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The impact of the COACH Community Mentoring Program on health and wellbeing

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Evaluation Report 2012

This evaluation was designed and conducted by Darshini Ayton from the School of Public Health and Preventive Medicine, Monash University in 2011.

The report was produced by Darshini Ayton on behalf of New Peninsula Community Caring Inc. and the Windermere Foundation.

This evaluation was funded by the Windermere Foundation Limited Special Grants Scheme 2011

Recommended citation: Ayton, D. (2012) The impact of the COACH Community Mentoring Program on health and wellbeing. Monash University, Caulfield, Melbourne.

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1 Introduction

1.1 COACH program overview

The COACH [Creating Opportunities and Casting Hope] Community Mentoring Program is conducted through New Peninsula Community Caring Incorporated (NPCCI). NPCCI is the welfare/community care arm of New Peninsula Baptist Church, located on the Mornington Peninsula in Victoria. NPCCI commenced through the efforts of six volunteers who began engaging with isolated and vulnerable families in a local public housing estate in the Mornington Peninsula area. These volunteers began assisting families practically through food parcels and community meals; and connecting with them socially and emotionally.

The COACH program evolved from this work and a desire to provide goal focused mentoring support to vulnerable families with a view to influence generational change. Vulnerable families can often find themselves in crisis, and as a consequence they can experience stressors that exacerbate and perpetuate the ongoing and potential generational aspects of their problems (Prilleltensky, Nelson et al., 2001). Generally families in these circumstances only have access to (mostly government funded), professional welfare and case management services for periods of 6 - 18 months due to the funding and resource constraints of the sector. After a period of support, these families may return to the front door of support services, once again in a crisis. The COACH program is positioned as a support mechanism for families moving out of the community welfare sector. By offering additional ongoing flexible support it is hoped that participation in COACH may mitigate any return to crisis and the associated stressors for vulnerable families.

Additionally COACH can function in an early intervention context, assisting families to avoid falling into crisis. At risk families can be referred into the program by community groups, local schools and welfare agencies. These families may be isolated, and struggling to manage a mental or physical health problem or battling with relationship difficulties. Problems such as these, if not addressed and managed, can place a family at risk of family breakdown, early school leaving for children, and homelessness or the development of addictions as coping mechanisms (Mackenzie and Chamberlain, 2003; The Centre for Social Justice, 2011). These problems can impact the capacity of parents to maintain or obtain employment, therefore locking families into welfare dependence (Arulampalam, Gregg et al., 2001; Schmidt, Dohan et al., 2002). Any of these issues has the capacity to place a family at risk of falling into crisis. Timely long term support with a program such as COACH may prevent a crisis and significant trauma associated with the deterioration of family circumstances. Hence the program may have the capacity to prevent entry into the mainstream welfare system.

COACH targets vulnerable families with at least one child aged 12 years or under. The rationale for this targeted approach is the belief that when young children and their families are supported, there is a greater window of opportunity to effect generational change. The client/mentor relationship is described as a *friendship with a purpose*. The parent/s of the COACH family articulate life goals that they would like to achieve in 12 monthly intervals which range from improved domestic skills, financial management, parenting skills and improving job prospects. The COACH family is then assigned mentor/s, often a husband and wife team who have children. The mentor/s then engage with the COACH family to achieve their life goals.

1.2 Background literature

Mentoring programs

Mentoring is a psychosocial intervention where an individual is matched with a more experienced and knowledgeable person who is able to provide support, encouragement and guidance (Smith, 2011). The academic literature generally focuses on mentoring relationships between an adult/young adult and child or youth. These research findings suggest that mentoring relationships foster positive developments and health for young people through the provision of social support, role modeling, opportunities to develop new skills and advocacy (DuBois and Silverthorn, 2005). A popular and well researched youth mentoring program is the Big Brothers Big Sisters School Based Mentoring program (BBBS). School based mentoring programs, such as BBBS are seen as an obvious way of providing at risk youth with a caring adult – a protective factor that may not be present at home (Herrera, Grossman et al., 2011). An impact evaluation of the BBBS program found that children engaged in this program performed better academically, had positive perceptions of their academic ability and reported having a supportive adult in their life when compared to the control group (Herrera, Grossman et al., 2011). Earlier studies of the BBBS program demonstrated improvements in family relationships, school performance, decreases in drug and alcohol use, and improvements in social and psychological variables (Kolar and McBride, 2011). Other school based mentoring programs described and discussed in the literature have highlighted the positive outcomes of the programs on child and youth health and wellbeing (Hurley and Lustbader, 1997; Black, Grenard et al., 2010; Smith, 2011).

However, research exploring mentoring programs for parents and the impact this has on child and youth health and wellbeing is not as common. With poor childhood health outcomes being associated with inadequate parenting and the family environment (Farber, 2009) it is surprising that parental/caregiver mentoring has not received more attention in the academic literature. Two relevant studies examining parent mentoring programs will be outlined as examples. A recent article by Cupples et al (2011) describes a peer mentoring program for first time mothers in socially

disadvantaged areas in Belfast. The randomised controlled trial study found that while no benefit was shown for infant or maternal health outcomes after the first year of the program, the mothers did appreciate the support provided by the mentors (Cupples, Stewart et al.). The authors believe that additional health outcomes may become apparent further down the track.

Farber (2009) conducted an evaluation of a parenting mentoring program for high risk low income Latino and African American families accessing well-baby care at an urban clinic in Washington D.C. The parent coach met the mentee family at an initial visit to the centre and continued contact with the family until the child reached 18 months of age (Farber, 2009). The parent coach assisted the family through providing child health and development assessments, observing and advising parent-child interaction and educating the family on relevant community resources to meet their needs (Farber, 2009). The evaluation outcomes of this study indicated increased family resources, improved nurturing and awareness of the child's development needs and greater personal resilience (Farber, 2009). Children in the study achieved the appropriate immunization milestones and development and language milestones (Farber, 2009). Furthermore, for children identified as at risk for developmental delay, the mentoring program provided early recognition and timely service delivery (Farber, 2009).

The COACH Community Mentoring Program (COACH) is an innovative program which addresses the social determinants of health. The majority of parent mentoring programs focus on behavior change strategies and skill building (Cupples, Stewart et al.; Farber, 2009), and while COACH addresses these areas as well, it also focuses on the economic and social conditions impacting families involved.

Social determinants of health

In 2005, The Commission on the Social Determinants of Health (CSDH) was established by the World Health Organization to assess the evidence as to what can be done to promote and achieve health equity globally (Marmot, Friel et al., 2008). The work of the CSDH is underpinned by commitments to health equity, human rights and empowerment. Health equity is the ethical foundation, human rights is the framework for social mobilisation and political leverage and empowerment is a strategy to achieve health equity particularly amongst socially vulnerable groups (CSDH, 2007). The basis for the social determinants of health (SDOH) is understanding the social and economic conditions which influence health disparities between countries and within countries (Wilkinson and Marmot, 2003).

Key social determinants of health include education, early life, employment, access to health services, and social support which are associated with health inequalities and inequities (Wilkinson and Marmot, 2003). Health inequities – the unfair and avoidable health disparities between population groups – arise from differences in income and wealth and also in the opportunities of individuals and

communities based on gender, ethnicity, class, education, disability, sexual orientation and geographical location (World Health Organization, 2011). These factors are often associated with where an individual or community is positioned on the social gradient. The socio-political context of society generates and reinforces the patterns of the social gradient through aspects such as the labour market, the educational system and political institutions such as the welfare state (CSDH, 2007). Research indicates that those positioned lower on the social ladder suffer higher occurrences of disease and illness and have shorter life expectancies (Wilkinson and Marmot, 2003). Consequently, children born to parents at the lower end of the social gradient and with issues such as mental and/or physical health problems, unemployment, poor housing, poverty, low education levels and lack of social support are more likely to experience adverse health events.

The structural determinants represent the components of an individuals' socioeconomic position. Key structural determinants and their proxy markers include income, education, occupation, social class, gender, race/ethnicity (CSDH, 2007). In the CSDH framework, the structural determinants are identified as factors which create or perpetuate the social gradient in society and the factors which define an individual's socioeconomic position (CSDH, 2007). The structural determinants are associated with the health opportunities of social groups dependent on their positioning within hierarchies of power, prestige and access to resources (CSDH, 2007).

The structural determinants operate via the intermediary determinants which are factors at the individual-level, including health-related behaviours and physiological factors. Intermediary determinants of health include material circumstances, psychosocial circumstances, behavioural and/or biological factors; and the health system itself as a social determinant (CSDH, 2007). An individual's socioeconomic position influences the conditions of life and an individual's vulnerability to poor health and the consequence of poor health (Graham and Kelly, 2004; CSDH, 2007).

