The power of low-key groupwork activities in mental health support work

Nick Pollard[1] and Sarah Cook[2]

***Abstract**: The UK government's Health and Social Care Bill (Department of Health 2011) proposes that the delivery of care, including mental health services, will be organised through a range of different providers including social firms and charities. General practitioners (GPs)will be at the core of this process (GPonline, 2011). This paper explores the group based practices of two voluntary social enterprise projects in one of the most impoverished inner city areas in England (Sheffield City Council, 2004). This paper results from a realistic evaluation project which explored how the service delivered benefits for members, using focus groups, a wellbeing survey, and interviews. The findings and thematic discussion show that both services are characterised by groupwork underpinned by local involvement and community feel. The groups have been developed so as to allow a low key, mutually negotiated level of engagement, focussed on attendance, support and enabling participation.*

***Keywords**: groupwork; primary care; severe and enduring mental health; horticulture; writing; community; voluntary sector.*

1. Senior Lecturer in Occupational Therapy, Sheffield Hallam University
1. Reader in Occupational Therapy, Sheffield Hallam University

***Address for correspondence**: Faculty of Health and Wellbeing, Sheffield Hallam University, 11-15 Broomhall Road, Sheffield S10 2BP. N.Pollard@shu.ac.uk*

Introduction

SAGE Greenfingers and the PMCHP are based in an area of the city characterised by cultural diversity and chronic deprivation. Added to this the area has an unusually high number of clients who experience enduring mental health conditions. Many of these people were discharged during the closure of the city's former asylum. Due to the decline of the area, a number of large Victorian houses, formerly the homes of Sheffield's industrial entrepreneurs, were available at low prices. These were attractive to retiring nursing staff who used their lump sums to develop private homes to accommodate former asylum patients. Consequently, by the mid 90's doctors and an occupational therapist working at the local general practice surgery found almost 100 patients with psychotic conditions (Cook, 2003; Cook and Howe, 2003; Cook et al, 2004). In 2010 the practice has 126 patients with diagnoses of schizophrenia, bipolar disorder and other psychoses for the practice with a list size of 8572.

In order to meet the needs of so many people with severe and enduring mental health needs the practice established a volunteer run project, which became the PMCHP 16 years ago to provide community services. Subsequently as further needs for mental health support work were identified for a more diverse population, SAGE Greenfingers was developed and became a stand-alone charitable horticultural project. Based on an allotment site it was able to provide mental health support to people in an ethnically mixed community without the stigmatisation associated with statutory mental health services. The two projects together provide support to around 100 members aged between 21-88 years, mostly referred from the primary care practice.

Both projects use groupwork to encourage the development of individuals' social capacities, self esteem and quality of life. The PMCHP runs groups which include writing and knitting activities, as well as occasional forays into walking, singing and reading, alongside support to individuals and families. SAGE Greenfingers has an extensive allotment site on which groups of members can work together in a variety of ways around horticultural based activities. This base is used to offer members support, care and counselling and opportunities for artistic and creative expression, recreation or other leisure time occupation and for education and training for work.

People with severe and enduring mental health problems associated

with diagnoses of schizophrenia and bipolar disorders and other psychoses are often socially marginalised because of their conditions. They spent much of their lives on medications which produce side effects such as muscle stiffness, involuntary tremors and facial movements, or weight gain, and have often resorted to chronic smoking habits to try and exert some control for themselves over their symptoms. The homes they live in often represent small institutions. They live on welfare benefits and have little disposable income. As a result they often develop complex and multiple health issues which combine with the communication problems that arise from their illness, the side effects of their medication, and their social isolation. Amongst the wider population of the UK with mental illness diagnoses this group tend to have been overlooked in the recent decades of complicated changes in NHS services (Department of Health, 2008; Lakhani, 2008).

Many such combinations of personal and social problems have been addressed in a fragmented and individualised way, rather than through group approaches which might foster social cohesion (Trevithick, 2005). Both these projects have developed their community based groupwork over a number of years with the specific aim of forming a supportive network for people with complex needs who experience difficulties in social engagement.

Need for evaluation

In 2009 the two projects approached Sheffield Hallam University's health and wellbeing faculty for assistance in developing an evaluation of their work, to meet their funders' need for information on how well each organisation met its clients needs and the effectiveness of partnership working with the local GP practice base.

