# Enabling Recovery

## The Benefits of Supporting Socialisation
### Report of a Randomised Controlled Trial

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In tribute to his contribution to mental health research,
this report is dedicated to the memory of

**Professor Eadbhard O'Callaghan**

**1957 – 2011**

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# Accessible Summary

This project set out to examine if supporting people who have difficulties socialising due to an ongoing mental health difficulty will help them to feel more a part of their community, to feel better about themselves and to reduce symptoms of their mental health condition. This research was based on a similar study undertaken in the United States by Larry Davidson and his team in 2004. People who participated in that study reported positive benefits and felt better able to socialise as a result of their participation. The study set out in this report used a randomized controlled trial method in which people taking part were randomly assigned to one of two groups: a control group and an intervention group. These people completed a number of questionnaires about socialisation, their symptoms and social networks. Everyone[1] who took part received a small amount of funding each month to contribute to social activities. In addition to the funding, those in the intervention group were also matched with a volunteer to socialise. The study took place over a period of 9 months. Everyone was asked to engage in a social activity each week for at least two hours and to keep a diary of their social activities.

Overall, the study revealed that being supported to socialise had positive benefits for all who participated in it. People increased their social activities, in particular, going for a coffee and going out to eat, going to the cinema and meeting friends. How people felt about themselves improved as did their confidence to go out and socialise more often. Symptoms of depression also decreased. Very importantly, at the end of this study people felt much less lonely, less socially isolated, more a part of their local community and had improved connections with their family and friends.

## Definitions

**Mental Health Difficulty** - the term mental health difficulty is used in this report to describe the full range of problems that might be encountered, from psychological distress to severe and persistent mental illness.

**Mental Disorders** – the term mental disorder is used in this report to refer to specific conditions such as depression, schizophrenia, and bi-polar disorder.

**Enduring, Persistent or Ongoing** – these terms are used interchangeably in this report to reflect the longer term nature of some mental health difficulties. Generally it is accepted that mental health difficulties lasting longer than one year in an adult can be classified as enduring or persistent.

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1 Volunteers did not receive any funding to socialise

**Enabling Recovery** - The Benefits of Supporting Socialisation Report of a Randomised Controlled Trial

# Acknowledgements

The authors would like to thank all the people who contributed to this study.

We extend out thanks for the contribution of two groups of volunteers who gave of their time so generously. We have, with the consent of volunteers, named those who participated in this study in the following pages. Without your contribution this study could not have happened thank you.

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Your participation has enabled us to gain new knowledge and understanding about how people who experience persistent mental health difficulties can be supported towards recovery and social inclusion. Thank you.

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# Chapter 1: Background to the Study

*At the heart of recovery process was the transformation from an illness-dominated identity to an identity of agency, competence and well-being*

**(Mancini, 2007: 50)**

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## 1.1 Introduction

Worldwide, at any given time, approximately 10% of adults are experiencing a current mental health difficulty. Over the course of a life time, 25% of the population, or 1 in 4 people, will develop a mental health difficulty (WHO, 2001). Mental disorders account for 13% of the global burden of disease and, by 2030, this figure is expected to rise to nearly 15%; by that date, depression is likely to be the second highest contributor to the global burden of disease (Mathers & Loncar, 2006). Despite the prevalence of mental health problems in society, stigma, social isolation, loneliness and reduced social integration persist among those who experience these difficulties.

The societal costs of enduring mental health problems are high; the adverse consequences pervade all aspects of life including physical health, family relationships, social networks and employment status. Most of the costs associated with mental health problems occur outside of the health sector, for example, lost employment, absenteeism and reduced productivity, and reduced contribution to society. While the economic costs can be calculated, the personal costs for the individual and families who experience persistent mental health problems are difficult to estimate.

Experiencing a persistent mental health issue can seriously disrupt a person's sense of self, that is, in terms of identity and how one relates to others and to the community. Mental health issues can also influence how others, including those personally associated with an individual such as friends and others within the wider community, perceive an individual. This fracturing of personal identity, loss of personal agency and relationships with family, friends, and community often have deep and enduring effects on all aspects of life, often spanning many years.

Local communities have a part to play in fostering and supporting positive mental health. Within mental health services, the ultimate goal of recovery is linked to community integration and the ability of people to establish and maintain meaningful, purposeful lives within their local areas through developing social networks, positive relationships and community engagement (National Economic & Social Forum [NESF], 2007). Successful recovery - depends less on the ability of mental health professionals to teach specific skills, and more on their ability to support individuals to find their place within naturally occurring communities rather than those created to deliver services.

The study reported here examined how supporting people to establish friendships and socialise within their local community can contribute to improving their social functioning and to building and extending their social networks while, simultaneously, reducing social isolation and loneliness.

## 1.2 Background to the Study

Although the vast majority of people with enduring mental health problems live, and receive treatment and care, within their local communities, few natural structures exist within communities for these individuals who, due to the combined impact of illness and stigma, experience difficulty maintaining existing friendships and relationships with family or developing new friendships. Consequently, social isolation, loneliness and stigma present significant challenges for them. While, over the past three decades, recognising the social needs of people with ongoing mental health problems has received some attention in the re-orientation of Irish

psychiatric services, these needs tend to be addressed within the formal mental health care system and, generally, fail to address the need for people to move beyond this system in order to re-integrate into wider social and community life.

For adults, friendship and social contact are established and maintained through the social roles that they occupy, for example, in education, work and leisure activities, and in intimate partnerships and parenting. The ability to engage in reciprocal exchange, that is, to contribute in an equal way, is a mechanism for forming and maintaining social relations at both the individual and the societal level. It is through social roles and relationships that social value and community inclusion are conferred. Lacking the capacity to engage in reciprocal exchange often results in marginalisation and social exclusion and this has particular relevance for people with enduring mental health problems.

In Ireland, there is evidence that reciprocal exchange is problematic for people with enduring mental health problems. Relationships within intimate partnerships for those who use Irish mental health services are a particular example and using marital status of mental health service users, as a proxy measure, clearly identifies the gulf between general population rates of marriage and rates of marriage among users of mental health services. Most recently, published data relating to marital status of Irish users of mental health services has indicated that a significant proportion of these individuals are unmarried (54.5%), widowed (4%) or divorced (4%) (Daly & Walsh, 2011). Furthermore, enduring mental health problems compromise the individual's ability to engage in normal work patterns as indicated by the high number of work days lost, high rates of unemployment and early retirement among people with mental health problems (Buxton *et al.*,

2005). Along with the absence of purposeful and meaningful occupation, restricted work patterns further reduce the opportunities for those with enduring mental health problems to engage in meaningful and supportive friendships and to establish and/ or maintain social networks.

## 1.3 Social Exclusion and Stigma

Social exclusion is a term of relatively recent origin which is often used to refer to individuals or groups within society who, for a variety of reasons, are unable to participate in key areas of the economic, cultural, political and social life of society. People with mental illness often report that they feel excluded from general society. Recovery and rehabilitation from mental health problems is complex; the well-being of people with mental health difficulties is profoundly affected by the attitudes and opportunities that surround them. Mental illness is still seen by many as a target for ridicule and is often misrepresented in all forms of media. Stigma has been identified as a major barrier to people with mental illness being successfully employed and as a factor that hinders friendships and family relationships. In recent years, particular psychiatric terms have become embedded in vernacular language. The use of these terms, such as schizophrenic and psychotic, and, importantly, their use as labels to signify fear, unpredictability and violence, has far-reaching consequences. The social labels that contribute to stigmatising an individual effectively separate 'us' from 'them' and emphasise the differences and 'social distance' between two groups of people.

The relationships between persistent or enduring mental health problems, social exclusion and stigma are complex, with many elements including housing issues, low income, unemployment and restricted social networks being both a cause and

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a consequence of living with persistent mental health difficulties (Repper & Perkins, 2003; Prince & Gerber, 2005).

### 1.3.1 Stigma

One of the most recognised barriers to participation and inclusion for people with mental health difficulties is the stigma associated with their conditions. While comparatively little is known about the experience of stigma and discrimination from the perspective of individuals with persistent mental health problems (Gonzales-Torres *et al.*, 2007), many experience stigma, and the results of this experience is almost unanimously negative. Stigma is considered to act in two ways, directly to exclude individuals with mental health difficulties from areas of participation, including work, education, travel and decent living conditions; and indirectly, with those experiencing mental health difficulties internalising wider societal attitudes resulting in self- stigmatisation. The outcomes of both processes of stigmatisation are perceived powerlessness, lack of control and loss of hope; lower self-esteem, social isolation and exclusion, depression and anxiety (Boardman, 2011; Mental Health Foundation [MHF], 2000). Stigma and discrimination are closely linked to social exclusion and the resultant marginalisation from wider society is both a cause of stigma and a result of it. The outcome is often a spiral of loneliness and lack of opportunity that people experiencing the impact of enduring mental health problems must struggle with, alongside the symptoms and other consequences of their mental health difficulty.

For many individuals with an enduring mental health problem, the source of discrimination comes from those close to them, including family and friends. Discrimination is often related to stereotypes and prejudicial notions about mental illness, such as being wilful, lazy, lacking in moral character and dangerousness. In addition, discrimination is experienced when interacting with health professionals including general practitioners, doctors, nurses and other related professional groups. Other sources of stigma and discrimination include employers, landlords, and insurance companies. Thus, the effects of stigma and discrimination work almost like a second illness (Gonzales-Torres *et al.*, 2007). The emotion of shame, a common response to stigma, leads to secrecy which, itself, is an obstacle to seeking assistance with mental health difficulties, treatment and recovery. Thus, stigma can act as a direct impediment to recovery.

For the person experiencing on-going mental health problems, the importance of acceptance by others, and by society, can be seen as vitally important. The support of friends and family is an integral part in providing the social and emotional support needed to combat the stigma which can be directed at individuals.

### 1.3.2 Social Isolation

A key consequence of stigma is the social distance that it creates between the general public and those with enduring mental health difficulties. Often, stigma and discrimination result in individuals concealing their difficulties and becoming isolated (Gonzales-Torres *et al.*, 2007). The creation of social distance and the resultant isolation and concealment is influenced by two prejudicial types – authoritarianism and benevolence (Corrigan *et al.*, 2001). Authoritarianism assumes that obedience to authority is critical in society, and that people who have on-going mental health difficulties are somehow inferior and require coercion in order to obey authority. In contrast, benevolence takes a kindly,

paternalistic view, leading to over-protection or an inability to allow people with mental health difficulties to make decisions or experience mistakes and successes. The stereotypes created by these polar forms of behaviour can be quite powerful. Even though the therapeutic value of meaningful activities, such as work, being a friend, a parent or taking on a responsible role in society, is now recognised and included in treatment; those who are socially excluded are unlikely to experience the benefits of such activities and opportunities (Mowbray *et al.*, 2005). The combined effects of experiencing persistent mental health difficulties, and the resultant stigma and discrimination, can result in marginalisation from many aspects of society. People in this situation have difficulty in obtaining employment, face obstacles to participating in community life, find it difficult to find affordable and appropriate housing, face financial and legal obstacles and also may find transport issues hard to overcome. Although these aspects of community life are intrinsic to social inclusion, frequently, they are not accessible in any meaningful form for those with on-going mental health difficulties (Lloyd *et al.*, 2006).

In addition to the psychological and social impact of stigma and discrimination, social exclusion is recognised as an important determinant of physical health and this is of particular importance for people with enduring mental health problems. Mental health problems can act as barrier to accessing and obtaining effective medical care; some mental health problems are also associated with increased medical morbidity. Those diagnosed with mental disorders such as schizophrenia can live up to 25 years less than the general population; and while suicide and accidents are partially responsible for these increased mortality rates, they provide only a partial explanation. Overall, physical illness

accounts for the vast majority of the gap in life expectancy between those with persistent mental health problems and the general population (Wahlbeck *et al.*, 2011; De Hert *et al.*, 2011).

## 1.4 Social Inclusion and Recovery

### 1.4.1 Social Inclusion

While recognition of the social needs of people with on-going mental health problems has been part of the re-orientation of Irish psychiatric services, such needs have tended to be addressed through programmes within the formal services, including the provision of supervised accommodation in hostels and group homes; day activity programmes in day centres and drop in centres; and employment within sheltered work environments. While these services are a necessary and beneficial aspect of service provision to people experiencing mental health problems, by their very nature, they are unable to adequately address the need for people to move beyond the formal mental health care system in order to re-integrate into wider social and community life. Furthermore, there is evidence that such programmes facilitate a transfer of institutional care models to community based services. This results in services tending to be regulated and controlled around the needs of the system rather than the needs of individual service users. There is evidence that individuals with mental health problems who live in sheltered accommodation, and who participate in formal service programmes over prolonged time periods, become subsumed by the mental healthcare system and thus become reliant upon such programmes to meet their friendship, social, occupational and leisure needs. Likewise, there is evidence that, rather than assisting those with mental health problems to be accepted by and re-integrate into their

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local community, individuals continue to remain apart from their community, and to feel lonely and isolated from the wider community (Catty *et al.*, 2001; Tedstone-Doherty *et al.*, 2007).

Being unable to fully access the local community can result in a series of setbacks and poor mental health that, ultimately, is not conducive to recovery. Individuals may feel lonely and isolated at being unable to participate in community life and these feelings lead to fear of stigma and of attempting further interaction with the community. Many people find it difficult to comprehend the likelihood of their recovery from mental health difficulties. The social isolation, withdrawal from everyday life, as well as lost opportunities for social engagement resulting from unemployment and the lack of intimate relationships can prevent successful reaching out. It can, therefore, be a vicious cycle of the symptoms of mental disorders leading to further isolation and the development of other disorders, such as depression, leading to restricted social opportunities, isolation, loneliness and lack of opportunity in life.

### 1.4.2 Recovery

Rebuilding a positive personal and social identity is a core component of recovery. Traditionally, recovery has been defined as an event, occurring at a discrete time point following an illness, when one's health is regained (Resnick *et al.*, 2005). While the notion of recovery in mental health can be traced to the 1930s (Onken *et al.*, 2007), its contemporary form emerged from the International Pilot Study of Schizophrenia which began to challenge the 'taken for granted' assumptions that serious mental illnesses, particularly schizophrenia, were progressive diseases without the possibility of recovery. Since the 1970s, and particularly over the past two decades, the notion of recovery has gained considerably

in strength and prominence (Davidson *et al.*, 2005). The movement towards accepting that recovery is possible was also inspired by political groups such as women's liberation disability movement and the black and gay rights movements (Schiff, 2004; Roberts & Wolfson, 2004). In many respects, the recovery movement was in essence, political, in that it aimed to promote the power of the 'patient' to challenge notions of dictatorial treatment and negative professional opinions. Moreover, it also aimed to promote the individual with mental health difficulties to the centre of his or her treatment, leading to a view that recovery is:

> *...a way of living a satisfying hopeful life and of contributing to life even with limitations caused by illness .... Includes the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness* (Anthony, 1993: 16)

In Ireland, over the past decade, there has been a growing focus on recovery within mental health services. As in other countries, there has been a gradual shift in emphasis away from reliance on conceptions of enduring mental health issues as synonymous with chronic illness which tended to place individuals in the:

> *segregated company of like-damaged others* (Hopper, 2007: 870)

with recovery only recognised as symptom remission over a prolonged time period accompanied by an associated improvement in functioning.

In contrast, the shift to more 'personal' or 'survivor based' ideas of recovery draws on the documented 'life journeys' of people who have experienced serious and persistent mental health problems, as well as their recovery journeys. Instead of focusing on the elimination of symptoms,

this view emphasises the rebuilding of a worthwhile life; the reclaiming of valued social roles; and the (re) establishing of a positive self-identity (Tew *et al.*, 2011). Recovering from severe mental illness is a process of individual self-discovery that involves developing a positive sense of self and personal meaning in life, despite the presence of psychiatric symptoms and their consequences (Roe & Chopra, 2003). Hope, a sense of personal empowerment and a desire to get well are central to recovery. From this perspective, recovery can be seen to be both a journey of personal change and a process of social (re)engagement.

Inextricably linked with elements such as self-determination and hope, gaining personal empowerment and insight into one's condition has a number of meanings and positive effects on mental health. Essentially, it is when an individual has the opportunity and willingness to take responsibility for his or her actions, take risks, make mistakes and learn from experience – elements of normal adult life – that recovery is possible (Davidson *et al.*, 2005). Furthermore, insight into the toll the condition has taken on health and relationships appears to be essential in the emergence of the need for change, and the belief that it is possible to change; as such awareness is a key element in the determination needed to recover (Corrigan *et al.*, 2004). Increased responsibility for one's actions also leads to an expansion of normal social roles in society. In this way, an individual may be able to resume his or her functioning as a spouse, worker and/or parent, thus contributing to the community in which they live (Davidson *et al.*, 2005); and caring for the welfare of themselves and those around them (Corrigan *et al.*, 2004). As these elements of personal growth expand, individuals can regard themselves as valued members of society, and as being in recovery, rather than primarily being

disabled. Likewise, the management of illness symptoms or setbacks also actively contributes to recovery, and assists by increasing one's sense of empowerment and control over the condition, rather than being controlled by symptoms. Linked to self-managed care, and also to self-empowerment, is navigation of the social assistance an individual receives from family, friends and health care-workers. Receiving support from others during recovery and giving support themselves is an important element of integration into community (Corrigan *et al.*, 2004).

Regardless of its origin, "recovery" is almost always understood as an individual process, one that can be helped along by professionals, family members, or a community of concern, but that ultimately has to be taken up by the person themselves (Weisser *et al.*, 2011). Internal aspects of recovery include concepts such as hope, personal growth, and a positive sense of self; these elements can be helped along by supports such as family support, peer support, and meaningful activity (Pevalin & Goldberg, 2003; Spaniol *et al.*, 2002). Less attention has been given, however, to the structural changes needed within society to ensure that social environments are created which support recovery including adequate income, housing and social environments that are free of discrimination (Weisser *et al.*, 2011; Tew *et al.*, 2011). Despite this lack of attention, there is evidence that new understandings of recovery are emerging which are beginning to address these limitations.

Traditionally, approaches promoting social inclusion and integration and, ultimately, recovery have relied heavily on the re-location of mental health services away from their original institutional base to the community. Likewise, in rehabilitation programmes the idea that providing training in social rehabilitation programmes and

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occupational skills development would enable people with enduring mental health difficulties to obtain employment and become socially competent thereby promoting integration, was the primary approach adopted. In recent times however, it has become evident that alternative approaches are required, as simply moving services to a community location and/or providing training are insufficient for achieving inclusion, integration and recovery. In contrast, the 'Capabilities Approach' takes as its measure the degree of human agency; that is, what people can actually do and be in everyday life. Human agency is contingent upon existing competencies and available opportunities to exercise these competencies (Ware *et al.*, 2007). The aim of immersing people recovering from persistent mental health problems into the community is to allow individuals to experience normal roles in society and to manage the challenges and situations, both positive and negative, that are a feature of normal, everyday life. However, for this approach to be effective, social environments must provide opportunities for the individual to develop and exercise competency.

Adopting this approach to promoting social inclusion and integration requires a re-orientation of the principles underpinning mental health services. Social inclusion and integration need to be viewed as a process that evolves over time, and allows individuals to increasingly develop and exercise capacity for connectedness and citizenship. Supporting personal recovery also involves moving away from a focus on treating illness and moving towards promoting well-being. Furthermore, it needs to support the construction and maintenance of social and interpersonal relationships which, in turn, support companionship and access to resources. It must also support the development of social competency, that is, the ability

to effectively articulate thoughts and feelings in ways that engage others and make oneself understood. Sustaining interpersonal connectedness requires both moral and emotional competence. Moral competency is the basis for trust; it involves accountability, reliability, creditability and honesty. Emotional competency pertains to being able to demonstrate empathy and having a capacity for commitment (Ware *et al.*, 2007).

The RCT of Supported Socialisation, reported here, has aimed to measure the impact of an intervention to help individuals with persistent mental health problems to experience a more true-to-life interaction both within and with the community they live in.

## 1.5 Supported Socialisation

Supported socialisation, as a process, evolved from social programmes that were designed to improve the housing and employment prospects of people with severe mental illness (Davidson *et al.*, 2004); the aim of these programmes was to improve an individual's access to wider society and enjoyment of peer interaction. In supported socialisation, a person is placed in the wider community and some type of support in order to function effectively and, hopefully, to thrive. Thus, the aims of supported socialisation are to facilitate coping with mental health problem and its consequences and to promote recovery. A benefit of supported socialisation is that people with persistent mental health problems are enabled to mix in the wider local community, rather than solely in a 'mental health' community consisting of day-care and other mental health service related centres. In supported socialisation, people are supported as they (re)gain their personal agency and sense of self as competent beings. Supported socialisation, by providing opportunities

for positive events to occur, contributes to developing and/or re-establishing social connectedness and social agency by directly ameliorating distress, or through buffering the adverse effects of the negative elements of a mental disorder, including the regulation of depressed mood (Davidson *et al.*, 2006).

### 1.5.1 Friendships

In adult life, friendships are formed in various circumstances, through work, interests and family members. An individual's desire to make friends and simultaneously cope with a persistent mental health problem can be hindered by the lack of access to or acceptance into arenas where friendships are made (Davidson *et al.*, 2004). Many factors influence friendship formation, including situational factors. Generally, we are more likely to make friends with people who are available, that we see often and interact with frequently. The frequency of contact with people is paramount in that it allows the building of knowledge about each other and provides opportunities to share experiences. In this way, a sense of shared existence is developed; which, of itself, is part of the cement of friendships. Over time, regular contact with others provides opportunities that allow us to get to know other people; and, simultaneously, to become known. Regular contact allows self-disclosure while building a feeling that the friendship is reciprocal. Once trust and closeness has developed between two friends, a friendship moves from acquaintance to one of support and affection. In other languages, such as French or German, there are formal linguistic markers for this process, such as the use of 'Vous' as a formal French word for 'you', being exchanged for 'Tu' a more informal address. However, in English, there is no similar convention, and the recognition of friendship development relies on more subtle clues, some of which, arguably, may be more difficult to pick up on by persons experiencing mental health problems, and who feel less confident and experienced in social interaction (Davidson *et al.*, 2004). This does not mean, however, that individuals with mental health problems do not want to form friendships.

While socialising with peers who are also experiencing mental health difficulties is supportive, well-intended peer support approaches to empowerment and reducing social isolation, may inadvertently reinforce stigma rather than reduce it. A key aspect in the success of social support programmes is developing a friendship with a person who does not have an enduring mental health problem (Shahar *et al.*, 2006; Davidson *et al.*, 2004). From previous research data suggests that participants assigned to partners without an enduring mental health problem experienced initial trepidation over whether the partners would accept them as friends, however, once a relationship developed, participants reported an increase in self-esteem and social functioning.

Conversely, although participants matched with a partner anticipated acceptance from their partners because of a shared background, the resulting relationship did not bring about such a significant difference in the lives of the participants (Shahar *et al.*, 2006).

## 1.6 Summary

Reconnecting and rediscovering a place in society requires participation in culturally valued activities that mark one as 'being normal' (Borg & Davidson, 2008) and re-building a functioning self; a person apart from illness (Hopper *et al.*, 2007). Thus, by its very nature, recovery is tentative and halting; starting, then stopping, and moving on again. Recovery consists of the quiet work of life; of 'fitting in' and 'getting on with it' or taking part in organised efforts to build connections (Hopper *et al.,* 2007; Borg & Davidson, 2008).

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Recovery is an ongoing process that unfolds in a variety of contexts while daily life is occurring; it occurs through the ordinary, the little things in life, in which activities and events happen in an unplanned way. Relationships connect people to the social world; encouraging people to maintain their ordinary lives, supporting families and existing friendships and providing opportunities to develop new friendships, all of which supports recovery.

