

The SCOPe Project 2008-2013

Supporting Carers and Older People

Review and Evaluation



Acknowledgements

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1. Introduction and Background



1.1 The SCOPe evaluation

The SCOPe Project (Supporting Carers and Older People) 2008-2013 was funded by the Big Lottery through the 'Investing in Communities' fund and was managed and delivered by GAMH (Glasgow Association for Mental Health) through its Later Life Team.

GAMH is a 35 year old independent Scottish charity that provides more than 2,000 hours of community based support every week to people in Glasgow who experience mental health problems and their carers.

This report is an independent evaluation of the SCOPe project and the outcomes for both the service users (older people with mental issues and older carers) and also the volunteers who worked with them. It is based on:

- consideration of the context of the work;
- examination of annual reports for the Big Lottery;
- analysis of underlying data;
- analysis of monitoring returns; and
- interviews with stake-holders.

Over thirty interviews were carried out either face-to-face or over the telephone and included:

- older people using the service;
- older carers using the service;
- volunteers who provided the service;
- creative artists who contributed;
- staff and managers;
- members of the Steering Group and Advisory Group; and
- external stakeholders.

Considerable help was given by the two volunteer co-ordinators, who tracked down background facts and figures and liaised with people to be interviewed. This report would not have been possible without their support. To all the people who contributed many thanks.

The purpose of the evaluation was to:

- Review the SCOPe project
- evaluate the degree of success according to the agreed outcomes
- record the views of those who took part
- suggest lessons to be learnt
- provide backdrop information for future funding applications

1.2 Context

People are living longer and remaining healthier longer. The number of people in Scotland aged 65 and over is projected to rise by 21% between 2006 and 2016 and by 63% by 2031 (83% for 75 and over). The fastest growth is in the numbers of people aged over 85 (the 'older, older'). In Glasgow currently 3.6% of the population is over 65¹: by 2020 it will be 20%.

This population shift is having an increasing impact on people's lives and on the planning and delivery of services. At the same time, the birth rate is falling and there are fewer people of a working age to contribute to the care of older people who need help. Much of the practical support is now being given by people who are retired themselves and are also helping to look after their partners or parents or grandchildren). Some older people contribute financially themselves, through taxation, funding of their care and supporting the next generations. Yet there are insufficient resources (primarily, but not completely, financial) to go round.

The changing pattern of need for both health and social care as we live longer means there must be a radical shift in how this care is delivered, including greater involvement of the 'younger, older' and the voluntary sector. To continue as we are, reliant primarily on statutory services such as hospitals, is unsustainable economically and logistically and is against the wishes of older people themselves.

These issues are addressed in reports, policies and strategies including:

- [Healthy Ageing - a Challenge for Europe²](#)
- [All Our Futures³](#);
- [Promoting Mental Health and Well-being in Later Life⁴](#);
- [Improving mental health and wellbeing in later life⁵](#)
- [Towards a Mentally Flourishing Scotland: the Mental Health in Later Life Reference Group⁶](#)
- [Reshaping Care for Older People: a Programme for Change 2011- 2021⁷](#)
- [Reshaping Care for Older People: Glasgow City Partnership Joint Strategic Commissioning Plan 2013-2016⁸](#)

¹ National Records Office 2012

² European Commission and partners 2006

³ Scottish Executive 2007

⁴ Age Concern and Mental Health Foundation (2006). [Promoting Mental Health and Well-being in Later Life](#)

⁵ NHS Health Scotland

⁶ Scottish Executive 2010

⁷ Scottish Executive 2011

⁸ Glasgow City Council 2013

The Scottish Government and local authorities recognise the importance of projects and services that:

- Increase self-help and promote independence in the community
- Reduce social isolation by increasing preventive interventions
- Build community capacity to enable people to be more connected
- Shift the balance of care from institutional settings to a community setting

The emerging public mental health agenda now includes later life⁹. The statutory sector (health and social work) focuses mainly on illness, treatment and care, but civil society (including the voluntary organisations) has a major role in illness prevention and the promotion of well-being. This applies to mental well-being as well as physical well-being and often the two are connected.

Research undertaken by Age Concern (now joined with Help the Aged to form Age UK) and the Mental Health Foundation¹⁰ identified five key features in maintaining mental well-being for older people:

- being valued versus being discriminated against;
- participating in meaningful activity versus having nothing to do or to contribute;
- good relationships versus isolation and social exclusion;
- good physical health versus illness;
- financial security versus poverty.

NHS Health Scotland's 'Improving Mental Health and Well-being in Later Life' programme disseminated and consulted on these findings throughout Scotland, holding regional seminars and local events, which involved around 900 people aged over 50 years, plus staff, managers and planners who work with older people.

The Age Concern/Mental Health Foundation recommendations were taken forward in a two-phased development. GAMH was chosen to take part in both phases and focused on 'hardly reached' minority groups.

⁹ 'Later life: challenges and opportunities' in Public Mental Health Today: a handbook. Ed Isabella Goldie. Pavilion, 2010

¹⁰ Age Concern and Mental Health Foundation (2006). Promoting Mental Health and Well-being in Later Life

1.3 Glasgow Association for Mental Health

What We Believe: GAMH Values

People First: We are many sorts of people with different backgrounds and histories. We all have the right to an identity separate from symptoms, diagnosis, illness or disability - we are not our labels - and everyone has the right to have their identity respected.

Experts by Experience: People are experts in their own recovery and wellbeing. They have within them the strengths and potential to find solutions to their own problems.

Equality and Social Justice: Are essential for recovery and wellbeing. Everyone should have the chance to make the most of their lives and their talents. People in recovery should have the same choices and opportunities as everyone else.

Significant Others: The contribution of family, friends and peers to the recovery and wellbeing of people with lived experience should always be recognised and valued.

Participation, Partnership and Collaboration: Services, organisations and the wider community are resources for recovery and wellbeing. They in turn benefit from the significant contribution of people with lived experience to their development and direction.

BOX 1: GAMH values

1.3.1 GAMH development work on mental health in later life

Core local authority funding for GAMH is for younger adults. Therefore, although people who reach the age of 65 are allowed to continue receiving services, no-one over that age can be accepted into a programme unless additional funding is obtained. There has been no large scale commissioning of low level social care services for older adults with common mental health problems which has restricted access to services for this group. The local authority has recently introduced a system of individualised budgets to fund social care needs which may improve access to social care mental health services for older people, however this will be dependent on whether these needs are deemed eligible.

In light of the increasing recognition that access to support for older people is difficult, in 2006 GAMH undertook a mental health and well-being Needs Assessment for older people in Glasgow¹¹.

This involved:

- carrying out an investigation of the legal and policy context for the needs assessment;
- undertaking a literature review relevant to older people and carers;
- carrying out in-depth interviews with individuals; and
- meeting with organisations working with older people and carers.

It reported that:

1. Older people talked of isolation, loss, physical health problems, past trauma and lack of support, leading to suicidal thoughts and actions.
2. 93% of carers said that the stress of caring affected their own physical and mental health.
3. Workers highlighted isolation and poor physical health as being key factors in the mental ill health of older people.

Many older people of course live happy and fulfilling lives. Being old in no way means inevitable unhappiness, vulnerability and exclusion. The task for society (including older people themselves) is to provide opportunities for this better quality of life for everyone.

Since 2008 there has been a separate Later Life Team operating within GAMH. Funding has been obtained for several Later Life projects, including:

- SCOPe
- Building Bridges
- Brighter Futures
- Improving Mental Health in Later Life Phase 1 (NHS Health Scotland)
- Improving Mental Health in Later Life Phase 2: Wah Kin
- Calm
- Later Life Matters

Details are available in the GAMH Annual Reports, project-specific reports and the GAMH website.

1.3.2 GAMH work with Carers

GAMH promotes the health and wellbeing of mental health carers by providing support and opportunities to enable them to sustain their caring role, for them to access their rights and entitlements and to encourage carers to have a life outwith their caring role. Workers in partnership with carers provide outcome focused support personal to the carer's needs. Support provided includes advice, information, training to enhance the carer's knowledge and understanding of mental ill health. Carers can access individual one to one support as well as meeting together in groups to share knowledge and experience of the caring role, specifically in relation to mental health.

¹¹ "No-one asks me..." Experiences of older people with mental health problems, older carers of people with mental health problems and carers of people with mental health problems. Kate Langmead, GAMH. 2006

The initial focus was on adult carers 18-65 years, but it became clear that older carers have similar, but different, issues and require targeted support. The Carers Lead is now leading on the SCOPE work.

1.3.3 GAMH work with volunteers

Volunteer Friendly Award

In recognition of our commitment and investment in volunteering GAMH has achieved the Volunteer Friendly Award from the Glasgow Volunteer Centre. The Volunteer Friendly Award is a quality standard which supports, recognises and rewards group and organisations who are good at involving volunteers. The award is based on the national standard Investing in Volunteers (IiV) which GAMH will look to achieve over the next year.



BOX 2: GAMH and volunteering

Part of the philosophy of GAMH is to maximise the involvement of volunteers wherever possible. This is not merely to reduce costs, a valid aim in itself, but in recognition that volunteering has been shown to be a positive experience for people who take part in terms of self-esteem, confidence and general well-being. Volunteers contribute a broader perspective than professional carers, bringing experiences from a whole range of personal and professional backgrounds. This benefits the organisation as a whole.

To ensure that volunteers undertake tasks in an acceptable manner, without risk to themselves or to people they are supporting, GAMH has developed clear guidelines on recruitment, training, supervision, accountability and management. One of the key concepts taught from the start is that of 'boundaries'. Just like professional staff, volunteers need to recognise the limits and limitations of their role. Just as the Project as a whole has to recognise the constraints of its remit.

1.4 Investing in Communities - The Big Lottery

1.4.1 Application for funding

Based on its ethos capabilities and organisational capacities, GAMH made application to the Big Lottery for funding for a project that would:

- provide opportunities for older people with MH problems to 'get out and about' by supporting them to take part in activities they choose themselves;
- provide similar opportunities for older people who have informal caring responsibility for people who have a MH problem;
- train and support volunteers to carry out these tasks.

Given that GAMH was already negotiating to be a partner in a similar project (Brighter Futures) that calls on peer mentors of a similar age to work with older people, it was decided to seek volunteering opportunities for all ages, with an extra emphasis on younger people and intergenerational working.

There would be particular attention paid to all equality issues¹² around;

- Age
- Gender
- Religion
- Race
- Sexual orientation
- Disability

The bid was successful and in 2008 GAMH was awarded £50,000 a year for five years for the SCOPe project. GAMH is very appreciative of this support and the fact that it was given for sufficient time to develop skills and experience.

¹² Equality Matters: a good practice guide. Big Lottery Fund

1.4.2 Project outcome targets

Three main Outcome criteria were agreed, with annual Milestones (including referral numbers), to aid management and monitoring. The Milestones are not reported in detail here, although they influence the report.

Project outcome 1:

By the end of the project, 40 older people with mental health problems and 40 older carers of people with mental health problems, including BME and LGBT older people, will be less socially isolated and will demonstrate improved confidence and self-esteem.

Project outcome 2:

By the end of the project, 40 older people with mental health problems and 40 older carers of people with mental health problems, including BME and LGBT older people will report significantly improved connections with their community.

Project outcome 3:

By the end of the project, 50 volunteer befrienders, including young people, will report increased self-confidence, self-esteem and life skills.

BOX 3: Outcome targets



SCOPE

**Supporting older people who
have mental health problems**

Are you over 60?

**Would you like to get out
of the house more often?**

If the answers to these questions are yes,
then contact us at SCOPE to talk about
how a befriender might help you.

You can contact us on:

0141 404 3769

scopeteam@gamh.org.uk

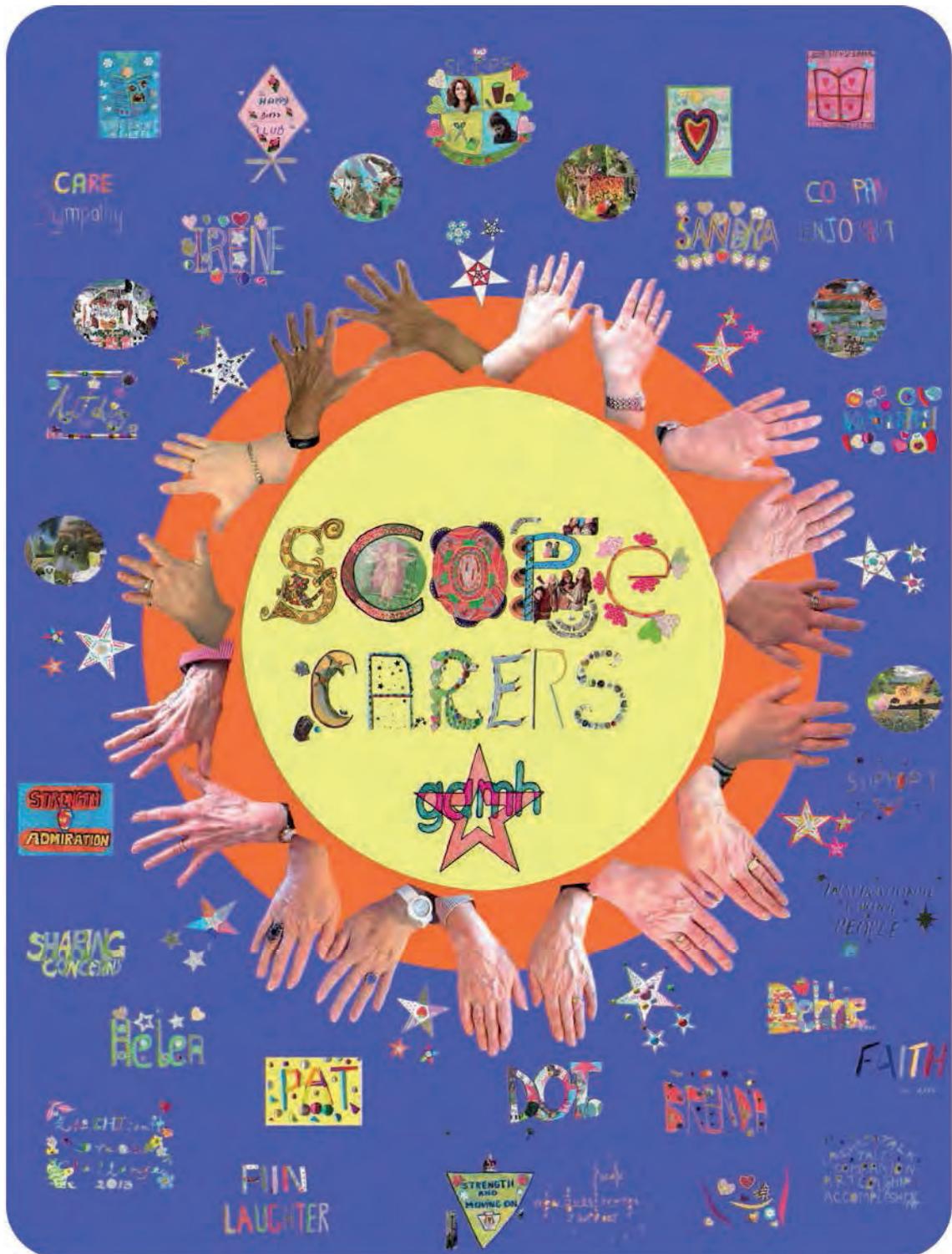
Design created from work by
older people and older carers.