Like many community based health and social care projects PMHCP and SAGE Greenfingers are based around small numbers and have limited funds available. This produces a particularisation effect. Each is concerned with practically addressing the immediate needs of small distributions of clients with particular combinations of needs across specific communities. As with the PMHCP and SAGE Greenfingers, it often happens that there is no firm baseline from which to measure the performance of the project. Previous evaluations of these projects had

only considered staff perceptions of the services, their effect on clients and interfaces with other mental health services (Cook, 2003; Cook and Howe, 2003; Cook et al, 2004). Given this individual circumstance it was impractical to use an experimental design in which one group is compared to another (Tilley, 2000).

After consultation it was decided that 'realistic evaluation' methods would be an appropriate means by which the projects could be assessed. Realist evaluation asks the basic question 'what works for whom in what circumstances?' (Tilley, 2000, p.4). They answer this by seeking to relate the way in which services operate to the context in which they work (Pawson and Tilley, 2003).

Methodology and ethical issues

The evaluation used a combination of questionnaires concerning experiences of social inclusion and self esteem combined with focus groups with project members/clients and individual interviews with staff and referrers. This paper reports the aspects of the evaluation relating to the focus groups and interviews which are more relevant to the discussion of groupwork. The questionnaire data, collected from a sample of 32 clients twice over a 6 month period, showed little improvement. There were several confounding factors in this, one of the most significant being that the second set of data on a horticultural activity was collected during one of the worst winters for 30 years, and another being that data collection proved to be demanding on top of workers' regular duties. Given that most project members were people with chronic severe and enduring mental health issues, it is possible that many had reached a plateau, and that this is characterised by their need for maintenance and support on a long term basis. A further data set from the same sample collected at a further six month interval may have produced more significant results, indicating whether there were variations or consistencies, but time and funds were limited.

In line with realistic evaluation's concern with people and context (Tilley, 2000; Pawson and Tilley, 2003), questions for the focus groups and interviews were devised in consultation with the project managers. This may seem at variance with a pure focus group approach where caution is needed to ascertain whether participants are operating an

influence on others, but is necessary because an outside evaluator cannot have in depth knowledge of in-house contextual issues; the use of an external facilitator reduces some of the potential for bias (Krueger, 1994). The questions, which were employed with additional probes from the interviewer, concerned perceptions of differences in life quality, self esteem, sense of well being, social engagement and interaction and the ways that these may have been produced through engagement in the two projects' activities.

In order to maximise the opportunity to take part in the evaluation, the questions were offered in the form of a questionnaire to all staff, volunteers and project members (see appendix). Written responses were sent anonymously to the evaluators. All 9 volunteers and staff and 3 members contributed data.

Eighteen project members voluntarily participated in the two focus groups which were facilitated by one of the evaluators without workers being present. One focus group was conducted with each project, using the allotment base and the community meeting base familiar to the participants. Nine members attended each session. Four interviews were conducted, two with referring doctors from the general practice, and one with each project's manager. The evaluation study was given ethical approval by the university. All participants were asked to sign consent forms on which it was clear that their data could be withdrawn from the study. None withdrew their data.

Individual and focus group interviews were tape recorded and transcribed by one of the evaluators immediately as some participants' voices were indistinct, others were using English as a second language, and there were a range of accents. Data was anonymised and each respondent was given a number code by the transcriber to preserve confidentiality. Transcriptions and other questionnaire responses were axially coded to identify thematic categories and other significant elements of data, or phenomena and conditions, and sifted to allow constant comparison to take place over various stages of analysis (Strauss and Corbin, 1998; Huberman and Miles, 1998). Themes and analysis were moderated from transcripts by the second author (Krueger, 1994) and then synthesised through discussion to produce a final set from which to organise the findings for the evaluation report. Drafts of the report were shared with projects' managers which enabled clarification of the key themes for the evaluation report.

Findings

This evaluation project produced rich data. The findings in this section, which are grouped and discussed thematically, are derived from statements obtained from all the participants, i.e. interviews, focus groups and written responses. Given the local nature of the service and the vulnerability of the client group, only a minimum of demographic details are given in the study to avoid the possibility that individuals could be identified. In the section that follows W designates the project workers, D the GPs who refer participants to the project, while P is used to designate the PMHCP service users, and S those from SAGE Greenfingers. One or two participants attend both projects, but because of the small numbers these have not been separately identified to retain anonymity.