The material circumstances are determinants which are associated with the physical environment such as housing (the conditions of the housing and its location), the ability to purchase food, clothing etc, the physical work environment and the neighbourhood environment. The quality of these circumstances will either provide resources for health or pose as health risks (CSDH, 2007). Psychosocial circumstances include psychosocial stressors such as negative life events and job strain, stressful living conditions, lack of social support, poor resilience and coping styles. Behavioural factors include either health protecting or enhancing behaviours such as exercise, good nutrition or health damaging behaviours (smoking, alcohol consumption, poor diet) (CSDH, 2007). Biological factors include sex, genetics and age (CSDH, 2007). The health system as a social determinant of health is relevant in relation to access to health care (CSDH, 2007).

The COACH program aims to break the cycle of generational poverty. This report will highlight how the COACH program addresses the structural and intermediary determinants of health thereby providing opportunities for individuals and families to move up the social gradient. The COACH program commenced at two sites on the Mornington Peninsula (Rosebud and Mt Martha), however the program has expanded to 13 sites in Victoria, NSW and Queensland. This evaluation has focused on the two original sites in the Mornington Peninsula region. The characteristics of this region are provided below to illustrate the community need for a program of this nature.

1.3 Mornington Peninsula Characteristics

The Mornington Peninsula is located over 70 km South East of Melbourne with a population size of approximately 150 000 residents. A study conducted in 1999 by Jesuit Social Services mapped social disadvantage in Victoria using ten indicators of disadvantage: mortality, unemployment, low birth weight, child maltreatment, childhood injuries, education, psychiatric admissions, crime, income and emergency relief (Vinson, 1999; Fitch, 2002). Of the top 30 postcodes with the highest disadvantage scores, four postcodes were from the Frankston and Mornington Peninsula region (Hastings, Frankston North, Rye and Rosebud West) (Vinson, 1999; Fitch, 2002). Another characteristic of the region is the gap between the poor and the rich with areas of affluence and pockets of disadvantage illustrated by Figure 1 below. Correspondingly, individuals at the lower end and upper end of the social gradient live in the area.

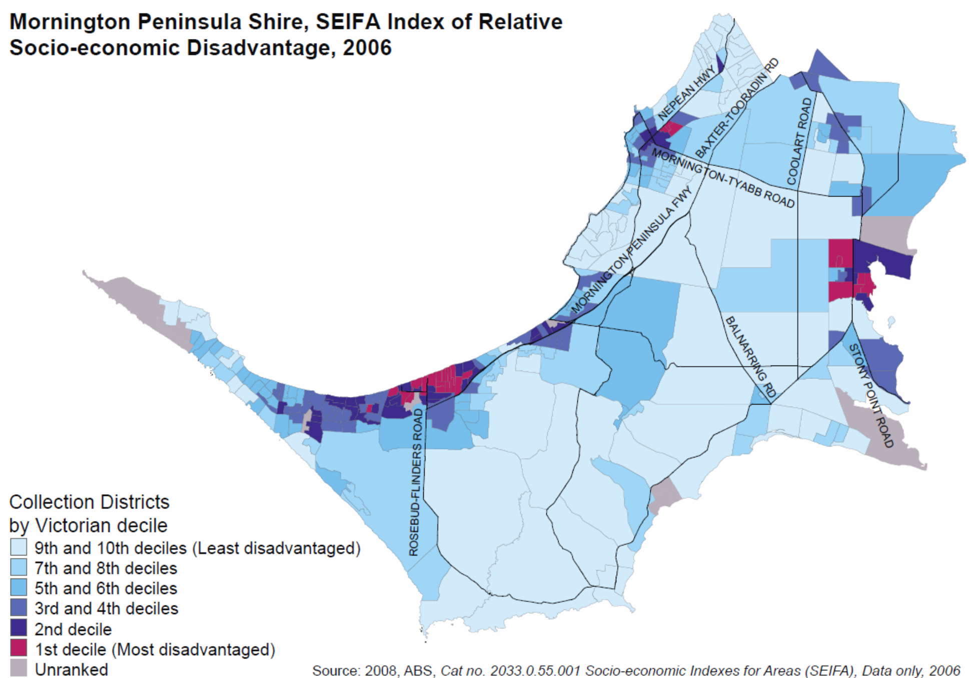


Figure 1. Mornington Peninsula Shire, SEIFA Index of Relative Socio-economic Disadvantage, 2006

2 Creating Opportunities and Casting Hope (COACH)

2.1 COACH Program Description

This section of the report will describe the processes and protocols of the COACH program including mentor selection and training, client referral and the selection of life goals. It is important to understand the context of the program and the support mechanisms that have been established to ensure the health and safety of both the mentors and clients. The program is coordinated by social welfare trained staff members at NPCCI who have had significant experience in the community welfare sector.

Mentor selection and training

The mentors of COACH are Christians who have been identified as having good interpersonal, and communication skills, life experience and wisdom enabling them to draw alongside families who are isolated, vulnerable and may not have healthy extended family support and relationships. Prospective mentors need to respond to a position description outlining the key skills required and responsibilities of being a mentor and an interview booklet. The interview booklet collects information regarding the prospective mentor's family dynamics, family lifestyle, interpersonal relationship dynamics, coping strategies, self-reflection and values. Individuals applying for the position of mentor also need to provide referees, obtain a working with children check and police check and also familiarise themselves with and acknowledge their adherence to the COACH Conduct and Safety Policy. Once these forms have been reviewed the prospective mentors participate in a formal interview process with the coordinator of COACH program. Completion of these forms and the interview process, along with the fourteen hours start up training, enables the staff at NPCCI to assess the suitability of the applicant and assist in appropriate client matching.

The mentor training and manual covers basic principles on how to communicate effectively, how to assist clients in setting life goals, risk management, values and conduct issues, how to work with families, how to influence parents to influence their children and behavior management strategies. Throughout the duration of the mentoring agreement, mentors and clients are also supported by the NPCCI staff through update training sessions, supervision and evaluation. The mentors understand their role as one of empowerment where they aim to assist and facilitate the client's decision making.

Client referral and engagement

As the COACH program is resourced by volunteer mentors who are matched to the client, a referral criteria guide was developed to assist community welfare services and schools with their referrals. For the two Mornington Peninsuala COACH sites involved in this project, Rosebud and Mt Martha, 52% and 66% of referrals were from community agencies respectively; 26% and 8% were from schools and 22% and 24% were from NPCCI's Back on Track emergency relief program. Families were not eligible to participate if they were experiencing current and frequent threats of violence; financial difficulties related to problematic and addictive behaviours; anger management issues; currently involved with Child Protection services; had a history of making threats to others; have severe or chronic health issues that preclude them from normal activities and require long term support; have mental health issues that are not being managed; have substance abuse issues that are significant and not being managed. Once a client has been assessed by NPCCI as being suitable for COACH, one of the staff members meets with the client to discuss the program and the client's life goals. Once the client has identified and agreed to their life goals, a support agreement is drawn up and signed by the client and mentor. Client progress is reported each month by the mentor to NPCCI staff via a mentor feedback sheet. NPCCI review these sheets and will follow up if there are problems or issues that need their involvement. NPCCI staff conduct six monthly reviews to assess the progress of the clients in their life goals. A 12 month review is conducted to assess the status of the mentor client relationship. If the client and mentor agree that further coaching is required, a new agreement is signed. If the client has achieved their life goal(s) and no longer requires the formal support of the program, the transition to an ongoing personal supportive friendship between the mentor and family is acknowledged and communicated with an exit letter sent to both parties indicating that the COACH relationship is closed, but the friendship is open.

Life goals

A key component of the COACH program is the client articulation of life goals and the mentor support of the client to achieve the identified life goals. Prior to entry in the program, NPCCI staff meet with the client to identify life goals. This is done using picture cards (to cater for literacy issues) which describe nine areas of desired development, with the option to explore other issues if required.

- relationships (relationships with others, parenting issues, children issues, family bonding activities, personal safety);
- personal development (self-reliance, independence, stability, education, training, employment);
- financial (financial management, budgeting, income security, housing);

- legal matters (court appearances, fines, mediation);
- substance use (alcohol management, drug management, smoking, gambling, other addictive behaviours);
- community connections (developing social and community networks);
- independent living skills (housekeeping, cleaning, cooking, shopping);
- health (physical health, diet, hygiene, dental);
- general wellbeing (maintaining mental health; self-esteem, happiness, stress management, self harm, suicidal ideation) and other issues.

