‘Local mums helping other local mums’

The Mentoring Mums Program Evaluation

Detailed Report

Dr Deborah Absler

Dr Gaye Mitchell

With Professor Cathy Humphreys

March 2011

Authors:

Dr Gaye Mitchell

Dr Gaye Mitchell is a social worker who works as a researcher, evaluator and social work practice consultant. She is also an Honorary Research Fellow with the Alfred Felton Research Program, Department of Social Work, at The University of Melbourne. She has worked principally in child and family welfare in community service organisations and her research and practice has focussed on families with intergenerational, serious, multiple, entrenched and intractable difficulties.

Dr Deborah Absler

Dr Deborah Absler is a social worker who operates a Mental Health, Social Work Practice and Research Consultancy. She is also an Honorary Research Fellow with the Alfred Felton Research Program, Department of Social Work, at The University of Melbourne. Deborah has a practice, research and policy background working extensively with vulnerable children and families, with organisations and in conducting evaluations. She has a particular interest in the practice and research of working in partnerships and collaborative approaches.

Professor Cathy Humphreys

Cathy Humphreys is the Alfred Felton Chair of Child and Family Welfare, a professorship established from a collaboration between the Department of Social Work at University of Melbourne and The Centre for Excellence for Child and Family Welfare in Victoria, the peak body for 98 child and family welfare agencies. The chair was established to ensure that research undertaken in the areas of domestic violence and vulnerable children, youth and families was developed with a view to strengthening evidence informed policy and practice.

Acknowledgements:

We thank the staff and management of CPS for commissioning this evaluation, and for the support they provided to the evaluation.

We offer our profound thanks to Marianne Mahony, Michelle Hawke, Abigail Dent, Bernadette Burchell, Janet William-Smith, Amanda Swift and Diana Pellegrino for their support of and involvement with the evaluation. It was invaluable. We are particularly grateful to Marianne, Michelle and Abigail, who, as the foundation manager and Volunteer Coordinators provided us with the opportunity to work with them as they established and developed this important program. We also express our deep appreciation to those who took part in the evaluation, especially to the mentors, the mothers and service providers. Their contributions to the evaluation were crucial.

And we express our admiration to mentors and mothers for their preparedness to engage with each other, to work together to help isolated mothers and their babies. Their combined strength, courage and openness contributed greatly to the success of the program.

Table of Contents

DETAILED REPORT

Introduction

The Mentoring Mums program is a volunteer program which provides a supportive relationship for socially isolated highly vulnerable women who are pregnant or who have recently given birth to their infants. The volunteer, a woman who herself is a mother, is required to 'walk along side' the isolated mother from the period of her late pregnancy or early in the life of her infant and support her to develop her parenting.

Mentoring Mums provides services to women living in the north east region of Melbourne. It is a program of the Children Protection Society (CPS) and funded by the Ian Potter Foundation.

Background

The CPS was established more than 100 years ago and until 1986 was responsible for investigating and dealing with cases of abuse and neglect. Since that period the organisation has concentrated on providing support services to vulnerable families. Its mission is to break the cycle of abuse and neglect in families and improve the life chances and choices for children who have experienced abuse and neglect.

The CPS vision is that all children will thrive in safe families and communities. Their values are best practice in all their work, responsiveness to the needs of children, parents, families and communities, fairness and equity, innovation, knowledge-sharing, leadership and accountability to the community.

A central component of CPS service delivery has been the development of a range of interrelated programs for vulnerable children and their families. In recent years CPS has taken an active role in developing projects and promoting networks to engage community effort to break the cycle of abuse and improve opportunities for vulnerable children.

Informed by evidence about the importance of addressing social disadvantage in the early years and the value of early intervention, CPS developed the Mentoring Mums program as an important new initiative to address the needs of vulnerable socially isolated women and their infants. CPS successfully applied to the Potter foundation to establish Mentoring Mums as a pilot program and the Program commenced in September 2008 with the employment of a three-day-per-week Volunteer Coordinator. The Mentoring Mums program was developed after a small piece of research identified the need for such a program.

A set of objectives was developed during the establishment phase of the program. These objectives were centred on objectives for the mothers, the infants, the volunteers and for CPS as an organisation. The objectives for the mothers included each mother developing a trusting and supportive relationship with the volunteer and increasing the bond between mother and infant; the mother's confidence in her parenting; her ability to respond to her infant's cues; and the mother's connections to the community. It was hoped that the program

would enable the infants to achieve developmental milestones and positive attachment with their mothers. A third set of objectives related to the volunteers: that they would value their relationship with the mother; be trained; and would feel part of CPS. Finally, the program designers wanted the program to be integrated into CPS, especially its Family Services teams, for CPS to develop a culture that valued and promoted volunteering, and for there to be smooth referral pathways into the program.

The vision for the Mentoring Mums program included the employment of evaluators who would walk alongside the program development throughout the pilot period. Thus the evaluation team was employed in January 2009.

This Final Evaluation Report follows an interim Report provided in July, 2010. The Interim Report was requested by CPS to provide a 'snapshot' of the achievements to that date and provided a glimpse of the data and findings, as a basis for CPS's planning for the future of the program, after cessation of the funding from the Ian Potter Foundation.

This Final Evaluation Report consists of the following:

1. Description of evaluation method
2. Description of the program
3. Snapshot of the program from program documentation.
4. Case studies of five matches
5. Profile of a sample of mentors involved in the program
6. Feedback on the program from the new mothers
7. Analysed data on infant development, attachment and parenting of a sample of new mothers and their infants from their Maternal and Child Health Nurses
8. Report on mentor views and experience of the program
9. Feedback from service providers on the program
10. Report on views of CPS Senior Managers and Mentoring Mums program staff
11. Conclusions and recommendations.

1. Evaluation Method

The evaluation chose a number of methods to describe the Mentoring Mums program, and its achievements. The methods all rely on rich and thick description (Geertz, 1973) of the new mothers, the work with them, program and practice processes and outcomes. Understanding program processes is an important component of any evaluation (Kettner, et al., 1999: 221), (Weiss, 1998: 129). The focus of this evaluation was exploration of the impact of the relationship between the mentor and the new mother on the new mother's parenting capacity and capacity to bond with her child, on her child's growth and development, and on her level of social isolation.

Multiple methods were chosen to discover common themes identified in the single methods. Sometimes multiple methods triangulate findings and give

greater confidence in them. Sometimes, they show differences that need to be taken into account, if a program is to be ultimately successful.

The following methods were selected:

1. An action research approach to develop conceptualisation of the program as a basis for evaluation.
2. Meetings with CPS senior management and Mentoring Mums program staff on the program's progress.
3. Case study of five matches to explore the processes and outcomes of the program at the case level.
4. Interviews with the new mothers to explore their experience of the program and what they think it has contributed to them, their parenting, and to their infant.
5. Focus groups with mentors to elicit their experience of the program.
6. Focus groups with referrers to the program to ascertain community perception of the program.
7. Survey of Maternal and Child Health nurses involved with the new mothers to gain information on the progress of infant development, attachment and parenting.
8. Mentors profile data.

Each part of the research approach is now outlined in more detail.

1. An action research approach to develop conceptualisation of the program as a basis for evaluation.

Because the Program was new, staff and management of CPS wanted the evaluation to assist in development of the conceptualisation of the program. To this end, the evaluators maintained close contact with program staff through regular meetings and case discussions throughout the evaluation. A focus of these meetings was on the significant implementation issues faced by the program in its early development. The meetings were initially held on at least a monthly basis. Conversations based on staff experience with new mothers, mentors and matches were undertaken. Detailed minutes were kept, and were shared with staff, so that the agreed minutes provided the data for analysis.

The process of defining the program was initially a difficult one. The program had expected to be inundated with referrals from the Mercy Hospital for Women Transition Clinic. This initial expectation was based on a small piece of research undertaken before the program was funded. Instead, very few referrals were received directly from the Transition Clinic. This caused considerable confusion and pressure for the program staff, who believed in the program and wanted it to commence.

Additionally staff were in the fortunate position of having successfully recruited a number of mentors who were keen to be matched with young mothers but were without the necessary referrals to make these matches. After a difficult period of

lack of congruence between the initial objectives of the program and the referrals being received, the referral criteria were reviewed, and broadened, in consultation with, and with agreement from, the Potter Foundation.

Eligibility for the Mentoring Mums program became the same as for referral to Child FIRST services. Specifically, the criteria included: social isolation, difficulty with parenting, and the presence of a number of other serious difficulties which jeopardised infant safety, the development of positive parent-child relationships and constructive parenting.

A key focus of the discussions with Mentoring Mums program staff centred on the need to conceptualise:

- The needs and problems of the families, including development of assessment tools for both practice and evaluation, with identification of the particular difficulties of families which would be the focus of intervention.

The assessment/data collection tool agreed to as a result of these processes is included in Appendix 1.[1] The completed data tool allowed description of each new mother involved in the program, a limited description of the intervention with the mother, and a limited evaluation of outcomes for each match. Outcomes were measured by a goal attainment score, and by two before/after measures. First, an eco-map of each family showed the extent of the family's social connection or isolation. Second, a problems list for each new mum and her family showed the extent and nature of families' difficulties. Both were to be used twice – during the initial assessment period or shortly thereafter, and then again at case closure or at the end of the data collection period, if a case was ongoing at that point. Other studies conducted by the evaluators have used these measures to good effect, see (Contole, et al., 2008); (Mitchell, et al., 2008b)

- The differential tasks and functions of the volunteers and of professional staff with the diverse clients to discern the various effects of the different parts of the intervention with the family.
- The diverse outcomes expected for different clients to develop relevant measures for both practice and the evaluation.
- Ramifications of these preceding factors for selection, matching and supervision of volunteers with particular clients.

The conceptualisation arising from these discussions is reflected in the findings, conclusions and recommendations of this report.

2. Meetings with CPS senior management on the progress of the program

Various meetings were held with senior management and staff at different points in the program. Two meetings with the CEO, Manager and Volunteer

[1] The appendices are collated in a separate document

Coordinator were held to discuss the progress and difficulties of the program. These meetings coincided with staff changeover, at the end of 2009. Further meetings were held with the program manager and the second Coordinator, throughout 2010. The evaluators met with the third Coordinator in 2011.

3. Case study of five matches to explore the processes and outcomes of the program at the case level.

Case studies of five current matches were undertaken during 2010. Data from the data collection tool already mentioned were combined with data from a focussed interview with the Mentoring Mums program Coordinator. The questions are provided in Appendix 2.

Case study method has a number of advantages (Gilgun, 1994); (Handel, et al., 1992); (Mitchell, 1995); (Walton, 1972); (Flyvbjerg, 2001); (Punch, 1998). It allows exploration of complexity and inter-related factors. It allows exploration of context and the whole situation, and of processes as well as outcomes. It allows examination of the intricacy of practice where various philosophies, theoretical bases and techniques are used. It focuses on the same unit of attention as does practice, so that the issues of the families and the Mentoring Mums program could be explored.

There are limits to conclusions that can be drawn from case study methods (Absler, 2006); (Mitchell, 1995). These relate particularly to reliability, validity and generalisability. Thick and rich description (Geertz, 1973: 6) and (Flyvbjerg, 2001), careful conceptualisation (Punch, 1998: 154) and care when making generalisations guards against these limitations. So does the use of multiple methods, as employed in this evaluation. Case study, properly used can provide strong tests of theory and ideas, programs, practice and systems, through posing questions at all these levels.

4. Interviews with new mothers to explore their experience of the program and what they think it has contributed to them, their parenting, and to their infant. The interview questions are provided at Appendix 3.

5. Use of focus groups

Focus group method is a well accepted method to elicit relevant data (Krueger and Casey, 2009); (Stewart, et al., 2007). Focus group method was chosen for particular participants in the program, because of their shared position and characteristics. Focus groups were conducted with some of the referrers, mentors and senior CPS managers.

5.1 With mentors to elicit their experience of the program

Two focus groups were held with mentors, one in 2009, one in 2010. The questions posed to the groups are outlined in Appendix 4.

5.2 With referrers to the program to ascertain community perception of the program

One of the evaluators met with staff from the Mercy Hospital, Social Work Department and conducted a telephone conversation with the Transition Clinic Coordinator. Further interviews were also conducted with representatives from the main services which had referred new mothers to the Program. The questions used for the service provider interviews are provided in Appendix 5.

5.3 With CPS staff

Both evaluators met with CPS senior managers and the acting CEO in late 2010. The focus group sought the views of the managers of the Mentoring Mums program and their sense of its integration within CPS.

6. A data tool was developed to provide a socio-demographic profile of the mentors involved with the Program. The tool was completed by 16 of the mentors. A copy of the tool is included in Appendix 6.

7. Survey outcome data from Maternal and Child Health Nurses involved with particular mothers

An evaluation of the children's developmental status across a number of areas, level of mother-infant attachment and parenting capacity was sought from Maternal and Child Health Nurses by the Mentoring Mums Coordinator. A copy of this tool is included in Appendix 7.

Building on existing research and a lengthy consultation process with senior Maternal and Child Health managers, Department of Human Services representatives and a consultant Enhanced Maternal and Child Health Nurse, the evaluators developed a specific data tool intended to have a dual function. Administered by the Mentoring Mums program Volunteer Coordinator, the tool provided feedback from the Maternal and Child Health Nurses regarding their observations of the level of attachment and bonding developing between the mother and child, the mother's developing parenting capacity, the infant's development across a number of markers and additional information including the mothers' involvement with the Maternal and Child Health Centres, the involvement of extended family and any comments the Maternal and Child Health Nurses had about the impact of the mothers involvement with the Mentoring Mums program.

The tool was developed to provide the program with important ongoing information from specialist service providers which would be used in an ongoing fashion throughout the course of each of the mother's involvement with the program. In addition, and with the mothers' consent, the data would provide the evaluation with objective external information regarding the mothers and babies progress.

Matters of Ethics

Questions of protection of participants from harm in the study were handled in a number of ways. Firstly, the study was explained carefully to all participants – the management and staff of CPS, mentors and new mothers. CPS management and staff were involved in the research design from the point of the application from the evaluators to conduct the evaluation, where the evaluation framework was described. Program staff were thoroughly involved in the design at every stage of the evaluation. All mentors and new mothers provided informed consent. The letters of explanation and consent forms are provided in Appendix 8. Privacy and confidentiality were further protected by disguise of case situations, names and locations.

Limitations of the evaluation as the evaluation unfolded

There were a number of unforeseen limitations to the evaluation

1. Underuse of the assessment tool

The assessment tool was developed to provide both practice and evaluation data. However, both Volunteer Coordinators struggled to complete it. Accordingly, we have 20 data tools from the 29 matches, some with data gaps. Additionally, we had hoped to measure outcomes of the program through the data tool for all cases, through a goal attainment scale, and two before and after measures – an eco map and the problem list. Unfortunately, these were not provided in a number of the data tools. While we are disappointed about the lack of data collected from these tools, we were able to gain strong outcome data from the case studies, interviews with mothers, the mentor focus groups, data from maternal and child health nurses, feedback from CPS staff, and feedback from referrers to the program.

A number of factors may have contributed to the underuse of these tools: the fit between program and evaluation requirements, time pressure for the Coordinators, pressure on the program because of its pilot nature, staff and leadership changes in the organisation and lack of clarity about the ongoing nature of the Volunteer Coordinator position and the program.

2. Limited number of mentors filling in the data tool on mentors

When it became apparent that only limited data was being kept by the program about the mentors, a specific data tool was developed. Unfortunately the period of time when the tool was developed coincided with the impending departure of the second Volunteer Coordinator. As a result completed data collection tools were only received for 16 of the 38 mentors who had taken part in the program.

3. Limited numbers of completed Maternal and Child Health Nurses Survey tools.

As described earlier, the tool developed for collection of this data was intended to be used as part of ongoing service review and liaison. Unfortunately, it was not. At the time of the second Volunteer Coordinator's announced resignation,

no tools had been completed. In the following months between October 2010 and March 2011 information was collected for twelve of the mothers and their babies involved with the program, by the second Volunteer Coordinator before she left CPS, and third Volunteer Coordinator and a CPS administrative staff member. That is, we have data on less than half the new mothers who were matched with mentors. This limits conclusions to be drawn, although does not negate the data on the twelve matches. We also have other outcome data which is congruent with the findings from the 12 matches.

4. Effects of change of staff – inability to follow up on data gaps after staff had left the program

5. Effects of organisational instability – inability to follow up on data gaps after staff had left the program and inability to ensure some data collection.

These effects have been discussed in points 1 and 3 above. Particularly, we were not able to follow up a couple areas of interest: the reasons a number of new mothers declined the service; and reasons for closure of several matches.

While these aspects limit the findings and conclusions, there is still rich data about the program from the data that was available

2. Description of the Mentoring Mums program

The first Manager of the Mentoring Mums program was the Manager, Organisational Development, who had drawn up the original funding proposal and had undertaken a small research project to ascertain the need for the program. A three-day-a-week Volunteer Coordinator was appointed to run the program.

The program was confronted initially by great success, and great difficulty. Work was done establishing and documenting organisational processes around volunteers. An advertising program in the community was very successful and 60 mentors volunteered. Many of these went through an orientation and training program.

Simultaneously, however, very few referrals were received from the intended primary referral source, the Transitions Clinic of the Mercy Hospital for Women.[2] This lead to a redefinition and broadening of the referral criteria. At the same time, the Program moved out of the development phase, and into an operations area within CPS. There was debate about where the Program would best be located (whether in Family Services, or in Early Childhood Services) with the decision being taken to locate it with the latter.

[2] There appeared to be inter-agency misunderstanding about this matter. CPS believed that all referrals would come from the Transitions Clinic, while the Mercy Hospital had the understanding that the Transition Clinic could not be the sole referrer.

At the same time as these matters were resolved, both the Manager, Organisational Development, and the first Volunteer Coordinator left the organisation.

A second Volunteer Coordinator was appointed. Referrals were now coming in regularly, and the Coordinator position was increased to a four-day-a week position. The increased hours were funded by shortening the length of time the program would be funded. This meant that the second Coordinator did not have job security beyond the 17 months of remaining funding from the Potter Foundation

The second Coordinator regularised all the program procedures. Orientation and training modules were written up, and a program manual was written.[3] Processes of supervision and support of the mentors continued with the larger number of mentors now taking part in the program as the number of matches increased. At the close of the evaluation period, the program had received 59 referrals, and had 38 mentors on the books. There had been 29 matches in the program, of which 18 were current. An additional mentor was matched to a family in Family Services. Program staff and management believed this to be a much more realistic target than the 45 matches originally planned. The experience of the program suggested that managing 20 matches was a full time job. The evaluators concur with this judgement.

As a result of the efforts of the two Coordinators, the third Coordinator (who commenced work early in 2011, at the end of the evaluation period) was appointed to a full-time position, at a higher classification than the previous Coordinators, reflecting CPS's understanding of the skilled nature of the position. The Coordinator inherited a program that had established recruitment processes and advertising programs; training programs; support and supervision processes; and client referral, intake and assessment processes, and practices of close liaison with the caseworker involved with each family.

3. Snapshot of the Mentoring Mums program

Introduction

From the program's commencement until mid December, 2010, the Mentoring Mums program had received 58 referrals. At this point, 29 matches had been made. Of these, 18 were active matches, and 11 had been matched and closed. (An additional mentor was placed with a family in Family Services but will not be included in this analysis.) Another 20 cases had declined the service. (Two had moved out of the area, and one was in a refuge.) Four women were unable to be engaged in the service, four had been assessed as inappropriate referrals, and two were on hold, one of these pending the discharge of her baby from hospital.

[3] The program manual is available from CPS.

Partly because of staff turnover at a late point in the data collection, the evaluation was unable to follow up reasons for the mothers declining the service, not engaging or being deemed to be an inappropriate referral. The following data come from a spreadsheet kept by the program on all referrals.

There were several referral sources.

- The Mercy Hospital for Women referred 24 women. Six different workers referred these 24 women, with two workers each referring eight new mothers.
- Maternal and Child Health Nurses referred three mothers
- One Enhanced Maternal and Child Health Nurse referred eight mothers
- A domiciliary midwife referred one mother, and a community midwife referred five mothers.
- Four Family Services agencies, including CPS, referred 11 mothers. Of the nine external referrals, three different workers in one agency referred six mothers, and two workers in another agency referred one new mother each. CPS had two workers refer one family each into the program.
- No data was entered for seven mothers.

These data are interesting, as they show that the program appeared to win the trust of several agencies and several workers within these agencies, including the Mercy Hospital for Women, Maternal and Child Health Nurses and the Enhanced service, and Family Services. They also indicate an extremely low level of referral from CPS.

Referral date:

Twenty one referrals were received in 2009, with the remaining 37 coming into the program in 2010. The earliest referral was towards the end of April, 2009, the latest in October 2010, when there was uncertainty within the program about future funding. Data collection then closed before it could be seen whether referrals recommenced coming into the program, when a decision was made to continue the program for another year.

