Journal of Peer Learning

Volume 6 Article 5

2013

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Recommended Citation
Townsend, Rob, The perspectives of health care professionals on the value of peer mentoring during rehabilitation, *Journal of Peer Learning*, 6, 2013.
Available at:https://ro.uow.edu.au/ajpl/vol6/iss1/5

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Journal of Peer Learning (2013-14) 6: 46-58

The perspectives of health care professionals on the value of peer mentoring during rehabilitation

Rob Townsend

ABSTRACT
There is growing acknowledgement that individuals who experience peer support following a major health event adapt more effectively to physical and psycho-social challenges. Research indicates that patients who experience peer mentoring support during the immediate rehabilitation period appear to adapt better and perceive themselves as better adjusted post injury or illness. Despite this, there appears to be only sporadic attention paid to the value that peer mentoring could play in health care delivery. This article reveals research that explored the beliefs, values, and experiences of five health care professionals about peer mentoring at a major urban rehabilitation centre. Three broad themes emerged from the research: bio-medicine and culture, transitions, and multidisciplinary understandings of peer mentoring. The research found that the dominance of bio-medicine impacted on the effective utilisation of peer mentoring in this culture.

INTRODUCTION
The value of peer mentoring relationships in supporting individuals through transitional periods is well known across educational and some professional settings. There is an increasing but limited body of research suggesting that patients who experience peer mentoring support during the immediate recovery period appear to adapt better, perceive themselves as better adjusted, and report higher levels of wellbeing and life satisfaction (Sherman, DeVinney, & Sperling, 2004; Veith, Sherman, Pellino, & Nakao, 2006). The research outlined in this article explored the perspectives of one rehabilitation health care team on the value of peer based mentoring programs and its impact on patients experiencing in-patient rehabilitation. The research is significant because of the paucity of literature around peer mentoring programs in health settings and also research that links the literature on peer learning and rehabilitation in health care.

Literature

In western industrialised nations, health care has remained within the realm of biomedicine since the 18th Century. Medicine became increasingly interested in the isolation of specific aetiologies within systems of the human body, which centred on the biological and physiological functioning of the human body (Germov, 2002). The Australian health care system has evolved from this traditional biomedical framework. Subsequently, assumptions about biological and physiological functioning and illness continue to influence how health care systems are structured, practiced, and delivered (van Krieken et al, 2005; Chan, da silva Cardoso, & Chronister, 2009; Taylor,

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Published by the University of Wollongong
ISSN 2200-2359 (online)

Foster, & Fleming, 2009). One indication of this is the absence of structured peer support programs within health care settings, such as in-patient and out-patient rehabilitation.

Peer led methods of education have existed for many centuries in many different forms, commencing with Aristotle and the monitorial systems which were popular in 18th Century Europe (Pollard, 1982). In the late 1950s, peer education experienced a revival in western countries, pursued as an effective approach to communicating with and educating "hard to reach" young people, specifically about health, welfare, and social issues (Pollard, 1982). In recent decades, peer education has been widely applied to health promotion, prevention, and counselling processes for HIV/AIDS education, sex education, drug and alcohol abuse, and smoking cessation (Centre for Harm Reduction, 2011; Messias, Moneyham, Vyavaharkar, Muraugh, & Phillips, 2009).

Haggis (2009) reveals that peer learning and increased participation in collaborative learning assists individuals, organisations, communities, and societies to know more about what we need to know for the future, the gaps in knowing: "the fleeting," "the distributed," "the multiple," and "the complex." Peer learning is seen to be able to improve problem solving in all contexts through increased collaborations (Willey & Gardner, 2010). Researchers have explored the realms of collaboration as central to peer activities, including games as pedagogy, student learning as communities of practice (Adam, Skalicky, & Brown, 2011), and workforce team learning as a means to improve health care.