Supported by
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2. The Work of SCOPE



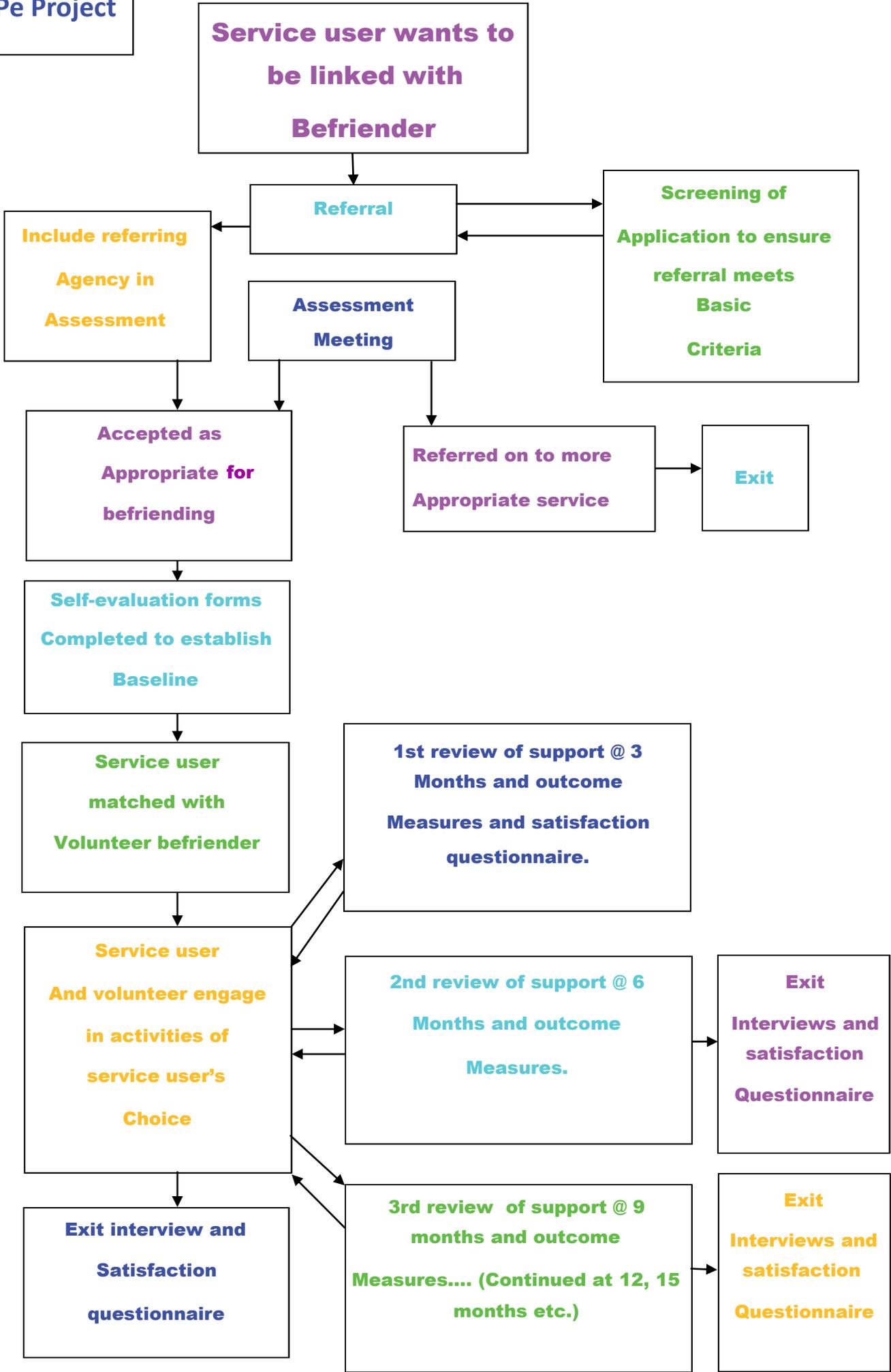


FIG 1 The service user's journey

2.1 Establishing the Project

Funding started in July 2008 and the formal launch of SCOPe took place in November 2008.

For the first year the major tasks were

- recruiting staff;
- determining policies and protocols;
- selecting and training volunteer befrienders;
- communicating about the project;
- accepting and assessing referrals of older people and older carers;
- collecting monitoring data;
- standardising evaluation procedures;
- matching service users with befrienders; and
- ensuring ongoing supervision and support.

These processes continued throughout the project, with appropriate adaptation in response to feedback.

GAMH had managerial accountability and responsibility for running the project, but it was recognised that expert external advice was also necessary. A Steering Group was established to meet quarterly with the purpose of:

- Monitoring whether the SCOPe project is meeting the agreed milestones and outcomes.
- Identifying areas where the SCOPe project is not meeting agreed milestones and outcomes.
- Producing an action plan to address any areas where the SCOPe project is not meeting agreed milestones and outcomes.
- Overseeing the implementation of any action plan.

The membership consisted of people from diverse backgrounds who had experience of similar projects. One third had caring responsibilities personally and a third came from a minority ethnic group. The age range did not include the very young adults, but a third were between 35 and 50 years old and the other two thirds aged 50 - 75. Their advice was seen as invaluable in guiding SCOPe through the earlier stages.

“The Steering Group was a great help, central to what we were doing. You could check back whether we were on the right track and they would be honest and come back with new ideas”

Half-way through the project, organisational changes meant that a broader-based advisory group was formed to cover all the GAMH later life projects. This appears to have been less successful, partly due to a broader membership, rotating chairs and poor attendance.

“It is difficult getting the balance right between service users and professionals so that both feel they can be honest and contribute”

2.2 Recruitment

Two part-time (one WTE) volunteer co-ordinators were appointed after open advert. In the first 2 years the volunteer co-ordinator for Older Carers changed twice, but the current person has been in post for three years. The volunteer co-ordinator for Older People has been with SCOPe throughout and they now share responsibilities across both groups (older people plus older carers). They were managed initially by the GAMH Development Worker for Later Life, then after her departure in 2011, by the Carers Lead.

In turn she reports to the Operations Manager.

The SCOPe team used a variety of ways to inform and attract clients including:

- formal launch
- promotional literature - leaflets and posters in multiple language
- review event and report
- DVD
- use of personal networks
- presentations to relevant caring agencies and groups

“I heard about it through a buddy”

“My CPN said it might suit me”

“I saw a message in the community centre”

“Went to the formal SCOPe stand”

2.3 Training

Before moving into training, all potential volunteers have to go through Enhanced Disclosure checks about criminality and have their references taken up. Once this has been done, training starts. It is not until this training has been completed that a decision is made to accept someone to work in the project.

A comprehensive training for SCOPe volunteer befrienders was developed on the back of existing GAMH programmes. The basic part-time six-week training covers:

- Introduction to GAMH volunteering opportunities
- Mental health awareness
- Communication
- Boundaries
- Equalities
- Endings (moving on and organisational procedures)

“The training was really comprehensive. The lady who spoke to us about her own experience was really good”.

“The induction training for SCOPe gave me an idea of various disadvantages in society”

“The induction training was ideal - gave an insight into how to support people”

“That induction was quite vital. It was about the basics, like knowing your client and how to communicate”

“A lot of people have these preconceived ideas about what a mental health problem is, the training does help you break that”

“I felt that everything was covered with opportunities to ask about anything”

As the work continued, additional training modules were made available in response to identified need

- Deaf Awareness;
- Visual Impairment;
- Moving and Handling;
- Dementia Awareness;
- Cognitive Impairment;
- Loss and Bereavement;
- Alcohol and Older People;
- Applied Suicide Prevention Skills (ASIST)
- Child Protection;
- Adult Support and Protection;
- Scottish Mental Health First Aid (SMHFA)

This in itself shows the significant issues that the befrienders had to cope with. It also demonstrates that SCOPe tried wherever possible to improve its skills to enable the participation of people with a whole range of difficulties rather than turning them down or referring them on. At the same time there were the constraints of agreed selection criteria and limitations on what could be achieved by relatively untrained volunteers. It was made very clear that volunteers were not to supplant the role of professionals and that this extra training was simply to enable them to better understand and cope with the problems that service users face and to alert the volunteers to when professional carers should be called upon. In practice most participants were already involved with treatment and support services and ongoing liaison took place.

The tension between being inclusive yet sticking to boundaries became apparent in the first set of data regarding referrals. There were considerably more referrals of older people than of older carers.

2.4 Referrals

2.4.1 Numbers

From the beginning there was an unexpectedly large number of referrals, well in excess of the planned numbers.

Over the five years 252 people were referred to SCOPe (207 older people with mental health problems and 45 older carers). The minimum Outcome target agreed with the Big Lottery funders was only 100 (the Milestone was 20 referrals every year), comprising equal numbers of older people and older carers.

This target was met

	Year 1 2008-2009	Year 2 2009-2010	Year 3 2010-2011	Year 4 2011-2012	Year 5 2012-2013
Older People	57	43	36	40	31
Older Carers	7	9	8	10	11
Total	64	52	44	50	42

TABLE 1: Referrals of older people and older carers each year

There was clearly a greater uptake of the service from older people who are facing mental health issues than from others of a similar age with caring responsibilities for someone with a mental health problem. The Outcome targets had been set on the assumption of equal numbers from each group.

During the first two years, when it was recognised that there was a disproportionately low numbers of carers being referred, this was first attributed to the fact that two volunteer co-ordinators left, which obviously caused delays. Emphasis was then placed on reaching out more to carers with additional promotional material and greater networking with carers' organisations. This was not very successful and it became apparent that there were many other possible reasons for carers not coming forward in the numbers anticipated.

Total number of referrals

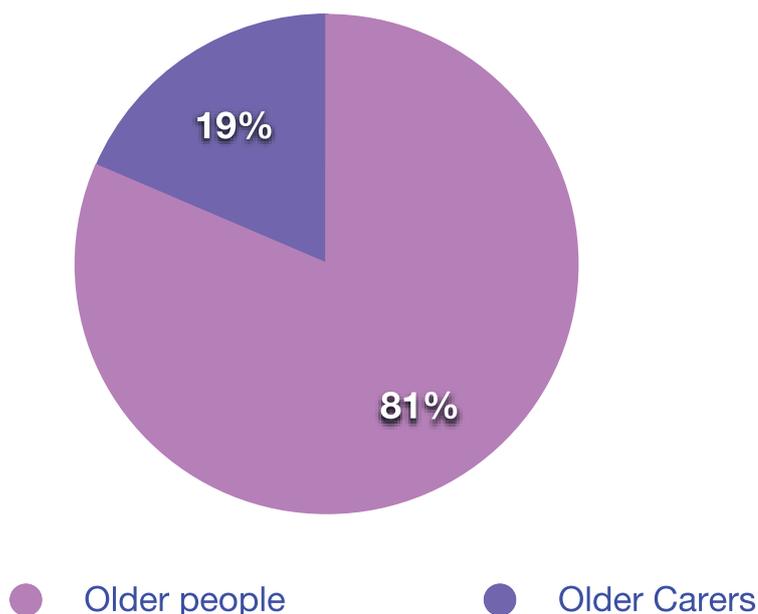


FIG 2: Proportion of referrals of older people and older carers

1. Several of the carers who did apply to take part in SCOPe said they would have preferred group activities and this may have held some people back from applying for individual befriending in the first place.
2. Another reason that older carers may not have taken up the opportunity would be because they had to cope with major time-consuming demands, so that their own needs often took second-place. Many described a struggle with the statutory services to get appropriate help for the person they were supporting, including respite time for themselves. Carers live in complex situations with multiple conflicting needs and their own needs sometimes take second place.
3. The possibility of increasing physical illness and disability. Carers get ill too.
4. Finally, and importantly, there may simply be less need. The number of older people caring for someone with MH issues may be smaller than older people personally facing them, especially because carers for people with dementia were excluded primarily because other targeted facilities are available. A preliminary needs assessment to estimate numbers is beyond the resources available to a small voluntary organisation.
5. The concern about the relatively low number of carer referrals was matched by concern about how to offer a service to the unanticipated high number of referrals of older people with MH problems. If there had been a similar number of carers referred it would have been impossible to deliver the service.
6. This high number of older people who were referred indicated that GAMH had identified an important need, but this still needed to be understood and coped with. Where were the people coming from and what were they seeking?

2.4.2 Source of referral

	Year 1 2008-2009	Year 2 2009-2010	Year 3 2010-2011	Year 4 2011-2012	Year 5 2012-2013	Total 2008-2013
Health	37	17	18	22	11	105
Social Work	5	5	4	6	1	21
Voluntary Sector	2	4	6	5	19	36
Self	17	6	13	12	6	54
Other	1 housing 2 family	3 housing 1 family	0 housing 3 family	1 housing 2 family	1 housing 4 family	18

TABLE 2: Source of referral

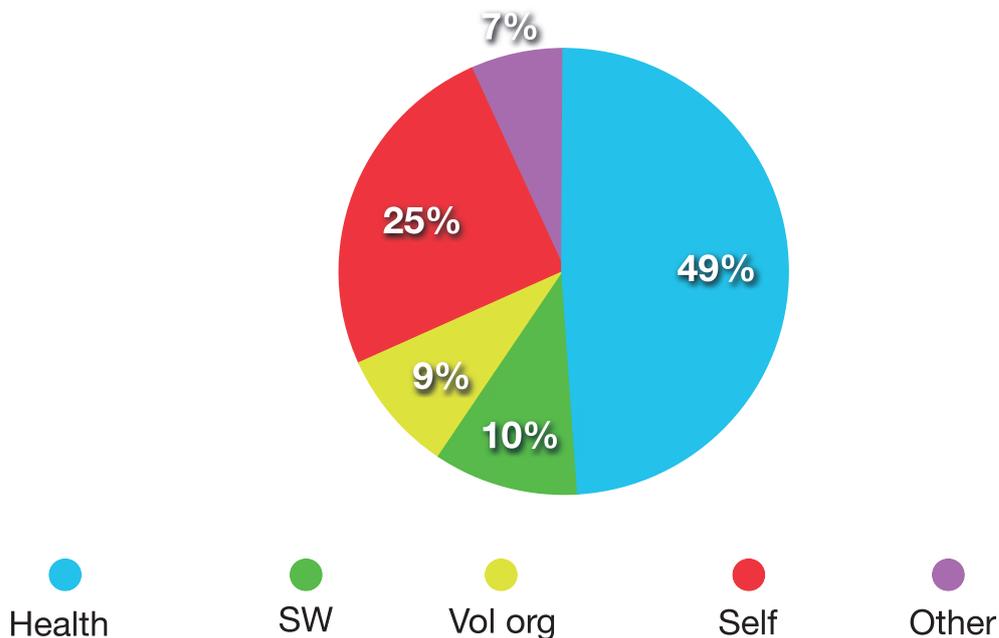


FIG 3: Source of referral

The high number of referrals from the NHS and social work through the Community Health Partnerships reflects the history of GAMH's close working relationship with the health service, especially in South Glasgow with whom a Working Protocol was established. The referrals were mainly from secondary care, which may in turn demonstrate the high rate of illness and disability in those who took part.

North: 9 East & West: 9 South West: 13 South East: 14
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BOX 4: CHCP Referrals (Year 3)

The second highest referral source was 'self', which is an encouraging indication of positive personal choice. In discussion, most people made clear that for them this had not meant picking up a leaflet or seeing a poster about a service they knew nothing about: they knew about it already through word of mouth. It seems that a high percentage knew about the project because they already had experience of the voluntary sector and community groups including GAMH itself. It seems that you can navigate around to get your needs met.

“Once you are in the system it’s OK”

“How do you get in?”

“Would you lose other health/social work/carers centre support? Can you have more than one thing?”

This access issue is one of the reasons why the GAMH Later Life Team had previously spent a lot of time in reaching out to people 'hardly reached' through conventional routes. Not everybody who lives alone is socially isolated, just as not everyone in a care home is socially included, however it is an indicator of potential vulnerability especially if associated with mobility or visual difficulties that make going out difficult.

Nearly half of the older people referred to SCOPE live alone.