3 Evaluation Methods

This section of the report outlines the research methods used in the evaluation.

3.1 Aim:

To explore whether participation in the COACH Community Mentoring Program has improved the life skills, social skills and parenting skills of vulnerable families.

3.2 Objectives:

- Assess how the COACH volunteers have engaged with the COACH family to assist them in achieving their life goals
- Explore what impact participation in the COACH Community Mentoring Program has had on the life skills, social skills and parenting skills of parents/caregivers
- Investigate the influence the COACH program has had on the health and wellbeing of children and youth

3.3 Methods:

A component triangulation mixed methods approach was used in the evaluation of the COACH Community Mentoring Program. This comprised of data collection from three separate sources (mentors, clients, NPCCI client notes). The data from these sources remained distinct throughout the data collection period, however the findings from one source was used to corroborate findings from the other sources in the analysis (Rallis and Rossman, 2003). This approach allowed the perspectives of the different stakeholders involved to be analysed to provide a holistic overview and depth to the data of the evaluation.

3.4 Data collection sources:

Mentor survey

Twenty-eight eligible COACH mentors across the Mt Martha and Rosebud sites were invited to participate in an online quantitative survey with open ended questions. Eligibility to participate was based on current involvement in COACH, or previous involvement and current contact with the mentored COACH client. The survey was conducted through the web-based program Survey Monkey[1]. An administrative staff member at NPCCI emailed the invitation to participate, project

[1] Survey Monkey is a free online data collection tool. www.surveymonkey.com

explanatory statement and survey link to all eligible COACH mentors. The survey contained questions including:

- how the participant became involved in COACH
- why the participant is involved as a mentor in the COACH program
- the challenges of being a mentor
- the benefits of being a mentor
- interactions with the COACH client
- assessment of COACH client progress
- impact of COACH on the health and wellbeing of children and youth using key health and wellbeing indicators.

COACH client semi-structured interviews

Twenty-three COACH clients were eligible to participate in an interview for this evaluation. Clients were eligible if they were current clients in the program or previous clients with ongoing contact with their mentor. Clients also needed to be able to provide informed consent and be able to communicate with the researcher. An administrative staff member from NPCCI contacted eligible COACH clients and provided them with the invitation to participate and the explanatory statement. If literacy issues were a concern, the NPCCI staff member verbally communicated the explanatory statement to the client to ensure they understood what participation in the study entailed. To comply with ethics requirements, the staff member explained to the clients that they were not obliged to participate and that participation was voluntary and that their involvement in COACH would not be impacted by their participation in the evaluation. If the client agreed to participate, their contact details were sent to the researcher in order to schedule the interview. The interview questions explored the following themes:

- Life circumstances of client before involvement in COACH
- How client became involved in COACH
- Methods of contact with mentor
- How the client felt their mentor assisted them to achieve their life goals
- Life circumstances during/after involvement in COACH

Children and youth were not invited to participate in this evaluation however sufficient data concerning the health and wellbeing of children was collected via the quantitative surveys with the COACH mentors and through the qualitative interviews with the COACH clients.

Client case reports

Client case reports are managed by the staff of NPCCI and contain staff observations in relation to the progress of the COACH client while participating in the program. The collection of these observations is standard protocol for the program and clients are aware of the reporting process. These reports were used in the analysis to provide another layer of data to complement the data collected from the mentors and clients. The staff of NPCCI are social science trained welfare workers and therefore they are often in a position of being able to assess client progress from a professional stand point in contrast to the lay understanding of the mentors.

3.5 Ethics approval

Ethics approval was sought in two phases. Phase one was approved on March 31st 2011 (**CF11/0805 - 2011000405**) as a low impact application for the quantitative mentor survey. Phase two was approved on the 30th of June 2011 (**CF11/1019 – 2011000513)** as a full application for the qualitative client interviews. The evaluation was divided into two phases for ethics as the researcher anticipated that the ethics committee may have had recommendations to make for the qualitative interview component of the evaluation due to the vulnerable nature of the potential research participants. Having two separate ethics applications allowed for a low impact application to be made for the quantitative mentor survey which was approved within one month, thereby avoiding delays in data collection for this component of the research.

3.6 Data analysis

Interview data were transcribed and thematically analysed through open and axial coding (Rice and Ezzy, 1999) using the qualitative software program Nvivo 9 (QSR International, Melbourne, Vic., Australia). Coding is the technique in which the transcripts are conceptualised line by line by the researcher (Orona, 2002). *Open coding* is the initial coding of the data and involves looking at the data to identify relationships between events and interactions and to develop descriptions of these relationships (Rice and Ezzy, 1999). The researcher aims to define the action in the data segment, highlighting implicit assumptions and identifying processes (Charmaz, 2005). *Axial coding* is the second step of the coding practice and involves reconstructing the codes which were deconstructed in the open coding phase. Rather than attempt to map each code to a category, each code is examined to ensure that it has been *"fully elaborated and delineated"* (Rice and Ezzy, 1999). The social

determinants of health was also used as a framework for data analysis. Quantitative data from the mentor survey was analysed using descriptive statistics and frequencies in Microsoft Excel 2010.

Throughout this report, words, sentences and phrases in italics indicate a quote from a participant in the research. These quotes will either be woven into the text of the paragraph in a narrative or will be written as a standalone quote. Pseudonyms have been used in the reporting of the results to protect the anonymity of the research participants.

4 The COACH mentors

4.1 Mentor demographics

Twenty-seven of the invited 28 actively engaged and matched COACH mentors participated in the quantitative survey. Twenty-one participants completed the survey online with the remainder participating in the survey via telephone with the researcher due to lack of internet access or poor computer literacy. The mentor participants comprised of 16 females and 11 males, with the majority being married and involved in mentoring the COACH client as a married couple. The mentors ranged in age from 34 – 81 years with the average age being 61. All but three mentors were attending either New Peninsula Baptist Church Rosebud or New Peninsula Baptist Church Mt Martha. The remaining three mentors were involved in other local churches in the Mt Martha/Rosebud area. The demographic characteristics of the participating COACH mentors are presented in Table 1 below:

Table 1: Participating COACH mentor demographics

Participant demographics	N (%)
Gender	
Male	11 (41%)
Female	16 (59%)
Age	
Average age	61 years
Range	34-81
Marital Status	
Married	25 (92%)
Divorced	1 (4%)
Widowed	1 (4%)
Church Attending	
New Peninsula Baptist Church – Mt Martha	12 (44%)
New Peninsula Baptist Church – Rosebud	12 (44%)
Other church	3 (11%)
Years of church attendance	
Average years attending current church	11 years
Range	4 – 39 years
Employment type	
Professional	7 (26%)
Trade	2 (7%)
Home duties/house wife/Retired	17 (63%)
Unemployed	1 (4%)
Number of years involved in mentoring current family	
Average number of years	2.7
Range	(2 months – 10 years)

4.2 Reasons for volunteering in COACH

The Australian Government has recognised the important role that volunteers contribute to the social fabric of the community (Volunteering Australia, 2004). Individuals volunteer for a range of reasons including altruistic reasons such as helping others and doing something worthwhile; personal reasons such as personal satisfaction, to learn or use skills and experience; and for social contact or religious beliefs (Volunteering Australia, 2004). The mentors in this evaluation were asked to list up to five reasons to explain why they volunteered in COACH. The reasons offered did not differ significantly from those described in the report by Volunteering Australia. The three main themes which influenced involvement was the desire to help; as an expression of faith and feeling they had the appropriate skills and time. Most of the mentors recognised that there was a *huge need in [their] local community of marginalised families*. Therefore the first and most popular rationale for volunteering in COACH was the desire to help people who were struggling in their community.

> *Opportunity to assist underprivileged people. (Bob)*

> *I wish to help people improve their relationships in families. (Jane)*

Volunteering for religious beliefs was one of the lower ranked reasons for volunteering (Volunteering Australia, 2004). However, since COACH was created and is conducted through the welfare arm of a church community – Community Caring Inc., it is not surprising that many participants felt that involvement in COACH was an *expression* of their Christian faith. The Christian call is based on bible teachings to love thy neighbour,[2] look after the widow and orphan[3] and to fight for the rights of the poor, weak and oppressed[4]. The mentors described the *call* to volunteer in a number of ways including *wanting to participate in God's work*, wanting *to show Jesus' love in a practical way,* and wanting *to serve those less fortunate*.

Participants also listed having life skills, life experience and time as a reason for volunteering. Volunteering Australia identified the importance of providing individuals with opportunities for giving back to the community through ways that align with specific skills and resources that they have. COACH is able to draw upon a wide range of skills and expertise as the clients articulate life goals which range from financial management, to parenting skills, and domestic skills. In addition to practical skills, the COACH mentors are also able to offer social support through friendship.