There has been recent appeal of formal peer learning programs in education contexts; however, international literature raises doubts about its usefulness in relation to student retention and progression as compared to the development of cultural and social capital (Dubois, Holloway, Valentine & Cooper, 2002; Jekielek, Moore, & Hair, 2002; Townsend, Delves, Kidd, & Figg, 2011; Townsend, Schoo, & Dickson-Swift, 2012). Research tends to focus on formal evaluations of individualised, localised forms of peer programs that concentrate on efficiency and value for money rather than outcomes for participants (Moodie & Fisher, 2009; Victoria University, 2007). Similarly, there is anecdotal evidence that informal peer learning may be a more common and effective activity amongst young people and students and therefore more influential in social support and student retention and progression.

Rehabilitation as health care service

Rehabilitation as a speciality in Australian health care emerged post World War II and was created to aid injured service people. The focus was on "getting people back to work" and maintaining a productive workforce (Australasian Faculty of Rehabilitation Medicine, AFRM, 2008, p.1). This emphasis on restoration of function shaped early rehabilitation models. In the 1950s there was a gradual shift within the Commonwealth Rehabilitation Services (CRS) with "teams of multi-skilled medical personnel led by medically trained doctors needed to co-ordinate local rehabilitation services within the public health system" (AFRM, 2008, p.1). This led to a greater awareness of the need to assist individuals living with long term disabilities. The rehabilitation multi/interdisciplinary team approach differentiates it

from most other acute models of health care as it is a compilation of medical, nursing, and allied health professionals (Graham & Cameron, 2008).

According to Disler, Cameron, and Wilson (2002, p. 385), rehabilitation is "a dynamic and critical component of the therapeutic continuum," which covers the inpatient, outpatient, and community service sectors. Rehabilitation services have been identified as the "missing link" between acute hospital care and community care services (Australian Rehabilitation Alliance, ARA, 2011, p. 3). However, the integration of rehabilitation within the overall landscape of the health system remains inconsistent. Lengthy separations from family, social, and other community supports during this time compound patients' psycho-social reintegration (Poulos & Eagar, 2007; Taylor et al., 2009).

Peer mentoring

Peer mentoring broadly refers to an individual who has successfully faced specific experiences who then provides empathic understanding to another person, helping that person adjust to a similar experience themselves (Hernandez, Hayes, Balcazar, & Keys, 2001; Townsend et al., 2011; Veith, et al., 2006). Whittemore, Rankin, Callahan, Leder, and Carroll, (2000, p. 272) state that peer support involves "mutuality, shared problem solving, and self-disclosure, which promote bi-directional relationships or interactions." Research indicates that the dual benefits of reciprocity found in peer support within health care settings can be supportive of holistic recovery and healing for both the mentor and mentee (Hernandez et al, 2001; Whittemore et al., 2000). Gitterman and Shulman (2005, p. 20) aptly stated that, "when we lend our strength to others, we strengthen ourselves," and it is the reciprocity found in peer support that can create relationships that foster support, advice, and encouragement. Alternative models can assist with lowering hospital complications and readmissions, providing a feasible adjunct between rehabilitation and community reintegration (Hernandez et al., 2001).

Research pertinent to peer support in health care systems indicates that the most successful peer mentors are those who have similar characteristics and who have successfully faced similar life experiences to that of the peer/patient (Hernandez et al., 2001; Sherman, et al., 2004). Veith et al. (2006) reported on the unique characteristics seen within peer mentoring relationships for spinal cord patients and identified that mentors could provide practical and emotional support during the formation of new identities that incorporate injury. This was a direct result of the mentor's credibility, equitability, acceptance, and normalisation of the experience. Of note, mentors were seen to have more credibility than staff as the lived experience made them equitable sojourners. Furthermore, mentors were more likely to offer support and advice that was overlooked by health professionals. In turn, opportunities for personal disclosure normalised the experiences and provided mentees with credible hope for their future.

The use of peer support has been reported for a vast array of chronic health conditions, with literature reporting the benefits of peer support for cancer (Rini et al., 2007), mental health, (Mead, Hilton, & Curtis, 2001; Travis et al., 2010), diabetes (Tabrizi, Wilson, Coyne, & O'Rouke, 2007), heart disease (Riegel & Carlson, 2004), burn survivors (Badger & Royse, 2010), multiple

sclerosis (Koch & Kralik, 2001), musculoskeletal, and other chronic pain conditions (Ostlund, Cedersund, Alexanderson, & Hensing, 2001).