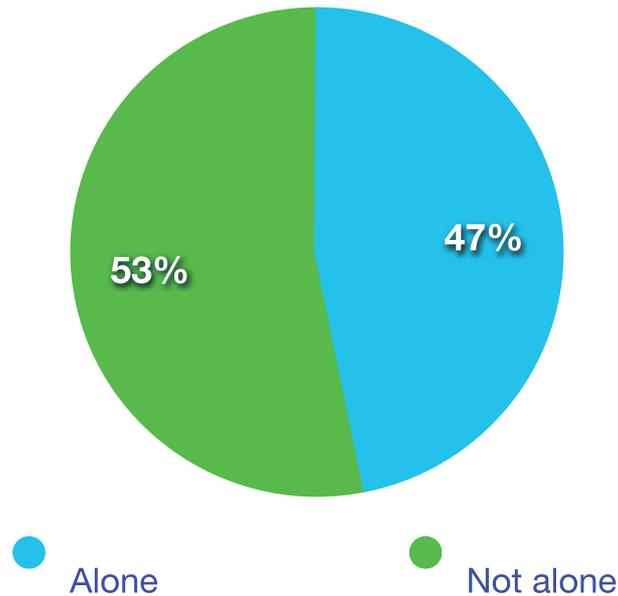


FIG 4: The older people who live alone

2.4.3 Outcome of referral

Only 114 (40%) of those referred went on to be matched with a befriender. Why?

Following the assessment interview the main reason (30%) for not carrying on to be matched with a befriender was that the person decided that SCOPE was not for her/him. Data was not collated about why this was. Fourteen people in addition to this are recorded as having wanted home visits.

The second highest reason for people not joining the befriending programme was that they were assessed as having “too high support needs” or alternately “already has high support”. This covered 15% of those referred. Given the degree of incapacity of many of the people who were actually taken on, this indicates a high level of complex need indeed.

The approach taken by SCOPE in order to reduce the number of referrals and avoid disappointment was to:

- ensure firm boundaries to what SCOPE could and could not do
- communicate this to referring agents who should be part of the decision
- clarify what the older person is seeking from a strengths-based perspective
- have the person share in the decision whether to go forward
- provide a range of alternatives, including those available at GAMH itself

This proved to be successful in that as the programme continued the number of referrals went down and the percentage being matched went up.

	Year 1 2008-2009	Year 2 2009-2010	Year 3 2010-2011	Year 4 2011-2012	Year 5 2012-2013
Numbers referred	64 34 women 30 men	52 40 women 12 men	44 34 women 10 men	50 33 women 14 men 1 transgender	42 32 women 10 men
Didn't want the service	21	24	13	10	5
Support needs too high	11	5	10	7	3
Wanted home visits	6	1	2	3	2
Deterioration in physical health/died	4	–	1 died	–	1 died
Already has high support	4	2	–	–	1
Too young	2	–	2	–	–
Referral withdrawn	-	3	-	2	2
Wanted a group	–	1	–	–	–
Not known				2	
Number of people matched	16	16 11 women 5 men	16 8 women 8 men	28 23 women 5 men	20 16 women 4 men

TABLE 3: Outcome of referral (older people and carers combined)

2.5 Matches for Befriending

114 people were matched with an individual or participated in a befriending group over the five years. The minimum Outcome target had been 60 matches in total (12 every year).

This target was met.

Matches

Year 1	12	4
Year 2	14	2
Year 3	14	2
Year 4	22	10
Year 5	12	8

TABLE 4: Number of matches each year

The matching process took some time and was occasionally difficult although the outcomes were successful as reported by both those using the service and their befrienders. At assessment the older people/older carers were helped to describe what their interests and skills were and what they wanted to do now. A match was then sought with a volunteer who had knowledge of that area, but the small numbers made this problematic. In practice few people had strong ideas about what they wanted to do and part of the befriending process was helping them become more aware about what was available that might interest them. At the Interim Event volunteers had asked for more help with this, perhaps as a central resource or database.

People were also asked if they held beliefs that might make it difficult getting on with a particular befriender. All except one said they had no qualms about anybody as long as they had been screened and trained (the exception being one person who would not

welcome ‘a homosexual’). Maybe such prejudice was one reason for a percentage of people choosing not to reveal their sexual orientation.

General feedback afterwards was that working with a volunteer from a different background (eg social class, race or age) was positive:

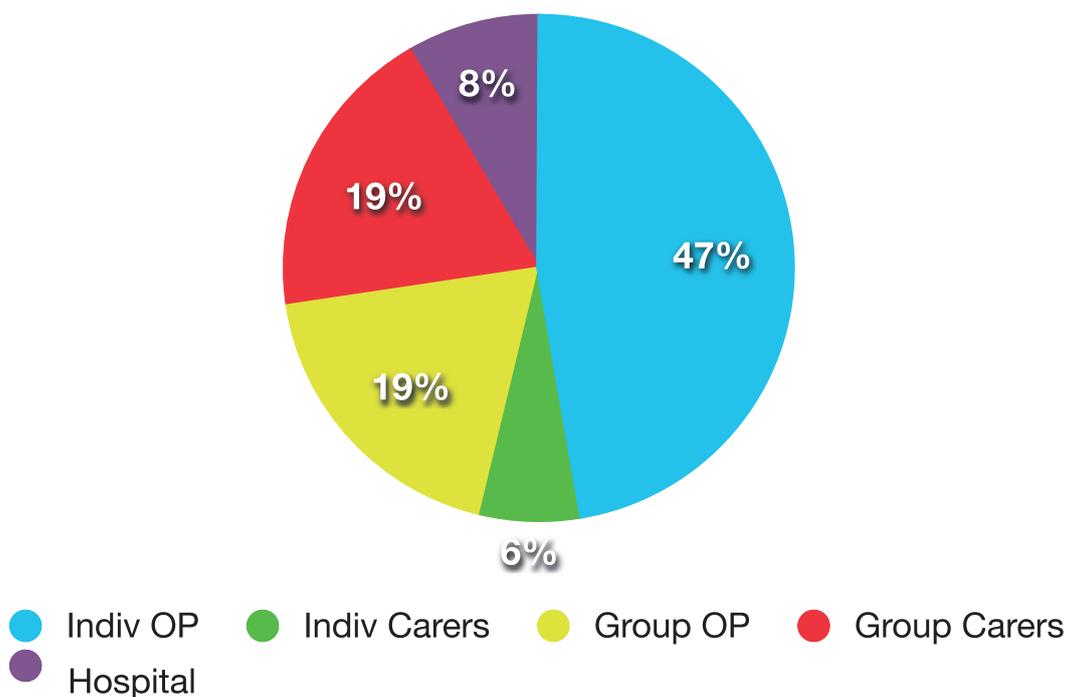
"It broadens your horizons"

"I would never get to meet someone like that normally"

"I thought I'd be embarrassed with a young person, but it really worked"

	Older People	Carers
Individual befriending	45	6
Carers' Group	N/A	18
Activity-based OP Group	18	N/A
Lightburn Hospital	8	N/A

TABLE 5 & FIG 5: Type of befriending



2.6 One-to-one individual befriending

SCOPE was set-up to provide individual support to help people go out and take part in activities they wanted to do or learn. This focus was welcome in most cases, although occasionally people would have preferred to do things at home, especially if they had mobility problems or were unaccustomed to going out for other reasons.



BOX 5: Examples of individual befriending

The befriending outings took place on a weekly basis for about a year. Helping people gain confidence in going out was one of the reasons why some volunteers were given additional training. It was important to ensure they were competent and comfortable in encouraging and accompanying someone who had significant problems getting around. All efforts were made to help people get out of their house and engage with the community.

This focus on activities (and having fun) was not an end goal in itself. The aim was to build confidence and reassurance that these activities could subsequently be carried out alone and provide opportunities to meet with others who had similar interests and so build a network of contacts and possible friends.

“It makes you go into places you wouldn’t go to on your own”

“It brings you out of yourself and you meet different people”

Mr A was referred to the SCOPe project by his CPN. He was matched with a young female Pakistani volunteer during March 2009. They began meeting regularly to visit galleries and go to the cinema. Mr A commented that he "enjoyed the company and sharing of ideas". He described his confidence increasing as the befriending relationship developed.

Mr A and his volunteer visited a clubhouse in Glasgow together. The purpose of the clubhouse is to support people with mental health problems to become involved in meaningful activity and gain structure to their week. After several visits, Mr A began attending by himself and started to learn computer skills.

The volunteer from SCOPe accompanied Mr A to church on a number of occasions. They spoke to other people and Mr A described beginning to feel more confident about attending church. By the end of the befriending relationship, Mr A spoke about being able to attend church by himself and talk to others. He described having made friends and said that he found the experience supportive.

The befriending relationship ended during August 2010. Mr A described the service as making "a big difference in my life. There's no doubt about it". He said that he had "lost confidence going out" and that he was now able to go out and mix with other people. Mr A said "since befriending my confidence has grown"

BOX 6: Example of befriending (Mr A)

Mrs B is a 62 year old white Scottish woman. She has a diagnosis of bipolar disorder and has on-going contact with psychiatric services.

Mrs B described becoming increasingly isolated since her husband died a few years ago. She was matched with a young white Scottish volunteer during July 2009. They began regularly attending a folk music night on a Sunday evening.

Mrs B was very positive about the befriending relationship from the beginning. She commented that she liked the fact that she was receiving support from a volunteer rather than a worker. She described having been slightly apprehensive about being matched with someone young, but found it “easy to talk to her”; “it’s so nice that – despite the age gap – we get on so well “. “It’s great fun”. After a few months she described being “delighted with the service” and said that it had had a “hugely positive effect” on her life.

After attending the folk music night with the volunteer, Mrs B began attending on her own. She knew other people that went along and felt comfortable going without support; “I’m able to go along as I’ve been with my volunteer before”.

Mrs B commented that going out with a volunteer had helped her to do other things by herself during the week. She said that she was “reclaiming and beginning to live life again”. She started attending a church group on a Sunday morning, and also went back to counselling which she hadn’t felt able to do before. Mrs B stated that having a befriender had made a “big difference to my confidence”;“befriending is wonderful”. The befriending relationship ended during May 2010.

BOX 7: Example of befriending (Mrs B)

2.7 Group befriending

One-to-one befriending was successful for many people, but sometimes engaging with groups or other services after befriending proved difficult. There were also referrals to the project for whom individual befriending would not have been appropriate, due to higher support needs, but where a group option might have been beneficial.

A pilot group programme was run in 2011, following the same formula as one-to-one befriending; participation in community based activities such as gallery visits and outings, but again there were some difficulties for people getting around. Perhaps the activities needed to be brought to people rather than the reverse.

An activity-based group was started in central Glasgow within a fully accessible space with excellent public transport links. Taxis were provided for those with greater mobility issues. The emphasis now was on helping people to express themselves through a range of creative activities, led by experts in their field who were skilled in working with newcomers. SCOPe is very grateful for the contribution from Project Ability. Initially this approach seemed daunting for some, but quickly the opportunities were taken up and welcomed.

Group Befriending Activities (1) **Creative Arts**

Story-telling
Creative writing
Poetry

With Project Ability

Painting
Ceramics
Glass work
Canvas painting
Fabric transfers
Plaster working
Sewing
General arts and crafts
Photography
Badge making
Collage

BOX 8: Group befriending (1)

“There’s a big difference. I really value the companionship. It’s great to have company. My confidence is coming back. It’s the best thing to happen to me in a long time”

“Hadn’t done this sort of thing before the start of the group - had a level of fear about participating. But I soon lost the awkwardness and got a laugh from being part of it. We all sort of bonded together and there are no wee cliques so you don’t feel left out”

“ I’d never have dreamt of going to something like this before. I had no confidence and anyway it would only be for arty people. If S... (volunteer co-ordinator) hadn’t persuaded me to try and been there too I would have missed out a lot”

“ I have learned new things that I enjoy with my grandson”

Some of this creative work was included in the booklet ‘Kaleidoscope’, with images selected for use on GAMH Later Life postcards and leaflets.

Feedback from Project Ability

This is a small but extremely sociable and pleasant group to work with. Everyone is really keen to try new activities and most people have a reasonable degree of confidence in their abilities although some do need a little encouragement. The "group generally have a high skill level and can work independently so I am able to push and challenge them and present activities that I may not to other groups. The usual 15 minute chat at the start of each session can sometimes run on for half an hour or so - there is lots of conversation in the group – particularly practical information-sharing on issues such as benefits, other carer support initiatives, transport and holidaying as a carer etc, and everyone in the group seems to really value each other’s company and advice. There is also lots of conversations around their own personal difficulties and experiences and most people in the group seem happy to talk openly and freely with one another and there is a friendly, supportive and understanding atmosphere where everyone relates to one another in a way that I feel those who haven’t the same shared experience may not be able to.

BOX 9: Feedback from Project Ability

The following year another group was started. Many carers had said that they did not need a befriender, but would instead like to have some time for themselves with other mental health carers.

“It wasn’t so much to talk about things, but to be with people who knew what it was like so you didn’t need to keep explaining that just because someone could walk it didn’t mean they were OK”

“I don’t need any more ‘support’ because I am lucky and get quite a lot. What I want is to escape, to have some ‘me’ time where I don’t have to talk about mental health issues, but can do something I want to do”

“I need some space to get away and do something that is just for me. Caring for my husband can be really awful at times, but nobody comes and asks about me, only about him and I get ignored”

Group Befriending Activities (2)

Complementary Therapies (with CALM)

Stress reduction workshop
Alexander technique
Reiki with a group purpose
Indian head massage
Laughter workshop
Reflexology
Tai Chi
Mindfulness
Aromatherapy
Yoga

BOX 10: Group befriending activities (2)

The group was developed in consultation with a small number of carers who helped to plan the nine week block of sessions. The focus this time was more on stress reduction and linked to the GAMH CALM programme.

Groups were then established on a regular basis for carers and another group for older people, so there was a choice for both older people and older carers to have individual or group befriending. In practice the group experience was largely taken up by carers.

Individual work had been based on a personalised one-to-one programme. Group work involved people joining together to work on activities brought in from outside. 'Courses' the users called them and indeed there was a significant learning component.

In addition to responding to the wishes of the service users, the group work was also one solution to the problem of high demand. Rather than one volunteer for each person, two to three volunteers worked with each group of eight to ten people. Three volunteers have been involved in group work, all under 25 and two from BME communities.

While this meant optimum use of the limited number of volunteer befrienders, it was not a cheap option. Each group was organised by a Volunteer Co-ordinator and fees were needed for the professional input to the groups and for hiring premises. There was also need for an interpreter in one instance (another GAMH staff member). Some of this extra cost came from the existing Big Lottery funding (with their agreement), and the rest from GAMH.

2.8 Hospital befriending pilot, year 2

Outside interest in the model used by SCOPe led to queries about using the befriending activity-based model for people in hospital and this resulted in a pilot within Lightburn Hospital, which provides rehabilitation services for older people. This enabled a young volunteer (aged 16) to contribute. At that age there are restrictions placed on working alone, so providing befriending opportunities alongside other staff enabled her to contribute to the project.

Of the hospital group, there was one man and seven women, all over 75 years of age with the eldest over 90. All enjoyed meeting with the volunteer and most felt better afterwards (two did not know).

Asked about what they did with the volunteer, all said that it was about 'chatting', 'talking' or 'speaking'.

"We spoke about old times"

"I have no family and it was good to chat"

"I was worried about not having enough conversation, I'm the quietest on the ward"

“Nice to have someone to talk to, my daughter can’t get here every week”

Asked whether they were able to take part in activities because of the volunteer’s support, only one said ‘yes’, four said ‘no’ and the other three ‘did not know’. They felt that this was less important than her interest and pleasant personality.

This volunteering pilot led to subsequent funding from the Robertson Trust to develop a new project which would offer volunteer befriending specifically within the residential care home setting. Unfortunately GAMH were unable to match the funding from the Robertson Trust in order for this project to progress.

2.9 Ongoing review of progress for individuals

Every three months each service user and volunteer befriender met with a volunteer co-ordinator to discuss how things were going and help plan the next steps. This was an important part of the programme, which ensured that the work was on course, that significant problems were identified and that the co-ordinators were aware first-hand of any issues that were arising.

At the beginning it was also a time when progress was more formally assessed using questionnaires. This appeared not always to have been helpful as some people felt it was a way of judging their volunteer rather than their own personal progress. The relationship with the volunteer was very important and separate from other very stressful events in their life. They felt pressured to ‘be better’ for the sake of the volunteer and the project.

