AN EVALUATION OF THE STANDING TOGETHER PROJECT

"I THRIVE ON SOCIAL CONTACT"

- A GROUP PARTICIPANT

PRODUCED BY

THE MENTAL HEALTH FOUNDATION

An evaluation of the Standing Together project

A partnership between the Mental Health Foundation and Housing & Care 21 and Notting Hill Housing, funded by the Big Lottery Fund

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Executive Summary

Background

There is evidence to suggest that peer-support groups can help to increase social connectedness among older people, thus improving their quality of life. Given that 3.6 million older people live alone in the UK (Age UK, 2018), and the associated health risks of these conditions, such as increased mortality and declining cognitive function, there is a need to further investigate the impact of peer-support groups on the health and wellbeing of older people. The Mental Health Foundation's Standing Together project was set up to address this through facilitated peer support and activity-based groups.

This evaluation sought to understand whether the Standing Together (ST) peer-support groups, which took place between 2015 and 2017, impacted on outcomes related to: loneliness and social isolation; emotional wellbeing; and meaningful activity. It initially aimed to do this by comparing participants' scores on these outcome areas at baseline and follow-up. A methodological shift during 2016, however, led to a greater focus on qualitative analysis. Focus groups with participants resulted in a richer, more nuanced understanding of the impact of the groups, which both complemented and enhanced the quantitative findings. The study also included a process evaluation to explore factors relating to the implementation of the groups, with a specific focus on assessing sustainability.

Key findings

The qualitative analysis from the focus groups provided a broader, positive insight into the impact of the ST groups on participants. Findings from the focus groups, which consisted of 45 residents at baseline and 57 at follow-up, demonstrated that most residents felt that participating in the groups led to positive impacts in all the outcome areas identified. That is, participants felt that the groups helped to: combat loneliness by strengthening a feeling of social

connectedness and belonging; improve wellbeing through discussion among peers and the presence of a kind, caring facilitator; and provide meaningful, stimulating activities around people with whom they felt comfortable. Residents also expressed desire for the groups to continue.

The quantitative analysis found non-significant differences for 13 participants across outcomes, indicating that the groups had no impact on the outcome areas relating to life satisfaction, loneliness, wellbeing and social connectedness. However, there are a number of reasons why these results might have occurred, which came to light in the qualitative analysis. Most notably, the time at which follow-up outcome data were collected could have negatively impacted participant scores; outcome scores may have reflected the participants' disappointment that the groups were coming to an end.

Standing Together groups ran in 19 schemes – of these, more than half (10) were able to sustain themselves following the completion of the initial programme. There are great challenges to sustainability, however, as this requires funding and volunteers, both of which are limited resources. The importance of strong facilitators and having designated court staff members to facilitate the group on the court's behalf were emphasised as key to promoting group sustainability.

The process evaluation confirmed the positive findings of the focus groups. Staff members from all levels of involvement in the programme also felt that the groups led to reduced feelings of isolation and loneliness, increased companionship, mental stimulation and social inclusion. The process evaluation also emphasised the value in having two skilled, tactful facilitators in each group who are able to effectively manage a group of residents, some of whom may have dementia or cognitive impairments.

Recommendations

A full set of evaluation recommendations will be published academically and shared on the Foundation's website separately to this report. However, three key recommendations for conducting future evaluations of group work in later life are summarised below:

1. Interviews or smaller focus groups are preferable to larger focus groups to facilitate more effective data collection;
2. A greater focus on the needs of the population to inform all aspects of the evaluation (including measurements used and data collection) is needed; and
3. Further thought should be given to the appropriate time at which follow-up data should be collected to ensure the data are not impacted by emotions induced by the programme ending.

1. Introduction

There are currently more people aged 60 or over in the UK than there are under the age of 18, with older people now representing 17.8% of the total population (Office for National Statistics, 2016). With a rapidly ageing population, it is crucial to explore and recognise factors that impact the health and wellbeing of older people. Older people are at an increased risk of being socially isolated or lonely, and it is nationally estimated that approximately 10-20% of the elderly population are lonely (i.e. mild, moderate or severe) (Age UK, 2012). The prevalence of loneliness in older people can be said to be linked to changes related to getting older that can challenge the extent of social contact in later life, such as retirement, living conditions, mobility impairment and death of one's peers (Age UK, 2015).

Social interaction and relationships are central to wellbeing and emotional fulfilment (Holt-Lunstad et al., 2010). Social isolation can be described as the objective state whereby there is separation from social contact (family, friends) and community involvement. Therefore, it is marked by an absence of strong social networks. Loneliness can be regarded as the psychological equivalent to social isolation, whereby an individual perceives their existing social relationships to be deficient in some way, either in the number or closeness of contact (Steptoe et al., 2013). Loneliness can be separated into its social and emotional aspects: *emotional loneliness* stemming from a lack of a close attachment or intimate relationships (a partner or best friend) and *social loneliness* arising from the absence of a broad social group (friends, neighbours, colleagues) (de Jong Gierveld et al., 2016). Whilst there is a lack of consensus on the concepts of social isolation and loneliness, it is generally agreed that the two concepts are distinct but related and it is possible to experience each on its own or together. For example, an individual can be socially isolated, but not feel lonely or an individual can have a large social network and also experience loneliness.

1.1. Loneliness and associated health risks in older people

With increasing age, it is common that older people lose connections within their social networks and find it more difficult to initiate new friendships and join new networks. Later life is a period of key transitions, with events such as the death of a partner and/or close friends, retirement or moving to care facilities that can affect the nature of relationships (Mental Health Foundation, 2016). Such events may negatively impact the quality of life and wellbeing of older people. Evidence suggests that this can pose a health risk, with low levels of perceived social support found to be associated with increased mortality, increased risk of depression and anxiety, as well as declining cognitive function (Ellwardt et al., 2015; Ong et al., 2016). There is evidence that highlights that certain groups are more vulnerable to

experiencing loneliness. Steptoe et al. (2013) found in a UK-based seven-year longitudinal study that loneliness was more prevalent in older women and strongly associated with poorer physical and mental health, particularly mobility impairments and depression. In addition, Shankar et al. (2013) found that cognitive function effects of social isolation and loneliness, such as poorer immediate recall and verbal fluency, were more pronounced in individuals with lower levels of education.