Profile of 20 referrals to the program

The summary provided below comes from data on 20 of the 29 matches, provided through a tool filled in by the Program Coordinators. Information was provided by the first Coordinator when she left the position in November 2009, by the second Coordinator, when she left in November, 2010, and the Manager of the program after that time. There are some data gaps, so not all categories reported below have data on the full 20 cases. The total number of women where data was provided will be given for each category if the number (n) is less than 20. Data on the fathers is less complete, given the number of sole parent mothers. Data of fathers will be given where available.

Referral date (n=19):

The earliest referral was towards the end of April, 2009, with three referrals in July, one in August, two in October, two in November, one each in December,

2009, and January, February, March and May, 2010. Three members of the sample were referred in July 2010, with one each in August and September, 2010.

Referral source (n=19):

Thirteen referrals came from the Mercy Hospital for Women. Three referrals came from three different Family Services agencies. Two referrals came from an enhanced Maternal and Child Health Nurse. One referral came from a community midwife. Despite expressed concern early in the program history, we note that the Mercy Hospital in fact provided the majority of referrals, both in the sample of 20 and the overall group of new mothers.

Whether the referrals matched program criteria:

The initial aim of the program had been to recruit very young mums (under the age of 18 years) or chemically dependent or aboriginal mothers of any age.

No aboriginal women were referred. Three chemically dependent women were referred, and substance abuse had been present in the past for three additional mothers.

None of the women were in the 10-19 year age group. Twelve women were in their twenties, seven were in their thirties, and one was in her forties.

However, all women met the revised criteria of eligibility for referral to Child FIRST, and were socially isolated.

Age of the fathers (n=14):

Three fathers were in their twenties, eight were in their thirties, two were in their forties and one was in his fifties.

Marital status – mothers:

Ten of the mothers were married, five were in defacto relationships, four were sole parents and one had separated from her partner.

Of these 20 families, three had very complex family structures with children having different fathers, and complex step and half relationships.

Postcode (n=9):

Four women lived in one suburb, the remaining six were in different suburbs from the one suburb, and from the other women.

Country of birth, ethnicity, language and English proficiency:

The new mothers were predominantly Australian born, but nearly a quarter were born overseas, with one mother and one father in two different families struggling with English. Five of the fathers were also born overseas.

Fifteen of the mothers were born in Australia, were Australian non-aboriginal, and English was their mother tongue. Five mothers were born outside Australia. We know that three women had migrated recently to Australia, one from the Indian subcontinent with her compatriot husband, the other from South East Asia with her Australian husband, and one from the Middle East, with her Middle Eastern husband. Two of the women spoke English well, while one spoke it not very well, but her husband spoke English well. We do not know how long the other two mothers had been in Australia. One was an Islander, and the other was from the Indian subcontinent. One was married to an Australian and the other to a compatriot and both they and their husbands spoke English very well.

Of the fathers, five were born overseas. As well as the already mentioned fathers from the Indian subcontinent and the Middle East, another was from the Indian subcontinent and the other was from Europe. One spoke English well, and the other did not.

Education (n=15):

The mothers had a range of educational experience – from the highly educated to the educationally disadvantaged. Four had completed university, another was currently deferred from her university course, and a sixth had commenced university, but had not completed it. However, two mothers had only completed year 9, four mothers had completed year 10, two mothers had completed year 11, one had completed year 12 and one had commenced a TAFE course.

Our data on the fathers is incomplete (n=10) but they had the same range of educational achievement. Five had completed university degrees. One had achieved year 8 or below, one had completed year 9, one had completed year 11 and another year 12.

Employment and income source (n=17-20 mothers):

The data suggest the existence of several groups of families: the fully employed, those experiencing underemployment (including some families with university education), and those excluded from the workforce – the excluded families. Eight of 20 families were reliant on government pensions.

All but three mothers who had some casual employment, were engaged in fulltime home duties, caring for their infants. Two mothers had never worked outside the home, and six listed themselves as unemployed for more than two years. Three families where the parents had completed or enrolled in university gained their income from the father's fulltime employment. Two other families where the father had completed university had casual employment – one full-time and one part-time. Another who had enrolled in university, but had not completed, had casual part-time employment.

Two other fathers had permanent full-time employment. One father had completed year 11, and we have no data on the educational achievement of either parent in the other family.

The family where the father had completed year 12 relied on his permanent part-time employment and a government pension. Three other families gained their income from casual part-time employment and government pensions.

Eight families were reliant on government pensions as their sole income. These included four sole parents and four two-parent families. Mental illness in both parents was the reason for receipt of government pension in one case, and the three other families were seriously troubled families where neither partner had worked for years, and substance abuse was present in one case. Of the eight families reliant on government pensions alone, six showed many of the characteristics of excluded families: multiple problems, difficulties with their families of origin, mental illness, chronic, long term unemployment, and sometimes, substance abuse and family violence. In one of these families, the father (who finished school in year 9) had never worked.

Housing (n=19):

The data on housing show that a minority of families were experiencing homelessness and housing insecurity, another minority at the other end of the spectrum were buying their homes, while the majority were renting – either privately or publically. Given the number reliant on government pensions, and the shortage of affordable rental housing, we would predict financial stress for many of the 10 families renting privately.

Looking at housing in isolation:

- Two mothers were in transitional housing
- One family was renting from the mother's parents
- Three families were renting public housing
- Ten families were in private rental
- Three families were purchasing their homes

The two mothers who completed year 10 as their highest education were both in transitional housing. Three families with permanent full-time employment were purchasing their homes (a unit in one case). In two of these families, the father had completed university education, while the two other tertiary educated father families were in private rental, either house or flat. Seven other families were renting private flats, and three families were public housing tenants. One family was renting accommodation from the mother's parents, and there is no data for one family.

Studying:

One mother was planning to study, one was studying part time, and one was undertaking full-time study.

Legal issues – Children's and Family Court (n=18):

One family was subject to a Children's Court Order, and three families were subject to Family Court Orders.

Criminal justice or other Legal issues (n=16):

Four families had legal issues. The father of the youngest baby in one family was currently in jail, and there was an intervention order against him having contact with the oldest child in the family. The mother in another family had previous charges, another mother was facing charges currently, and a third had filed for bankruptcy.

Family history and social contact as discerned through geno grams:

Collection of data through geno-grams was disappointing. Nine geno-grams were missing entirely, and a further six had very limited data. The information may have been known by the Coordinators, but not transcribed onto the data collection tool.

Six families had cut-off or severe tension with their families of origin. Two of these had histories of child abuse and neglect in their own childhood, which affected their current relationships with their families.

Three families had very complex family structures – children by different partners, and a similar pattern in their immediate family of origin.

The geno-gram data of three migrant families showed that the refugee mother was separated from a widely dispersed family of origin, while the other two mothers maintained daily contact with their families via the computer.

Social isolation:

Eco maps were only completed for nine of the 20 families. The nine showed that social isolation was a serious problem in many of the families. The problem list (which was completed for many more families), provides supporting evidence for this conclusion, showing isolation as a problem for 18 of the 20 families.

The eco map data divided the families into two groups, with the two overseas-born women) being more isolated from the service system than their seven Australian-born counterparts, but having much closer and more supportive relationships with their extended families overseas.

1. Families where the mother was recently arrived from overseas.

Despite physical isolation from extended families overseas, two recently arrived mothers maintained daily phone/computer-based phone contact with their mothers and were able to communicate with other family members as well. In both cases, the husbands were in fulltime employment here in Australia. However, both mothers lacked friends and relations in Australia. Both were gradually being linked into the Australian service system, mainly through the birth of their baby, to services, such as enhanced maternal and child health nurse and family support services (in one case). Both had less contact with the service system than the mothers born in Australia.

2. Families with mothers born in Australia.

All seven mothers had helping agencies involved in their lives – six had mental health services sometimes combined with additional counselling services and the others were clients of Family Services. All were involved with the Maternal and Child Health Nurses and two were involved with the Enhanced Maternal and Child Health service. One was involved with a Crisis Housing service.

The eco maps show more isolation within the informal network. Six of the seven were either isolated from or have tension and conflict with their extended families. None were blessed with a variety of friends. Two had no friends, one had a tension-filled relationship with her only friend and one mother had one friend.

The eco map of two families, one a recently migrated family, showed that all the friends in the network were on the father's side – the mothers were lacking friends.

Problems faced by the families:

All the families faced a number of serious problems, and all but one family had difficulties in all three levels: family-environment level, the family system level, and the individual level.

The family with the highest number of problems had 21 difficulties. The range of number of difficulties was 4, 5, 6, 7, 8, 9, 9, 10, 10, 11, 13, 13, 13, 14, 14, 15, 16, 16, 18 and 21. The mean was 11.6 problems per family.

The type of problems included financial difficulties, inadequate housing, educational disadvantage, unemployment, involvement with the criminal justice system, isolation from the service system, isolation from extended family, isolation from social networks, destructive neighbourhoods, physical and mental ill-health, intellectual and physical disability, substance abuse (current and past) sexual assault history in childhood and adulthood, child behaviour difficulties, unresolved family of origin issues, trauma (current and past) parental involvement in child welfare services as a child, parenting difficulties, relationship issues between the adults in the families, family violence, and migration issues. Specifically:

- Seventeen families experienced some degree of mental ill-health.
- Seventeen families had physical isolation from, or serious conflict with, extended family. (In three cases, the mothers were physically separated from them.)
- Seventeen families suffered some kind of employment disadvantage. Five experienced short-term unemployment, six were long term unemployed, nine experienced under-employment, and four experienced inappropriate work conditions.
- Twelve families were isolated from social networks. (For three families, the reason was recent migration.)
- Twelve experienced severe financial difficulties.

- Ten families had educational disadvantage.
- Ten were living in inadequate housing or were experiencing insecure housing or homelessness.
- Seven were living in neighbourhoods characterised by high levels of violence and criminality.
- Eleven had some degree of isolation from the service system.
- Eleven had unresolved family of origin issues.
- Twelve had adult-adult relationship issues.
- Ten had experienced current or past trauma.
- Six had been involved in the child protection system as children.
- Nine were having adult-adult relationship difficulties.
- Eight were experiencing parenting difficulties.
- Five had experienced family violence in the past, and the violence was still current for one.

Six families had physical health problems, two had an adult member with intellectual disability, and six families had been affected by substance abuse, two in the past and four currently.

Apart from the very high number of families facing mental illness difficulties, the most worrying feature to emerge from this description is the extent of negative factors in the environment that impinge on the families. Poverty, homelessness and housing insecurity, unemployment and poor work conditions, educational disadvantage, isolation from the service system, and neighbourhoods identified by the mothers as unsafe, all combine to make it much more difficult to raise infants and children well.

In addition, large numbers in the sample have experienced trauma and carry scars from their families of origin. A smaller group in the sample have had to cope with substance abuse and its aftermath, family violence, and sexual assault.

In short, the data suggests that the environments of the families were less than supportive of family life, and that the families themselves bore many burdens at the family-environment, family system and individual levels.

Linkage to the service system (n=18)

The 18 families were all linked into the service system. Seven families had at least two organisations involved in their care (in addition to the Mentoring Mums program). Six families were involved with three other organisations, one family had four organisations, two families had five organisations and another two had six organisations involved in their care. Despite this, eleven of the families were listed by the Coordinator as being isolated from the service system indicating that, as is frequently the situation for vulnerable families facing complex difficulties, the quality of engagement with these services may have been

minimal. In some cases, there were areas of need where no service was involved. Lack of trust and excluding processes between the mothers and the service system may also have contributed to this sense.

Characterisation of the families

There is sufficient data on 16 of the 20 families to be able to make a classification of the families involved with the Mentoring Mums program. Of the sixteen,

- Eight appear to be excluded families
- Four appear to be experiencing crises of migration and resettlement
- Three seemed to be affected primarily by mental health factors, and
- One appeared to be a mother suffering a crisis of transition to motherhood.

Mentors with excluded families will need assistance in understanding the complexity of their lives, their cut-off from community norms, and a range of normatively unacceptable behaviour and attitudes.

Mentors involved with mothers affected predominantly by mental illness will need particular support to understand the effects of mental illness, and the specific needs for treatment and recovery.

Mentors involved with newly arrived migrants or refugees will face the ever-present reality of cultural differences and misunderstandings, as well as having to face language barriers.

It is clear from this, and from other data (focus group sessions with mentors) that mentors need particular knowledge in relation to their particular new mother, if the relationship between mentor and new mother is to grow into a rewarding, constructive and trusting one, and if match is to be ultimately successful.

The focus groups with the mentors, the feedback from the mothers, from the Coordinator, and the data from the case studies suggest that mentors can be matched and supported, and that the mentor-new mother relationships can be sustained and achieve goals, with this range of families.

Outcomes data

We had hoped to measure program outcomes through a goal attainment scale, and two before and after measures – an eco map and the problem list. We have these measures for the five case studies. Of the remaining 15 cases, seven were closed. Of these, there is only outcome data provided on one case. The goal attainment scale gave the second highest rating for both the establishment of the mentor-new mother relationship, and for the goals attained. The problem list and eco map at closing were not provided. Other outcome data for the program is reported in other sections of this Report.

In summary, the mothers met revised program eligibility. They had a variety of backgrounds and faced a large number of serious and entrenched difficulties. Of the sample of 16, half appeared to be excluded families, those with the most profound and longstanding difficulties. But the data also showed that, despite this, the program was successful in gaining referrals, establishing its reputation in the service system, effectively recruiting, training, matching and supporting matches between mentors and new mothers.

4. Analysis of five case studies

The evaluation design incorporated detailed case studies of five mentor-new mother relationships, to explore the characteristics of the new mothers able to be supported by the program, the processes of the program and the outcomes achieved by it.

Description and categorisation of the five new mother families

All five families met the revised referral criteria for the Program. All were socially isolated, had other serious difficulties, and there was concern about the wellbeing of the infants. All were eligible for referral to Child FIRST. Three mothers were referred from the Mercy Hospital Social Work department, the fourth from a community midwife, and the fifth mother was referred from a Maternal and Child Health Nurse. Both these mothers were also involved with the Mercy Hospital for Women and there was liaison between the Hospital and the Mentoring Mums program. All mothers had multiple serious problems at the individual, family and family-environment levels. All needed help and support with their parenting. All were involved with Family Services or the Enhanced Maternal and Child Health Nurse service (in some cases, both) and four of the five mothers had regular contact with mental health services.

One mother's problems included severe financial difficulties, inadequate housing, isolation from extended family (as a result of childhood abuse and family fragmentation), past substance abuse and current adult-adult relationship issues. This mother was a sole parent, was in her early twenties, and, at the time of the interview her infant was about ten months old. The mentor had been involved for nearly nine months.

We typify this mother as struggling with parenting as a result of childhood abuse and its aftermath on current parenting, exacerbated by social isolation, itself stemming from the childhood abuse and the pathways into which this had precipitated the mother. Although there is some lack of data due to the reluctance of the mother to provide data about her family of origin, we suggest this mother was, in all probability, an excluded family.[4]

[4] 'Excluded family' is a specific term first used by Tierney (1976) and then by Mitchell (1995, 2008) and summarised by Mitchell and Campbell (2010) to describe a particular group of families typically present in any group of families presenting to homelessness services, Family Services, child protection, or out of home care services. These families have particular characteristics. They are described individually here, are discussed in general terms below.

The second mother was married to her partner, and both were in their forties. Their baby was 5 months old at the point of the research interview, and the mother had been involved with Mentoring Mums for about six months. The mother suffered serious mental health difficulties, as did her partner. Both were involved with the mental health services system. Family Services and an Enhanced Maternal and Child Health Nurse were also involved. There were fears about the well-being of the infant. Neither parent was able to work, and both were dependent on government pensions. They resented the intrusion of services into their lives, were often reluctant to be involved, felt overwhelmed and judged by services, and had little support from extended family. They had parenting difficulties and sometimes, difficulties with each other.

We typify this family is as being deeply affected by longstanding mental illness and its multiple effects on individual and family functioning and on social exclusion, over time.

The third mother was in her mid twenties. She had a pre-school child while living with a partner (though he was not the father of the child), from whom she had been separated for two years, and a new partner and father of her unborn baby. Family violence had typified her first relationship. The new mother suffered serious depression, and had had psychotic episodes which required hospitalisation. The family had at least 14 serious difficulties. Although the presenting problems included severe psychotic episodes requiring hospitalisation for the mother, these presenting problems overlaid long-term, entrenched and serious difficulties since childhood. These included childhood abuse and neglect, fractured living arrangements in childhood including periods of time in out of home care, a highly complex family structure of parents, step parents on both sides, siblings, and half-siblings with cut-off relationships and estrangement typifying some of these relationships, and family violence, substance abuse and gambling problems for her parents.

Our assessment is that this family was an excluded family, with the picture complicated by serious mental illness in the mother.

The fourth mother was in her thirties, had a one month old infant, and lived with her partner at the point she was referred to the New Mum's program. The family were living in a house completely shut up, with all windows blacked-out on the insistence of the partner. Shortly after the mentor became involved, the mother moved into a women's refuge to separate from the partner. The family had 16 major problems. These included severe childhood abuse of the mother as a child, her experience as ward of the state (which included child abuse while in care) and the more recent difficulties with her partner, and current housing and financial problems. The mother was divorced from a previous husband, but they had no children. The mother had no contact with either of her parents or any other family member, and had no friends at all. A number of the difficulties had been present for many, many years. The mother suffered mental illness, and regularly attended a mental health service.

Our assessment is that this mother was part of an excluded family,

The fifth mother was in her early twenties. She had been diagnosed as suffering schizophrenia, and was living with her current partner who suffered drug-induced psychosis and was under a court order to attend psychiatric services. As in the case of the third mother described above, the fifth mother and her partner also experienced childhood abuse and neglect. This mother also had a pre-school age child by a previous partner, with whom she had experienced severe family violence – the cause of the ending of the relationship two years previously. The child showed symptoms of developmental and speech delay, and the mother had not attended any ante-natal care during her current pregnancy, prior to the involvement of the mentor.

Our assessment is that both parents in this family were members of excluded families, and were continuing the life of exclusion, which included living in sub-standard accommodation rented from an unscrupulous landlord, and the already described problems of mental illness, and substance abuse.

There are several matters of note in the preceding description of the case study mothers.

1. Mental illness

Four of the five mothers and two of their partners experienced severe mental illness. In all but one family, we see their mental illness as part of a more complex presentation typical in excluded families (see discussion of excluded families below). In all four cases, the mental illness was severe, with psychosis being experienced by three of the four women and both of the male partners. This characteristic presents particular challenges to professional staff in mainstream services, and even more so for mentors (given community fear, and lack of understanding, of mental illness generally). Mentors therefore need specific support and expertise to be able to respond to the needs of such families.

2. Severe social isolation

All five women suffered social isolation, especially within their informal networks of friends and extended family. One mother had no friends and no contact with family. Two mothers had contact only with associates that they saw as destructive of family life – those who would pull them away from parenting responsibilities and back into substance abuse or adult entertainment industry networks. The fourth mother had very limited contact with only some members of her extended family, but was estranged from several other members of that network. Although data is lacking on the social network of this mother, she did not appear to have friends she could call on for any emotional or practical support. The fifth mother and her partner had a supportive relationship with one couple in their extended family, but their mental illness had proved an insurmountable barrier to development and maintenance of friendships.

Social isolation rarely appears as the sole difficulty of families or individuals. Nonetheless, a range of theory and research, from attachment theory, child development theory, ecological and network theory and research, as well as practice experience, all suggest that its negative effect on individual and family

functioning, and on people's sense of well-being and happiness, can be taken largely for granted. It seems that it is well nigh impossible to raise children successfully in social isolation. This is one characteristic of the families in the New Mum's program that the program was established to change.

3. Excluded families

Three of the families were excluded families, and a fourth mother may have been a member of such a family – her reluctance to provide information about her family of origin made it difficult to make this assessment with certainty. Excluded families are a specific group within Family Services and they have been described in detail elsewhere (Tierney, 1976, Mitchell, 1995, Mitchell *et al*, 2008, Mitchell and Campbell, 2011 in print). There characteristics are summarised in the Table 1.

Table 1: Characteristics of a sample of excluded families (from Mitchell and Campbell, 2011, in print)

<table>
<tr><th>Range of problems</th><th>Indicators of complexity</th><th>Informal network</th><th>Formal network</th></tr>
<tr><td rowspan="2">Family violence
Sexual abuse
Substance abuse
Poverty
Social isolation
Educational disadvantage
Mental illness
Severe problems in parenting
Low motivation to change
(Commonly, many of these problems appear in each excluded family)</td><td rowspan="2">Multiple, serious, entrenched , chronic and interacting problems at multiple levels – individual, family and environment
Complex family structures and processes
Long histories of contact with Child Protection as parents
Experiences of multiple trauma</td><td>Difficulties persist across at least three generations
Parental history of childhood abuse and neglect with or without placement
Problems with the informal world of friends and relations : weakened or blurred boundaries, or cut off and extreme isolation</td><td>Exclusion from services
Family members resisting contact with services.
Interventions from services which fail to provide consistency, connectedness or stability to parents or children, and fail to address their problems</td></tr>
<tr><td colspan="2">Isolation and cut-off from mainstream community life.</td></tr>
</table>

A cursory consideration of Table 1 shows the difficulties excluded families will have in trying to rear their children successfully. It also indicates the barriers that the service system has in trying to bring about change in the multiple, entrenched, chronic and serious difficulties experienced by excluded families. It highlights the likely points of culture clash and difficulties for engagement and gaining agreement on goals, as excluded families put all their efforts into struggling to survive and the service system focuses on prevention of harm and other child-centred foci. And it demonstrates the fundamental need for mentors to address social isolation within the informal network, and the complete cut-off

excluded families have from community norms about parenting, child development, and network development and maintenance, while also indicating some of the reciprocal difficulties mentors and new mothers might have in engaging and remaining engaged, with each other. The data we have on at least three and possibly four of the five case study families will allow us to draw conclusions about involving mentors with excluded families, at the end of this section.

