Talking Therapies

March 2018 - March 2020
with an extension until December 2020

Delivered by Oasis-Talk, Carers Support Centre and Second Step

Oasis-Talk
Emotional health & well-being

If you care, we care.
Carers Support Centre
Bristol & South Gloucestershire

SECOND STEP
PUTTING MENTAL HEALTH FIRST

BRISTOL AGEING BETTER

COMMUNITY FUND

APRIL 2021

Bristol Ageing Better (BAB) is a partnership of organisations working to reduce social isolation and loneliness among older people and help them to live fulfilling lives. It is funded by the National Lottery Community Fund as part of the national Ageing Better: Fulfilling Lives programme.

This report provides an overview of the Talking Therapies projects, delivered by Oasis-Talk, Carers Support Centre and Second Step. In line with BAB's 'test and learn' approach, this report will highlight key points of learning and recommendations which may be useful for other projects and services both within Bristol and nationally.

Structure of this report:

- Background
- Project Overview
- Impact on Participants: Summary
- Learning, including during Covid-19
- Recommendations
- Case studies
- Appendices: Demographics and detailed outcomes data

Background

As part of the 'test and learn' approach, BAB commissioned five wellbeing pilot projects which ran from November 2016 – August 2017. The purpose of these pilot projects was to **trial different wellbeing interventions and learn about what worked well.** This learning was then used to inform BAB's larger scale commissioning, including the Talking Therapies projects focused on in this report.

More information about the wellbeing pilot projects can be found *here.*

Project Overview

Building on the learning from these pilot projects, BAB commissioned two larger Talking Therapies contracts, delivered by three partner organisations using three different project models.

1) Talking Therapies delivered by Oasis-Talk and Carers Support Centre

- Funded by BAB from March 2018 – February 2020, with an extension until December 2020.
- The project offered up to **six sessions of counselling, either face-to-face** (Oasis-Talk) in Southmead, Horfield or the city centre, or **via the phone** (Carers Support Centre). Each session lasted up to **one hour**. It was available to anyone aged 50+ and living in Bristol.
- The project was delivered by three part-time therapists (one for Oasis-Talk and two for Carers Support Centre) and two part-time project coordinators.
- The project supported **414 clients between March 2018 and December 2020**. Client ages ranged from 51 – 99, with an **average age of 64 years old.**

2) Talking Therapies delivered by Second Step

- Funded by BAB from June 2018 – March 2020, with an extension until October 2020.
- The project offered up to **six sessions of face-to-face counselling in client homes,** with each session lasting up to **1.5 hours**. It was available to anyone aged 50+ and living in Bristol, with a particular focus on those with **low mobility or who were housebound.**
- The project was delivered by two part-time therapists (one FTE) and one part-time senior therapist/project coordinator (0.8 FTE). Therapists were trained in CBT for long-term health conditions due to the client group.
- The project supported **124 clients between June 2018 and October 2020.** Client ages ranged from 54 – 99, with an **average age of 72 years old.**

Impact on Participants: Summary

Summary of outcomes data

Clients completed a wellbeing questionnaire at the start of their involvement with the project and then again a few months later, forming a 'matched pair'. More detail is provided on the following pages and in the appendices. However **findings should always be interpreted with the sample size in mind** (between 36 and 68 matched pairs).

At the start of project involvement, clients from all three delivery partners had:

- **Far higher levels of loneliness** than the UK average for older people – mean scores categorised as "intensely lonely" on the De Jong Gierveld scale.
- **Lower levels of social contact with non-family members** in the local area than the UK average for older people.
- **Lower levels of mental wellbeing** than the UK average for older people.
- **Far poorer self-reported health** than the UK average for older people.
- **Very low levels of participation** in clubs, organisations and societies.

> ***He was very good at picking up my throwaway comments. I felt I was becoming more insightful and able to re-evaluate aspects of my life towards the end which felt good. I am not so hard on myself. The counselling was invaluable and made such a difference to my life.***
>
> *- Client, Carers Support Centre*

Face-to-face counselling in the community, delivered by Oasis-Talk

The following data is based on 51 - 68 matched pairs.

At follow-up approximately three months later, this project had a **statistically significant impact** (i.e. likely to be due to the project's intervention) on:

- **Mental wellbeing** using the SWEMWBS scale (p=0.004).
- **Health** using the EQ-5D-3L index (p=0.010).
- **Health** using the EQVAS scale (p=0.000).
- **Membership of clubs, organisations and societies** (p=0.000).
- **Co-design** of activities (p=0.049).
- **Unpaid help or volunteering** during the past 12 months (p=0.003).

Telephone counselling, delivered by Carers Support Centre

The following data is based on 36 - 44 matched pairs.

At follow-up approximately three months later, this project had a **statistically significant impact** (i.e. likely to be due to the project's intervention) on:

- **Mental wellbeing** using the SWEMWBS scale (p=0.000).
- **Loneliness** using the De Jong Gierveld scale (p=0.002).
- **Perceived frequency of social activities** compared to peers (p=0.015).

Face-to-face counselling in client homes, delivered by Second Step

The following data is based on 50 - 62 matched pairs.

At follow-up approximately three months later, this project had a **statistically significant impact** (i.e. likely to be due to the project's intervention) on:

- **Mental wellbeing** using the SWEMWBS scale (p=0.001).

Learning

Location

Travelling to where a therapist is based may not be suitable for many people including:

- Those with **low mobility and physical health conditions.** Older people are more likely to have mobility difficulties due to disabilities and long-term health conditions. Second Step, in particular, worked with lots of clients with physical health conditions, including cancer, ME and back problems.