A large Ireland-based study (Santini, 2016) found that support from friends and better relationship quality with children was protective against depressive symptoms and anxiety in older age. Similarly, Chen & Feeley (2014) observed that strain from four sources of social support (family, friends, children and partners) intensified the experience of loneliness for older people, whilst support improved perceived satisfaction with life and overall wellbeing.

1.2. Impact of meaningful activity and peer-support approaches for older people

Participation in meaningful activity is essential to maintaining social connectedness, as many activities provide opportunities to socialise either directly (e.g. visits, volunteering, holidays) or indirectly (e.g. attending events, shopping). A Dutch study evaluating the relationship between leisure activities (e.g. voluntary work, holiday, hobbies, cultural activities) and social connectedness found that participation in leisure activities successfully reduced social isolation in older people. Additionally, greater involvement in leisure activities was associated with better physical and psychological health in later life (Chang et al., 2015).

Such evidence is crucial in developing initiatives to increase social connectedness and consequently, improved quality of life for older people. Peer-support groups have shown promise in this regard. A US-based peer-support intervention paired older adults with other older adults to meet once a week for 10 weeks to establish and work towards setting goals such as improving self-care, engaging family and friends, and developing problem-solving skills (Chapin et al., 2013). At the end of the 10-week intervention period, participants showed significant improvement in symptoms of depression, as well as improved scores on quality of life, health and cognitive functioning indicators. Moreover, studies have found that older adults experiencing loneliness participating in peer-support groups have reported finding new friends (Routasalo et al., 2008) and show improved cognition (Pitkala et al., 2011).

A UK inquiry into mental health and wellbeing in later life (Age UK, 2009) highlighted the value of peer support in the maintenance of wellbeing in older age, recommending that more emphasis be put on the promotion of peer-support and community initiatives whereby older people are enabled to help both themselves and each other. A Bristol-based community initiative known as ACE (Active, Connected, Engaged) employed older volunteers to support

socially isolated older peers (60 years old and over) by increasing trips out of the house and facilitate participation in community activities and groups. An evaluation of the initiative revealed that older people who attended community-based activities as well as the older volunteers, valued the increased chance to leave the house, have something new to do, and meet new people (Withall, 2016).

Whilst residential care settings provide programmes to address psychosocial needs of residents such as gatherings and group activities, evidence suggests that older people living in residential care experience loneliness far greater than those living in the community (Savikko et al., 2005; Theurer et al., 2015). Many residents report having trouble maintaining meaningful social relationships, as well as experiencing increased challenges in communication due to complex health conditions such as dementia and speech impairments (Cipriani et al., 2006; Alzheimer's Disease International, 2013). Theurer et al. (2015) suggest a Resident Engagement and Peer Support (REAP) model, whereby group activities in residential care are developed based on resident needs, and the likelihood that these activities will foster relationships and be sustained.

Dementia peer-support groups in extra care housing reported a positive impact on wellbeing, social connectedness and practical coping strategies in day-to-day activities (Chakkalackal & Kalathil, 2014). Participants also reported improved communication skills and management of their memory problems. Moreover, housing staff and volunteers valued the benefits of the peer-support group for those attending and their families, reporting that attendees enjoyed the sense of involvement, whilst family members were encouraged by the resources available to their loved ones in the housing schemes.

1.3. Present study

1.31 Background on Standing Together

Following the successful outcome of our previous peer support groups within extra care settings for individuals living with dementia on reducing self-reported loneliness and social isolation (Chakkalackal & Kalathil, 2014; Chakkalackal, 2015), there was a noticeable demand from residents who did not have dementia to attend the peer support groups. The Standing Together (ST) project is a direct response to these needs as well as the evidence base as outlined above. Standing Together aims to facilitate and provide peer support to people living in retirement or extra care housing (R/EC) as a means of reducing isolation and loneliness in later life.

1.32 Standing Together Programme

Standing Together groups were modelled on a peer support approach previously employed by Mental Health Foundation-led self-management with peer support groups for individuals with dementia (Chakkalackal & Kalathil, 2014; Chakkalackal, 2015). Each group ran once a week for six months in extra care housing schemes within Housing & Care 21 and Notting Hill Housing Trust. Each group was led by two trained facilitators to ensure that enough

support was available for participants. Participation in the group was voluntary and comprised individuals living in the housing schemes who expressed interest in attending. However, isolated people were also actively encouraged to join the groups, often through visiting their apartments. The role of facilitators involved engaging participants in discussions to share opinions, ideas and past experiences mutual among members. Moreover, facilitators organised weekly activities designed to increase meaningful participation and aid cognitive stimulation, focusing on the participants' identity and their passions. Activities could include be a film quiz or discussing as a peer group what are the practical things people do if they are having a difficult day.

1.33 Evaluation of the Standing Together Programme

The present study aimed to evaluate the impact of the Standing Together peer support groups on participants' emotional and social wellbeing in extra care settings. The evaluation assessed whether participation in Standing Together had an effect on the following outcomes:

- Reduced loneliness and social isolation by increasing social interaction and networks
- Improved emotional wellbeing
- Increased level of meaningful activity, sense of purpose and community engagement

Furthermore, the evaluation reviewed the sustainability of the groups and whether they became an essential part of the housing schemes following completion of the project. In addition, a process evaluation was included to assess factors related to implementation of the groups.

2. Methods

2.1. Present study

2.11 Selection of participants

Following a piloted evaluation focusing specifically on residents with dementia, participants for this analysis were pre-selected by group facilitators. Programme facilitators sought to include all residents from the extra care housing group including individuals with mental health difficulties, dementia, learning disability and/or significant loneliness. Facilitators met with all court managers prior to the start of the programme to communicate the group's objectives and emphasise the importance of the peer support programme for their intended audience. While the programme sought to include residents experiencing loneliness or cognitive impairments, the programme did not uphold strict inclusion criteria for participation, for instance, facilitators and court staff distributed flyers to resident flats with information about the group.