Evident throughout these studies was the positive connection between peer support and improved health outcomes. Klein, Cnaan, and Whitecraft (1998) explored case management and peer support for mental health clients and discovered that patients who experienced case management alongside peer support had fewer hospitalisations and reported improved quality of life and well-being compared to patients who received case management alone. When exploring the role of peer support within mental health, Mead et al. (2001, p. 135) argued that by stepping outside the traditional medical model of care, peer support "can offer a culture of health and ability as opposed to a culture of 'illness' and disability." In this way, my research explores the link between health care and peer mentoring and whether peer learning can contribute to a more holistic approach to rehabilitation services.

METHODOLOGY

My research was qualitative with an ontological basis that was post-positivist, conceptually arguing a stance that health care "realities are multiple," constructed, and reconstructed over time (Liamputtong, 2009). The epistemological stance of this research was social constructionist, the socially constructed nature of which indicates that "whilst reality cannot be measured, it can be interpreted" (Liamputtong, 2009, p. 20). The research was qualitative in the interpretive paradigm and as a pilot study, did not attempt saturation but to develop a thematic analysis that could inform future studies on peer learning in a range of education and health care contexts.

This research relied on purposive sampling techniques. The selection criterion was specific, based on what constitutes a multidisciplinary team commonly seen in a rehabilitation health care setting within Australia. The sample size was five individuals, representative of five major disciplines: medicine, nursing, social work, physiotherapy, and occupational therapy (Portsmouth, Coyle, & Trede, 2008). Of the five individuals who were interviewed, three were female, two were male, and their ages ranged between 22 and 65. Consistent with purposive sampling techniques, a gatekeeper was utilised during recruitment, which in this instance was the manager of a specific urban rehabilitation service. Dual ethics approval was obtained from the La Trobe University Ethics Committee (Approval No: FHEC 10/74) and the Austin Health Human Research Ethics Committee: (Approval No: H2010/03992).

Data was collected through face to face semi-structured interviews. Patton (2002) states that interviews allows for exploration of another person's perspective, and semi structured interviewing allows for a more natural flow in conversation (de Laine, 1997). I utilised an interview guide of questions which led the discussion with each participant. Each interview was audio recorded and transcribed. Two interviews were conducted initially. These interviews were then transcribed and the resulting data influenced the remaining three interviews by exploring a narrower focus on peer mentoring in the experience of the participants.

Qualitative research relies on inductive reasoning to interpret meaning (Dudley, 2005), with a combination of thematic and coding strategies guiding

analysis (Liamputtong, 2009). Initial theme identification commenced during data collection. A line by line search of the data was undertaken with comments noted. All data was read multiple times, then compared across documents and coded respectively. Five overarching themes were developed whilst some themes were divided or combined into subcategories or eliminated due to lack of representation across the transcripts. The remaining emergent themes were coded and then categorised into three major and interconnected themes that had been identified across all interviews.

RESULTS

The five team members interviewed were representative of a health care team and consisted of Josh, a medical registrar; Betty, an occupational therapist; Shaun, a physiotherapist; Mary, a social worker; and Leigh, a nurse.[1] Three of the participants identified that they had worked in rehabilitation, specifically spinal cord rehabilitation, for over 10 years, and the other two participants identified that they had worked in either a hospital or rehabilitation setting for over a four year period. From the interviews, three recurrent themes emerged: biomedicine and culture, transitions, and understandings of peer mentoring. The culture of health care delivery, unsurprisingly, was primarily situated within a biomedical model.

The underlying organisational culture of biomedicine within this inpatient rehabilitation setting was an overarching theme. This was evident in the discourse and use of subtle rhetoric seen within the data. Several participants expressed that patient care needed to stem from a biomedical perspective. Josh, the medical representative, remained wholly focused on the medical issues for a patient and expressed that structurally: “We have a more objective and overriding view, rather than the more local view which a therapist might have.” This highlighted the hierarchal dominance of the medical team within this organisation.