> *Felt I had practical gifts so could contribute in that way, be a friend, be helpful (Sam)*

---

[2] Matthew 22:39

[3] James 1:27

[4] Psalm 82 and Isaiah 1:17

I'm an ex-banker and therefore financially astute. I'm also a father and I have a good basics on ethics (Greg)

4.3 Benefits of being a COACH mentor

All participating mentors strongly agreed or agreed that they received sufficient training and support to participate in the COACH program. All mentors also affirmed that they were made aware of the duties and responsibilities associated with being a COACH mentor. Research has found that volunteer training is vital to ensure that volunteers do not cross boundaries between being a lay volunteer and a professional worker. Training safeguards against the volunteer taking on the role of counselor and also protects against volunteer exploitation (Taggart, Short et al., 2000). The COACH program has established policies and processes of volunteer recruitment, training and support including the use of position descriptions, interviews and client and mentor matching based on skill set, personal qualities and client needs (outlined in section 2 of this report). These practices enrich the experience of the volunteer and also improves retention (Hager and Brudney, 2004)

Twenty-six of the mentors also agreed or strongly agreed that they believed they benefitted from their involvement in COACH. The mentors highlighted the opportunity COACH provided them in being able to engage *with people from all walks of life;* people who may traditionally be outside of their social circle. Consequently they were able to learn about the plight of others in their community and develop an understanding of themselves through that process. Mentors were also encouraged by the life change they saw in the clients, and described feeling a sense of joy at their accomplishments.

I saw my client come off drugs, get involved in career training, become more positive. Also her relationship with her child improved. (Elsie)

You learn more about yourself...you realise you don't have answers to lots of things. (Bill)

Watching people learn new skills and having more confidence to be able to achieve their goals. (Anna)

4.4 Challenges of being a COACH mentor

The COACH mentors also articulated the challenges associated with mentoring the COACH clients. Volunteering Australia found lack of time to be a significant barrier for those not involved in a volunteering capacity (Volunteering Australia, 2004). Finding the time to be involved was also identified as one of the challenges of being a COACH mentor. The duties and responsibilities of being a mentor are not small and therefore *spending the time being involved* requires a degree of

commitment. The mentors also describe the time and effort it takes to *develop a relationship with a family* and the *need to be patient and not expect things to happen overnight*. The mentors also described struggling with the different values and ideas of the client and also dealing with issues of mental illness and addiction. It was sometimes difficult to find the balance between problem solving for the client and empowering the client.

> *The extra time, spending the time being involved...you have your own family. You do what you can. I have to put that time aside and be organised. (Sam)*
>
> *Hoping that the support one offered was sufficient and not try to solve their issues but empower them. (Shannon)*
>
> *My mentor family's lifestyle and mine were very different, as were our values. It was a challenge to see things from their point of view at times. (Scott)*
>
> *Our client suffers from schizophrenia. Endeavouring to bring up two boys (16, 13) both from different fathers. Finding it hard to discipline them. Very challenging...in our opinion they are not helping themselves have a better life and I worry about that. (Bill)*

Such challenges are not small and while some mentors seemed to respond well to these challenges, others found them frustrating and discouraging. The support offered by the staff at NPCCI gave mentors the opportunity to discuss any worries or concerns they may have about their client with social welfare workers. At times the NPCCI staff members would step in and meet with the client to offer an additional layer of support and care or they may refer the client to other community programs or health services as required.

4.5 Engagement with COACH clients

The mentors were asked to select how often they had contact with the COACH client and the type of contact they maintained with the COACH client. Most mentors reported meeting with the client face to face on a weekly or fortnightly basis. In the initial stages of the mentoring relationship, contact was often frequent and long, however once the relationship was established or the client's life had stabilised, contact became less frequent. Table 2 below indicates the frequency and type of mentor contact.

Table 2: Mode and frequency of mentor/client contact (N=26)

Type of contact	Frequency (N)					
	Daily	Weekly	Fortnightly	Monthly	As the need arises	Not applicable
Face to face	0	10	13	2	1	0
Telephone	1	12	3	2	8	0
Text message	0	6	0	1	7	12
Facebook	0	0	0	0	0	26
Email	0	1	0	0	1	24

When the COACH mentor and client did meet face to face, generally it was for a period of a few hours (N=18) or an hour or less (N=7). One mentor reported the face to face catch up taking up approximately half the day.

Type of support provided

The mentors were asked to describe the main forms of support they offered to the clients. Three main themes identified fall under the banner of guidance: *providing advice*, *exploring options* and *providing encouragement*. The mentors would first listen as their COACH client described what they were experiencing. They would then provide advice based on knowledge or life experience, assist the client in exploring the available options and provide *encouragement and emotional support* to help the client address the issue.

> *I have shared with my COACH family from my own personal experiences. She often just likes to talk things through and to feel she has a friend who is prepared to listen and understand her situation. (Catherine)*

> *Accountability with goals. Encourage her with her child to communicate with teacher regarding [her] child's learning challenges. Encourage her with relationship with her mother. Listen to her and stress her potential to turn her life around, which has happened. (Elsie)*

Further examples of how the COACH mentors are involved in providing support can be found in the next section of this report from the perspective of the client. While all of the mentors articulated at some point during the survey examples of providing advice to the COACH client for the most part, they recognised that the advice was not to be directive or authoritative and was provided as guidance in the client's decision making.

The mentors were also asked to describe their engagement with the children of their client. It is important to note that the program is designed to support the client in their life skills, social skills and parenting skills in the hope that this will improve the family environment and parenting of the child. Therefore a number of the mentors (N=7) reported little to no engagement with the child/children of

their client. For those who did report engagement with the child/children, this ranged from school pick up and drop off, providing encouragement, playing games with the children, taking the children on outings and attending birthday parties.

> *Parents were our priority, but as children were around we would assist the parents to develop appropriate habits to assist their children's progress. (Bob)*

> *Encouraging him in reading, sporting activities, and healthy eating. Remembering his birthday. Playing with him. (Anna)*

This section has explored the mentor's perspective of the COACH program including reasons for involvement and their engagement with the COACH client. The main reasons provided for volunteering in the COACH program were as an expression of faith, to serve those less fortunate and due to having the time, skills and experience to offer the program. Challenges included finding the time for the program while balancing work and family commitments, having different values and beliefs to the COACH client and dealing with issues of addiction and mental illness. The mentors however felt they learnt about themselves and others through engagement with their COACH client and were encouraged by the positive changes in the life of the client.

5 The COACH Clients

This section of the report examines and discusses the COACH program from the perspective of the clients. In the interview, clients were asked to describe the COACH program, their life circumstances before and after the program and skills or assistance their mentors have provided them. Throughout this section, client stories demonstrating the life changes experienced by the clients will be presented.

5.1 The client perspective of COACH

The main themes arising from the client description of the COACH program include the provision of practical support, encouragement and social support. These themes echo the themes identified by the mentors in relation to the type of support offered. The clients also discussed how the mentors were there to guide decision making and not there to be paternalistic or authoritative. Below is a quote from COACH client Michelle. She is an anxious and isolated mother who has difficulties with handling her four year old daughter. She describes how her mentor is there to empower her to problem solve as opposed to doing the problem solving for her.

> *It's like [having] someone from lifeline in your lounge room. It's more of an encouraging...it's not someone who is going to do something for you, it's someone who will assimilate things for you to do like encourage you, perhaps you could look at it in a different way, maybe this might work – it's not someone who is going to come to your house and fix things for you, it's someone will give you the tools of how to feel about yourself and look at a way it can be fixed and maybe then help a bit. (Michelle)*

Belinda is another client who highlights the benefits of having someone to talk to outside of family and friends.

> *To be able to talk to somebody about your problems where you wouldn't talk to friends or family it's...they are there to be able to help you, listen to you, give you advice when it's needed, um I don't know where I'd be actually. I really think the COACH program saved me. (Belinda)*

Clients also emphasised how they liked the non-professional status of the COACH mentors. The clients felt that the mentors were more like friends as opposed to a case worker and they liked that the mentors volunteered their time and support instead of being paid, as this indicated that the mentors wanted to be engaging with the client. Also COACH is available to the client for a longer period of time than most other support programs as these generally have a 12-18 month time frame. Mentors were also available outside of business hours for a chat and catch up.