2.12 Ethics

Participation in the evaluation was voluntary. All participants where the group facilitator did not highlight concern about consent were deemed to be able and capable to provide consent. Information sheets and consent forms were provided by the researcher prior to participation.

2.13 Design & procedure

The evaluation of the outcomes is based on a mixed-methods design whereby both quantitative and qualitative data were collected. The evaluation was conducted in four cohorts taking place between 2015-2017. Each cohort, where the evaluation took place, included 3-5 groups (See Table 1). Following from low numbers of engagement in the evaluation in the first year of the group, a change from a largely quantitative assessment of outcomes (i.e. use of standardised measures) to a more qualitative approach was employed.

Cohort	Method of assessment	Number of groups
1	Quant	4
2	Quant & Qual	3
3	Qual	5
4	Qual	3

Table 1
Method of Assessment and Number of Groups per Cohort

The revised qualitative evaluation was designed as an observational study of aggregate group change on assessed evaluation outcomes compared to previous assessment recording differences at an individual level. Staff assessments of group outcomes were also collected from each housing scheme. All participants were assigned an individual participant code to protect their anonymity. All data were stored in accordance with the Data Protection Act 1998.

2.14 Quantitative

Quantitative data were collected at two points: baseline (T1) and 6 months (T2), via in-person sessions or over the telephone. These included measures on participants' mental wellbeing, as well as social and emotional wellbeing.

The following measures were included:

1. **Short Warwick-Edinburgh Mental Wellbeing Scale** (SWEMWBS; Stewart-Brown et al., 2009): A 7-item scale created based on the original 14-item Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). As a measure of positive mental wellbeing, higher scores on the SWEMWBS indicate positive wellbeing.
2. **De Jong Gierveld Loneliness Scale** (De Jong Gierveld & Tilburg, 2006): A 6-item scale for overall, emotional and social loneliness. Higher scores on overall and individual loneliness scales indicate intense loneliness. Given the distinction between emotional loneliness and social loneliness, participants were also asked to provide data for these two measures using a 0-3 scale (0-not emotionally/socially lonely; 3- intensely emotionally/socially lonely).
3. Subjective Well-being: **a 7-item scale taken from the Mirrored Core Questions for 65+ of the Big Lottery Fund Wellbeing Evaluation** (Big Lottery Fund UK, 2009). During a focus group at T1 and T2, participants engaged in an activity intended to record their subjective wellbeing using post-it notes and an adapted version of the SWEMWBS. Whilst it was not possible methodologically to summarise these findings quantitatively, we have utilised the information for the qualitative analysis section.
4. Social Connectedness: **short questions relating to contact with friends and family taken from the Mirrored Core Questions for 65+ of the Big Lottery Fund Wellbeing Evaluation** (Big Lottery Fund UK, 2009).

2.15 Qualitative

The methodological shift began half way through year two of the programme, at which point cohorts one and two had completed quantitative evaluations, and prior to the start of cohort three. Qualitative data were collected via focus groups held at two time points, with baseline data collected in weeks 2-3 to enable participants to have an introduction to the groups and a sense of what the groups were about before taking part in the evaluation. Qualitative data were also collected after 3 months (approximately the half-way point of groups running; T2). With this, a total of eight focus groups were held at baseline and 10 were held during the follow-up period including the two evaluations from cohort two. Focus group interview schedules were developed for baseline and follow-up which addressed the aims

of the evaluation (see Appendix 2). Focus group discussions were facilitated by two researchers trained in facilitating groups and ran for approximately 30-45 minutes. The end of the Standing Together group (after six months) is referred to as T3.

All focus group discussions were held on days alternative to the regularly scheduled ST group meetings. This helped distinguish the objectives of the focus groups from those of regular sessions. A group facilitator accompanied the research team to each focus group to help facilitate introductions; however, they did not attend the focus group discussions themselves. This was done to ease resident concerns over the lack of familiarity with researchers, facilitate the start of the focus groups and to provide residents with a forum for anonymous, unbiased feedback. Residents were encouraged to attend each focus group through the same methods as regular group attendance (i.e. a combination of hand delivered flyers, intercom announcements and word of mouth). All discussions were recorded and stored securely by the evaluation team. Focus group interviews were then transcribed and anonymised for analysis.

2.15-1 Staff Questionnaires
In addition to the above, monitoring information for residents attending Standing Together groups were collected by staff at each housing scheme. Data collected included: demographics, aspects around group members' physical and mental health, and perceived levels of loneliness and social support (see Appendix 1). The questionnaire was given to housing staff at two time points: baseline (T1) and at the end of the Standing Together group run (T3).

2.15-2 Process evaluation
To assess the impact, sustainability and perception of Standing Together as a mental health intervention, 15 to 20-minute semi-structured telephone interviews were conducted with seven staff members from a wide range of housing staff including housing managers, housing provider senior management staff and court-level staff (see Appendix 3). In addition, the 3 programme facilitators were interviewed after the conclusion of the ST project for their feedback on process and sustainability (see Appendix 4).

2.16 Analysis

2.16-1 Quantitative Analysis
Baseline (T1) and six-month follow up (T2) quantitative data measures on life satisfaction, subjective wellbeing, mental wellbeing, loneliness (emotional and social) and social connectedness were collected from participants. The data were analysed using a non-parametric Wilcoxon Signed-Rank test.

2.16-2 Qualitative Analysis
Eighteen focus group interview transcripts and ten process evaluation interviews transcripts were assessed using the Framework Method (Gale, 2013). Interview transcripts were systematically coded using this approach, and themes were identified both inductively, based on the content of each interview, as well as deductively, through previous literature and existing project outcomes. Researcher collaboration facilitated a critical analysis of each interview's content, discussion over deviant cases and ultimately helped to identify the underlying themes.

3. Results

3.1. Participant characteristics

Characteristics of participants who attended groups in cohorts 3 and 4 were gathered from staff questionnaires, which provides an insight into the participants across all cohorts. According to the staff questionnaire data on participant characteristics at baseline (see Appendix 1), just over half of all group members (45, 52%) were men and 48% (42) were woman. Of these residents, 5% (4) were aged between 50-59 years, 17% (14) were between 60-69 years, 36% (30) between 70-79 years, 27% (22) between 80-89 years and 16% (13) were aged 90 years or older. Around 83% (70) of the residents were either single, separated, divorced or widowed. Over half of residents (47, 54%) were white British with 7% (6) white Irish and 13% (11) Caribbean.