Building confidence

Both projects have specific roles in relation to the communities of members with whom they work. The PMHCP is concerned with the needs of people with chronic mental health conditions for maintenance. Their conditions, their low personal confidence and the low expectations others had of this group meant that they lacked services. The PMHCP's workers have developed a style of engagement to encourage members' independence and acceptance of the responsibility for maintaining the groups. Recently the PMHCP has recognised that it has to create some spaces for new referrals, which has led to the introduction of changes to encourage a sense of ownership and responsibility for the group amongst its members. For example, at first handing over to the members the responsibility of contributing to the rent for meeting space, incrementally increasing their ownership until they are sufficiently secure in running the group that the facilitator can move on:

> *We're going to start saying [...] people need to make a donation of 20p or 30p and collect a bit of rent to pass on to [the cafe] each week. And [support worker]'s going to spend 6 months getting that set up [...]. Because it may be that the knitting group can carry on and she can move on and set up something else. [...] some people are very dependent on the facilitator presence for the safety, trust and some people will lose. But we can't carry on offering such an exclusive service, I don't think it's really difficult.* (W1)

Allotments as a valuable setting for informal groupwork

SAGE Greenfingers was established as a gardening, rather than a 'mental health' project, to enable members, particularly those from ethnic minorities, to take part without stigmatisation. The allotment site is a popular community facility supported by local people:

> *It's a large site so visually it's very attractive, it's south facing, it's overlooking the river with good views out over the whole of the city, so it's got that feeling of space [...] it's also got flexibility in terms of the activities that we can offer to people. We can do everything from like hard physical labour of digging and clearing beds and cutting hedges, through to more fine detailed stuff like sowing seeds [...] and a whole range of different social settings that people engage with.* (W2)

The gardening project consequently offers a range of activities. People have the chance to try food and vegetables that they might not have experienced - and members contribute their own skills - for example Turkish cuisine. The allotment base provides multiple possibilities for grading engagement, with areas for relaxing, raised beds for people with physical disabilities, heavy digging and other seasonal tasks, cooking and potting in the shed, group activities in the larger garden with everyone else, or more sheltered spots away from other people, or in another allotment site where people can experience more independence. A small group of SAGE/Greenfingers members are thinking about starting their own allotments together, suggesting a higher level of independence and co-operation.

Informal groups support the natural development of social relationships

There are

> *No conditions (beyond basic ground rules) on people's attendance at Greenfingers' sessions; no pressure to achieve anything or evidence 'progress' in any specific ways.* (W22)

Members can make group decisions about what the plots should be like. It is

[...]not target driven, not getting people 'work ready'' but 'creating [a] relaxed friendly down to earth atmosphere'. (W23)

An informal culture of banter runs through their activities in which people can come together, *'have a laugh and a joke'* [S14] and gradually realise that:

Until you start talking to other people you tend to think you might be only one that's suffering like this, what's different about me? You find out that in slightly different ways everybody else's in' same boat. And suddenly you're not some sort of freak, you're just an ordinary person with ordinary problems and you've got people you can share them with, it's wonderful. (S16)

Informal groups facilitate the exploration of cultural diversity

The supportive banter and low key, literally organic learning focused on plants and their uses has an important role in introducing people to and enabling them to explore aspects of cultural diversity in the local community. This is facilitated through the interactions between different members and the different foods cultivated and cooked there.

Greenfingers is [...] more co-operative with other people, with other religions and such different groups of ethnicity and that. (P5)

Coming here I've made good friends like, they help out with plants and cooking food, making friends, it's unbelievable for me and look to continuing this project. (S20)

The PMHCP writing and knitting groups both involve men but involved more women than the gardening group. As a result there was clearly some female solidarity. For these women the groups were an important space in which to recover the importance of self-worth:

Sometimes [my boyfriend] likes me to be with him, we go to Leeds and all other places – and I said 'I can't go today duck, you know, it's women's group [...] (P7)

Self worth, feeling valued and reducing social isolation

A personal 'ownership' of responsibilities is encouraged through the continuous and wider group engagement. This enables members not only to learn to value themselves...

> *They teach you to value yourself, and to know that you've got to spend time, you know give time to yourself, they reinforce that fact, which I never thought was important.* (P10)

...but also to perceive themselves as worthy of others' interest. One poignant comment concerned the detail of refreshments provided as part of the group setting:

> *She always produces nice biscuits, they're not just Poundland [i.e. from a discount store], and I think that's a very important part of the group isn't it? that we're nurtured as people, because all of us for different reasons have had rubbish in our lives.* (P13)

Focus group participants repeatedly mentioned how the ethos of human concern they felt from the staff and volunteers is very significant in increasing their self esteem. For example, some members acknowledged difficulty in sustaining social relationships with their partners or the other residents in their homes. Engaging in informal group activities also provides members with subject material which they can use in conversation with others, enhancing personal confidence and reducing the lack of stimulation that derives from social isolation. Over time, activities such as the writing group has enabled clients to develop individual outcomes which pursue objectives in the surrounding community. Members have become confident enough to act upon and pursue interests for themselves:

> *You tend to travel further for yourself, going to your groups, you get used to them, you get the help, you get to know the area, after a while you tend to do more go to more parks, more green areas [...]* (P5)

> *I tend to do different courses, primary health courses like [...] childcare. I just like gone out of my own way and to do different things. I work [...] as a volunteer helping with the disabled to be creative and do baking and things like that, it's*

been alright I've done things like cake decorating as well. (P19)

Thus the projects enable occupational spin-off (Rebeiro and Cook, 1999; Rebeiro, 2001) - i.e. participation in one activity leads to participation in other activities. Respondents identified over 23 local agencies from housing organisations to voluntary arts and activity groups with which members were engaged. Having a local base enables service users to move on to other local organisations for their own development.

The importance of continuity

A particularly valued feature of the groupwork for the GP referrers is its continuity. This sustains good communication, has a positive impact on members' self esteem, and offers some stability to members' family members and friends:

Regular contact is really helpful for these people because some of them have just got such low self esteem the fact that someone is concerned about them and wants to keep in touch with them [...] and values them is terribly important. [...] I know from having seen their friends and relatives regardless that huge loads have been taken off from those people. [...] people going out of the house is a huge thing sometimes, and so the carer can see someone leading a slightly more meaningful life and that's a big thing as a carer. (D3)

Group continuity is also valued by members:

Cause it's regularly every week, you know, you've got that to look forward to every Wednesday afternoon, I've got Friday afternoon, knitting, if I can. So, you've always got something but if you have a big break, I think you'd be reluctant, think, oh, I've not bothered these weeks, so I'll not bother going back. (P9)

Several members themselves pointed out the cost benefits of their engagement with the project groups. They reported both feeling less depressed and needing to see their GP and other healthcare staff less. A significant issue for more than one member was a reported reduction in the risk of self harm:

I have tried to do myself in. If it hadn't been for this writing group and [support worker] and the people round it, I wouldn't have been here. Cause it gave me a way to express what caused that. (P10)

The long term engagement gap

One of the potentially important suggestions from the participants is that these services appear to be meeting needs which cannot be addressed by services focussing on short term interventions. Many benefits from the activities provided by the PMHCP and SAGE Greenfingers occur organically, facilitated through the long term engagement by which people gradually come to find themselves capable of new things:

Most people who come to it are able to walk to the site or it's a short bus ride away, [...] it means both that they can get to it very easily and also that other people that they're meeting on site are also quite local as well, so they're beginning to get more involved in the local community, and form friendships with other people who live locally. (W2)

These factors support developments that many people would take for granted in their own lives, and may not recognise as significant.

Two or three years ago before I came to Greenfingers I were [...] entirely alone and whatever was offered to me didn't have any effect [...] but from the day I went into – onto the allotment I started to get this feeling that if I did anything outside and I come back I could share it with them. (S18)

Statutory services provide therapies like counselling but not model social opportunities for people to practise social skills and experience gains in confidence. The informal PMHCP and SAGE Greenfingers groups have provided a stable facilitating environment through which people have been able to develop. This appears to meet a need that statutory services do not provide for:

You go from counselling to nothing. It was mentioned to me about this writing group and that was like the next step for me, but if that hadn't have been mentioned I'd have been just sat at home. I wouldn't have got up and gone looking for things to do. (P10)

It is not clear from this small sample that the use of informal group activities reduces demand on GP services, but there is a suggestion that it may help to focus that contact on more appropriate usage. This pattern is reported by members themselves...

> *I go less to my GP, I'm hoping to cut down on my anti-depressants.* (P9)

> *Since I started I've been seeing my GP less because I'm less depressed since I've started [...]. I used to see her once a fortnight, started once a week, then once a fortnight, now I see her every six months since I started.* (P8)

... as well as by the GP referrers:

> *It's more likely that we're seeing more of them because someone's actually paying attention to them. [...] Before we had the PMHCP we just didn't know about these patients and now I can think of lots of examples of people who are engaged in useful, meaningful activity in their weeks that we didn't have before.* (D4)

This implies a wider impact on the community served by the primary health care centre. Both GP referrers suggested that there were benefits for members' carers and relatives. The combination of groupwork and individual support in locally accessible services enables good communication between the projects and the surgery. Many responses emphasised the locality of the service to clients, resources and the primary care service, and its staffing by local people:

> *Very experienced and knowledgeable support workers who have been in post for a long time, thus developing strong relationships with our members (clients) and having local knowledge, so able to signpost to other services.* (W24)

There was evidence of a strong network of bonds between people in both projects and with the GP practice, and an impression of the whole network functioning as a wider group within which the specific group activities and individual engagements were held. This is a key to its communication, sustainability, ability to make use of resources and the community spirit within the projects.