Description of the mentors with which the new mothers were matched

Four mentors were involved with the five cases, with one mentor being placed sequentially with two of the mothers. One placement finished when the mother and her partner decided that there were too many people visiting the home, and that the mentor relationship should be put on hold for a period.

Four mentors were of Australian birth, with the fifth being born in the UK. One was in her early thirties with a partner and three children. She was described as very easy going, interested and non-judgemental of the mother she was involved with, but also as very observant. The family had a lot of energy, with all being heavily involved in sporting activities and additional activities outside of their work and family life.

The second mentor, matched with two new mothers consecutively, was a middle aged woman with adult children and a partner. This mentor had had some serious difficulties in her life including experience of abuse. Her life experiences contributed to her obvious strength of character, despite her quiet demeanour. These qualities were recognised by the two new mothers with whom she was placed, and contributed to the strength of the mentor-new mother relationship in both cases. The new mothers recognised someone who was sympathetic to their situation because that person had experienced difficulties in life too. The mentor was committed, talented (though she might be embarrassed by this description) and very thoughtful about the new mother and her situation.

The third mentor lived with her two children, her partner and her mother. She was in her early forties, happy and confident in her position in life, with a fulfilling career as a yoga teacher, strongly influenced by a family culture of concern for those less well-off in life and commitment to assist them wherever possible.

The fourth mentor was retired, in her mid to late sixties. She had previously worked as a kindergarten and prep teacher, before managing her own business. She had four adult children and two grandchildren. She had worked in a socio-economically disadvantage area as a teacher, and was committed to supporting the new mother with whom she was matched, who was a member of an excluded family.

Goals set for the volunteers' involvement with the new mothers.

All cases shared three main goals, although there was variation in the wording of the goal:

- establishing the relationship between the mentor and the new mother;
- greater attachment between mother and infant
- reducing social isolation and building connection to the community

These are unsurprising goals, given the objectives of the Mentoring Mums program. However, the goals were particularised to each of the new mothers, according to their needs and situation. The example of play illustrates this point.

> One of the mothers was setting herself enormously high standards, without any experience in her own childhood of age-appropriate attention. Helping her to understand her particular baby's needs for age-appropriate play, attention and stimulation was a major focus.
>
> The second mother was beset by injunctions from services about how to care for her baby, and had very little confidence. She would do all the practical care of her baby, but felt very uncertain about interacting and playing with her. Teaching her some basic ways to play with her baby become an important focus of the mentor. The co-ordinator and the mentors had a clear understanding of these goals for each new mother.

Three cases had a number of additional goals. They demonstrated that the mentor intervention was particularised to the needs of each mother. The additional goals may also reflect that these three cases were matched by the second co-ordinator, and demonstrate her understanding of the possible breadth of scope of the mentor-new mother relationship. Or, the additional goals may have developed as the program staff learnt from experience with the mentors just how much they could undertake with their new mother.

In three cases, a goal related to the mother's mental health: supporting her to maintain mental health support (three cases) and supporting her to take medication (one of these three).

In three cases a number of goals could be seen as directed towards teaching members of excluded families community norms about accessing and interacting with the formal service system, and norms of constructive parenting practices focussed on child development. The co-ordinator did not relate the goals to explicit theory about excluded families, but understood that these goals needed to be realised, if successful parenting and connection to the community were to be achieved. In all cases the situation to be changed was serious, but in two of the cases, the changes needed were extreme. In relation to the formal service system, goals included supporting mental health service contact in three cases, linking into some TAFE training so that employment could be found (one case), and attending ante natal and paediatric assessments and follow up, and enrolling a child in kindergarten and school in another case.

> In this case the mother had not attended any ante natal appointments and her oldest child had had no contact with kindergarten, despite being nearly 5 years old.

In two cases the changes needed in parenting were extreme.

> For one mother, goals included removing cardboard and black plastic from windows to allow the baby to experience light, getting the mother to take the baby outside the

house, and helping the mother see that her baby was not exhibiting sexualised behaviour (flirting and manipulation) – rather she was just being a baby.

In the other case, it involved helping the mother to see basic needs of an older child (nearly five years) – his need for attention and affection, attention to his serious health and development needs (the child had had an untreated throat infection for many months and had never attended pre-school).

In all three cases, the mother needed help with structure, organisation and routine that centred on the babies and children. Sometimes the mother's mental health contributed to these difficulties, but in all cases it also reflected the mother's difficulty in seeing and organising herself around the needs of her baby or older child.

An underlying need which the co-ordinator hoped the mentor would address was that of helping these three excluded family mothers to develop the motivation to change these areas of their lives. Problems with such motivation has been identified as one of the characteristics of excluded families (Mitchell, 1995, p.67-73).

The process of helping

Analysis of the processes of helping shows delicate sensitive work on the part of all the mentors and the Mentoring Mums Coordinator. It shows strength and resilience in all parties, including the new mothers. It shows deeply held and enacted commitment of the mentors to each mother, and an openness and courage on the part of the new mothers to allow the possibility of a supportive relationship to develop. It also shows high levels of skill, art, knowledge and theory necessary in the Coordinator position. Analysis of the processes of helping also shows how the mentor, Coordinator and new mothers realised the changes that were made.

<u>The mentor – new mother relationship</u>

Professional literature has identified a number of common processes known to be effective in establishing and maintaining relationships and bringing about change.

The processes used by mentors included: consistency, reliability, and honesty, being warm and friendly, often keeping the relationship light and enjoyable and using humour, careful listening, acceptance of the mother by the mentor at all times, and regardless of how challenging or difficult the mentor found particular behaviour or attitudes, being non-judgemental in all circumstances, affirmation of feelings expressed by the mother, and praise of the mother's mothering and caring capacities.

While professionals would see the use of these qualities in a relationship as being essential in developing trust (a task most necessary with this group of new mothers for whom distrust based in experience of abandonment and betrayal, were common) the mentors themselves talked of this in terms of women supporting women to do 'women's work' – mothering – which should

come naturally to us, but which, in the eyes of the mentors, is often not valued as it should be in our society.[5]

All mentors also spent considerable amounts of time noticing the baby, noticing the things the mother did that were positive, and speaking their 'noticing' out loud to the mothers. They shared from their own experience as mothers

> 'When my kiddies cheeks were red like that they were often teething' leading to a discussion of the signs – the child being unsettled and crying more (because teething hurts), and the dribbling. This was followed by discussion of things that might help: 'what does the Maternal and Child Health Nurse say? My kiddies seemed to get some relieve from those teething rings you put in the fridge, so that they are biting on something that is cooling, and therefore, soothing.'

In the two cases where there was an older child, the mentors both used the same approach to help the mother focus on the needs of the older child, or to share knowledge about children's needs, or parenting approaches.

> One mentor talked with her new mother about what she used to do for her children, if she had to go to an appointment which meant lots of waiting around. She talked about taking a special 'outing' bag, with a change of clothes, a picture book, some toys, something nice to eat and drink, so that there was something for the four year old to do. After a few visits of talking about this as she got the bag ready, she found that the new mother had the bag ready when she arrived to take her and the four year old to the appointment.

All mentors did a lot of modelling of responsiveness to babies and teaching of parenting from their own experience. The previous examples of what to do when the baby was teething, or how to amuse an older child while waiting for appointments, are cases in point. Here is another example

> One mother was very good at all the physical care, but did not relate very much to her baby. The mentor began a conversation about action songs and nursery rhymes. Could the mother remember any of that from when she was a child? (The mother had no such memories). Would the mother like her to teach her some? Yes, she would. So she began with 'Rock a bye baby', bouncing the baby on her knee and letting the baby 'fall' between her legs at the right moment in the rhyme. The baby was delighted. The mentor supported the mother to give it a go. She talked about how babies learn by repeating this sort of thing many, many times, and that they seem to go on loving it, no matter how many times you do it. After a while the mother was able to do this without prompting from the mentor. Later still, on one visit, the mother was doing the rhyme and the mentor noticed the baby starting to laugh at the beginning of the 'When the bough breaks' line. She was able to 'notice' this with the mother, so they could all see how the baby was learning, how clever the baby was, how the mother must have been practising this with the baby for this learning to have happened. And what a good mother she was being.

Modelling was combined with a number of other components, like noticing the baby and praising the mother:

> Another mentor noticed immediately that the mother was holding the baby at arm's length to feed her. She noticed out loud that the baby didn't look too comfortable, and shared by showing, how she used to hold her own babies when she fed them. When the mother held and cuddled the baby, in response to the mentor's modelling, the

[5] Focus group discussion with mentors

> mentor noticed the responsiveness in the baby: 'Isn't she such a lovely baby, and look how she's looking at you and smiling at you. You must be doing such a good job, to have such a lovely response from her.'

There was evidence in two of the cases that the new mothers saw the mentors as models for themselves, not just as mothers, but as women. The mentors lived lives to which the new mothers aspired. They were the women the new mothers would like to be. This was the case despite the differences between the new mothers and the mentors, with the new mothers in question being excluded families, and the mentors being middle class, comfortably-off women with all the advantages of education and material security. In one case, the new mother's life was full of drama and constant crisis, while the mentor's life was calm and ordered. Far from wanting to continue a life of crisis, the new mother saw the possibility, perhaps for the first time, of a different way of living, and was attracted to that way.

Paradoxically, the mothers also saw the mentors as people just like them. They did not see the middle class, well-off, secure and confident women some others saw. Instead, they were able to identify with the mentors as women who had also had their struggles in family life and parenting. This process of identification promoted development of trust, which in turn enabled them to use the support and guidance of the mentors in a way that had not been possible in their relationships with professionals.

In the second case, the mentor and new mother were able to talk about some difficulties they had shared – one in a previous marriage relationship, the other in her relationship with her current partner. The new mother could see that the mentor had survived a very difficult relationship, could acknowledge the effects of that relationship on her (which helped the new mother to do the same) and that a variety of paths were actually open to her.

All of the relationships were involved in helping to link the new mother to the community, though this was particularly evident in three of the cases. Linking involved taking the new mother to appointments so that the mother accessed formal services or taking the mother to the local library or health centre or play-group, and encouraging the new mother towards regular attendance. In another case it involved spending time supporting the intervention of professionals involved in the case. The mentor would ask – what does the Maternal and Child Health Nurse say – and then support that, rather than confusing the mother with different points of view.

One case showed an even more active role, with the mentor mediating the formal service system to the mother. The mentor was introduced to the mother during the last trimester of her pregnancy. She had not attended any ante-natal medical care. The mentor provided emotional and practical support and drove her to an appointment, supported her through the obstetrician's anger (on behalf of the unborn baby), mediated the obstetrician's perspective to the new mother ("she is just so concerned about your baby – that's why she was so angry") and then supported her to the next appointment. On this occasion the doctor was warm and caring, and the mother began to understand the doctor's

previous reactions. These processes were observable in all the cases, to varying extents.

One mentor-new mother relationship showed the benefits of a very clear brief – for all the parties concerned. The new mother suffered serious depression. The initial contacts between the Coordinator, new mother and mentor focussed on what the new mother wanted the mentor to do when she was depressed. Did she want the mentor to accept the new mother's cancellation of the visit? Did she want the program to persist in trying to phone her when she was depressed? The new mother was clear that she withdrew when she was depressed, that her withdrawal was unhelpful to her, and that she wanted the mentor, through the Coordinator, to persist in contacting her, and to encourage her not to cancel arrangements with the mentor. The Coordinator and mentor felt clear about their roles and that they were doing what the mother wanted. They persisted, and the new mother found that she could keep the arrangements, even when she was depressed.

One mentor illustrated the ways mentors negotiated the differences in interest and motivation, between themselves and the new mother with whom they were matched. This mentor had to make the effort to be interested in what the new mother was interested in. She herself was a very active woman, and loved nothing more than to go for a walk in the park. This was not the way for the new mother, however. She didn't like to walk anywhere, and loved shops and shopping. Without very much disposable income, the trips the mentor and new mother regularly took involved window shopping and a coffee – which the new mother enjoyed enormously.

The same mentor had to find how to keep a relationship with someone who was, on occasions, very defensive, and very reluctant to take advice. A number of the mentors had to negotiate similar situations. This particular mentor overcame the hurdles by carefully listening to the mother, finding out what she wanted and then followed, supported and affirmed the mother in the role of decision maker. Over time, the new mother came to be able to ask the mentor's opinion, because she knew it would not be forced on her, that she was free to take or leave advice she sought.

One mentor learnt to go at the pace of the new mother, rather than at her own. The mother concerned suffered acrophobia, and, while she wanted to go out for a walk, found it very difficult to do so. The mentor remained patient. If the mother could, they would; if she felt she couldn't, they didn't go. An associated process was this mentor's firm adherence to the rule that every day is a new day. Just because the mother couldn't go out last week, did not mean she would not be able to go out this week.

This same mentor brought small hand-made gifts to the mother to build the relationship. She also offered practical help – to drive the new mother to an appointment, for example. She also faced the problem of pressure on the couple from all the services involved with them, leaving them feeling overwhelmed. With the Coordinator leading the meeting, it was agreed that the mentor would reduce the amount of time she spent on each visit. She then had to enact this in the face of the mother always wanting her to stay longer.

One mentor had the happy knack of being able to appropriately be honest about herself and her situation, so that the new mother felt able to give back to the mentor. She appropriately sensed that this level of disclosure was the key to bonding further with this particular mother. She shared with the new mother that she had to undergo an operation, and was open about the nature of the medical problem and the procedure. This enabled the new mother to express care and concern for the mentor. The mentor, through this approach, was establishing and allowing, normal reciprocity.

Finally, attention needs to be given to some of the dramatic levels of time and commitment given by some mentors, who had the time, and were prepared to give it. One mentor spent many hours in addition to the 'recommended' level of time commitment. She did this because she could see that the new mother had a high level of unmet need. The mother was entirely without any other supports and had a four year old child who was developmentally delayed who needed but was not accessing services and was not participating in kindergarten. The mother had multiple serious and entrenched difficulties, as did her partner. She was not accessing ante natal care. Her four year old was developmentally at risk, the un-born baby was already at risk due to lack of medical care, and the family were socially isolated and excluded from the community. Services could see the need, but did not have the resources to meet it. The mentor, on the other hand, had the time, was prepared to give it, and in consequence, the four year old was medically assessed, attended treatment, and the mother accessed and became a regular attender for antenatal care. In addition, the mentor and mother were developing a strong and trusting relationship – no mean feat for a mother who had many experiences of abandonment and betrayal, and none of reliable, consistent and trustworthy friendship.

In contrast, another mentor did not meet the minimum requirements of contact. This illustrates the individual differences in each mentor-new mother relationship, with various elements in different balance in each. We will chart the effects of these processes in a later section.

Conceptualising the role of the mentor

The original application for funding for the Mentoring Mums program likened the role of the mentors to "Doulas", wise & worldly women, who were to "provide a supportive, caring voluntary relationship to assist vulnerable Mums".[6] Doulas, now called mentors, were to be "suitably recruited, trained and supported ... who would walk with the woman during her pregnancy and maintain contact and a supportive relationship during the early childhood years". The application explained the origin of the idea: "'Doula' is an ancient Greek word for a non–medically trained support person who provides continuous emotional, physical and informational support through pregnancy, labour and after childbirth. Traditionally, this role has a specific emphasis on the childbirth experience, but in our program, we would wish to extend that role into early childhood." A small research project explored the views of some women giving birth at the Mercy and found that four of the nine women interviewed said that they "would like a

[6] Application to Potter Foundation, CPS

‘kindly’ ‘experienced’ ‘older ‘support’ person to assist them in their parenting”. The application linked the needs for mentors to attitudes of the interviewed women: “a mixture of apprehension and lack of self confidence and a strong desire in this time of transition to be the best mother they can be”.

This conceptualisation gave the mentors a different role from either friendship or family-like support relationships, on the one hand, and professional services on the other. The analysis of what the mentors actually do with the new mothers with whom they are matched, and conversations with the mentors in the focus groups suggest that there are pulls on the mentors towards either friendship or quasi-professionalism, but that they are attempting to maintain a position different from both, but closer to a friendship role than perhaps was first envisaged. Some of the elements that have emerged from the case study data and the discussion in the focus groups are spelt out here to provide the basis for conceptualisation of the mentor role.

1. The role of primary group values - mentoring and friendship:

Outlining of what mentors actually do in the relationship with the new mothers, as we have earlier in this sub-section, shows that there are strong elements of primary group values in the role of mentor. The mentors were friendly, warm, visited the mother’s home, and took part in jointly negotiated activities. One brought small gifts. Despite injunctions from the program about not giving personal phone numbers or addresses, at least four mentors shared these, and found that the new mother respected that information, and only rang either at pre-arranged times, or to alter or set up arrangements. Mentors differed in their views about this. Some felt very uncomfortable not sharing their contact details, others were happy to always go through the Coordinator. The mentors also focussed on the strengths of the new mothers, rather than giving attention to risk and problem definition, which they saw as a professional role. These attitudes and activities, typical of primary group relationships, all helped the mentors establish and maintain the relationship with the new mother.

Mentors defined their role as different to professionals. In their words, they are different from professionals because their main motivations are, first, to be involved with the new mothers because they care, not because they are paid, and second, to be neighbourly, which they expressed as being mothers themselves and ordinary members of the community reaching out to other members of the community who are mothers and who are in need. To this extent they see themselves as being on the same level as the new mothers. They have been mothers too. They therefore bring ordinary life experience to their relationship with the new mothers.

2. Pulls towards professionalization of the mentor role.

One mentor talked about wanting clearly established goals, discussed with the new mother, early in the development of the relationship. Some of the other mentors were not so sure about this idea, but did want to know the focus of their involvement with the new mother, and hoped that this could be shared between the parties. Another conversation centred on mentors wanting to know what the

professionals involved with the new mother were doing and aiming towards, so that they could support those aims.

By the time of the second focus group, there seemed to be less pull towards professionalization of the mentor role. If anything, the major pull was towards friendship and strengthening the primary group values of the relationship – perhaps to be expected as the mentors and new mothers came to know and trust each other, with mentors realising that their relationship with the new mother was highly valued by the mother and that they were not being 'used' within it. Rather, both parties found liking, respect and affection to be growing in their relationship. They saw themselves as being 'on the same level', all being mothers together, while at the same time honestly recognising that their experience was helpful to new and isolated mothers.

3. Ramifications of these factors

The role of the mentor is defined by a combination of factors. These include: what is done; the way it is done, who does it, and the motivations of and incentives involved in doing it. Professionals, friends or relatives and mentors might all be concerned that a mother is not playing with her baby. They will each interact with the mother in terms of differences and similarities in legitimacy, knowledge, motivation and incentives. The mentors suggested that their incentives lie in primary group values of being able to provide a 'free gift', of giving according to need, without thought of personal reward. Congruent with adherence to primary group norms is development of reciprocity in the relationship, where they can see that the new mother values them and their involvement. And, while it is important that everyone involved with a family has an idea about the involvement of others, it is also important that mentors are helped to see that their role is specific and unique. The focus group discussion near the end of the second year of the program suggested that the mentors themselves were aware of this. They were involved because they want to be. They recognised that they can focus on addressing social isolation by the relationship they provide and through helping the mother link in to the community – to walk in the park, to meet other mothers and babies and to use community facilities. They can teach the mother about relationships through the relationship they have with the mother – through modelling friendliness, openness and through providing the opportunity to practise being with other people, as well as through helping her to come to a supported play group. They can model good parenting as any professional would and know that their modelling has a different powerfulness because they are seen by the mothers as having been 'in the same boat', as an ordinary person in the community. But, they can also bring the expertise of being an experienced parent and share that knowledge and wisdom – not because they are professionals, but because they are experienced mothers who are prepared to share their experience with other mothers in the community.

The role of the Coordinator in the five cases

The Coordinator clearly plays a central role in the program. The discussion with the first and second Coordinators about the five cases displayed many areas of values and knowledge that informed their work.

Values

- Commitment to seeing the worth and value of every new mother, her infant and the family in which she was located.
- A belief in the positive contribution of the community and social networks to enjoyable and constructive family life.
- A belief in the capacity and agency of people who seek help, and in strength and resilience, despite the presence of difficulties.

Knowledge and skill

The Coordinator showed

- sensitivity to both mentor and new mother,
- a commitment to strengths and competency based practice,
- an understanding of normative friendship and possible support relationships within the community,
- an understanding of Family Services work (the knowledge of what constitutes adequate parenting, how to improve parenting, and risk assessment of infants and children),
- an understanding of the service system and the need for integrated services for families,
- an awareness of the importance of and skills involved in case management, and
- a depth of knowledge about Family Services clients, the situations and processes that brought the new mothers to seek help, and knowledge about what was required to bring about change for the mothers.