Other participants saw their primary role in rehabilitation in terms of their therapeutic roles and how their professional discipline and specific knowledge was provided to patients to aid recovery. Leigh believed that in terms of patient care, nurses focused on “bowel, bladder and skin and if we don’t get our part of the process right, it doesn’t matter what you do around a physio and OT and stuff like that, you’re never going to leave the house.” Shaun, the physiotherapist, focussed on teaching patients “wheelchair skills,” and Mary reflected that social workers were primarily responsible for the discharge of patients in a “timely manner.”

Mary stated that: “The focus here is on equipment and getting people trained in their nursing needs, so they can be safe in the community.” Leigh stated: “So let’s get the task stuff out of the way and then you can start to think about where to from here.” Whilst holistic health care provision was mentioned by three participants, this term appeared to have different meanings amongst participants. Josh and Betty situated holistic care within a multidisciplinary team approach. Betty stated that: “The medical team directs management ... it remains a rehabilitation model rather than a medical model.” The medical team were ultimately responsible for patient care and

[1]All participants either chose or were given a pseudonym.

management, and this statement only reinforced the dominance of medicine within the hierarchal organisational structure.

Mary, however, believed that holistic care centred on all aspects of individual care and felt that the organisational culture did impact upon and determine how she was able to deliver that care. There was little further acknowledgement that rehabilitation, as described within the literature, should encompass the emotional, social and environmental functionings of an individual.

Transitions

Four of the five participants focused on the physical and functional processes that needed to be undertaken to successfully reintegrate and transition through a major injury and ongoing disability. There was little discussion by participants about the emotional and psychological processes that may be involved during this time. The focus on the physical and functional components of rehabilitation shadowed the organisational context that promoted discharge of patients in a "timely manner" (Mary).

A further component of transition that Shaun, Mary, and Leigh discussed in varying degrees was the shortage of resources that aided transition and reintegration of patients within the community. They believed that some of these services were inconsistent and ineffective at providing ongoing support for people with chronic health conditions. Shaun had very specific thoughts surrounding the current state of post discharge service provision, as he worked in a dual position within the outpatient setting. He remarked:

> Once they go home, the services for people just, like, drop off. I know our inpatient rehab here, I would say it's well-resourced with all these great things…Yet, once they go home, it's none of that… People then lower their expectations about what's possible and there is an underlying feeling of discontent.

Transition therefore was perceived to been seen differently by the organisation, the health care provider, and the patient. Mary pointed out that: "We've got some patients who have been here for two years and the patients become very angry and frustrated and increasingly the anger of patients is projected onto us as staff group." Mary emphasised the key themes surrounding transition from the organisational, health care professional's context, as well as that of the individual. From the organisational context, bed stays stretching to twelve months left organisations in a precarious situation of being accountable for such lengthy admissions.

Certainly there was an acknowledgment by participants that adjustment is more than just the physical and functional restorative processes for patients. Participants did discuss the fears and emotions that patients may have in transitioning out of the rehabilitation setting, but in most instances this was referenced in terms of the physical practicalities or equipment needed to aid adjustment. As Leigh stated, rehabilitation is "more about giving people the tools to be able to function in the community, rather than trying to find a cure." Most participants skimmed over the psychosocial dimensions that a patient may be transitioning through during this time. They failed to identify an interconnection between the biological and psycho-social aspects and how

this then impacted upon transition, which only highlights the influence of the biomedical model in this organisation.

Mary, representative of social work, was the only participant that made a connection between the bio-psycho-social complexities of adjustment for an individual during this time:

> Personally, I feel we could do more to assist patients to cope better, to psychologically adjust and help them through their grief and loss process, to move on to acceptance and adjustment. I feel that as social workers, and as a service we could do more.

Peer mentoring in rehabilitation service delivery

Peer mentoring was evident within the data and participants discussed their understandings of creditability and trust, readiness for rehabilitation, the lived experience of rehabilitation, the length of time in hospital, and length of time since injury. These issues were situated alongside participants' beliefs about selection and formats of peer mentoring within a rehabilitation setting. Similar to the theme of transition, the utilisation of peer mentoring was influenced by the organisational culture.