The study reported on in the following chapters set out to establish, implement and evaluate a programme of supported socialisation with people experiencing persistent mental health difficulties within the mental health services. This study, a Randomised Controlled Trial (RCT) based on the CONSORT principles, was funded by the Health Research Board (HRB), and was undertaken within mental health services in the Dublin–Mid-Leinster region. The study examined whether being supported to socialise leads to improved social functioning, increased self-esteem and extended social networks, a reduction in social isolation, social, emotional and family loneliness and a reduction in illness related symptoms such as depression.

# Chapter 2: Methods
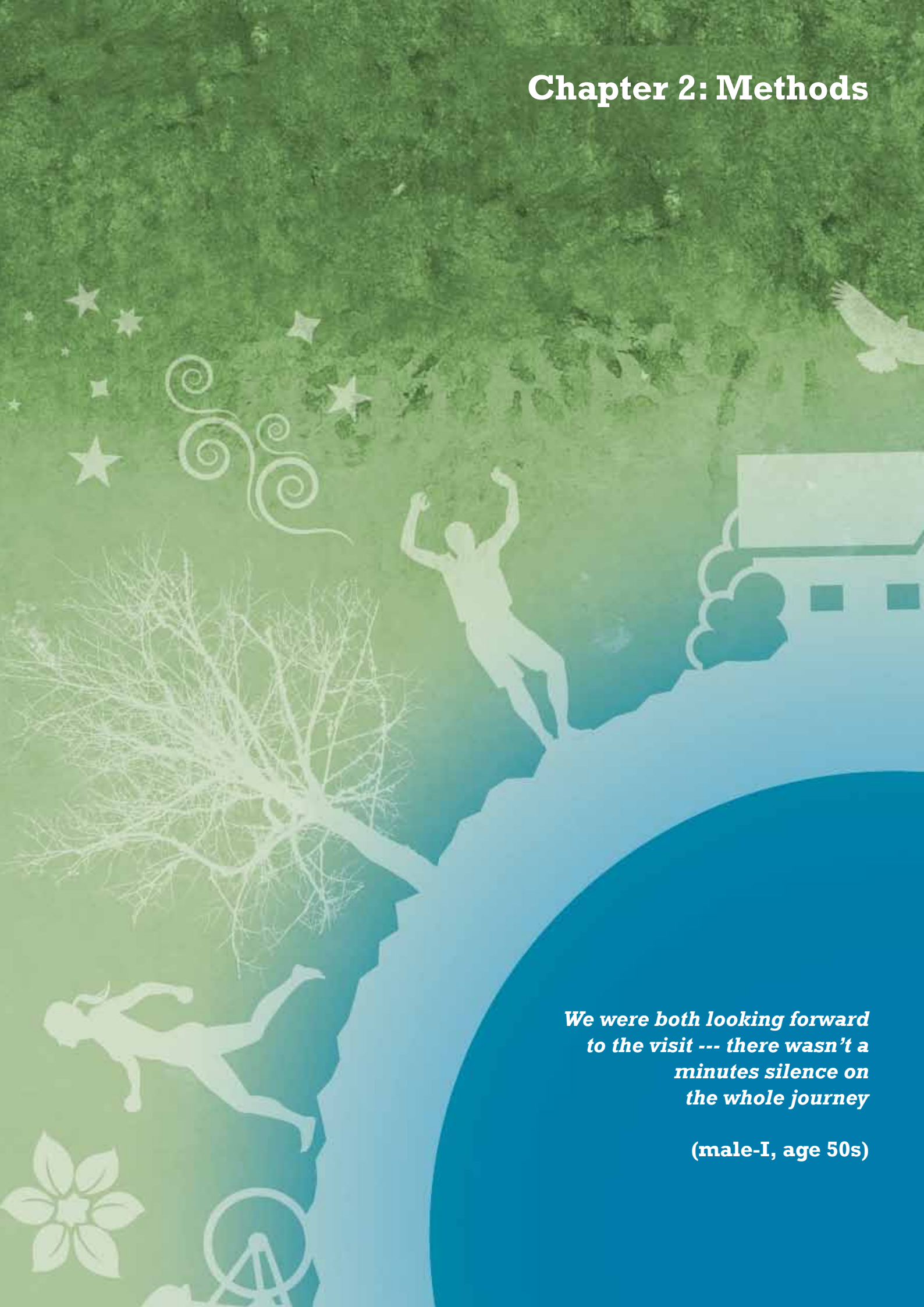
*We were both looking forward to the visit --- there wasn't a minutes silence on the whole journey*

*(male-I, age 50s)*

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## 2.1 Introduction

This study set out to establish, implement and evaluate a programme of supported socialisation with people experiencing persistent mental health difficulties living in the community. A complex intervention was the cornerstone of this study and this complexity is reflected in the study's design. Although RCTs, by their nature, offer numerous challenges to researchers, they remain the most reliable method for evaluating "...the effects of a single intervention such as a drug" (Campbell *et al.*, 2000 : 694) and are considered the gold standard for evaluating interventions. When a non-pharmacological intervention is used, such as 'supported socialisation', the challenges of implementing an RCT are greatly increased due to the multiple components and interconnecting concepts at the heart of such interventions.

The intervention, completed over a nine-month period, involved multiple groups (people with persistent mental health problems; volunteer partners and data collectors; health professionals, an expert panel, and the project team); multiple cohorts (six separate cohorts commencing at different time points): multiple locations (five separate clinical services and 10 separate clinical sites): numerous public venues (hotels public houses); and the UCD School of Nursing, Midwifery and Health Systems. The intention of the intervention was to promote a 'friendship' between volunteer and participant comparable to ordinary social friendships existing outside of the usual constraints of the mental health care system. For the intervention group participants, the social/leisure activity was with their volunteer partner. Data collection with participants entailed three time points: baseline within two weeks of intervention commencement, mid-point (4-months) and endpoint (during month 10 within one month of completion).

In this chapter, the study's design and implementation are described.

## 2.2 Objectives

The study's objectives were to:

- Establish and implement a programme of supported socialisation for people with serious mental illness who were in contact with mental health services.

- Determine the impact of the supported socialisation programme on individuals with serious mental illness in terms of: i) improved social functioning; ii) symptom reduction; iii) enhanced self-esteem.

- Explore the feasibility of establishing ongoing programmes of supported socialisation to enhance the social integration of people with serious mental illness within local communities in Ireland.

## 2.3 Study Design and Setting

A prospective RCT study, based on the CONSORT principles (Schulz *et al.*, 2010), was conducted. A community based trial design was employed within the Dublin Mid-Leinster region from 2007 to September 2011. Service users diagnosed with enduring mental illness and attending one of five mental health services were invited to participate (see Appendices: 1 Clinical Information Sheet; 2 Participant Poster; and 3 Participant Information Leaflet). Following agreement to participate and signed voluntary consent, baseline data were collected by the research team (see Appendix 4 Consent Form ). Participants recruited into the study were then allocated, using a computerized random number generator in SPSS (Version 16), to either an intervention or a control group for the duration of the trial.

- The groups were the same in that both received a stipend of €20 monthly, and were asked to engage in a weekly social or leisure activity.

- The intervention group differed in that participants were matched with a volunteer partner.

At two time points, 4-months and within one month of completion of the intervention, follow-up outcome data were collected by interviewers who were blinded to the randomisation process and were independent of the study. At 3-monthly intervals, both the intervention and the control groups completed monthly diaries which they submitted to a member of the research team.

## 2.4 Sample Size

Social functioning was the primary outcome measure and power analysis was calculated. The criterion for significance (alpha) was set at 0.05. The effect size (f) was set as a medium effect of 0.50, yielding a power of 0.80. This power analysis was for a t-test with two groups and resulted in a requirement of 64 participants per group and a total of 128 cases. Allowing for non-response and attrition from the study, the sample was increased by 20% resulting in 77 participants per group; thus, requiring a total sample size of 154 for the study.

### 2.4.1 Sample

The sample was attained through six recruitment phases during the lifetime of the study. Of the 275 people who expressed an interest in participating in the study, 143 consented and completed an initial assessment (a profile of social and leisure activities). A total of 118 participants completed the baseline assessment prior to randomization and 107 participants completed the study.

## 2.5 Ethical Considerations

Ethical approval for the study was provided by the UCD Human Research Ethics Committee and the ethics committees of each service of the five providers in the study. As this research included a vulnerable group and required the recruitment of volunteers, the safety of all participants was of paramount importance. A rigorous volunteer recruitment process including Garda clearance ensured best practice and reassurance for participants. The availability of a dedicated telephone number and an emergency contact telephone was provided to all participants and to all active volunteers for the duration of the study. Structured monthly peer support meetings were provided for the volunteers and all were encouraged to avail of these resources. Additional support for volunteers and participants was provided as and when required. Participants were further protected by having agreed protocols with service providers and the provision of clinical support for the duration of the RCT.

All reasonable precautions to ensure security and safety of participant data were taken. Participants' names and assigned codes were stored separately and only designated research team members had access to both. All electronic data files were password protected with access being restricted to designated research team members. Hardcopies of questionnaires were stored in locked secure cabinets in the research unit in the School of Nursing, Midwifery and Health Systems in UCD; the research unit is a restricted access unit. In compliance with ethical approvals, data will be used only for the purpose for which it was collected and will be retained in line with organisational and professional guidelines. Destruction of data will be undertaken by the principal investigator on site in line with agreed university and organisational policies.

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## 2.6 Recruitment Process and Implementation

### 2.6.1 Participant Recruitment

Five mental health service providers in the Dublin Mid-Leinster region participated in the study. Senior staff from each provider were contacted and meetings were held with members of the research team. Subsequently, clinical staff circulated the study's promotional materials amongst service users (see Appendices 2 & 3). Interested service users were invited to attend meetings where they could meet members of the research team and receive further information about the study. Those who expressed an interest in participating in the study provided contact information. Suitability for participation in the study was confirmed by the assigned Consultant Psychiatrist or responsible clinician[2] to the research team. Potential participants were aware that their suitability had to be confirmed prior to enrolment. The recruitment process commenced in February 2008 and was completed in September 2010 (see Figure 2.1 Flow Chart). In total, six separate recruitment and commencement phases were completed with the five providers. This sequential approach of recruitment and commencement ensured the effective management of the multiple elements

**Table 2.1** *Sequencing of Recruitment and Commencement Process for Participants*

| Cohort | Number of participants who commenced study | Control Group | Intervention Group |
|---|---|---|---|
| November 2008 | 23 | 13 | 10 |
| February 2009 | 14 | 6 | 8 |
| June 2009 | 21 | 11 | 10 |
| November 2009 | 10 | 5 | 5 |
| April 2010 | 6 | 3 | 3 |
| September 2010 | 33 | 17 | 16* |
| **Total** | **107** | **55** | **52** |

*Six participants delayed commencement until December 2010 due to delays with Garda vetting.

involved in the completion of this complex intervention study (see Table 2.1).

### 2.6.2 Inclusion/Eligibility Criteria

- Adults over the age of 18 years.

- Identified serious/enduring mental illness as denoted by International Classification of Disease 10 (ICD-10) criteria for Schizophrenia, schizophrenia spectrum and delusional disorders (F20-29); Mood [affective] disorders (F30-39); and Mental and behavioural disorders due to psychoactive substance use – drug induced psychosis (F10-19) (ICD-10).

- Determined to have moderate to severe impairment in social and occupational functioning (e.g., limited social friendships [excluding family members], and social, vocational or educational activities).

- Psychiatrically stable for the preceding six months (confirmed by Consultant Psychiatrist or responsible clinician).

2 A number of individuals who attended facilities organised and/or managed by mental health services such as Cornerstone Club or other social clubs; or heard about the study from a friend, relative or through project advertising self-referred to the study. In these instances General Practitioners or a Private Consultant Psychiatrist was contacted to confirm suitability.

- Have sufficient physical ability to participate in the project.

- Be willing to leave house to engage in social activity.

- Does not present safety threat (physical, psychological and/or behavioural) to others (volunteer partner).

- Should not have participated in other research within four (4) months preceding commencement of this study.

- Patients with identified presence of co-existing substance use disorders were not excluded from selection.

### 2.6.3 Exclusion/Non-eligibility Criteria

- Less than 18 years of age at commencement of study.

- A diagnosis of personality disorder.

- An intellectual disability.

- A psychological development disorder.

- Physical incapacity which prevents independent travel.

## 2.7 Pilot Study

The use of pilot studies are recommended in clinical trials to assess procedural issues, such as the acceptability of the study to prospective participants along with the testing of data collection forms or questionnaires, and recruitment and consent processes. Prior to commencement of the main study, a pilot study was undertaken with five individuals who met the eligibility criteria for the main study. The primary objective of this pilot study was to test the procedural elements of the main study particularly those relating to administration of the data collection social and clinical instruments. The pilot was also useful in

assessing the effects, emotional and physical, of the instruments on the participants, as well as establishing the time required to administer all instruments. As the literature did not suggest any preferable order to present the instruments, this issue was also examined in the pilot study.

The pilot study identified that the process of data collection was less demanding than anticipated with the majority respondents taking just one hour to have the instruments administered. Participants in the pilot study also indicated a general level of satisfaction with the proposed study and the instruments used. They believed that participating in the main study would have a beneficial effect on their social lives, and expressed a feeling of enthusiasm towards it. Concerns of participants noted in the pilot study included not being assigned a partner, not taking to their partner or not "fitting in". On completion of the pilot study, procedures and documentation informing potential participants about the study, application to participate in the study and the processes for obtaining consent and clinician support were consolidated for the main study.

**Figure 2.1** *Flow Chart for Randomised Controlled Trial*

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**Volunteer Recruitment Process**

- Application
- Garda Clearance
- Training
- Social and Leisure Profile

*N=73*

**Total number of service users expressing an interest in participating** *N=275*

Exclusions *N= 132*
n=102 Changed mind
n=11 Inclusion criteria not met
n= 12 Did not respond to subsequent calls
n=7 Relapsed, hospitalised unable to continue

Registered but not randomised Consent, Demographic, Social and Leisure Profile data collection
*n=143*

Total number of patients registered
Baseline Data n =143
*n=118 (randomised)*

Post Randomisation
*N= 118* (11 withdrew following allocation)

**Commencement Meeting**

Pairing with Volunteer

n=63

**Intervention Group**

Baseline n=52
Follow-up Time 1 n=32
Follow-up Time 2 n=32

Completion of monthly diaries

**Usual Care Group (Attended Commencement Meeting only).**

Baseline n=55
Follow-up Time 1 n=37
Follow-up Time 2 n=38

## 2.7.1 Instrument Administration Guide

The pilot study also indicated the need to develop an instrument administration guide. The purpose of the guide was to provide direction for data collection with regard to administering the five instruments included in the study. The guide provided direction to all data collectors and emphasised the importance of adequate preparation in advance of conducting data collection interviews. Information within the guide advised that prior to commencing a data collection session, each participant would be advised as to the duration of the interview and there would be an agreed schedule facilitating rest breaks for participants. Data collectors were also advised to ensure that prior to the commencement of each data collection session, all documentation be checked in order to ensure that the data collection pack was complete. Following guidance on preparation, detailed instructions for each instrument was provided including key information for the time period for each instrument. The instrument administration guide was used as part of the data collector training process and a personal hard copy of the guide was given to each data collector.

## 2.8 Data Collection

From the outset, participants were aware that participation in the study did not guarantee being assigned a volunteer. Eligible participants were invited to attend a meeting or presentation with a member of the research team and to complete a consent form and a detailed Social and Leisure Profile. This information was used to match participants (if randomised into the intervention group) with volunteer partners based on shared interests. In total, 275 participants expressed an interest in participating in this study. Appointments to explain the study in more detail and obtain informed consent were made by contacting participants either directly by phone, through service clinics and/or by liaising with clinical staff.

Data collection interviews were arranged within a location familiar and convenient to the participant. Such locations included locally based mental health service centres or local hotels, coffee shops where appropriate. After obtaining consent, receiving completed Social and Leisure Profile and confirming suitability with responsible clinician, data collection interviews were arranged within a location familiar and convenient to the participant. Such locations included locally based mental health service centres or local hotels, coffee shops where appropriate. Each participant was required to complete a package of standardised social and clinical instruments at baseline (pre-randomisation), midpoint (4-months) and endpoint (within one month of completion) and requested to complete weekly diaries.

### 2.8.1 Social and Clinical Instruments

In this study data were collected at three time points using five instruments. Five areas of social and emotional function were being examined: social functioning, self-esteem, symptom reduction, loneliness, social networks. These instruments were:

- Social Functioning Scale Modified (Birchwood *et al.*, 1990)

- Rosenberg Self Esteem Scale (Rosenberg, 1965)

- Beck Depression Inventory II (Beck *et al.*, 1996a)

- Social and Emotional Loneliness Scale for Adults – Short Form (SELSA-S) (Di Tommaso *et al.*, 2004)

- Practitioner Assessment of Network Type (Wenger, 1994)

**The Social Functioning Scale (SFS)** – This instrument measured participants' competence and degree of activity. This instrument was used to explore seven areas: (1) Social engagement/withdrawal; (2) Interpersonal behaviour; (3) Pro-socialactivities; (4)Recreation; (5) Independence/competence; (6) Independence/activity; and (7) Employment/occupation. In the SFS a distinction is made between lack of competence or ability (absence or loss of an ability), and lack of performance (disuse or abandonment of an existing ability). Items are rated on a 5-point scale ranging from 1-never to 5-often, with 5 indicating increased social functioning. The developers of the scale (Birchwood *et al.*, 1990) have identified that the Social Functioning Scale is reliable, valid, sensitive and responsive to change. In the present study the Cronbach's Alpha reliability was calculated on data at baseline yielding a score of 0.90.

**The Rosenberg Self-Esteem (RSE)** – Participants' self-esteem was measured using the Rosenberg self-esteem scale (Rosenberg, 1965). This is a 10-item scale measuring self-esteem through an examination of self-acceptance and self-worth. Items are rated on a 4-point scale

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ranging from strongly agree to strongly disagree. The scale has been widely used and has acceptable face, convergent, predictive, and construct validity. Reliability has also been reported as high with test-retest correlations reported of between 0.85 and 0.92 and internal consistency coefficients of between 0.72 and 0.84 (Bowling, 1997). In the present study the Cronbach's Alpha reliability was calculated on data at baseline yielding a score of 0.90. The Rosenberg Self-Esteem scale has also been found to be both reliable and valid when used with patients with mental health problems (Van Dongan, 1996).

**The Beck Depression Inventory II (BDI-II)**- The BDI-II was used to measure depression. It is a 21-item inventory measuring cognitive symptoms and behavioural manifestations of depression (for example, sadness, self-dislike, weight loss, insomnia, social withdrawal) which are present over the previous two weeks. Each item has four response choices which are ranked in order of severity from 0-3 (low –high). A summary score is calculated (maximum score = 63) and scores are examined for the degree of depression [normal (0-13), mild (14-19), moderate (20-28), severe (29-63)]. Moderate to good levels of validity and reliability coefficients ranging from 0.89 to 0.91 have also been reported by Beck *et al.* (1996a; 1996b). In the present study, the Cronbach's Alpha reliability was calculated on data at baseline yielding a result of 0.93.

**The Social and Emotional Loneliness Scale for Adults – Short Form (SELSA-S)**. The SELSA-S is a 15 item multidimensional instrument that measures both social and emotional loneliness. Emotional loneliness is further divided into two subscales that measure family loneliness and romantic loneliness. Items are rated on a 7-point scale ranging from strongly disagree to strongly agree. Previous testing

of the SELSA-S has ascertained content, concurrent, discriminant and construct validity of the research instrument (Di Tommaso *et al.*, 2004, National Council on Ageing & Older People [NCAOP], 2005). Di Tommaso *et al.* and the NCAOP's study identified Cronbach's alpha scores ranging from 0.87 to 0.90 and 0.75 to 0.90 respectively for the three loneliness scales. In the present study, Cronbach's Alpha reliability scores were calculated on data at baseline yielding results of 0.73 (romantic loneliness subscale), 0.81 (family loneliness subscale) and 0.88 (social loneliness subscale).

**The Practitioner Assessment of Network Type (PANT)**- The PANT was used to measure social networks. Loneliness and social isolation are associated with the level of support individuals receive from their social networks. Wenger (1994) identified social networks as individuals, family and communities who are involved with the person in a significant way. These networks include members of a person's household, the provision of companionship and friendship, emotional support and help from individuals and the community. The network instrument developed by Wenger allows for the identification of the support the individual receives within their social network. These supports are identified in five areas: family dependent support network, locally integrated support network, local self-contained support network, wider community focused network, a private restricted support network (see Table 3.7, Chapter 3 for a more detailed description of the five networks).

### 2.8.2 Follow-up Data Collection

Follow-up data were collected and recorded manually on the instruments, identified above, by trained independent data collectors who were blinded to the

randomisation process, and by members of the research team who were not involved in data collection at baseline. Data collection assessments were undertaken within mental health centres and local hotels at four months and within one month following completion of the intervention.

All instrument packs had a front page inserted which prompted data collectors to begin the data collection process by reminding participants not to reveal their assigned group (intervention or control). On completion of the data collection interview, data collectors were required to complete an additional document which recorded whether the participant had revealed his/her allocated group and at what stage during the interview this revelation had occurred. If assigned group had not been revealed by the participant, data collectors were asked to guess the participants group and return this with the assessment pack.

### 2.8.3 Recruitment and Training for Follow-Up Data Collection

The two follow-up stages of the study involved independent, blinded data collection. Those recruited as data collectors were either university lecturers and registered nurses, or post graduate psychology students; initial recruitment training was organised by the research team. Training focused on ensuring that data collectors were familiar with all instruments, and issues pertaining to inter-rater reliability were addressed regarding clinical instruments. The training sessions were organised to take place either during the day, as a full day session, or in the evening, over two sessions. Opportunities were also provided for data collectors to attend refresher sessions, if required. All data collectors were fully informed about the nature and purpose of the study and each was provided with an Instrument Administration Guide to support the

assessment interview process. Training focused on ensuring that data collectors were familiar with all instruments, and issues pertaining to Interrater reliability were addressed regarding clinical instruments.

### 2.8.4 Qualitative Data: Diaries

Diaries were used to acquire an understanding of the first-hand experience of the socialisation process in the voice of the participants as they made efforts to engage in socialisation activities on a weekly basis. The diaries were designed to capture the process of the socialisation experience, in terms of how people spent their time, what activities were engaged in, whether they made plans, and what factors facilitated or impeded them in going out and/or engaging in an activity. Each diary consisted of a calendar coversheet, decorated with images of the season, and pages which contained questions about each week's activity such as the date, the type of activity, the amount of time spent on the activity, the weather, one's feelings about the activity (e.g., likes, dislikes, things to do differently), and plans for the following week(s) (see Appendix 5 Diary). The diaries also contained an empty space to be used for pasting items, such as ticket stubs, photographs, or brochures, and/or for writing or drawing. The diaries were pre-tested for ease of use on the volunteers who attended the first volunteer training sessions.

All participants who progressed beyond the randomisation stage were provided with a 3-month diary at the commencement meeting of their respective groups (intervention or control). Instructions on how to complete the diary were provided at the commencement meeting, at which time, participants were asked to record, on a weekly basis, one socialisation activity that they had participated in and to make

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comments about this activity. For those who, for whatever reason, were not able to attend the commencement meeting, a member of the research team met with them individually soon after the group meeting. At the end of each 3-month period, a member of the research team travelled to a facility that the participants attended in order to collect diaries and provide a new diary for the next three months. Sometimes several visits to the site were required. In a few cases, where participants were not attending a facility, arrangements were made for a member of the research team to meet at a place convenient to the participant.

Initially, the diaries had one page devoted to each week and included a log sheet; however, over time, due in part to volunteer feedback at support group meetings, the diary evolved. For example, changes were made after volunteers reported feeling that they were recording the same thing over and over again; these changes included eliminating the log sheet, reducing the space for answering questions about activities, and asking questions about likes, dislikes, doing things differently and future plans at the end of the month rather than weekly. In the third cohort, specific questions about the commencement meeting were added to the diaries which pertained to worries about attending the commencement meeting, having a good time, likes, difficulties, and improvements needed. Near the end of the project, two scale questions were added, of which, one referred to the launch, "Overall, on a scale of 1 to 10[3] how was the socialisation launch for you?"; the other question, to be answered at the end of each month was in regard to the socialisation experience, "Overall, on a scale of 1 to 10[4] how is the socialisation project going

for you?". For both questions, participants were asked to circle a score on a continuum ranging from one (bad/poorly) to ten (very good/very well).