Informal groupwork fosters mutual regard and confidence

There was a high degree of mutual regard between the workers and the members, and the GP referrers. All those involved whether project staff or members referred to each other by name rather than by a title such as 'support worker' suggesting a strong ethos of personal engagement, 'ownership' and sense of community within the project. This enables project workers to have a good degree of knowledge of members. As a consequence the referrers are confident in the worth of the project and its activities

> *I know what's happening to these patients with these local groups. And it's got to do with small size and just proximity, we just regard them as part of our healthcare team really, we know them all, [...] so we often find them coming in very diplomatically and nudging us [...] so we're very grateful for that – cos they just keep nagging away.* (D4)

This informed relationship adds to the efficiency of the work carried out while project staff are confident in the support they have from the general practice:

> *I think it personally gives me a lot of confidence to take risks really – I know that I'm literally only a few seconds away from that back-up if I need it. [...] I think there's this balance between heavy weight mental health support and [referrer's] ability to contain and hold a lot of mental health input because he carries a lot more than a lot of GPs would, with doing very practical real activities, digging, sewing, knitting. It's that balance – so it's giving due place to the surgery's role in all of this. So it seems a long way from a primary care practice to a knitting group, but it isn't.* (W1)

Sustaining the groups as a local resource over a number of years has allowed the evolution of a local mental health ecology reflecting the symbiosis of projects, referrers, the members and the wider community:

> *The beauty of it is it's a very joined up sort of therapy, it's not just about talking, it's about physical things, it's about mental things, it's about emotional things, spiritual things, social things. Everything is sort of like in there in the mix, so rather than like one- to-one talking therapies, or even going down to the gym, it's a sort of therapy that joins everything up and so really addresses the whole person.* (W2)

Nothing's helped me personally like Greenfingers has. I used to go to day services, I've recently been discharged but they were no longer doing anything for me. They did, at first, help me to build my confidence back up, but the service has changed and I've moved on and the service to me is not as thorough and as personal as what you get at Greenfingers. I felt more like being a number' S16)

However, as GP referrers also recognised, the particular quality of service that has developed is rare:

I think the quality of staff we've recruited to our project is really very good. [...] I guess that the formula may not be terribly easily reproduced. (D4)

The personal approach can appear to promise an open-ended engagement to a group of members who may develop an over-dependency. While some members can be encouraged to become more independent, the projects recognise that others will not have this capability.

...they basically need permanent support of some sort just to keep them going. [...] it's important for us to offer the support that people need but to be opening up their eyes to other possibilities and to the fact that within themselves they might gradually be gaining the confidence to engage in those other activities. (W2)

Some members indicated that the projects maintain people who might not expect to make significant reductions in their level of need, but who could experience deteriorations in their conditions if support was unavailable:

I find now, when I've got time on my own, instead of thinking dark thoughts I now think – make poetry up and writing, you know [...] which I wouldn't have done, if I was here, I don't know where I'd be now, might not even be here, you know. (P9)

Discussion

A wider group: Community and good management

The overwhelming finding from the discussions with members, workers, managers and referrers is that there is a strong community group feel or collective efficacy (Bandura, 1995) about the projects. This derives in part from continuity. People are demonstrably concerned about each other, and this is reinforced through good communication in the interrelations between the workers and the members and the project and the referrers. Issues are pursued, members themselves are followed up, people are sure of each other and of their importance to the teams with which they are involved. Yalom (1995) advocates alliances between clients and people running groups and the encouragement of people to be active within groups as significant in enabling group members to benefit.

The alliance process described here is delivered through the good management indicated in the functioning of the projects. This is reflected in earlier findings (Cook, Howe and Veal, 2003). Members frequently said that their confidence had increased, and this was because the project has retained its staff for several years. Those coming into the project benefit from long term working relationships. This appears to relieve some pressure from the referrers, who appear to be able to share some of the responsibilities of managing their caseload through known and established project workers.

The long running, informal and continuous nature of the groups had enabled members to appreciate their growing confidence. Through the support and engagement there was less temptation to withdraw. This reassuring stability and basis in mutual respect and membership is very suggestive of Cabness's (2009) schizophrenia groupwork change process. The client group here is community based and far less institutionalised than the one Cabness (2009) describes; it is clear that many members are insightful regarding their own difficulties with social engagement. They attribute the experiences they have had in the project groups to each other's progress as well as their own. Like Maidment and Macfarlane's (2009) craft group, or as Parr (2007) traces in the history of gardening and horticulture in mental health environments such effects have been located in group activity rather than 'therapy'. It also fosters relationships from which occupational spin-off opportunities

are generated (Rebeiro and Cook, 1999; Rebeiro, 2001), both from the association with project workers and volunteers, but, possibly of more significance, spontaneously amongst the members themselves.

