and "skill" (self-regulation) for middle school at-risk black male students</p> <ul style="list-style-type: none"> * paired with high achieving Black male older students at high school * 8 week program 	<ul style="list-style-type: none"> * Improved self-efficacy, grades and teacher conduct ratings 	<p>Tomlin, 1995</p>
<p>Mentoring for black males in junior high school</p>	<p>Although there were trends in grades and school behaviour in the favoured direction, they were not statistically significant</p>	<p>Jones, 1995</p>
<p>Low-income teen mothers (aged 16-24 yrs) were assigned a professionally employed adult mentor while in high school</p>	<ul style="list-style-type: none"> * mentors influenced their educational plans, and each articulated how they had been assisted and influenced by their mentor * discussions of the kinds of jobs and income gains that would result from completing high school and pursuing further education were most influential type of assistance 	<p>Zippay, 1995</p>

Youth - Students (cont.)		
Program Description	Findings	Publications
Mentorship students (aged 16-21 years) who were selected for the Mentor Connection program	<ul style="list-style-type: none"> * Career development was the area most affected by the mentorship * Females felt more strongly than males that the mentorship helped them look at ways to integrate career and family * 16 and 18-yr-olds reported long-term friendships with mentors was an important benefit 	Beck, 1989
<p>Adolescent mentors for elementary school-age children</p> <ul style="list-style-type: none"> * in dyads the children participated in 2 hour weekly group sessions. Doing structured activities (academic/social) in the school gym, cafeteria or library 	<ul style="list-style-type: none"> * the mentor's initial impressions of their mentees influenced the subsequent mentoring relationship and persistence * the mentee's openness to seek support was important, and so was their experience of empathy, praise and attention – these affected the mentor's feelings of self efficacy – Mentors need regular supervision, guidance, praise, encouragement 	Karcher, Nakkula, Harris, 2005



Adult Students		
Program Description	Findings	Publications
<p>A program for college science women.</p> <ul style="list-style-type: none"> * Emphasising a diverse set of mentors and a pro-active student role * 2-week “future career concerns” workshop series designed to introduce the “composite mentor” strategy * Role model web site, focus groups with women professionals and assignments 	<ul style="list-style-type: none"> * students’ conceptions of mentoring moved in the direction of a composite mentor; students expanded their mentor selection criteria to include men and people out of their fields and saw a pro-active role for themselves * students reported new mentoring and career-related experiences * students’ experiences of clash between their future selves (e.g., being a “science person”, combining family and career) remained at the end of the program, students were now motivated rather than discouraged by these concerns. Seeing clash as an on-going tension shared by the professionals across fields * students reported a renewed motivation to stay in the field, both at the conclusion of the program and 16 weeks later. 	<p>Packard, 2000</p>
<p>Undergraduate students in a student-faculty mentor 1-year-program</p> <ul style="list-style-type: none"> * matched mentors-mentee on gender and ethnicity 	<ul style="list-style-type: none"> * mentored students had higher grades, completed more units and had a higher retention rate * 11 years later grades at graduation did not differ from comparison student group and there were no differences in graduation rate. But, the mentored students remained on campus to pursue graduate study at a higher rate * There was no advantage of matching students with mentors based on gender * students matched with mentors of the same ethnicity showed a higher cumulative grade average and graduation rate and also entered graduate study at a higher rate 	<p>Campbell & Campbell 2007</p>

Adult Students (cont.)		
Program Description	Findings	Publications
<ul style="list-style-type: none"> * Academic mentoring and tutoring program carried out over 1 semester for students whose overall grade point average was below a pass, at risk for academic dismissal * Goal-setting approach was used to aid the students in identifying and overcoming the obstacles to their academic success 	<ul style="list-style-type: none"> * Mentoring was better than the tutoring-only and no-program group - the mentoring program motivated students to action, increasing grades and retention rates 	Sorrentino, 2006
<p>Senior Mentor Program for medical students training in geriatrics</p> <ul style="list-style-type: none"> * mentored by senior volunteers – to provide experience relating to elderly patients 	<ul style="list-style-type: none"> * student mentees and senior mentor viewed the program positively * mentoring relationship has a far-reaching, educational, professional and personal impact * Both students and seniors agreed that myths and stereotypes about aging were dispelled and students indicated that a close, caring relationship with an older person will change the way they practice * increased students' skills and compassion for caring for older adults 	Corwin, Frahm, Ochs, Rheume, Roberts, Eleazer, 2006
<p>Medical students follow their patient mentors through major venues of care</p> <p>Students participate in weekly, case-based tutorials and participate in a social science curriculum focusing on self-reflection, communication skills, ethics, population sciences and cultural competence</p>	<ul style="list-style-type: none"> * students performed better than traditional students on annual clinical exams * expressed more satisfaction with their curriculum and felt better prepared to cope with the professional challenges of patient care 	Ogur, Hirsh, Krupat, Bor, 2007
<p>Mentor - group leader – for occupational therapists</p> <ul style="list-style-type: none"> * over 4 years 	<ul style="list-style-type: none"> * viewed their mentors predominantly as a role model or counsellor and emphasised knowledge, experience, guidance and support as desirable attributes of a mentor * contact with mentors continued after graduation * mentees reported that peer mentoring had also occurred 	Milner & Bossers, 2004