In total, information was acquired on the activities of 70 participants; 34 in the intervention group and 36 in the control group. In a few cases, information on the activities of intervention group participants was obtained from the volunteer's diary.

## 2.9 Randomisation Process

Following baseline data collection, participants were randomly assigned, using a simple, random number generator in SPSS version 16, to allocate participants to either the intervention group (partnered with a volunteer) or the control group (no partner assigned). Following the randomisation process, participants in the intervention group were matched with a volunteer. Matching was based on general interest (as indicated in the Social and Leisure Profile), age and gender. Before the commencement meeting, both groups of participants were contacted and informed as to which group they had been assigned and information regarding their attendance at a commencement meeting was provided.

## 2.10 Volunteer Recruitment

As the population under research was a vulnerable group, ethical approval was contingent on potential volunteers complying with a rigorous selection process. Recognising that recruitment, vetting, training, managing and supporting volunteers is an intricate process that requires particular knowledge and skill, the research team engaged in consultation with other organisations who had experience using volunteers with comparable vulnerable groups. Special Olympics Ireland and the North Dublin Befriending Group openly shared their experiences and documentation. Following this consultation

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3 The scores on the continuum ranged from `1 – It was very bad!' to `10 – It was very good!'

4 The scores on the continuum ranged from `1 – Going very poorly' to `10 – Going very well!'

process, the research team developed an extensive strategy for volunteer recruitment, management and support. As part of the recruitment strategy, a dedicated e-mail account was established. The advertising and recruitment strategy involved:

- Advertising in a variety of areas including two universities (UCD, TCD), parish groups, sporting organisations, patient and service user organisations, self-help and advocacy groups in mental health, retirement groups, and accessing the Volunteering Ireland website.

- Presentations to interested groups and employers by members of the research team.

- Distribution of a broadcast e-mail to all staff and students in UCD following organisational permission.

- Advertising in student union and on the UCD Campus following permission from student bodies.

All individuals expressing an interest in volunteering were sent a full application pack including postage paid envelope. The application pack consisted of; an application form: a Social and Leisure Profile; a Garda vetting form; a reference request; information leaflets outlining the nature and duration of the volunteer work; and a list of volunteer rights and responsibilities. Following receipt of the completed forms, interviews were arranged with members of the research team in order to determine suitability, motivation for volunteering, expectations of the study, travel capacity and to address concerns. In total, 98 interviews were conducted (see Appendices: 6 Volunteer Poster and 7 Volunteers' Information Sheet).

Eligible volunteers, who successfully completed an interview, were requested to provide two character references and complete Garda vetting documentation.

Following this application process, successful volunteers were invited to attend for training in UCD. In total, 73 volunteers attended a 1-day training programme (see Table 2.2).

| Table 2.2 *Sequencing of Volunteers from Initial Contact to Commencing Study* | |
|---|---|
| **Sequencing process** | **N** |
| Indicated interest in volunteering | 236 |
| Submitted application | 120 |
| Attended interview | 98 |
| Completed Garda vetting | 74 |
| Attended training | 73 |
| Commenced volunteering | 63 |

## 2.10.1 Training Programme for Volunteers

All volunteers were required to attend a compulsory training programme in UCD. The training programme was designed to prepare candidates for their role as volunteers and addressed the study's goals and objectives. The programme's content included an education on the broad concepts of mental health and illness, the impact of mental illness on the individual, and defined recovery from the service users' perspective. The programme focused on exploring attitudes to mental illness, expectations of the volunteering role, and preparing for initial meeting. In the first programme, a presentation by a service user was incorporated to assist volunteers to become aware of what the experience of having mental health difficulties is like, and how individuals with such difficulties manage their daily lives and progress towards recovery. In subsequent training programmes, a service user and a volunteer who had completed the intervention, presented during the day. This presentation provided an opportunity for sharing of experiences and for assisting new volunteers to gain insight into the commitment required for the study. Opportunities for role playing volunteer- participant interactions

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were provided in order to further assist the process of building friendships and trouble-shooting potential difficulties. All volunteers were provided with an emergency telephone number that was available 24-hours per day and 7-days per week and was supported by a member of the research team.

Volunteers were advised that, if they encountered any difficulties with their partner, they could contact the research team at UCD using the office number or, alternatively, they could access the emergency number. Following training, volunteers were contacted when they were matched with a participant. In total, 63 volunteers commenced the study.

### 2.10.2 On-going Volunteer Supports

To support volunteers for the duration of the study, monthly volunteer peer support meeting were held in UCD. During these meetings, discussions were held between members of the research team and volunteers. Although attendance of these meetings was not compulsory, all active volunteers were encouraged to attend to either gain support and/or to provide support amongst peers. Volunteers were reminded that the emergency telephone support was available if required. In total, 20 volunteer support meetings occurred over the lifetime of this study. Where volunteers were unable to attend meetings and/or required additional support, such assistance was provided by members of the research team via phone, e-mail and/or in person.

## 2.11 The Intervention: Supported Socialisation Programme

All participants were provided with a stipend of €20 per month to assist them to engage in activities. The intervention,

the supported socialisation programme, consisted of partnering individuals with enduring mental health difficulties with a volunteer for a period of 9-months. Each partnership was asked to spend approximately 2-hours per week engaged in social or recreational activities in the community. Following an initial guided meeting and introduction, participants and volunteers were responsible for all decision-making related to, activities, meeting times, and other arrangements.

### 2.11.1 Activity Pack and Newsletters

As part of this study, a detailed activity suggestion pack was developed. The purpose of this pack was to provide both the participants and the volunteers with ideas of different types of social/leisure activities they could engage in. The activity pack was designed to act as a support, particularly during the early stages of the friendship, and was included as part of the information provided at the commencement meeting. The pack was also designed to identify low cost activities and activities that were free of charge. This information was considered particularly relevant given that the majority of study participants were unwaged and volunteers were self-funding. The information in the activity pack reminded participants and volunteers that they should decide which activity they wanted to spend their time engaging in together and that both must feel comfortable with whatever activity was chosen each week. It further suggested that they may want to begin with doing something simple, such as meeting for coffee and/or a walk and that, as the friendship developed, other activities could be considered. The activity pack provided detailed information for activities both locally and more generally including: cinema, theatre and music venues; comedy clubs and television shows; local markets, walks and art galleries; parks and sporting

activities including football, golf, pitch and putt and swimming.

Over the course of the study, a number of newsletters were prepared and distributed to participants, volunteers and health service personell to keep them up-to-date about progress. This information and communication was particularly important when long delays were encountered, especially those related to garda vetting. Copies of the two newsletters are included in Appendix 8.

## 2.12 Commencement Meeting

An initial commencement meeting was held separately for participants in the intervention and the control groups. In total, 12 commencement meetings were held during the project; a number of additional meetings were held to facilitate those participants who were unable to attend the official commencement meeting. Commencement meetings were generally held in a location convenient to the majority of participants. While the intention was to avoid, where possible, hosting such events within mental health services, on two occasions such venues were the most convenient for the majority of the participants and were deemed suitable on these occasions.

### 2.12.1 Intervention Group

The majority of commencement meetings for the intervention group were arranged at either a room in a local hotel or a lounge area in a local public house at a location that was convenient and acceptable to those attending. These commencement meetings were guided by members of the research team and provided the opportunity to:

- Provide first instalment of stipend.
- Introduce participant to volunteers.
- Review basic personal safety guidelines and provide an out-of-hours

contact number that participants and volunteers could access a member of the research team, if required.

- Allow participants and volunteers to work through and agree basic operational issues including exchanging contact details, types of activities, and planning for the first independent meeting.
- Dealing with any questions or concerns.

### 2.12.2 Control Group

As with the intervention group, most of the commencement meetings for the control group were arranged and held in a room of a local hotel or a lounge area of a local public house that was convenient and acceptable to those attending. These commencement meetings were guided by members of the research team and provided the opportunity to:

- Provide first instalment of stipend.
- Provide an out-of-hours contact number for the research team.
- Deal with any questions or concerns.
- Encourage participants to socialise more than they had been doing up to commencement of the study.

## 2.13 Closure Meetings

The closure meetings were organised as a social event; all were held in a function room in a local hotel or attached to a local public house, convenient and acceptable to those attending. These meetings provided an opportunity to formally conclude participation in the study and to demonstrate appreciation to all participants and volunteers by providing a formal meal and presenting each participant and volunteer with a certificate of participation (see Appendix 10).

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## 2.14 Data Analysis

### 2.14.1 Quantitative Data Analysis

Data was analysed using predictive analytics software package (PASW version 18.0). Both descriptive and inferential statistics were used in the analysis through the use of univariate, bivariate, and multivariate methodologies. Differences between the two groups and within the two groups on the outcome measures over the time periods for the study were completed using a series of t-tests and repeated measures Analysis of Variance (ANOVA). In the analysis, the reliability (Cronbach's alpha and inter-item correlations and item stability) of the instruments used in the study was ascertained.

### 2.14.2 Qualitative Data Analysis

The aim of the qualitative analysis was to generate knowledge from first-hand experience of what it was like, on a weekly basis, to try to engage in a social or leisure activity with or without a partner. Participant names were replaced by pseudonyms (alternative names) in order to protect the identity of individuals; in this document, participants are referred to by gender, group (intervention or control), and age category. The participants self-selected to complete the diaries; diary entries ranged from a few words in one diary to comprehensive descriptions in all three diaries; some participants rigorously completed all sections, some recorded only the activity undertaken, while others responded to some questions but not others. A participant was viewed as having completed a diary if she or he submitted one of the three diaries with some content, aside from his/her name, in it.

As the diary questions were pre-set, data analysis entailed content and thematic approaches, aided by Nvivo-9 computer software (QSR International 2010). The data were coded into categories according to the question being asked, after which, they were organised into themes. A sequential approach was used in which the completed diaries were read and re-read in order to gain a sense of the experience of going out. Then, the accounts of activities were compared in order to identify commonalities and differences in the weekly process of going out.

## 2.15 Conclusion

The chapter presented the detailed methods used in this randomised controlled trial. The following two chapters will present the results and findings arising from this study.

# Chapter 3: Results

*I enjoyed doing the assessments [I] liked someone being interested in my health*

*(male-C, age 30s)*

## 3.1 Introduction

The aim of this study was to establish, implement and evaluate a programme of supported socialisation for people experiencing persistent mental health difficulties living in the community. This chapter outlines the results of the supported socialisation intervention on participants who were allocated into one of two groups: intervention and control. Participants in the intervention group were partnered with a volunteer while those in the control group were not partnered with a volunteer. All participants received a €20 monthly stipend and both groups were requested to engage in a social/leisure activity for two hours weekly over a nine month period. The intention of the intervention was to promote a 'friendship' between volunteer and participant comparable to everyday social friendships and existing outside of the mental health care system.

To ascertain the effectiveness of the intervention a number of outcomes were measured including: social functioning, self-esteem, loneliness, depression and social network type. Data on all outcome variables was collected at three time points: baseline (within two weeks of intervention commencement), mid-point (4-months following commencement) and endpoint (10-months following commencement). The first section of this chapter provides a comparative demographic overview of both groups. This overview is followed by an analysis of the impact of the intervention on the primary outcome measure, social functioning, which included the frequency with which participants engaged in common social activities such as going to the cinema or meeting for a coffee. The participants' self-esteem, experience of loneliness and depression and impact on social networks as an outcome of the intervention are also reported.

## 3.2 Demographic Profile

Table 3.1 outlines the demographic profile of the sample overall and a comparison of the control and intervention groups at baseline. The average age of the sample was 51 years and approximately 52% of the participants were female. The vast majority of respondents were not married at the time of the study (this included respondents who were single, never married, widowed, separated or divorced). A majority of the sample stated that their highest level of education was at secondary level with approximately a third reporting that they had completed trade/technical training or higher education. Approximately a third of the sample lived in their own home with over a quarter reporting that they lived in supported housing. Approximately 35% of the respondents were living alone; a quarter of the sample lived with their family at the commencement of the study.

| Characteristic | Control | Intervention | Total | Group Comparisons |
|---|---|---|---|---|
| | $n = 55$ | $n = 52$ | $n = 107$ | |
| **Age in Years** M, (SD) | 51.5 (11.9) | 49.2 (10.4) | 51.0 (11.4) | $t^{100} = .46$, $p = .64$‡ |
| **Gender % (*n*)** | | | | $\chi^2 = .67$, $p = .72$‡ |
| Male | 50.9 (28) | 44.2 (23) | 47.7 (51) | |
| Female | 49.1 (27) | 55.8 (29) | 52.3 (56) | |
| **Marital Status % (*n*)** | | | | $\chi^2 = 1.9$, $p = .38$‡ |
| Married/Living with a Partner | 10.9 (6) | 3.8 (2) | 7.5 (8) | |
| Not Married | 89.1 (49) | 96.2 (50) | 92.5 (99) | |
| **Highest Level of Education % (*n*)** | | | | $\chi^2 = 1.9$. $p = .43$‡ |
| No Formal Education | 1.8 (1) | 1.9 (1) | 1.9 (2) | |
| Primary | 3.6 (2) | 11.5 (6) | 7.5 (8) | |
| Secondary | 52.7 (29) | 44.2 (23) | 48.6 (52) | |
| Trade/Technical | 12.7 (7) | 17.3 (9) | 15.0 (16) | |
| Higher Education | 18.2 (10) | 21.2 (11) | 19.6 (21) | |
| Other | 10.9 (6) | 3.8 (2) | 7.5 (8) | |
| **Accommodation % (*n*)** | | | | $\chi^2 = 1.2$, $p = .88$‡ |
| Own Home | 33.3 (18) | 25.0 (13) | 29.2 (31) | |
| Relative | 16.7 (9) | 15.4 (8) | 16.0 (17) | |
| Rented | 20.4 (11) | 23.1 (12) | 21.7 (23) | |
| Supported Housing | 24.1 (13) | 30.8 (16) | 27.4 (29) | |
| Other | 5.6 (3) | 5.8 (3) | 5.7 (6) | |
| **Living Arrangement % (*n*)** | | | | $\chi^2 = 4.3$, $p = .49$‡ |
| Living Alone | 40.0 (22) | 28.8 (15) | 34.6 (37) | |
| Living with Spouse/Partner | 7.3 (4) | 5.7 (3) | 5.5 (7) | |
| Living with Family | 25.5 (14) | 23.1 (12) | 24.3 (26) | |
| Living with Sibling/Cousin | 3.6 (2) | 5.8 (3) | 4.7 (5) | |
| Living with Someone Unrelated | 23.6 (13) | 36.5 (19) | 29.9 (32) | |

**Table 3.1** *Comparative Baseline Characteristics of the Control and Intervention Groups and Sample Overall*

‡Not significant

No statistically significant differences were found between the control and intervention group on baseline demographic data including: age, gender, marital status, education level, residency and living arrangements (see Table 3.1).

## 3.3 Primary Outcome – Social Functioning

The Social Functioning Scale (SFS) was used to assess the primary outcome of the intervention, supported socialisation, on the control and intervention group at three time points (baseline, midpoint and endpoint). Table 3.2 displays the extent to which both groups of participants changed over time on selected variables which related to social functioning targeted by the intervention. The greatest level of change for both groups related to the activities, going to a movie, enjoying a conversation and going for a coffee.

Over the 9-month period of the intervention, the control group changed in cinema going from approximately 15% at baseline reporting that they attended sometimes or often, to 16% at midpoint, and approximately 23% by the end of the study. This change represents an 8% increase between baseline and endpoint. In comparison, the intervention group also changed in the extent to which they attended the cinema sometimes or often, from a baseline of 17% through to 31% at midpoint and 34% at endpoint; showing a 17% increase in cinema attendance in the intervention group from the commencement of the study to the completion of the intervention (see Figure 3.1).

The same pattern of change was evident in the extent to which both groups of participants went out for a coffee. At baseline approximately 45% of the control group and 56% of the intervention group reported that they sometimes or often

went for a coffee in the last three months. At the end of the programme this had risen to approximately two-thirds of the control group and approximately 88% of the intervention group. The control group increased in this activity by approximately a fifth whereas the increase in the intervention group was by about a third (see Figure 3.2).

Both groups of participants also changed in the extent to which they stated that they sometimes or often enjoyed an interesting conversation. This changed from approximately 46% for the control group and 48% for the intervention group at the commencement of the study, to approximately 66% for both the control and intervention group at the end of the study.

**Table 3.2** *Frequency\* with which Control and Intervention Groups Participated in Social Activities at Baseline, Midpoint and Endpoint*

| Activity | Control | | Intervention | |
|---|---|---|---|---|
| | Never/Rarely % (*n*) | Sometimes/Often % (*n*) | Never/Rarely % (*n*) | Sometimes/Often % (*n*) |
| **Going to a Movie** | | | | |
| Baseline | 72.7 (41) | 14.6 (8) | 71.2 (37) | 17.3 (9) |
| Mid-point | 65.8 (24) | 15.8 (6) | 57.6 (19) | 31.0 (10) |
| Endpoint | 59.0 (23) | 23.1 (8) | 46.9 (15) | 34.4 (11) |
| **Go to a concert/ play** | | | | |
| Baseline | 89.1 (50) | 3.6 (2) | 86.5 (45) | 5.7 (3) |
| Mid-point | 89.5 (33) | 2.6 (1) | 72.7 (24) | 9.1 (3) |
| Endpoint | 84.6 (32) | 7.7 (3) | 75.0 (25) | 9.4 (3) |
| **Go to a gallery/ museum** | | | | |
| Baseline | 74.5 (42) | 11.0 (6) | 67.3 (35) | 15.4 (8) |
| Mid-point | 78.9 (29) | 10.5 (4) | 69.7 (23) | 21.3 (7) |
| Endpoint | 79.5 (32) | 15.4 (6) | 68.8 (22) | 21.9 (7) |
| **Visit a place of Interest** | | | | |
| Baseline | 64.8 (36) | 16.7 (9) | 53.8 (28) | 25.0 (13) |
| Mid-point | 60.5 (22) | 7.9 (3) | 51.5 (17) | 30.3 (10) |
| Endpoint | 47.4 (18) | 26.3 (10) | 51.6 (16) | 32.2 (10) |
| **Go for a Coffee** | | | | |
| Baseline | 27.3 (16) | 45.4 (25) | 32.7 (17) | 55.9 (29) |
| Mid-point | 18.4 (6) | 73.7 (28) | 12.1 (4) | 75.7 (25) |
| Endpoint | 17.9 (7) | 64.1 (25) | 12.5 (4) | 87.6 (28) |
| **Go out to Eat** | | | | |
| Baseline | 45.5 (25) | 32.7 (19) | 30.8 (16) | 34.7 (18) |
| Mid-point | 34.2 (13) | 41.2 (15) | 33.3 (11) | 54.6 (18) |
| Endpoint | 35.9 (13) | 38.5 (15) | 40.6 (15) | 56.2 (18) |
| **Enjoy a Conversation** | | | | |
| Baseline | 27.3 (15) | 45.5 (26) | 26.9 (14) | 48.1 (25) |
| Mid-point | 18.4 (7) | 65.8 (24) | 22.4 (14) | 57.6 (19) |
| Endpoint | 18.4 (7) | 65.8 (25) | 9.4 (3) | 65.7 (22) |
| **Use Money** | | | | |
| Baseline | 9.1 (5) | 81.9 (45) | 6.0 (3) | 84.0 (42) |
| Mid-point | 7.9 (2) | 92.1 (35) | 15.2 (2) | 84.9 (28) |
| Endpoint | 5.1 (2) | 92.3 (35) | 9.4 (3) | 87.6 (29) |

\*Midpoints from the 5-point scale are omitted.

**Figure 3.1** *Mean Change in 'Attending the Cinema' Over Time (measured on a 5-point scale from 0 – never to 5 - often).*
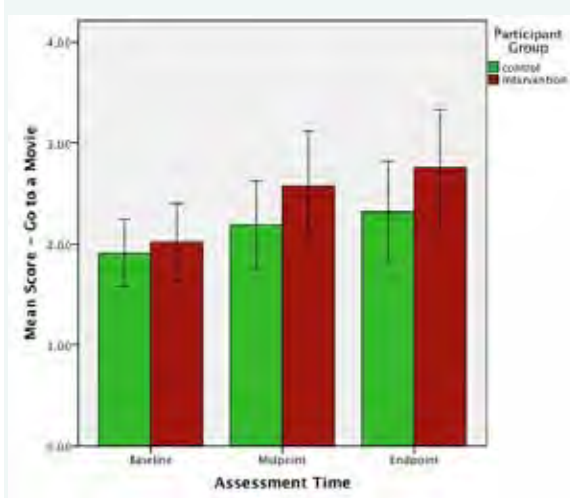


**Figure 3.2** *Mean Change in 'Going for a Coffee' Over Time (measured on a 5-point scale from 0 – never to 5 - often).*
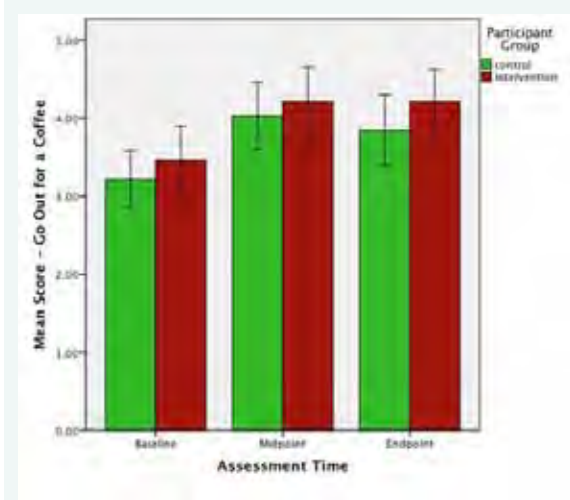


Table 3.3 outlines participants' overall level of social functioning as measured by the Social Functioning Scale (SFS). The SFS also consists of a number of scales that measured the control and intervention groups' level of recreation (engagement in hobbies and interests), pro-social activities (engagement in common social activities such as going to the cinema or going out to eat), independence-competence (ability to perform skills necessary for independent living) and independence-performance (the actual performance of skills necessary for independent living). Due to the different means and standard deviations of the scales, they were standardised and normalised using a T-transformation, as recommended by Birchwood *et al.* (1990). This T-transformation was based on a mean of 100 and a standard deviation of 15. There was no significant difference between the control group and intervention group at baseline (time 1) on independence-performance ($t^{93}$ = .07, p = .94), recreation ($t^{100}$ = .46, p = .64), pro-social activities ($t^{95}$ = .17, p = .87), independence-competence ($t^{96}$ = .17, p = .88) or overall total social functioning ($t^{78}$ = .19, p = .85) (see Table 3.3).