- Those who are **carers**, as they may not be able to leave the person they are caring for.

- Those in **socio-economically disadvantaged areas**, who may experience a number of barriers including transport costs and perceptions of certain neighbourhoods as unwelcoming.

- Communities where there are **high levels of stigma** around mental health.

- Individuals from all backgrounds often have a **certain perception of a venue or neighbourhood,** and whether they are the 'type of person' to go there.

> ***Anxiety had taken over my life. I wasn't going out before I spoke to Second Step. The people that come to your house seem to have a good understanding of what you need. It's made me more aware of myself, I just have to put my mind to it and slow and sure, I feel able to go down to the shops.***
>
> *- Client, Second Step*

> ***It's easier when you can't see the counsellor's face. I would make myself a coffee and wrap myself up warm ready for the call. It was my time of self care.***
>
> *- Client, Carers Support Centre*

Length and number of sessions

Talking Therapies commonly offer up to six sessions of therapy, each lasting 50 – 60 minutes. This service model may be unsuitable for some people due to:

- The **nature of chronic loneliness;** the therapist may be the only person that individual sees each week. A longer session may be needed to allow time for the individual to talk, express themselves and process things at a slower pace without feeling rushed.

- For older people, it may be the **first time in their lives that they have accessed mental health support**. It takes time for them to build up trust with the practitioner and they may have complex lifelong issues to work through, possibly requiring longer sessions or a greater number overall.

- When therapy is via the telephone, it can be more tiring than face-to-face support due to the **lack of visual cues.** Shorter sessions may therefore be needed in these circumstances.

- A variety of **other health conditions** may also mean that some individuals require shorter sessions, but potentially more of them.

DNA ('Did Not Attend') policies

Many mental health services have a strict DNA ('Did Not Attend') policy. If someone misses two appointments then they are often no longer able to access the therapy, even if they inform the therapist in advance that they are going to miss the appointment (e.g. if they are on holiday), or if it is for a medical reason (e.g. they are in hospital).

This DNA policy does not work for everyone, particularly older people with long-term health conditions. Second Step, for example, worked with many people who had a multitude of medical appointments and were sometimes admitted to hospital. Similarly, clients who were carers had to fit their talking therapy around the medical appointments of the person they cared for.

These projects found that, in some cases, mental health support for older people can have a DNA rate that's almost 50% higher than for IAPT ('Improving Access to Psychological Therapies') services.

Barriers to accessing mental health support

In addition to the barriers already mentioned regarding travelling to an external location, these projects **learnt more about the other barriers to people accessing mental health support.** Some of these barriers include:

- The belief that they are **not 'ill enough'** to access mental health support.
- **Fears about having to tell the administrator everything** in detail first in order to be seen by a therapist.
- **Fears about not being able to 'prove'** they meet a certain threshold of poor mental health.
- **Cost** - including the 'suggested donation' of low cost therapies as people reported sometimes feeling pressured to pay this amount.
- **Preference to have a particular type of therapist** (e.g. someone of a particular gender or cultural background) which is not an available option.
- **Being unfamiliar with mental health,** including the stigma that is often attached to it.
- Feeling **uncertain** about what the mental health support will involve and **what will be required of them.**

When clients needed extra encouragement, it **helped to frame the first session** as an opportunity for the individual to meet the therapist and **'try out' the therapy before deciding if they wish to continue** with the future sessions. This increased the number of people then going on to receive the support.

Specialised services for older people

Mental health services often have a **lower uptake among older people** (Baker, 2018). This may be due to a number of reasons, some of which have been outlined above.

Some clients within these BAB talking therapy projects reported **previous negative experiences with mental health support,** including therapists assuming that they feel lonely or depressed *because* of their age, and that this is simply a natural part of ageing. This can result in lower therapeutic expectations for older clients compared to younger clients.

Therapists in the BAB projects found it useful to have specific training related to the mental health of older people, for example CBT for long-term health conditions.

Relationship to loneliness and isolation

Mental health support can **impact on loneliness and isolation** through improvements in feelings of anxiety, depression and self-esteem.

Talking therapies can help clients to **feel more worthy** of going to a social activity, **more confident** that they can contribute within a social setting and **less anxious** about the different factors involved in doing so. In this way it is also **preventative**, benefitting those who do not currently feel lonely as well as those who do.

> ***During the course of counselling, Annie also began to re-engage in her interests outside the home and make changes in a situation that had previously felt stuck. Annie developed more capacity to prioritise herself without feelings of guilt.***
>
> *- Therapist, Carers Support Centre*

Practical support

Talking therapy clients **often had practical needs to be met in addition to their wellbeing,** for example around food or heating. These practical needs **often needed to be addressed first** before the individual could focus on their mental health.

It was vital for the talking therapy projects to **work closely with other services,** particularly those providing social prescribing support who could help clients find solutions to these practical needs. **A joined up approach between mental health services and social prescribing is key to supporting clients' wellbeing in a holistic way.**

Interpreters

Oasis-Talk used interpreters within the face-to-face therapy sessions when needed. However they found there was **large variation in the quality of interpretation,** which was a challenge.

In some cases the interpreter would not translate everything the client had said, meaning the therapist was **unable to understand the full nuanced picture of the client's experience,** and therefore potentially not able to help the client as much as they otherwise would have been able to.

Confidentiality was also a concern when interpreters were used, as some clients did not feel as comfortable opening up via an interpreter. This was particularly the case when the interpreter was known within the local community.