The Coordinator's tasks and functions

All mentors seemed well prepared for their involvement and were able to mentor their respective new mothers in a compassionate, thoughtful and constructive way.

The Coordinator provided ongoing support and further training to all mentors. Contact with each mentor varied: according to need; the difficulty of the match; the needs of the new mother; and of the mentor, and the Coordinator's availability. All mentors were required to attend monthly mentors' meeting where training and group supervision and discussion occurred. In addition, some mentors were seen on a fortnightly basis. The intention, as far as possible, was for the Coordinator to contact each mentor after each visit to their new mother – either by phone, or by email. Some mentors used the email to reflect on the time with the new mother and to convey their experience to the Coordinator, who would respond according to the need for contact. Some mentors liked this means of communication better than phone or face-to-face contact, because it gave them the time and space to reflect. All mentors expressed confidence in the Coordinator – that they knew they could contact

her whenever they needed to do so. In addition, the Coordinator would meet with each mentor on semi-regular basis.

In the individual or group sessions with the mentors, the Coordinator listened to what had occurred in the visits, explored the mentors feelings and reactions, and discussed any doubts the mentor might express about how they handled a situation, or what to do in future. The role involved debriefing, education, support, advice, and affirmation. One mentor was very unconfident, but as the Coordinator listened to her account of the visits with the mother, it was very clear that the mentor was doing an excellent job. In that case, parallel processes to those used by the mentors with the mothers were in evidence – noticing what the mentor did, and affirmation and validation of the mentor and her behaviours with the new mother. Another mentor had to cope with hearing about some very negative matters that evoked unpleasant feelings, and which shocked her. The Coordinator listened, explored her feelings and reactions, affirmed them as normal and expected, and praised her for remaining neutral in her reactions to the mother. Both Coordinator and mentor knew that a judgemental reaction would never be helpful. In other cases, the Coordinator had to help the mentor with a variety of difficult situations where the mentor was struggling to understand the mother and to find a way to respond and interact that would be constructive for the mother, the baby and the mentor. The Coordinator successfully imparted knowledge and understanding of why a new mother might say or do what she did, and supported mentors in a number of relationships to understand their own reactions, while building sympathetic understanding of the new mother. Without these processes, our evaluation is that a number of the relationships would have struggled to survive.

The Coordinator also liaised with other services involved with the new mother, and ensured that the mentors were aware of and able to support the work of the other agencies. In all cases the Coordinator had contact with multiple agencies. Sometimes this meant understanding the work of others in detail, so that the mentor could give support or advice which was thoroughly congruent with the intervention of the other service. In one case the Coordinator communicated with other workers about the different perspective held by the mentor (a much greater recognition of strengths), and supported the mentor when intervention by others had focussed on risk to the baby and problems in the parents. In this case, an important role was supporting the mentor to remain in the mentor role, to keep the focus on strength, capacity and resilience, and to leave risk assessment to the formal services. On some occasions the Coordinator actively advocated for the mentor, for the new mother and her family. Although the Coordinator was not a case manager, in some ways she played this role, at very least ensuring that the work of the mentor was understood by other services, that the work of the other services was understood by the mentor, and that all were keeping the mother, baby, and father (if present) at the centre of attention.

Examination of the role of the Coordinator in a couple of the cases revealed the challenge and delicacy involved in working with staff in other agencies that had a case management role for the family. Theoretically, the program design of the Program meant that the Coordinator could be working with as many different

case managers and their organisations as there were matches. This is a considerable workload for the Coordinator. In some situations it required ensuring that the external agencies remained involved with the mother rather than using the involvement of Mentoring Mums as an opportunity to withdraw their services. The effectiveness of the liaison between the Program and the case management agency depends on the professionalism of each party - their respectfulness of each other's expertise, their knowledge of, and openness towards each other's program and role, their thoughtfulness about the client situation, and their preparedness to communicate openly with each other and to listen carefully to the different perspectives that are brought by people occupying different roles in relation to the new mother. Additionally, this has to occur where the case manager and the Coordinator have little to do with each other, outside the particular case situation. The experience of the Coordinator was that this relationship could work very well, or it could be very difficult. There were certainly occasions where a case manager from an agency external to CPS formed an excellent working relationship with the Coordinator, despite having only one case in common. In general, however, the experience of the Coordinator was that it was much easier for the relationship to be effective where the case manager knew the Coordinator. This was the case when the case manager was within a CPS program, or when the case manager had managed a number of cases where a mentor was involved.

The Coordinator also explored where the mentors could be involved in the Mentoring Mums program more generally. Experienced mentors were used in the recruitment, information giving and selection processes – to make presentations, to be present in discussions and to be on interview panels. One mentor expressed her enjoyment and appreciation of this.[7] It was clear that she felt honoured and valued to be invited to play this role, and that she had learnt a great deal from it – about how good and kind people were and how different people were from each other (she was talking about the different prospective mentors).

In short, the role of the Coordinator is a complex, sensitive and sophisticated one which requires a high level of skill, knowledge and experience in working with individuals (adults and babies) and families, with and within organisations, and with a complex set of service systems and their interactions and their interactions with the families.

Involvement of the case workers

We do not have data on the full extent of the case work practice in the cases. A housing worker was the case manager in one case. In the other a range of services were involved – psychiatric, medical, Maternal and Child Health Nurse and Family Services. The Family Services caseworker was a staff member of CPS. She was in the early stages of involvement, and was still undertaking assessment. The Mentoring Mums program and the CPS caseworker were maintaining close contact and sharing information (with the consent of the family). At the time of the research interview, there were different views held by

[7] In a focus group

the Maternal and Child Health Nurse about the level of risk to the baby. The Mentoring Mums Coordinator was liaising with the Family Services caseworker about these differences. In three other cases, two other Family Services agencies held case management, until, in one case, that agency withdrew after change of staff and failure of the engagement between the new mother and the new worker. In all cases, a range of other agencies were also involved: mental health services, Family Services, individual counselling services, the Mercy Hospital for Women, and Maternal and Child Health or Enhanced Maternal and Child Health services.

Factors helping and hindering goal attainment.

Factors in the Mentoring Mums program, the mentors, the new mothers, and the environment of the families helped or hindered goal attainment.

1. Factors that help

The program: The availability of support from the Coordinator to the mentors seemed to be vital for maintaining mentors in the relationship, and helping to plan constructive pathways through various barriers.

The first Coordinator was able to gain engagement of two mothers – something the current Coordinator and the mentors deeply appreciated. The second Coordinator also proved she was well able to engage a range of new mothers, including excluded families, arguably the most vulnerable group of mothers needing support.

Case Analysis and mentor feedback showed that the role of the Coordinator in guiding, supporting and supervising the mentors was essential to the success of the matches.

The role of the Coordinators was crucial in the case of excluded families. It was also apparent that mentors were able to both intuit and be supported and guided, in ways that helped excluded family mothers to change their parenting practice. In some cases the changes achieved were crucial for infant safety and well-being.

The mentors: All mentors contributed to goal achievement.

i) Kindness, compassion and care: All mentors were extremely kind, compassionate, caring and committed to their respective new mothers.

ii) Thoughtfulness: The mentors were very thoughtful about their involvement and the situation of the new mothers, and demonstrated a great ability to think about what the mother needed and to respond to that need.

iii) Ability to provide advice and modelling without creating a diminished sense of confidence and agency in the new mother.

iv) A range of flexibility and responsiveness: The case study material showed the varying levels of ability to be flexible and responsive to the

needs of the new mothers, with some mentors able to contribute many hours of support when it was needed by the mothers.

v) Being governed by norms of the primary group: The mentor described immediately above illustrates an ethos which seemed to govern the actions of a number of the mentors. They did not start with professional concerns (some would say pseudo-concerns) about 'creating dependence'. Rather they used a rule of thumb: What would I need if I were in this situation? What would I do for a daughter or close friend? Thus, one mentor simply acknowledged the difficult realities of getting to places with a new-born and a toddler on public transport, and decided to offer transport to help the new mother – as she would for any other friend, or her daughter. (This service of kindness also proved vital in getting the mother to ante natal care, and to other appointments essential for the health of the mother and her older child.)

vi) Maintenance of personal boundaries and knowing you are part of a team: This quality needs to be set alongside the previous one of adherence to primary group norms. Yes, the mentors were able to respond to the needs of the new mother, but they also knew not to interfere, and when to pull back, either to protect their own sanity, or to protect the independence of the new mother. This was the case even when needs of the new mother were extreme. The mentors learnt to contact the Coordinator, share their concerns, and knew that they were part of a team helping the new mother – it did not all depend on them.

vii) The importance of acceptance, non-judgemental attitudes, respect, and establishment of trust: All mentors practised these attitudes and stances. All were kind and compassionate. All were able to accept considerable difference, to maintain a neutral attitude in the face of things that shocked them, to maintain a non-judgemental attitude and were respectful of their particular new mother. All were able to realise that the task of establishing trust and of being trustworthy was vital for these particular mothers, and proved themselves to be consistent, reliable in their contact, and trustworthy when the mothers divulged information that had caused them to be shunned in the past.

viii) A range of personal qualities and characteristics of the mentors: There were a variety of mentors and their various qualities seemed to act to strengthen the relationship with each the new mother in a number of cases. One mentor was bubbly, outgoing and highly energetic – which her particular new mother responded to very positively. Another was quiet, a little nervous and unassuming, characteristics which set the new mother concerned at ease. Another was a well organised, capable woman, who applied her experience and intelligence to the plight of the new mother, and commenced problem solving with her and with the Coordinator. It seemed that all the new mothers were able to respond to the individual qualities of their mentors and to value them.

ix) Support from the family of the mentor: One mentor was emphatic that the support of her partner was vital to her being able to offer and sustain the relationship with two very challenging new mothers.

The new mothers: All five mothers brought factors into the relationship which fostered the relationship and goal attainment.

- All mothers wanted to be involved because they wanted to do a better job as mothers.

- All were open to involvement in the program, in some way or other.

- In four cases, the love and commitment of the mothers to their infants was seen by the Coordinator as being essential to the establishment and development of the relationship between the mentor and the new mother. The obvious love and commitment helped the mentor remain committed when particular difficulties arose in the relationship between the mentor and the new mother.

- Insight and ability to reflect: one couple had insight into the fact that they and their parenting were affected by their mental illnesses, and another mother showed an ability to reflect on what had happened in her life thus far, wanting a better future for her second child (compared to her first child's early years). This insight and ability to reflect was encouraging for the mentor, who could see the mother learning within the relationship.

The relationship between the mentor and the mother: In all cases, a level of trust, give and take, mutual concern and respect developed between the mentor and the new mother. The strength of the relationships sustained each partner when difficulties arose. For example, one mentor was deeply worried by the way the new mother talked in a derogatory about her infant. While this was seen (legitimately) as a problem, the mother's openness to the mentor, her willingness to listen, and her appreciation of the relationship with the mentor strengthened the resolve of the mentor to continue in the relationship.

The surrounding service system: In three cases, the Coordinator believed that aspects of the service system were significant in helping the mentor-new mother relationship develop and achieve goals.

- In one case, that support came from the housing support worker and the Enhanced Maternal and Child Health Nurse, and was especially important in the phase where the relationship between the new mother and the mentor was being established.

- In another case, the support from the Mercy Hospital social worker and psychiatrist was central, while in another case the Mercy Hospital, this time in the form of the obstetrician, as well as support from the community midwife and the Maternal and Child Health Nurse featured as essential supports to the relationship.

- In two of the cases, the various staff from different agencies, all working together in the same direction and communicating well together, were judged by the Coordinator to be very helpful. The mentor could see that the service system was working to help and support the mothers – it didn't all depend on them, they just had to do their part. Both these mothers were members of excluded families, their needs were serious and substantial, and the mentors would have felt swamped by the level of need, had the service system not been involved.

2. Factors that hinder

Organisation and program: Change of staff in the program to a new Coordinator after the first 18 months of the program was seen as a hurdle that had to be overcome in one case. The mentors in the focus groups also talked about the changes in the sorts of mothers they were being matched with that occurred after the change of staff, as something that had to be adjusted to. While such matters may be unavoidable, they have an impact on mentors. In both cases, the mentors seemed able to adjust and continue with constructive relationships with the mothers.

Towards the end of the evaluation period, the second Coordinator resigned, after 12 months in the position. The effect of this on the matches, on the mentors and on the program is beyond the scope of this evaluation (the case study data collection had been completed when she resigned). However, we might predict a negative effect on mentors who saw their commitment to the program and to their particular mother, as ongoing. It is also a concern that consistency of staff was not able to be guaranteed by the organisation. (In the period of the evaluation, the Program had three Coordinators, two different program managers, and the organisation also changed CEOs. The first CEO had been a champion of the Program.) Time will tell the effect of these changes.

In one case, the mentor was not able to visit as regularly as generally required by the Program. The Coordinator felt that, although the relationship between the mentor and the new mother was very positive and constructive, the relationship might have been more powerful still, had more time been able to be given.

The new mothers: All new mothers brought elements to the relationship that caused difficulty establishing and maintaining it. One mother was very prickly and defensive. She had very difficult elements in her early family history which made it difficult for her to relate to others, and tended to pull her towards networks and activities that would be destructive to her, her relationship with her baby and her parenting. Four mothers suffered mental illness which had ongoing effects on their ability to relate to others. Four mothers had experienced some degree of childhood abuse or neglect – emotional, physical or sexual – in their childhoods. All four variously had difficulties coping with the effects of difficult or traumatic childhood experiences, creating difficulties in relating to others, including the mentor. In one case, there were specific current stressors that took considerable time and energy of the mother, and limited what could be achieved through the mentor-new mother relationship.

The environment including the service system: The environment of all the mothers in some way or other, presented barriers to goal attainment.

Social networks and neighbourhood factors: In one case, social networks centred on a past life and substance abuse remained in the background. In a second case, the mother's concern about lack of safety in the neighbourhood (known for its substance abuse networks) and a very unhelpful landlord, added to her stress. In a third case, the mother had recently left her partner. In this same case (although this point relates to all five mothers) the sheer extremity of social isolation meant the mentor felt burdened by the legitimate needs of the new mother. She was the only non-professional support for the new mother.

Service system factors: In one case, the service system, while providing help and support to the family, also placed heavy demands of attendance at various appointments and meetings. In two other cases, there were other barriers and problems within the service system. In one case, a main support worker was defensive and non-communicative with the Mentoring Mums program. This caused the mentor to feel awkward, and to wonder if she was sufficiently supportive of whatever (unknown) direction the main worker was heading. In another case, the lack of continuity of worker, culminating in withdrawal of the main support worker, left the Mentoring Mums program without case management support in the case. In one of these cases, conflict between two different parts of the service system was very hard for the mentor, who felt torn because their judgement was that the mother was not getting the help she needed. These service system difficulties are all the more difficult when the mothers were members of excluded families, with multiple and serious difficulties, and where the Mentoring Mums Coordinator and the mentors see the absolute necessity of effective service system intervention.

Goal Attainment and Achievement of Outcomes

1. Goal attainment

All five mentor-new mother relationships were current and ongoing, so that comments on goal attainment refer to 'work in progress'.

In relation to the earlier summarised goals set for each mentor-new mother relationship in Sub-section 5, the following generalisations can be made:

Establishing the mentor-new mother relationship

Bearing in mind that all relationships were relatively 'new' at the point of data collection (3, 4, 7, 8 and 9 months of involvement), all sets of mentors and mothers had established secure relationships with each other. Trust was building in all but the one relationship and the mentors and mothers seemed to be enjoying the visits and the relationship. The one exception was where the new mother had terminated with the Mentoring Mums program, because of pressures on her from so many appointments in the service system. Different management of this case might have protected the mentor-new mother relationship, but the professionals involved were extremely concerned about risk to the baby, and the one contact deemed to be 'inessential', that is, the

mentor, was the one to be dispensed with. Several goals were achieved with this mother, however, prior to termination of the relationship.

Building and supporting attachment

Substantial progress had been made in four of the five cases in building and supporting attachment between the mother and her infant. The four mothers were playing and interacting more with their baby in the presence of the mentor. One mother was adopting language from the Maternal and Child Health Nurse and talking about 'tummy time' and 'floor time'. In another case, the mentor could tell from the baby's reactions to some action songs that the mother had been practising interacting in between visits. In one case, the mother was holding and cuddling her baby, and the Maternal and Child Health Nurse assessment was positive – that the baby was happy, outgoing and sociable, and achieving all developmental milestones. In the fourth case, the Maternal and Child Health Nurse was glowing in her assessment on this baby's development and progress. In the fifth case, the mentor-new mother relationship was only 3 months old, and while progress was being made, the Coordinator continued to be concerned about the care of the baby and attachment between mother and baby. However, the Maternal and Child Health Nurse assessed the attachment as positive.

Reducing social isolation and linking to the community

Substantial progress was made in all cases, although progress was still hoped for in all. Three mentors were still working on the goal of getting the mother involved in a supported play group, while two had managed to get their new mothers, both extremely isolated, to attend regularly. One of these mothers was also regularly attending ante natal care, and appointments for her older child's development, a picture greatly changed from the one before the involvement of the mentor. The other began to regularly go to the park, and to cafes as well attending the local health centre.

Of the other three mothers, one mother who was very unresponsive to the idea of a supported play group was now beginning to talk about how she would like to attend. One mother went out regularly with the mentor, window shopping and to a café to have coffee. Another who suffered severe agoraphobia, occasionally managed to accompany the mentor on a walk to the park.

Supporting the mother's mental health

This was set as a goal for three of the mothers. In one case, a careful negotiation between the new mother and the mentor and Coordinator established an agreement about how the mentor was to respond when the new mother became depressed. This agreement was enacted and the new mother continued to see the mentor, even when she was depressed.

In this and a second case, the mentor reminded and encouraged taking medication, and in the second case, the mentor drove the new mother to mental health services appointments. Her mental health had remained stable to the point of data collection. In a third case, the involvement of the mentor resulted

in black plastic and cardboard being removed from windows so that light could enter the house, in the mother going out into the community to the park, cafés and the local health centre and the joining of some groups in the community (though continuing to attend remained a difficulty).

Teaching norms and behaviours of relating to the formal service system

Three mothers who were members of excluded families had difficulty relating constructively to the formal service system. In the most extreme example already cited, the mother had not attended any ante natal care, had not had her older child's developmental and speech delay assessed or treated, was irregular in attending mental health services and was taking her medication inconsistently. Since involvement of the mentor, she had attended ante natal appointments and mental health services regularly and was consistently taking medication. Her oldest child had been assessed and was receiving treatment, to which the mother was taking her consistently. Through all these activities, the mentor encouraged, supported, explained reactions from the professionals, and helped the new mother see that, when her behaviour changed, so did the behaviour of the professionals. The other two cases all provided less extreme examples of the same processes and achievements.

Developing motivation in the new mothers

In three cases, one of the symptoms of exclusion – low motivation in relationship to pursuit of developmental goals in the face of pressing survival demands – was addressed by the mentors. In all cases it remained a 'work in progress'. However, in the three cases and with the support of the mentors, the new mothers were able to engage in activities and make and keep commitments that had hitherto been beyond their reach. Two started going to a supported play group. Others took medication regularly. Some began being able to leave the house and take enjoyment in public playgrounds, with their children. These were small steps, but were beginning to put structure and enjoyment into the lives of these mothers and their children.

2. Outcomes

A set of outcomes for the program was established by the evaluation, based on the initial conceptualisation of the Mentoring Mums program by CPS. The outcomes were as follows:

- Increased connectedness to local and mainstream community, through increased connections to
  - the service system (health, welfare and income support, education and training, and employment)
  - cultural and recreational activities (both adults and children)

- Reduction in social isolation
  - Increased constructive contact with extended family
  - Reduced connection to negative networks
  - Increased number of friends

- Improved parenting
  - Increased confidence
  - Improved skills and strategies

- Children's well being
  - Improved Social well-being
  - Improved Emotional well-being
  - Child/ren achieved developmental milestones

- Children's safety
  - Number of notifications
  - Instances of danger
  - Improvement of safety

Increased connectedness to local and mainstream community in relation to both the service system and to cultural and recreational activities, and a reduction in social isolation .

All new mothers saw improvement in these areas.

One new mother was able to continue contact with the Maternal and Child Health Nurse through the support of the mentor, and regularly visited a shopping complex and had coffee with her mentor, rather than remaining at home as she was before the mentor was involved.

Another mother was able to go for an occasional walk in the park with the mentor despite her agoraphobia, which had previously made such an activity impossible for her.

A third mother was already well supported by formal services, but the mentor helped link her to local community services, including the health centre, and to use community facilities like parks, cafés and so on.

A fourth mother was attending a supported play group, had joined a local walking group (but was finding consistent attendance difficult) and was attending supported community activities organised through CPS. The mentor had also encouraged this mother's contact with a brother, and a distancing from destructive extended family of an ex-partner (although these contacts and distancing may have occurred regardless of this support).

A fifth mother had been effectively linked to ante natal care, specialist medical assessment and treatment for her oldest child, and had joined a supported play group.