[It's] not like...other programs...you have help and they might see you couple of times and that's the end of it. But with the COACH program there is no end date. (Belinda)

I don't know of any other program where I would still be under the umbrella of after three years. Normally it's 12 months, 18 months tops and then you are passed onto the next lot of people who MIGHT be able to help you. I found that after I had been in program after program after program that I just got sick of it. (Katie)

It's more a personal one...personal sensation feeling that you get with them compared to when you go to the psychologist...you are there for a reason. Say when you are going to St Vincent's de Paul...Southern Peninsula Community Services...when you go through with them you are always like a number or like a business transaction where this is more...it just gives you that more personal sensation, touch to it...ease...(Craig)

For Michelle, she did not qualify for support from an agency as the family was not considered at risk. Therefore COACH was able to fill the gap left by professional services by offering the support of a pseudo grandparent to Michelle and her four year old daughter.

I knew I needed help and I didn't care where the help was going to come from and if it was going to come from another mother I thought that would be great, rather than an agency that was already snowed under and didn't have the resources. Our problem was that there was just the three of us and there was no break and we didn't have the family members that we needed to assist us. But it was pointed out very quickly and very clearly that the child wasn't at risk and so they wouldn't be able to help us anyway...and if they did help us it would take 12-18 months before we were in a position where we would get any help at all anyway. (Michelle)

5.2 Support received through COACH

The type of support and guidance offered by the COACH mentors was dependent on the client. As the client articulated life goals, the staff at NPCCI attempted to match the client and mentor by life experience and skills. For some clients all they needed was the social support offered through a friendship. Other clients needed gentle advice and guidance on matters related to parenting. Many talked about the practical support offered through the management of finances, being driven to appointments or the shopping centre and the teaching of domestic skills.

Jack is the father of a five year old son. His relationship with his ex-partner is turbulent and consequently Jack often goes for periods of time with limited or little access to his son. He is living in a caravan in the local caravan park. He is currently struggling with depression, mild alcohol addiction and is unemployed. He has been supported by the COACH program in a number of ways – including

transport, accessing dental services, assistance to re-enter the workforce and advice and guidance in how to handle his relationship with his ex-partner. The quote below illustrates Jack's amazement at the support he received through the program.

> *If I need a lift somewhere, [my mentor would] make sure I've got there. If I just need someone to chat to, they are there. If I need someone to say some prayers for me, they are there. And they even help me financially with different things as well. That's above and beyond anybody's means. To me, having people doing that and there is nothing they want in return but for me to be the best father that I could be, is um...I don't know...I just find it so bewildering. (Jack)*

Grace and her husband experienced a season of separation as he was verbally and emotionally abusive to their children. COACH offered her support through this time as she recognised that she couldn't do it herself. The quote below provides an indication of what Grace would discuss with her COACH mentor during this period.

> *How I was feeling, my frustrations with working through stuff with my husband...She would also check up about the kids... So she knew about the issues that were happening with them, so we would talk about the kids and how they were coping and yeah she would just try and be encouraging. She would give me some suggestions sometimes about how to look on a bit more positive aspects of things. (Grace)*

Sarah sought assistance through the COACH program as she has cerebral palsy and is in a wheelchair. She was looking for a program which provided assistance with her daughter to be *able to get out into the community and do activities and things like that*. Her daughter was 6-7 months old when Sarah joined the program. Sarah talks about how her mentor encouraged her to develop her own parenting skills and style and also provided physical and practical assistance.

> *She was also happy for me to build upon my own mother's skills. And we went to the park and just really...got out and about more which was really what I wanted because at the time I wasn't able to do that with [my daughter]. When you go out with a baby you have to pack a lot of stuff, I can't drive and so that was definitely a benefit to go to local places with [my mentors]. (Sarah)*

The mentors played a vital role in facilitating client access to health services and professional services. Lisa had left her partner due to issues of domestic violence. Her four year old son had some behavioural problems which needed to be addressed and through the advice and direction of her mentor investigations were conducted to rule out autism.

She has made recommendations about certain things I might look at considering. And then she followed through with me to see whether or not I've got in contact with that person...She got me in touch with a support called Noah's Ark and which has been able to help talk to me about whether or not we need to see a psychologist or a paediatrician and that sort of thing. So we have [ruled] out things that we may have thought were issues in the past which we can now say are not issues because we have gone down that track. We've investigated autism and that sort of thing. So I think without [my mentor] I probably would have just thought I can't do it and just let it go until some time when I'm desperate which is obviously not a good idea to get to that point. (Lisa)

For Michelle, her daughter can be quite demanding and Michelle struggles with discipline and boundaries with her child. Michelle describes her retrospective realisation that advice given by her mentor in relation to her child's behaviour was true even though Michelle did not recognise it at the time.

Like she said a while ago, I think [your daughter] needs something a bit more challenging than playgroup and maybe that's why her behaviour is going awry ...she also said [my daughter] might need some routine in her life to stabilise her life... But I didn't want to accept that so I stayed away a little bit and now I realised that what [my mentor] suggested was exactly what [my daughter] needed 12 months ago and now I'm only figuring out that she was totally on the ball. But still she was patient about it and gentle and said do you really want my opinion before she gave it. And she is just so skilful... she is very insightful. (Michelle)

COACH client and mentor support mechanisms

The COACH program has many support mechanisms in place for both the mentors and clients. Such processes are important to ensure the health and wellbeing of the mentors and clients and also to ensure that appropriate boundaries are in place to prevent the exploitation of the mentors or any harm to the clients. The below quote provides insight into the support mechanisms from the client perspective:

It's just a fabulous program because the people who volunteer to be coaches they are supported. It's not like you are an individual person doing it off your own bat and you can burn yourself out. It's got a limited time frame so it supports them as well. If you don't connect you can go back and say okay well I'm not really connecting with this COACH, have you got somebody else as well? I think it's a great program. (Grace)

I don't know what training the mentors have had but whatever it was it has worked perfectly because it was just so natural. (Michelle)

COACH client Rose, had a prior relationship which was characterised by domestic violence. She described her first COACH mentor as important in linking her with playgroups and providing adult conversation; however her second COACH mentor played a key role in helping her deal with the issues and circumstances surrounding her ex-partner and domestic violence. This case highlights the importance of matching the client and mentor appropriately. Rose's second COACH mentor became involved in the program once the 12 month period with the first COACH mentor came to a close. The second mentor had some experience with domestic violence and therefore Rose felt she understood her situation and was able to provide appropriate support and guidance. This included a period where Rose had broken both her wrists and her second mentor invited Rose and her two children to live with her for two months while she recuperated. Such support prevented Rose from engaging with her ex-partner in efforts to obtain the extra support she required. Rose feels that she has learnt to be a stronger person and become more honest through the COACH program. She also feels that she copes with her children's behavioural problems better.

5.3 Perspectives on COACH being run through the welfare arm of a church

The initial interviews conducted with the COACH clients highlighted an interesting theme of how clients felt about COACH being conducted through the welfare arm of a church. For some people in the community, the Christian Church holds negative connotations of control, lunacy, judgemental attitudes and proselytising (Kinnaman and Lyons, 2007). Therefore it would not be uncommon for someone to express apprehensions about accessing a program that is coordinated by the welfare arm of a local church. Despite early concerns of being judged or being preached at, clients felt that the mentors were balanced in how they presented their Christianity. Clients don't need to be Christian to qualify for the program and they do not feel pressured to attend church or to convert to Christianity.

[I thought] they are going to find out that I smoke marijuana...they are Christians and they are going to find out and that would be the end of me. But it wasn't. [There] wasn't any pressure to give up. Just reminders or advice that it's really not good for you...Do you want to change it or do you want stay as you are? But it wasn't by any means forceful. It was guidance...a lot of guidance. (Katie)

I admire her objectiveness. ..She is fairly neutral in all her directions and that's one of the things that I do notice that I like about her because I'm generally not a religious person but I find she comes with a very gentle natural approach which appeals to me. (Lisa)

She is a good Christian woman and a lovely mother... I think that's an enriching thing for a COACH to be, especially for someone who is reluctant to go to church like me, it's actually a very positive thing that she is from the church. And that I'm not pressured into it, I haven't been pressured one bit. (Michelle)

5.4 Impacts of COACH involvement

The COACH program has impacted the lives of the clients in a number of ways. Not only has it improved the health and wellbeing outcomes of the children (further details in section 6 of this report); it has improved the life of the client in relation to their social skills, parenting skills and life skills. Clients talked about improvements in their self-esteem and confidence, life circumstances (including housing and employment situations), social connection and community engagement and access to health services.

Oh there are 1000 ways she has helped; I just don't understand myself how to express that help she has given me. She made me feel better about myself which was a self esteem issue, to the point where I don't doubt myself like I used too...I used to think that I needed to take medicine and maybe the baby needed to too – to settle her down but she has helped me see what is normal and not to do be unrealistic about my expectations and not to beat myself up emotionally which is what I was doing. (Michelle)

To further illustrate the impact of participating in COACH had on the life of the clients, Katie's story is outlined below.