Referrals

In some cases, people forgot that they had been referred or were confused about who was delivering the therapy (particularly when this was based within another venue). As such, it worked best when the member of staff booking in the appointment **provided a clear explanation without assuming any prior knowledge.**

It can be valuable to offer an **online self-referral form for those who have access to the internet and wish to do this.** The ability within online forms to make some questions compulsory meant that referrals completed this way were often quicker to process as all of the necessary information was submitted without anything being missed.

Getting feedback from clients

These projects had a **high rate of return for the BAB evaluation forms.** In the Second Step and Oasis-Talk projects, the therapist completed these forms with clients, whereas this was done by the Project Coordinator within the Carers Support Centre project.

This high rate of return is likely due to a number of factors including:

- There is a **clear 'entry' and 'exit' point** to the therapy.
- Therapists are **experienced in using similar tools** with clients, and often used these other scales (e.g. GAD7 and PHQ9) alongside the BAB evaluation forms.
- Therapists are **able to ask evaluation questions in a therapeutic way** which can inform their session at the same time as completing the form.
- Therapists and Project Coordinators are **experienced in overcoming any initial uncertainty** from clients.
- Clients **expect to be talking about difficult emotional issues** during therapy and are therefore more open to answering sensitive evaluation questions in connection to this.

When asking clients for their feedback on the project, many wanted to thank the therapist and **needed extra encouragement to provide constructive suggestions.** This was the case even when it was a different member of staff asking for the feedback.

Oasis-Talk overcame this by specifically asking clients to name three things that the project could improve. Similarly, Carers Support Centre asked clients to talk about what their experience was like, rather than only filling in set answer boxes.

Learning during Covid-19

During the pandemic, Second Step and Oasis-Talk had to **completely adapt their project model to deliver via the telephone.** For Second Step, home visiting was an essential part of the project and it was challenging when this aspect was no longer possible. A national shortage of PPE meant that they were **not able to return to face-to-face therapy as quickly as they would have liked.**

Referrals initially slowed slightly at the very beginning of the pandemic while everyone adapted to a new and different situation. However referrals soon picked up and **there was a very high level of demand as well as a high level of complexity in the referrals received.**

> ***It takes longer because you can't read subtle body language cues you would normally see in a face-to-face appointment. You don't know, for example, if the client is still considering a question or if they haven't heard you. Sometimes if there is a long pause I'll say "I'm still here" so they feel listened to.***
>
> *- Therapist, Second Step*

Therapists found they needed to be **even more flexible about the duration and number of sessions for each client.** In some cases clients required more maintenance-oriented friendly conversations rather than the traditional recovery and goal-oriented interventions.

Due to the pandemic occurring towards the end of the BAB funding, these organisations needed to **assess how many new referrals could be accepted** in order for all clients to receive therapy before the end of the funding. This was challenging, particularly given the level of demand, and at one point some of the projects had to temporarily stop receiving any new referrals. However **this was well managed and nobody was promised therapy without then being able to receive it.**

It worked well for these projects to be **connected to the Bristol Support Hub for Older People.** Mutually trusting relationships between these Support Hub organisations enabled them to **coordinate care in advance before the client began therapy**, which provided the client with a smoother experience. For example Oasis-Talk were able to allocate clients with learning disabilities directly to their therapist experienced in this area, avoiding the risk of the client needing to change therapist after the first session. This **collaboration between voluntary sector organisations greatly enhanced the benefits for clients** as they were able to get the right type of support first time.

> ***Clients have commented on the vital service [during Covid-19] and how it supported them to manage their distress. Being able to receive therapy via telephone has prevented long waiting times and enabled people to receive support when they most need it.***
>
> *- Therapist, Second Step*

Recommendations

1 Location

Mental health services need a **mixed model which can offer people a choice of how and where they access support,** including face-to-face, telephone, home-based or in a community venue.

Home visits are particularly vital and can reach a client group who would not usually access other services, while also improving the effectiveness of other home-based services.

> ***I'm not brilliant at talking on the phone but it was a godsend. Going out for too long made me anxious. I was amazed at how much I talked...I feel in control again.***
>
> *- Client, Carers Support Centre*

By delivering a mixed model, it enables some **clients to progress through locations.** For example an individual who may require a home visit at first due to anxiety levels may later be able to attend appointments at an external location as their mental health improves.

2 Length and number of sessions

Flexibility needs to be built into service models, allowing the length and number of sessions to be tailored to the individual circumstances. In order to have this flexibility, models need to have an **agreed framework for deciding when to extend the number of sessions beyond six.** This decision should be made jointly by the therapist and a clinically-informed line manager in order to balance the wish to tailor to the individual, while also meeting the needs of those on the waiting list.

Six sessions might work in cases when there is other reliable mental health support for the client to access afterwards. If not, then there needs to be the option of offering a greater number of sessions per individual when needed.

3 Flexibility with appointments and non-attendances

DNA ('Did Not Attend') policies need to consider individual circumstances and whether the person is generally motivated/engaging, not simply the number that they have missed. That said, the individual needs to be engaging and to inform the service about cancellations if possible.

It would be useful to set up a system to send **automated text reminders** to people who have mobile phones and who would find this useful, so that they do not forget about their appointment. Another option is that when somebody helps the client to self-refer (e.g. they

are supported by a friend or family member), the service could **ask whether the client would like them to liaise with this individual instead** in order to assist with remembering and attending appointments.

Similarly, it is important to **build in flexibility around the days and times of appointments,** recognising that there may be many reasons why somebody cannot stick to a consistent time each week (for example due to having a lot of medical appointments).