**Table 3.3** *Comparison of Control and Intervention Groups' Scores\* on Outcomes Related to Social Functioning*

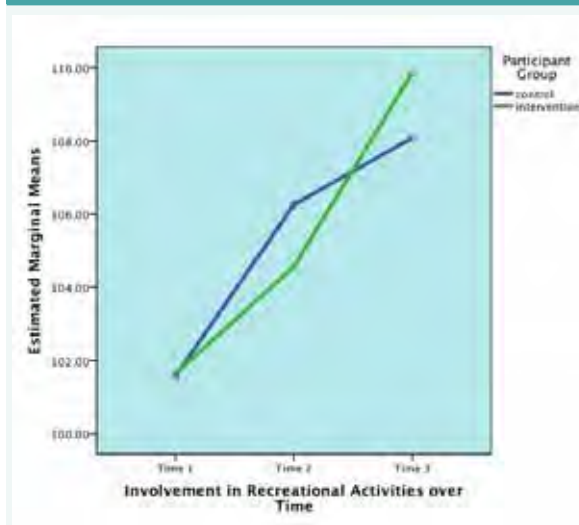| Scale/subscale | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) |
| Independence/ Performance | 100.1 (13.8) | 101.6 (13.6) | 101.1 (13.9) | 99.8 (16.3) | 103.6 (14.7) | 104.7 (15.6) |
| Recreation | 99.3 (15.3) | 104.5 (14.9) | 105.0 (16.6) | 100.6 (6.4) | 105.4 (13.1) | 107.1 (15.5) |
| Pro-social | 100.2 (16.4) | 103.2 (12.4) | 104.7 (15.2) | 99.7 (13.5) | 106.7 (15.8) | 104.2 (13.2) |
| Independence/ Competence | 100.2 (13.6) | 100.5 (13.7) | 100.1 (8.4) | 99.7 (16.4) | 102.2 (15.0) | 103.1 (16.1) |
| **Social Functioning** | **99.7 (15.1)** | **105.7 (13.9)** | **106.0 (27.0)** | **100.4 (15.0)** | **108.0 (15.2)** | **104.1 (23.4)** |

*\*Higher sores indicate higher social functioning. Scale/subscales are T-transformed to a mean of 100 and a standard deviation of 15.*

Both the control and intervention groups changed from baseline through to the endpoint of the study on all outcome measures. The greatest level of change was in the area of recreation for both the control and intervention group. Overall social functioning positively changed throughout the three time-points from a mean of 99.7 (SD = 15.1) at baseline to a mean of 106.0 (SD = 27.0) at the endpoint for the control group and from a mean of 100.4 (SD = 15.0) at baseline for the intervention group to a mean of 104.1 (SD = 23.4) at the endpoint for the intervention group. It should be noted that overall social functioning was highest for the control group at the midpoint of the study (mean = 108.0, SD = 15.2).

A mixed between-subjects analysis of variance was used to assess the impact of the interventions (stipend and partnering with a volunteer) on independence-performance, recreation, pro-social activities, independence-competence and overall social functioning over three time periods (baseline, midpoint and endpoint). There was no significant interaction between intervention type and time on independence-performance (Wilks' Lambda = .98, $F_{(2, 48)}$ = .42, p = ..65), recreation (Wilks' Lambda = .98, $F_{(2, 52)}$ = .42, p = .52), pro-social activities (Wilks' Lambda = .96, $F_{(2, 37)}$ = 0.70, p = .50), independence-competence (Wilks' Lambda = .98, $F_{(2, 48)}$ = 0.48, p = .65) or overall social functioning (Wilks' Lambda = .96, $F_{(2, 30)}$ = 0.61, p = .55). There was a substantial main effect for time on recreation (Wilks' Lambda = .82, $F_{(2, 52)}$ = 5.90, p = .005, partial eta squared = .18). However, there was no substantial main effect for time on independence-performance (Wilks' Lambda = .92, $F_{(2, 52)}$ = 1.96, p = .15), pro-social activities (Wilks' Lambda = .92, $F_{(2, 37)}$ = 1.55, p = .22), independence-competence (Wilks' Lambda = .96, $F_{(2, 49)}$ = 1.0, p = .36) or overall social functioning (Wilks' Lambda = .88, $F_{(2, 30)}$ = 2.13, p = .14, partial). The main effect comparing the two types of intervention (stipend and matching with volunteer) was not significant for independence-performance ($F_{(1, 49)}$ = .003, p = .95), recreation ($F_{(1, 53)}$ = .04, p = .98), pro-social activities ($F_{(1, 38)}$ = .004, p = .95), independence-competence ($F_{(1, 50)}$ = .05, p = .95) or overall social functioning ($F_{(1, 31)}$ = .66, p = .42). Figure 3.3 demonstrates that involvement in social recreational activities increased significantly over time for both the control and intervention groups. There was a slightly higher level of recreational involvement in the intervention group, however, the difference between both groups was not statistically significant.

**Figure 3.3** *Participants' Change in Recreation Scores for Control and Intervention Groups over Time*



## 3.4 Self-Esteem

The self-esteem of the participants was measured at three time points using the Rosenberg scale. There was no significant difference between the control or intervention group at baseline on the total self-esteem score ($t^{102}$ = .85, p = .40). At the commencement of the programme both the control (mean = 17.47, SD = 4.9) and intervention (mean = 18.43, SD = 5.3) groups demonstrated good levels of self-esteem (scores below 15 suggest low self-esteem). The levels of self-esteem remained consistent for both groups throughout the study (see Table 3.4).

### Impact of the Intervention on Social Functioning

It was evident that the stipend (control group) and stipend and socialising with a volunteer partner (intervention group) positively affected a number of social activities including: attending the cinema, going out for a meal, meeting for a coffee and enjoying a conversation.

Social activities, in particular, going for a coffee and going out to eat, increased substantially for participants in the intervention group.

In relation to social functioning overall, the intervention significantly increased levels of recreation (engagement in hobbies and interests) for both the control and intervention groups.

| Table 3.4 *Participants' Scores\* on the Rosenberg Self-Esteem Scale* | | | | | | |
|---|---|---|---|---|---|---|
| Scale/subscale | Control | | | Intervention | | |
| | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) |
| Independence/ Performance | 17.47 (4.9) | 17.94 (5.6) | 20.15 (4.7) | 18.43 (6.4) | 19.84 (5.2) | 18.93 (5.3) |

\*Scores range from 0 to 30 (Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.).

A mixed between-subjects analysis of variance was used to assess the impact of the interventions (stipend and partnering with a volunteer) on self-esteem over three time periods (baseline, midpoint and endpoint). This analysis showed no significant interaction between intervention type and time (Wilks' Lambda = .95, $F(2, 52) = 1.33$, $p = .10$). There was also no effect for time (Wilks' Lambda = .89, $F(2, 52) = 2.98$, $p = .06$, partial eta squared = .18). The main effect comparing the two types of intervention was also not significant ($F(1, 52) = .63$, $p = .43$). Figure 3.4 demonstrates that the self-esteem of both groups increased slightly over time; however, the increase was not statistically significant.

**Impact of the Intervention on Self-Esteem**

At the commencement of the programme the overall level of self-esteem for both the control and intervention groups was identified as being within the normal range.

Participants' level of self-esteem changed positively over the course of the intervention, however, the extent of change was not found to be statistically significant.

**Figure 3.4** *Participants' Change in Self-Esteem Scores over Time*
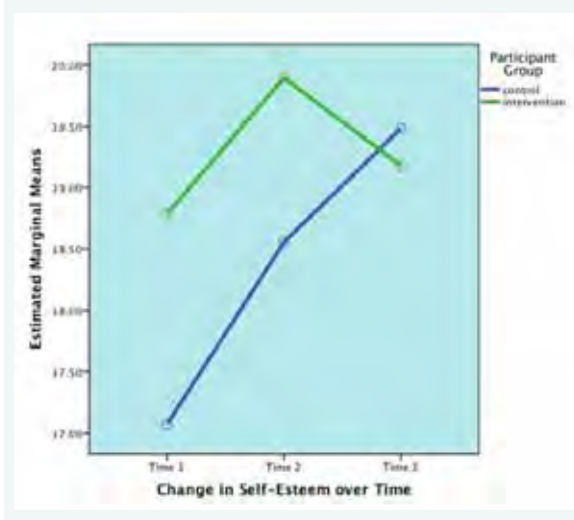
## 3.5 Social and Emotional Loneliness

At baseline the overall social and emotional (family and romantic) loneliness scores on the three subscales were moderate to high on a 7-point scale, with mean scores ranging from 3.3 (control group and intervention group) for family loneliness to 3.6 (control) and 3.7 (intervention) for social loneliness, with romantic loneliness scoring the highest for both groups (mean = 5.1 - control group and 4.9 - intervention group) (see Table 3.5). There were no significant differences on social ($t^{103}$ = .51, p = .61), family ($t^{103}$ = .14, p = .86) or romantic ($t^{104}$ = .75, p = .46) loneliness scores between the control and intervention group at baseline.

For both the control and intervention groups, social, family and romantic loneliness scores decreased over time. The greatest change was in relation to participants' experience of social loneliness. For the control group, this changed from a baseline mean of 3.6 (SD = 1.7) at the commencement of the programme to a mean of 2.9 (SD = 1.5) for the intervention group and a change from a mean of 3.7 (SD = 1.8) at baseline to a mean of 2.6 (SD = 1.3) at the endpoint for the (see Table 3.5).

A mixed between-subjects analysis of variance was used to assess the impact of the interventions (stipend and partnering with a volunteer) on social and emotional (family and romantic) loneliness over three time periods (baseline, midpoint and endpoint). There was no significant interaction between intervention type and time on social loneliness (Wilks' Lambda = .96, F(2, 52) = 1.33, p = .36), family loneliness (Wilks' Lambda = .95, F(2, 52) = 1.33, p = .27) or romantic loneliness (Wilks' Lambda = .99, F(2, 49) = 0.10, p = .90). There was a substantial main effect for time on social loneliness (Wilks' Lambda = .81, F(2, 52) = 6.04, p = .004, partial eta squared = .19) and family loneliness (Wilks' Lambda = .84, F(2, 52) = 4.99, p = .01, partial eta squared = .16), but not for romantic loneliness (Wilks' Lambda = .95, F(2, 49) = 1.3, p = .28, partial eta squared = .05). The main effect comparing the two types of intervention was not significant for social (F(1, 53) = .78, p = .38), family (F(1, 52) = .03, p = .86) or romantic loneliness (F(1, 50) = 1.65, p = .21). Figures 3.5, 3.6 and 3.7 demonstrate that the social and family loneliness of both groups decreased significantly over time, with the greatest decrease identified for social loneliness; although romantic loneliness scores also decreased over the three time periods, the decrease was found to be not statistically significant.

**Table 3.5** *Comparison of Control and Intervention Groups' Scores\* on Outcomes Related to Social, Family and Romantic Loneliness*

| Scale/subscale | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) |
| Social Loneliness | 3.6 (1.7) | 3.0 (1.8) | 2.9 (1.5) | 3.7 (1.8) | 2.9 (1.2) | 2.6 (1.3) |
| Family Loneliness | 3.3 (1.8) | 2.7 (1.6) | 2.5 (1.6) | 3.3 (2.0) | 2.7 (1.4) | 2.4 (1.5) |
| Romantic Loneliness | 5.1 (1.5) | 5.3 (1.7) | 4.5 (1.3) | 4.9 (1.6) | 4.6 (1.5) | 4.4 (1.9) |

*Scores range from 1-no/low levels of loneliness to 7 – high levels of loneliness

**Figure 3.5** *Participants' Change in Social Loneliness over Time*
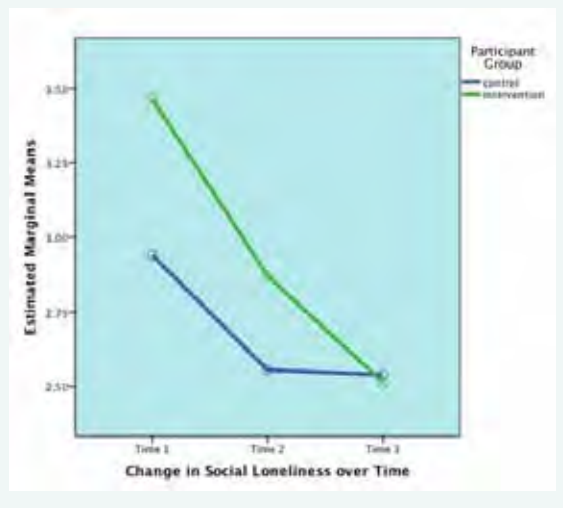


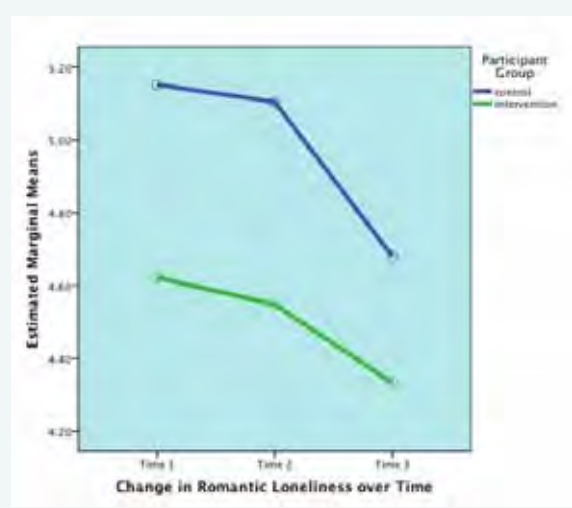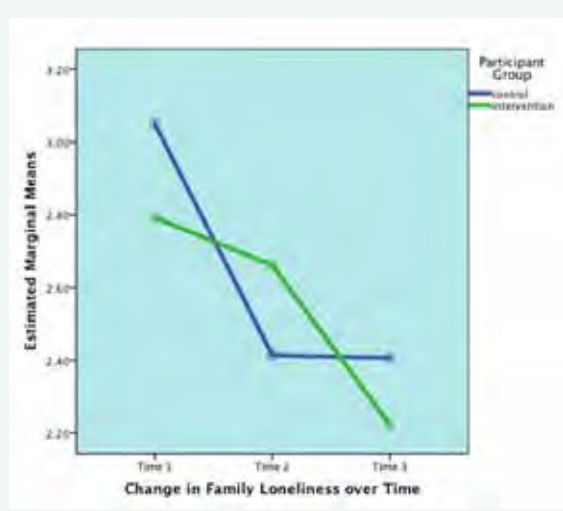**Figure 3.6** *Participants' Change in Family Loneliness over Time*



**Figure 3.7** *Participants' Change in Romantic Loneliness over Time*



## Impact of the Intervention on Loneliness

At the commencement of the programme participants, overall, had relatively low levels of family loneliness, however, there were moderate levels of social loneliness and high levels of romantic loneliness.

For both the control and intervention groups, social, family and romantic loneliness scores decreased over time.

Both family and social loneliness were found to change significantly from the commencement of the study to the end of the intervention.

Levels of romantic loneliness decreased somewhat during the study, however, this level of change was not found to be statistically significant.

The greatest change was in relation to participants' experience of social loneliness; this type of loneliness declined significantly for both control and intervention groups over the course of the study.

## 3.6 Depression

The Beck Depression Inventory (BDI) measured participants' level of depression, over the three time points of the study (baseline, midpoint and endpoint). The 21 items that comprise the scale are summated into an overall score that ranges from 0 to 63. A score between 0-13 is identified as minimal, 14-19 as mild, 20-28 as moderate, and 29-63 as severe depression. Both the control (mean = 12.6, SD = 12.4) and intervention groups (mean = 11.5, SD = 12.5) were at the upper end of the minimal category at the commencement of the intervention. There was no significant difference between the control and intervention groups on depression scores at baseline ($t^{95}$ = 0.44, p = .67). The total BDI scores of both the control and intervention group declined from baseline to endpoint. The greatest change in both groups' depression levels was from baseline to midpoint, however, overall levels of depression, as measured by the BDI continued to decline throughout the study. At the endpoint of the study both the control group's (Mean = 3.7, SD = 5.3) and intervention group's (Mean = 3.8, SD = 4.9) BDI scores were at the lower end of the scale, indicating minimal levels of depression.

A mixed between-subjects analysis of variance was used to assess the impact of the interventions (stipend and partnering with a volunteer) on depression over three time periods (baseline, midpoint and endpoint). The analysis showed no significant interaction between intervention type and time (Wilks' Lambda = .99, F(2, 47) = .22, p = .80). There was, however, a substantial main effect for time (Wilks' Lambda = .62, F(2, 47) = 14.48, p = .001, partial eta squared = .38). The main effect comparing the two types of intervention was not significant (F(1, 48) = .49, p = .48). Figure 3.8 demonstrates that the depression scores of both groups decreased significantly over the three time-points of the study (baseline, midpoint and endpoint).

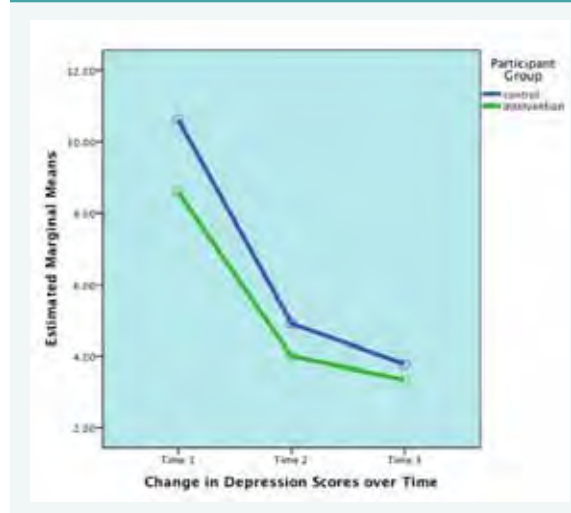**Figure 3.8** *Participants' Change in Depression Scores over Time*



Change in Depression Scores over Time

| Scale/subscale | Control | | | Intervention | | |
|---|---|---|---|---|---|---|
| | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) | Baseline Mean(SD) | Midpoint Mean(SD) | Endpoint Mean(SD) |
| BDI Total | 12.6 (12.4) | 6.0 (6.5) | 3.7 (5.3) | 11.5 (12.5) | 4.7 (5.2) | 3.8 (4.9) |

**Table 3.6** *Participants Scores\* on the Beck Depression Inventory (BDI)*

\*Scores range from 0 – 63. Higher scores indicate greater levels of depression.

Both the control and intervention groups were, on average, within the minimal range for depression at the commencement of the intervention; however, the average depression scores were at the upper end of this category.

Changes in participants' depression scores declined significantly over the course of the intervention.

The greatest level of change for both groups was between the commencement and the midpoint of the programme.

At the end of the study both the control and intervention groups' depression scores were at the lower end of the scale, indicating minimal levels of depression.

## 3.7 Social Networks

The measurement of the support networks of the sample was undertaken using the Practitioner Assessment of Network Type instrument. This 8-item instrument identified the core group of people that participants in the study relied on for advice, help and support. The instrument identifies social networks as individuals, family and communities who are involved with the person in a significant way. These networks include members of the person's household, the provision of companionship and friendship, emotional support and help from individuals and the community. These supports are identified in five network typologies (see Table 3.7 for an overview of each network type).

**Table 3.7** *Description of Network Types (Adapted from Wenger, 1994; Bowling, 1997; Wenger & Tucker, 2002; Drennan et al., 2008)*

| Network Type | Description of network |
|---|---|
| Family-dependent support network | People in this network have close family ties, but limited contact with friends or neighbours. There is little community involvement. The person's family meets the majority of the individual's support needs. |
| Locally integrated support network | People in this network have close relationships with family, friends and neighbours and have usually lived long-term at their residence. |
| Local self-contained support network | People in this network have infrequent contact with relatives living in the same community (sibling, niece or nephew). Reliance for social contact and support and contact is mainly on neighbours and lifestyle is focused on the household. Community involvement is very limited. |
| Wider community-focused support network | This network is classified by an absence of local relatives. However, contact is maintained over a distance and there is an engagement in community and voluntary organisations. Individuals in this network make a distinction between family and neighbours. |
| Private restricted support network | This network is characterised by a lack of local relatives and very little contact with neighbours or community involvement. People in this group tend to rely on their spouse/partner or are withdrawn and live alone and have become isolated from their community. |

The eight items that comprise the network instrument provide an overview of the level of contact that the participants had with relatives, friends and neighbours as well as involvement with social groups. There was variability of the extent to which participants in both the control and intervention groups interacted with relatives, neighbours and friends over the course of the intervention. Contact with relatives was relatively frequent for both groups of participants; however, at the commencement of the programme approximately a fifth of participants had no contact with friends with approximately a third reporting that they never had contact with neighbours. Contact with social or community-based groups were also relatively low, with over half of both the control and intervention groups reporting at the commencement of the study that they never attended social groups.

The main change was the extent to which participants reported having contact with friends on a weekly basis. There was approximately a 7% increase in contact with friends on a weekly basis in the control group (18.2% at baseline to 25.6% at endpoint) and intervention group (15.4% at baseline and 21.9% at endpoint). The proportion of respondents in both groups who had no friends remained relatively unchanged throughout the intervention, however there was a slight dip at the midpoint of the programme for both the control and intervention groups.

| Table 3.8 Control and Intervention Groups' Contact with Relatives, Friends and Neighbours | | | | | | |
|---|---|---|---|---|---|---|
| Contact | Control | | | Intervention | | |
| | Baseline % (n) | Midpoint % (n) | Endpoint % (n) | Baseline % (n) | Midpoint % (n) | Endpoint % (n) |
| **Contact with Relatives** | | | | | | |
| Daily/2-3 times/week | 32.7 (18) | 42.1 (16) | 43.6 (17) | 40.4 (21) | 36.3 (12) | 43.8 (14) |
| Weekly | 34.5 (19) | 28.9 (11) | 25.6 (10) | 26.9 (14) | 30.3 (10) | 34.4 (11) |
| Monthly/Less Often | 27.3 (15) | 26.3 (10) | 28.2 (11) | 26.9 (14) | 30.3 (10) | 15.7 (5) |
| Never/no relatives | 5.5 (3) | 2.6 (1) | 2.6 (1) | 5.8 (3) | 3.0 (1) | 0.0 (0) |
| **Contact with Friends** | | | | | | |
| Daily/2-3 times/week | 43.6 (24) | 42.1 (16) | 48.6 (20) | 48.1 (25) | 27.3 (9) | 50.0 (16) |
| Weekly | 18.2 (10) | 28.9 (11) | 25.6 (10) | 15.4 (8) | 39.4 (13) | 21.9 (7) |
| Monthly/Less Often | 18.2 (10) | 15.8 (6) | 7.7 (3) | 19.2 (10) | 21.2 (7) | 12.5 (4) |
| Never/no friends | 20.0 (11) | 13.2 (5) | 15.4 (6) | 17.3 (9) | 12.1 (4) | 15.6 (5) |
| **Contact with Neighbours** | | | | | | |
| Daily/2-3 times/week | 31.0 (17) | 31.6 (12) | 43.6 (17) | 27.0 (14) | 42.4 (14) | 41.9 (13) |
| Weekly | 9.1 (5) | 21.1 (87) | 12.8 (5) | 15.4 (8) | 15.2 (5) | 19.4 (6) |
| Monthly/Less Often | 27.2 (15) | 26.3 (10) | 20.6 (8) | 30.8 (16) | 27.3 (9) | 16.2 (5) |
| Never | 32.7 (18) | 21.1 (8) | 23.1 (9) | 26.9 (14) | 15.2 (5) | 22.6 (7) |
| **Attend Social Clubs** | | | | | | |
| Regularly | 38.2 (21) | 42.1 (16) | 33.3 (13) | 30.8 (16) | 36.4 (12) | 46.9 (15) |
| Occasionally | 7.3 (4) | 10.5 (4) | 0.0 (0) | 11.5 (6) | 12.1 (4) | 0.0 (0) |
| Never | 54.5 (30) | 47.4 (18) | 66.7 25) | 57.7 (30) | 51.5 (17) | 53.1 (17) |

At baseline, both the intervention and control groups were dispersed throughout a variety of social networks. The majority of respondents were living in either locally integrated support networks (29.8% control group, 32.2% intervention group), indicating that they had close relationships with family friends and neighbours, or local self-contained networks (29.0% control group, 22.0% intervention group) indicating that they were socially isolated and had minimal access to support networks. A significant proportion of respondents were living in family dependent networks at the commencement of the programme (16.0% control group,

Overall, at the commencement of the study approximately 57% of the control group and 54% of the intervention group were living in social networks (family dependent, local self-contained and private restricted) in which they had relatively limited contact with friends or neighbours. Of the two most socially vulnerable networks, local self-contained and private restricted, 41% of the control group and 40% of the intervention group were in these susceptible networks at baseline and subsequently had infrequent contact with family, friends or neighbours.

| Table 3.9 Social Network Type of Participants at Baseline, Midpoint and Endpoint | | | | | | |
|---|---|---|---|---|---|---|
| Scale/Subscale | Control | | | Intervention | | |
| | Baseline % (*n*) | Midpoint % (*n*) | Endpoint % (*n*) | Baseline % (*n*) | Midpoint % (*n*) | Endpoint % (*n*) |
| Family Dependent | 16.0 (21) | 16.7 (6) | 15.8 (6) | 24.6 (29) | 21.2 (7) | 35.5 (11) |
| Locally Integrated | 29.8 (39) | 27.8 (10) | 39.5 (15) | 32.2 (38) | 39.4 (13) | 35.5 (11) |
| Local Self-Contained | 29.0 (38) | 30.6 (11) | 23.7 (9) | 22.0 (26) | 21.2 (7) | 12.9 (4) |
| Wider Community-Focused | 3.8 (5) | 5.6 (2) | 2.6 (1) | 9.3 (11) | 6.1 (2) | 9.7 (3) |
| Private Restricted | 12.2 (16) | 5.6 (2) | 10.5 (4) | 7.6 (9) | 3.0 (1) | 6.5 (2) |
| Inconclusive | 9.2 (12) | 13.9 (5) | 7.9 (3) | 4.2 (5) | 9.1 (3) | 0.0 (0) |

24.6% intervention group). This indicated that they had little community involvement and principally relied on their families for support and friendship. Approximately a tenth of respondents were living in a private restricted network type at the commencement of the study. People within this network type are vulnerable to social isolation, as they have limited or no contact with family, friends or neighbours. Approximately 10% of respondents in the control group and 5% in the intervention group were in borderline or inconclusive social networks at baseline, indicating that their support network may be in a state of flux or shifting from one network type to another due a change in family circumstance or illness (see Table 3.9).