At follow-up, there were more women participating (53, 57%) than men (40, 43%). Of these, only 1 participant was reported by staff members to be aged fifty or under and 4% (4) were aged between 50-59. 15% (14) of participants at follow-up were between 60-69 years, 35% (33) were between 70-79 years, 30% (28) between 80-89 years, and 14% (13) aged 90 years or older. A greater proportion of residents (86, 93%) at follow-up relative to baseline were either single, separated, divorced or widowed. Again, the majority of participants were White British (55, 59%), 19% (18) were Caribbean and 6% (6) white Irish.

3.2. Quantitative

3.2-1 Demographics

A total of 13 participants took part in the quantitative element, of which 11 were female and 2 were male. The mean age of participants was 75 years old. Over three-quarters (77%) were White British; 15% were Black-African and 8% were Irish.

3.2-2 Life satisfaction

Life satisfaction of participants was measured using a 0-10 scale (0-extremely dissatisfied; 10- extremely satisfied). Though the mean score of participants' life satisfaction appeared to increase from 5.50 at T1 and 6.00 at T2, the change was not statistically significant ($Z=-.816$; $p = .414$).

3.2-3 Loneliness

Participant responses on the De Jong Gierveld Loneliness Scale (De Jong Gierveld & Tilburg, 2006) found that the mean participant at score at T1 was 2.25 and at T2 was 3.08; however, this difference was not statistically significant ($Z=.905$; $p=.365$).

The emotional loneliness measure, though not statistically significant, was close to achieving significance ($Z=-1.897$; $p=0.058$) and actually indicated that participants felt more emotionally lonely in T2 (2.25) compared to T1 (.92). This is a surprising finding and, though not significant, warrants further investigation. As discussed previously, this result may have been

negatively influenced by the timing of the T2 scores, which occurred at a time when the groups were coming to an end, thus some residents were likely feeling disappointed. There may also be underlying factors which contributed to the result, such as seasonal changes, changes within the housing scheme etc. A slight increase in the mean participant scores of social loneliness was witnessed in T2 (1.33) compared to T1 (1.54), though this was a non-significant difference (Z=-.549; p-.583).

3.2-4 Wellbeing

Mean participant mental wellbeing scores indicated a small increase in T2 (21.84) compared to T1 (21.52), though this finding was not statistically significant (Z=.549; p=.583).

3.2-5 Social Connectedness

Participants were asked short questions relating to contact with friends and family from the Mirrored Core Questions for 65+ of the Big Lottery Fund Wellbeing Evaluation (Big Lottery Fund UK, 2009). The mean score across participants was slightly higher in T1 compared to T2, indicating higher social connectedness at baseline; however, this difference was not statistically significant (Z=-.103; p=.918).

3.2-6 Summary of results

In summary, non-significant differences were found across participants' measures (p>0.050), thus, on the basis of just the quantitative analysis, we cannot conclude that the evaluation had any impact on participants in these five areas. One housing scheme staff member was able to provide some narrative around why these results may have occurred, stating that the timing of collecting participant scores might have been problematic. Given that T2 scores were collected at a time when the groups were coming to a close, the scores may have been influenced by the fact that residents were feeling quite low about this ending. Indeed, participants often asked why the groups had stopped running and expressed desire for them to continue.

3.3. Qualitative – Focus Groups

3.3-1 Participants in the focus groups

A total of 45 residents participated in the evaluation at baseline, of which 21 were male and 24 were female ranging from age 50-90+. A total of 57 participants were present at follow-up, 38 of whom were women and 19 were men also ranging in ages 50-90+ (see Appendix 1 for complete participant characteristics for participants who consented). All participants had attended the Standing Together group on at least one occasion prior to evaluation.

3.3-2 Learning about the groups

Most residents found out about the groups either through staff notifying them in person or via the noticeboards. More often, though, the staff would physically bring participants to the group. The next most common way for residents to become aware of the group was through the Mental Health Foundation (MHF) facilitator. Residents also told each other about the group and several residents joined in the starting group after passing by. Most attendees were those who had been identified by staff and encouraged to attend.

3.3-3 Loneliness and social isolation

This included assessment of the following:

- Participants report considering other group members as new friends.
- Participants attending groups report an improved sense of social connectivity.
- Participants report a reduction in feeling lonely.

The most common expectation residents mentioned for attending the groups was to have more social contact and camaraderie. They expected to foster stronger interpersonal relationships. Some indicated they had been lonely and hoped the groups would allow them to meet new people and to get to know the other residents. They hoped the groups would therefore be a good way to avoid isolation and to spend less time alone.

Residents also indicated they were hoping to stay mentally sharp. They appreciated activities that were engaging, dynamic and stimulating and held their interest. Some residents were motivated by curiosity to attend and wanted to *'figure out and see'* what the groups entailed. The promise of discussion and activities attracted participation. Residents were also hoping to gain relief from things that were on their minds. They expressed the importance of feeling part of a community and found the groups to be inclusive and sincere. Overall, attending the group provided an opportunity for social connections.

'It is much nicer to be with people, it is a good thing to come outside your flat and to meet with other people I think'

Residents tended to gauge their loneliness through how much contact they have with other people. They did report spending a lot of time alone and feeling isolated.

'I enjoy it actually, I had never had groups before but I like this, I enjoy this, coming down here, talking to the people and that because I have always been a loner'

Coming to the group helped residents feel less lonely. For some, this represented a new experience of belonging to a group where they felt included and supported:

'All I needed was people to like you to come together and to instead of pass me by and stop and chat and involve me. That is all I wanted really you know'

The majority of residents reported an improved sense of social connectivity after attending the group. They appreciated the attention from others, being around people who care about them, being socially connected and having a sense of belonging,

'I like being with people'
'I thrive on social contact'

A few residents highlighted the importance of appreciating each individual's different life experiences, mentioning that they would like to be involved in each other's life more, whilst acknowledging that *'it is very easy to be cut off because everyone is so busy now with their own lives'*.