Adult Students (cont.)		
Program Description	Findings	Publications
Peer mentor program for students enrolled in athletic training education	<ul style="list-style-type: none"> * mentoring prerequisites included accessibility, approachability and mentee initiative * interpersonal foundations involved the mentor and protege having congruent values, trust and a personal relationship * educational dimensions category involved the mentor facilitating knowledge and skill development, encouraging professional perspectives, and individualising learning 	Pitney & Ehlers, 2004
Junior faculty mentoring program in obstetrics and gynecology department	<ul style="list-style-type: none"> * participants felt better supported by the department and appreciated a greater sense of camaraderie * most mentees noted the program's success in the following areas: having a role model, increased visibility and having someone to turn to 	Tracy, Jagsi, Starr, Tarbell, 2004







Service Map of Peer Support Programs

Chronic Illness (Consumers with physical health conditions and their Carers) – Peer Support Models		
Organisation Location	Name of Program/s Target Group	Program Description
MS Society	<p> Peer support program - Telephone, Online and Face-to-face support</p> <ul style="list-style-type: none"> - For people with Multiple Sclerosis and their families/carers - Running since 2001 	<ul style="list-style-type: none"> - Peer support workers: people who have Multiple Sclerosis themselves, at least 2 years post-diagnosis - Training: 2 days <p>Training Modules: learning survey regarding peer support role and actions to take in different situations (answers before and after are compared), aims/expectations, medical overview of MS, communication skills, values/attitudes, Policies/procedures, services and resources, self care as a peer support worker, thinking/memory/emotions, loss and change, suicide intervention.</p> <p>Additional Training: Internet and group facilitation as required</p> <p>Ongoing: refresher training</p> <ul style="list-style-type: none"> - Selection: there is a position description, 18 month commitment, assessed for suitability - Program development: setting up mentoring program - Staff have a Certificate IV in Assessment and Workplace Training, they are health professionals with volunteer sector experience
The Cancer Council	<p> CancerConnect / Family CancerConnect</p> <ul style="list-style-type: none"> - Telephone-based, links a person with cancer or those caring for a person with cancer with peers with similar experiences. Also those carrying a gene that increases their risk of developing cancer may use this service 	<ul style="list-style-type: none"> - Telephone Peer Support Program. Puts people in touch with others who have had similar cancer experience. Volunteers offer emotional and practical support and understanding at diagnosis, before/after treatment - Matching: people access the service via the Cancer Helpline. A cancer nurse talks with you about your experience and matches you to a volunteer according to the cancer type, treatment, age and family circumstances

Carers of People with Mental Illness – Peer Support Models		
Organisation Location	Name of Program/s Target Group	Program Description
Carers Victoria	<p>☞ “Just For Carers”, education sessions</p> <ul style="list-style-type: none"> - for carers in general 	<ul style="list-style-type: none"> - These education sessions are not peer support programs as such but they do create a peer support setting around carer wellbeing, advocacy and caring role issues. Of particular interest are the sessions entitled “Carer Support Groups-Facilitators Workshop” and also the session “Connected Carers: Online Support Group Training”
Mental Health Council of Australia	<p>☞ “Carers Engagement Project”</p> <ul style="list-style-type: none"> - for carers of people with mental illness, from a range of backgrounds 	<ul style="list-style-type: none"> - These 1-day workshops are being run Australia-wide. They will provide an empowering experience where mental health carers will have the opportunity to share their experiences of caring and learn with peers, while also providing the Mental health Council with relevant information/needs to advocate for better MH care – a staff member will facilitate these workshops
Eating Disorders Foundation of Victoria	<p>☞ A series of workshops for family and friends</p> <ul style="list-style-type: none"> - for family/friends of people suffering from an eating disorder 	<ul style="list-style-type: none"> - Workshops cover – understanding eating disorders, coping strategies, recovery journeys, strategies on how to relate to your loved one, self care, treatment/ services - Opportunities to speak with counsellors, specialists, MH nurses and peers who completed the recovery journey
Grow Victoria	<p>☞ Grow Better Together</p> <ul style="list-style-type: none"> - for carers and people with mental illness meeting together 	<ul style="list-style-type: none"> - Carers and people with mental illness meet weekly to share experiences, gain support, increase coping skills, knowledge and understanding. Fostering a connecting link between carers, family and the person with mental illness – raising community awareness and promoting holistic practice - the meetings are structured