## Impact of the Intervention on Social Networks

At the commencement of the study a significant proportion of participants had limited or no contact with friends or neighbours.

Over half of participants were living in socially vulnerable networks at the commencement of the programme. This indicated they had limited access to advice, help and support and were somewhat socially isolated.

By the end of the programme the level of contact with friends increased for both the control and intervention groups.

Although there was variability in the extent to which the social networks of the control and intervention groups changed throughout the process of the intervention, there was a decline in the proportion of participants in the two most vulnerable networks by the end of the programme.

The largest decline was the proportion of participants in the socially vulnerable local self-contained network.

The proportion of the sample in the second socially vulnerable network, private restricted, did decline somewhat over time; however not to the same extent as other socially vulnerable networks.

## 3.8 Conclusion

The aim of this study was to evaluate a programme of supported socialisation for people experiencing persistent mental health difficulties living in the community. The participants were allocated into one of two groups: intervention and control. Participants in the intervention group were partnered with a volunteer while those in the control group were not partnered with a volunteer. All participants received a €20 monthly stipend and all were requested to engage in a social/leisure activity for two hours weekly over a 9-month period. The intention of the intervention was to promote a 'friendship' between volunteer and participant comparable to social friendships.

There were no significant differences between the control and intervention groups at the commencement of the intervention on demographic characteristics or on the main outcome measures of interest including: social functioning, self-esteem, loneliness, depression and social network type.

The intervention had a number of impacts on the control and intervention groups over the course of the programme. For both groups a number of social activities were positively affected. These activities included: attending the cinema, going out for a meal, meeting for a coffee and enjoying a conversation. These activities, in particular, going for a coffee and going out to eat, increased substantially for participants in the intervention group. In relation to social functioning overall, the intervention increased levels of recreation (engagement in hobbies and interests) for both the control and intervention groups.

Participants' level of self-esteem also positively changed over the course of the intervention, however, the extent of change was not found to be statistically

significant. It should be noted that at the commencement of the programme the overall level of self-esteem for both the control and intervention groups was identified as being within the normal range.

At the commencement of the programme participants, overall, had relatively low scores of family loneliness, however, there were moderate levels of social loneliness and high levels of romantic loneliness. For both the control and intervention groups, social, family and romantic loneliness scores decreased over time. Both family and social loneliness were found to change significantly from the commencement to the end of the intervention. The greatest change was in relation to participants' experience of social loneliness; this declined to a significant effect compared to either family or romantic loneliness. Levels of romantic loneliness decreased somewhat during the study, however, the change was not found to be statistically significant.

Although both the control and intervention groups were, on average, within the minimal range for depression at the commencement of the intervention, the average depression scores were at the upper end of this category. Changes in participants' depression scores, as measured by the (BDI), declined significantly over the course of the intervention. The greatest level of change for both groups was between the commencement and the midpoint of the programme. At the end of the study both the control and intervention groups' BDI scores were at the lower end of the scale, indicating minimal levels of depression and that level of depression had decreased significantly over time.

There was variability in the extent to which participants in both the control and intervention groups interacted with relatives, neighbours and friends throughout the course of the study. At the commencement of the study a significant proportion of participants had limited or no contact with friends or neighbours. By the end of the programme the level of contact with friends increased for both the control and intervention groups. Over half of participants were living in socially vulnerable networks. This indicated that they had limited access to advice, help and support and were somewhat socially isolated. Although there was variability in the extent to which the social networks of the control and intervention groups changed throughout the process of the intervention, there was a decline in the proportion of participants in the two most vulnerable networks by the end of the programme, especially in the proportion of participants in the local self-contained network. However, the proportion of the sample in the second socially vulnerable network, private restricted, remained relatively resistant to change for participants in both the control and intervention groups.

In summary, although the intervention showed no statistical differences between the control and intervention groups on the outcome measures, both the stipend and the stipend plus meeting with a volunteer partner led to an increase in recreational social functioning, a decrease in levels of social loneliness, a decrease in depression and a reduction in the proportion living within a vulnerable social network.

# Chapter 4: Findings

*The good news about seeing recovery as a gradual reconnection with life is that with proper support, it is open to all who are ready to start fighting for such reconnection*

(Kartalova-O'Doherty & Tedstone Doherty, 2010: 51).

## 4.1 Introduction

Recent research has started to view recovery as a social process of everyday life (Borg & Davidson, 2008), this contrasts with previous research in which recovery from mental health difficulties has been viewed as an individual process that occurs in mental health settings. Connectedness, hope and optimism about the future, identity, meaning in life and empowerment are five recovery processes[5] identified in Leamy *et al.*'s (2011) systematic review and narrative synthesis on personal recovery in mental health difficulties conducted in the United Kingdom. The important role that social connection plays in emotional, mental, and physical health was also noted in Montclaire's (2011) study on the effects of Compeer friendships for people experiencing mental illness that was conducted in Australia. Similarly, in Ireland, striving to reconnect (developing hope, self-determination, and self-esteem) were identified as the service user's main concern in Kartalova-O'Doherty and Tedstone Doherty's (2010) grounded theory study on personal experiences of recovering from mental health problems. They found that recovery involves three types of reconnection (reconnecting with self, reconnecting self with others, and reconnecting self and others with time [6]) and various aspects of cognitive, emotional, spiritual and physical functioning. In particular, their study revealed that reconnecting with life is an individual, gradual, open-ended process of trial and error in which one's personal strengths and abilities are acknowledged, explored and developed.

After beginning their article on processes of recovery in serious mental illness with the following statement:

> *At the bowling alley it doesn't matter if you're mentally ill, if you're a foreigner, an asthmatic, a dyslexic … In a bowling match everyone's a bowler. It's the number of strikes that counts, nothing else. (young man with schizophrenia)* (Davidson *et al.*, 2005: 178)

Davidson *et al.* commented that although starting a scholarly article in this way may seem irreverent or as diminishing the seriousness of such conditions, people with first-hand experience of serious mental health difficulties, either their own or that of others, will recognise obvious aspects of recovery that are often overlooked, that is, `what people do with their time' and `how they spend their time each day.' In the present study, as with Davidson *et al.*'s (2005) study, the participants seemed eager to have a social role beyond that provided by health services, specifically, to be able to go out with others, to engage in everyday activities, to be accepted, and to `just have a normal life'.

Befriending programmes offer a way to address the social consequences of mental health difficulties as engaging in activities with another person fosters the development of a supportive, one-to-one, regularly occurring social relationship (Mitchell & Pistrang, 2011). As a befriending approach, supported socialisation facilitates caring, reciprocal relationships, structured opportunities and supports for people with ongoing mental health difficulties which enables them to participate in community life and to realise that they have something of value to offer others (Davidson *et al.*, 2004). However, McCorkle *et al.* (2009) highlighted the lack

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5 The acronym CHIME is used to refer to these recovery processes collectively (**C**onnectedness, **H**ope, **I**dentity, **M**eaning, **E**mpowerment).

6 Reconnecting self and others with time involves considering the past, present and future.

of literature on the impact of volunteer befriending programmes for people with ongoing mental health difficulties and on programme characteristics that produce particular outcomes. They noted that such research, except for Davidson *et al.* (2001), focused on outcomes only and not on the experiences or perceptions of participants or volunteers. McCorkle *et al.* (2009) also referred to the earlier research of Bradshaw and Haddock (1998) on befriending people with mental health difficulties, noting that although it was similar to that of Davidson *et al.* it only provided general descriptions of benefits, did not discuss the mechanisms that promote benefits or disadvantages of befriending, and did not explore the volunteers' perspective.

Future research on supported socialisation, as advocated by McCorkle *et al.* (2009: 209), should explore the following unanswered questions. Firstly, do successful relationships have a "click factor", that is, do partners get on very quickly from the first meeting and do supported relationships, like other relationships, involve stages of deepening? Secondly, what effect does befriending have on traditional outcomes? In other words, what impact do social support, psychological well-being, and assistance in dealing with various issues have on symptoms, service use, or employment? Similarly, the critical importance of understanding the service users' perspective in terms of what they feel works and what support(s) are needed from services in the journey of recovery was also emphasised by Kartalova-O'Doherty and Tedstone Doherty (2010). A major gap in the befriending literature, as noted in Mitchell and Pistrang's (2011: 152) study, is knowledge on the process of "*how befriending works*". In the present research, in an effort to see how befriending works, diaries were used to explore the question of `*What are the barriers and/or benefits to re-entering the community?*'

The remainder of the chapter is organised into five sections: the diaries, the commencement meeting, the socialisaiton activities, socialisation experience and reflection. The participants' descriptions of this socialisation experiences are followed by a notation that indicates their gender, group (intervention or control) and age category. For example, if Melissa was in the control group and her age was 47 years old, the notation after her quote would be presented as follows: (female-C, age 40s). In the next section, information on the number of diaries and diary entries and a possible explanation regarding the difficulty of making a diary entry are presented.

## 4.2 The Diaries

The diaries were created, as noted in the methods chapter, in order to acquire information about the socialisation experience. In total, information was acquired on the outings of 70 participants; 34 from the intervention group and 36 from the control group. The highest number of outings reported was 38. For participants in the intervention group, the number of outings ranged from two to 31; the median outing was 16.5. For control group participants, the number of reported outings ranged from two to 38; the median reported was 12.5. Twenty-six participants (13 intervention, 13 control) reported going out 20 times or more.

The highest percentage of diary entries occurred in the first three weeks of the project; for the control group, this occurred in week one (78%), for the intervention group, it was week two (82%). Although some fluctuation occurred, a downward trend in diary entries occurred from week three onward. By week six, the percentage of diary entries for both groups was the same (50%). Although the percentage of diary entries in the intervention group increased in weeks seven (71%) and eight (68%) to

levels similar to the first week, this was followed by a steep decline in weeks nine (41%) and ten (26%).

It is important to note that, for some participants, completing the diary may have been challenging or frustrating due to the routine nature of their everyday life, as illustrated in the following quotation:

> *I find it a bit difficult to fill in the form. It seems to be the same thing again. Generally what I do for socialisation is go [to] town, go [to] the pictures, go to the library and go out with some members of my family at the weekend. We go for a meal and visit somewhere different each time. For Christmas each year I go to one or other of my [siblings] for a few days which I enjoy very much as it's a change in my routine* (male-C, age 60s).

Information about the commencement meeting, socialisation activities, and socialisation experiences recorded in the diaries are reported in the following sections.

## 4.3 The Commencement Meeting

> *For individuals with enduring mental health problems, integration into the community is often an ideal rather than a reality* (Mitchell & Pistrang, 2011: 151).

The purpose of the commencement meeting or launch, as noted earlier, was to introduce people and to remind them about what the project involved. The launch was a gala event for both the intervention and control groups and efforts were made to greet the participants near or at the door so that they would immediately feel welcomed and put at their ease; as noted in the following comment:

> *I was directed to the first floor where I was warmly welcomed. The chat was friendly*

*and encouraging* (female-C, age 50s)*.*

The atmosphere of the commencement meeting was unexpected:

> *It was much more relaxed and informal than I expected* (female-I, age 30s).

In particular, those attending liked "*THE Friendliness*" (male-C, age 50s), "*that people were friendly*" (female-C, age 20s); as one participant put it:

> *The people were very friendly, and I got on with them all* (male-I, age 50s)*.*

Overall, the commencement was viewed as "*entertaining*" (male-C, age 40s). While some participants "*enjoyed meeting with [the] grou*p" (female-C, age 70s), others noted the "*refreshments*" (male-C, age 30s) and other elements:

> *I enjoyed the speeches and the talking, the sandwiches and lemonade* (male-C, age 60s).

> *Friendly, informal, food, not too long, chat, the colourful gifts (I particularly like those)* (female-C, age 30s)*.*

> *The friendliness and kindness of everyone the party & gift* (female-I, age 30s)*.*

The general experience of the matching process for those in the intervention group was captured succinctly in the words of one participant:

> *The whole group met and each person was matched up with their partner and most were satisfied with the result including myself* (male-I, age 31)*.*

The work that had been put into preparing the launch was also commented on:

> *The manual was well produced and thought out* (male-I, age 50s)*.*

> *I noticed the thoughtful detail in the presentation ...* (female-C, age 50s)*.*

> *A lot of thought and effort had gone*

*into making the launch special and memorable. I was very impressed* (male-I, age 40s)*.*

Although responses to questions about difficulties or dislike regarding the commencement meeting received minimalist responses such as, "*no*" or "*nothing*", for some participants, this meeting reinforced the fact of not being paired with a partner. A participant, who had attended a commencement meeting on one of the hottest days of summer, noted disliking the "*climate*" (male-C, age 30s) while others responded positively to the question about difficulties or dislikes:

*I can't really think of anything that I didn't like because it's the first time I've felt relaxed socialising in ages* (female-C, age 20s).

However, apprehension about attending the commencement meeting was experienced by participants and volunteers before arriving. From the pilot study onward, concerns raised in regard to this meeting centered on the issue of being nervous about meeting other people which is illustrated in the following comments:

*I was a bit nervous going to the [hotel] and meeting people ...* (female-C, age 20s)*.*

*Nervous meeting up with [my volunteer partner] and as to would I get on with them* (male-I, age 40s)*.*

Although participants wondered whether the commencement meeting would suit them, they found a reason to convince themselves to attend:

*I didn't know if it would be relevant to me but on the other hand I usually like most social activities* (female-C, age 30s)*.*

The overall experience of apprehension about the launch is illuminated in the following comment made by a participant who had completed the study:

*I was a bit nervous I was looking forward to it. Once it was over I was looking forward to it --- like starting something new* (male-C, age 30s) *.*

One suggestion for improving the launch was to be "*able to choose your own partner*" (female-I, age 50s). Others noted that they were "*happy enough*" (male-C, age 60s), that "*the people were lovely*" (female-I, age 40s) or that they could not think of anything.

In later cohorts, questions about the launch included a question about the participant's hopes and/or plans for the socialisation experience. In particular, the participants wanted to feel more at ease:

*to be less nervous about meeting new people* (male-C, age 40s).

and to have more confidence in themselves and more awareness and knowledge of others and their environment, as indicated below:

*More confidence, make new friends. More awareness of what is going on in the city* (male-C, age 50s).

*Meet other people. Learn about things and how other people live* (male-I, age 60s).

## 4.4 The Socialisation Activities

*In the recovery process the individual forms social relationships and seeks out socially rewarding environments as a way of managing, and reducing, symptoms* (Schön *et al.,* 2009: 346).

The activities and patterns of participant engagement were diverse. Some participants did similar activities each week, others did something different from week to week, however, most participants fell between these extremes. The activities are divided into four broad categories: coffee, meals, shopping, travel, and films; concerts, performances, galleries, museums, and places of interest; walking, physical activities and games; and family, friends or solitary activities.

### 4.4.1 Coffee, Meals, Shopping, Travel and Films

Most often, the participants seemed to like going out for tea or coffee, either alone or with others, in coffee houses, cafés, department stores, restaurants, hotels, or pubs, as one participant wrote:

*I'm looking forward to the outing I'm looking forward to the coffee and the atmosphere of the coffee shop* (female-I, age 50s).

Coffee outings sometimes entailed going for a walk and, to a lesser extent, involved going for a meal and/or doing various types of shopping including window shopping:

*I met up with [my Volunteer] and had a lovely evening going round the shops ... We talked a lot which was lovely & helpful to me. I felt very happy afterwards* (female-I, age 30s)*.

The participants liked talking, as one participant wrote, it was `"*cool*" to talk' (male-I, age 50s). As Borg and Davidson (2008: 132) noted, "[w]hat seems most crucial to `being normal' is spending time in ordinary environments with ordinary people" in practical and mundane ways such as having a coffee, shopping, and paying bills.

In response to questions about what they liked about an activity, some participants commented that it was something to "*get me out of the house*" (female-C, age 70s) or that:

*It was nice to get out of the house for a few hours* (male-C, age 40s)*.

However, participants also referred to uncertainty or insecurity and noted being nervous or worried about engaging in an activity. Comments were made about being uncomfortable in crowds, of getting restless due to sitting too long, or of being anxious that the conversation might be difficult. As one participant wrote:

*a bit anxious that we won't have much to say to each other* (female-C, age 40s).

On some occasions, the participants liked not meeting with the Volunteer:

*did not meet I was glad I wanted a bit of time to sit and relax and do nothing* (female-I, age 30s).

Participants also went to the outdoor markets such as the ones in Dun Laoghaire or Temple Bar and/or travelled by train or bus to other cities, for example, Belfast or Galway. Some participants liked "*Travelling about, not staying in one place*" (male-C, age 60s). Participants in the intervention group appreciated not having to travel to meet their Volunteers:

*It was easy and I didn't have to travel* (female-I, age 30s)

*It was nice to do something in [the place] where I live* (male-I, age 50s)*.

Both groups of participants reported attending numerous films and, with some exceptions, the film titles reflected gendered preferences.

*Have really liked some of the activities, so far, really like going to the cinema going to concerts* (male-I, age 20s).

A few participants reported watching DVDs or football matches on television with their friends or family.

### 4.4.2 Concerts, Performances, Galleries, Museums, and Places of Interest

#### Concerts and Performances

Participants attended a variety of concerts including the Brennan Sisters, the Irish Youth Orchestra performance at the Royal Irish Academy of Music Annual Gala Concert, Jack Lukeman (Jack L), Jean-Luc Ponty, the Music of Nat King Cole, RTÉ Summer Lunchtime Concerts, the Three

Irish Tenors, and *Strictly a Swing Thing*; other musical events included flamenco shows and musicals, such as *Guys and Dolls*.

Diverse theatre productions, plays, pantomines and performances were also attended including *All My Sons* at the Gate Theatre, *The Asylum* (Keith Barry) at the Olympia Theatre, *Cinderella* at the Gaiety Theatre, *Playboy of the Western World* at the Peacock Theatre, *Put Out the Light* and *The Tailor* and *Antsy* at the New Theatre, and *Women on the Verge of HRT* at Mermaid Theatre. Other performances included comedy shows, the *Street Performance World Championship* and cultural performances or events such as *African Storytelling*, Dance and Comedy, *Culture Night*, and the *Dun Laoghaire Festival of Cultures*.

## Galleries and Museums

A vast array of galleries was explored including the Hugh Lane (Dublin City) Gallery's exhibits of `Francis Bacon A Terrible Beauty Centenary' and `The Quick and the Dead' and the National Art Gallery's exhibitions of Edvard Munch and Irish 20th Century Art. As one participant wrote:

> *Visited the National Gallery. I really enjoyed it. ... We discussed J.B. Yeats and his paintings. Vermeer painting was on loan. Looked at the Impressionists Van Gough, Bonard. It was both informative and uplifting* (female-I, age 30s)*.*

Other galleries visited included Apollo, Bad Art, Naugton, Oisin, Origin, the Royal Hibernian Academy (RHA), the Photography Galleries in Temple Bar, the Signal Arts Centre in Bray and art exhibitions in Merrion Square and on St Stephen's Green were also viewed. Attending the galleries was something that the participants liked doing:

> *... met [my Volunteer], visited an art exhibition as I am very interested in art* (male-I, age 20s)*.*

and was viewed as a learning experience:

> *We learnt an awful lot about art with all the shows we went to. Normally I wouldn't go to exhibitions much so it was a good incentive* (male-I, age 50s).

Participants went to the *National Library of Ireland's* exhibition of the life and works of William Butler Yeats and to the `Bubble' and `What If' exhibitions at the Science Gallery in Trinity College Dublin.

Museums were also visited by the participants including Collins' Barracks, where a `Soldiers and Chieftains' exhibit was on display, the *Chester Beatty Library/ Museum*, which had an exhibition on world religions, the *Irish Museum of Modern Art,* and the *National (Natural History) Museum of Ireland*, where `Iron Age bog bodies' were exhibited. The *Dublin Writers' Museum*, the *National Transport Museum*, and the *Wax Museum* were also visited.

> *This week we went to the Museum of Modern Art. They have in the exhibit a series of cutglass windows which are fantastic and another which are made of different coloured plastic and resemble Big Bird of Sesame Street* (male-I, age 50s)*.*

## Places of Interest

Other exhibitions that the participants went to see were `The Human Body' in the Ambassador, `King Tutankhamun' in the RDS, Bord na Mona's `Heartlands' in St Stephen's Green and Michael Jackson Memorabilia at Newbridge Silverware. Some participants did other things such as a tour of Dublin City, a tour of Grange Cemetery, a Liffey river cruise, and/or engaged in seasonal activities such the St Patrick's Day parade, summer barbeques, seeing the Christmas lights in Dublin and/ or the Christmas parade and fireworks in Dun Laoghaire. A few participants attended football or GAA matches.

Formal gardens were also of interest to some participants such as Airfield Gardens,

Charleville Estate, Kilruddery Home and Gardens, Mount Usher, Powerscourt and the Zoological Gardens; such visits often entailed other activities:

*Went to Powerscourt Gardens. We had lunch and walk about the garden* (female-I, age 60s).

Other places of interest included Christchurch Cathedral, St Patrick's Cathedral, Dublin Castle, Malahide Castle, The Guinness Storehouse, Sea Life in Bray and Dublin Zoo, as described below:

*... There was an entrance fee of 8 euro for students, pass cards & senior & medical cards. The Aquarium had everything except for frogs & terrapins but I saw seahorses, squid octopus & We saw a feeding of some fish at 4 pm* (male-I, age 50s).

*Went to Dublin zoo with seven friends had a picnic lunch and we took some photographs of the animals and each other* (male-C, age 50s).

### 4.4.3 Walking, Physical Activities, and Playing Games

Many of the participants went for walks which varied in the length from a stroll in the park or a brief walk then to a cafe, to walking Dun Laoghaire pier or Bray seafront, to the cliffwalk from Greystones to Bray. One long walk involved going from St Stephen's Green to the Liffey through the Grand Canal Dock and ending up in Sandymount Green and then back the same route. Participants commented that they liked:

*[being] out in the fresh air* (male-I, age 40s)

*the walk the chat* (female-I, age 50s).

Some participants engaged in organised exercise such as aqua aerobics, boxing or pilates, while others went swimming or to the gym. As one participant commented, it was "*nice to be doing something new*" (female-C, age 30s).