These various changes meant that all mothers were less socially isolated than they were prior to the involvement of the mentors. All were able to go out, with their mentor. Four were now accessing ordinary community facilities, such as shopping centres, cafés, parks or community centres. Three were becoming positive about joining a supported play group and two had joined one, allowing interaction with others apart from their mentor. One was supported to limit and

control contact with the father of her child, which in turn meant a reduction of contact with a friendship group based largely on substance abuse. One had more positive contact with a sibling and had reduced contact with destructive extended family members.

Changes in parenting

All five parents showed positive changes in their parenting practices. Two parents showed increased ability to pay attention to their babies, to notice what they were doing and needing, and to initiate playful interactions. Two different parents showed improved parenting practices with their older children, again, with ability to take them to parks, to play with them, and to see some of their needs. Another mother was able to hold and cuddle her baby while feeding, and was able also to respond to the baby's socialising, despite still saying some very negative things to the baby (which remained of considerable concern to both mentor and Coordinator). This mother was also able to remove black plastic and cardboard from the windows, which had blocked out all daylight from the baby. A fifth mother, in addition to paying more attention to her older child's needs, was able to see her responsibility to care for herself during pregnancy, and was focussing on her attention to the baby, wanting this baby's experience to be different from that of her older child.

On the less positive side, and despite some positive changes, one mother (the relationship that was terminated) was admitted to a mother-baby unit because of concerns about the infant's weight gain.

Increased child well-being and safety

In four of the five cases, there were positive changes in well-being for the infants and, in one case, an older child. In the fifth case, work towards the goals was still very much in the early stages, and the Coordinator did not think there was enough evidence to claim increased well-being. In the other four cases, however, there was more positive interaction between the mother and infant in four cases, the babies were all achieving developmental milestones in a normative fashion, and they were developing as responsive, and happy, infants.

In relation to child safety, there were no notifications of any of the children, though one mother was admitted to a mother-baby unit because of concerns about failure to thrive in her infant. In another case, the parents ceased smoking inside, decided against running from the attention of Child Protection, and were taking the older child for assessment and treatment. These changes were seen as directly linked to the involvement of the mentor by both Coordinator and evaluators. That is, children in four of the families could be said to be safer, as a result of the mentor involvement.

In summary: significant outcomes were achieved in all cases. These changes are seen as directly linked to the work of the mentors, although other services were also involved in achieving the positive results. Our evaluation is that specific goals were set in relation to these outcomes, and the mentors and Coordinator, and in some cases the referring agencies and the Maternal and

Child Health Nurses, all thought that the support and involvement of the mentors contributed to them.

The Coordinator, the mentors and the evaluators all identify further desirable changes. These include further progress in development of positive parenting, and further reduction in social isolation, specifically, increases in constructive social network relationships in addition to that of the mentor.

Summary: The case studies present data that supports the conclusions of the larger sample. The program was achieving substantial and very important outcomes with this group of very vulnerable mothers and infants. The program was able to recruit, select, match and support mentors in constructive relationships with the mothers. The case studies highlight the crucial role of the Volunteer Coordinator, the skills and effective processes used by the program to achieve change, and enable conceptualisation of the role of the mentor.

5. New mum's feedback about the program

Interviews were conducted with four of the mothers involved in the program. Two interviews occurred in their homes with their babies present and two were interviewed by telephone at their request. At the time of their interviews one mother had been involved with the Program for 3 months, one for 7 months, one for 11 months and one for 15 months. For three of the mothers their mentor had been involved with them before their child's birth. Three of the mothers interviewed were those included in the case studies.

Three of the mothers had been referred to the program through the Mercy Hospital Social Work Department and one from her maternal and child health nurse. All said they accepted referral into the Program because of their feelings of loneliness and isolation, lack of support, distance from their families and anxieties about coping with their first baby. One outlined that at that time, she was '*freaking out. I didn't want the baby and thought I would be the world's worst Mum*.' Two also commented that their acceptance of the program was based on what the program offered and their wish to be '*….with another Mum.' "… I wanted a match with people who have been there."*

All the mothers were very positive about their experience with the program describing it as very helpful and making it '*easier for me to cope*.' For one mother, having the mentor in her life had been '*….a god send*. *I adore her. She brings joy to everything.*'

The mothers perceived the program as having a range of strengths and benefits for them. These included:

1. That the mentor comes to their home and provides a diverse range of services. These include:
    - practical assistance – caring for the child while she has a shower,

- providing guidance – information, talking about solutions, '*how to look after my baby*,' helping with the baby's sleeping problems
- emotional support both in a general way through providing company and *'..someone to talk to'* but also promoting a sense of safety that allows the women to share their concerns and difficulties - '*I can talk to her about my feelings*.' '*She calms me*,' '*she helped me through a difficult time*.'
- interacting with her baby – one mother identified that when her mentor is present her baby is more talkative

2. That the mentor provides support outside the home by:
    - taking her shopping, for coffee, lunch, taking her to appointments. In relation to the latter one mother said '… *When I first met her I was 7 months pregnant and hadn't been to see anyone. She said I must go and made sure I did'.*
    - As one of the mothers explained, '*providing the sort of support you would have if you had your family around'* e.g. '*..helped me home from hospital after I had my baby.*

It was critical for two mothers that their mentor was a single mother like they were and therefore understood their experiences. For another it had been critical that the mentor was older, '*..like a grandmother, a second mother*' while another described her mentor as *'..a friend, my daughter likes her, it's been the best thing for me.'*

The mothers identified a number of changes that have occurred due to their involvement with the Program. These included feeling more confident about parenting, not having the previous negative feelings about her baby or herself, raising self-esteem, not feeling as isolated, knowing where to go to receive help, having the confidence to attend appointments. One spoke about how the program '*…gave me light at the end of the tunnel*.'

The mothers were very positive about how the program operated ('*..it is a wonderful program')* and strongly supported its continued existence and expansion to other areas and encouraged other young mothers to participate *'…give it a go because you can always opt out if it isn't for you.'* One of the mother's advice was that if there was reluctance to accept the referral it might be helpful for the new Mum to speak to mothers already involved rather than only to professionals.

While all the mothers thought the program was well organised one also had some areas that she had been unhappy with. She would have liked her mentor's visits to be longer and more frequent and for there to be opportunities to spend time with the mentor's own family. She also suggested that the mentors have more training in baby development

Three mothers suggested changes to the Program. Two mothers hoped that the suggestion of a play group for the Mentoring Mums and their babies that had been mentioned would be established in the near future. One wished that the program also offered child care.

When asked for their final thoughts, two of the mothers said, '*…it is perfect particularly for people who don't have family.'* & '*…when you are so isolated it is an extra link you really need.*'

6. Maternal and Child Health Nurse Assessment of outcomes

After discovering, near the end of the data collection period that the data from the Maternal and Child Health Nurses had not been collected as planned, the evaluators encouraged the staff to focus their efforts on receiving the surveys relating to the five mothers included in the case studies and the four included in the client interviews. The Maternal and Child Health Nurse data was collected on these nine mothers and on an additional three. Information was collected twice on one of the mothers. Seven maternal and child health nurses were interviewed, one of whom had been involved with four of the mothers and two had been involved with two mothers each (including two case study mothers). The length of their involvement with the mothers ranged from a minimum of two to a maximum of 20 contacts. Some had completed their involvement and some were ongoing.

An analysis of the information collected provides a very useful and important snapshot of the development and progress of the mothers and their babies from skilled experienced community health practitioners completely separate from the program.

The information received presented extremely positive information about the children's development status, the strong level of attachment and bonding that had developed between the mothers and their babies, the mothers' extensive parenting capacities and the many positive changes that have occurred for the mothers through their involvement with the program.

The information stands out as it reveals a picture that one would expect to see within any cohort of twelve mothers picked randomly from the caseload of maternal and child health nurses working within this catchment area. Thus despite their range of considerable difficulties this group of mothers involved with the program and their babies are doing exceptionally well.

<u>Children's Development</u>

The 12 babies were described as all functioning at a normal developmental level in relation to their vision, fine motor development, hearing and play. Eleven out of twelve was described as demonstrating normal social behaviours; ten had normal gross motor development, normal speech and language development. Thus two were described as having difficulties in speech and language development and gross motor development and one was somewhat below in their social development.

In addition only one of the twelve had experienced an injury (unspecified by the maternal and child health nurse) and three experienced health problems, two were minor problems such as constipation and eczema and one had slow weight gain.

Attachment and Bonding

Seven of the mothers were characterised as having established positive attachment with their babies, three demonstrated anxious attachment and two were described as having difficulties in attachment. With the latter two the Maternal and Child Health Nurses communicated their concern about the mother's '…*significant anxiety and inability to relate to baby'* and for another due to the mother's difficulties the baby was being cared for mainly by her grandparents.

Only half the Maternal and Child Health Nurses were able to comment on the level of attachment between the baby and other family members. This seemed to be a relatively large number. Of the seven families where there was data, four of the fathers were assessed as having established positive relationships with their infant. In one family there were positive relationships between grandparents and the infant. Two of the relationships between the fathers and babies were described as problematic due to one being anxious and controlling and another being prevented from any contact with the baby by the mother's anxiety.

Parenting Capacity

The parenting capacity results were also very positive. Nine of the mothers were described as appropriately responding to their babies cues with three sometimes responding appropriately. As is commonly the case, the areas of most difficulties were in relation to establishing feeding and sleeping routines (although not disproportionately compared to the general community). Seven babies were described as having no feeding or sleeping problems, three had some problems but they had settled or were in the process of settling down, while two had significant problems with feeding and one with sleeping both of which required placements in mother-baby units.

Eleven of the mothers were described as providing appropriate general care and nurture and ensuring satisfactory child safety and eight were providing satisfactory play and socialisation routines with three showing a variable capacity – all highly impressive results.

Changes for the mothers

Ten of the maternal and child health nurses noted positive changes in the mothers during their involvement with the Mentoring Mums program. Three nurses described increased confidence and comfort in the Mothers' parenting, noticing the mothers experiencing more enjoyment of, and attachment to, their babies, more confidence in attending external activities such as a playgroup, and speaking positively about their mentor and the program.

A question related to whether the mothers involved in the program had become involved in any other activities based at the Maternal and Child Health Centre. It is unfortunately consistent with this particular cohort of socially isolated women that only two had attended a parents' group with one known to have continued ongoing attendance. This indicates that while improvements had occurred in a

number of areas for these mothers the issue of social exclusion is one that continues to be present.

Finally the Maternal and Child Health Nurses were asked to make any other comments. Five did and were all positive about the program and its outcomes communicating that it was a '….*great program – hope it continues'.*

The Case Study Mothers

Examination of the five case study mothers show even more remarkable findings, given that four of the five families were 'excluded'. Four of the babies were all described as developing within normal parameters. The fifth was described as being somewhat below normal in their social behaviour. In addition one of the mothers was noted to experience concern that her child was not developing normally in relation to her gross motor development but this was due to the mother's sensitivity rather than the actual situation.

There was a (slightly) higher representation of the case study babies in relation to the health problems. Two of the three babies who had experienced health problems. However only one, slow weight gain, was a more serious health problem.

Attachment and bonding findings were also positive. Four of the case study mothers were described as having developed positive attachment, the fifth was assessed as experiencing anxious attachment which her maternal and child health nurse noted was showing '*definite improvement*.'

It was clear that the maternal and child health nurses were also delighted by how well these particular mothers were doing. One commented in relation to one excluded family mother, that '…*I am really very surprised how positive the attachment is – this baby has been amazing – mother absolutely loves being a Mum'*. Another stated; *'mother has engaged well with baby despite her background issues.'*

However, (and not surprisingly), this group was negatively over-represented in other family members lack of involvement. The Maternal and Child Health Nurse had not had any contact with the wider family of four of the mothers. These data illustrate this cohort's even greater level of isolation and vulnerability. There was one contrary and positive case. Two interviews about one mother were conducted with one Maternal and child Health Nurse. At the first contact the Maternal and Child Health Nurse could not comment on any other person's involvement with the mother. At the second interview she described positively the partner's involvement with, and attachment to the baby, reflecting that contact had occurred with the partner during this time.

Parenting capacity of the case study mothers did not stand out as being more problematic than their peers. Four of the five responded to their baby's cues, did not have problems with establishing sleeping, feeding, play or socialisation routines and were seen as able to ensure their child's safety. One nurse commented on how impressed she was with the mother's ability to reflect on the child's safety needs. All five were described as providing adequate general care and nurture. The mother whose nurse was interviewed twice was identified as

initially having some difficulties with feeding but no problems were identified at the second interview highlighting the gains the mother had made.

Three of the mothers were also singled out for positive changes their Maternal and Child Health Nurses had noted during their involvement with the Mentoring Mums program. One commented on how the mother is now '…*engaged well with services due to her mentor'* and another described how the program had '….*definitely helped Mum.'*

7. Profile of Mentors

A data tool was completed by 16 of the 38 mentors involved with the program. An analysis of the information received demonstrated that four had commenced involvement with the program at the first intake in March 2009, four in the second intake in June 2009 and seven in the June 2010 intake. All the mentors were matched with a new mother.

The large majority of the mentors (14) had heard about the Mentoring Mums program through their local newspaper, one through a local community volunteer organisation and one through a friend who was a mentor. Clearly this had been an excellent and successful strategy for recruiting local women to the program.

The mentors were, on the whole, women who had significant previous experiences as volunteers and were highly experienced volunteers. Eleven of the mentors had considerable and widespread previous involvement in a range of voluntary activities (two had 30-40 years experience). The profile demonstrates that the mentors were women who had been active volunteering in activities across a broad spectrum ranging from commitments related to their own families, for example children's kindergartens, schools and sporting clubs. They were also involved in local community activities such as churches (committees plus Op Shops), services for local councils e.g. Meals on Wheels and broader community organisations. Some had volunteered for professional organisations such as Lifeline, or Nursing Mothers. A few of the mentors were also currently volunteers at other community based organisations. For five of the mentors this was their first experience of volunteering.

Considering that this was a cohort of women with a highly developed level of experience and involvement in a range of other volunteering activities, it was clear that they had made a very thoughtful and clear decision to become involved with this particular program.

Eight mentors were attracted by the nature of the program– the opportunity to work with this particular client group and what could be achieved through their involvement. As one stated: *'....women helping women to better raise our children – can assist children from pre-birth and help mothers to gain confidence and further insight into improved parenting, encouraging links to better networks of education and support.'*

The second most common reason for volunteering was that they felt that their previous and current skills and experiences were useful and relevant for this particular program. These included their personal experiences of having been a mother (and a mother who had been fortunate to receive a great deal of support) and their professional experiences for example as a midwife, a Breastfeeding counsellor and teaching maternity related yoga classes. Personal experience was also identified as a motivating reason for four of the volunteers but in this situation they were relating to their own challenging experiences when they were new mothers and therefore felt they brought a level of understanding, empathy and identification with the issues the mothers in the program were facing.

The next grouping of reasons for the volunteers involvement related to their values, and their wish to *'...to do something useful and make a contribution to the community*'. Practical factors were relevant for a number of the volunteers with their personal circumstances having recently changed enabling them to have the time to make this commitment (this was relevant at different significant transitional points such as two mentors having recently retired, another taking a break from the paid workforce, one's youngest child having started school and another having completed their previous voluntary activity.)

The analysis also provided information about the volunteers' demographic features. They present as a personally stable group with some areas of homogeneity. All 16 had been married (12) or were in defacto relationships (4). One of the 16 had recently separated. As would be expected all had children. One had seven children, eight had three children, six had two children and one had one child. The youngest child was one years old and the oldest was 43. Five of the women were also grandmothers and had 13 grandchildren between them.

Their age range was broad. Five were between 60-69, three between 50-59, five between 40-49 and three between 30-39. They live across eight postcodes with the most (five) living in Ivanhoe, three in Briar Hill and two in Eaglemont.

All the women identified English as their first language with four identifying they also had proficiency in either Mandarin (two), French or Maltese. Ten were born in Australia, with two born in the UK and one in Singapore, New Zealand and Malta. Ten identified their ethnic identity as being Australian (non Aboriginal), two European and one Asian.

In relation to their education most had completed tertiary education either university (eight) or Trade or TAFE (three) and three had completed year 12. For their employment type (either current or previous), the largest grouping was in the clerical and administrative area (six), then professional (four) then sales (two). Most described their current occupation as home duties (nine), retired (five), self-employed (three) and working casual part-time (three).

Another area of homogeneity related to the mentors description of their household's income source as being from a full-time wage earner. Fourteen were purchasing or had purchased their own home.

Thus the mentors were women living in one of the surrounding suburbs to the agency, in their own homes, mainly married and with children, of Australian European ethnicity with mainly tertiary education and having worked or still working across clerical and professional sectors. Half were aged over 50 and half were aged under. Most had experience working previously as volunteers across a range of related health and welfare areas and some had also had considerable experience working in related professional occupations.

What they also all clearly and strongly shared was a strong sense of social commitment to working with and empowering vulnerable young women and their children to enable them '....*to break the cycle*.' As one volunteer stated, '*....this fits with my own and my family's value system and activities...*' She could certainly have been speaking for the rest of the group.

8. Focus group with the mentors

'…*it is local Mums helping other local Mums*.

Two Focus Groups were held with the mentors, one in early 2010 attended by four mentors and one in late 2010 attended by eleven mentors.[8] Eleven had been matched with a mother (and in some cases involved with two or three mothers) and two were waiting to be matched.

<u>Mentors' feedback about the program.</u>

The mentors participated openly and enthusiastically in both focus groups and generously contributed a range of responses. A lively, warm and robust exchange revealed the strong commitment they felt to the program and their thoughtful insights into the subjective worlds of their mothers, the external environments that impact on them and the effect of their involvement.

<u>Comments on changes in the mothers</u>

The mentors were very positive about the work they were involved with. *'We're doing something vital – helping mothers with children. If we help we'll have better, happier children. We'll help break the cycle – which is very important*.'

They noted a number of positive changes for the mothers and their babies which strongly align with the program outcome goals; the development of a trusting relationship between the mentor and mother, changes in the mother, in her relationship with her baby in relation to an increased capacity for attachment and bonding, the baby's progress and development, changes in the mother's parenting skills, changes in the mother's level of social isolation and some increased participation in broader activities outside the home.

These changes were demonstrated by many of the mothers' increased confidence in themselves as parents; '…*learning about parenting*, *evolving and growing,*

[8] Two mentors attended both Focus Groups

becoming more relaxed with their babies, reading cues better', 'increased capacity to play and interact' and their babies *'having their developmental needs met.'*

The mentors hypothesised that these changes occurred as a result of the help they have provided. They articulated that they have supported the mothers to increase their confidence in their parenting capacity through acting as mentors and guides, sharing their own knowledge and experiences, offering continuity, a '*sounding board,'* providing practical guidance about how to play with their child, establish feeding and sleeping routines, supporting the mothers to trust their instincts and learn from what their babies teach them. One commented that she believed they '*….fill that space' (created by severe isolation) ' in the mum's life'.*

The mentors were able to articulate the processes and skills involved in their work with the mothers which involved '*….being still, following mother's path at her pace,' '…. taking one step at a time,'* being non judgemental. They also demonstrated a capacity to note the subtlety of changes that occur as the mothers develop trust with them and become more comfortable as mothers, the need go at the pace the mothers could manage, for example, making gentle suggestions in relation to sleeping routines and then seeing them being taken up.

The mentors shared a number of stories that reflected the impact of their work. One described how she has watched her new mother shift from being very stiff with her baby, to now being able to hold her closer and greet the mentor at the door with the baby in her arms. Another described how the husband of her new mother had stayed home from work one day to be able to meet her and thank her for the work she has done. Another described with pride how it felt when her mother, who suffers from agro phobia is now able to go outside the house for a walk with her.

One described the *transitional stages* her mother had progressed through in relation to attending a music group with her baby. How she had been reluctant to attend but the mentor initially planted the seed discussing it for months before the mother was able to attend, initially with the mentor present until she was able to attend every week on her own and their individual meetings could resume.

At the second focus group, some of the mentors had had a longer period of involvement with their mothers. They were able to reflect on the changes and stages that have occurred during their contact. One commented '*…as the baby grows your relationship is with mum <u>and</u> the baby – seeing the baby/child's trust in you grow.'* Another mentor commented '*..as a volunteer you meet the mother's needs as they change.'*

<u>Comments on the positive experiences of being a mentor:</u>

The mentors were extremely positive about the experience of being a volunteer in this program. They have found it to be a *wonderful, enjoyable, rewarding* and *fun experience*. It has *broadened* them because '*…it is establishing links between people who wouldn't usually have contact.'* They described the good things about this role as '*…..seeing the fruits of your labour, seeing things improving, seeing the impact*.' Many agreed that '*….I didn't expect to get as much out of it as I have*.' They stressed that a

central aspect of that enjoyment was that they were entering into '*….. a two-way relationship.'*

The mentors identified the gains they personally have received from their involvement with the program as being multifaceted. The gains have included learning about different cultures, different types of family lives, about the breadth of services available for vulnerable families but also on a more personal level, the joy of finding commonalities with the mothers among the differences, feeling humbled by their mother's openness, resilience and strength. As one commented '*…the discovery of learning about your Mum, seeing her competencies, strength of character, love of the baby and what that has meant.'*

They have gained insights into the number and complexity of issues the mothers face and have to handle, the experience of social isolation, the loneliness of migration, the cruelty of the community towards those perceived as different, for example, those living with mental illness and to their own preconceived stereotypes which have been successfully challenged. *'It has been a window to another world*.'