It is also valuable to be able to **offer people the option of putting the therapy on hold for a little while.** When people's situations change, they **may first need to address new practical needs that have arisen** in order for them to be in the best headspace to benefit from the therapy. Carers Support Centre, for example, found that the least successful referrals for carers tended to be when the person being cared for had recently been admitted to hospital, as the carer was in a time of crisis and found it difficult to focus on their own needs. In these situations it worked well to have the option of **putting the therapy on hold until the situation had stabilised.**

4 Specialised mental health support tailored for older people

Specific mental health support tailored to people aged 50+ would **enable therapists to become skilled in the circumstances that disproportionately affect this age group** such as long-term health conditions, bereavement, long-standing traumas and patterns of thinking or behaviour engrained over the course of many decades.

Moreover, a **direct connection between physical therapists and mental health therapists** would enable both services to work in tandem regarding an individual, providing support that complements each other and boosts effectiveness. This would require the alignment of physical and mental health services, both strategically and operationally.

5 Work closely with social prescribing services

Many of the referrals came from social prescribing services, and **enabled people to benefit from mental health support who would have been unlikely to access this support otherwise.**

Recommendations to improve this connection even further:

- **Inform local social prescribers about the service as soon as possible,** so that they can begin to make referrals from the beginning.
- **Arrange for social prescribing link workers to meet with the therapists themselves** so that they be fully aware of what the service is offering and can

provide their clients with reassurance that the therapist is welcoming and approachable.

- **Possibly deliver therapy within the same building as a social prescribing service** to increase awareness of the therapeutic support available and for clients to feel comfortable attending within that environment.

6 Flexibility to draw on a number of different therapy styles

It is valuable to be able to **flexibly tailor the therapy style to the individual** client rather than being commissioned to deliver specific types of therapy which may not suit everyone.

The therapists in the BAB-funded projects drew on a wide variety of styles and schools of thought beyond CBT (Cognitive Behavioural Therapy), for example when clients did not want this type of therapy or the service deemed it unsuitable for their situation.

7 Client input and co-design

Service models should include **formal and informal mechanisms for client input and co-design** at all stages of the service. This might include steering groups, client boards, feedback forms, opportunities to informally suggest ideas or clients becoming volunteers.

However, for these processes to bring genuine value, models need to be open to adaptation and staff need to be willing to listen and reflect. In some cases this may involve significant adaptations to the original model.

8 Sustainability

Expand traditional mental health service models to **include a focus on sustainability.** The starting point for this may be to ensure that current and former clients are involved in the design and delivery of the service, getting their input about **what would have helped them to maintain their wellbeing** after the formal support finished. Sustainability may also involve **connecting with existing community groups** in the places where individuals go on a day-to-day basis.

Case Study: Oasis-Talk, prior to Covid-19

Debbie sought counselling when dealing with some difficult relationships in the family and in order to help her daughter, who was having difficulties of her own at the time. Debbie felt that her daughter may be carrying her feelings and felt that some feelings were immobilising her, “I felt stuck”.

Debbie had previous experience of counselling during times of ill health and bereavement, she recognized that brief therapy could not “unpack a whole life” and her therapy prioritized what mattered most at this time. Debbie’s aims were for more confidence, motivation and energy and less anxiety.

Debbie felt that the mode of counselling and the therapy offer for older people might suit her better than larger general services.

Debbie joined a waiting list and was offered a cancellation for fortnightly sessions. Debbie found having sessions every other week helpful as it allowed her time to think about and absorb what they were working on in the counselling. Debbie used her time in the other weeks to do some reflective writing.

Debbie has some health issues which make it hard for her to get up and going in the morning and let Oasis-Talk know that she appreciated having an appointment in the afternoons.

Debbie felt that her therapist was clear, accessible and professional. Debbie appreciated the person-centered approach saying that “the topics were mine, my own agenda”. Debbie felt heard during the counselling, saying “when I heard what I had said reflected back it helped me understand myself better”.

Since the therapy Debbie has felt she is better able to identify things that she cannot change and make peace with them. She is also actively identifying things that are therapeutic for her, such as wellbeing activities. Debbie found the counselling helped her recognise the worth in doing things that make her feel good.

Debbie felt that she wasn’t sidelined because of her age and that the counselling helped her level of confidence which brought her into more contact and gave her more confidence in joining groups and activities.

Looking back at how she felt before and after the therapy, Debbie stated that she felt more confident, motivated and in control. She is working on increasing energy and searching for effective treatment for a chronic health issue.

Debbie said “if I had to visualize the process I would describe it as “alchemy. Transforming base metal into something of more value”.

Case Study: Carers Support Centre, prior to Covid-19

Barbara cares for her husband who has cancer. Barbara's husband was told that his cancer was terminal and when we began our counselling sessions it was expected that he had a few months left to live. Barbara and her husband had been living with his cancer treatment and its impact for a number of years. Barbara has 2 children.

Over the course of the sessions Barbara was able to make good use of the support – she committed to making sure that she was is a quiet confidential space each week in order to engage fully. Part of the focus of our sessions was to provide a space for Barbara to talk openly about her relationship with her husband and to begin to come to terms with and accept their relationship as a whole – both the good, and more difficult parts. It was also important to Barbara to think about how to talk to her children about their dad's illness, and how she could support them to cope when he died.