Carers of People with Mental Illness – Peer Support Models (cont.)		
Organisation Location	Name of Program/s Target Group	Program Description
Family Drug Help	<p>Family Drug Helpline</p> <ul style="list-style-type: none"> - For people concerned about a relative, friend, workmate or neighbour. The drug may be alcohol, an illegal substance or prescription drug 	<ul style="list-style-type: none"> - Aim: to give people a chance to talk with a person who has a similar experience, to get accurate information, information about services and coping, to reduce isolation, to respect/value difference, promote empowerment and refer callers to relevant services - peer support volunteers all have personal experience of alcohol or other drug misuse within their family or friendship group - Training: includes listening and counselling skills, effect of drugs on the human body, drug dependence, stages of change in dependency and recovery, withdrawal and rehabilitation, family experiences, family violence, anger management, communication skills, MH issues, crisis calls and self care - Ongoing training and personal development : regular meetings with other peer support workers, supervision and training workshops
Mental Illness Fellowship	<p>“Well-Ways” and “Double Trouble”</p> <ul style="list-style-type: none"> - for family and friends who care for a person with mental illness (struggling with mental illness and substance abuse) 	<p>Provides information about services/ supports for the person with mental illness/ dual diagnosis, skills in managing illness-related or addiction-related behaviour, coping and problem solving skills, and opportunities to share experiences and network with other carers</p> <ul style="list-style-type: none"> - Both consist of 3 hour weekly group sessions plus 4 follow-up sessions over 12 months - Facilitators of both programs are experienced carers of a person with mental illness or dual diagnosis

Carers of People with Mental Illness – Peer Support Models (cont.)		
Organisation Location	Name of Program/s Target Group	Program Description
ORYGEN Youth Health Parkville	<p>☞ “Families Helping Families”</p> <ul style="list-style-type: none"> - for families/carers of young people with mental illness 	<p>Family peer-support workers are employed to provide telephone and face-to-face information and support to families new to the Orygen service.</p> <ul style="list-style-type: none"> - Family carers of people with mental illness receive a call from the peer support worker: sharing experience, hope, how to navigate MH system, details regarding information sessions, they are encouraged to document difficulties and to follow-up concerns with professionals - Training for peer support workers includes: <ul style="list-style-type: none"> * Using lived experience * Interpreters * emotional distance management * managing illness behaviour * mental health services * boundaries/roles - families are welcomed in the resource library, where the peer support workers are based
Royal Children’s Hospital Melbourne	<p>☞ “Paying Attention to Self”</p> <ul style="list-style-type: none"> - PATS is targeted to young people aged 12-18 years who have a parent with mental illness 	<p>Provides an opportunity to share their experiences and be supported by other young people in a situation similar to their own.</p> <ul style="list-style-type: none"> - Objective: to increase knowledge of mental health issues, to improve help seeking, promote coping and increase sense of connection with peers/community/family - Peer support groups consist of 6/8 youth who meet weekly for 8 weeks. Co-facilitated by a health professional and peer leader. Topics covered are: understanding their parents illness, improving their relationship with parents, communication problem solving, dealing with stigma, coping with parent’s behaviour and staying healthy themselves - Peer leader training: 3-day course regarding peer support, mental illness, communication skills, group dynamics, leadership skills, public speaking and activity planning. To develop skills and confidence - Peer leaders are responsible for social aspects of the group – activities, encouraging youth to mix and talk. They are involved in advocacy and community awareness at a local level - Four social gatherings for all participants annually - Evaluation: the program was found to increase confidence, reduce feelings of isolation, learning about parental illness, reduction in self-blame and better coping strategies (Hargraves, O’Brien, Bond, Forer, Basile & Davies, 2005)