Katie's story

Katie's story is one of the many success stories from COACH. Katie is a single mother of two boys (aged 10 and 14 at the time of engaging with the COACH program). She has schizophrenia and dissociative identity disorder. Prior to commencing COACH she was living in a cabin in the local caravan park, she was heavily smoking marijuana, she was unemployed, obese, suicidal and incontinent due to medication she was on. Her housing situation was unstable and the cabin was often a *pig sty*. She only had custody of her oldest child and the living environment she was providing for him was not healthy. Her psychiatrist told her that she would never work again.

I was pretty sick mentally. I have schizophrenia and DID [Dissociative Identity Disorder]. I was pretty crook. I was smoking cannabis 24/7. I was in a smelly horrible little caravan cabin sort of thing with my older son. I didn't' have my younger boy with me at the time. It was just; it was just one nightmare that dragged on. It was the same thing every day. Smoke dope smoke dope smoke dope and hope that I don't die overnight sort of thing. And sometimes it was even I hope I do die that night...you know...it was pretty dismal

Katie had three life goals that she wanted to achieve with the support of the COACH program. She wanted to improve her parenting skills particularly in relation to discipline and strategies to address the behavioural problems of her children, manage her finances better and enhance her employment opportunities. Three years later with the support of three mentors, Katie's life has been transformed. She now lives in a private rental and has custody of both her children. She is a healthy weight and is no longer incontinent due to changes in her medication. Her mental health has improved significantly and she is following her treatment regime. She owns her own business working part time cleaning. Her finances are managed by the state trustees to ensure that all bills are paid on time and that she has sufficient funds for essential items. Katie has experienced improvements in her self-esteem and confidence, domestic skills and has reduced her marijuana use. Her children are showing her more respect and she has learnt how to spend quality time with them. The quote below from Katie illustrates her thoughts on the COACH program:

> *I almost feel as though I've been shaken upside down get rid of all the crap that has come out of my pockets and been put back on my feet right...and then every now and again someone will come along and say, hang on, that doesn't belong in your pocket, get rid of that one, deal with that issue and let you have time to resolve the issues you've dealt with... the challenges that I have been given in the COACH program have never been unsurpassable. (Katie)*

An experienced case worker from a local welfare agency describes Katie's transformation as "*the greatest casework outcome I've seen" (Client case notes)*

The client perspective of the COACH program is overwhelmingly positive. The reasons for this may stem from the fact that the clients may not have experienced a program of this nature and consequently value the personal contact and support offered through the COACH program. The program is run through the welfare arm of a church with all the mentors being active members of a church, yet the Christian basis of the program did not seem to deter client uptake – particularly for clients who described themselves as not religious. None of clients reported negative experiences of evangelism or proselytising from staff or volunteers of the program. Further health and social impacts of the program are described in sections 6 and 7 of this report.

6 Child and Youth Health and Wellbeing Outcomes

6.1 Mentor perspective: Impact of COACH on child and youth health and wellbeing

The COACH mentors were asked to report on a number of indicators to assess progress in the COACH client's management of factors which impact on their child's health and wellbeing. They were asked to compare how the COACH client (parent) had progressed on the indicators from when they first entered the COACH program to the present. One mentor did not complete this section of the survey. Progress was seen particularly in relation to encouraging school attendance, providing a safe and nurturing environment, showing respect to the children, providing necessities such as food, clothes, bed and transport and promoting social interaction with other children. Little or no progress was seen in the areas of fitness and exercise and diet. Table 3 outlines the mentor ratings of these indicators.

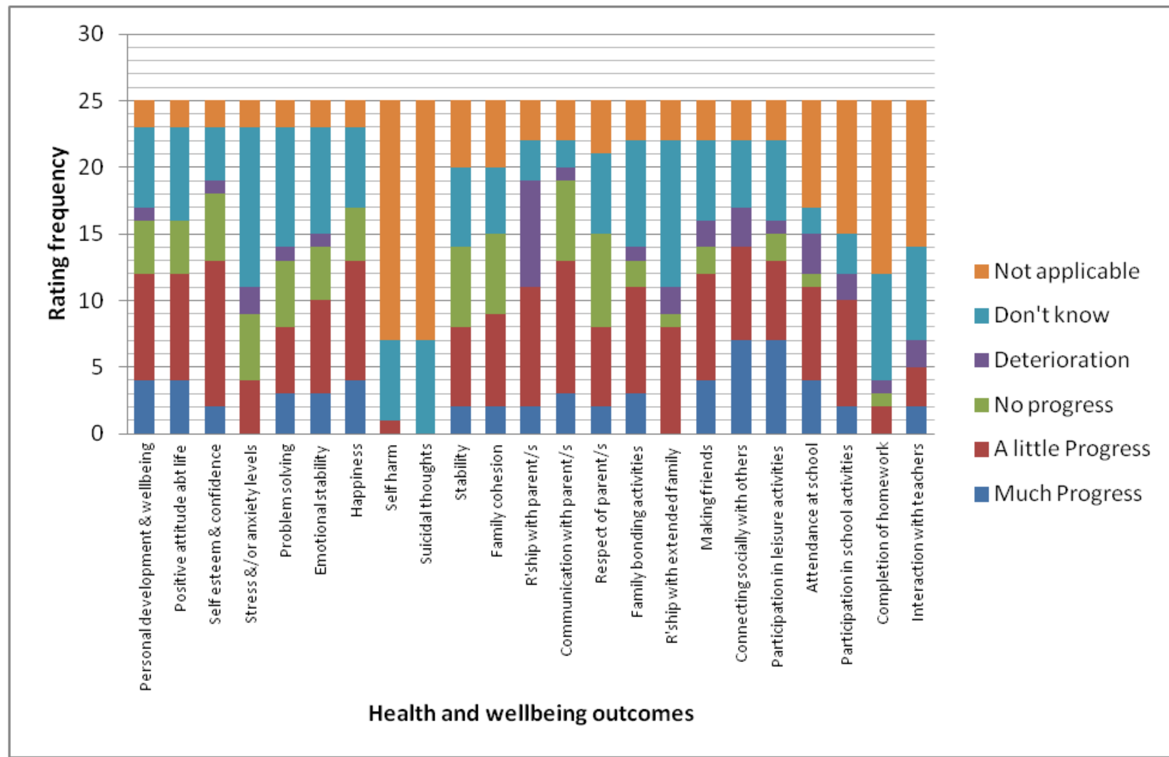
Table 3: COACH mentor ratings of client progress in promoting child and health wellbeing (N=26)

Health & Wellbeing indicator	Much progress	A little progress	No progress	Don't know	Not applicable
Facilitates access to health services	6	5	2	6	7
Facilitates access to mental health services	5	6	2	6	7
Facilitates access to family support services	4	5	4	6	7
Facilitates access to dental services	2	3	4	11	6
Encourages adherence to treatment regime	3	7	1	8	7
Provides a healthy diet	2	10	5	4	5
Encourages fitness and exercise	4	9	6	3	4
Promotes personal hygiene	2	10	3	3	8
Encourages school attendance	7	10	0	7	2
Provides a safe and nurturing environment	6	10	2	2	6
Shows respect	7	10	5	0	4
Promotes social interaction with other children	7	8	2	3	6
Provides necessities (food, clothes, bed, transport)	7	11	0	0	8
Promotes family cohesion	3	11	5	2	5
Encourages participation in household chores	4	9	5	4	4

The mentors ranked progress on key indicators of child health and wellbeing for each of the children in the COACH family. The data for the oldest child in each of the families has been collated to provide an overview of progress on these indicators depicted in Figure 2 below. The dark blue and red sections of the bars indicate the number of mentors who perceived that the oldest child in the family had progressed on the indicator. The graph demonstrates that progress was made for the indicators personal development and wellbeing, positive attitude about life, self-esteem and confidence, happiness, communication with parents, making friends, connecting socially with others, participation in leisure activities and attendance at school. While for many children in COACH, progress was made in the relationship with their parent/s; for some children the mentors reported

deterioration in this relationship. Similar trends were seen for the siblings of child one. Two mentors did not complete this section.