All of the participants were able to articulate an understanding of peer mentoring programs and how this would be structured in a hospital setting. Josh, representative of the medical team, expressed the most limited understanding and initially discussed peer mentoring in relation to the orientation of new staff. Josh stated: "I thought peer based mentoring programs were about supporting new team members when they come along, helping them settle into the new unit." With some clarification, however, Josh noted that: "I presume it means, other patients to mentor the newly coming in patients, for example, the ones that have recently been discharged, they might come back and talk to the current patients about life." Josh was unaware of any such program at this rehabilitation setting: "I've not seen any formal programs here, I must say." These comments seemed surprising, but may be reflective of the rotations that registrars undertake, transitioning between hospitals and different ward settings biannually.

Other participants had succinct opinions about peer mentoring and these were founded mainly on their knowledge of the program running at their facility. Betty remarked: "My very specific understanding of a peer based mentoring program, would be, what we are doing here, now."

A key finding was that an awareness of peer mentoring and the program structure were separate issues. Only Betty was able to express an understanding of how peer mentoring was structured and conducted within this organisation. This was indicative of her extensive involvement in such programs at this facility and these experiences flavoured her interview. Betty commented: "Primarily it's face to face contact, so a couple of peers would come here once a week and spend an afternoon." Accordingly, Betty mentioned that the current program was unstructured and informal in nature and that the visiting peer mentors "operate on a very much drop in … they'll kind of hover, they tend to sit themselves in the dining room or they'll move into the therapy area." Leigh's comments, however, were characteristic of the other three participant's understandings: "I've never got involved with it. I

mean, I know the people who come in and a couple of them I'd nursed ten years ago."

The selection of peers seemed crucial to the overall success of the program. There was general agreement by all participants that the length of time a person "had been in a chair" (Leigh), directly contributed to their suitability to be a peer mentor. Mary indicated that she believed that level of injury and compensable status had an impact on the peer/patient relationship and commented that: "They've got different experiences and what the patients and families seem to be expressing is that the matching process needs to be better."

Furthermore, it was noted by three of the participants that mentors were deemed suitable if their views and values were in keeping with the organisational culture and the principles and protocols in play within the facility. Josh explained: "Some patients who have gone through the system may have preconceived ideas that are not fitting with the rehab unit and those people whilst strong advocates for the spinal cord injury population as a whole, wouldn't be that suitable to mentor patients in this unit."

All of the participants acknowledged that the peer mentors were quickly able to gain credibility and trust with patients. Similar lived experiences were central to how a peer could provide an added dimension to the rehabilitation process. Leigh stated: "There is a little bit more credibility there with them, because they've been through or they are going through, some of the same issues that these guys are going through as well." Shaun reiterated this saying: "It is nice for people to know that somebody else has been through what they have been through and that there are some solutions to some of the challenges that might be in front of them."

Interestingly, it was noted by several participants that peer mentors needed to be able to gain credibility and the trust of health professionals before they would be utilised effectively. Leigh believed that in their facility, peer support was made possible because the peer mentors had previously been "through our service and because we have confidence in them, they have trust in us. They're our guys, they are one of us."

As with the previously discussed themes, the underlying biomedical culture, combined with the concept of rehabilitation being a transitional process, shaped how participants perceived and believed peers could be utilised within this setting. Four of the five participants indicated that peers were an aid that could assist with the physical and functional aspects of rehabilitation and that learning new skills was central to this. Shaun remarked:

> They're learning various things about what it is to live with a spinal cord injury, they get some learning from us, the health professionals, but then they might also get some learning from a person who has a spinal cord injury that has had it for many years.

Shaun reinforced and pinpointed the underlying biomedical culture by commenting:

> So we help teach them a bit, but also peers can help them with goal setting. So then that inpatient can make some more informed

> decisions before they go home or to help them go home. So, it can help the inpatients with possibly better decision making and possibly learning some of their skills a bit faster. So, I'd say, it could potentially be financially beneficial for hospitals to have a peer program as part of their rehab to speed up some of these things.