Carers of People with Mental Illness – ARAFEMI Peer Support Schemes	
Name of Program Target Group	Program Description
<p> COPES- Carers Offering Peers Early Support</p> <ul style="list-style-type: none"> - Collaborative partnership project between Eastern Health and ARAFEMI Victoria for carers and families whose relative/friend is in receipt of services from Central East Area Mental Health or ARAFEMI Services 	<ul style="list-style-type: none"> - Paid peer support workers, contracted 3 days per week - Telephone and face-to-face support for carers to reduce isolation and improve knowledge of the MH system. Also the peer support worker is responsible for linking with PDRSS and clinical health services to increase family/carers supports
<p> Carer Helpline</p> <ul style="list-style-type: none"> - Short-term support and information for carers of people with mental illness 	<ul style="list-style-type: none"> - Selection: support workers are volunteers with knowledge about mental illness, effective listening/interpersonal/phone/ internet skills and preferably a carer - Telephone support worker training: <ul style="list-style-type: none"> 4-day training covers: <ul style="list-style-type: none"> <i>Day 1:</i> ARAFEMI mission/values, short-term support and guidelines, Bio-psychosocial model, mental illness and stigma, self-disclosure, confidentiality, overview of national and state MH services <i>Day 2:</i> active listening, reflecting feelings, paraphrasing, clarifying, questioning, reframing <i>Day 3:</i> problem solving, summarising, ending calls, at-risk callers/intervention, challenging callers <i>Day 4:</i> debriefing and supervision, grief and loss for carers, cultural background, duty of care, referrals, self-care, paperwork 3-month self-paced orientation: <ul style="list-style-type: none"> - covers navigating system, resources, discussing calls with supervisor, clinical material regarding mental illness
<p> Carer Support Groups</p>	<p>Peer support group convenors undergo training in group dynamics and practicalities around setting up a peer support group for carers of people with mental illness</p>
<p> Family Education Group Workshops and Courses</p>	<p>These are group workshops that promote learning, advocacy, peer networking and sharing:</p> <p>e.g., Carer Coping Skills, Recovery the Carers Journey, Supporting Self and Others and Carer Advocacy Skills Training. These courses vary in length from single session to 10 weeks</p>

Service Map of Mentoring Programs

Symbols explained:



Peer-run

Purpose - Facilitating Mutual Support





Volunteer-run



Purpose - Gathering Community Support





Professional-run



Purpose - Coaching Peer Leaders

Persons with Mental Health Issues (consumers) – Mentoring Models		
Organisation Location	Name of Program/s Target Group	Program Description
<p>Richmond Fellowship of Victoria</p>	<p>☰ “PALS” (Partnership and Linking)</p> <ul style="list-style-type: none"> - program established for 12 years for people experiencing psychiatric illness 	 <p>provides partnership and linking with a community volunteer to prevent isolation. Aims to improve self-confidence through participating in social and recreational activities (walks, conversation, spending time with, movies, coffee) with the PALS volunteer</p> <ul style="list-style-type: none"> - a volunteer is sensitive to the issues relating to psychiatric illness and would like to contribute to the life of a person who is experiencing social isolation - volunteers receive initial and ongoing training (e.g., encouraged to maintain roles/boundaries and prevent over-dependency). Volunteers are supported all throughout by the client’s case manager
<p>National Government Package</p> <ul style="list-style-type: none"> - run across several organisations/ regions, e.g., Jobco Employment Services- Brunswick, Moorabbin, Wantirna 	<p>☰ “Paying Attention to Self”</p> <ul style="list-style-type: none"> - for people aged 16-64 whose lives are affected by severe mental illness, not necessarily with a diagnosis 	 <p>provides opportunities, support and connections with services in the community</p> <ul style="list-style-type: none"> - volunteers come from a range of backgrounds (qualifications, skills, experience). They are people who understand mental illness, the sufferer’s needs and expectations - volunteer helpers/mentors negotiate goals/wishes with the person and can include family, carers and/or friends if nominated by the person - personal helpers/mentors work in teams. They assist the person to manage everyday tasks (finance, housekeeping, transport); help get family relationships and friendships back on track; and assist with access to clinical support and community activities