Figure 2: Mentor perception of health and wellbeing outcomes for child one of COACH family (N=25)



The mentors were also asked an open-ended question to describe how they felt the COACH program had impacted on the health and wellbeing of the children. Some mentors did not feel or see any positive impact on child and youth health and wellbeing. Reasons for this negative perception included not seeing a significant change in the behaviour or lifestyle of the parent or feeling that COACH only supported the parent which led to little positive impact for the child:

> *I don't think it has had much effect on the three elder ones. Our client wanted to regain their respect, but I don't think she ever did, due to continued alcohol abuse, and consequent unpredictable actions. We made a little progress with the youngest child while she was home with her mother, but now we rarely see her. (Scott)*

> *The program has had only a small impact. This is partially due to meeting with the parents during the day when the child is at school. (John)*

However other mentors described many positive changes and developments in the children involved. These included the client displaying better boundaries and emotional health and improved family dynamics due to healthier communication. The mentors also believed that being there to support the child and be a role model was beneficial.

It is excellent as the more you help the mother to understand the importance of boundaries, health, [and]emotional support, the better parents they learn to be - with encouragement and positive input. (Anna)

Children beginning to respond to calmness and consistency. (Shannon)

Very Positive. Assisted with communication skills within [the] family to create more cohesion and respect for mum. (Melanie)

Made an impact, know that [the child] can speak to us, support him...a little bit of a male role model. When I do see them they have opened up and we chat about things. (Catherine)

6.2 Client perspective: Impact of COACH on child and youth health and wellbeing

The client interview data and case notes provided from NPCCI provided insight into how COACH has influenced the health and wellbeing of children and youth. For example, Lucy is a single mother with two early adolescent boys. She has an intellectual disability and schizophrenia. The client case notes provided by the social welfare staff at NPCCI document how the COACH program has assisted Lucy in accessing dental care for her oldest child. Through improved socialization and support to adhere to her treatment regime, Lucy's mental health has improved, which has enhanced her ability to communicate and cope with her teenage sons. Lucy described how her COACH mentor attended parent teacher interviews at the school with her *because [she] didn't understand what they talked about* and therefore her mentor was able to ask the appropriate questions to gauge how the boys were progressing at school. The mentor also engages in conversation with Lucy's sons on the importance of education. Lucy's situation highlights how an improvement in the social, emotional, mental and physical health and wellbeing of a parent positively influences the home environment, parenting capacity and overall wellbeing of the child. This trend was also observed among other COACH clients including Belinda.

Belinda entered the COACH program following the death of her brother. She was also experiencing difficulties coping with her youngest son who was having behavioural problems at school. The stress of both circumstances felt overwhelming to Belinda.

I had a lot of trouble with my youngest...he would have been 10? 9 or 10? And the death of my brother so just the two combined I felt like I was heading down a road that led to the

biggest hole and I was never going to be able to dig my way out. I actually think I was heading into depression and frustration and everything!

When asked to expand on her son's behaviour, Belinda described the following:

Just mucking around at school, being defiant, always getting into trouble, not being able to do what he was told.

Belinda's oldest son is dyslexic and was also struggling at school. The COACH program addressed Belinda's emotional, social and parenting needs by referring her to counselling to deal with the grief surrounding the death of her brother and assigning her to a mentor with parenting experience who could provide guidance on parenting strategies but was also someone for Belinda to talk about her parenting struggles with. For Belinda, having someone validate her parenting experiences helped provide perspective on her situation.

Because she has kids of her own so she has been there and done that and it was probably helpful to hear that you are not the only person in the world having problems. It's not like your child is the only one who likes to push the boundaries and things like that.

The COACH client notes provided by the social welfare workers at NPCCI indicated improvements in Belinda's mental and emotional health. Belinda's son's behaviour at school also improved with the school providing Belinda with daily reports on her son's positive and unhelpful behaviours. These reports have allowed Belinda and the school to work together to address her child's needs and to focus on his strengths. Consequently the social worker believes Belinda's son is more likely to complete his education. The social welfare workers had also observed how Belinda's enhanced emotional stability has enabled her to parent more effectively thereby avoiding the likelihood of family breakdown and deterioration.

Another COACH client, Sarah discussed how having COACH mentors impacted positively on her child's growth and development as she was limited in her ability to physically interact with her child due to being in a wheelchair.

When we are really active with [the mentors] she developed a lot better, a lot more with being able to interact with them because I was unable to lift her onto the floor and have that important floor time which is essential to their development in the first [year]...and that was something that I couldn't do physically... so that was really good.

The COACH client and NPCCI client notes stress the important role the COACH mentors and the COACH program have played in promoting the health and wellbeing of the children of the COACH family. Interestingly, not all mentors shared this positive perspective with some feeling that the

program had little to no impact on the health and wellbeing of the children and family. Sustained change is a slow process and not all clients have demonstrated a continuous positive trajectory – particularly those who have only been involved in the COACH program for a short period of time. However the small steps clients have taken in the right direction should not be overlooked. The social welfare staff at NPCCI recognised these small steps as small wins. Katie's story is an example of this, with one of her mentors stating that *in our opinion they are not helping themselves have a better life and I worry about that.* This comment is in contrast to a local social worker who has described Katie's transformation as the *greatest casework outcome I've seen.*

7 The COACH Program & Key Social Determinants of Health

The unique design of the COACH program is its ability to address key social determinants of health. For many of the families engaged in the program, prior to commencement in the program they were dealing with issues of unemployment, housing instability, mental health problems, financial difficulties, food insecurity and social isolation. The COACH program utilises a holistic approach when working with each of the families. The mentors are able to offer social support and guidance in relation to finances, parenting, socialisation, and improving employment and housing circumstances. The key social determinants identified by Marmot and Wilkinson in the World Health Organization publication *'Social Determinants of Health – the Solid Facts'* (2003) will be used as a framework to discuss how the COACH program has addressed these factors. The social determinants are interlinked and interrelated – for example, the social gradient often gives rise to stress, social exclusion and addiction and is often due to factors such as unemployment or poor work situations.

The Social Gradient

As mentioned in the introduction of this report, a social gradient can be observed in the Mornington Peninsula region with those at the top of the gradient experiencing wealth, employment, better health outcomes and housing situations and those at the bottom being in situations of unemployment, poverty and housing insecurity. The social gradient is one that entrenches disadvantage with children born to parents at the bottom of the social gradient being more likely to develop into adults at the lower end of the gradient (Manor, Matthews et al., 2003). While changes in the social gradient cannot be observed in a short time frame the goal of the COACH program is to break the cycle of generational poverty and to provide families and children with the opportunities and life skills to move up the social gradient.

Stress

The literature on the social determinants of health recognises the impact of stress on poor health and wellbeing outcomes. Long term stress is associated with anxiety, low self-esteem and confidence, social isolation and lack of control over home and work life and physiological changes which increase the risk of cardiovascular disease and impacts immune system functioning (Wilkinson and Marmot, 2003). The COACH clients describe how having a COACH mentor has changed their perspective on life and also provided them with strategies in coping with stress.

> *My brain is different; my outlook is different. (Michelle)*

> *When you get to the stage where you don't really want to get out of bed...because you don't want to deal with what's going on during the day because it's just going to be problems. Although I still get really down and stuff like that. I'm able to pick myself up again – go and*

have a good sleep, get up, new fresh day and start again. I'm always going to have problems but I think it's realising that they are not always going to be there, and the COACH Program helped me with that. (Belinda)

If it wasn't for them I feel like I'd be in the Looney bin...I'm not joking. I feel like it would have driven me that crazy that I would have had to admit me self or something. (Jack)

Early life

Research has demonstrated that the periods of early childhood and prior to birth are foundational development stages for adult health. Poor health and emotional support during childhood increases the risk of poor physical and emotional health and functioning in adult life (Wilkinson and Marmot, 2003). Through the COACH program, families were supported to access appropriate health care, change family dynamics and the home environment, implement parenting strategies and encourage school attendance.

I've learnt how important it is to have the house tidy even though I still struggle with it. I'm learning how... I used to smoke away from the boys...so I'm not used to spending a lot of time with the boys...I'm learning from [my mentor] just through talking about things, not to spend so much time out in the shed, which is where I smoke, but to come into the house [and spend time with the boys]. (Katie)

I guess it goes back to that feeling like there is something else outside for me for when it all gets too much, there is someone else there who can pull me into line and say you are being ridiculous and why do you need to go down that path there?... In this case she has offered me alternatives to look at in terms of finding solutions to problems in regard to my son's behaviour. That has all been very good. (Lisa)

Social exclusion & Social support

Many COACH clients did not know how to be a friend. Individuals struggling with mental illnesses or poor life circumstances often develop a selfish outlook on life which makes initiating and maintaining friendships difficult. Having a mentor who was able to demonstrate friendship through word and action not only increased their confidence and feelings of worth, but also enabled them to instigate and sustain friendships outside of the program. Michelle describes how she has been able to make two friends since commencing the COACH program.