Shaun contends that utilising peers could be "financially beneficial for hospitals" and demonstrates how ingrained cost efficiency and length of stay is within the culture of health care delivery.

Furthermore, Shaun points out that the extended length of stay that some patients have in this ward setting can "inadvertently" make staff the key social support for these patients. The limited availability of peer mentors on the ward during the week in part has disengaged peers from becoming a social network during this time. Participants acknowledged that informal peer support can occur between current inpatients, and whilst level of injury and compensable status were important factors in the pairing process for mentorship, these same things were not factored into room sharing strategies between current inpatients.

DISCUSSION AND CONCLUSIONS

The dominance of the biomedical model and the influence of evidenced-based practices found within this study contribute to the lack of understanding surrounding why, how, and what makes experimental communication, such as peer mentoring, effective in the health care environment. The health care professionals identified themselves as experts in particular fields, governed by a biomedical model. This was influential in how peer mentoring was situated within this setting as peers remained disconnected from professionalism, as their knowledge is gained from the lived experience. As a result, peers are overlooked as individuals who can provide expert knowledge to others during this time. Rini et al. (2007) indicated that social support as an alternative intervention in health settings is not considered as valuable, nor is it as readily available within the course of clinical care. If such knowledge is not valued, then this may contribute to the under-utilisation of peer mentoring in such settings.

Time constraints and cost efficiencies simply outweigh the ability for health professionals to provide holistic health care to patients and as a result the focus shifts from the provision of holistic health care to discipline specific roles that are outcome orientated and increasingly task centred. Peers' understanding of the illness experience itself could provide invaluable insider information surrounding practical, emotional, and social support, and this could compliment health care provision during a critical phase of adjustment post-injury.

The participants in this study spoke candidly about the organisational culture in their health care setting and how peer mentoring was utilised. Significantly, peer mentoring in this context sat alongside but separate from the broader rehabilitation process. Length of time since injury was an important factor for consideration for staff when utilising peers within this setting, as this influenced their credibility as mentors in the ward setting. Prior knowledge about mentors (as former patients in this setting) enabled confidence and trust in that the sharing of information by mentors would be

beneficial to patients. Participants were keen to have peer involvement as long as these peers complemented and remained supportive of the ethos and culture of the organisation.

There is a paucity of literature surrounding health care professional perspectives on peer mentoring programs in ward settings. Hernandez et al. (2001) briefly mention an association between staff acknowledgement of informal peer relationships developing in the ward setting and their positiveness towards the introduction of a formal peer mentoring program in their facility. Future research is required that explores health care professional perspectives of peer mentoring programs and the influence prior knowledge of potential mentors has on the utilisation of peers and whether recruitment, organisational program affiliation, and structuring affect utilisation of peers in ward settings. Current research surrounding the utilisation and benefits of peer mentoring remains unclear about what specifically makes these relationships effective in the recovery process (Chan et al., 2009; Ostlund et al., 2001; Tabrizi et al., 2007).

Implications and recommendations

This paper appears to be the first known research study that specifically explores health care professional perspectives of the utilisation of peer support within health in an Australian context. Larger in-depth inquiries are needed in this field to ascertain which components make peer mentoring relationships effective in hospital settings. Health professionals have indicated that they continue to practice in environments that are time and resource poor. What factors therefore specifically impinge upon staff utilising peers in the ward setting?

Further exploration of the following interactions and relationships should also be considered. First, peer mentoring is known to hold reciprocal qualities, yet understanding the reciprocity qualities from the mentor perspective remains underexplored. Second, more in-depth analysis needs to be done on the cost effectiveness of peer support within inpatient and community health settings. This analysis should also examine what benefits social support brings for the longer term physical and emotional complications associated with certain conditions. Third, informal peer mentoring and/or social support between current inpatients and their family/carers remains poorly understood. Further investigation of this phenomenon is warranted in order to take advantage of its potential benefits. Lastly, future collaborative research could explore the utilisation and evaluation of peer mentoring programs within rehabilitation facilities nationally and this data could be then used more broadly in an international and comparative study.

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