Many also considered other group members to be new friends which indicates a reduction in their social

isolation. The groups facilitated deeper knowledge of each other and allowed residents to feel connected through their commonalities. Residents varied in terms of their feeling of connectedness prior to joining the group. Whilst several already experienced an element of closeness and a familial-type bond, others did not and found the groups to be an opportunity to increase socialisation. Attending the groups enabled residents to make new friends and provided a space in which they could share information and conversations. Residents were also positive about the age range of the group, which facilitated this sense of closeness in the groups, allowing residents to fully connect with their peers.

Some residents made the distinction between being isolated and lonely. Whilst isolation refers to feeling cut off from other people or your environment, loneliness relates to a level of distress at feeling disconnected. Though residents of the group appreciated the company of others, this served to reduce feelings of isolation but did not counter loneliness if they were missing family or a partner:

'Well I only feel good when I have seen the children'

Though most residents felt that the groups were a good opportunity to develop connections with peers, some expressed that the groups did not foster new social connections but rather, provided entertainment:

'We see a lot of each other anyway, it is the same faces'

A group of residents, who considered themselves lonely because they missed family, found that moving from their own house to court life helped to reduce their isolation. Among almost all residents, contact with others decreased feelings of loneliness and isolation, which were expressed by one resident as problems *'to mend'*. The residents that were physically active were also able to maintain social connections outside the home. Loneliness was found to be influenced by a lack of mobility and the availability of carers; if no carers were available to take residents out, residents described themselves as being *'stuck here'*:

'It can make you feel a little bit lonely when you don't have someone to take you out'

A number of residents rejected the notion that they may feel lonely or have felt lonely in the past. Some residents also mentioned having good friends helps to combat loneliness, whereas others expressed that they did not mind being on their own. One group was very focused on their own living spaces, for example, several residents expressed comfort in looking after their own place and cooking for themselves.

In conclusion, most residents agreed that the group helped them combat loneliness. They felt more socially connected and viewed the groups as an opportunity to make new friends, which fostered a sense of belonging.

3.3-4 Wellbeing

The majority of residents were very positive about the MHF facilitators, and

expressed that the facilitators' kindness and personal qualities increased their own enjoyment in attending the groups.

'They were absolutely wonderful people'

Group aggregate wellbeing was creatively assessed within the framework of the two focus group discussions. In terms of improved emotional wellbeing, most of the residents agreed that the group helped with loneliness and overall mood. They expressed that the groups were good for their wellbeing.

'It lifts your spirits, you can have a laugh'

They mentioned the positive feelings resulting from having a safe forum in which they were able to share feelings. Some experienced feelings of happiness by attending the groups; residents generally found the groups to be motivating and enjoyable, as evidenced by the consistent attendance rates.

During the groups, the topic of improving from illness was raised by some residents. They discussed the relativity of wellbeing and health, and the positive wellbeing scores of these residents highlights the benefits of discussion and sharing experiences. Wellbeing was understood by some to be a measure of physical health, with physical ailments such as anaemia and sleep problems leading to poor levels of wellbeing among residents.

In summary, most residents agreed that joining the groups improved their emotional wellbeing. They looked forward to it and tried to attend the groups as often as possible. The kindness and personal qualities of the facilitators positively impacted the residents' enjoyment of the groups. Wellbeing was understood differently by residents, with some taking it as a measure of physical health.

3.3-5 Meaningful activities

This assessed the following:

- People report a greater confidence and sense of self, which supports them to do new activities.
- People report being better able to overcome barriers to participation, such as incontinence, hearing loss and mobility problems.
- People report learning coping strategies that help them communicate better and more widely.

Not everyone was convinced about the groups at baseline; some were uncertain, sceptical and even apprehensive:

'Once you start doing it properly we will know more won't we, what it all involves won't we'

A few residents expected the group to be boring but once they attended, they grew familiar to the concept and 'got used to it'. One barrier that emerged was the varying level of motivation among residents in relation to the group activities, which some found repetitive, and group discussions. Some appreciated the range of activities on offer; others were content with the activities that they had.

'The more activities the better even if they are repetitive'

Residents that desired more activities mainly mentioned that they would like to go outside, maintain social connections and be physical active. They would also want to be inspired to do other things.

There was a remaining group of able-bodied people who still did not attend, and some residents expressed disappointment that not everyone shared their desire to engage in the community setting. Some residents had reduced cognitive function. In some cases, they were not aware of the group or wanted to leave the group and go home. Residents also mentioned challenges with being resettled and various life changes associated with older age. There were some individuals who did not get on with other court members and consequently, did not want to join the group.

The most common barriers to attendance were conflicting commitments and physical limitations. Some members participated in other weekly or monthly groups. The fact that the group was held in-house was an advantage to residents reliant on caregivers or family. Those residents who were physically able were also active in other groups both inside and outside the house. Some people who were limited physically but cognitively strong reported a desire to be kept mentally stimulated.

'I hope some people can fire their imagination a bit because there is so many things you could do to make life interesting, which is so close to, all of them you could do'

At follow-up, residents frequently mentioned their general enjoyment and feelings of happiness when attending the groups. Some were curious at the beginning, attended by chance, or were bored and motivated to engage in something new. Standing Together was experienced as being different to other groups, such as coffee mornings, as they provided a mutual learning environment which was beneficial for all and allowed the discussion of new, stimulating ideas. Quizzes were prominent activities in the groups, as well as other team and group activities. The residents expressed the value in Standing Together's varied approach to activities; it ensured that things were kept interesting and helped to break up monotony.

'It is you learn something and we learn something'

Residents felt safe to share their feelings and experienced the groups as an opportunity to express themselves through conversation. They also stated they enjoyed that facilitators encouraged them to reminisce.

'Because people are non-critical it helps let you let down your guard'

They emphatically expressed enjoyment of being surrounded by others with whom they could have a laugh and joke. They enjoyed the activities, desired more and had hopes that the groups would continue. Most residents said that they would encourage others to join the group, with one resident emphasising that everyone could benefit from attending:

'It is good for everyone, everywhere'

3.4. Qualitative - Process Evaluation

A process evaluation was incorporated into the evaluation approach to understand: i) the process of embedding groups within extra care settings, and ii) staff perception of the peer support groups as a mental health and wellbeing intervention. Seven members of staff from the Housing & Care 21 (H&C21) and Notting Hill Housing Trust (NHHT) including commercial managers, court leaders and strategic engagement managers participated in the process evaluation interviews.