I've actually made two friendships since being in COACH with my mentor. But if I had never had my COACH mentor I would have never been able to approach these two ladies that I've approached saying would you like to get together... I wouldn't have thought that I was valuable enough to make a nice friendship. I wouldn't have gone for people who really may

not have been good friends for me. But now I feel like I'm a bit more valuable, that I'm worthy of having a nice friendship... (Michelle)

Work & Unemployment

Being employed is better for health than being unemployed, however the literature also shows that poor work conditions contribute to stress which is associated with illness and disease and premature death (Wilkinson and Marmot, 2003). A number of COACH clients wanted to improve their employment situation. For some this involved returning to study, others required dental work to enhance their appearance and a few needed to address their addiction or mental health issues which were preventing them from being functional in an employment situation. For Jack, COACH has assisted him in fixing his teeth, decreasing his dependence on opiates and finding opportunities for part time work.

I actually got some work. Just some part time work, three hours a week through the COACH program. (Jack)

Through the COACH program, Craig was able to find part time employment and also improve his appearance through extensive dental treatment.

With the Mentors encouragement, Craig found part time employment which assisted to offset the family's financial difficulties and inject hope into their situation. Through networking with the Brotherhood of St. Laurence the COACH program facilitated expensive dental treatment for Craig that enhanced his sense of confidence and self esteem that in turn, enhanced the likelihood of him gaining employment. (Client social work notes)

Addiction

The literature on the social determinants of health recognises that while drug use is often an individuals' response to social breakdown, it is also associated with deterioration in health and an increase in health inequalities (Wilkinson and Marmot, 2003). Higher rates of smoking, drug use and alcohol use are found amongst those experiencing social deprivation, yet these activities also lead to downward social mobility (Wilkinson and Marmot, 2003). Through the social support and encouragement offered by mentors and also the social welfare workers of the COACH program, a number of clients were able to address their addictions and either cease or decrease their reliance.

Anything to do with getting off marijuana is difficult and challenging. But it is put in such a way that it's my choice. Like [the NPCCI welfare worker] ...said, look I know you want to cut down Katie, maybe you could try by only having a cone every hour. Just give it a go, and see what happens. And I was willing to try that because that seemed almost achievable. And then the next week when I saw him...he said okay you've done that – because I used to keep a

diary for him about how much I'd smoked, and so he said you have achieved that...how about we try you for two hours this week. So it was just little tiny steps all the way. (Katie)

Food

Access to healthy and nutritious food is a key social determinant of health (Wilkinson and Marmot, 2003). Malnutrition and diet deficiency diseases are associated with lack of food and food variety whilst excess food consumption is associated with chronic diseases such as diabetes, cardiovascular disease and stroke (Wilkinson and Marmot, 2003). Consequently improving access to healthy food is a vital community development approach in vulnerable communities. In response to the food insecurity in the Mornington Peninsula, NPCCI offers food parcels and financial counselling for many COACH clients and others experiencing disadvantage in the community.

If I don't have food I just have to let [COACH] know and I can get a food parcel. (Jack)

Through improved financial management (often facilitated through the State Trustees) many clients found themselves in a position of being able to pay off their bills with enough money left over to purchase food. Consequently the dietary intake and food security of many families is no longer at risk.

Transport

Active transport is vital for health and wellbeing and therefore communities need to foster greater reliance on walking, cycling and public transport (Wilkinson and Marmot, 2003). Many of the clients involved in the COACH program either could not drive or did not have access to a car and therefore were reliant on public transport or walking. While this is beneficial for some, others experiencing conditions associated with pain or impaired mobility, or needing to travel long distances inaccessible by public transport, were at times left stranded. COACH mentors regularly drove their clients to appointments or to recreational activities if they were unable to arrive by other transport means.

...recently she has got me to a trip to the hospital. I need[ed] a procedure and need[ed] a driver and someone to pick me up and because I'm on my own. (Lisa)

The COACH program presents a unique model of how to address key social determinants of health in vulnerable families located in disadvantaged communities. Through mentors adopting an empowerment approach, COACH clients were able to transition from circumstances that were detrimental to their health to opportunities which promote health and wellbeing. Improvements were demonstrated in key social determinant areas of employment, social support, stress, addiction and access to food and transport.

8 Discussion and Recommendations

COACH is a mentoring program described as friendship with a purpose which addresses key social determinants of health. The program seeks to empower the parents of vulnerable families to improve their life skills, social skills and parenting skills, thereby improving the health and wellbeing of the children and parents. The program receives referrals from other community groups including schools and welfare agencies with eligibility being based on one child being aged 12 years or under. This evaluation explored how COACH mentors engaged with the COACH family to assist them in achieving their life goals; the impact of participation in the COACH program on the life skills, social skills and parenting skills of the parents/caregivers and the influence the COACH program had on the health and wellbeing of children and youth.

Three sources of data were collected and utilised in this evaluation: mentor survey, client interview and client case notes produced by the NPCCI social welfare workers. The data from each source was used to corroborate the findings of the other sources. Due to this type of analysis, interesting distinctions were made between the perceptions of the different people involved in the program. Overall the mentors believed that they received sufficient training and support to be mentors in the program. They were involved in meeting with the client on a weekly to fortnightly basis and had regular phone contact if face to face meetings were less often. The majority of support offered by the mentors included social support, encouragement and advice and practical support in terms of financial management, domestic skills and improving employment prospects. A number of mentors did not feel that COACH had an impact on the health and wellbeing of the children and clients. However, this sentiment was not shared by the clients or the social welfare workers involved in the coordination of the program.

The clients of the COACH program felt that they had been empowered in various aspects of their life which resulted in improvements in their living, social and parenting circumstances. Throughout this report, client stories were presented to illustrate the life transformations that had been made possible through the support of COACH. For client Katie, this resulted in improvements in her mental health, drug taking, housing situation, employment situation and relationship with her children. For Michelle she was able to learn how to set boundaries with her child and formed relationships with two other women as a means of social support. Sarah's mentor assisted her to play with her child as Sarah was confined to a wheel chair and therefore could not lift her child or play on the ground with her child easily. Many other stories were included in the results sections of this report. However at times there is a discord in the mentor perception of COACH impact and the client perception.

The reason for this difference may be the high expectations that the COACH mentors have in terms of an individual's ability to process and act on advice or guidance. The program is neither paternalistic

nor authoritative, however, a normally functioning individual may find it difficult to understand why someone does not immediately change or adopt healthier behaviours. If the mentors do not see their expected rate of change or uptake of healthier behaviours, they seem to think that they are having little impact on the client. However the clients have articulated how the support from the mentors has facilitated their ability to function better in a number of key life areas. The social welfare workers have also been able to affirm the improvements in the client's life and in the lives of their children. Therefore to ensure the sustainability of the program and the continued participation of mentors, it is important for the coordinators of COACH to continually encourage the mentors in their role in bringing about life change for the clients.

Some mentors did have more difficult clients than others. A few clients weren't always in the mental or emotional space to adopt different strategies to achieve their life goals and consequently the mentors found this frustrating. Careful assessment of families to ascertain client suitability for the program is one of the steps the COACH program uses to avoid this scenario. However, there will be a small number of clients who are assessed as suited, whose circumstances or capacities may change, therefore presenting difficulties for them to work towards achieving their goals. Knowing that the mentors are lay people and not trained in social work necessitates the need for greater support if they are working with a client with mental health issues or addiction issues.

A number of processes and protocols have been developed and put in place in the COACH program to protect the health and wellbeing of both the mentors and clients. Documentation associated with these processes can be accessed through Community Caring Inc. Having the support of welfare work trained individuals is a key component of the program as professional support can also be offered to the clients. Other churches/Christian organisations seeking to adopt this program will benefit from having someone with social welfare (or similar) qualifications to oversee the program. Both the mentors and the clients spoke highly of the social welfare workers involved in the program, particularly in relation to strategies associated with addiction support and mental illness.

The COACH program moves beyond traditional mentoring programs which often address issues of social isolation, positive role modelling and behavioural interventions, to being a program which considers the social determinants of health. The program creators had experience in community development and welfare and thus have a holistic understanding of the needs of individuals and communities. They were able to assess and understand the importance of these key determinants in promoting the health and wellbeing of the family. The strength of this program is that the clients are not blamed or stigmatised for their circumstances, rather they are empowered in a number of the social determinants in attempts to break cycles of poverty and disadvantage. As health promotion and

public health transitions from a behavioural model of health and disease, this model of a mentoring program is important to examine and adapt to other social situations, particularly amongst disadvantaged or vulnerable communities.

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