Other participants went fishing, sailing, whale watching or to the beach or played pool, bowling, green grass bowling or pitch and putt.

### 4.4.4 Family, Friends and Solitary Activities

In examining the participant's everyday experiences, as advocated by Davidson *et al.* (2006), the present study revealed that many of the participants were in regular contact with family and friends and engaged in various activities with them. These activities included birthday, wedding, and anniversary celebrations, as well as, visiting the sick and attending funerals. In regard to attending a wedding, one participant commented that she was:

*Happy because I was with my family, for good reasons* (female-I, age 50s).

Some participants were providing care for children or adult family members. As Borg and Davidson (2008: 133) noted, "family life offered regularity in contact and activities", allowing individuals to have regular contact and activities and to assume roles, such as parent or spouse, in common social settings.

Participants also engaged in solitary activities and hobbies, such as photography or gardening, or sampled various classes. As Borg and Davidson (2008) found, the participants presented themselves as individuals within a cultural and social context, like people in general, they engaged in social and cultural norms and activities, such as going out for coffee and/or a walks and supporting one's family.

### 4.4.5 Comments on the Activities

When asked whether they would do anything differently in regard to an activity, sometimes participants indicated no, they would not do so:

*I don't think I would change anything as I enjoyed my day* (female-C, age 40s)

At other times they focused on correcting a mistake made on the present occasion. For example, that they would have preferred going out on a sunny day or when the weather had improved, would wear lighter or warmer clothing, arriving earlier, later or on time, or would sit in a different place, choose a lower calorie food or, as one participant noted:

> *Not go to see a film after eating [a meal]* (male-C, age 40s).

Others commented that they should relax more and be less stressed, take more time doing something or that they should buy more of a particular item.

The participants tended not to comment on the money (stipends); when they did, it was to say how much they appreciated the money.

> *I very much appreciate the money. I was able to socialize with cups of coffee meeting people and chatting* (male-C, age 60s).

> *Went to Collin's Barracks to see soldiers & Chieftains exhibition which was excellent & very educational. We followed this with coffee & snack --- which reminds me to say thanks for giving the €5 per week towards this (female-I, age 50s).*

However, based on the list of activities engaged in, as presented above, it is readily apparent how the money was spent.

## 4.5 The Socialisation Experience

*Recovery relies not only on the indiviudal's emerging sense of integrity and purpose (first order change) but also on sociey's increasing ability to acknowledge and support that integrity and purpose (second order change)* (Onken *et al.,* 2007: 19).

In reflecting on the socialisation project, some participants felt that they had not changed and/or commented that they wished they would have had a partner as evident in the following quotations:

> *I do not think I have changed in any way. As I had no person to join up with. However, towards the end of the study I have met up with a few girls from [a club] & feel I may be able to meet with them* (female-C, age 40s).

> *I would have liked to have seen what my life would be like with a volunteer partner* (male-C, age 60s).

Difficulties noted by some participants pertained to feeling uncomfortable, afraid or at risk in terms of travelling, particularly in regard to travelling into Dublin city centre, being on the DART, and/or travelling at night. Intervention group participants who were employed sometimes had difficulties arranging time to meet in situations where the volunteer partner was also working.

Other participants indicated that they had enjoyed the socialisation experience:

> *I really enjoyed the socialisation experience. I always looked forward to meeting [my Volunteer] ...* (male-I, age 50s).

and/or commented that the project had motivated or helped them in some way:

> *I think it has helped me to do activities, more than I normally would* (male-C, age 30s).

> *I could bring the children to some of those places I know Dublin very well now* (female-I, age 40s)*.*

An awareness of the importance of socializing was also evident in the some of the participants' diaries:

> *Since I was first in hospital ... I've made a point of going out & socialise etc*

*more often so I feel that the past three months have been a continuation of this* (female-C, age 30s).

They acknowledged that socialising was not easy, that changes do not occur immediately and that making the effort to go out to engage in a social or leisure activity had positive outcomes, as illustrated below:

*I was conscious that I needed to socialize and to push myself when I would normally not bother and it gave me confidence in myself It was like setting myself targets* (female-C, age 40s).

*I am enjoying it --- it gets me out to socialise --- to do social activities. I probably would not have done it without the project. Sometimes I don't want to go out but I enjoy it when I do! It is now part of my routine* (male-I, age 40s).

Ordinary community environments provide meaning and an opportunity to discuss general topics (Borg & Davidson, 2008). In this study, as Montclaire (2011) found, going out with a friend helped the participants feel normal in that they talked about things other than mental health issues and also experienced increased confidence. The word `confidence' was often used by intervention group participants to describe the socialisation experience, as can be seen in the following examples:

*One of the primary effects of the course is that I have more confidence when dealing with people, am more adept at conversation and am more at ease with myself* (male-I, age 50s).

*I feel the experience has helped me have more confidence with people. And in particular the opposite sex* (male-I, age 50s).

*[My volunteer] has helped me greatly & I have new confidence & higher self esteem as a result of having her as a friend* (female-I, age 50s).

Participants viewed socialising and acquiring confidence as a learning experience:

*The more you socialise the more confident you become. You also learn to talk to people with similar and other interests. You become less nervous and learn to relax the more you mix with other people* (female-C, age 40s).

As in previous studies, such as Mitchell and Pistrang (2011) and McCorkle *et al.* (2009), participants were exposed to a new relationship, engaged in new activities and, in the process, learned different ways of dealing with situations; such positive experiences instill hope and can be conceptualised as a "fresh start" (Mitchell & Pistrang, 2011: 165). The findings were also similar to those of Borg and Davidson (2008) in that the development of the relationships involved caring, sharing, and reciprocity and efforts were made to maintain a balance of give and take.

*It is fun doing things you like. So much so, you end up looking forward to them. When you realise what suits you, you tend to want to do these things all the time. You can ask people to fall in with your plans, but sometimes you also have to put yourself out* (female-I, age 30s).

*I think it is good that our friendship is a 2 way thing* (female-I, age 50s).

Some participants referred to the pleasure of giving gifts:

*Looking forward to meeting [my Volunteer] I have a small present for her* (female-I, age 40s).

Others noted their appreciation of receiving a gift:

*The beautiful gift she made me. A lot of work went into it* (female-I, age 40s).

In reflecting on engaging in activities in the socialisation project, some participants referred to feeling happy. Some comments were stated simply, for example, "*I WAS VERY HAPPY*" (male-C, age 30s) or "*am happy with progress*" (male-I, age 40s), while others provided more detailed descriptions, as can be seen in the quotations of two other participants:

> *I was happy to meet [my Volunteer]. after the time I had during the week it was something to look forward to* (female-I, age 30s).

> *We talked a lot which was lovely & helpful to me. I felt very happy afterwards* (female-I, age 30s)*.*

As one participant explained, engaging in the socialisation project allowed him:

> *To be able [to] act out my dreams about being happy every day* (male-C, age 30s).

and going out helped him in:

> *being ... happier when experiencing dull moments* (male-C, age 30s).

Such statements support Kartalova-O'Doherty and Tedstone Doherty's (2010: 43) argument that: "once active self-driven reconnection with self, others and time is underway, persons are better prepared to face their bad days in the future."

The socialisation project was viewed as a learning experience and, as Borg and Davidson (2008: 135) found, appreciating the "little things" and taking pleasure in managing small tasks was emphasised:

> *I found that the socialisation project was a great learning experience for me. It gave me the encouragement and opportunity to go out and mix with people. I experienced gradually week by week my confidence increasing. Although what I did from week to week was similar. ... I learned to interact and communicate with people. It made me feel more confident when socialising* (female-C, age 40s).

A comment made by one participant reflects the experience of some of the participants:

> *... although I feel very normal most of the time, and I forget that I'm one of many managing a mental illness ... Then I have a few doubts when I have an `off day'* (male-C, age 30s).

## 4.6 Reflection

*The personal recovery journey often seems to be a tortuous one, and the ending unplanned. `A man does not know how far he has to go until he starts walking', runs a Ghanaian proverb, and before he disappears into the jungle and is lost to oblivion we need to give him some sense of direction without being accused of taking over control* (Tyrer 2011: 526).

Evidence on the role of social factors in contributing to the onset of mental health difficulties has increased, however, systematic research on the role that social factors play in recovery is minimal (Tew *et al.*, 2011). In this study, the diaries revealed much about the process of everyday life in contemporary Ireland for people with mental health difficulties. Peter Tyrer's statement, above, is an evocative summation of the recovery experience that many of the participants had encountered. Recovery entails various phases, the emphasis of this study was on supporting participants in taking steps to connect with others in the community. Although the first steps were difficult, over time, with effort, such difficulty was reported to diminish for those who actively engaged in the socialisation process.

Davidson (*et al.*, 2005) argued that opportunities and supports need to be developed to enable people with mental health difficulties to experience pleasure, play and joy and proposed guiding principles to use for relearning what people can do

for themselves in order to minimize the destructive influence of the illness and to reclaim their lives. These principles are as follows: to view people with mental health difficulties as active agents who direct their own lives; to conceptualize health as "the fortunate coincidence of a lot of things going right"; to view recovery as more likely to occur in and through one's activity and efforts; and to recognise that recovery is not achievable by minimising illness only (p. 160). In understanding recovery, "the trivialities of everyday life must be seen as anything but trivial" (Borg & Davidson, 2008: 138).

More recently, Leamy *et al.* (2011) highlighted that developing and evaluating interventions that support the CHIME recovery processes of **c**onnectedness, **h**ope, **i**dentity, **m**eaning, and **e**mpowerment is an emergent research priority. They argue that the goal of such research is to create an evidence base in which recovery is understood as a unique, individual experience and also aids mental health professionals to support recovery. The findings of the present study fit well with Leamy *et al.*'s (2011) review and synthesis in which five recovery stages were identified (precontemplation; contemplation; preparation; action; and maintenance and growth) and mapped onto a transtheoretical model of change. In the transtheoretical model, the first three stages of recovery entail dealing with the impact of illness and adjusting to changes related to the illness and its treatment. In this study, many of the participants appeared to be in the latter stages of recovery, that is, in the action and maintenance and growth phases. The action stage involves a process of learning, of becoming more aware and independent, engaging in meaningful activities, discovering important elements for one's well being, regaining what was lost and moving forward from semi-recovery

or living with a disability to full-recovery and living beyond disability. Living beyond disability, the maintenance and growth stage, entails making efforts towards community integration, active coping as opposed to passive adjustment, improving quality of life and self-esteem.

The diaries revealed that although the participants were eager to engage in activities, at times, making the effort to do so sometimes proved difficult, but they kept on trying and their efforts were often rewarded, as indicated in the following comment of an intervention group participant:

> *For me, this project has meant success. It proves that having a "well" friend helps confidence & brings about ability to tackle social situations that wouldn't be possible before* (female-I, age 50s).

However, for others, the recovery process was viewed as not yet complete, as a control group participant commented:

> *I still feel I have a lot more to do. I now need to build on the confidence I have gained from the socialisation project and go from there* (female-C, age 40s).

# Chapter 5: Discussion
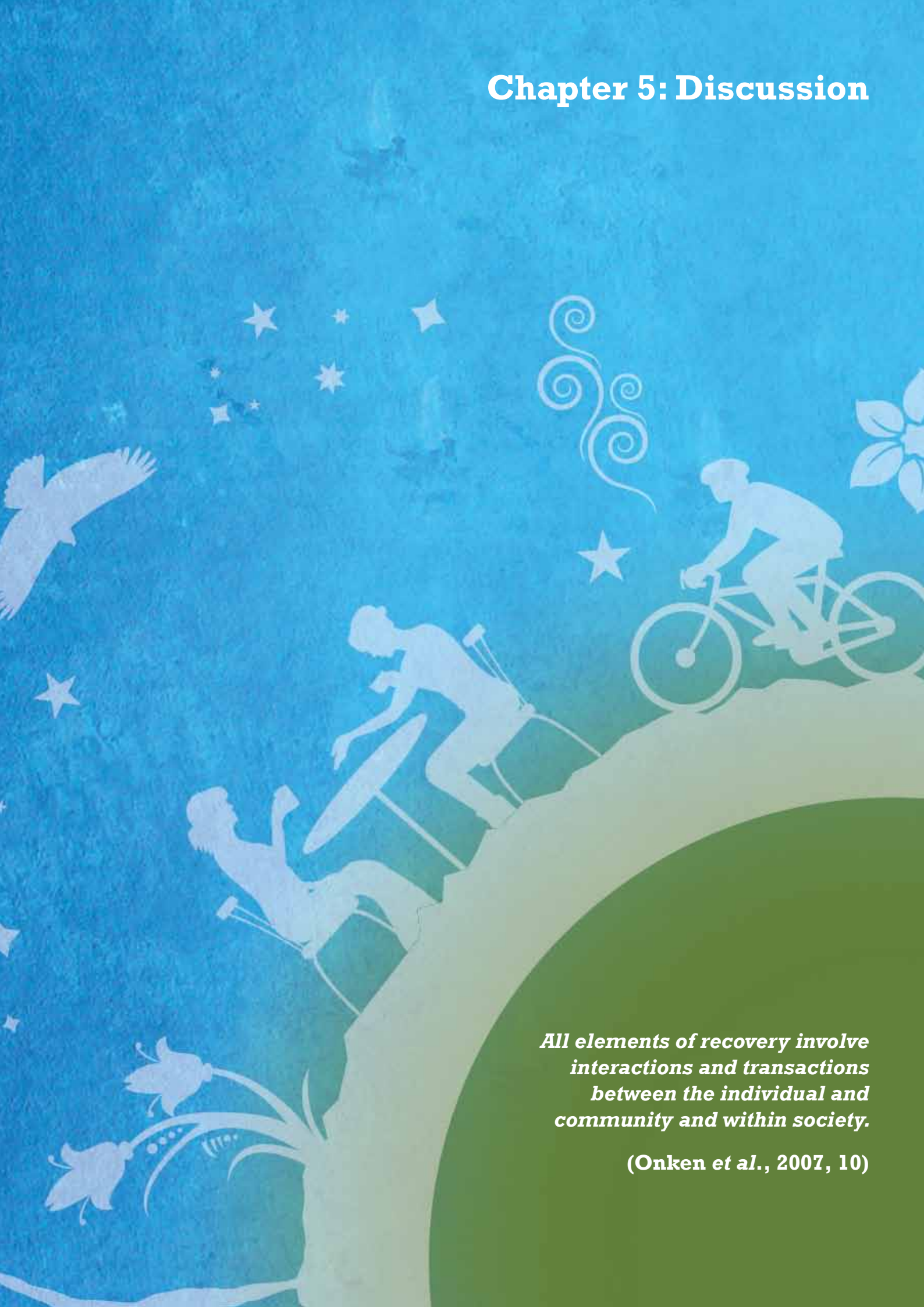
*All elements of recovery involve
interactions and transactions
between the individual and
community and within society.*

**(Onken *et al.*, 2007, 10)**

## 5.1 Introduction

Despite decades of de-institutionalisation and the efforts of mental health services to provide community based care and intervention, for many individuals who experience on-going mental health difficulties, the reality that they continue to lack socially valued activities, personal relationships, adequate income and recognition and respect from others remains. In a very real sense, these individuals continue to exist outside the mainstream and are socially excluded (Ware *et al.*, 2007). This study, an RCT based on the CONSORT principles, examined whether being supported to socialise leads to improved social functioning, increased self-esteem and extended social networks, a reduction in social isolation, social, emotional and family loneliness and a reduction in illness related symptoms such as depression. The aim of this study was to establish, implement and evaluate a programme of supported socialisation for people experiencing persistent mental health difficulties living in the community.

This chapter discusses the effects of the supported socialisation intervention on participants who were allocated into one of two groups: intervention or control. Participants in the intervention group were partnered with a volunteer while those in the control group were not partnered with a volunteer. All participants received a €20 monthly stipend and all were requested to engage in a social/leisure activity for two hours weekly over a 9-month period. The intention of the intervention was to promote a 'friendship' between volunteer and participant comparable to ordinary social friendships existing outside of the usual constraints of the mental health care system. In the case of the intervention group participants, the social/leisure activity was with their volunteer partner.

In total, 107 participants who had contact with mental health services in the Dublin–mid Leinster area and 63 volunteers recruited from the community took part in this study. The average age of the participants was 51 years and approximately 52% of the participants were female. At the time of the study, the vast majority of respondents were not married, a majority of the participants reported that their highest level of education was at secondary level, while approximately a third indicated that they had completed trade/technical training or higher education. Approximately a third of the participants lived in their own home, while over a quarter stated that they lived in supported housing. Almost 35% of the respondents were living alone; a quarter of the participants lived with their family at the commencement of the study.

At the outset of this study, no significant differences were found between the control and intervention groups in terms of demographic characteristics and the main outcome measures of social functioning, self-esteem, loneliness, depression and social network type. However, as identified in Chapter 3, over the course of the 9-month intervention, the intervention had an impact on the control and intervention groups in several ways. In this chapter, the study's results and findings are linked to the existing knowledge on recovery and supported socialisation.

## 5.2 Context

Recovery and rehabilitation from mental health problems are complex; the well-being of people with mental health difficulties is profoundly affected by the attitudes and opportunities that surround them. Although the vast majority of people with enduring mental health problems live and receive treatment and care, within their local communities few natural structures

exist within communities for these individuals who, due to the combined impact of illness and stigma, experience difficulty maintaining existing friendships and relationships with family, or developing new friendships. Consequently, social isolation, loneliness and stigma present significant challenges for them (Davidson *et al.,* 2004).

The present system of mental health care has evolved from one in which consensus, conformity, and adherence to rules were emphasised. A major issue for implementing recovery based principles is moving beyond the ideas associated with conformity and rule adherence and shifting the emphasis away from the need to meet targets set solely by professionals, to focusing on what the service users feel is needed. The recovery movement has attempted to change these ideas and have highlighted the need to create structures and opportunities for people with mental health difficulties. For example, Onken *et al.* (2007) proposed that what is needed is two types of change: change in the individual and change in the system. In addition, the mental health care system needs to work in cooperation with other structures. Thus, both macro-level processes, such as housing and employment policy and micro-level process, for example, how hope and confidence are restored needs to be emphasised.

Being unable to fully access the local community can result in a series of setbacks and poor mental health that, ultimately, is not conducive to recovery. Individuals may feel lonely and isolated at being unable to participate community life and these feelings lead to fear of stigma and of attempting further interaction with the community. Social isolation and withdrawal from everyday life, as well as lost opportunities for social engagement resulting from unemployment, lack of intimate relationships and close friendships, can prevent successful reaching out. It

can, therefore, be a vicious cycle of the symptoms of mental disorders leading to further isolation and the development of other disorders, such as depression, leading to restricted social opportunities, isolation, loneliness and lack of opportunity in life.

## 5.3 Changes that Occurred

This study clearly demonstrate that being supported to socialise resulted in improvements in social functioning, reduction in social and family loneliness, extended social networks, increased self esteem and a reduction in illness related symptoms of depression.

### 5.3.1 Social Functioning

It is well recognised that social factors contribute to mental health and illness and that supporting individuals to regain their sense of personal agency requires providing supportive social situations and opportunities for engagement to promote recovery. Critical to supporting recovery is developing equitable relationships with peers and friends which in turn enhance participation in the community at large. In relation to social functioning, this study demonstrated that for both groups being supported to socialise, increased levels of overall social functioning, particularly in terms of recreation (engagement in hobbies and interests). Being supported to socialise positively affected a number of specific social activities including: attending the cinema, going out for a meal, meeting for a coffee and enjoying a conversation. These activities, in particular, going for a coffee, increased from 45.4% to 64.1% for the control group, and from 55.9% to 87.6% for the intervention group; and going out to eat, increased from 32.7% to 38.5% for the control group and from 34.7% to 56.2% for the intervention group. Importantly these changes demonstrate a substantial increase in these activities for participants in the

intervention group who were matched with a volunteer partner.

The findings of this study are consistent with those of Davidson *et al.* (2004) which demonstrated that providing structured support relating to social and recreational activities had benefits for individuals with serious mental illness in terms of improved social functioning, symptom relief and self-esteem. Davidson's study, which formed the basis of this study, also demonstrated several important findings. Firstly, that individuals with serious mental illness, despite appearing withdrawn, were willing to participate in activities once invited to do so. Secondly, that providing a stipend dedicated to social activity, as opposed to normal requirements such as paying bills, enhanced participation in social activities, regardless of being matched with a volunteer. The importance of having the financial means, along with the discretion as to how this resource may be utilised has also been identified as supporting greater integration and social independence (Tew *et al.*, 2011).

The study reported here also identified that for people with persistent mental health difficulties, having friends who did not have mental health difficulties was considered important. The importance associated with these 'well friend' relationships identified by participants in this study was that they provided opportunities to engage in social situations they would not have otherwise tackled and promoted their personal sense of confidence and achievement. Thus as with Davidson *et al.*'s study, being provided with the support and opportunity to participate in supported social activities away from mental health services has proved beneficial for people with serious mental health difficulties in terms of outcomes, particularly a sense of mastery and recovering a sense of personal agency. The evidence clearly demonstrates, that,

being facilitated to move away from the mental health system, towards the broader community, results in people with serious mental health difficulties being provided with the opportunity to 'feel and act normal' thereby developing more socially valued roles within their community and becoming less stigmatised (Davidson *et al.*, 2004; Borg & Davidson, 2008).

### 5.3.2 Self-Esteem

Self-esteem is considered a central component of subjective well-being and mental health in general. Enhancing the self- esteem of people with persistent mental health difficulties has been a core tenet of rehabilitation, and subsequently, recovery based interventions. The association of stigma, its internalisation and its association with self-identity and self esteem is recognised as acting as a barrier to recovery through undermining hope, confidence and engagement in mainstream social activities. At the outset of this study, it had been anticipated that the self-esteem of participants would be below the normal range. However, at the commencement of the intervention the overall level of self-esteem for both the control and intervention groups was identified as being within the normal range, albeit at the lower end of that range. Therefore, while study participants' level of self-esteem positively changed over the course of the study intervention, the extent of this change was not found to be statistically significant.

The finding that self-esteem was within normal range at the outset of this study is a positive one. However, some caution is required in interpreting this result in that the findings for self-esteem at the baseline of this study appear to be at variance with other related measures including social functioning, network assessment and loneliness scores. It is possible however, that service users who agreed to participate

in this study possessed a higher degree of hope, confidence and positivity about the potential of the intervention and their likelihood to benefit from it, than those who decided not to participate. Thus, these results may indicate that self-esteem is an important factor influencing readiness for engagement in recovery focused activities as well as being necessary for sustaining that engagement over extended time periods. Additionally, the recognised interaction between stigmatisation and self-esteem whereby rejection by others can lead to perceptions of being negatively evaluated may have been challenged by both the invitation to participate in, and the referral to this study, as well as the impact of being matched with a volunteer partner. However, further work is required in the area of self-esteem to extend knowledge and understanding of how it impacts readiness for and sustains engagement in recovery.

### 5.3.3 Depression

Recovery is a complex and dynamic process. Unlike recovery from physical disorder, recovery from mental health difficulties cannot simply be described as an absence of the symptoms of illness. A key aim of this study was to measure the impact of the supported socialisation interventions on the reduction of symptoms. To achieve this, the Beck Depression Inventory (BDI) was used to measure participants' level of depression over the three time points of the study (baseline, midpoint and endpoint). At the outset of the study the BDI score was (mean = 12.6, SD = 12.4) for the control group and (mean = 11.5, SD = 12.5) for the intervention group respectively, both groups reported scores at upper end of the minimal category for level of depression and no significant difference ($t^{95}$ = 0.44, p = 0.67) was found between the two groups at baseline.

Over the course of the study intervention, the total BDI scores of both the control

and intervention groups declined from Baseline to Endpoint. The greatest change in both groups' depression levels was from Baseline to Midpoint, however, overall levels of depression as measured by the BDI continued to decline throughout the study. At the endpoint of the study the BDI scores for both the control group's (mean = 3.7, SD = 5.3) and intervention group's (mean = 3.8, SD = 4.9) were at the lower end of the scale, indicating minimal levels of depression.