3.4-1 Loneliness and social isolation

According to staff from all levels of involvement, the ST groups successfully addressed and showed marked improvements for all the outcomes set forth by the programme including reduced feelings of loneliness or isolation, increased companionship, mental stimulation and social inclusion. The group's ability to create a space where residents felt *'seen'* or *'acknowledged'* drew interest and helped maintain engagement:

'[It provided] an opportunity to figure out what they share with other people in their community, and I think that helps sort of shore up their sense of place, particularly at a time when, you know, a lot of people when they move into particularly extra care, and sometimes retirement, it can be quite disorienting'

The emphasis on confidentiality and the establishment of a safe environment helped ease uncertainties among residents around engaging in discussions with new acquaintances. However, wariness among staff members around using the term *'mental health'* to explain the purpose of the group was observed as a potential source of deterrence or hesitation among residents:

'The phrase mental health can throw up a red flag for people sometimes, and so I think sometimes when we use that phrase, even though we would always try and like talk through our particular view of mental health, it still... it made some other people uncomfortable'

Staff expectations about resident interest in the programme and attendance levels were exceeded, as evidenced by the number of residents known to exhibit antisocial or reclusive behaviours who attended the groups regularly.

'Sometimes I couldn't believe it when I went downstairs and I would see the attendance was really not what I expected'

Many of the observing staff members attributed the level of interest in the group to its emotional wellbeing benefits including feeling a sense of *'togetherness'*, *'safety'* and *'belonging'*. Emphasis on the importance of consistency when running the groups, both regarding timing of each session and consistency among facilitators, across all sessions was expressed. Reliability and continuity helped facilitate attendance as previous groups have failed due to lack of continued support leading to the disappointment of court members.

'People were really positive about it and said how much of a difference it makes to their week and it breaks the week up and they look forward to it and their routine and consistency'

3.4-2 Wellbeing

Mental and physical capacity is a challenge inherent to this population and may affect the stability and maintenance of the groups over time. All staff expressed the importance of group facilitators remaining both aware and sensitive to the physical and cognitive impairments of group members. While some members may experience physical impairments like hearing or sight, cognitive impairments including memory and communication barriers often inhibited group interactions. Such impairments may also impact on attendance as many court residents were reliant on care workers to physically get from their flats to the group:

'People have their care delivered in time slots and they may not necessarily have the support at the time which is needed for them to come out of their room'

One facilitator noted that *'what we actually found is that a big part of the job was to actually get the people into the space, support people out of their flats... that seemed to make the biggest difference and the change of scenery for people'*.

Successful management of group disturbances by facilitators, particularly among participants seen as disruptive or aggressive, helped keep the groups moving successfully and *'to ease the situation'*. Sensitivity to individual differences, when possible, helped increase inclusion and encourage participation:

'The woman had really advanced dementia and could not necessarily answer questions or understand what we were saying but we found by coincidence, that she could read...so we started bringing in a white board and we would write when we did a warm up'

One facilitator also emphasised the importance of using tact when encouraging resident involvement by balancing persistence with respect for individual desires:

'I think it's paramount to respect people's ability to be like 'no'... the way we tried to deal with that was just to leave the invitation open and just sort of re-engage with people... and for a few people I think toward the end they would kind of, they were like 'ok I'll come''

Overall the general objectives of the group including combatting isolation and loneliness and improving emotional wellbeing were expressed as being met, with the groups making a huge positive contribution to mental wellbeing:

'And just having that sort of stimulation and contact I think it has been really positive'

A wide range of staff were represented in the process evaluation, providing a rich holistic perspective on the functionality and sustainability of the ST groups. Future efforts to promote sustainability, given the possible damaging effects to residents of losing support that was once

provided, are particularly important to consider.

'Downside is that people have this place, this space where they felt, I think, quite seen, and acknowledged, and like... and that was good for them, but then we... there came a time when we had to withdraw, and that was... and I think that felt like a loss to people'

Partnerships and funding are being set up to replicate Standing Together in other parts of the UK. Efforts will be made to establish community engagement posts focusing specifically on sustainability to strive to prevent such feelings of loss.

3.4-3 Sustainability

Throughout the project, ST groups ran in 19 schemes, 10 of which were able to sustain themselves following the conclusion of the initial programme. Three groups ran with paid staff, one with a volunteer and one was facilitated by residents. In another scheme, residents continue to meet but very informally. It was observed by facilitators that sustaining groups has been a challenging part of this project, despite the help from some *'fantastic volunteers'*.

To sustain the groups, each court requires funding and volunteers, both of which are limited in availability. While volunteer programmes in NHHT are currently running for extra care housing, lack of consistency and high turnover of volunteers challenges the sustainability of the programme. One staff member emphasised that the success of the group *'is very dependent on the quality of the skills of the volunteer'*, specifically that facilitators with strong interpersonal skills encourage attendance, increase comfort and foster feelings of a safe environment.

In terms of funding, one of the housing scheme managers observed that *'what is provided to one court within a housing scheme must be offered to all'*. This significantly impacts the feasibility of funding such programmes and highlights the need for volunteers to help sustain them. One commercial manager suggested that the volunteer model is in fact preferred for the sake of sustainability in the long term and a possible remedy to funding limitations. It was also recommended that all court staff increase their exposure to the group to help spread awareness and encourage skills like active listening and reflection when interacting with residents, particularly those with dementia.

Additional factors facilitating successful implementation of the groups included efficient communication, effective collaboration and strong facilitators. The majority of staff felt that there was strong communication from the ST facilitators prior to the start of the programme, who provided insights into the process of the group, programme objectives and outcome measures, all of which facilitated a smooth process throughout.

Facilitator personality and demeanour was also identified as influential to group interest and the success of groups over time, with many staff members positively remarking on the *'patience'* and *'professionalism'* of the group facilitators.