“If I don’t do well he’ll be blamed and I am letting him down when it is not his fault. He is a really nice person and it is everything else that is going wrong for me”

“I can’t even get this right”

“It’s all bureaucracy”

“Success is based on people”

In the event, the SCOPe team recognised this was perceived as a pressure on service users to do better and feel better whatever was happening to them, and therefore reduced the requirement to complete the forms every three months down to a beginning baseline and follow-up at the end. This was appropriate.

This has to be borne in mind for future similar projects. Sometimes the goal of providing support for people in very vulnerable situations should be to help maintain the current level of functioning and emotional resilience, rather than necessarily ‘improving things’. Helping people to ‘hang on in there’ can be good enough and in itself hard to achieve.

Further discussion and analysis of the questionnaires is in Section 5.

2.91 Moving on from SCOPE

The befriending that was offered was time-limited, usually weekly for one year, but this could be extended due to circumstances such as illness or departure of a volunteer, which had interrupted the work.

To ensure that people did make the separation and move on from the project, numbers were monitored, with the minimum outcome target of three older people and three carers leaving every year. This was the hardest part for many people. After a while roles get blurred and a befriender can become a 'friend'. Although this may seem a positive outcome, it can lead to disappointment and possible exploitation on both sides. This is an example of where the issue of 'boundaries' becomes important and supervision of volunteers is necessary. SCOPE achieved this.

	Year 1	Year 2	Year 3	Year 4	Year 5
Older people	0	16	12	4	15
Older carers	0	1	2	2	4
Total	0	17	14	6	56

TABLE 6: Number of people moving on

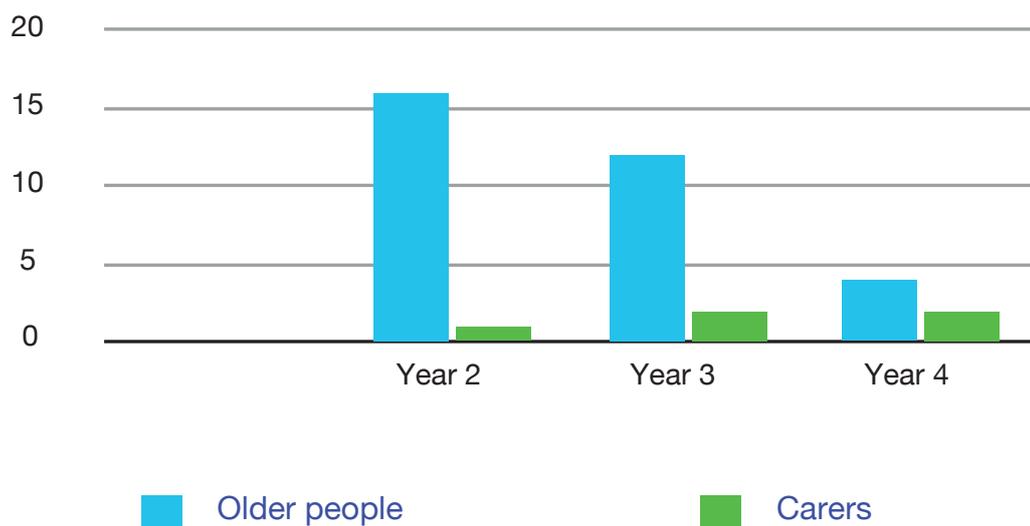


FIG 6: People moving on each year

Moving on Year 1-4

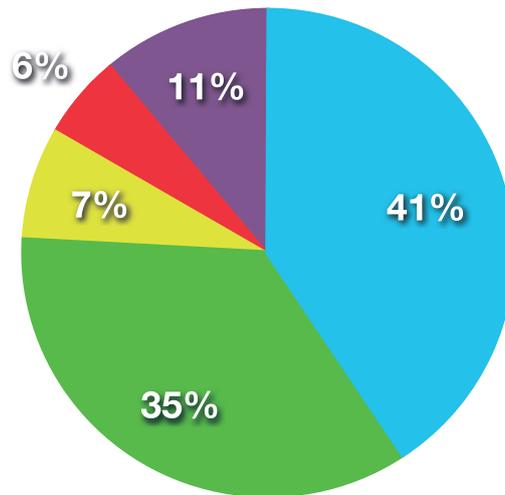


FIG 7: On leaving SCOPE

- Referred back
- Later Life Matters
- Withdrew (phys H)
- Other community services
- Withdrew (caring responsibilities)

The majority of people completed the befriending satisfactorily as planned, with individual goals being achieved.

On completion of the SCOPE programme, most people simply went back to their previous support systems, some were introduced to other community services (including GAMH Later Life Matters) and some who had received individual befriending moved on to a group. Some unfortunately had to withdraw due to deteriorating physical health or increased caring responsibilities.

The target of three people in each group finishing the befriending programme each year was met for older people, but not for carers. This was obviously linked to the smaller number of carers in the system. Overall numbers leaving, however confirmed that people were being facilitated to move on rather than becoming dependent on SCOPE, so reaching the goal.

This target was met.

3. The older people and older carers 'service users'





The older people

3.1.1 Overview

The term ‘older people’ in this context means people aged 60 and over who have a mental health problem and referred themselves (or were referred) to SCOPe for befriending. They may have recent stress and depression or a long-standing mental health condition. People whose primary problem is dementia or substance misuse were excluded.

Over the five years **252** older people were referred to SCOPe, five times the outcome target of 50 (ten every year).

This target was met.

3.1.2 Age and gender of the old people

The majority of people were women in their sixties, more than double the number of men referred. Men are in the minority, potentially a disadvantaged group.

	Year 1 2008-2009	Year 2 2009-2010	Year 3 2010 -2011	Year 4 2011-2012	Year 5 2012-2013
No of referrals	57	43	36	38	31
Age	60-69 27 70-79 19 80-89 7	60-69 23 70-79 16 80-89 4	60-69 19 70-79 13 80-89 4	60-69 25 70-79 11 80-89 2	60-69 16 70-79 12 80-89 3
Gender	34 Female 23 Male	31 Female 12 Male	26 Female 10 Male	25 Female 12 Male 1 transgender	24 Female 7 Male

TABLE 7: Gender of the older people

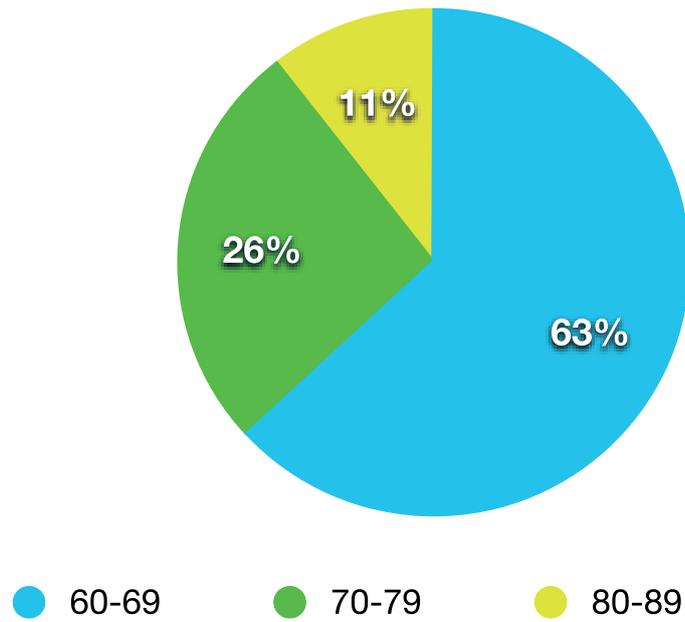


FIG 8: Age of the older people

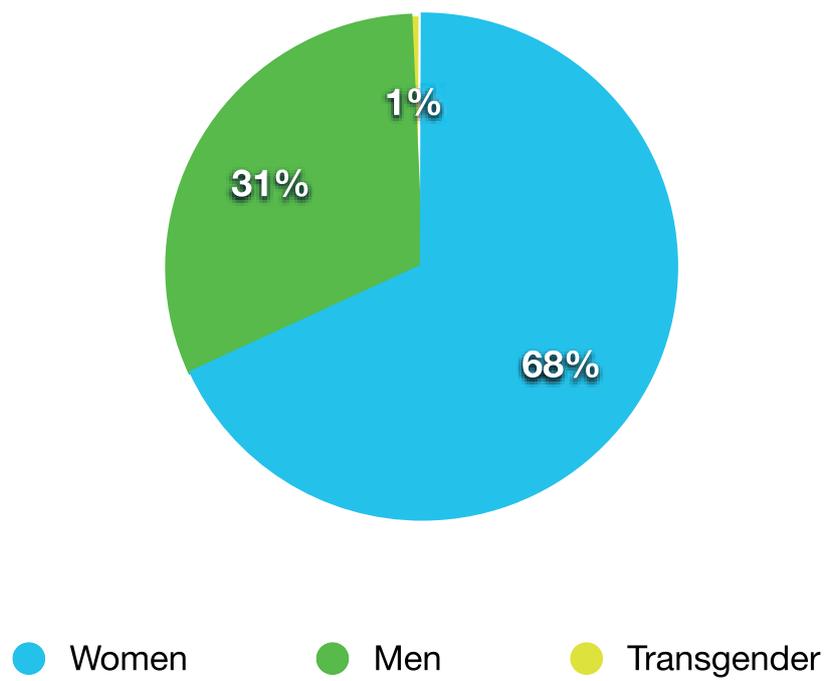


FIG 9: Gender of the older people

3.2 The older carers

3.2.1 Overview

‘Older carers’ in this context means people aged 60 and over who are helping to look after someone who has a mental health problem other than dementia.

Over the five years **45** older Carers were referred to SCOPe. The Outcome target was initially 40 though reduced to 4 in years 4 and 5, so 32 (eight every year).

This target was met.

3.2.2 Age and gender of the older carers

	Year 1 2008-2009	Year 2 2009-2010	Year 3 2010 -2011	Year 4 2011-2012	Year 5 2012-2013
No. of referrals	7	9	8	10	11
Age	60-69 5 70-79 2 80-89 0	60-69 6 70-79 3 80-89 0	60-69 5 70-79 2 80-89 1	60-69 7 70-79 3 80-89 0	60-69 7 70-79 3 80-89 1
Gender	6 women 1 men	9 women 0 men	7 women 1 men	10 women 0 men	11 women 0 men

TABLE 8 : Age and gender of the older carers

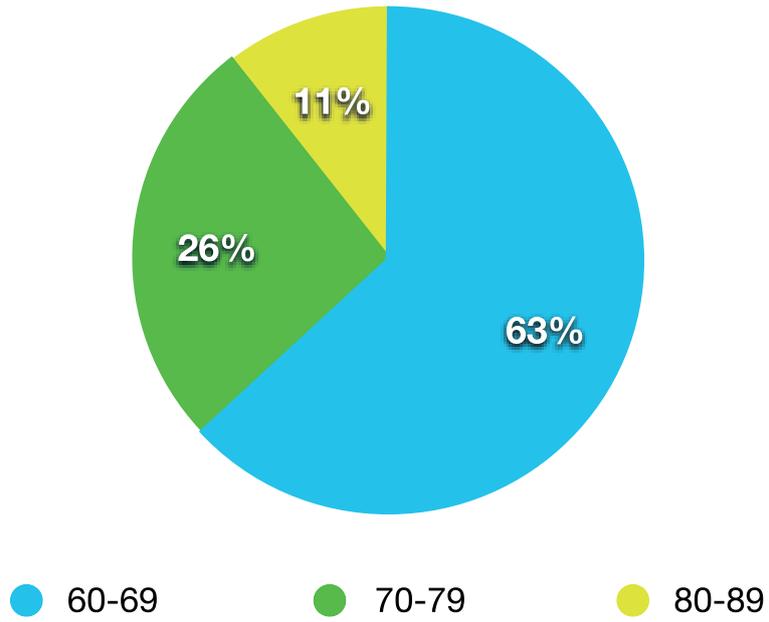


FIG 10: Age of the older carers

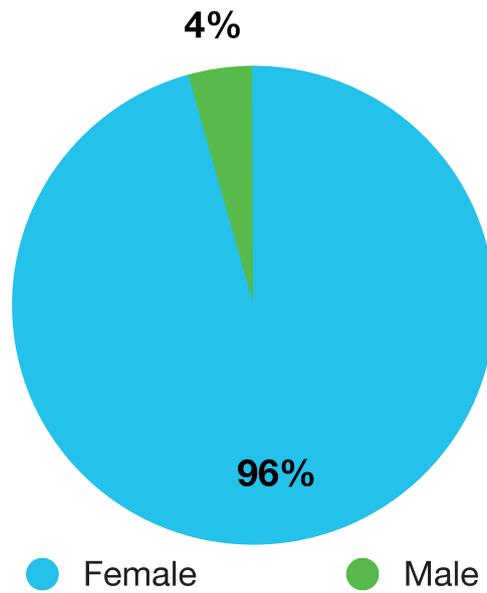


FIG 11: Gender of the older carers

There is a clear difference in the gender balance between older people and older carers. 70% of the older people were women, whereas 96% of the carers were female. It is likely that this is partly related to the age profile in that the life expectancy of men is lower, partly to the stereotypical (also real) role of women as carers and partly to the (again stereotypical) image of men as being ashamed to say they are not coping and to seek help. The range of ages in each group is not statistically significant, but the trend is for carers (perhaps not surprisingly) to be younger.

3.3 Equality of access to the service

3.3.1 Overview

The SCOPe team reached out actively to several minority organisations and communities (including faith communities), although sadly the LGBT centre had closed. They made publications available in several languages, provided interpreters when necessary and facilitated transport for those with mobility issues. There is not the slightest doubt that SCOPe saw tackling inequalities as a priority and worked hard at it.

A major problem when tracking and assessing the engagement of minority groups is lack of knowledge about the overall population size for each group, especially when some people dislike seeing one aspect of themselves being labelled as an identity that makes them part of a specific 'community'. To undertake epidemiological research (for example starting with the Scottish Household Survey) is not the responsibility of a small voluntary organisation. One has to rely primarily on knowledge gained through experience in the field. After the project ended Census information became available.

It is very clear that this was an inclusive project. It is only men who seem to be less included, which is the case in all such projects.

This commitment was met.

Disability

It is known that poor general health makes people vulnerable to mental health problems and on the risk assessment when people applied, it quickly became apparent that many of the older people had significant physical problems that would have an impact on the befriending process and require more training for the volunteers. These included:

- sensory impairment (visual and/or hearing loss)
- mobility problems (arthritis, stroke)
- breathing difficulties (heart or lung problems)
- other physical problems leaving them vulnerable (eg epilepsy, diabetes, cancer)

Not all of them would define themselves as disabled (nor be registered as such), but the fact that **73%** of the service users were recorded by SCOPe as having significant physical problems, when the selection criterion was mental health has significant implications for planning future similar programmes.

People with disability were not proactively sought out specifically as a group who might be disadvantaged; this was simply the result of not making physical health issues an exclusion criterion. It is likely that there are many more people who are inactive and isolated linked to physical health problems.