Comments on what has helped in becoming a mentor:

All the mentors commented on how becoming a mentor has involved '*..a real learning process*.' What has assisted them is the training they have received, the input from the Volunteer Coordinators, the support they receive from each other and the monthly meetings – '*hearing others stories'* and feeling part of a team. They also stressed the importance that their own experiences as mothers and other life experiences had played in enabling them to fulfil the role.

They described the training they receive as very helpful, how it prepared them well and that it was critical that the training prepared mentors to be flexible, given the range of different new mothers with whom they could be involved.

In particular the advice they would give a new mentor was to '*…go in with an open mind'* and *'really think about if you are prepared to give the time and consistency and cope with the different things you'll see.'* They saw it as vital for the mentor to understand realistically what was involved in the work but to also know that *'it would be a journey'* and to *'...enjoy it because you will learn a lot about yourself*' and *'...expect that this experience will change you.'*

Comments on the challenging experiences of being a mentor:

The mentors also spoke openly about the challenges of the role which included finding ways of coping with being exposed to the circumstances of the mothers' situations and learning about the right way to connect to their mother. A number expressed the importance of '*…trying to remember that the job of the mentor is to support someone and help them come to a decision, rather than force your own views on the mother'* but this was not always easy to do. Another spoke about learning '*where is the boundary'* of the work, how to be supportive without stepping over the line.

Two of the mentors also commented that, in their situations, a third party was frequently present (a husband and the new mother's own mother) and this required an adjustment to their work and involved some stressful elements.

Comments on the program strengths:

The mentors articulated that the core strength of this service was that it is based on '…. *women supporting women who lack support – women being able to help other women who need help*.'

They saw the program being built around the use of volunteers, not professionals as one of the program's greatest strengths. '*We're there because we want to be there'* as members of the community offering support. They also spoke about the challenge of knowing where the role began and ended, grappling with a lack of certainty about the role. As one asked '...*Are we a friend? No, we are in the middle (between friendship and being a professional). I am feeling more relaxed about that now*.'

The mentors commented on how well the matches have developed because the staff '..*know what they are doing'* and have carefully selected the mentors for each mother. They all felt well supported by the Program and by CPS.

An issue raised in the first focus group was whether the support received would be able to be maintained and whether there will be a need for increased staff positions. This view was re-visited at the later focus group and the opinion was expressed that there was a need for increased staff and administrative support.

One suggestion for future program development was the opportunity for the mentors and the mothers to meet together as a group, to increase the networks of the mothers.

Areas of concern:

The mentors also identified some concerns. Some felt that they had not received enough background information about why their mother was accepted into the program and required information and educative input about how to help with the work particularly when the mother was struggling with mental health issues. They also highlighted the need for ongoing training to assist them to keep developing the relationship so that it remains helpful to the new mother.

Some expressed frustration that the process had been too slow – waiting for training and then waiting for a match.

One mentor felt strongly that more formal goal setting was required at the early meetings between the mentor, new mum and Volunteer Coordinator to clarify the role of the mentor for the mother.

Some mentors expressed concern about some of the actions and decisions being made by external workers involved with their mothers. With two of the mentors external workers had re-connected with the mother which they thought was not indicated but they not been consulted about the decision nor received any communication about the reasons for the re-involvement of the

professional. This experience left the mentors feeling that they were not seen as a resource by the professionals involved with the women and were clearly located outside the new mother's professional network. They believed that it would be helpful for them to attend meetings with external workers such as Maternal Child Health Nurses.

As for the future the message was clear '*…..the program should continue.'*

9. The CPS view of the program

1. Volunteer Coordinator views

Interviews were conducted with the first and second Volunteer Coordinators before their departures from their positions. The first interview was held in December 2009 and the second in November 2010. The following section consists of a summary of the key issues raised in the interviews.

The Volunteer Coordinators were asked to identify the greatest achievements and highlights they experienced working in the Mentoring Mums program. They said that it was the opportunity to: recruit; train and work with the mentors; the Mothers' and their babies and watching these relationships thrive; and make a difference. They felt achievement in receiving referrals, processing them, participating in the assessments, being part of the experience of mothers initially attaching to them and then transferring their attachment to the mentor. There was also achievement working on program development and implementation, developing and collating the documentation. Working with case workers who were interested in the program was also a highlight.

Both Coordinators identified that the experience of working with the evaluation had been a rich one; at times good and useful and enhancing the work of the program and at other times frightening, exposing and feeling intimidated by the amount of work involved.

Both Coordinators were asked to identify the main lessons that had emerged from their experiences working with the Mentoring Mums program in relation to the following areas:

<u>The Program</u>:

The Volunteer Coordinators said that the Mentoring Mums program required clear and transparent structures and processes that articulate the program model and the role of the Coordinator. Having these structures provides direction for those working in the program, enables those outside the program to be informed about what is being achieved and results in other's confidence about the program.

The Mentoring Mums program also requires good supervised reflective practice to promote thinking about the needs of the mothers and the volunteers. In

addition the Mentoring Mums program requires ongoing work to sustain positive working relationships with the community agencies with whom they interact.

The Families:

One clear lesson was that the client group involved with Mentoring Mums require the involvement in their lives of both professionals and volunteers. The Coordinators believed that these mothers have specific needs, but also thought it was important to remember that their experiences were both different from, and the same as all new mothers' experiences. There is a universality in the experience of all new mothers and it is important for them and those working with them to acknowledge this rather than thinking that all their struggles are a result of their backgrounds and 'pathologising' all their behaviours.

It is also important to recognise that these women's backgrounds make it critical for them to receive regular, reliable assistance based in their home environment. This has occurred in the Program and has enabled the women to learn to trust the mentors, feel accepted and relax within the relationship. Some have provided feedback that they feel that '…*this is the only program that you say you're going to do something and you do it*.'

A critically important strength of the Program was that the mentors *are* volunteers; that they are not being paid to be with the new mother. This enabled the families to be less on edge with the mentor than they are with professionals. This helped the new mothers feel accepted by the mentor. It provided the mothers with the essential experience of being accepted by someone outside their normal network.

Mentors

A critical learning from the program was the importance of recruiting mentors from the right target group which is not necessarily based on socio-economic backgrounds but on them being experienced mothers, who have the capacity to reflect on their own mothering experiences, know what is helpful in engaging this client group (which is modelling, rather than telling people what to do), who have the confidence to impart their knowledge and wisdom, the capacity to identify what they need to be able to do the work but who are also open and curious about the women they are working with and able to learn about their backgrounds, struggles and differences.

What also promotes the mentors' capability is that the Program recognises their skills and abilities, what they bring to their roles and draws on their strengths. The co-ordinator's role involved recognising the attunement in the mentors, their attunement to the baby and the new mother and supporting that attunement.

This recognition gives the mentors permission to utilise their wisdom while also providing relevant training, modelling and opportunities to observe. It was also important to provide support, direction and clarity to the mentors about their roles and to have ongoing opportunities to discuss issues in the team meetings.

The Coordinators felt that the mentors who had been recruited fitted these categories, that they had the capacity to do the work and '….*know what to do and be and see*.' The interactions between the mentors and the new mothers used modelling, showing and gently suggesting as means to develop and strengthen the new mother's parenting.

The Volunteer Coordinators also discovered that the fact that mentors '*….don't have the background noise of this is what a professional should do*' enabled the mentors to do their work effectively.

Outcomes:

The Coordinators strongly believed that most of the mothers involved in the Program had developed good relationships with their mentors. Most had experienced breakthroughs with their parenting. For example, a mother who had never done so before, was now reading to her child. Other mothers were beginning a process of strengthening their parenting capacity. However due to the complexity of most of the new mother's circumstances and their need for support with other issues there was still a lot more to work to do in relation to their mothering.

In the area of child development, the Coordinators believed that many of the babies were developing well and the mentors' involvement was a protective factor. The mentors' involvement had ensured that the babies received regular social interaction, and exposure to stimulating activities which hopefully were being integrated into their lives.

The Coordinators also believed that some of the mothers were less socially isolated and had expanded their social networks as a result of their involvement in the program.

The Coordinators believed that some integration with CPS had been achieved. CPS was more aware of the program and some of the programs had made referrals to the Mentoring Mums program. However the location of the program at the Children's Centre had contributed to the Program's marginalisation because it was not part of CPS' core activities. Both Coordinators believed that a better location would be with the Family Services Program.

The Coordinators believed that the Mentoring Mums program had changed CPS. They felt that CPS was now more aware that volunteers can be useful and have developed some interest in utilising volunteers within some programs. However, both were concerned that volunteer work was still seen as not being 'the real work.' Both felt this perception minimised the contribution volunteers could make to both CPS and, especially to client families.

Future Recommendations for the Mentoring Mums program:

One of the Coordinators felt that the Mentoring Mums program would benefit from being locally based rather than covering a large region. This would enable the program to provide localised activities for mentors and mothers together, for

example, mentors and their mothers becoming involved in a shared activity together, such as walking to a play group.

Another recommendation was that the Mentoring Mums program requires staffing of a minimum of two workers because it is very isolating to work as a sole position. Another component to supporting the position and the program would be for Mentoring Mums to be located within the Family Services Program and supported a by team leader position. The Coordinators felt that it would be preferable for referrals to be received mainly from within CPS. This would enable the development of strong relationships with case workers and reduce having to work with a number of different other agencies and workers.

The Mentoring Mums program would benefit from having further focus on developing a clear referral and intake path, clear recruiting and matching processes and clear documentation including around training. The question of CPS senior management's attitude and commitment to the program and its future was also identified as critical for the program's future.

2. CPS Senior Managers Feedback

A Focus Group was held with four members of the Senior CPS Management Team in late 2010. Many of the questions were the same as those used in the other stakeholder interviews. In addition questions were asked to gain feedback about the original program goals of integration of the Mentoring Mums program within CPS and how the Mentoring Mums program has impacted on CPS developing a culture that 'values and promotes volunteering.'

Level of contact with the Mentoring Mums program

The senior managers reported that they had had varying levels of involvement with the Mentoring Mums program. Involvement had occurred in phases rather than throughout the length of the program's operation. Most of their involvement had occurred during the early planning and initial establishment phases when they provided input into the program design, and in the period since the current manager became involved and second Volunteer Coordinator was employed.

From the initial establishment of the program until the first manager and Volunteer Coordinator left they reported that '…*not a lot was heard within CPS about the program*.' They viewed this lack of knowledge about the program as highly problematic. Their involvement in the more recent period has included (for some) participation with developing policies and procedures for the Mentoring Mums program, participation in training mentors, managing staff whose clients were matched with mentors, and hearing information about the Program's progress at senior management meetings.

Strengths of the Mentoring Mums program

The senior managers identified a number of areas of strength in the program. They thought these strengths occurred due to the changes in the program after the second manager and second Coordinator were employed. As a result there is now '…..*a program which started to go well.*' The changes were described as a great relief by two of the senior managers.

The strengths of the Program were:

- An increased number of matches and the mentors now engaging well with the mums,
- That the Volunteer Coordinator position now received support through her increased contact with other CPS programs which included attending case discussion meetings with them.
- The increased involvement and communication between the Mentoring Mums program with other CPS programs particularly Child FIRST and Family Services. It was particularly important to some of the Senior Management Group members that communication was now occurring about how the mentors and co-ordinator were recognising, assessing and handling risk,
- That the program now had gained the confidence of other CPS program staff
- The Volunteer Coordinator position that provided excellent support to the mentors. She was seen as available and helpful.
- That systems and policies had been developed for the program which were running smoothly. These included referral and matching and feedback-liaison procedures with the mother's case workers, code of conduct for volunteers and HR policies.
- There was regular feedback to the senior managers meetings about the program which promoted more involvement from and contribution into the program by senior managers.

Outcomes and Changes Achieved

Whilst the strong message was that the most significant positive outcomes of the Program had occurred during its second stage, some of the managers acknowledged considerable activity during the first phase of the Program. Others thought this had not been the case.

The outcomes and positive changes that had been achieved by the program were:

- That the program was based on a good foundation – volunteers working with service users who in turn receive excellent support from a co-ordinator.
- That it was an operational and functional program, *'getting some wins on the board. They have proved they are a credible option*.'
- That despite its small size and small beginnings it is very beneficial for the group of families with which it works.

- That there were no occasions where risk had not been managed appropriately by the Program.
- They had been successful in recruiting younger and different volunteers to the role – people from a range of backgrounds
- That the Program is marketable and cheap
- It builds community capacity

Outcomes and changes for CPS:

The managers thought that the Mentoring Mums program had become integrated into CPS and that there were some positive outcomes for CPS having the Mentoring Mums program as part of their range of services. In particular they commented on how

- The program fits in well and is aligning itself within CPS
- The program being located in the Children's Centre has given it a place to belong. The Children's Centre's Manager becoming the Mentoring Mums program Manager has enabled the program to '*get off the ground'* which would not have happened if it had been located in the Family Services Program.
- The CPS Family Services Program staff perceived the Mentoring Mums program as a credible, viable and helpful support for the families with which they work, in particular providing informal support for clients and practice support such as transport. It works well to have this option to offer clients.
- The Mentoring Mums program has changed CPS previous negative view about using volunteers to a positive attitude which could create further spin-offs.
- Community agencies are very positive about the program which is helping CPS's community links and profile.

Program Difficulties and Challenges

The area where the Senior Managers were most vocal was in relation to the difficulties and challenges the program itself and CPS had experienced particularly in relation to the period after the program commenced and before the current manager and second Volunteer Coordinator became involved. One described what others also spoke about: the *'alarm in the agency when it became known that not much had happened in the program*.' Other concerns that were reported included concern that in this earlier period there hadn't been sufficient involvement with the Family Services and other CPS programs, the program hadn't been articulated well, there had been a lack of policy and processes regarding volunteers and thought about the impact for CPS using volunteers.

In relation to current concerns:

- One senior manager expressed a concern that the program carries organisational risk because it only consists of one position which is isolating for the worker and the impact for the program if the worker leaves. It is also in contradiction to the CPS philosophy that teams

should have at least 5 members. Therefore it needs to become a component of another program.

- The Senior Managers also discussed the difficulties of securing ongoing funding for programs that are receiving time-limited funding and the impact of insecure funding on a program.
- One described how the buy-in by the agency for the Program has only just begun.
- A number of issues and concerns were raised by some of the senior managers in relation to the use of volunteers both in a general sense and in relation to the Mentoring Mums program. The concerns were:
  - That there is a risk factor of working with volunteers particularly in relation to ensuring their commitment to remaining involved with the families
  - The lack of diversity of the volunteers backgrounds which doesn't reflect the diversity of the Mentoring Mums client group
  - A concern about whether the volunteers are trained sufficiently to undertake their role
  - One member expressed concern about the level to which volunteers should be incorporated into CPS because while volunteers were helpful to provide practical and general support they could not undertake much of CPS' core work.

Future

The Senior Managers were also asked about their recommendations for the future of the Mentoring Mums program. They raised a number of different possibilities. These included:

- That the program be directed to serving Child FIRST and Family Services clients and be located as part of these services.
- That the program is located in local government because it belongs in a broader community base.
- That other CPS programs are able to access the volunteers to become involved in their programs
- That the Program is expanded to provide a service to other regions.

Summary and evaluation

In comparison to the focus groups and interviews with external stakeholders, the focus group with the CPS Senior Managers reflected a sense of distance from and ambivalence to the Mentoring Mums program. There was a strong sense that this had been seen as a program that had started well and with a lot of promise but had lost its way and while this direction was seen as having been addressed and the program was now seen as operational and performing well, a lack of enthusiasm for and knowledge about the program was evident. What were most prominent were the mixed feelings about the program's viability and its contribution and place within CPS.

There were problems with the data from this focus group.

First, the senior managers seemed ignorant about some achievements of the program in the first 12 months of the Program's operation. They seemed unaware of the large number of volunteers who had been recruited into the program in its initial phase, which was a very significant achievement. This ignorance is surprising, given that several of them had been involved in the orientation and training programs of those volunteers. They also seemed unaware that referrals were taken into the program in the early phase, albeit, at a much lower rate than had been hoped, and that matches had occurred. This is also surprising, because the first Volunteer Coordinator, who was part time in that role, and part time in another position, was under the supervision of one of the senior managers for her second role.

Second, the views of the managers were inconsistent – sometimes expressing the view that the program was an excellent addition to CPS, then suggesting that the program should be located in local government, or else expanded by CPS to cover number of regions.

Third, they appeared unable to be reassured about questions of risk, despite acknowledging that all their experience was that risk was extremely well managed by the Program.

Fourth, there was, at least by some members of the group, a minimisation of the positive contribution the mentors were making to the mothers. This was despite clear feedback from CPS practice staff that the mentors were very helpful to their client families.

Fifth, there seemed to be no common view about the future of the program, and no concern that this lack might have, in any way, contributed to the failure to retain staff in the Program. Indeed, there was a minimising of the loss of staff in the program.

Given these matters, it is difficult for the evaluators to assess the data from the senior managers. The focus group took place at a point where the CEO who had been a champion of the Program had left the agency. Leadership of the organisation was in a hiatus. The future of the Program had been guaranteed for a further 12 months, but not before the second Volunteer Coordinator had resigned. There was no certainty about the Program after the 11 month extension. Nor were we, as evaluators, aware of internal dynamics within the leadership team that may have affected what was said in the focus group (one of the senior managers was acting up in the CEO role until a new CEO was appointed. A second senior manager had resigned and was soon to leave the agency.) We were not able to assess the effects of all these matters on the data provided to us in the senior managers' focus group.

What we can say is that, while there was some evidence that the Mentoring Mums program had become integrated within CPS, there was also evidence that the 'buy-in' was a limited one and that the extent to which the Mentoring Mums program has impacted on CPS developing a culture that 'values and promotes volunteering' was less evident.

10. Service providers view of the program

Interviews were conducted with eleven stakeholders representing five organisations. Six were interviewed directly in a focus group and five telephone interviews were conducted. The organisations and individuals included the social work staff of the Mercy Hospital for Women and its Transition Clinic, Family Services programs from a local council and Community Support Organisations, an Enhanced Maternal and Child Health Nurse and a Community Health Centre Midwife. All have had considerable involvement across the whole period of the program's operation including having made the majority of referrals to the program.

The stakeholders were extremely positive about the program describing it as '*…a hugely important program, based on a great premise*' which '*...gives these mums a chance.'*

Program Strengths

The stakeholders identified a number of areas of strength:

- The quality of the operational processes: the smooth and easy referral process, the excellent matching process, the flexibility, responsiveness, efficiency and good communication.
- The positive qualities of the Coordinators: their availability, professionalism, dedication and skills with clients.
- The quality of the mentors: women who have responded well to the needs of the clients and demonstrated a capacity to '*...stick with people who have complex problems'* and provide camaraderie to them. An important feature was that they were women who the mothers could relate to, '*...who they identified with – who shared their stories with them and helped them realise it wasn't just her who had difficulties.'*
- The service provided by the mentors: a service providing another layer of support fitting '*...in a space and gap in service delivery'*. The strength of the service was the '*... non-professional contact which offers actual social connection,'* including their ability to offer services which were otherwise very difficult to access such as brokerage, transport, making linkages to other services and practical support.
- The stakeholders clearly stated that it was the strength of the program that the mentors were not professionals and therefore offered a different type of relationship not complicated by the power relationships that are often present between professionals and this particular client group. As one stated:

  '*... the mentor comes from outside the service system, sits on the periphery. It is not my role as a professional to make friends with clients but the mentors can which is what is needed for this client group. The clients want to connect with people in a different way to how they do with professionals.'*

  Another identified that, '*….we need the extra person to work alongside the case management, professional support.* '
- The flexibility and creativity of the program: particularly in relation to the range of ways the mentors had been used. Examples included

assisting a community midwife run groups for isolated mothers and a mentor engaging with an isolated multi-problem country family while they stayed in Melbourne due to the baby's placement in the Mercy Hospital special care nursery.

All the stakeholders clearly stated that:

> '*… because of the scarcity of resources for this client group; vulnerable, isolated mothers, it is very positive to have this as a resource for referrers'*

The program was an asset and there was a strong need in the community for such a program.

Outcomes and Changes Achieved

Some of the stakeholders were unable to provide information about the outcomes for the clients due to the short-term nature of their contact. However those who were still involved with the women spoke highly of the women's experiences and the changes that have occurred and expressed the view that '*….the program achieves a lot when you consider it is such a small operation with only one person employed*.'

The achievements were seen as wide ranging. *'The clients are very socially isolated and it has made the biggest difference for them.'* These differences included the mothers feeling supported and affirmed in their role as mothers, having improved self esteem, providing extra help to attend appointments, supporting them to leave the house when they had previously struggled to, receive support when ill, receiving much needed brokerage and practical assistance, being nurtured and not judged which '*...allows the women to be themselves*.'