One staff member reflected on their experience working with facilitators: *'[they] treated court members in a very special unique way…the quality of life improved because of that.'*

A facilitator reflected on their own experience of running the groups, stating that: *'it's not so much what people remember because they will not necessarily remember having met you, but it is how you make people feel.'* Multidisciplinary efforts among the court staff and group facilitators, with most staff listing *'collaboration'* as a success factor, underlies the functionality of each group.

'There has also been ongoing contact and communication and I think it is really key to have that'

Appointment of a designated court staff member to facilitate the group on the court's behalf, with such staff members also helping to maintain clear communication regarding timing and frequency of each session, was a consistent recommendation. The use of court staff also reportedly provided insights and understanding into individual patient needs and limitations, as they work with the residents on a daily basis.

3.5. Limitations

3.5-1 Limitations of the quantitative element

A number of methodological issues emerged during the data collection phase, which are worth noting as they may have had some impact on the final results. Where data were obtained via the telephone, there were sometimes difficulties regarding hearing and in some cases, obtaining contact numbers from each member. In addition, it was not always possible to meet with participants, even during site visits, and time schedules were not always adhered to, meaning that follow-up visits could be conducted significantly later than the initial scheduled date. The age of the participants, and the fact that some had cognitive impairments or learning difficulties, added a further complication to the collecting quantitative data from participants, as some may have found it challenging to complete a lengthy quantitative questionnaire.

3.5-2 Limitations of the qualitative element

In several focus group recordings, there were some sections which could not be accurately transcribed due to audio issues, which may mean that valuable insights were missed in the analysis. Focus groups require structure and a number of challenges arose in conducting focus groups, specifically in relation to this population. These included: difficulties around effectively involving participants with hearing problems in the groups; questions from facilitators which could be considered as leading, and the potential issue of groupthink. Whilst it was not possible within the scope of this project, we suggest in future that may benefit from understanding the effect of the group on the individual.

In addition, it would be valuable to gain further information about residents, specifically how long each resident has been in the court, if they are just adjusting or been there a long time already.

4. Concluding thoughts

We have identified a number of recommendations for conducting future evaluations of Standing Together or similar programmes, which will be published academically and shared on the Foundation's website separately to this report.

Finally, it is important to acknowledge that Standing Together had positive effects on participants, which could be attributed to the programme's focus on co-production. The fact that there were two facilitators in each group really allowed them to *'listen completely'* to all residents, which is particularly valuable as 1.9 million older people often feel ignored or invisible (Age UK, 2017). Given that older people in residential care report feeling more lonely than those in the community (Bolton, 2012), programmes like Standing Together have a real potential to promote higher levels of connectedness and belonging among participants, thus alleviating feelings of loneliness. However, further evaluations incorporating the recommendations identified from this study are required to fully establish the programme's effectiveness, strengthen evidence and identify mechanisms of change.

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Appendix 1: Complete participant characteristics

Table 1: *Characteristics of Group Members at Baseline (T1)*

		Total (%)
Gender	Men Women	52 48
Age	<50 50-59 60-69 70-79 80-89 < 90	0 5 17 36 27 16
Marital Status	Single Long term relationship Married Separated Divorced Widowed Same-sex Separated same-sex Legally dissolved same-sex Surviving partner same-sex Prefers not to say	31 0 13 2 16 35 0 1 0 0 1
Sexual Orientation	Straight Homosexual Bisexual Other Prefers not to say	80 1 0 0 18
Ethnicity	White British White Irish White Gypsy White Other Mixed White Black Caribbean Mixed White Black African Mixed White Asian Mixed other African Caribbean Black African Caribbean Other Asian Indian Asian Pakistani Asian Bangladeshi Asian Chinese Asian Other Arab Other Prefers not to say	54 7 0 5 3 0 3 0 5 13 3 3 0 0 1 0 0 2 0

		Total (%) cont.
Number of care hours	Low: <5 hours (basic care needs) Medium: 5-15 hours (low-level care needs) High: 15-26+ hours (intermediate care needs)	41 34 25
Depression	Suspected Diagnosed NA	25 14 61
Anxiety	Suspected Diagnosed NA	19 15 66
Visitors	Daily Weekly Monthly Once every few months Few times per year Not at all	11 39 22 7 8 13
Loneliness	Acute Chronic NA	35 16 48
Activities inside the home	Two or more times a week Once a week Fortnightly Monthly Not at all	64 31 1 3 1
Activities outside the home	Two or more times a week Once a week Fortnightly Monthly Not at all	29 24 5 8 35

Table 2: *Characteristics of Group Members at Follow-up (T2)*

		Total (%)
Gender	Men Women	43 57
Age	<50 50-59 60-69 70-79 80-89 < 90 Prefers not to say	1 4 15 35 30 14 0
Marital Status	Single Long term relationship Married Separated Divorced Widowed Same-sex Separated same-sex Legally dissolved same-sex Surviving partner same-sex Prefers not to say	40 2 3 9 18 26 0 0 0 0 2
Sexual Orientation	Straight Homosexual Bisexual Other Prefers not to say	76 1 0 0 23
Ethnicity	White British White Irish White Gypsy White Other Mixed White Black Caribbean Mixed White Black African Mixed White Asian Mixed other African Caribbean Black African Caribbean Other Asian Indian Asian Pakistani Asian Bangladeshi Asian Chinese Asian Other Arab Other Prefers not to say	59 6 0 2 2 0 2 2 2 19 0 3 0 0 0 0 1 0 0

		Total (%) cont.
Number of care hours	Low: <5 hours (basic care needs) Medium: 5-15 hours (low-level care needs) High: 15-26+ hours (intermediate care needs)	26 36 38
Depression	Suspected Diagnosed NA	20 17 62
Anxiety	Suspected Diagnosed NA	29 11 60
Visitors	Daily Weekly Monthly Once every few months Few times per year Not at all	11 49 18 6 5 10
Loneliness	Acute Chronic NA	14 32 54
Activities inside the home	Two or more times a week Once a week Fortnightly Monthly Not at all	55 30 5 4 5
Activities outside the home	Two or more times a week Once a week Fortnightly Monthly Not at all	24 13 9 17 37