3.3.3 Religion

Religion	Percentage
None	28%
Christian	55%
Muslim	6%
Hindu	8%
Other	3%

TABLE 9: Religion of service users

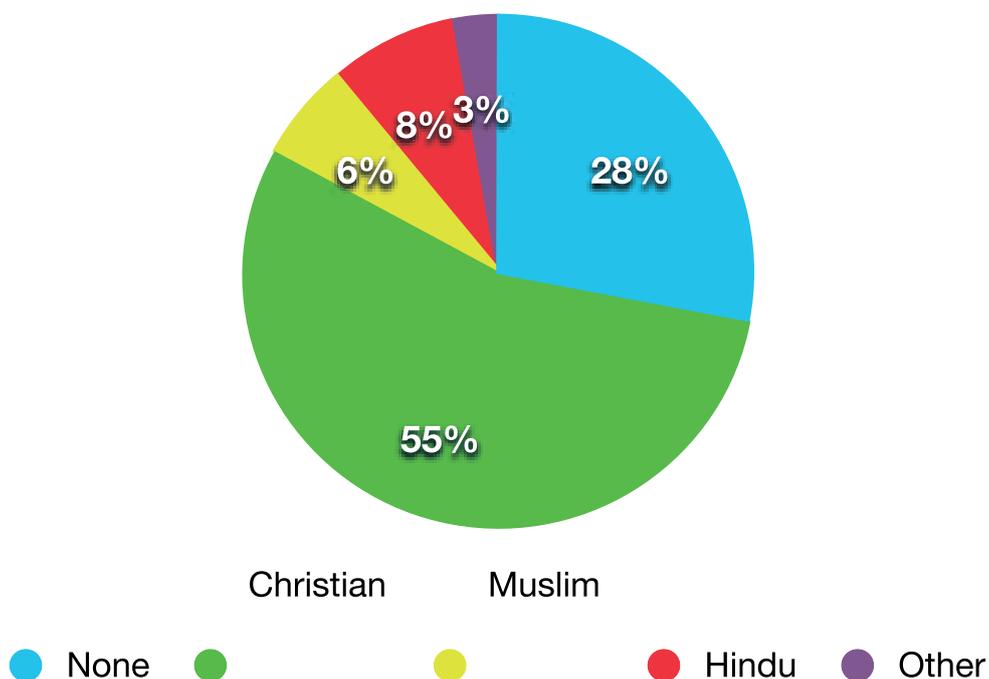


FIG 12: Religion of service users

3.3.4 Ethnicity

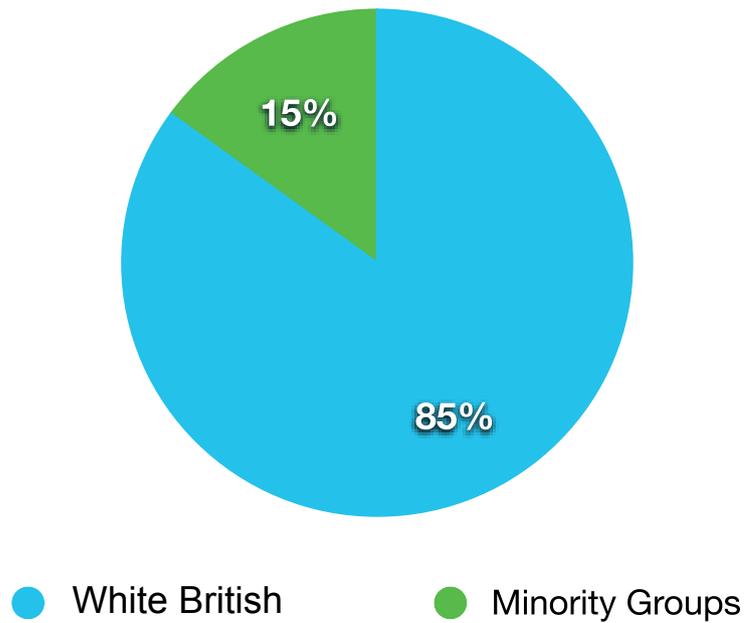


FIG 13: Ethnicity of service users

3.3.5 Sexual orientation

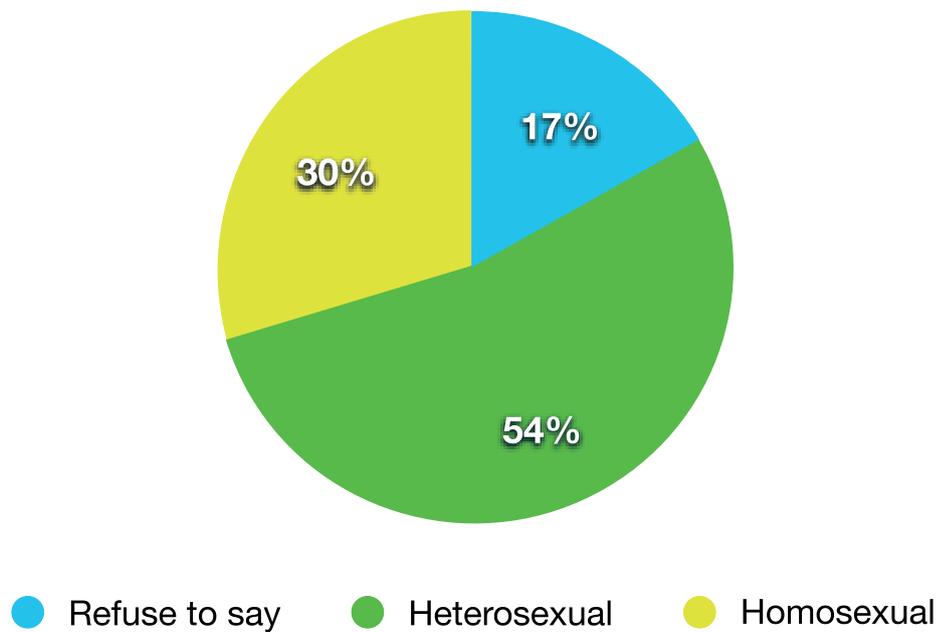


FIG 14: Sexual orientation of service users

The SCOPe project engaged with a diverse range of people.

**EXAMPLE OF EQUALITY AND DIVERSITY
YEAR 4 2011-2012**

23 older people and 10 older carers

GENDER

Female	27
Male	5
Transgender	1

ETHNICITY

White Scottish	27
White Other"	2
Asian/Pakistani	2
Chinese	2

RELIGION/BELIEF

No religion	9
Christian - Protestant	16
Christian - Roman Catholic	4
Muslim	1
Other	3

SEXUAL ORIENTATION

Heterosexual	31
Homosexual	1
Declined to answer	1

DISABILITY

None	4
Physical health problem	11
Mental health problem	27
Long term condition	17

BOX 11: Service user equality and diversity Year 4 (2011 - 2012)

4. The Volunteer Befrienders



Volunteering isn't about age, it's about attitude...

We need volunteers for the SCOPe Project. SCOPe provides befriending for older people experiencing mental health problems and older carers of people with mental health problems.

The SCOPe Project
Hyde Park Business Centre
Units 13, 14 & 15
60 Mollinsburn Street
Glasgow G21 4SF

Tel: 0141 404 3769
Email: scopeteam@gamh.org.uk





The Crunchy Auburn leaves

Crackle when Crushed

The Smell of Changing Seasons

From warm to cold

The leaves ride along the wind

Smashing into passer by's

Autumn the season of change

How beautiful & Barce

4.1 Recruitment

Volunteers were recruited in a variety of ways including:

- Glasgow volunteer centre
- existing volunteers working with GAMH
- promotional literature - leaflets and posters in multiple languages
- personal networks
- presentations to organisations

YEAR	NO. OF VOLUNTEERS RECRUITED
1. 2008-2009	21 (20)
2. 2009-2010	16 (15)
3. 2010-2011	9 (6)
4. 2011-2012	3 (1)
5. 2012-2013	10

TABLE 10: Volunteer recruitment (numbers in brackets are numbers of the new recruits who became active)

The overall Outcome target was for 50 volunteer befrienders to be recruited.

This target was met.

The guidance on supervision of volunteers is for up to 20 to 24 people at one time to be supervised by one person (in this case two half-time people). The numbers were compatible with this, although to keep within those limits the recruitment drive had to be slowed down when the turnover of volunteers was less than anticipated, due to some people remaining available for a second match.

Commitment had not been asked for more than one year in the first instance, in recognition of the fact that many volunteers would be in transition between jobs or getting work experience related to a university course. The training and experience gained from being a SCOPE volunteer was seen from the beginning as an important component of the project, so that volunteers leaving for those reasons was not seen as a particular problem. Providing volunteers with skills and confidence to move on was one of the goals. However, people who did remain with SCOPE were very helpful in retaining skills and passing on experience. Similarly, a few trained volunteers moved into SCOPE from other GAMH volunteering programmes, bringing valuable experience with them.

4.2 Demographic information

4.2.1 Age of volunteers

One of the goals had been to ensure younger people had the opportunity to volunteer and there is clear evidence of intergenerational working - the highest proportion being people aged 16-25.

This commitment was met.

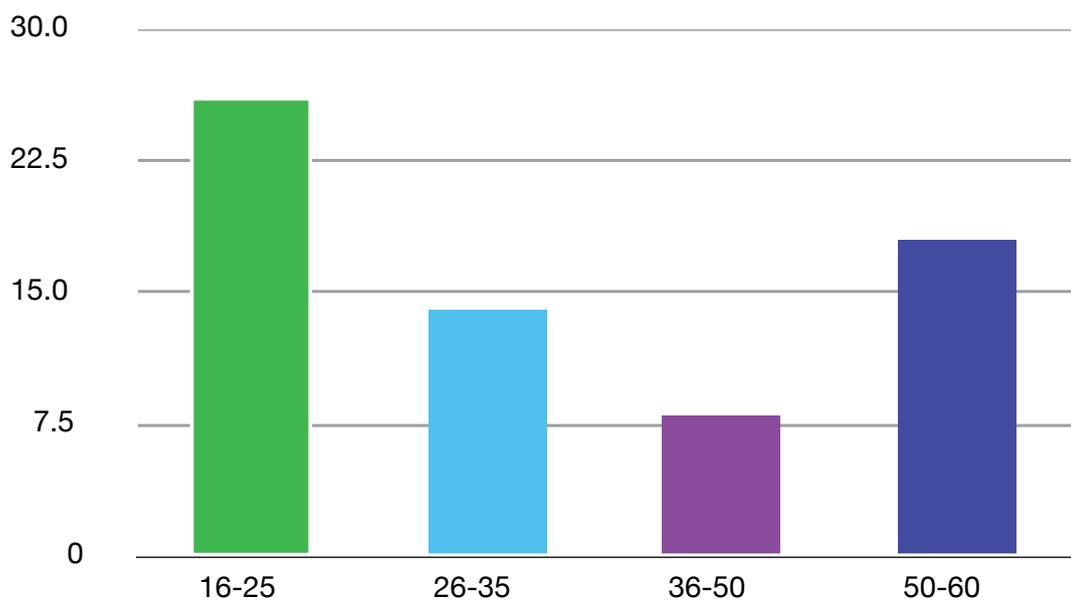


FIG 15: Age of volunteers

4.2.2 Gender of volunteers

The gender balance of volunteers is more similar to that of the older people rather than the older carers. **65%** were women.

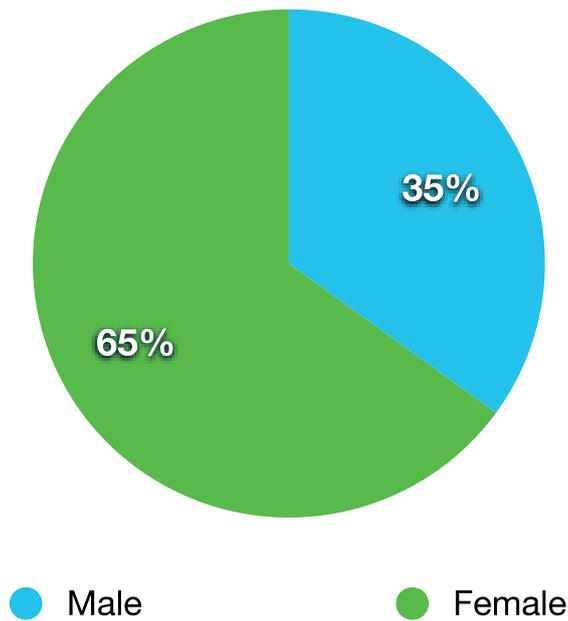


FIG 16: Gender of volunteers

4.2.3 Religion of volunteers

The religious mix of the volunteers was virtually identical to that of the service users, although this was not a major criterion for matching unless specified by the service user. Similarly people were not matched automatically with someone from the same ethnic group unless language was an important feature.

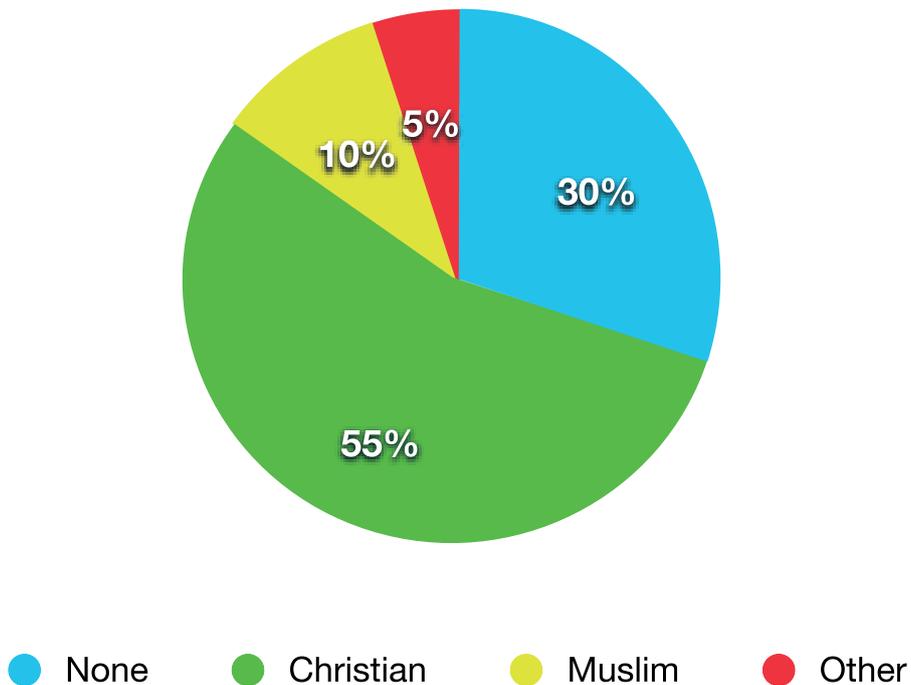


FIG 17: Religion of volunteers

4.2.4 Ethnicity of volunteers

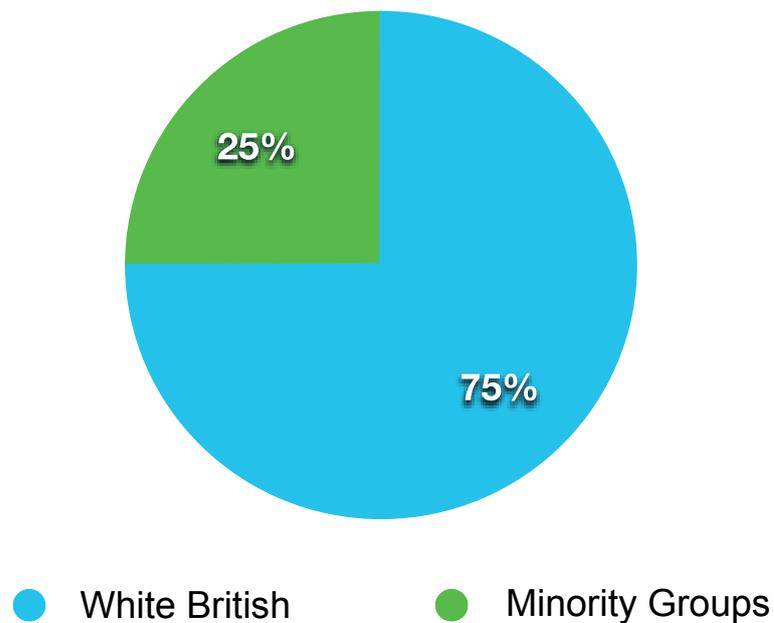


FIG 18: Ethnicity of volunteers

About 25% of volunteers were from BME groups (compared to 15% of the service users). The Population by Ethnicity Glasgow Estimates 2011 showed that the BME community population was 11.58% city wide, this highlights that the project was successful by making its services accessible to those from BME communities for both volunteers and service users.

4.2.5 Disability in volunteers

One of the volunteers was disabled.

4.2.6 Sexual orientation of volunteers

Full data is not available on this.