The result that supporting socialisation led to changes in the symptoms of depression over the course of the intervention suggest that positive life events such as being engaged in a programme, having activities and social relationships to look forward to, and having some financial resources to spend on social activities, have an impact on illness symptoms. There is evidence that the effect of positive life events supports a person's efforts to rebuild personal agency through ameliorating emotional and/or physical distress caused by illness, as well as though their general restorative power (Davidson *et al.*, 2006). It is also likely that engaging in positive events such as social activities acts to distract people from the more intrusive and negative effects of conditions such as depression and provides respite from symptoms. Furthermore, a systematic review of the effects of befriending on depressive symptoms (Mead *et al.*, 2010) identified that in a community based population with depressive symptoms, the use of befriending as an intervention had a modest effect on the symptoms of depression and psychological distress in varied patient groups. Thus, the findings of this study provide clear evidence that providing opportunities for people to engage in positive life events through the promotion of socialisation and use of befriending has an effect in the reduction of illness related symptoms, particularly those associated with depression. These results

can clearly be seen to have a potentially broader impact in the area of community well-being and mental health promotion.

### 5.3.4 Loneliness

Relationships are vital to recovery; they shape identity and contribute to or hinder well-being; having one or more personal relationships that provides hope and encouragement is considered to be a critical factor in recovery (Spaniol *et al.*, 2002). For adults, friendship and social contact are established and maintained through the social roles that they occupy, for example, in education, work and leisure activities, and in intimate partnerships and parenting. The ability to engage in reciprocal exchange, that is, to contribute in an equal way, is a mechanism for forming and maintaining social relations at both the individual and the societal level. It is through social roles and relationships that social value and community inclusion are conferred. Lacking the capacity and/or opportunities to engage in reciprocal relationships can result in marginalisation and social exclusion, ultimately resulting is social, emotional and romantic loneliness.

At the outset of the intervention period, the overall social and emotional (family and romantic) loneliness scores on the three subscales of the SELSA-S were moderate to high for participants from both the intervention and control groups, indicating that the experience of loneliness was a reality for most participants particularly romantic loneliness (see Chapter 3, Table 3.5). On completion of the intervention social, family and romantic loneliness scores decreased over time for both groups. The greatest change identified was in relation to participants' experience of social loneliness. This changed from a baseline mean of 3.7 (SD 1.8) the commencement of the programme for the intervention group to a mean of 2.6 (SD 1.3), and from a baseline

mean of 3.6 (SD 1.7) to a mean of 2.9 (SD 1.5) for the control group at the study endpoint.

The results of this study indicate that immersing people recovering from persistent mental health problems into the community, allowing them to experience normal roles in society and to manage challenges and situations is liable to prove more beneficial and enduring than providing training in social skills development alone. Similarly, providing opportunities to build supportive friendships, to exercise personal agency and utilise competencies are also beneficial. The findings from the diaries maintained by participants support this result. For example, participants in both the control and intervention groups often referred to having the opportunity to meet with others and to go out to socialise as being critical in giving them the chance to practice, modify and develop their skills, thus building confidence and competence in social interactions. In other words –practice makes perfect!

These results provide evidence that the supported socialisation intervention was effective in promoting social inclusion and integration. The study also provides evidence, particularly from the diaries maintained by participants recovering is a process which evolves over time, and that supported socialisation as an approach allowed individuals to increasingly develop and exercise capacity for connectedness and citizenship. By supporting the construction and maintenance of social and interpersonal relationships which, in turn, support companionship and access to resources, the supported socialisation intervention assisted in the development of social and emotional competency including being able to demonstrate empathy and a capacity for commitment which act together to sustain interpersonal connectedness.

## 5.3.5 Social Networks

One of the consequences of experiencing an enduring mental health difficulty is a reduction in the number of social arenas with which the person has contact. For a significant number of people, the only social arenas in which they engage are dominated by others in a similar situation and by health professionals (Eklund & Hansson, 2007). While recognition of the social needs of people with on-going mental health problems has been part of the re-orientation of Irish psychiatric services, such needs have tended to be addressed through programmes within the formal mental health services. However, evidence suggests that relying exclusively on mental health service based initiatives may perpetuate difficulties with re-integration for individuals who are reliant solely upon mental health services, as they continue to remain apart from their community, and to feel lonely and isolated from society as a whole, (Catty *et al.*, 2001; Tedstone-Doherty, Moran, & Karatalova-O'Doherty, 2007).

The level of contact that participants in this study had with relatives, friends and neighbours as well as involvement with social groups, was examined. Overall approximately 57% of the control group and 54% of the intervention group at the commencement of the study were living in social networks (family dependent, local self-contained and private restricted) in which they had relatively limited contact with friends or neighbours. Of the two most socially vulnerable networks, local self-contained and private restricted, 41% of the control group and 40% of the intervention group were in these susceptible networks at baseline, and subsequently, had infrequent contact with family, friends or neighbours.

The results demonstrate that there was variability in the extent to which participants in both the control and intervention groups interacted with relatives, neighbours and friends over the course of the intervention. Contact with relatives was relatively frequent for both groups of participants; however, at the commencement of the programme approximately a fifth of participants had no contact with friends, with about a third reporting that they never had contact with neighbours. Contact with social or community-based groups were also relatively low, with over half of both the control and intervention groups reporting at the commencement of the study that they never attended social groups. The main change over the course of the study intervention was the extent to which participants reported having contact with friends on a weekly basis. There was approximately a seven per cent increase in contact with friends on a weekly basis in the control group (18.2% at baseline to 25.6% at endpoint) and intervention group (15.4% at baseline and 21.9% at endpoint). The proportion of respondents in both groups who had no friends remained relatively unchanged throughout the intervention.

Among people with persistent mental health difficulties, social networks have consistently been identified as being small when compared to people without persistent mental health difficulties, and as being restricted to a small number of family members with few other groups from which to receive support. It has also been identified that restricted social networks, apart from contributing to social isolation and loneliness, have implications in terms of poorer health outcomes, reduced quality of life and less favourable illness course (Müller *et al.*, 2006), and the perception of being supported by a social network is of major importance for community adaptation of people who have experienced serious mental disorders including schizophrenia (Clinton *et al.*, 1998).

As already identified, promoting social inclusion and integration requires more than the efforts of individuals with enduring mental health difficulties to have hope and commitment. Relationships that situate the person as someone with abilities and as a person whom is able to exert influence, provide opportunities to re-discover personal agency and efficacy (Schön *et al.*, 2009: 345). Therefore, structural change is needed which requires a re-orientation of the principles underpinning mental health services. Such a reorientation requires the placement of social inclusion and integration as a core service aim which recognises that integration evolves over time, and allows individuals to increasingly develop and exercise capacity for connectedness and citizenship. Supporting personal recovery requires all concerned within mental health and associated services to shift away from the traditional and exclusive focus on treating illness, moving towards promoting well-being and connectedness within the community. Furthermore, re-orientation needs to support the construction and maintenance of social and interpersonal relationships which, in turn, support companionship and access to resources.

The results of this study clearly demonstrate that engaging people with enduring mental health difficulties in a programme of supported socialisation enhances social interaction principally through providing opportunities for engagement with others apart from family, mental health professionals and/or peers within mental health services. In this study providing the opportunity to extend social contacts resulted in an alteration of network type reducing the proportion of participants in the two most vulnerable networks by the end of the programme.

## 5.4 Challenges and Limitations

According to Campbell and colleagues "complex interventions are those that include several components" (2000: 694). This study used an RTC to evaluate the impact of a Social Support Intervention for people with persistent mental health difficulties. While the intervention was simple, the implementation of the study was complex in that it involved multiple groups, multiple sites and multiple assessments, thus, posing multiple challenges.

### 5.4.1 Challenges

Key challenges experienced within this study included the following:

**Ethical Approval Process** – a number of challenges associated with obtaining ethical approval to conduct this study were encountered

* The identification of people with mental health difficulties as a vulnerable group resulted in additional requirements for the conduct of this study such as Garda vetting of volunteers. While appreciating fully the need to protect vulnerable individuals, the blanket application of vulnerability across all potential participants could be considered as paternalistic and failing to recognise the personal agency and competency of people with mental health difficulties. Given that a substantial proportion of participants in this study were living in the community and managing their lives away from mental health services, the continued exercise of control over personal agency seems at odds with the promotion of recovery.

- A second challenge was the multi-site, multi-agency nature of this study. Ethical approval for this study had to be obtained from five organisations. Each organisation had separate procedures, documentation and requirements, necessitating five distinct ethical applications and reviews and involved four presentations to ethics committees.

**Maintaining Motivation and Level of Engagement** – Given the requirement of the intervention for weekly engagement, maintaining participant and volunteer motivation and engagement throughout the course of the intervention proved challenging, particularly around the mid-point of the intervention period.

### 5.4.2 Limitations

A number of limitations with this study were identified including:

- Sample Size- While the sample in this study is robust and sufficiently powered in terms of determining intervention effect, a larger sample size would provide increased robustness along with the opportunity to undertake additional statistical analysis.

- Geographic Location – the restriction of this study to one area of the country and to an urban population limits to some extent the generalisability of the findings.

- Garda Vetting – the requirement to have all volunteers vetted resulted in major delays to commencing participants and volunteers in this study. Consequently, a number of participants and volunteers who were ready and awaiting commencement, withdrew.

## 5.5 Summary, Recommendations and Conclusions

Social interaction, building social relationships and creating a social life are significant aspects of social inclusion, and they remain central to whether an individual with an on-going mental health difficulty will participate successfully in other significant life areas including employment and education (Eklund & Hansson, 2007). Social inclusion involves both an active form of citizenship and a subjective sense of belonging which can only result from being part of the mainstream; of being part of and experiencing social networks as supportive and non-restrictive; and having opportunities to engage in meaningful social activities within the community (Prince & Gerber, 2005; Tew *et al.*, 2011). Traditionally, approaches promoting social inclusion and integration and, ultimately recovery, have relied heavily on the re-location of mental health services away from their original institutional base and into the community. Likewise, provision of training in social and occupational skill development to enable people with enduring mental health difficulties to obtain employment and become socially competent thus promoting integration, was the primary approach adopted in rehabilitation programmes. In recent times, however, it has become evident that alternative approaches are required; simply moving services to a community location and/or providing social training are insufficient of themselves for achieving inclusion, integration and recovery.

While participation in service and peer led programmes offers a degree of support for social inclusion, they do not always provide the bridge into the wider community and may act as a long term segregated alternative to mainstream participation (Tew *et al.*, 2011; Davidson *et al.*, 2004).

In contrast the 'Capabilities Approach' takes as its measure the degree of human agency; that is, what people can actually do and be in everyday life. Human agency is contingent upon existing competencies, and upon available opportunities to exercise these competencies (Ware *et al.*, 2007). Recovery is an ongoing process that unfolds in a variety of contexts whilst daily life is occurring; it occurs through the ordinary - the little things in life, in which activities and events happen in an unplanned way (Borg & Davidson, 2008). Relationships connect people to the social world; encouraging them to maintain their ordinary lives, supporting family participation and existing friendships as well as providing opportunities to develop new friendships, all contribute to supporting recovery. The aim of immersing into the community, people who are recovering from persistent mental health problems, is to allow them to experience normal roles in society and to manage challenges and situations – both positive and negative – that are a feature of everyday life. However, for this approach to be effective, social environments must provide opportunities for the individual to develop and exercise competency.

Having personal social relationships with friends is central to recovery, and while recognising that such relationships will vary widely between people, the evidence is unequivocal: supporting the development of positive relationships supports recovery.

Initiatives, such as the supported socialisation programme presented in this study, act to support individuals with persistent mental health difficulties to access and develop positive social relationships. In doing so, such programmes extend social networks and enable local communities to bring people together which results in enhancing levels of social capital. Social intervention, rather than being viewed as an optional extra, needs to be recognised as central to recovery in mental health services. Investment in such activities, will require a reorientation of service and professional aims, and redeployment of resources to facilitate its implementation. Furthermore, to enable people to achieve their rightful aspirations, risk aversion practices that seek to safeguard individuals and system, but which often act to restrict patterns of social inclusion will need to be reconsidered.

On the basis of the evidence presented in this report a number of recommendations are made which relate specifically to supporting recovery within an Irish context. It is important to recognise that recovery requires change at the level of the individual and the system, and consequently these recommendations are structured to reflect this requirement.

### 5.5.1 Recommendations on Provision of Opportunities

To ensure people experiencing persistent mental health difficulties can embark on and sustain their recovery process, social circumstances must provide opportunities for individual competency to be both developed and exercised. However, it must equally be noted that any one approach alone will not meet all needs. Thus, numerous approaches to supported socialisation are needed and should include a mix of one-to-one and various small group socialisation opportunities. Furthermore, the same person may require different approaches at various stages of their recovery process. Such opportunities to develop and exercise competency should be promoted in the following ways:

- Recognition of the individual as an active agent in their own life, and consequent encouragement for individuals to set and pursue their own goals and interests.

- Adoption of a capabilities approach, encompassing assistance to the individual to identify and build on their strengths and abilities, so as to promote personal agency.

- Given the difficult financial circumstances of many people with a long term mental health condition, provision of a modest stipend directed towards social and recreational activities as part of care planning processes, differentiated from paying rent or bills, should be seen as a validated therapeutic outlay.

- Establishment of community based socialisation groups, utilising the protocols developed from this study, to enable community to foster these processes.

- Embracing the link between the university and the community by exploring the role of academic institutions in providing support to the development of community based projects, such as Supported Socialisation, by sharing expertise in areas such as project design, implementation and evaluation.

- Strengthening relationships between existing community groups such as active retirement clubs, church and other faith groups, and social clubs, with local mental health services to develop socialisation and befriending initiatives based on the volunteering approach utilised in this study.

These recommendations are societal – they address the increasing inclusion of people with a long term mental health difficulty into the mainstream of society, by enabling the individuals to develop social competence through social interaction, enabled by the provision of supported opportunities and understanding. This recommendation

requires cross-sectorial commitment and action, ranging from opportunities for society to reach out, through to changes in service-based support, and consideration of what is considered 'therapeutic'. Such changes may take time, but the intention of this evidence-based report is to give impetus by demonstrating that such an approach is effective. Other recommendations require more specific action by mental health services, as follows.

## 5.5.2 Recommendations on Service and Professional Practice

Existing clinical and health service approaches to treatment and service delivery have traditionally focused primarily on adherence to prescribed medication and rehabilitation programme participation. While such focus is necessary, it is recognised that such an emphasis can result in inculcating passivity and compliance with the wishes of services and/or health professionals. The fostering of passivity and compliance in people with persistent mental health difficulties is inconsistent with the goals of a recovery oriented service. Therefore, recognition is required among all health professional and service based staff including policy makers, service planners and managers, that achieving a recovery oriented service will require fundamental changes within existing structures and processes including:

- Recognition of the importance that social interaction and building a social life have for all domains of an individual's life.

- Targeting of socialisation interventions towards people who are most vulnerable to social isolation and loneliness.

- Training and development of all service staff to re-orient them to the attitudes and skills required for a recovery focused service.

- The provision of funding linked to recovery and socialisation.

- The introduction of assessment of social networks and levels of loneliness among those with enduring mental health problems as a key part of the care planning and service delivery process.

- Establishing systems to develop and co-ordinate socialisation initiatives for the most vulnerable.

## 5.6 Conclusion - A Service and Societal Opportunity

This report presents the outcomes from a study which sought to address the question does supported socialisation offer an effective approach to facilitating the reduction of social isolation, loneliness and illness symptoms and, in doing so, increase the social networks, and social functioning of persons with an enduring mental health difficulty? It applied the most rigorous scientific method (a randomised controlled trial) used in the assessment of new therapy protocols including pharmaceutical, surgical and other more traditional and technology-based treatments.

By showing the benefits of supported socialisation for this group of people, it not only provided evidence of the value of such an approach within mental health services, but also yielded two other outcomes. First, it promoted the interests of people with mental health difficulties as a valued societal group worthy of the best science. Secondly, it emphasises that, as appropriate, mental health interventions can consist of a range of tools, of which supporting socialisation is now one.

These results provide both an opportunity and a challenge, yet are in keeping with a period when finance is no longer the sole driving force, and societal cohesion and values are being re-recognised as central to societal well-being. Adoption of supported socialisation for this group of people now becomes an ethical necessity, to enable them to benefit from a proven approach and so increase their re-entry into society. Supported socialsiation will necessitate some changes in attitude by formal service provider organisations and professionals, and indeed in turn by monitoring and educational bodies. But it also presents a challenge to society – one already taken up by the study's volunteers – to put into effect a caring society, knowing that there are only those who will gain, and no losers. Whilst supported socialisation is now clearly established as a recognised intervention, it should in due course become a norm in societal support of individuals with mental health difficulties.
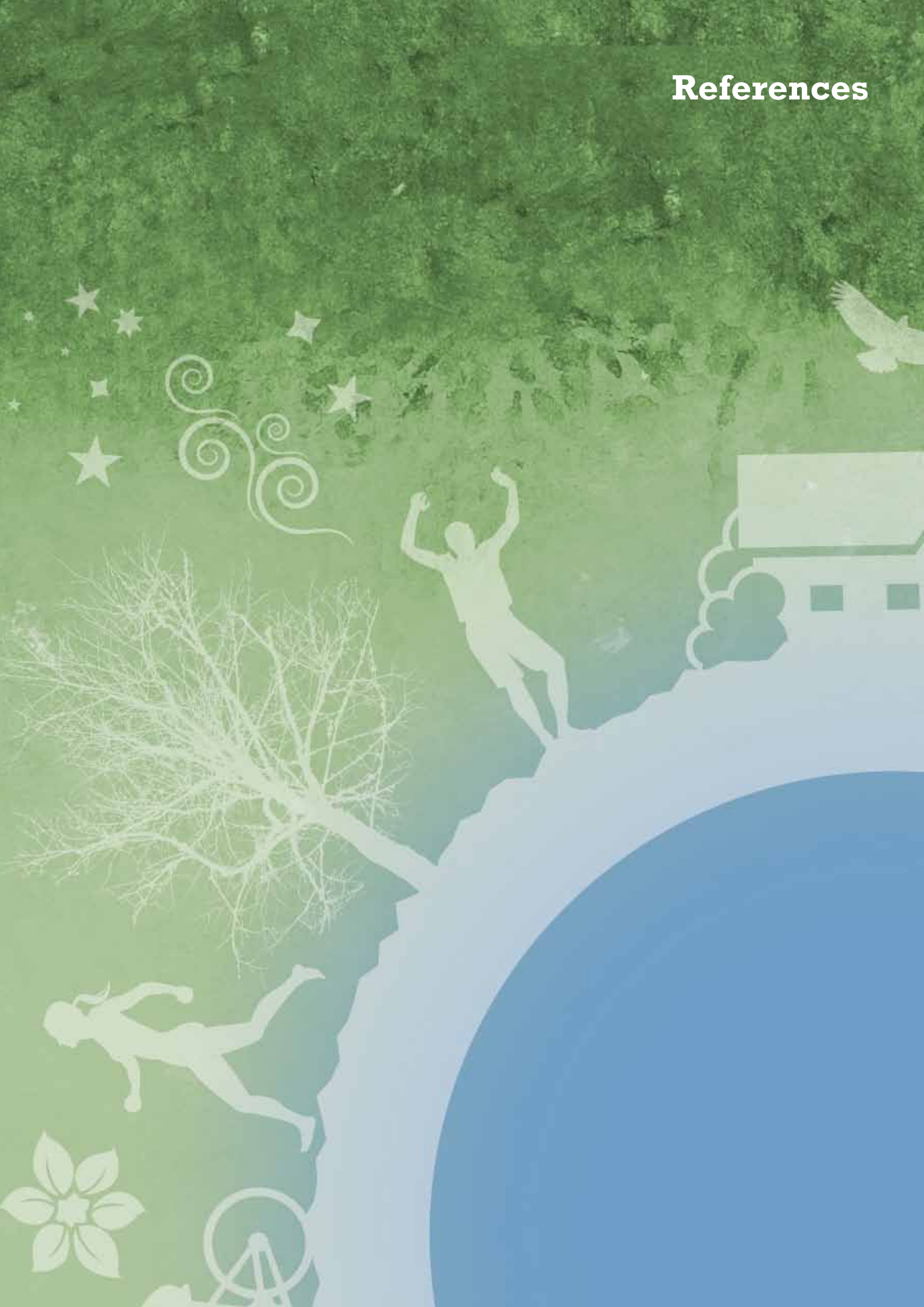
# References

Anthony, W. A. (1993) Recovery from Mental Illness: The guiding vision of the mental health services in the 1990s. *Psychosocial Rehabilitation Journal*, 16 (4), 11-23.

Beck, A.T., Steer, R.A., Browne, G.K. (1996a) *Manual for Beck Depression Inventory II* (BD-11). San Antonio, TX: The Psychological Corporation.

Beck, A.T., Steer, R.A., Ranieri, W.F. (1996b) Comparison of the Beck Depression Inventories-IA and -II in psychiatric outpatients. *Journal of Personality Assessment*, 67, 588-797.

Birchwood, M., Smith, J., Cochrane, R., Wetton, S., Copestake, S. (1990) The Social Functioning Scale. The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *British Journal of Psychiatry*, 157, 853-859.

Boardman, J. (2011) Social exclusion and mental health – how people with mental health problems are disadvantaged: An overview. *Mental Health and Social Inclusion*, 15 (3), 112-121.

Borg, M., Davidson, L. (2008) The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 2, 129-140. doi:10.1080/09638230701498382.

Bowling, A. (1997) *Research Methods in Health: Investigating Health and Health Services*. Buckingham: Open University Press.

Bradshaw, T., Haddock, G. (1998) Is befriending by trained volunteers of value to people suffering from long-term mental illness? *Journal of Advanced Nursing*, 27, 713-720.

Buxton, J.W., Singleton, N., Melzer, D. (2005) The mental health of early retirees. *Social Psychiatry and Psychiatric Epidemiology*, 40 (2), 99-105.

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D., Tyrer, P. (2000) Framework for design and evaluation of complex interventions to improve health. *British Medical Journal*, 321, 694-696.

Catty, J., Burns, T., Comas, A. (2001) Day centres for severe mental illness. *The Cochrane Database of Systematic Reviews*, 2. Art No.:CD001710. DOI: 10.1002/14651858.CD001710.

Clinton, M., Luney, P. l, Edwards, H., Weir, D., Barr, J. (1998). Perceived social support and community adaptation in schizophrenia. *Journal of Advanced Nursing*, 27 (5), 956-965.

Corrigan P.W., Edwards, A. B., Green, A., Diwan, S.L., Penn, D.L. (2001) Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin*, 27 (2), 219-224.

Corrigan, P. W., Salver, M., Ralph, R. O., Songster, Y., Keck, L. (2004) Examining the factor structure of the Recovery Assessment Scale. *Schizophrenia Bulletin*, 30 (4), 1035-1041.

Daly, A., Walsh, D. (2011) *HRB Statistics Series 15 Activities of Irish Psychiatric Units and Hospitals Main Findings 2010*. Dublin: Health Research Board.

Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R., Sells, D. (2005) Processes of recovery in serious mental illness: Findings from a multinational study. *American Journal of Psychiatric Rehabilitation*, 8, 177-201.

Davidson, L., Haglund, K.E., Stayner, D.A., Rakfeldt, J., Chinman, M.J., & Tebes, J.K. (2001) `It was just realizing ...that life isn't one big horror': A qualitative study of supported socialization. *Psychiatric Rehabilitation Journal*, 24, 275-292.

Davidson, L., Shahar, G., Lawless M.S., Sells, D., Tondora, J. (2006) Play, pleasure, and other positive life events: "Non-specific" factors in recovery from mental illness? *Psychiatry*, 69 (2), 151-163.