A few mentioned the feedback they received from the mothers about the relief they expressed about how '*nice* and '*lovely*' the mentors were. One commented on how pleased she was to see the mother she referred being relaxed with her mentor which she believes is because *'....the mentor role is not as loaded as with workers. It is an informal relationship where the mentor can talk informally about parenting and doesn't have a specific agenda, which is important for this mother.'*

Program Difficulties and Challenges

Whilst the stakeholders were predominately very positive about the Program and some said they experienced no difficulties working with it, some concerns were raised. The Mercy Hospital social workers raised the problem of the problem of relying on Transition Clinic clients as the sole referral source at the beginning of the program, and what an improvement it was to accept referrals from a wider range of sources. This view was also reinforced by one of the external stakeholders who said '*...it was music to my ears when they broadened their referral base*.'

Other concerns included periods of time when there were long delays in the program's response capacity and when some matches didn't work. Some provided qualified criticism about the lack of communication and feedback from the program. The qualifications were that communications had mainly improved and that some of the lack of communication occurred at times of staff

changeover. A few mentioned the challenges of Mentoring Mums being '*…a very small operation with only one worker and at times it is hard to get in contact with (the Coordinator) but considering she is only one person running the whole program she does really well*.'

One stakeholder was critical of an initial program requirement of the referrer attending a home visit with the Coordinator. This was seen as '*…time consuming and made no sense and this expectation created a hurdle and referrals dropped off*.' Another thought that joint meetings between the external worker, mentor and mother would be useful but was not encouraged. This person felt it was cumbersome for all communication to go through the Coordinator.

Program Changes

The stakeholders had a number of suggestions about ways the program could work more effectively. These included expanding the mentor role, increasing the time the mentors spent with the mothers and extending the length of involvement, expanding the current catchment area and being able to cater for isolated non-English speaking women.

Future

The following sentiment represented the views of all the stakeholders:

'*It is a hugely important program. Don't let it go*.'

11. Conclusions

A complete summary of findings is provided in the Summary Report. The detail of these will not be repeated here.

The findings from the evaluation data are unequivocal:

- The Mentoring Mums program is successful in doing what it set out to do, at both case and program levels.
- It is meeting unmet needs of a significantly disadvantaged and at risk group of new mothers.
- In doing so it is reducing risk to their infants.
- It appears to be able to bring about change that professional services have difficulty doing in some cases, and in others appears to be a strong support and to make a constructive contribution to achieving goals set by professional with the families.
- It is an extremely low cost service.
- It deserves to be made a regular component of Family Services within the Child FIRST networks, state wide.

These findings are entirely congruent with other local research which have found that volunteers matched with disadvantaged families at high risk in the child and family welfare field achieve significant outcomes when combined with effective casework, in areas that casework alone struggles to achieve (Mitchell, 1995), and (Mitchell and Sheehan, 2003).

Recommendations

1. That CPS continues the Mentoring Mums program as a core service to Family Services clients with infants. It is as an essential component of services to this client group.
2. That CPS shares the findings of the evaluation with DHS to encourage them to fund mentoring programs such as the Mentoring Mums program, as a standard component of Family Services program models.
3. That CPS disseminates the findings of this evaluation report to its management and staff, and inaugurates targeted processes to ensure that the Mentoring Mums program is appropriately valued and integrated into CPS.
4. That the Mentoring Mums program model be maintained. The model in its entirety is effective, and it is vital that a designated Volunteer Coordinator is maintained with full-time responsibility for the program.
5. That the Mentoring Mums program be located within Family Services.
6. That the Program continue to receive referrals from a variety of sources, in addition to the Child FIRST referral network, to promote effective early intervention and prevention.

References

Absler, Deborah. "Relationships, Connectedness and Engagement : A Study of the Multidimensional Components of 'Good-Enough' Collaborative Approaches for Young People with Complex Needs and Their Families." Thesis (Ph D), University of Melbourne, School of Social Work, 2006., 2006.

Contole, J., C. O'Neill, G. Mitchell, and D. Absler. "Counting the Kids: Final Evaluation Report." Melbourne: Odyssey House Victoria, 2008.

Flyvbjerg, Bent. *Making Social Science Matter : Why Social Inquiry Fails and How It Can Succeed Again*. Cambridge: Cambridge University Press, 2001.

Geertz, Clifford. "Thick Description: Toward an Interpretive Theory of Culture." In *The Interpretation of Cultures : Selected Essays*, ix, 470. New York: Basic Books, 1973.

Gilgun, Jane F. "A Case for Case Studies in Social Work Research." *Social Work* 39, no. 4 (1994): 371-80.

Handel, Gerald, Jane Frances Gilgun, and Kerry J. Daly. *Qualitative Methods in Family Research*. Newbury Park, Calif.: Sage Publications, 1992.

Kettner, Peter M., Robert Moroney, and Lawrence L. Martin. *Designing and Managing Programs : An Effectiveness-Based Approach*. 2nd ed, Sage Sourcebooks for the Human Services. Thousand Oaks, Calif.: Sage Publications, 1999.

Krueger, Richard A., and Mary Anne Casey. *Focus Groups : A Practical Guide for Applied Research*. 4th ed. Thousand Oaks, Calif.: SAGE, 2009.

Mitchell, Gaye, Cathie Hutchinson, Jo Smart, and Julie Wassle. "Comprehending Complexity, Fighting Exclusion: Evaluation of South East Family Services: Detailed Report." Connections UnitingCare, http://www.connections.org.au Follow links to "publications" and then to "research publications".

Mitchell, Gaye Lorraine. "Child Welfare Families: Elaborating an Understanding through Social Work Practice and Research and the Use of Volunteers." Ph.D, University of Melbourne, 1995.

Mitchell, Gaye, and Jenny Sheehan. "'The Only Friend I've Ever Had': Building Relationships with Excluded Families." Melbourne: MacKillop Family Services, 2003.

Mitchell, Gaye; and Campbell, Lynda. "The Social Economy of Excluded Families." *Child and Family Social Work* (2011).

Punch, Keith. *Introduction to Social Research : Quantitative and Qualitative Approaches*. London ; Thousand Oaks, Calif.: SAGE Publications, 1998.

Stewart, David W., Prem N. Shamdasani, and Dennis W. Rook. *Focus Groups : Theory and Practice*. 2nd ed, Applied Social Research Methods Series. Thousand Oaks: SAGE Publications, 2007.

Walton, Richard E. "Advantages and Attributes of Case Study." *Journal of Applied Behavioural Science* 8, no. 1 (1972): 73-78.

Weiss, Carol H. *Evaluation : Methods for Studying Programs and Policies*. 2nd ed. Upper Saddle River, N.J.: Prentice Hall, 1998.

‘Local mums helping other local mums’

The Mentoring Mums program Evaluation Report

Appendices

Dr Deborah Absler
Dr Gaye Mitchell
With Professor Cathy Humphreys
March 2011

MENTORING MUMS EVALUATION FINAL REPORT APPENDICES

APPENDIX ONE: Data tool for mothers

EVALUATION TOOL[1]:

Data needed about the new mums [this form to be filled out by the Volunteer Coordinator for each new mum]

Date: …….

A. CASE IDENTIFICATION

1. Family Number: (Gaye to fill out)……...
2. Name of new mum 1:
3. Name of father:
4. Date of first contact with the Mentoring Mum's program: ……..……
5. Referral Source: …….

B. FAMILY DETAILS

6. Household membership: [need adults, and children and any other person]

First name [Only so the researcher can not get confused in analysis – won't be used in write up]	**Age and DOB**	**Relationship within the household (parent, step parent, child, step or half child mother or father, visitor, boarder, etc**
Add as many rows as needed		

7. Details of family members not in the household:

First name [Only so the researcher can not get confused in analysis – won't be used in write up]	**Age DOB**	**Relationship within the household (parent, step parent, child, step or half child mother or father, etc) and details of who they are living with**	**Detail of any access arrangements with the client family**
Add as many rows as needed			

[1] This form is adapted from a form developed by Dr Margaret Kertesz, Anglicare Victoria, for the Anglicare evaluation of their Innovations Projects, and from evaluation tools developed previously by Dr Gaye Mitchell for use within Connections, and Odyssey House.

8. Brief description of the development and well-being of any older children. Include comments about child development, health, education, and history of any separations from the parent.

Take as much room as needed

……

9. Family Details: Fill out for new mum, the father of the baby, and mother's current partner, if different from the father and if living in the household.

a. Age group: new mum (please circle): 10-19, 20-29, 30-39, 40-49, 50-59

father (please circle): 10-19, 20-29, 30-39, 40-49, 50-59

current partner (please circle): 10-19, 20-29, 30-39, 40-49, 50-59

b. Marital status: new mum (please circle):

Never married	Single	married	Defacto	separated	divorced	Partner deceased	Not known

Marital status: father (please circle):

Never married	Single	married	Defacto	separated	divorced	Partner deceased	Not known

Marital status: current partner (please circle):

Never married	Single	married	Defacto	separated	divorced	Partner deceased	Not known

c. Postcode .....

d. Language: new mum: English? Other? .....

father: English? Other? .....

current partner: English? Other? .....

e. English proficiency: new mum: (please circle): Very well, Well, Not well, Not at all.

father: (please circle): Very well, Well, Not well, Not at all.

current partner: (please circle): Very well, Well, Not well, Not at all.

f. Country of Birth: new mum: Australia? Other? .....

father: Australia? Other? .....

current partner: Australia? Other? .....

g. Ethnic identity: new mum: (please circle)

Australian (non aboriginal)	Australian Aboriginal or Torres Straight Islander	Asian	European	Middle Eastern	North American	South American	Other (please specify)

father: (please circle)

Australian (non aboriginal)	Australian Aboriginal or Torres Straight Islander	Asian	European	Middle Eastern	North American	South American	Other (please specify)

Current partner: (please circle)

Australian (non aboriginal)	Australian Aboriginal or Torres Straight Islander	Asian	European	Middle Eastern	North American	South American	Other (please specify)

h. Highest Education level completed: new mum: (please circle)

Year 8 or below	Year 9	Year 10	Year 11	Year 12	Trade or TAFE not completed	Trade or TAFE completed	University not completed	University completed

Education level: father: (please circle)

Year 8 or below	Year 9	Year 10	Year 11	Year 12	Trade or TAFE not completed	Trade or TAFE completed	University not completed	University completed	Not known

Education level: current partner: (please circle)

Year 8 or below	Year 9	Year 10	Year 11	Year 12	Trade or TAFE not completed	Trade or TAFE completed	University not completed	University completed

i. Employment status: new mum: (prior to having baby) (please circle)

Unemployed – never worked	Unemployed (more than 5 years	Unemployed (more than 2 years	Unemployed More than a year	Unemployedless than a year	Casual part time	Casual full-time	Part-time permanent	Full-time permanent

Employment status: new mum: current (please circle)

Unemployed – never worked	Unemployed (more than 5 years	Unemployed (more than 2 years	Unemployed More than a year	Unemployedless than a year	Casual part time	Casual full-time	Part-time permanent	Full-time permanent	Home duties

Employment status: father: (please circle)

Unemployed – never worked	Unemployed (more than 5 years	Unemployed (more than 2 years	Unemployed More than a year	Unemployedless than a year	Casual part time	Casual full-time	Part-time permanent	Full-time permanent	Not known

Employment status: current partner: (please circle)

Unemployed – never worked	Unemployed (more than 5 years	Unemployed (more than 2 years	Unemployed More than a year	Unemployedless than a year	Casual part time	Casual full-time	Part-time permanent	Full-time permanent	Not known

j. Household Income source: (please circle, and circle more than one category if there is more than one source):

Social security payment	Casual employment	Part time permanent	Full time	No income

k. Housing Situation *(please circle, or replace the right box with a blue font)*

Renting – private: flat/unit	Renting – private: house	Renting – Ministry of Housing - flat	Renting – Ministry of Housing - house	Purchasing/owning flat/unit	Purchasing/owning- house	Homeless – sleeping rough	Staying with relatives or friends	Emergency accommod-ation	Transitional housing	Rented caravan

Refuge	Boarding	Other, please specify

l. Current study: new mum: (please circle)

father:

Not studying	Part time study	Full-time study	Planning to study

Not studying	Part time study	Full-time study	Planning to study	Not known

Current partner:

Not studying	Part time study	Full-time study	Planning to study

m. Any current legal involvements:

new mum: (please circle)

None	There have been previous convictions	There are current charges	Family court involvement	Children's court involvement

father

None	There have been previous convictions	There are current charges	Family court involvement (past or current)	Children's court involvement (past or current)	Not known

Current partner

None	There have been previous convictions	There are current charges	Family court involvement (past or current)	Children's court involvement (past or current)

Are there any current Children's Court Orders? (please circle) **Yes** **No**

Are there any Family Court Orders? (please circle) **Yes** **No**

n. Current Health and substance use and history:

Please list any current health or mental health problems.
Please specify the nature of these problems.
Please note whether the new mum is currently receiving service in relation to the problem
Please give any history of substance abuse, and describe any current use

o. Short history of any contact of either parent, or of biological parent of child (if not living in the household) with the Child welfare system during their childhood:

10. Provide a genogram of the family, in so far as you know it, going back at least 3 generations, if possible. Provide brief notes on any relationship you think is significant for the client family.

11. Social networks

In the evaluation, two eco maps of the family will be required: See attached sample eco map at the end of this document for instructions and guidelines.

a. At the point of first working with the family.

b. At the end of the data collection period for the evaluation or at case closure, whichever occurs first. *[In this second eco map, mark with red, any relationship, person or organisation that is new to the eco map since the family was referred to The Mentoring Mums Program]*

12. Organisations with whom the family is in contact – at referral: *[Consider normal and special organisations, recreational and cultural, in relation to adults and children in the family.*

Name of organisation	**Family member**	**Nature of contact, activity**	**Frequency of contact**
Add as many rows as needed			

13. Organisations with whom the family is in contact – at case closure, or end point of data collection for the evaluation

Name of organisation	**Family member**	**Nature of contact, activity**	**Frequency of contact**
Add as many rows as needed			

14. Issues, difficulties, problems and challenges faced by the family:

Please fill out the list on the following pages ***twice,***

First: The case when you first met the family
Second: The case now, or at case closure. *[We are asking for the second list to see if any of the identified issues have either been eradicated, or modified in severity.]*

First list – the situation when you first met the family
On the following sheet:

- Please include all issues which were present in the family, whether you were working on the problem/issue or not.
- Please indicate the degree to which these issues significantly interfered with basic family functioning.
- If possible, indicate how long this issue has created problems for the family.

14i) Issues identified at intake and during intervention

Issues	**Seriousness of issue in significantly interfering with family functioning** 1. always interferes 2. sometimes interferes	**History / Duration of Issue**
The family's relationship with its environment		
Financial difficulties – severe		
Inadequate Housing		
Insecure housing/homelessness		
Education disadvantage for the new mum, the father or her current partner		
Unemployment – short-term		
Unemployment – long-term		
Under-employment, employment insecurity		
Inappropriate/low standard work conditions		
Involvement with criminal justice system – current		
Involvement with criminal justice system – past		
Isolation from the service system		
Isolation from or serious tensions with extended family		
Isolation or serious tensions with other parts of the new mum's social networks (friends, acquaintances)		
Violence and or criminality in the neighbourhood		

Issues	**Seriousness of issue in significantly interfering with family functioning** 1. always interferes 2. sometimes interferes	**History / Duration of Issue**
If there are older children:		
Education / School difficulties - child		
Individual family members		
Health – physical – adult		
Health – mental – adult		
Disability – intellectual – adult		
Disability – Physical – adult		
Substance Abuse - past		
Substance Abuse - current		
Sexual assault – childhood history		
Sexual assault – adult history		
If there are older children:		
Health – physical – child		
Health – mental – child		
Disability – intellectual – child		
Disability – Physical – child		
Child Behaviour (incl. ADHD)		
Family System matters		
Unresolved Family of Origin Issues		
Significant trauma – current		
Significant trauma – past		
Parental involvement with child welfare services as a child		
Parenting Difficulties		
Relationship issues between adults		
Family Violence – past		
Family Violence – current		
Migration/cultural issues		
If there are older children:		
Relationship issues between adult & child		
Abuse of child - emotional		
Abuse of child - physical		
Abuse of child - sexual		

Child Neglect			
Other (please specify)			
	1. always interferes 2. sometimes interferes		**Leave this column blank**

Please repeat the procedure on the list on the following pages to indicate the situation as you see it now, at the current time, or what it was at case closure.

14.ii) Second list: Issues identified at close of service

Issues	**Seriousness of issue in significantly interfering with family functioning** 1. always interferes 2. sometimes interferes	**History / Duration of Issue**
The family's relationship with its environment		
Financial difficulties – severe		
Inadequate Housing		
Insecure housing/homelessness		
Education disadvantage for the new mum, the father or her current partner		
Unemployment – short-term		
Unemployment – long-term		
Under-employment, employment insecurity		
Inappropriate/low standard work conditions		
Involvement with criminal justice system – current		
Involvement with criminal justice system – past		
Isolation from the service system		
Isolation from or serious tensions with extended family		
Isolation or serious tensions with other parts of the new mum's social networks (friends, acquaintances)		
Violence and or criminality in the neighbourhood		
If there are older children:		
Education / School difficulties - child		

Issues	**Seriousness of issue in significantly interfering with family functioning** 1. always interferes 2. sometimes interferes	**History / Duration of Issue**
Individual family members		
Health – physical – adult		
Health – mental – adult		
Disability – intellectual – adult		
Disability – Physical – adult		
Substance Abuse - past		
Substance Abuse - current		
Sexual assault – childhood history		
Sexual assault – adult history		
If there are older children:		
Health – physical – child		
Health – mental – child		
Disability – intellectual – child		
Disability – Physical – child		
Child Behaviour (incl. ADHD)		
Family System matters		
Unresolved Family of Origin Issues		
Significant trauma – current		
Significant trauma – past		
Parental involvement with child welfare services as a child		
Parenting Difficulties		
Relationship issues between adults		
Family Violence – past		
Family Violence – current		
Migration/cultural issues		
If there are older children:		
Relationship issues between adult & child		
Abuse of child - emotional		
Abuse of child - physical		
Abuse of child - sexual		
Child Neglect		
Other (please specify)		

	1. always interferes 2. sometimes interferes		**Leave this column blank**

15. List any Protective Issues present at referral: [Fill out only if there are older children]

D. Case Closure

i. Date of case closure: .....……

ii. Goal achievement: *[please circle]*

a) Relationship between the new mum and the volunteer: *[please circle]*

A strong relationship of mutual liking and enjoyment was developed between the volunteer and the new mum.	A relationship of moderate strength was developed between the volunteer and the new mum.	A weak relationship between the volunteer and new mum was developed	There was conflict and/or negativity between the new mum and the volunteer.	The new mum withdrew from the relationship with the volunteer.

b) A general rating of goal achievement for this match: *[please circle]*

All Goals fully achieved	Goals mostly achieved	Between mostly achieved and some-what achieved	Some goals mostly achieved, some partially achieved, Some failure to achieve goals	More failure to achieve goals than goals achieved	No goals reached

iii. Date of case study if case not closed .....

Guidelines for completion of eco maps[2]

Social Isolation is one of the key challenges faced by many clients. Research and anecdotal evidence shows that families with weak or conflictual support networks are at greater risk than families who are well connected to social and institutional networks. For this reason, the evaluation is examining any changes in social networks that occur during the course of Mentoring Mum's involvement, in the 5 case studies being undertaken.

Guidelines:

1. Please complete, or provide two eco maps for the family.

   - The first eco map should indicate the connectedness of the family at the time Mentoring Mum's started working with the family.

   - The second eco map should indicate the connectedness of the family now.

[2] I am very grateful to Dr Margaret Kertesz of Anglicare whose instructions for constructing the eco maps have been adapted here.

- Please date both eco maps and label them so that the two can be identified as the same family, while preserving the family's anonymity.