In the case of gardening this is specifically through a relationship with nature as the means to reconnection with the wider world. This has been found significant not only with mental health users but also with asylum seekers (Rishbeth and Finney, 2006). In both this relationship to the organic world and with each other, the members and other participants have organically acquired an interdependent and 'can-do' approach (Cabness, 2009, p.67) based on friendships (Kinsel, 2005). For example, an asylum seeker was befriended by other group members and taken to football matches (even though he supported the other team in the city's soccer allegiances). Another member found the experience of bringing a packet of seeds and a propagator home gave an interest to the rest of the week when he was unable to attend the project, and engaged other people in his house. Others had attended courses or were taking on allotments of their own or with other people. One person began work in a residential home; another was going to shortly begin work as a translator. With low levels of personal confidence and the low base from which they entered the project these changes cannot develop quickly, but need time and space to grow.

A way of understanding this interrelationship might be to see the gardening, knitting and writing groups as part of an onion, the outer layers of which comprise the supporting group of volunteers and workers within the further layer of mental health care and GP practice. Because of the proximity of each layer, the entire whole acts as a larger group, enabling the components within it to be supported.

The importance of 'local' facilities

The maintenance of members' mental health and wellbeing is sustained by local relationships between the workers and volunteers in the projects, the use of the local café, and the connection between a wide range of local services. Local accessibility has enabled participation in a range of community events, for example, through having stalls or through the writing group itself having an identity within the community so that it can perform. The allotment site is close to members' homes so some of them work on it at other times in the week. This comes from a high

degree of trust between the members and the support workers which would not be possible without good communication and the continuity, and itself contributes to the sustainability of the project.

Over the years since the first of these projects was established, good networking has sustained a confidence shared by GP referrers as well as the members. Most of the members are vulnerable and their previous experiences of mental health services have been uneven (for example the tendency for engagement to cease once a course of counselling or other therapy has been completed without anything to replace it), a problem widely noted in enduring mental health care (Watkins, 2009).

GP referrers pointed out that the informal group activities provided by the projects are 'a missing opportunity'. Social and economic changes have reduced the kinds of opportunities that formerly existed for people with enduring conditions to find low paid and undemanding work, and a place in the wider community (Parr, 2007; Watkins, 2009). The PMHCP and SAGE Greenfingers projects allow members' participation in community activities at their own pace of adjustment. A similar form and set of benefits from engagement seem to be evident in craft groups for older women (Kinsel, 2005; Maidment and Macfarlane, 2009), in which empowerment arises through the group facility for encouraging friendships. Some members of the PMHCP and SAGE Greenfingers projects recognise their need to increase their independence but acknowledge that this will be difficult. The GP referrers, project managers and workers understand that some people need to be maintained in the community rather than moved on. As Parr (2007) found, this maintenance is not 'therapy', but a means of providing social inclusion opportunities for people who may risk isolation and remain needy because of their long term conditions.

Supportive relationships

Supportive relationships between members and staff are modelled throughout the organisation, for example by sharing meals together at the allotment site. Although members are interested in the gardening, cooking, knitting and writing, significantly they can also just come for company, (another important finding of Maidment and Macfarlane, 2009). Members who had been unable to attend had been followed up by the project. This encouraged confidence that someone cared about

them. The fact members remarked on this as a significant difference in their treatment from statutory services, suggests that the importance processes are sometimes overlooked, for example those which maintain vulnerable people, or facilitate a stable and low key group environment where lasting friendships can develop.

In some fields of health and social care the concept of professional distance which is a core principle of training has been criticised as inappropriate if it is fixed, but requires a high level of skill to manage (Green, Gregory and Mason, 2006; Bates, 2010). The experience of project members suggests that there may be a need to consider person centred approaches combined with group skills. There are real problems of engagement for this client group who often make few demands on the statutory services despite having complex needs, and consequently can be passed over in provision. The result for them is poorer health, poorer access to care, and a much reduced quality of life combined with social isolation (Marks et al, 2005; Lempp et al, 2009). Members' responses about the difference involvement in the projects have made to their experiences of life, structure to their week and even their survival, make this very evident. It is also clear that the engagement offered through the activities and contacts accessed by the project have a positive effect on perceptions of confidence, self esteem, social connectedness and community participation, akin to the growth found in the recovery process (Morgan and Carson, 2009)

Motivators and differences in the kinds of things members do for themselves

Although horticultural projects have become a vogue in mental health (Simson and Straus, 1998; Sempik, Aldridge and Becker, 2005; Parr, 2007), the SAGE Greenfingers project demonstrates clearly why they and similar activities such as writing and 'knit and natter' groups can be so significant. The range of activities described, everything from growing one's own produce on one's own allotment, to going to plays, joining other groups and classes would not have developed without a nurturing low key activity around which a relationship could develop.