Appendix 2: Focus groups interviews baseline and follow-up

Standing Together Evaluation

Focus group 1

Introduction

- Welcome and Greetings, thanking group for their time
- Introducing members of evaluation team, explaining purpose of focus group
- "We want all participants to feel comfortable, and hope you each will share your views but should you wish to not answer a question or feel you would like to withdraw from the group discussion at any point, please feel free to do so. However, we encourage for everyone to take part."
- "Please speak clearly when answering questions. And let one person speak at a time. We will do our best to give everyone a chance to speak, but not all participants may be able to answer every question due to time allowance. However, we do ask that you do not interrupt or disagree with others whilst they are speaking. "
- Emphasise that confidentiality will be maintained. Ask if group members are OK to have the discussion recorded.
- Before beginning the discussion, we need to obtain consent (take consent)
- Ask each member of the group to introduce themselves (first names only are fine)

Questions

1. How did you first hear about Standing Together groups and what made you want to attend?
2. [Define peer support group] Have you previously attended a peer support group?
3. What do you hope you might gain from participating?

   [Prompt: Do you feel the groups help with:
   Feeling less lonely? A little or a lot?
   Making new friends? A little or a lot?
   Doing more/new activities? A little or a lot?
   Having more social support? A little or a lot?] [Define social support]

****Wellbeing and loneliness activity here****

4. How many people do activities inside/outside the home? If so, what kind of activities? How often?
5. Is there anything that may make it difficult for you to attend the group? [Prompt with examples if needed]
6. Do you have any other comments regarding your expectations of the group/experience of the group so far?
7. Summary: "The key points I'm taking away../My understanding is that... Does anyone have anything else to add?"

Thank you for your time and participating in the discussion!

Standing Together Evaluation

Focus group 2: 3-month follow-up

Introduction

- Welcome and Greetings, thanking group for their time
- Introducing members of evaluation team, explaining purpose of focus group
- "We want all participants to feel comfortable, and hope you each will share your views but should you wish to not answer a question or feel you would like to withdraw from the group discussion at any point, please feel free to do so. However, we encourage for everyone to take part."
- "Please speak clearly when answering questions. And let one person speak at a time. We will do our best to give everyone a chance to speak, but not all participants may be able to answer every question due to time allowance. However, we do ask that you do not interrupt or disagree with others whilst they are speaking. "
- Emphasise that confidentiality will be maintained. Ask if group members are OK to have the discussion recorded.
- Before beginning the discussion, we need to obtain consent (take consent)
- Ask each member of the group to introduce themselves (first names only are fine)

Questions

1. How would you describe your overall experience? What things did you like/dislike about the group, anything you'd like to stay the same/ change? [You may want to mention some of the activities Ben has said the group has done]
2. Do you think by attending the group, you met new people or became closer to other residents you already knew? Do you think the group helps people feel less lonely? If yes, how? If no, why not?[Outcome 1]
3. Did attending the group allow you to do new activities that you would not have otherwise done? [Prompt with activities relayed by Ben]. Did this push you to do things outside of the group? [Outcome 3]

****Wellbeing and loneliness activity here****

4. Do you think by attending the group, it improved your everyday wellbeing – mood, optimism, coping ability? [Outcome 2]
5. Would you encourage others to participate in the groups? Why/why not?
6. Summary: "The key points I'm taking away../My understanding is that... Does anyone have anything else to add?"

Thank you for your time and participating in the discussion!

Appendix 3: Staff Survey

Standing Together Peer Support Group

Staff Survey

We would like to invite you to participate in the evaluation of Standing Together. We are interested in hearing from staff from the housing providers where the groups are running in order to capture views on the implementation of such groups in retirement and extra care settings. This can include any benefits, downsides or challenges experienced in setting up the groups.

The findings from the survey will be used towards the final evaluation report. All personal details from the survey will be anonymised and stored securely by the research team at the Foundation.

Please let us know if you have any other questions and we will happy to discuss these. You can contact Lauren Chakkalackal, Senior Research Officer at the Mental Health Foundation if you wish to do so. Contact details are indicated below.

Full name:
Official job title:
Brief description of your role at the housing court:

1. What is your understanding of:

Peer-support

Self-help

2. Are you familiar with peer support groups, such as Standing Together, and have you any previous experience being involved with such groups?

3. What is your understanding of the purpose of the Standing Together groups? Did you have any expectations of the group when they began?

4. Were you given enough information about the groups before they began, such as who the groups were for etc.?

5. What is the extent of your involvement with Standing Together? If you are not involved, would you like to be?

6. Were there any challenges in setting up the groups?

7. Are there any factors that might make it difficult for residents to attend the groups?

8. If any, what were benefits of the group?

9. If any, what were the downsides of the group?

10. Do you consider the groups to be useful to the mental health and wellbeing of those attending? Please indicate your reasons for your answer.

11. Are the groups currently running at Ronald Buckingham? If yes, who is running them? If not, were there any challenges in sustaining the groups?

12. Would you like to see the groups as a regular component of the care provided at Ronald Buckingham?

13. Please use the space below to add any extra comments you may have regarding the groups.

Thank you for your time!

Appendix 4: Facilitator Survey

Standing Together Peer Support Group

Facilitator Survey

Full name:
Official job title:
Brief description of your role at Standing Together project:

1. Were you familiar with peer support groups, such as Standing Together, and have you any previous experience being involved with such groups?

2. What is your understanding of the purpose of the Standing Together groups? Did you have any expectations of the group when they began?

3. Were you given enough information about the groups before they began, such as who the groups were for etc.?

4. What is the extent of your involvement with Standing Together?

5. Were there any challenges in setting up the groups?

6. Are there any factors that might make it difficult for residents to attend the groups?

7. If any, what were benefits of the group?

8. If any, what were the downsides of the group?

9. Do you consider the groups to be useful to the mental health and wellbeing of those attending? Please indicate your reasons for your answer.

10. Do you have any knowledge about continuation, if groups are currently still running? If yes, who is running them? If not, were there any challenges in sustaining the groups?

11. Would you like to see the groups as a regular component of the care provided at the courts?

12. Please use the space below to add any extra comments you may have regarding the groups.

Thank you for your time!

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