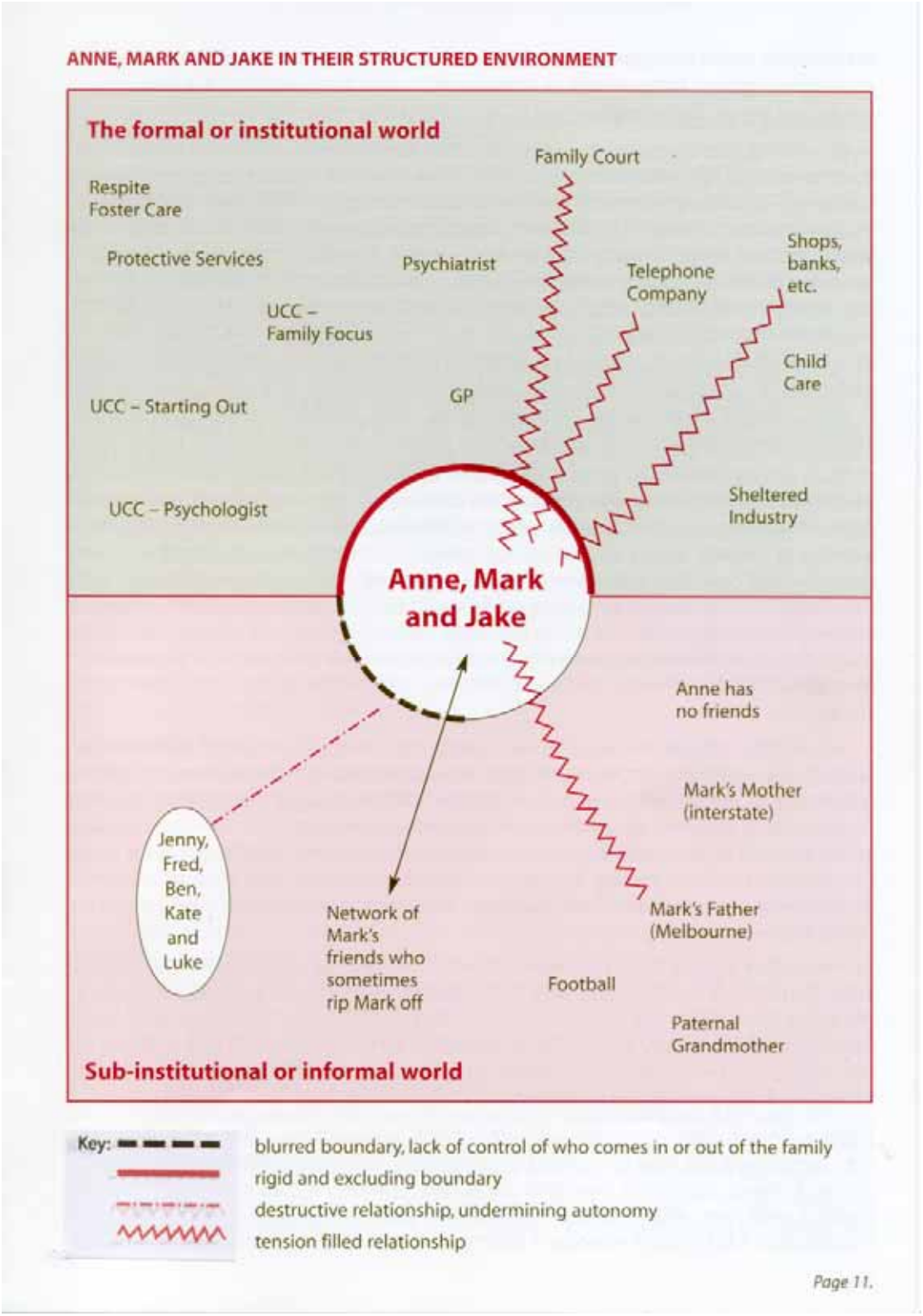
- On the second eco map, please note whether the case is closed or still active.

- Please add any other notes that you think are useful and explanatory

2. An example of the eco map design can be found on the following page.

    - The circle in the middle includes the family unit with whom you are working. Do not include surnames (but relationships should be indicated).

Please divide your eco map into two halves, following the example. The top half should show the formal or institutional connections, the bottom half should show the family's informal networks.



-

Sample Ecomap based on "The structured and culturally meaningful environment of family life" (Valsiner, 1988), see Mitchell, G.L. (1995) *Child Welfare Families: elaborating an understanding through social work practice and research and the use of volunteers*, Ph.D. University of Melbourne, p.77

APPENDIX TWO:

EVALUATION TOOL[3]: Case Studies: Intervention and achievements

Date of interview with co-ordinator: ……

A. CASE IDENTIFICATION

16. Family Number: ……...

17. Name of new mum 1:

18. Date of first contact with the Mentoring Mum's program: ……..……

19. Check the geno gram and make sure it is as detailed as possible

20. Check the eco maps and make sure it is as detailed as possible

21. Goals

Goal number	Statement of Goal	Is the goal the goal of the mum, the mentor or both?
		1. the mum 2. the mentor 3. both
1		
2	Use as many rows as needed	

[Use more rows if needed]

22. The processes involved in the volunteer and family meeting their goals. What was done, list any barriers and difficulties, what was done to overcome the difficulties, stages of the relationship, etc:

[3] This form is adapted from a form developed by Dr Margaret Kertesz, Anglicare Victoria, for the Anglicare evaluation of their Innovations Projects, and from evaluation tools developed previously by Dr Gaye Mitchell for use within Connections, and Odyssey House.

a. **Description of the processes between the volunteer and the new mum:**

Goal number	**Process of helping – what was done to achieve the goal**
	Use whatever space is needed

b. **Description of any casework intervention:**

Number and Description of the goal	**Process of helping – what was done to achieve the goal**
	Use whatever space is needed

Use of any other services within CPS*:*

CPS program name	
Description of intervention	Use whatever space is needed
Length of intervention	
Goals set	
Outcomes	

23. Goal Attainment, and consideration of outcomes of the volunteer involvement:

Goal number	**Goal attainment score** 1. Fully achieved 2. Substantially achieved 3. Partially achieved 4. Goal not reached	**Description of the achievement: the basis of why the volunteer co-ordinator, the volunteer and the new mum give the rating they do on each goal (i.e., evidence)**
		Use whatever space is needed

24. Factors helping or hindering goal attainment (Volunteer co-ordinator's view)

Factors helping goal attainment [Specify if any of the helping or hindering factors relate to a specific goal. Give the goal number if they do. Otherwise, comments will be read as applying to the goals in a general sense]	**Factors hindering (or barriers to) goal attainment**
Use whatever space is needed	

25. Were outcomes worked towards or achieved, or did the family situation deteriorate, in relation to any of the following

(Please specify under each heading)	**Positive change**	**Negative change**	**What or who brought about, or contributed to these changes (MM's, the family, the service system, what combination)**
Increased connectedness to local and mainstream community **The service system** • Health, Welfare and income support • Education and training • Employment **Cultural and recreational activities** • Adults • Children			
Reduction in social isolation • Increased constructive contact with extended family • Reduced connection to negative networks • Increased number of friends			
Changes in parenting • Increased confidence • Improved skills and strategies			
Children's well being • Improved Social well-being • Improved Emotional well-being			

• Child/ren achieved developmental milestones			
Children's safety • Number of notifications • Instances of danger • Improvement of safety			

Case Closure

i. Date of case closure: .....……

ii. Goal achievement: *[please circle]*

All Goals fully achieved	Goals mostly achieved	Between mostly achieved and some-what achieved	Some goals mostly achieved, some partially achieved, Some failure to achieve goals	More failure to achieve goals than goals achieved	No goals reached

iii. Date of case study if case not closed .....

**********Do you have any other comments about this case and this family?

APPENDIX THREE

QUESTIONS FOR MUM'S INVOLVED WITH MENTORING MUM'S PROGRAM

1. How long have you been involved with Mentoring Mums?
2. How did you hear about Mentoring Mums?
3. What made you decide to become involved with Mentoring Mums?
4. What has the experience been like being part of the Mentoring Mums program?
5. What have been the good things about Mentoring Mums?
6. Have there been any things that you haven't liked?
7. What is different now for you and your family since being involved with Mentoring Mums?
8. Is there anything else you had hoped for, when you first got involved?
9. Is there anything else you wish Mentoring Mums could help you with?
10. Are there any things you would like Mentoring Mums to do differently?
11. Any other comments?

Thanks for your time

APPENDIX FOUR

QUESTIONS FOR MENTORS REGARDING THE MENTORING MOTHERS PROGRAM

1. What has it been like being a mentor?
2. What have been the good things about being a mentor?
3. What has been hard or difficult about being a mentor?
4. What has helped you in taking on this role?
5. What difference do you think it has made for the Mum and her baby and her family receiving this service?
6. Have there been any surprises?
7. Is there anything you like to be different about this Program so that it would work more effectively –either for the Mum's or for you as a mentor?
8. What advice would you give a new mentor joining the Program?
9. Any further comments?

Thank you for your time – if you have any further feedback you would like to give us at a later date please feel free to contact us – deborah.absler@bigpond.com

APPENDIX 5: QUESTIONS FOR REFERRERS TO THE PROGRAM

1. What is the nature of your contact with the Mentoring Mum's Program?

2. How much contact have you had with them and over what period?

3. What has been good about working with the Mentoring Mum's Program?

4. What has been hard or difficult about working with the Mentoring Mum's Program?

5. Has it made any difference to your service having access to the Mentoring Mum's Program?

6. What feedback can you give about the difference the Mentoring Mum's Program has made for the young Mum's receiving the service?

7. Have there been any surprises in your contact with the Mentoring Mum's Program?

8. Are there any ways in which it could work more effectively?

9. Is there anything you like to be different about this Program?

10. Any further comments?

Thank you for your time – if you have any further feedback you would like to give us at a later date please feel free to contact us – deborah.absler@bigpond.com

APPENDIX 6: MENTOR DATA TOOL

Children's Protection Society – Mentoring Mums – Evaluation Tool

(To be filled out by the mentors)

A. MENTOR NAME AND REASONS FOR VOLUNTEERING

First name (optional. Only asked so that the evaluators do not get any information mixed up):

When did you do the training program for Mentoring Mums? (Please give month and year)

Have you been matched with a new mum yet? **Yes** ☐ **No** ☐

Reason for volunteering and Prior volunteer history

Where and how did you hear about volunteer program?

Is this the first time you have been a volunteer? **Yes** ☐ **No** ☐

If you have volunteered previously, can you tell us a little about your volunteer experience?

Can you tell us why you volunteered to become a mentor with the Mentoring Mums program?

Family details: Can you tell us a little bit about your family?

First Name	Age (years)	Relationship to mentor (e.g., partner, son, daughter

Do you have grand children? Yes ☐ No ☐

If yes, how many? ……..

C. SOCIO-ECO DETAILS: Please put a cross in the appropriate box.

Age

Under 19	20-29	30-39	40-49	50-59	60-69	Over 70
☐	☐	☐	☐	☐	☐	☐

Marital status

Never Married	Single	Married	Defacto	Separated	Divorced	Partner Deceased	Not Known
☐	☐	☐	☐	☐	☐	☐	☐

Postcode: ……..

Language and ethnicity

First LANGUAGE	English?	Other (please specify)
	☐	

ENGLISH PROFICIENCY	Very well	Well	Not well	Not at all
	☐	☐	☐	☐

Country of Birth	Australia	Other (please specify)
	☐	

ETHNIC IDENTITY	Australian (non Aboriginal)	Australian Aboriginal or Torres Straight Islander	Asian	European	Middle Eastern	North American	South American	Other (ple specify)
	☐	☐	☐	☐	☐	☐	☐	

EDUCATION

Highest	Year 8	Year	Year	Year	Year	Trade or TAFE	Trade or TAFE	University not	Univer

Education Level Completed	or below	9	10	11	12	not completed	completed	Completed	Comple
	☐	☐	☐	☐	☐	☐	☐	☐	☐

EMPLOYMENT (circle current and previous, if you are not currently working)

Unemployed (long-term)	Unemployed (short term)	Home duties	Retired	Self-employed	Casual Part time	Casual Full-time	Part-time permanent	Full-time permanent
☐	☐	☐	☐		☐	☐	☐	☐

Employment type (circle current and previous, if you are not currently working)

Employment type (current or past if retired or home duties	Manager	Professionals	Tech and trade	Community and personal services	Clerical and admin	Sales	Manual labour	Other
	☐	☐	☐	☐	☐	☐	☐	☐

If other, please specify:

Household income source

Social Security Payment	Casual Employment	Part-time Permanent Employment	Full-time employment	Private superannuation
☐	☐	☐	☐	☐

HOUSING SITUATION:

Renting or purchasing : public housing	Renting: private flat/unit	Renting: private house	Purchasing or purchased own flat/unit	Purchasing or purchased own house	Other (please specify)
☐	☐	☐	☐	☐	☐

Thank you very much for filling in this survey for us!

APPENDIX 7: MATERNAL AND CHILD HEALTH SURVEY

MENTORING MUM'S EVALUATION DATA COLLECTION RE CHILD DEVELOPMENT, ATTACHMENT & BONDING & PARENTING CAPACITY

Name of Mum (or client number) & baby and baby's age…….
…….
Name of MCH……
Number of contacts & length of involvement between Mum and MCH Nurse
……..
Date when contact ended……
Date of interview……

1. HOW WOULD YOU DESCRIBE THE BABY'S DEVELOPMENT IN THE FOLLOWING AREAS? (Please circle)

Gross motor development:

Normal Somewhat below Below on most items Grave concerns about baby's development

Vision:

Normal Somewhat below Below on most items Grave concerns about baby's development

Fine motor development:

Normal Somewhat below Below on most items Grave concerns about baby's development

Language:

Normal Somewhat below Below on most items Grave concerns about baby's development

Speech:

Normal Somewhat below Below on most items Grave concerns about baby's development

Hearing:

Normal Somewhat below Below on most items Grave concerns about baby's development

Social behaviours:

Normal Somewhat below Below on most items Grave concerns about baby's development

Play:

Normal Somewhat below Below on most items Grave concerns about baby's development

2. HAS THE CHILD EXPERIENCED ANY INJURIES?

   (Please circle)
   YES NO

   Comment……

3. HAVE THERE BEEN ANY HEALTH PROBLEMS?

   (Please circle)
   YES NO

   Comment……

4. PLEASE COMMENT ON THE ATTACHMENT AND BONDING THAT HAS DEVELOPED BETWEEN THE MOTHER AND HER BABY:

   (Please circle)

Positive attachment **Anxious attachment** **Difficulties in attachment**

   Comment……

   Can you comment on the attachment between the baby and other family members?

   Comment……

5. PLEASE COMMENT ON THE FOLLOWING AREAS RELATING TO THE MOTHER'S PARENTING:

   (Please circle)

   Responding to baby's cues:

   Yes Sometimes Rarely Never

   Feeding:

   No problems Some problems Area of difficulty

   Establishing sleeping routines:

   Most of the time Sometimes Area of difficulty

General care & nurture:

Satisfactory Variable Area of difficulty

Establishing play and socialisation routines:

Satisfactory Variable Area of difficulty

Ensuring child safety:

Satisfactory Variable Area of difficulty

Comments……

6. DID YOU SEE ANY CHANGES FOR THE MUM AND HER CHILD DURING THE PERIOD OF INVOLVEMENT WITH THE MENTORING MUM'S PROGRAM:

   (Please circle)
   YES NO

   Comment……

7. DID THE MOTHER ATTEND ANY OTHER ACTIVITIES AT THE CENTRE?

   (Please circle)
   YES NO

   Comment……

8. ANY OTHER COMMENTS?

……

Thank you for your time

APPENDIX EIGHT: PLAIN LANGUAGE STATEMENTS AND CONSENT

Plain language statement, new mums

Dear -----,

We are delighted that you are participating in the Mentoring Mums project which has been recently established within the Children's Protection Society (CPS). The aim of the Mentoring Mums project is to match pregnant women or women with very young babies with a volunteer who will 'walk beside' them in a supportive relationship during baby's early years.

This is an exciting new project and different from other projects currently operating in Australia. Because of this, we are keen that the project is evaluated from its beginning. Gaye Mitchell and Deborah Absler have joined the Mentoring Mums team as researchers who will support us by thinking about how the project is working.

Deborah and Gaye come to the project with considerable knowledge and experience in evaluating programs working with children and families and are both experienced social workers.

Gaye and Deborah's role as evaluators is to help us find out about how well Mentoring Mums works, how it is helping you and the other new mums. They need to understand what its been like for you to become a mum, what it has been like to have a volunteer mentor, and what difference this has made for you, your baby, and for the mentor. To answer these questions, they will need to speak to some new mums, some mentors, Michelle, and some Maternal and Child Health Nurses who work with the new mums. They will want to look at the answers to a number of questions that we ask you, as part of running the program.

In lots of ways, Gaye and Deborah's work is very similar to Michelle's work. Michelle asks you questions when she meets with you so that she can understand how to best help you. The answers you give to those same questions will help Deborah and Gaye to understand your situation and what Mentoring Mums is doing to support you. Thus we are seeking your permission for us to discuss these things with Deborah and Gaye.

We would also like your permission for Deborah and Gaye to talk with Michelle, and your volunteer about how Mentoring Mums works, and what it achieves. Gaye and Deborah also want to speak to the Maternal and Child Health Nurse of some new mums in the program. They want to do this because the Nurse knows a lot about babies and being a new mum. She measures how your baby is growing and developing, and knows how you are learning and growing as a parent. These are all things that will help us know

how Mentoring Mums is working. These are the only things Deborah and Gaye would talk about with the Maternal and Child Health Nurse.

We would like to stress that Gaye and Deborah are bound by the same strict confidentiality and privacy rules that all CPS Staff and volunteers follow. Consequently, they will disguise all details about you and your family so anything written about Mentoring Mums will not identify you or your family. If you would like, we would give you a copy of the report they are required to write for the funding body. If you had thoughts about what they write, they would include your comments in the report. (What they write about Mentoring Mums might be talked about at meetings of professional people (like social workers, psychologists, nurses and teachers), or published in journals that professionals read. We do this so that others can learn about how to support new mums.)

We hope that you will give permission for Gaye and Deborah to talk with the people we have mentioned and for them to be able to look at the work that the Mentoring Mum's Program will be doing with you. Studies like this help us do a better job of assisting other new mums. However, if you do not give permission, we will understand and respect your decision. Whatever your decision, there will no change in the services you receive from CPS now or into the future.

If you give your permission, we would like you to sign the attached consent form.

If you have any questions or worries about this study of Mentoring Mums, we and Gaye or Deborah will be only too happy to talk with you about the study. If you do want to speak to Gaye or Deborah we will provide you with their contact details.

Yours Sincerely,

Marianne Mahony (Manager Donor Relations and New Projects)

Michelle Hawke (Mentoring Mums Coordinator)

Plain Language Statement: Mentors

22-3-2010

Dear -----,

This letter is to explain the evaluation of the Mentoring Mums project that is being conducted for CPS. As you know, the aim of the Mentoring Mums project is to match pregnant women or women with very young babies with a volunteer like yourself, who will 'walk beside' the new mums in a supportive relationship during baby's early years.

This is an exciting project and different from other projects currently operating in Australia. Because of this, we are keen that the project is evaluated from its beginning. Gaye Mitchell and Deborah Absler have joined the Mentoring Mums team as researchers who will support us by thinking about how the project is working. Most of you will have met Deborah and Gaye in one of your training sessions.

Deborah and Gaye come to the project with considerable knowledge and experience in evaluating programs working with children and families and are both experienced social workers.

Gaye and Deborah's role as evaluators is to help us find out about how well Mentoring Mums works and how well it is helping the new mums. They need to understand what it's like for the mums, what it's like for them to have a mentor, what it's like for the volunteers, and what difference this has made for the mums, the babies, the mentors and CPS. To answer these questions, they will need to speak to some new mums, some mentors, CPS staff, and people in other organisations who refer the mums to the program. In relation to your involvement in Mentoring Mums, they will be interested in the training and ongoing support you receive as mentors, how you've found the experience, how your relationship with the mum has developed over time, your view of the difference you have made for the mum and baby, the difference being involved in the program has made for you, and perhaps some other questions that will emerge as the evaluation progresses. They will explore these questions with you through a range of ways: perhaps a group discussion, perhaps a survey and perhaps an individual interview. Deborah and Gaye will also talk with Abigail about how each relationship between the mentor and the new mum is developing.

We would like to stress that Gaye and Deborah are bound by the same strict confidentiality and privacy rules that all CPS Staff and volunteers follow. Consequently, they will disguise all details about you so that anything written about Mentoring Mums will not identify you in any way.

The report of the evaluation will be provided to CPS, and you are most welcome to a copy of it. It is hoped the evaluation will be available to, and

helpful for others interested in running such a program, and the results of the evaluation may also be published through conference papers and journal articles. Our hope is that the evaluation will help us, and other agencies like CPS, to do a better job of assisting families.

We hope very much that you will agree to take part in the evaluation. If you agree, would you sign the attached consent form? We will then arrange for Deborah and Gaye to be able to contact you to organise your participation in the evaluation.

While we most sincerely hope that you will be able to take part in the evaluation, your participation in it is entirely voluntary. If you do not give permission, we will understand and respect your decision. Whatever your decision, there will no change in your relationship with CPS now, or at any time in the future.

If you have any questions or concerns about this study of Mentoring Mums, we and Deborah or Gaye will be only too happy to talk with you about the study. If you do want to speak to Deborah or Gaye we will provide you with their contact details.

Yours Sincerely,

Janet Williams-Smith
(Program Development Manager, Early Childhood Services)

Abigail Dent
(Mentoring Mums Coordinator)

Consent Form: Mentoring Mums Evaluation

I have a copy of the Plain Language Statement dated 22/3/10. I have read it, I've been able to ask any questions about it and I understand it.

I agree to take part in the evaluation of Mentoring Mums as described in the Plain Language Statement

I understand that I can stop being involved in the research at any time without this affecting my involvement in Mentoring Mums in any way at all

I understand that my identity or any personal details about me will not be revealed if information about this project is published or presented in any public form.

Participant's Name (printed) …….

Signature ……Date

Name of Witness to Participant's Signature (printed) …….

…….

Signature ……Date

Note: All parties signing the Consent Form must date their own signature.

I would like a copy of the research report when it is finished

Yes ☐ No ☐