The project groups cover a spectrum of opportunities from the provision of basic structured activity through to work, according to members' needs.

You wake up in a morning and you think 'Monday!, Ah I can go somewhere,' you start feeling you belong somewhere, to me. (S6)

Finding work and attending a range of courses is clearly not the main thrust of the projects so much as support and continuity in providing an atmosphere of personal encouragement, confidence building and the experience of being valued. Although both groups referred to themselves as being like a 'family' this did not imply an overdependence, more that they were a community who had developed principles of looking out for each other.

People evidently enjoyed their experiences, and have found that the things they were doing could be a source of interest to other people, whether through taking plants back to their homes or through having what they had done as a subject for conversation with others. As Maidment and Macfarlane (2009) found, enjoyment, fun, and having something to laugh about were experiences that members clearly valued and appreciated. Most of the members described educational courses, community facilities such as the conversation club and voluntary work to which they had been introduced and were pursuing of their own accord. Several of them indicated low points in their mood or functioning, from which they could not have imagined that they would be able to do what they now found themselves to be capable of.

Limitations of this study

Several limitations arise from being based in an evaluation rather than a larger piece of research. This may have affected the critical depth of the data: group pressures may operate, such as the perception that the projects need positive comments, and some members may exert an influence on others (Krueger, 1994).

Interview questions were determined with project staff and one of the GP referrers. While this was in line with the evaluation's purpose, being to determine what works in what circumstances, it detracted from developing a more critical approach to the methodology and the data.

Conclusions

PMHCP and SAGE/Greenfingers provide locally based services to a population with a high proportion of chronic and enduring mental health needs, within the area of a GP practice which has inherited and continues to have many referrals from this group of people. Clients with needs arising from these conditions are likely to have complex health needs and can easily be neglected. This happens because they often do not make many demands on services since they lack the confidence and skills to demand the services they need. The implication from the interviews and other responses is that PMHCP and Sage/Greenfingers deliver a high quality value for money service producing both cost savings and more efficient use of resources for this group of vulnerable people with complex health needs, and suggest that there may be positive benefits for their families, carers and partners. The service is committed to realistically achievable goals for this client group, one of which is their maintenance given the vulnerabilities resulting from their long term conditions. A strong base in locally accessible resources and a community ethos strengthens its flexibility and accessibility.

Both PMHCP and SAGE/Greenfingers have developed opportunities which facilitate and enable their members to engage independently with other community organisations. Their approach has evolved through many years of groupwork and experience and the fostering of close working relationships with other agencies in the local area, including the residential homes in which many of the members live. Their pattern of active engagement facilitates members in accessing community resources, but also takes account of the periods when members may feel so low as to not engage so well. Continued monitoring and the continuity of groups has enabled members to feel valued and to re-engage with services as they feel able to, confident that they can go back to their place in the groups of which they have been a part. Thus a low key range of group activities and style of management enables people to feel very comfortable with the service they receive and at the same time long term relationships mean that work can be tailored to individual needs. The groupwork is at the heart of the connectedness which facilitates a bespoke approach to brokering care in the local community.

Recommendations

Cook (2003) suggests that in practice the activities provided by these projects may meet multiple and simultaneous needs but be difficult to separately identify and assess. The problems of data collection on self esteem and social inclusion using questionnaires have already been discussed, and the use of more extensive data collection could explore the impact on carers, and seasonal variations in activity and engagement given that gardening is subject to variations in the weather. Since this evaluation the recent introduction of a system of financing care which allocates money to clients to determine how to meet their own care needs, introduced in 2009 (Department of Health, 2009), has been extended to people with severe mental illnesses. The introduction of these 'personalised care budgets' may have coincided with other local council funding restrictions for services (Wood, 2011), bearing out some of the suspicions concerning their sustainability voiced at their introduction (Kaye and Howlett, 2008). SAGE Greenfingers have recently advised their members that they had to withdraw places to people who do not have personalised budgets until another funding source is identified. An economic evaluation is needed to determine whether delivery of groupwork activities through community and charity organisations may bring cost benefits in comparison to statutory services and can be sustainable enough to provide continuity. A further useful development would be the quantitative analysis based on GP referrers' records to assess the cost benefits of these interventions.