Example: Year 4 volunteers

Year 4 Volunteers

Of the twenty volunteers who were active:

- Eight were aged 16-25, nine 26-30 and three were over 50
- Seven were men and 13 were women
- Three had a BME background
- Two were LGBT

Nine left during that year, because:

- Two had increased caring responsibilities
- Seven found full-time work

Eleven remained, four of them waiting for a second befriender.

BOX 12: Year 4 Volunteers

5 Interim Review 2010

One of the planning Milestones was to undertake a mid-term review and this was carried out by running an event in April 2010 that engaged with all stakeholders in order to report on progress, launch a DVD about SCOPe and get feedback.

5.1 Feedback from service users and carers

What are the good things about the support provided by the SCOPe Project?

What has worked well?

- Can relate better to a stranger than to family.
- Good to mix age groups.
- Gives a focus - something to look forward to.
- Builds people's self-esteem.
- Being listened to. Can talk instead of bottling things up.
- Builds confidence in lot of ways - speaking to other people and meeting new people.
- Gives regularity - know that on a certain day you will have something to do

What could be improved? What would you like to be different?

- Wider publicity about the project. Making people more aware of it.
- Put information into GP surgeries, libraries, social work offices, churches, hospitals.
- Expand the pilot project to care home settings.

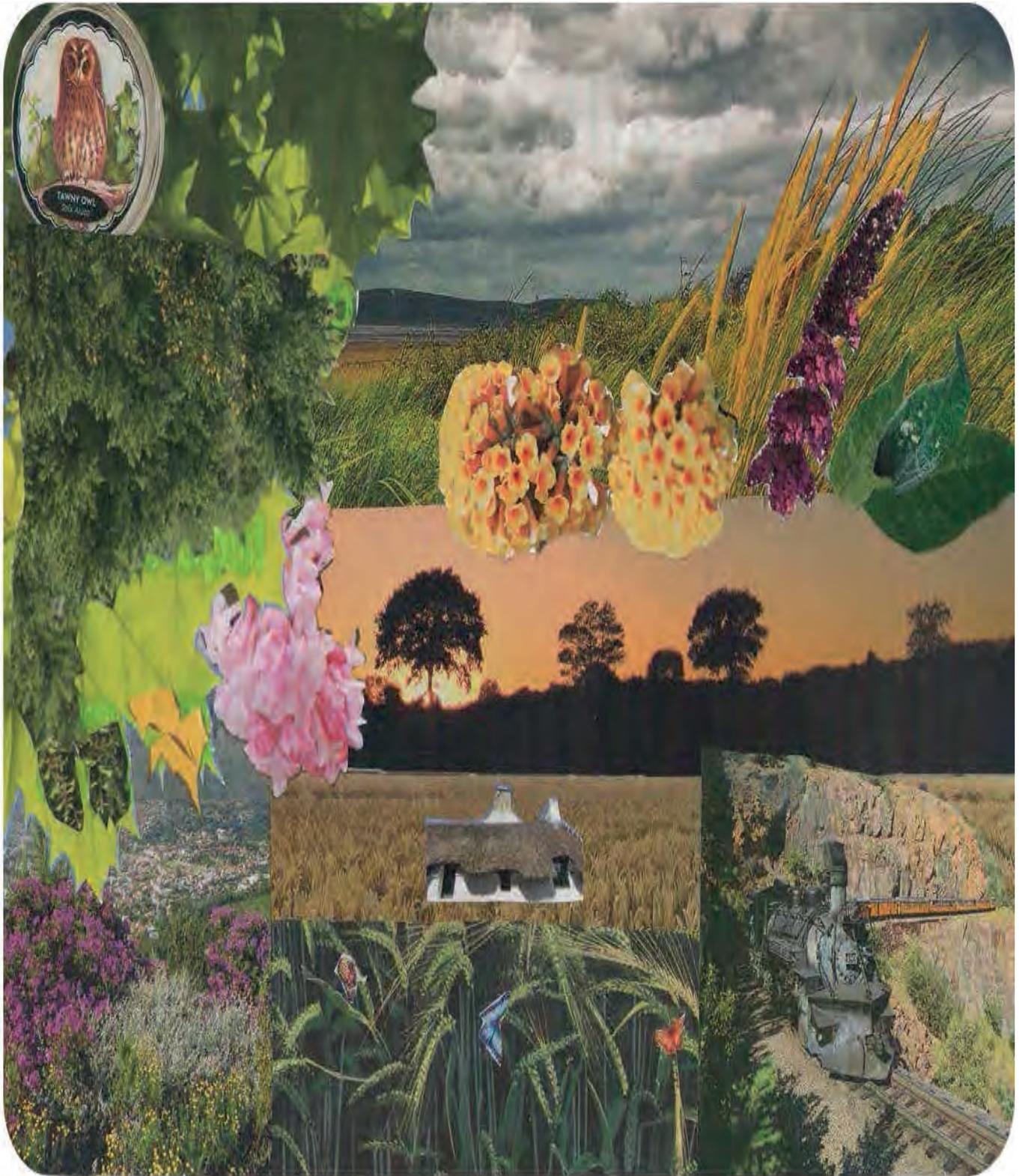
5.2 Feedback from volunteers

What are the best things about being a volunteer with the SCOPe Project?

- Gives you an insight into the life of an older person before you experience it for yourself.
- The induction training gave an idea of various disadvantages in society.
- Something to do with your life - freedom.
- We have chosen to do this - they know you want to be there.
- Person-centred approach.
- Induction training was ideal - gave an insight into how to support people.
- Feels like you are making difference.
- On-going training.

What would enhance the experience of being a volunteer with the SCOPe Project?

- More chances to meet up with other SCOPe volunteers and volunteers from other GAMH projects.
- Peer support group for volunteers.
- Events like this.





- When you start being a volunteer with SCOPe, to meet up with volunteers who have done it for a while.
- More information about activities you could do with service users/carers when you start. Resource library for volunteers to dip in to - volunteers and service users/carers could build this together.
- Opportunities for befriendeds and befrienders and GAMH staff to come together to share experiences.

5.3 Feedback from professionals

What links/partnerships do you think the SCOPe Project should develop or build on in the forthcoming 12-18 months?

- Links with CHCPs who are keen to 'join-up' services and make connections.
- Links with Community Mental Health Teams - transition from adult to later life services.
- Links with Colleges.
- Health Improvement.
- Commissioning for older people.
- Community learning, education, employability.
- Partnerships with day centres and day hospitals.
- Connections to CHCPs lead to community ownership and being embedded in the community.

How would you like the SCOPe Project to develop over the next one year, five years, ten years?

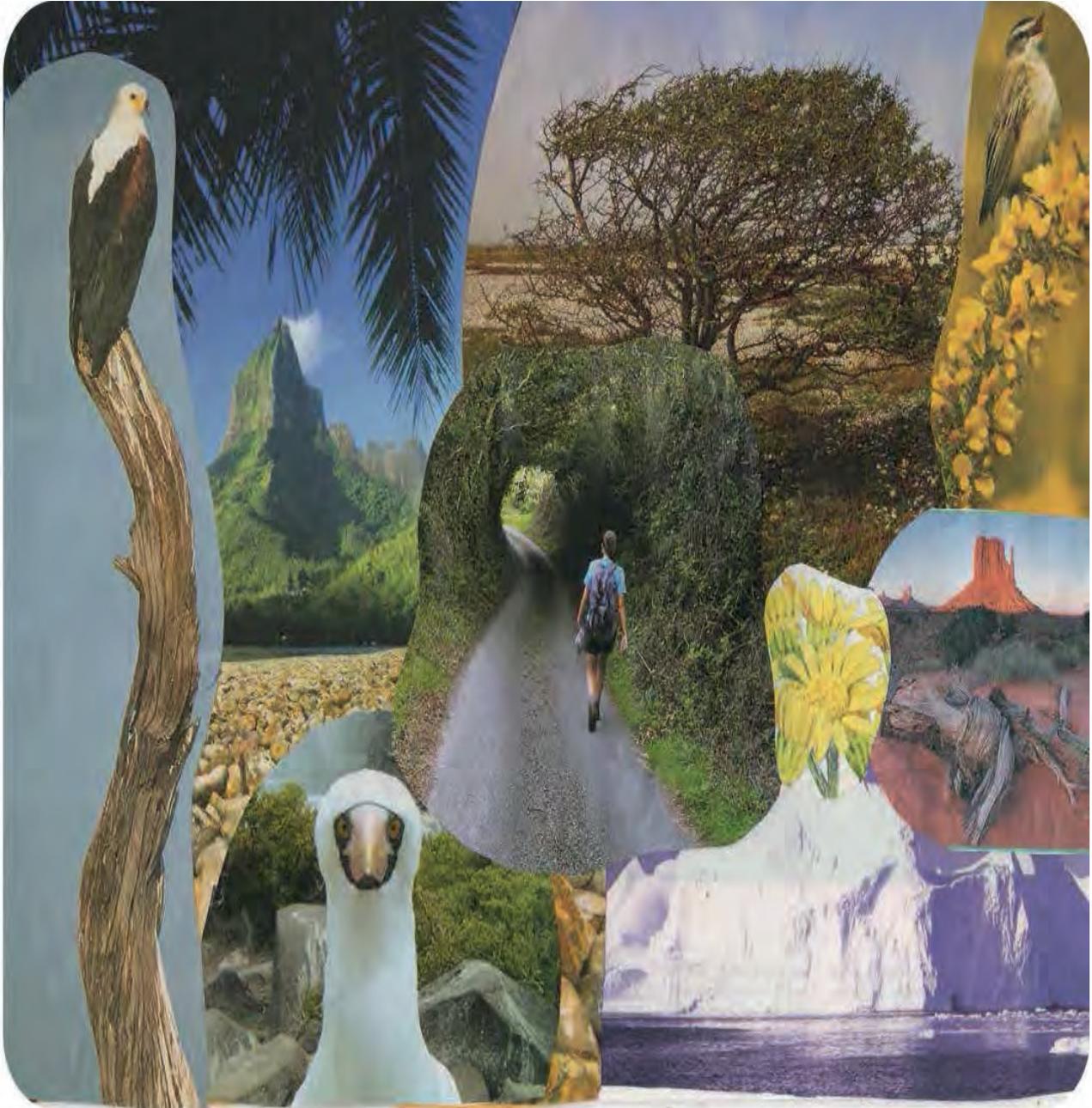
- Flexibility about age for using the service.
- Flexibility about length of time of befriending relationship - some people have long-term needs.
- Work with people with complex needs.
- Develop intergenerational focus.
- Develop capacity to respond to high level need.
- Local authority to buy into best services such as SCOPe.
- Plan the end of the befriending relationship from the beginning.
- Users group - share ideas and create opportunity for peer support at the end of the service.
- Provide taster sessions of what people could engage with after the befriending service ends.

5.4 Response to the review event

The response at the time to the Review event was extremely positive. People benefited from hearing what had happened so far and welcomed the opportunity to contribute to the future planning.

Did the feedback change things? Yes and no. Many of the comments endorsed the present work and wanted it to do even more: advertising more, linking with more groups, extending eligibility to people with higher needs, seeing people for longer.

6. Evaluation





6.1 Overview

Monitoring and evaluating a complex five year social programme is a major challenge, which puts pressure on resources and demands skills and competencies perhaps more appropriate for an academic research project, especially when there are such stretching targets to be met.

SCOPE collected systematic ongoing data by means of questionnaires and subjective accounts.

The desired Outcomes were:

1. Forty older people with MH problems and 40 older carers will demonstrate:

- **Less social isolation**
- **Increased confidence**
- **Increased connections with their community**

2. Fifty volunteer befrienders will demonstrate:

- **Increased self-confidence**
- **Increased self esteem**
- **Increased life-skills**

The task therefore was to establish whether these factors had been demonstrated, as opposed to simply recording the numbers of people who took part. There is no standard method of measuring most of these attributes, so the SCOPE team, aided by the Steering Group, drew up self-evaluation questionnaires for all participants. The questionnaires about individual befriending had nine items to be graded out of 10 (later amended to 5). Five of the questions could be considered as indicators of 'less social isolation and increased community links' and the other four as indicators of 'confidence'. An international measure of population self-esteem was also used.

The methodology had a number of flaws and was adapted in the light of user feedback, which showed good flexibility (although made analysing the data a bit difficult). The service users made insightful comments about responding to a question when their situation was rapidly changing. As already stated, they worried that negative ratings might lead to the befriender being judged badly, when it wasn't his or her fault - it was all due to the external events. Clearly the relationship itself was the key component of the work.

Many forms appear either not to have been completed or were lost in transit (it is important to record that the team had moved its operational base from headquarters to a less accessible site). However, this low return is not particularly unusual (although seldom reported in evaluations). There was still sufficient data available for a relatively robust analysis.

All the evidence points unequivocally to significant gains. On every measure (including individual questions) improvement was clear.



FIG 15 : Social Inclusion and Confidence (individual befriending)

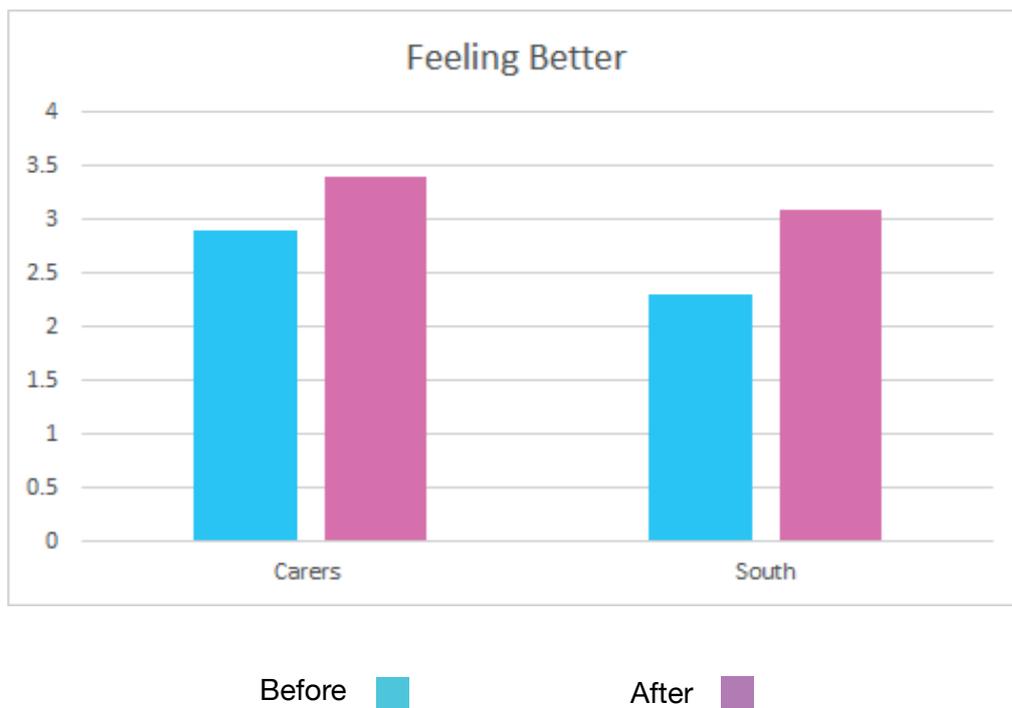


FIG 16: Feeling better (group befriending)

6.2 Individual Befriending

Less social isolation and increased community links			
Scale 1-5 (average)			
	Before	After	Change
Feeling of contact or <u>involvement</u>	2.4	4.0	+ 1.6
<u>Knowledge</u> about your local community	2.3	2.8	+ 0.5
Feeling of <u>belonging</u> to your community	2.5	3.0	+ 0.5
Ability to go <u>outside your home</u>	2.9	3.4	+ 0.5
Interest in life generally	2.4	3.3	+ 0.9

The average improvement was 80%.

BOX 13 : Engagement with the community

62% of the service users improved their social inclusion score by an average of 80%.

The outcome target was 40 older people and 40 carers. As a total these figures were more than met, although (as before) the main component was the older people, not the older carers.

This target was met.