Persons with Mental Health Issues (consumers) – Mentoring Models (cont.)		
Organisation Location	Name of Program/s Target Group	Program Description
<p>Uniting Care Prahan Mission</p>	<p> PMP (Parents Mentoring Project)</p> <ul style="list-style-type: none"> - Emergent program for parents with a mental illness. They must have at least one child under 21 years of age 	<div style="display: flex; align-items: flex-start;">  <p>provides support of another (mentor) parent who has experienced a mental illness, who has been through similar experiences but is at the point in their recovery to be able to assist others in their recovery and parenting journey. Mentor/mentee meets 2 hours a fortnight, having coffee / outings / talking, over a 12-month period (informal agreement)</p> <ul style="list-style-type: none"> - Principles: “Founded upon the value and strength of having a trusted guide.” “Mentors do not work as quasi-professionals. “They are part of the mentee’s support network” - Selection: Mentors are interviewed and their support worker contacted to gauge their suitability for mentoring in the PMP program - PMP Staff are prior consumers and parents themselves - Matching: mentee parents are matched with parent mentors with similar interests, mental illness and geographical location etc... - Training: Mentors undertake 5 weeks (4 hour) initial training and ongoing support/ training. There are monthly peer support groups for mentors - Monitoring: Staff keep in contact with mentors and mentees </div>

Persons with Mental Health Issues (consumers) – Mentoring Models (cont.)		
Organisation Location	Name of Program/s Target Group	Program Description
St Vincent De Paul Society Victoria	<p>☰ “Compeer”</p> <ul style="list-style-type: none"> - The program is for people who are receiving treatment for mental illness - Compeer Victoria is a member of Compeer International, which has been established for 30 years. Here in Australia it has been established in Sydney since 1996 (Melbourne in 2004 and Bendigo in 2007) 	 <p>provides weekly companionship in the person’s home, community or public venues</p> <ul style="list-style-type: none"> - compeer volunteers come from all walks of life, all nationalities, all religions. Men and women aged over 21 years who are friendly, accepting, emotionally mature/ stable, able to commit for 1 year or more and live in proposed region (e.g., Melbourne/Bendigo) - the volunteer selection process includes an information session, written application, interview, 3 referees and police check - volunteer is matched with a person according to gender, age and geographical location - volunteers undertake training, ongoing supervision and continuing support provided by staff/mental health professionals - training is about respecting role boundaries and compeer policies around safety and privacy: “boundaries are both personal and informed by policy and guidelines, often there is no right or wrong, your position will change and must be based on the context before you” - other training topics: communication/ relationship issues and people with mental illness, handling personal crisis, medical crisis, abusive situations, potential suicide, encouraging confidence and independence in your compeer friend. Juggling change in your own personal/volunteer commitments and conflict in time/energy demands - how training is conducted: Within a group workshop, each issue is presented as a scenario, in a specific context, with lots of time for role plays and discussion

Carers of People with Mental Illness – Mentoring Models		
Organisation Location	Name of Program/s Target Group	Program Design
Carers Victoria	<p>☞ “Young Carers Peer Mentoring Project”</p> <ul style="list-style-type: none"> - 2007/2008 emergent program for carers aged 15 to 18 years at risk of disconnecting from work/study, living in Wyndham or Melton. The person they care for may have a physical or mental illness, disability, alcohol or other drug dependency 	 <p>provides a break from the caring role, one-on-one support, information and community networking/service-linkage.</p> <ul style="list-style-type: none"> - The Mentor screening process: Information session. Application form. Interview. Work Personality Inventory. Training. Referee checks. Supervision. - Training process of Mentors: initially provided with 5 x 2 hour training sessions. Then mentors are offered monthly training and supervision
Carers Queensland	<p>☞ “Carerconnect”</p> <ul style="list-style-type: none"> - 2007/2008 emergent program for carers 	 <p>provides mutual support and companionship. Links more experienced carers with less experienced carers. “It’s simple, it’s just about being there.” “No one understands the caring role better than another carer”. There is an informal 12-month agreement between mentor-mentee to meet approx. 2 hours weekly. There is an annual review for those who would like to meet for longer and anyone can leave at anytime without providing a reason</p> <ul style="list-style-type: none"> - Training: The first day training is for all interested, mentors, mentees and undecided. Topics include an overview of the program, interpersonal and listening skills, assertion and boundary setting (mentee/mentor roles) and administrative processes. The second day for mentors covers more on mentoring and interpersonal skills - Matching: is based on cultural background, expectations of the program and location and transport. Then mentee and mentors meet to clarify interests, expectations and compatibility - Ongoing support: each mentor is contacted to check progress/questions. There are regular peer workshops for mentors to discuss experiences and do further training