Through the sessions, we were able to talk about how Barbara might build her resilience to cope, not just in the present, but during the difficult months ahead. Barbara was able to identify and make space for activities that gave her a break from work and caring, such as dancing, spending time in the countryside, and being with friends who were both supportive and fun to be with. Investing in positive relationships with friends helped Barbara to feel more relaxed, and hopeful that she would have support around her after her husband died.

At the end of counselling Barbara was able to reflect on her relationship with her husband, acknowledging her sadness, but also recollecting happier times. She also said that she felt she had a good mix of support in place to help her to cope with the months ahead.

After the counselling Barbara fed back to the counselling coordinator that: "It was so useful. I feel my positive experience of counselling has helped my older child think about counselling for himself. The impact of my counselling has had far reaching effects for my family."

Case Study: Second Step, prior to Covid-19

Lisa was referred to Second Step by one of the Bristol Community Navigators as she was experiencing depression and anxiety.

When I first met Lisa she was isolated and didn't leave the house very much. She was keen to participate in more social activities but felt her physical health was a huge barrier for her. She suffers with Pustular psoriasis on her hands and feet as well as arthritis in both knees. Both of these cause her a lot of pain and mean that she cannot walk for long distances. She had been smoking more than usual due to worries about her health and about her family.

Over our sessions together we worked on her worries and her social anxiety by recognising unhelpful thinking patterns and finding alternative ways of looking at things. We looked at relaxation methods and Lisa tried breathing techniques and hobbies such as knitting or colouring. Lisa was very focussed and committed to making changes and so she threw herself into everything we discussed and started to find herself able to relax more. She started to let go of worries regarding other people and things that were out of her control. We use our own scores for depression and anxiety and by the end of therapy Lisa's scores had reduced drastically.

In her feedback Lisa said, "Anxiety had taken over my life. I wasn't going out before I spoke to Second Step. It's just nice to be able to talk and know you're not alone. You can't talk like this at the doctor's because they don't have the time but the people at Second Step are wonderful. The people that come to your house seem to have a good understanding of what you need. It's made me more aware of myself, I just have to put my mind to it and slow and sure, I feel able to go down to the shops."

I have recently got back in contact with Lisa to complete a 6 month follow up and she told me that a health scare had put her back a little and she spent a short time not leaving the house after an operation. However, this time Lisa was able to get herself out of this and challenged herself to go to the local shops. This gave Lisa some of her confidence back that she can do this for herself. I have researched some activities in Lisa's local area and she is hoping to attend an art group and a social meeting in the future.

Appendices

Project Reach: Demographics

During the main funded period (prior to any extension), **these projects reached a combined total of 318 individuals.** Of these, 255 provided their demographic information.

This is shown in the table below:

	Face-to-face counselling in the community (Oasis-Talk)	**Telephone counselling (Carers Support Centre)**	**Face-to-face counselling in client homes (Second Step)**
Number of people providing this demographic data	110	69	76
Age	Ranged from 52 – 99 years, with a mean age of 65 years old. The largest age group was 55 – 59 years old (36%).	Ranged from 51 – 92 years, with a mean age of 62 years old. The largest age group was 55 - 59 years old (27%).	Ranged from 54 – 99 years, with a mean age of 72 years old. The largest age group was 75 – 79 years old (20%).
Gender	71% female, 29% male.	87% female, 13% male.	65% female, 29% male, 7% no response or preferred not to say.
Ethnicity	3% Asian or Asian British, 3% Black or Black British, 4% mixed ethnic background, 3% other ethnic background (unspecified), 86% White or White British, 2% no response or preferred not to say.	6% Asian or Asian British, 3% Black or Black British, 1% other ethnic background (unspecified), 87% White or White British, 3% no response or preferred not to say.	3% Black or Black British, 3% mixed ethnic background, 89% White or White British, 5% no response or preferred not to say.

Religion	3% Buddhist, 36% Christian, 2% Muslim, 14% other religion (unspecified), 37% no religion, 8% no response or preferred not to say.	32% Christian, 1% Hindu, 1% Sikh, 4% other religion (unspecified), 30% no religion, 30% no response or preferred not to say.	50% Christian, 3% other religion (unspecified), 30% no religion, 17% no response or preferred not to say.
Sexual orientation	1% bisexual, 3% gay or lesbian, 88% heterosexual, 8% no response or preferred not to say.	91% heterosexual, 9% no response or preferred not to say.	83% heterosexual, 17% no response or preferred not to say.
Disability	55% reported having a disability, 41% reported no disability, 4% no response or preferred not to say.	54% reported having a disability, 45% reported no disability, 1% no response or preferred not to say.	88% reported having a disability, 7% reported no disability, 5% no response or preferred not to say.
Living arrangements	53% lived alone, 12% lived with family, 26% lived with a spouse or partner, 3% had other living arrangements, 2% lived in residential care, 5% no response or preferred not to say.	15% lived alone, 46% lived with family, 39% lived with a spouse or partner.	74% lived alone, 11% lived with family, 8% lived with a spouse or partner, 3% had other living arrangements, 1% lived in residential care, 4% no response or preferred not to say.
Caring responsibilities	32% had caring responsibilities, 61% did not have caring responsibilities, 6% no response or preferred not to say.	93% had caring responsibilities, 6% did not have caring responsibilities, 1% no response or preferred not to say.	11% had caring responsibilities, 83% did not have caring responsibilities, 7% no response or preferred not to say.