“I’m surprised how much I value chatting to my volunteer, it was easier to talk to her than a worker. I enjoyed the activities: we went swimming, bowling, to the cinema, for walks. I would feel OK about going swimming myself now and would even go to the cinema on my own”

“I’m now in contact with more people”

Less Social Isolation

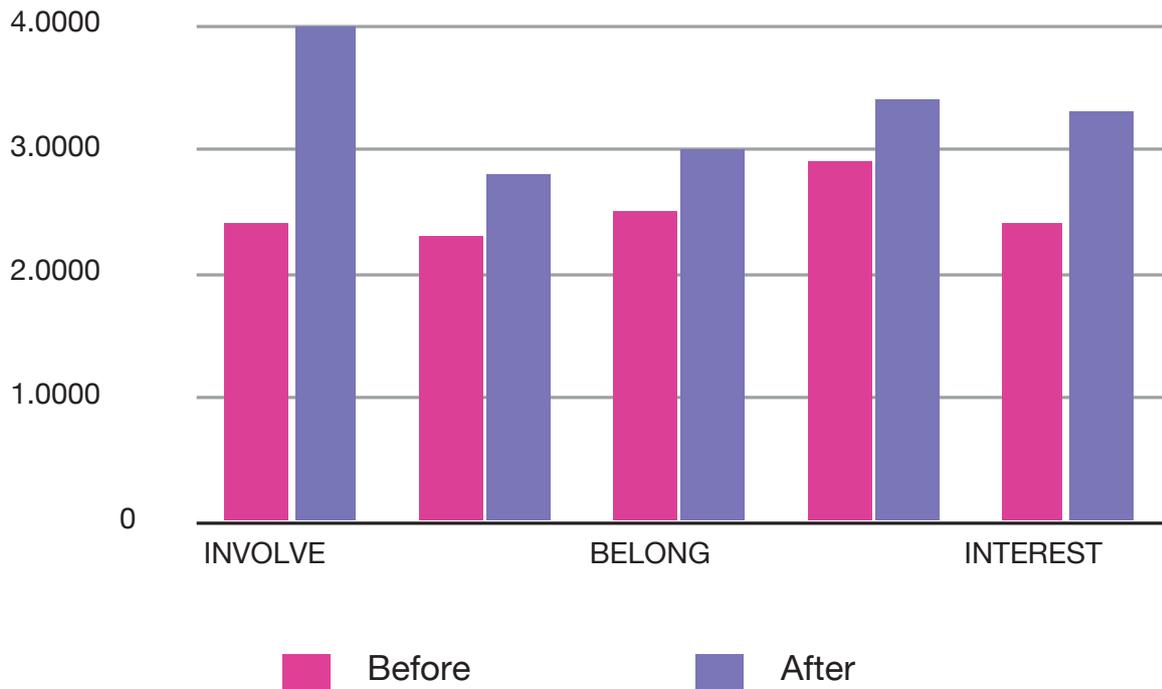


FIG 17: Social isolation

“I felt lonely and isolated. Getting out with a befriender has helped a lot”

“I tend to stay in my nightie all day and sometimes don't bother getting up. But each week when I know my befriender's coming and we're going out I get spruced up and am ready hours before”

“They've got it to a T. I'm meeting people and getting out, although I can't get far still because of my legs”

Increased Confidence			
	+	Same	-
Confidence in <u>meeting</u> people	65%	26%	9%
Confidence to take part in <u>activities</u>	73%	17%	10%
Confidence to take part in <u>conversations</u>	74%	21%	5%
General <u>self-confidence</u>	56%	38%	6%

67% are more confident

26 % remain the same

7% are less confident

BOX 14: Increased confidence



FIG 18: Increased confidence

“It’s like a snowball - going out with my befriender has helped me with other things. I’m now going places on my own. I’m able to go because I’ve been with my befriender before”

“It’s good to learn about new people and places”

“It has made a huge difference to my ability to go out. I’m more confident to go to different places”

6.3 Group befriending

	Scale 1-5		
	Before	After	Change
Ability to cope with <u>daily life</u>	2.4	3.3	+0.9
Ability to manage <u>stress</u>	2.4	2.9	+0.5
<u>Mental health</u> and well-being	2.0	3.6	+1.6
<u>Physical health</u> and well-being	2.9	3.0	+0.1

77.5% have improved

BOX 15: Coping and well-being (Central Glasgow Group)

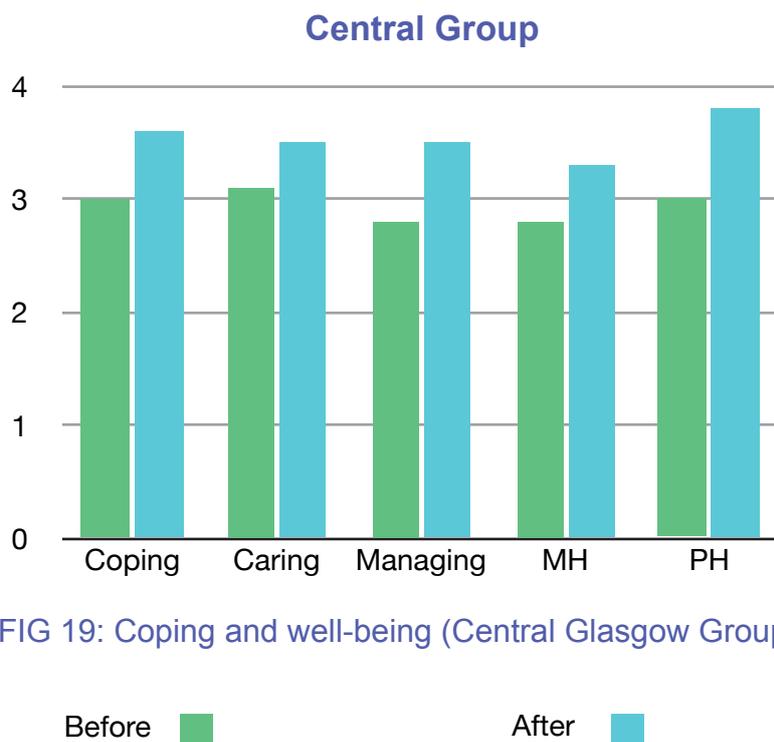


FIG 19: Coping and well-being (Central Glasgow Group)

Before ■ After ■

Central Group

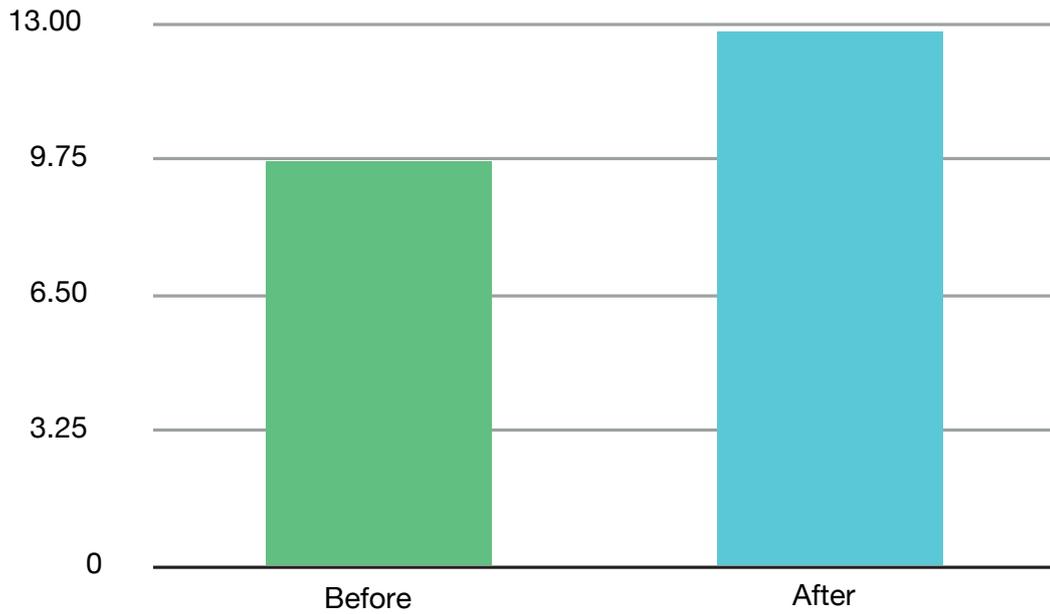
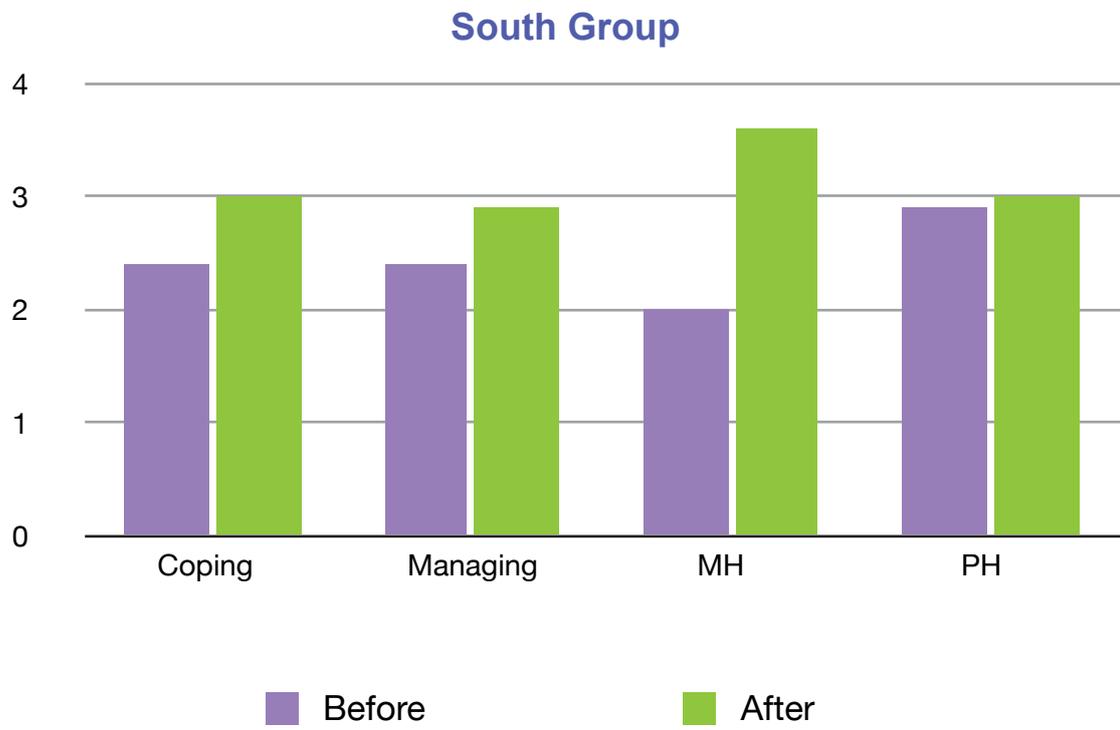


FIG 20: Coping and well-being (2) Central Glasgow Group

	Scale 1-5		
	Before	After	Change
Ability to cope with <u>daily life</u>	3.0	3.6	+0.6
Ability to cope with <u>caring role</u>	3.1	3.5	+0.4
Ability to manage <u>stress</u>	2.8	3.5	+0.7
<u>Mental</u> health and well-being	2.8	3.3	+0.5
<u>Physical</u> health and well-being	3.0	3.8	+0.8

60% have improved

BOX 17: Coping and well-being South Glasgow Group



FIGs 21 & 22: Coping and well-being (South Glasgow Group)



WELL-BEING (Scale 1 -5)

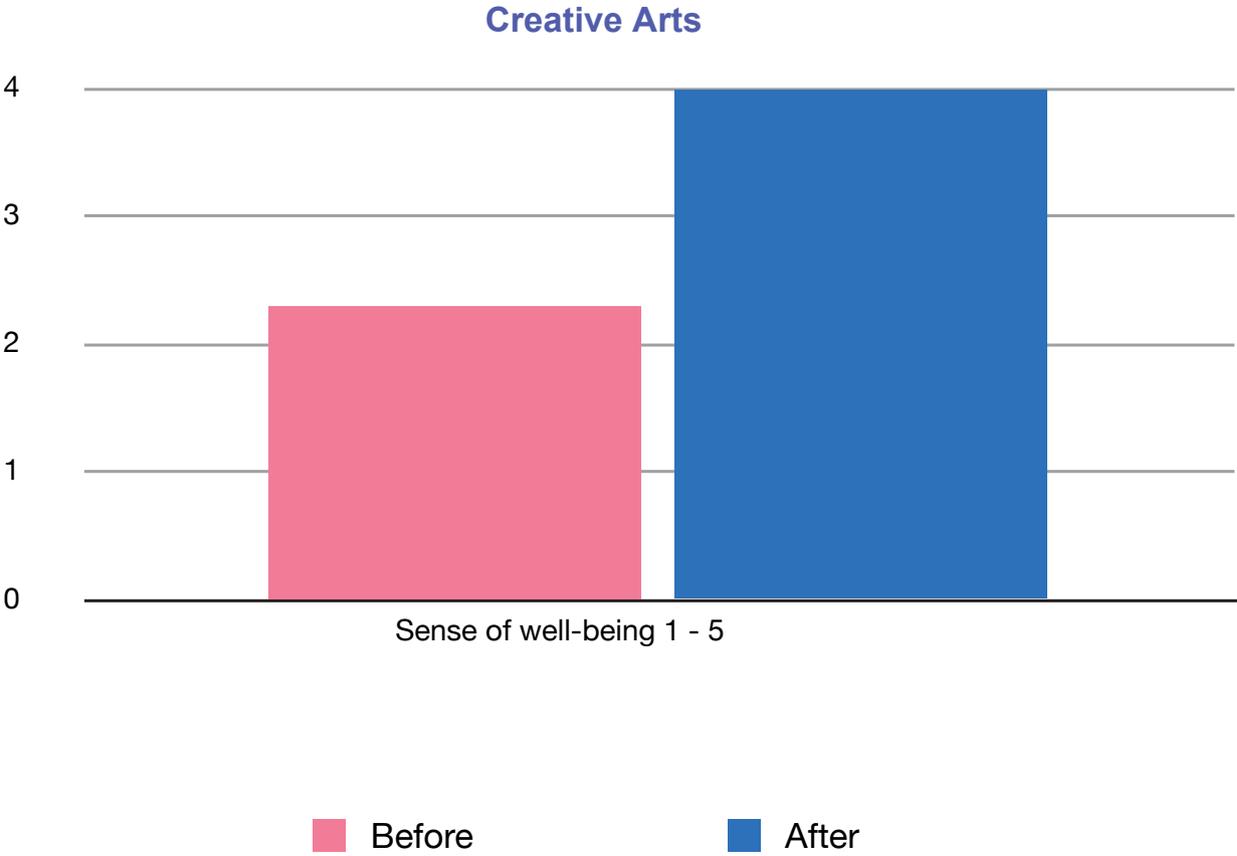
BEFORE: 2.3

AFTER: 4.0

CHANGE + 1.7

73.9% described an increased sense of well-being.