Davidson, L., Shahar, G., Stayner, D., Chinman, M.J., Rakfeldt, J., Kraemer Tebes, J. (2004) Supported socialization for people with psychiatric disabilities: Lessons from a randomized controlled trial. *Journal of Community Psychology*, 32 (4), 453-477.

De Hert, M., Correll, C.U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., Detraux, J., Gautam, S., Moller, H.J., Ndetei, D.M., Newcomer, J.W., Uwakwe, R., Leucht, S. (2011) Physical illness in patients with severe mental disorders. Prevalence, impact of medication and disparities in health care. *World Psychiatry* 10 (1), 52-77.

Drennan, J. Butler, M. Treacy, P, Byrne, A. Fealy GM, Frazer, K. Irving, K (2008) 'Support Networks of Older People Living in the Community'. International Journal of Older People Nursing, 3 (3):234-242.

DiTommaso, E., Brannen, C., Best, L. A. (2004). Measurement and validity characteristics of the short version of the social and emotional loneliness scale for adults. *Educational and Psychological Measurement*, 64, (1), 99–119.

Eklund, M., Hansson, L. (2007) Social network among people with persistent mental illness: Associations with socio-demographic, clinical and health-related factors. *International Journal of Social Psychiatry*, 53, (4), 293-305.

Gonzales-Torres, M.A., Oraa, R., Aristegui, M., Fernandez-Rivas, A., Guimon, J. (2007) Stigma and discrimination towards people with schizophrenia and their family members: A qualitative study with focus groups. *Social Psychiatry and Psychiatric Epidemiology*, 42, 14-23.

Hopper, K. (2007) Rethinking social recovery in schizophrenia: What a capabilities approach might offer. *Social Science & Medicine*, 65, 868-879.

Kartalova-O'Doherty, Y., Tedstone-Doherty, D. (2010) *Reconnecting with Life: Personal Experiences of Recovering from Mental Health Problems in Ireland*. HRB Research Series 8, Dublin: Health Research Board.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., Slade, M. (2011) Conceptual framework for personal recovery in mental health: Sytematic review and narrative synthesis. *The British Journal of Psychiatry* 199, 445-452.

Lloyd, C., Tse, S., Deane, F.P. (2006) Community participation and social inclusion: How practitioners can make a difference. *Australian Journal for the Advancement of Mental Health*, 5 (3) [available online: www.auseinet.com/journal/vol5iss3/lloyd.pdf.

Mancini, M. (2007) The role of self-efficacy in recovery from serious psychiatric disabilities. *Qualitative Social Work*, 6 (1), 49-74.

Mathers, C.D., Loncar, D. (2006) Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine*, 3, 2011-2030.

McCorkle, B.H., Dunn, E.C., Wan, Y.M., Gagne, C. (2009) Compeer friends: A qualitative study of a volunteer friendship programme for people with serious mental illness. *International Journal of Psychiatry*, 55 (4), 391-305.

Mead, N., Lester, H., Chew-Graham, C., Gask, L., Bower, P. (2010) Effects of befriending on depressive symptoms and distress: Systematic review and meta-analysis. *British Journal of Psychiatry*, 196, 96–101.

Mental Health Foundation (2000) *Pull Yourself Together! A Survey of the Stigma and Discrimination Faced by People who Experience Mental Distress.* London: Mental Health Foundation. [www.mentalhealth.org.uk].

Mitchell, G., Pistrang, N. (2011) Befriending for mental health problems: Processes of helping. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 151-169.

Montclaire, A. (2011) *Friendship really matters: Exploring effects of Compeer friendships for people experiencing mental illness.* Victoria, Australia: St. Vincent de Paul Society, Box Hill.

Mowbray, C.T., Holter, M.C., Mowbray, O.P., Bybee, D. (2005) Consumer-run drop in centers and clubhouses: Comparisons of services and resources in a statewide sample. *Psychological Services*, 2 (1), 54-64.

Müller, B., Nordt, C., Lauber, C., Rueesch, R., Meyer, P., Roessler, W. (2006) Social support modifies perceived stigmatization in the first years of mental illness: A longitudinal approach. *Social Science and Medicine*, 62 (1), 39-49.

National Council on Ageing and Older People (2005). *Loneliness and Social Isolation Among Older Irish People.* Report 84, Dublin: National Council on Ageing and Older People.

National Economic & Social Forum (NESF) (2007) *Mental Health and Social Inclusion.* NESF Report 36. Dublin: National Economic and Social Forum.

Onken, S.J, Craig, C.M., Ridgway, P., Ralph, R.O., Cook, J.A. (2007) An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31 (1), 9-22.

Pevalin, D. J., Goldberg, D. P. (2003). Social precursors to onset and recovery from episodes of common mental illness. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences*, 33 (2), 299-306.

Prince, P.N., Gerber, G.J. (2005) Subjective well-being and community integration among clients of assertive community treatment. *Quality of Life Research* (February) 14 (1), 161-169.

QSR International (2010) Nvivo9 [Computer Software]. Victoria, Australia: QSR International.

Repper, J., Perkins, R. (2003) *Social Inclusion and Recovery. A Model for Mental Health Practice.* Edinburgh: Bailliere Tindal.

Resnick, S., Fontana, A., Lehman, A F., Rosenheck, R A., (2005) An empirical conceptualisation of recovery orientation. *Schizophrenia Research*, 75, 119-128

Roberts, G., Wolfson, P. (2004) The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment*, 10, 37-49.

Roe, D., Chopra, M. (2003) Beyond coping with mental illness: Toward personal growth. *American Journal of Orthopsychiatry,* 73 (3), 334-344.

Rosenberg, M. (1965) *Society and Adolescent Self Image.* Princeton, NJ: Princeton University Press.

Schiff, A.C. (2004) Recovery and mental illness: Analysis and personal reflections. *Psychiatric Rehabilitation Journal*, 27 (3), 212-219.

Schön,U-K., Denhov, A., Topor, A. (2009) Social relationships as a decisive factor in recovering from severe mental illness.

*International Journal of Social Psychiatry*, 55 (4), 336-347.

Schulz, K.F., Altman, D.G., Moher, D. for the CONSORT Group (2010) CONSORT 2010 Statement: Updated guidelines for reporting parallel group randomised trials. *British Medical Journal*, 340, c332.

Shahar, G., Kidd, S., Styron, T.H., Davidson, L. (2006) Consumer support and satisfaction with mental health Services in severe mental illness: The moderating role of morale. *Journal of Social and Clinical Psychology*, 25 (9), 945-962.

Spaniol, L., Wewiorski, N. J., Gagne, C., Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*, 14 (4), 327-336.

Tedstone-Doherty, D., Walsh, D., Moran, R. (2007) *Happy Living Here… A Survey and Evaluation of Community Residential Mental Health Services in Ireland*. Dublin: Mental Health Commission.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., Le Boutillier, C. (2011) Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work*, (June), 1-18. DOI:10.1093/bjsw/bcr076

Tyrer, P. (2001) From the Editor's desk. *The British Journal of Psychiatry*, 199, 526.

Van Dongan, C. (1996) Quality of life and self esteem in working and nonworking persons with mental illness. *Community Mental Health Journal*, 32 (6), 535-548.

Wahlbeck, K., Westman, J., Nordentoft, M., Gissler, M., Laursen, T.M. (2011) Outcomes of Nordic mental health system: Life expectancy of patients with mental disorders. *British Journal of Psychiatry*, 199, 453-458.

Ware, N., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2007) Connectedness and citizenship: Redefining social integration. *Psychiatric Services*, 58, 469–474.

Weisser, J., Morrow, M., Jamer, B. (2011). *A Critical Exploration of Social Inequities in the Mental Health Recovery Literature.* Vancouver, BC: Centre for the Study of Gender, Social Inequities and Mental Health (CGSM). http://www.socialinequities.ca.

Wenger, G. C. (1994) *Support Networks of Older People: A Guide for Practitioners.* Bangor, Wales: Centre for Social Policy Research and Development, University of Wales.

Wenger, C., Tucker, I. (2002). Using network variation in practice: Identification of support network type. *Health and Social Care in the Community*, 10, 28-35.

World Health Organization Report (2001) *Mental Health: New Understanding, New Hope*. Geneva: World Health Organization. http://www.who.int/classifications/icd/en/

**Enabling Recovery** - The Benefits of Supporting Socialisation Report of a Randomised Controlled Trial

# Appendices

# Appendix 1

## Clinician Information Sheet



# A Randomised Controlled Trial of Supported Socialisation for People with Serious/Enduring Mental Illness

Social isolation and loneliness present two of the most significant challenges faced by people with serious/enduring mental illness. In an attempt to address this challenge we are undertaking a **Randomised Controlled Trial of Supported Socialisation**. The overall aim of this study is to establish, implement and evaluate a programme of supported socialisation.

The major objectives of this research project are to:

**Establish and implement a programme of supported socialisation for people with serious/enduring mental illness who are in contact with mental health services.**

**Determine the impact of the supported socialisation programme on individuals with serious/enduring mental illness in terms of i improved social functioning; ii symptom reduction; iii enhanced self-esteem; iv isolation & loneliness**

**Determine the effect of a supported socialisation programme on the incidence and duration of relapse rates of people with serious/enduring mental illness.**

**Explore the feasibility of establishing ongoing programmes of supported socialisation to enhance the social integration of people with serious mental illness within local communities.**

The intervention, which is based on that of Davidson et al. (2004), will take place over nine months.

It will consist of

- Randomly allocating participants to one of two groups:
  i)   partnered with a volunteer,
  ii)  not -partnered
- Providing all participants with a small stipend
- Asking partnered group to spend minimum of 2 hours per week participating together in social/ leisure activities in the community.
- Asking non-partnered group to plan and undertake a weekly social activity.

Participants will be encouraged to take part in a wide range of activities. Participants and volunteers will be responsible for all decisions relating to activities, meeting times and other arrangements. Orientation and training will be provided for volunteers and monthly peer support meeting will be held throughout the project

**All volunteers are Garda vetted.**

Study Funded by

**HRB**
Health Research Board

**UCD DUBLIN**

**UCD School of Nursing, Midwifery & Health Systems**

The key results of the original study undertaken by Davidson et al. (2004) demonstrated that a supported socialisation project provided benefits for **All Participants** within the study, and not just those participants matched with a volunteer. Key finding indicated that:

*Individuals with serious/enduring mental illness, despite appearing withdrawn, were willing to participate in activities once invited to do so.*

*Providing a stipend that was dedicated to social activity as opposed to normal requirements such as paying bills, enhanced participation in social activities.*

*Providing the support and opportunity to participate in supported social activities away from mental health services proved beneficial for people with serious/enduring mental illness in terms of the following outcomes - symptom reduction, increased social functioning and self-esteem and reduced relapse and (re) hospitalisation rates.*

Therefore it is likely that as in the study undertaken by Davidson et al. (2004), participants in this study will derive benefits through participation.
This study also represents the first of its kind in Ireland.

For further Information Please contact the following

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UCD School of Nursing, Midwifery & Health Systems

# Appendix 2

**Participant Poster**

# Appendix 3

## Participant Information Leaflet

**What Next?**

If you are interested in being a part of this study you can get more information and see if you are eligible by contacting any of the following

Mr Donal O'Keeffe

Phone: 01-7166672

E-mail socialisationproject@ucd.ie

Dr Ann Sheridan

Phone: 01-7166427

E-mail: ann.sheridan@ucd.ie

Alternatively, you can leave your name and telephone number with the receptionist/ staff member and we will contact you.

This Study is Funded by

**HRB**
Health Research Board

University College Dublin

UCD School of Nursing, Midwifery & Health Systems
Health Sciences Centre
University College Dublin
Belfield, Dublin 4

**UCD** University College Dublin

**Supported Socialisation Project**

**Information for Participants**

St John of God Services

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### About the Project

This project sets out to examine if linking people who have a serious mental illness with a volunteer partner and providing them with a small amount of funding for socialising will

- reduce their symptoms of illness,
- improve how they feel about themselves
- help them feel more a part of their community.

This research is based on a similar study undertaken in the United States. People who participated in that study reported a lot of positive benefits and felt better able to socialise after the project.

### About the Study

The supported socialization study is a particular type of study called a Randomized Controlled Trial. In this study

- you will be randomly assigned to one (1) of two (2) study groups.
- You will receive a small amount of funding each month to contribute to social activities.
- People in group one (1) will be matched with a volunteer partner.
- People in group two (2) the control group, will not be matched with a partner but will receive the funding for social activities

The study will run over a period of Nine (9) months

The study will attempt to find out if there are any differences between the two groups. If you agree to participate you will be asked to complete a number of different questionnaires on three occasions during the study.

### To Be Included

To be included in the study you will have one or more of the following

- limited social outlets and supports
- limited social life.
- find it difficult to make new friends or keep contact with old friends
- spend a lot of time on your own.

### Why Should You Participate?

This project will offer you a number of benefits

- It will give you an opportunity to meet new people in a supported way
- It will give you an opportunity to get out and socialise in a planned way with a volunteer partner.
- It will give you a small amount of money towards your social activity each month.

# Appendix 4

**Consent Form**

**Consent Form – Project Participation**

**Study Title: Supported Socialisation for People for with Enduring Mental Illness**

| | |
|---|---|
| **Principal Researcher:** | Ann Sheridan, PhD |
| **Contact Details:** | School of Nursing, Midwifery & Health Systems |
| | UCD Health Sciences Centre |
| | University College Dublin |
| | Belfield, Dublin 4 |
| **Phone Number:** | 01 716 6427 |
| **e-mail** | ann.sheridan@ucd.ie |

I, _____ have spoken with the
researchers about the supported socialisation project.

- I understand that I am agreeing to participate in the project and that this will include completing a range of assessment tools when the project begins, mid way through and at the end of the project and allowing my doctor to provide information about episodes of relapse prior to and during the study periods.
- I understand that my contact details will be given to the researchers who will administer the assessment tools over the course of the project.
- I understand that the things I say and the results of the assessment tools are confidential and that I will not be recognised, as my name will not be used.
- I understand that I can stop answering questions and/or withdraw from the study at any time and this will not affect the service I receive from the Cluain Mhuire Services in any way.

I agree to:

1. Participate in the project and complete all of the assessment tools.
2. Allow my doctor to provide specific information about relapse episodes to the principal investigator.
3. Allow my contact details to be given to the researchers for the purpose of conducting the assessment.

| Name: | Signed: | Date: |
|---|---|---|
| Witness: | Signed: | Date: |

# Appendix 5

**Diary**

## Diary (continued)

You can draw, write or paste items here … add a page if you need more space!

**At the end of the month please comment on your socialisation experiences here.**

1. Looking back over the past month, please tell me about your socialisation experiences.

2. What did you like the best?

3. What did you find difficult or that you liked the least?

4. What did you try new this month?

5. If you could do the month over again is there anything you would change? If so, what would you change?

6. What socialisation activities do you plan to do next month?

7. Overall, on a scale of 1 to 10 how is the socialisation project going for you? (Please circle the number that indicates how things are going for you)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Going very poorly!!     Going very well!!

---

*** Each week, please include the day and date that you go out ***

27 June-3 July 2011. This week for my socialisation activity I …

Next time I would like to …

4-10 July 2011. This week for my socialisation activity I …

Next time I would like to …

11-17 July 2011. This week for my socialisation activity I …

Next time I would like to …

You can draw, write or paste items here … add a page if you need more space!

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**Please comment on your socialisation experiences of the last three weeks here.**

1. Looking back over the past three weeks, please tell me about your socialisation experience.

2. What did you like the best?

3. What did you find difficult or that you liked the least?

4. What did you try new this month?

5. If you could do the month over again is there anything you would change? If so, what would you change?

6. What socialisation activities do you plan to do next month?

7. Overall, on a scale of 1 to 10 how is the socialisation project going for you? (Please circle the number that indicates how things are going for you)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Going very poorly!!     Going very well!!

Please look back over your diary entries since the end of June and tell me how the socialisation experience has been for you overall.

**Please Note:** There is one more section to complete

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**Congratulations!** You have completed the 9-months of the project! Looking back over all of the nine months of the socialisation project, please tell me what the socialisation experiences was like for you. Please tell me about both the good and the not so good aspects.

I am interested in any recommendations you have for improving the project. If you have any recommendations, please list them below!

As you know, if you need more space please add some pages. Otherwise, thanks for keeping track of all your activities for me!!! It is now time to return your completed diary to Jane one last time!!! Please call me to arrange an appointment to meet so that I can collect this diary? My telephone number is *** ****! I look forward to seeing you soon!

# Appendix 6

**Volunteer Poster**

# Appendix 7

**Volunteer Information Sheet**

## SOCIALISATION PROJECT INFORMATION FOR VOLUNTEERS

St. John of God Services  ·  UCD DUBLIN  ·  HRB Health Research Board

### The Study

This study is about people who have an enduring mental illness and are considered by their clinicians (doctor, nurse, psychologist or social worker) to have low social functioning.* Low social functioning means that a person has a very limited social life, probably finds it difficult to make new friends or to keep in contact with old friends, and tends to spend a large period of time alone. The study is setting out to discover if assigning people who have an enduring mental illness and low social functioning to a volunteer partner and encouraging them to take part in weekly social or leisure activities will help to reduce the symptoms of their illness, improve how they feel about themselves and help them to feel more a part of their community.

*THIS GROUP WILL BE REFERRED TO AS PARTICIPANTS IN THIS STUDY.

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### A 9-Month Randomised Controlled Trial: Commencing 2008

This study is a Randomised Controlled Trial (RCT for short) which will take place over a period of nine months. A Randomised Controlled Trial means that the people who are participants in this study will be assigned randomly to one of two groups:

- **Group A** - matched with a volunteer partner
- **Group B** - not matched with a volunteer partner

Both groups of participants will be given a small amount of money on a monthly basis and will be encouraged to spend this sum on social activities.

To be selected for the study, the participants must meet the following requirements:
- be recommended by their clinician
- be well for the preceding six months
- be considered to have low social functioning.

The study wants to find out if there are any differences between the two groups of participants, so a number of different questionnaires will be used. Participants will be requested to complete these (with the help of the researcher) before the project begins, midway through the project (about month-4), and on completion of the project in month-9.

## What will be required of Volunteers?

### Weekly Activity and Monthly Meeting

As outlined above, the study wants to find out if taking part in social or leisure activities with a volunteer partner helps people with mental illness to feel better about themselves and to feel more a part of their community. The study will take place over a 9-month period. During that 9-month period you will be expected to participate in social or leisure activities weekly for about two (2) hours with your allocated partner and to attend a volunteer group meeting once a month. However, normal holiday periods (up to three weeks) can be accommodated within the study.

### Training

Before the study begins you will be provided with training to ensure that you are well prepared for your role as a volunteer in this study. While the training will address issues relating to mental health and illness, the study is about helping people with an enduring mental illness to re-integrate into their community through regular social and leisure activities. To make sure that you and the participant get the most out of the study, the training will focus on being a volunteer partner and on how you can plan and organise activities with your partner.

### Support

The research team consists of experienced health professionals including a consultant psychiatrist, nurses and psychologists. Ongoing support in the form of monthly group meetings and regular phone contact with the study team will be provided to volunteers throughout the project. A dedicated mobile phone line is available at all times and manned by a member of the research team. All participants will be in regular contact with their own clinician, the person who recommended them to the study. Additional support services will be available, if required. It is important to know that a protocol will be agreed to ensure that if, at any time, as a volunteer, you consider that the participant you are matched with requires additional support, this can be accessed rapidly.

### Safety

To ensure everybody's safety, all participants will be recommended by their clinician. All volunteers will be required to provide two character referees and to agree to Garda vetting (a normal procedure for volunteering). Volunteers will be asked to complete an application form. You will also be asked questions about the kind of social and leisure activities that you like to do, so we can match you, as closely as possible, with a participant with similar interests.

### Saying Yes

If you say YES, a member of the research team will meet with you to discuss the project and your role as a volunteer in more detail. Once selected to be in the study, volunteers will be asked to attend education/preparation sessions where more detailed information will be provided on:

- the project
- mental health and illness
- supported socialisation and recovery in mental illness
- being a volunteer

**If you would like more information about the project and think you can help please contact:**

**Mr Donal O'Keeffe**
**Dr. Ann Sheridan** or **Dr. Jonathan Drennan**
School of Nursing, Midwifery and Health Systems,
University College Dublin
Belfield
Dublin 4
Telephone – 01 716 6672 Or 6427 / 6404
E-mail: socialisationproject@ucd.ie
**Thank you for your help with this important project.**
**We look forward to hearing from you!**

**Newsletter 1**

## Supported Socialisation Study Update

### On the Starting Blocks – at Last!

This brief newsletter is to keep you informed about what is happening with the supported socialisation study

As you know, we have been busy recruiting participants over the past 9-months. At the same time, we have also been recruiting and preparing volunteers.

Recruiting the volunteers has taken more time than we had expected. Mainly, this was due to having to ensure that all of the volunteers have received Garda vetting which has taken up to eight weeks.

Another difficulty we had in recruiting volunteers was that we had intended to recruit two groups. The first group of volunteers was to be made up of people who had experienced a mental health problem themselves and the second group was to include people who had did not a personal experience of mental health problems.

However, despite our best efforts we were not able to recruit volunteers to the first group thus we had to make minor alterations to the study plan.

This change will not affect you directly. You will still have the same chance of being matched with a volunteer.

However, because of these issues we have been delayed. In addition we are required to inform the **St. John of God Services Ethics Committee** and the **Health Research Board** about the change and these changes need to be approved before we can start.

The next meeting of the Ethics Committee is on October 21st. We hope to have a positive response and be ready to begin the study in November.

We will begin the study with one small group and gradually build up to include all participants and volunteers. So do not worry if you are not in the first group, you will be included in one of the other groups as we progress.

Please remember that not everyone will be matched with a volunteer but all participants will receive €20 a month during the study to spend on social or leisure activities.

### Start Date

- November

### What we are doing now ?

- Getting your consent to participate

- Completing the Social and Leisure Profile

If you have any questions or want more information, please contact Dónal O' Keeffe on 716 6672 or email socialisationproject@ucd.ie.

# Appendix 9

**Newsletter 2**

## Supported Socialisation Project Update

DECEMBER 2008

### Study Commences with First Two Groups

On the 24th and 25th of November 2008, the socialisation project began with the first two groups (one partnered group and one non-partnered group). A separate meeting was held for each group in order to get things up and running.

The first meeting, on 24th November, was with the control group and was hosted in Burton Hall. While some of the participants in the control group were disappointed not to be matched with a partner, most people are happy to continue in the study. However, two people did decide to withdraw at this stage and we were sorry to lose them.

The meeting for the partnered group was a also a great success. This meeting was held in the St. John of God Conference Centre on the hospital grounds in Stillorgan and seemed to work well for all concerned. The participants had the opportunity to meet their partners and to begin to get to know each other before arranging their first social outing.

It was agreed that the first volunteer support group meeting for those volunteers who commenced in November would be held in January as people are so very busy in December. We will however, make contact by phone to find out how things are going for them.

In addition, everyone who commenced (participants and volunteers) was given an out of hours phone number in case anyone needs to contact us out side the normal business hours.

We wish you all a very enjoyable and restful Christmas and look forward to meeting everyone in the New Year!

*Contact*
Ann Sheridan or Donal O'Keeffe
UCD School of Nursing, Midwifery & Health Systems
Health Sciences Centre
University College Dublin
Belfield, Dublin 4
Ph 716 6672 or 716 6427

### The Next Phase

We are aware that many participants and volunteers have been waiting to get started for a long time. Garda Vetting has been the main delay for us; it is taking much longer than anticipated.

We hope that the next batch of Garda Vetting forms will be returned to us from the Gardaí, before the Christmas break and expect to get the next two groups started by mid-January.

We are still recruiting participants and volunteers to the study. If you would like to join us in this study or know of anyone who would like to do so. Please get in touch with us!

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# Appendix 10

**Certificate of Participation**



*Certificate of Participation*

This certificate is awarded to

in recognition of valuable contributions as a
participant on the Supported Socialisation Project

UCD School of Nursing, Midwifery & Health Systems