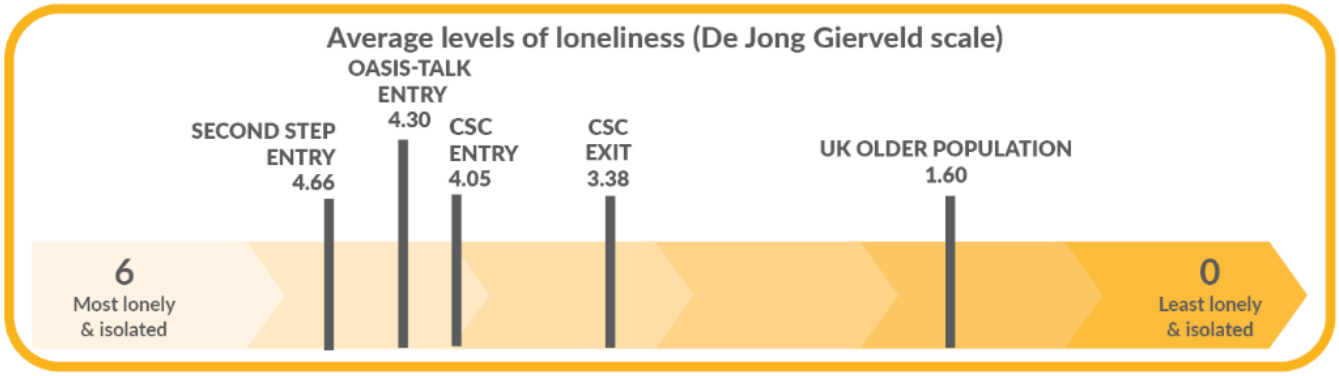
Detailed outcomes data

Loneliness: De Jong Gierveld scale

Clients' mean scores were:

	Oasis-Talk (based on 53 matched pairs)	**Carers Support Centre (based on 39 matched pairs)**	**Second Step (based on 50 matched pairs)**
Project entry	4.30 ('intensely lonely')	4.05 ('intensely lonely')	4.66 ('intensely lonely')
Project exit	Change not statistically significant	3.38 ('moderately lonely') **Statistically significant change (p=0.002)**	Change not statistically significant

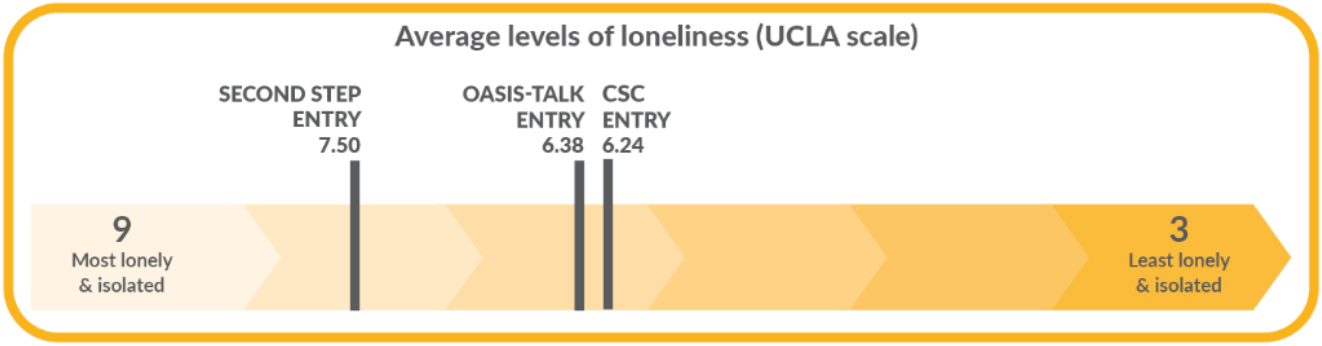
As a comparison, the average score for people aged 63+ in the UK is 1.60 (TNS Omnibus, 2016).



Loneliness: UCLA scale

Clients' mean scores were:

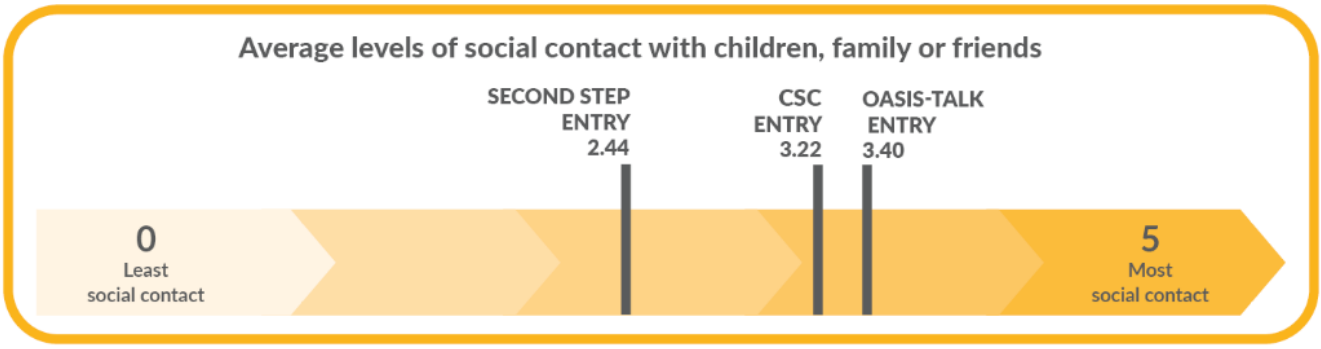
	Oasis-Talk (based on 64 matched pairs)	**Carers Support Centre (based on 41 matched pairs)**	**Second Step (based on 52 matched pairs)**
Project entry	6.38	6.24	7.50
Project exit	Change not statistically significant	Change not statistically significant	Change not statistically significant



Social contact with children, family and friends

Clients' mean scores were:

	Oasis-Talk (based on 54 matched pairs)	**Carers Support Centre (based on 41 matched pairs)**	**Second Step (based on 52 matched pairs)**
Project entry	3.40	3.22	2.44
Project exit	Change not statistically significant	Change not statistically significant	Change not statistically significant



Social contact with non-family members in the local area

Clients' mean scores were:

	Oasis-Talk (based on 70 matched pairs)	**Carers Support Centre (based on 44 matched pairs)**	**Second Step (based on 56 matched pairs)**
Project entry	6.53	6.73	6.00
Project exit	Change not statistically significant	Change not statistically significant	Change not statistically significant

As a comparison, the average score for people aged 63+ in the UK is 7.36 (TNS Omnibus, 2016).