BOX 16 & FIG 23: Sense of well-being Creative Arts Group



6.4 GROUP COMMENTS

“Things improved surprisingly well when it’s been a very stressful time”

“The group was really good, takes you right out of yourself to a different world. It was also good fun and brought lots of smiles when we were learning to do something new”

“I have had a lot of stress with family illness and after being really ill myself ... my ability to cope/manage stress comes from attending SCOPE and other carers groups. Without them I would not get out of bed or if I did I would not leave the house”

“I’m more positive, more assertive, more outspoken now. I’m even taking more exercise and walking more”

“I had no motivation. This group has given me a reason to get out”

“I wanted to kill myself or disappear. I’d experienced many bereavements and it was a very difficult time”

“I felt much worse before the group started”

“I still sometimes feel agitated but the group really helps”

“The week is long when you’re on your own. I look forward to a Wednesday. Time passes more quickly. Then when I’m in town I can do my shopping too and wander about. I like seeing the people in the group”

This is totally for me. It is giving me the tools to cope. The caring role goes out of my mind for two hours and I am with people who understand what I am going through and don’t need to ask”

“I’d have been mincemeat on the M8 by now if the group hadn’t started”

“ ...sometimes I am so stressed from caring I just hide away at home because caring for my daughter who at times does not allow me to rest mentally I cannot cope physically...it is so good to go where people can understand your problems but at the same time can encourage you to be positive and keep trying to go on”

“My ability to cope/manage stress comes from attending SCOPe and other carers groups. Without them I would not get out of bed or if I did I would not leave the house”

“People around me give me a lift and the support workers are jolly too”

“ I have learned new things that I enjoy with my grandson”

“Good to have tea and a blether and meet new people who are also carers”

6.4 Self-esteem

The Rosenberg Self-esteem Scale is one of the most internationally recognised scales for measuring population self-esteem, although not that individuals. One of the reasons it is academically sound caused problems for some service users. Statements to be rated are linked not only to positive self-esteem, but also to negative self-esteem. These are written the same way and interspersed with the other questions. This can be confusing for people under stress and some people felt they “weren’t doing it right” and were pushed back to a “*black hole*” of negativity when they were doing their best to concentrate on wellness and well-being despite their problems.

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

1.	On the whole, I am satisfied with myself.	SA	A	D	SD
2.*	At times, I think I am no good at all.	SA	A	D	SD
3.	I feel that I have a number of good qualities	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.*	I feel I do not have much to be proud of.	SA	A	D	SD
6.*	I certainly feel useless at times.	SA	A	D	SD
7.	I feel that I’m a person of worth, at least on an equal plane with others.	SA	A	D	SD
8.*	I wish I could have more respect of myself.	SA	A	D	SD
9.*	All in all, I am inclined to feel that I am a failure	SA	A	D	SD
10.	I take a positive attitude toward myself.	SA	A	D	SD

Please note when these are being scored questions with asterisks will be reversed during analysis.

BOX 18: Rosenberg self-esteem scale

The response of SCOPe was correct: to concentrate on the needs of those using the service. The frequency of filling in the scale was reduced from every three months to only a beginning baseline and a follow-up at the finish. By the end it was being phased out.

Despite these Methodological reservations, once again the results were very positive.

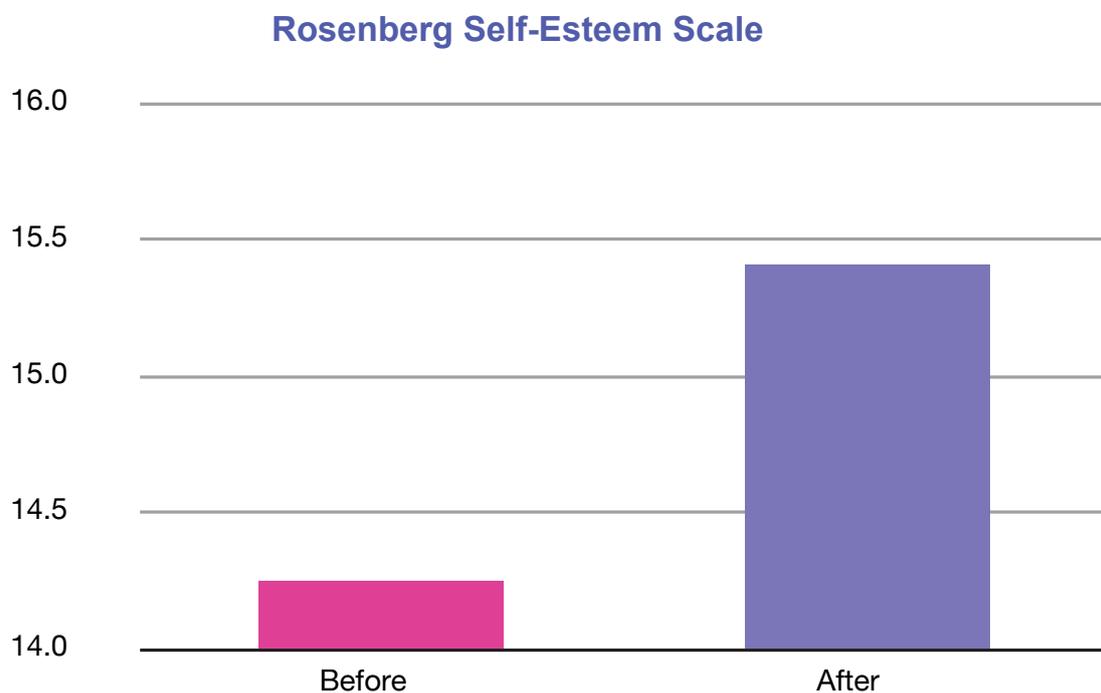


FIG 24: Self-esteem

The higher scores indicate higher self-esteem and on average this has clearly risen. Most of the initial responses were below what is regarded as 'normal' (15). Looking at the individual returns, not just average scores, it was clear that most people said their self-esteem had risen a lot. This disguises the fact that a few people started with very low self-esteem and this did not improve: they remained very low. This is to be expected, after all people with long-standing mental health problems will not easily have their self-esteem raised and the fact that so many did is an immense credit to the work of SCOPe. It does mean, however, that care should be taken to ensure excellent links with the formal carers in the statutory sector for the few who did not benefit.

6.5 Volunteer self-appraisal

The Outcome target was for fifty volunteer befrienders to demonstrate:

- Increased self-confidence
- Increased self esteem
- Increased life-skills

Returns were not available for 50 people, given that some volunteers did not follow-through, but of the rest there was unanimous agreement about how positive the experience had been. Volunteers had to complete a nine item questionnaire, rating on a scale from 1-10 their personal experience of the benefits of volunteering.



FIG 25: General self-confidence

Confidence in meeting people

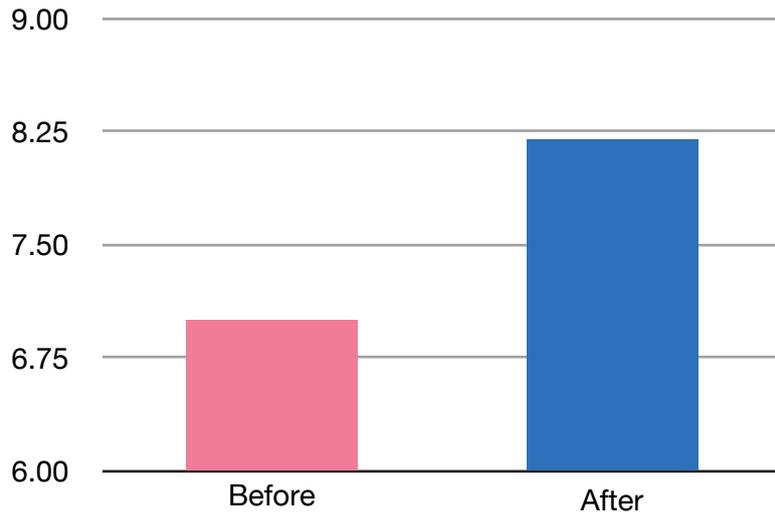


FIG 26: Meeting people

Confidence to take part in new activities

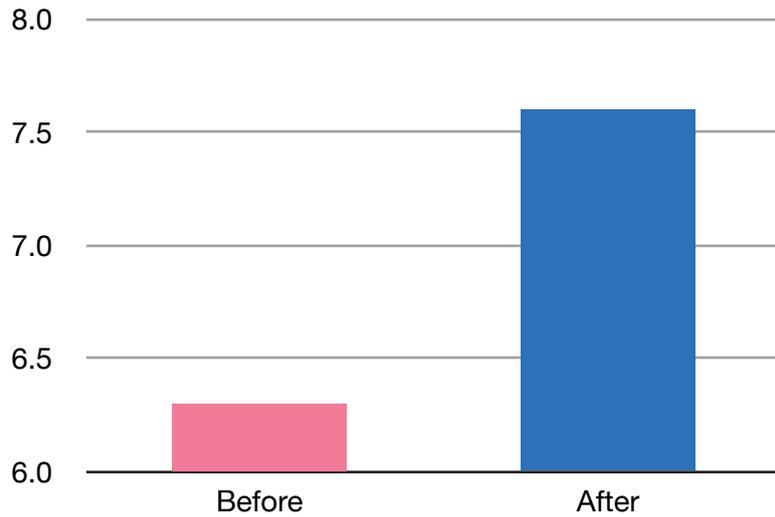


FIG 27: New activities

Confidence to try new things in the future

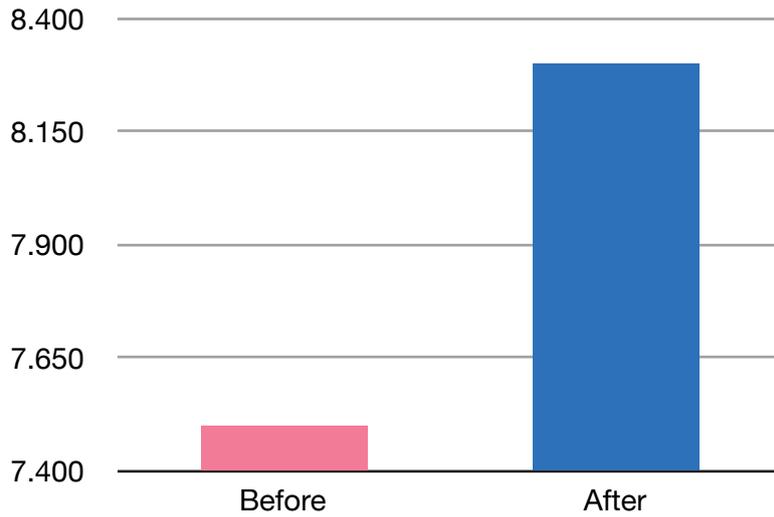


FIG 28: New things in the future

Ability/Interest in accessing and sustaining employment

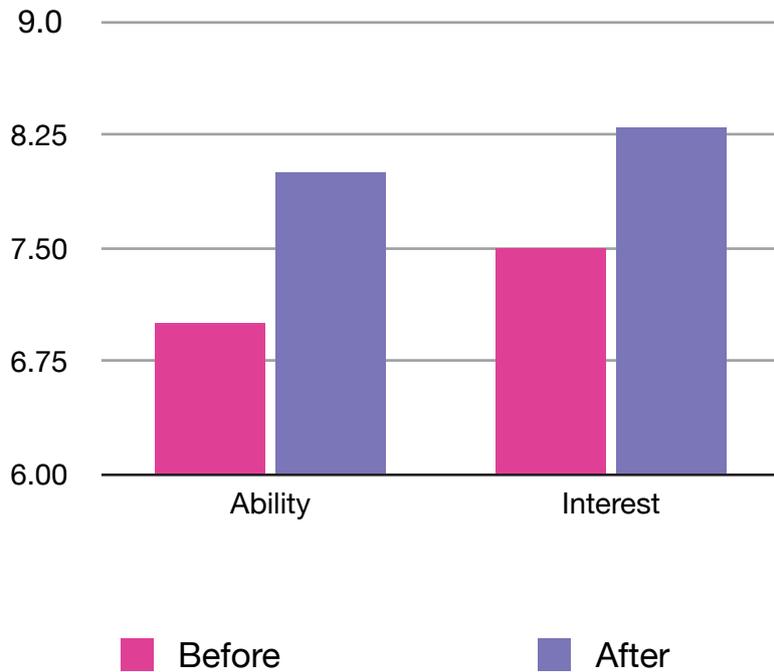


FIG 29: Employment

Ability/Interest in new educational opportunities

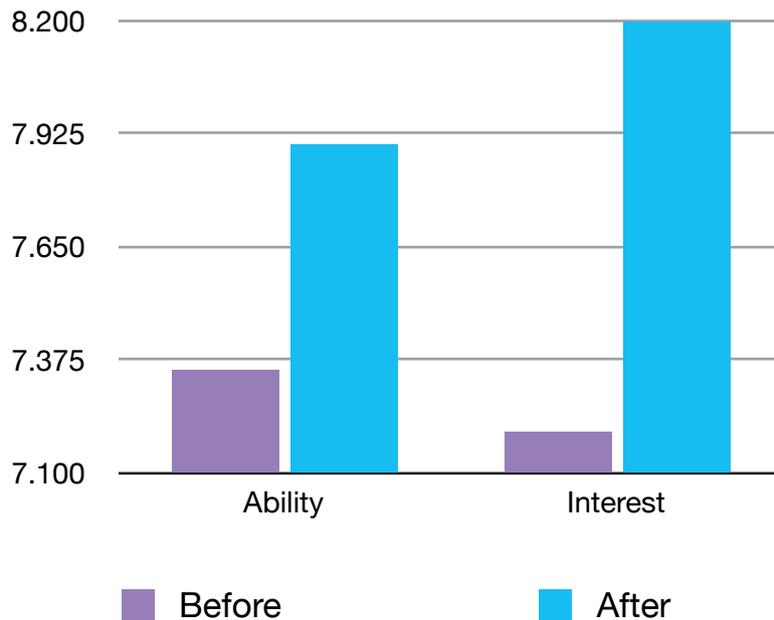


FIG 30: Education

Asked to rate the overall impact of volunteering the average score was **9 out of 10**. Confidence was increased in all areas: social, employment and education. People's interest in work and education increased along with the ability to take part.

This target was met.

"It's overall an excellent project - I love it"

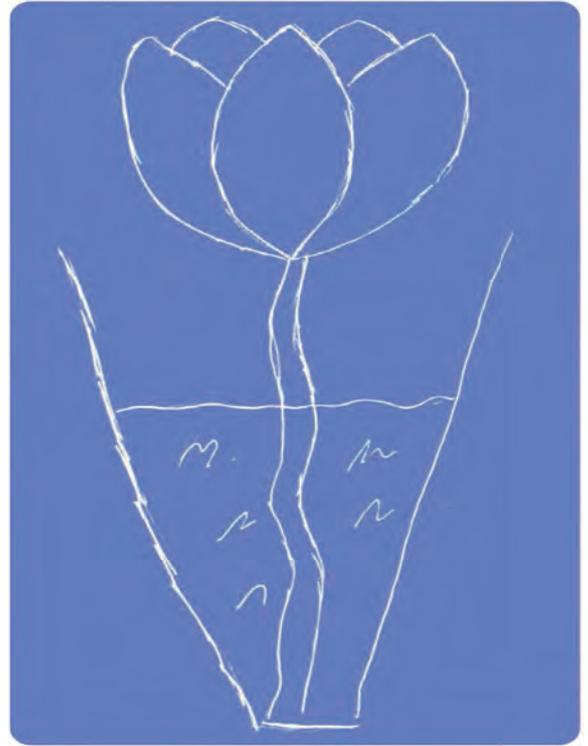
"It's an eye-opening experience"

"You get to see this person grow thanks to what you are doing...it's been fantastic"

"It's part of my life now, I wouldn't miss it"

"It was very useful especially for me as it was my first time in the UK and volunteering I met such a nice group of people"

7.6 Conclusions





Conclusions

1. The SCOPe Project has been extremely successful and GAMH and the Big Lottery are to be commended. It did not just meet, but exceeded, its Outcome Targets in terms of numbers, evaluative data and feedback from both service users and volunteer befrienders.
2. The number of older people referred who were experiencing mental health problems was more than the number of older people who were caring for a person with mental health problems. Consideration should be given to whether it might be better to address their needs separately. The carers appear to prefer group work (although this might stretch the definition of 'befriending').
3. A high number of people also had significant physical health problems, indicating that people with poor general health may have a large unmet need for similar social support.
4. The only concern about SCOPe was the difficulties with data collection, especially given the large amount of information needed for evaluation. Collecting this had proved to be time-consuming and not very user-friendly and it got confused with monitoring individual progress. Given the importance of this project it would have benefited from a greater administrative infrastructure and possible collaboration with an academic research centre.
5. Finally, it must be stressed that the success of SCOPe is down to a few individuals whose vision, dedication, commitment and sheer hard work made it possible. The last word goes to the service user who said.

*“success is
based
on people”*