Carers of People with Mental Illness – Mentoring Models (cont.)		
Organisation Location	Name of Program/s Target Group	Program Design
Mental Health Council of Australia Canberra	<p>☰ “National Register of Mental Health Consumer & Carer Representatives”</p> <ul style="list-style-type: none"> - 2008 emergent program for carers (or consumers) who submitted applications and were accepted as national representatives 	 <p>successful carer representatives are provided with a 2-day workshop in advocacy skills, committee representation, leadership, policy development and communication skills. Also includes ongoing training in carer representation, support and mentoring for carer reps by professionals</p>
Victorian Quality Council (Safety and Quality in Health) Melbourne	<p>☰ “Consumer Leader - Development Program”</p> <ul style="list-style-type: none"> - pilot program for carers (consumers & community members) with an involvement in quality and safety in the health sector 	 <p>focuses upon how to effectively influence the health care system in order to promote the consumer perspective and bring about change</p> <ul style="list-style-type: none"> - selected carers are provided with 5 days education, a facilitated peer support network and mentoring from a professional - candidates are selected based on their demonstrated interest in improving the health care system, experience in advocacy, linkage with health consumer bodies and their ability to communicate the concerns of others

Carers of People with Mental Illness – Mentoring Models (cont.)		
Organisation Location	Name of Program/s Target Group	Program Design
Carers Victoria	<p>☰ “Young Carers Peer Mentoring Project”</p> <ul style="list-style-type: none"> - 2007/2008 emergent program for carers aged 15 to 18 years at risk of disconnecting from work/study, living in Wyndham or Melton. The person they care for may have a physical or mental illness, disability, alcohol or other drug dependency 	 <p>provides a break from the caring role, one-on-one support, information and community networking/service-linkage.</p> <ul style="list-style-type: none"> - The Mentor screening process: Information session. Application form. Interview. Work Personality Inventory. Training. Referee checks. Supervision. - Training process of Mentors: initially provided with 5 x 2 hour training sessions. Then mentors are offered monthly training and supervision
Carers Queensland	<p>☰ “Carerconnect”</p> <ul style="list-style-type: none"> - 2007/2008 emergent program for carers 	 <p>provides mutual support and companionship. Links more experienced carers with less experienced carers. “It’s simple, it’s just about being there.” “No one understands the caring role better than another carer”. There is an informal 12-month agreement between mentor-mentee to meet approx. 2 hours weekly. There is an annual review for those who would like to meet for longer and anyone can leave at anytime without providing a reason</p> <ul style="list-style-type: none"> - Training: The first day training is for all interested, mentors, mentees and undecided. Topics include an overview of the program, interpersonal and listening skills, assertion and boundary setting (mentee/mentor roles) and administrative processes. The second day for mentors covers more on mentoring and interpersonal skills - Matching: is based on cultural background, expectations of the program and location and transport. Then mentee and mentors meet to clarify interests, expectations and compatibility - Ongoing support: each mentor is contacted to check progress/questions. There are regular peer workshops for mentors to discuss experiences and do further training

Youth Mentoring		
Organisation Location	Name of Program/s Target Group	Program Description
<p>Big Brothers Big Sisters Melbourne</p>	<p> Big Brothers Big Sisters Program</p> <ul style="list-style-type: none"> - Preventative program which provides young people aged 7 to 25 years with a caring adult mentor in their lives <p>It is the largest and most prominent provider of mentor services internationally. It has been operating in Australia for 25 years. There are Big Brothers Big Sisters organisations around the world including the USA, New Zealand, U.K, South Korea, Japan and Canada</p>	<p></p> <ul style="list-style-type: none"> - Volunteer mentors: come from all walks of life, whether married, single, with or without children. Big Brothers and Big Sisters are not replacement parents or social workers, but mentors: someone to trust, to have fun with, to talk and go to when needed. volunteers commit to spending 1-4 hours with young people 3-4 times each month for at least twelve months - Provides: simple activities such as having a picnic at a park, cooking, playing basketball, going to a football match - activities that enhance the friendship and contribute to an environment where the young person can develop positive self-esteem and life direction - Selection: After an initial information session which all interested volunteers are required to attend, there follows a very detailed volunteer selection procedure. This includes: submitting an application form, citing four references, a police check, psychological test, comprehensive interviews and a home visit by a coordinator - Training: There is training before and after being matched with a young person after being matched to a young person.



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