Membership of clubs, organisations and societies

Clients' mean scores were:

	Oasis-Talk **(based on 66 matched pairs)**	**Carers Support Centre** **(based on 38 matched pairs)**	**Second Step** **(based on 55 matched pairs)**
Project entry	1.09	0.84	0.45
Project exit	1.59 **Statistically significant change (p=0.000)**	Change not statistically significant	Change not statistically significant

Perceived frequency of social activities compared to peers

Clients' mean scores were:

	Oasis-Talk **(based on 68 matched pairs)**	**Carers Support Centre** **(based on 44 matched pairs)**	**Second Step** **(based on 57 matched pairs)**
Project entry	1.21	0.84	0.60
Project exit	Change not statistically significant	1.09 **Statistically significant change (p=0.015)**	Change not statistically significant

Co-design of activities

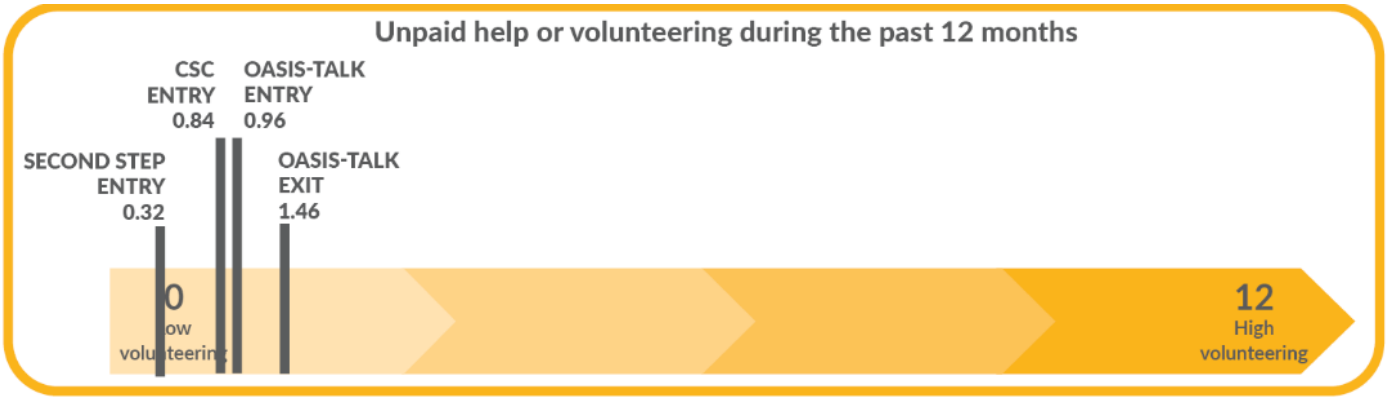
Clients' mean scores were:

	Oasis-Talk (based on 69 matched pairs)	**Carers Support Centre (based on 41 matched pairs)**	**Second Step (based on 57 matched pairs)**
Project entry	1.62	0.44	0.33
Project exit	1.14 **Statistically significant change (p=0.049)**	Change not statistically significant	Change not statistically significant

Unpaid help or volunteering during the past 12 months

Clients' mean scores were:

	Oasis-Talk (based on 69 matched pairs)	**Carers Support Centre (based on 43 matched pairs)**	**Second Step (based on 57 matched pairs)**
Project entry	0.96	0.84	0.32
Project exit	1.46 **Statistically significant change (p=0.003)**	Change not statistically significant	Change not statistically significant

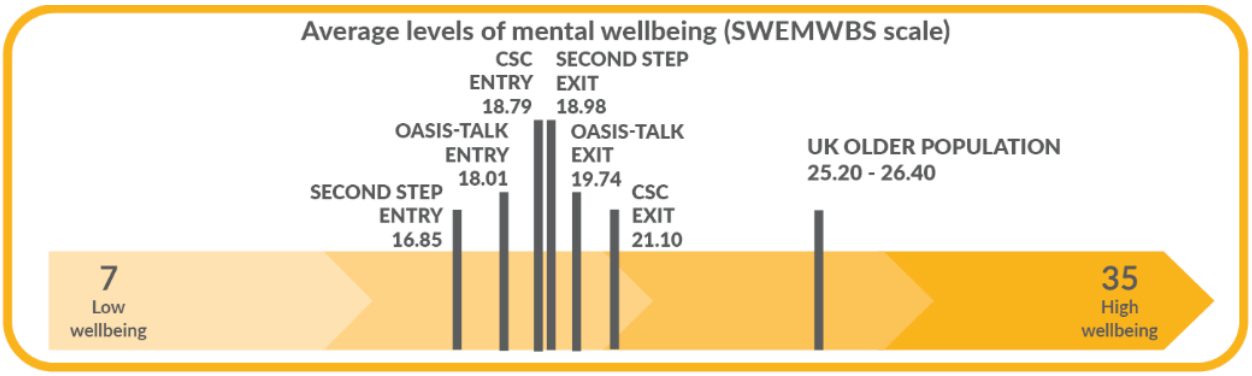


Mental wellbeing: SWEMWBS scale

Clients' mean scores were:

	Oasis-Talk (based on 51 matched pairs)	**Carers Support Centre (based on 43 matched pairs)**	**Second Step (based on 50 matched pairs)**
Project entry	18.01	18.79	16.85
Project exit	19.74 **Statistically significant change (p=0.004)**	21.10 **Statistically significant change (p=0.000)**	18.98 **Statistically significant change (p=0.001)**

As a comparison, the UK average is 25.20 for people aged 55-64, 26.40 for people aged 65-74 and 25.90 for people aged 75 and over (ONS, 2015/2016).

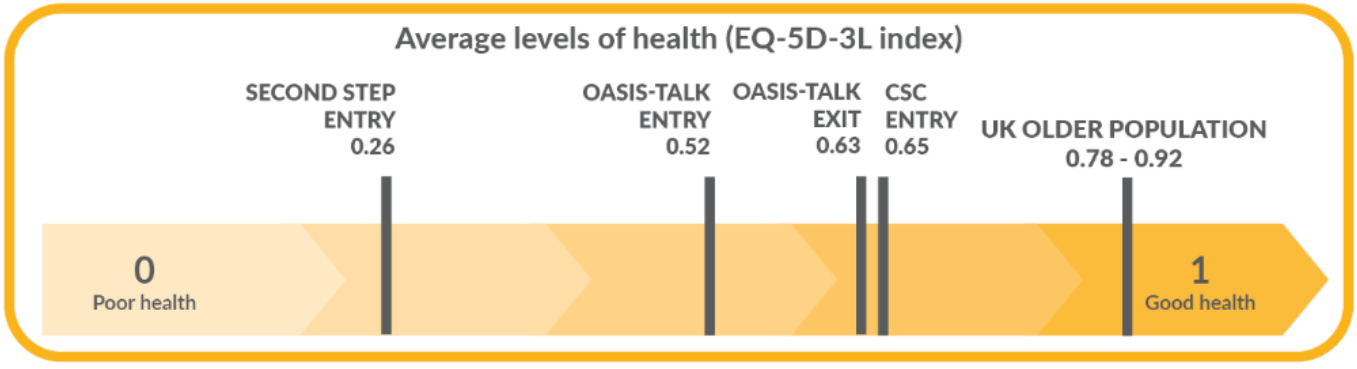


Health: EQ-5D-3L index

Clients' mean scores were:

	Oasis-Talk (based on 60 matched pairs)	**Carers Support Centre (based on 36 matched pairs)**	**Second Step (based on 52 matched pairs)**
Project entry	0.52	0.65	0.26
Project exit	0.63 **Statistically significant change (p=0.010)**	Change not statistically significant	Change not statistically significant

As a comparison, the UK average for people aged 55+ ranges between 0.78 and 0.92 (Health Survey England, 2012).

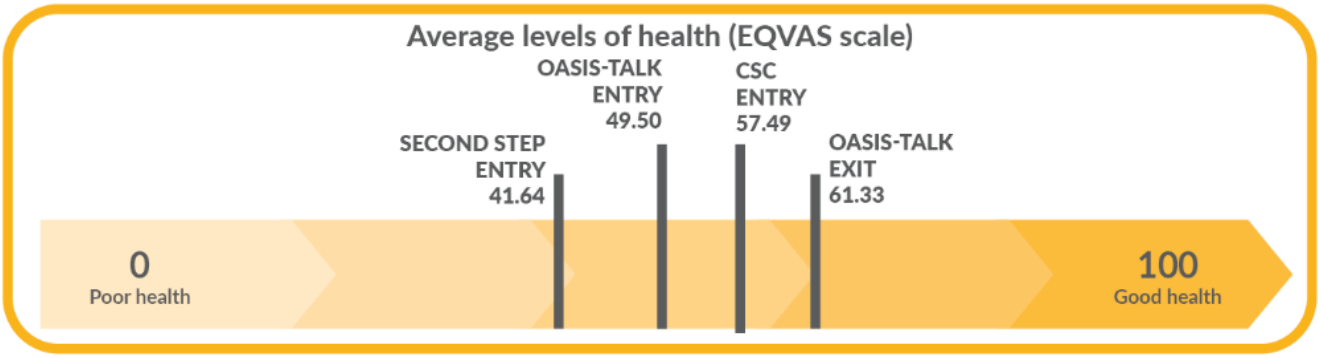


Health: EQVAS scale

Clients' mean scores were:

	Oasis-Talk **(based on 58 matched pairs)**	**Carers Support Centre** **(based on 43 matched pairs)**	**Second Step** **(based on 56 matched pairs)**
Project entry	49.50	57.49	41.64
Project exit	61.33 **Statistically significant change (p=0.000)**	Change not statistically significant	Change not statistically significant

As a comparison, the UK average is between 71 and 80 for people aged 55-84, and between 60 and 70 for people aged 85+ (Health Survey England, 2012).



Bristol Ageing Better
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bab@ageukbristol.org.uk
0117 928 1539

Further BAB learning resources can be found at:
https://bristolageingbetter.org.uk/learning-and-evaluation-hub/

Oasis-Talk
Emotional health & well-being

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SECOND STEP
PUTTING MENTAL HEALTH FIRST

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