References

Bandura, A. (1995) Exercise of personal and collective efficacy in changing societies. in A. Bandura (Ed.) *Self-efficacy in changing societies*. Cambridge: Cambridge University Press (pp.1-45)

Bates, P. (2010) Thinking about professional boundaries in an inclusive society. in P. Gilbert, P. Bates, S. Carr, M. Clark, N. Gould and G.Slay (Eds.) *Social work and the value of everything.* Lyme Regis: Russell House (pp.18-24)

Byng, R., Norman, I., Redfern, S. and Jones, R. (2008) Exposing the key functions of a complex intervention for shared care in mental health: case study of a process evaluation. *BMC Health Services Research* 2008, 8:274

doi:10.1186/1472-6963-8-274 [Accessed 12 September 2011 at http://www.biomedcentral.com/1472-6963/8/274]

Cabness, J. (2009) Social efficacy in the reintegration of the self: A groupwork model in schizophrenia care with older adults. *Groupwork,* 19, 2, 63-78

Cook, S. (2003) Generic and specialist interventions for people with severe mental health problems: can interventions be categorised? *British Journal of Occupational Therapy,* 66, 1, 17-24

Cook, S. and Howe, A. (2003) Engaging people with enduring psychotic conditions in primary mental health care and occupational therapy. *British Journal of Occupational Therapy.* 66, 6, 236-246

Cook, S., Howe, A. and Veal, J. (2004) A different ball game altogether: staff views on a primary mental healthcare service. *Primary Care Mental Health,* 2, 77–89

Department of Health (2008) *High quality care for all, NHS next stage review.* London: Department of Health

Department of Health (2009) *Supporting people with long term conditions. Commissioning personalised care planning.* London: Department of Health

Department of Health (2011) *Health and Social Care Bill.* London: Department of Health

GPonline (2011).DoH czar explains how commissioning will affect all GPs, 13th July 2011 [Accessed 12 September 2011 at www.gponline.com/News/article/1080011/exclusive-doh-czar-explains-how-commissioning-will-affect-gps/]

Green, R., Gregory, R., and Mason, R. (2006) Professional distance and social work: Stretching the elastic. *Australian Social Work,* 59, 4, 449-461

Huberman, A.M. and Miles, M.B. (1998) Data management and analysis methods. in N.K.Denzin and Y.S. Lincoln (Eds.) *Collecting and interpreting qualitative materials.* Thousand Oaks CA: Sage (pp.179-210)

Kaye, C., and Howlett, M. (2008) Harnessing the flow. in C. Kaye and M. Howlett, (Eds.) *Mental health services: Today and tomorrow. Part two: perspectives on policy and practice.* Oxford: Radcliffe (pp 3-17)

Kinsel, B. (2005) Resilience as an adaptation in older women. *Journal of women and ageing,* 17, 3, 23-39

Krueger R.A. (1994) *Focus Groups, A practical guide for applied research*. Thousand Oaks CA: Sage

Lakhani, M. (2008) *No patient left behind: how can we ensure world class primary care for black and ethnic minority people?* Leeds: Department of Health

Lempp, H., Thornicroft, G., Leese, M., Fearns, N., Graves, H., Khoshaba, B., Lasalvia, A., Scott, D. and Tansella, M. (2009) Implications of long-term

conditions for both mental and physical health: comparison of rheumatoid arthritis and schizophrenia. *Quality of Life Research,* 18, 6, 699–707

McGowan, B. (2004) *A realistic evaluation of undergraduate perceptions of the definition, operationalisation and effect of supernumerary status.* University of Ulster. [Accessed 11 October 2009 at www.health.heacademy.ac.uk/projects/miniprojects/mcgowan.pdf]

Maidment, J. and Macfarlane, S. (2009) Craft groups: Sites of friendship, empowerment, belonging and learning for older women. *Groupwork,* 19, 1, 10-25

Marks, D.F., Murray, M., Evans, B., Willig, C., Woodall, C, and Sykes, C.M. (2005) *Health psychology: theory, research and practice.* London: Sage

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., and Geddes, I. (2010) *Fair society, healthy lives.* London: University College London. [Accessed 23 March 2010 at http://www.ucl.ac.uk/gheg/marmotreview/FairSocietyHealthyLives

Morgan, S. and Carson, J. (2009) The recovery group: A service user and professional perspective. *Groupwork,* 19, 1, 26-39

Parr, H. (2007) Mental health, nature work, and social inclusion. *Environment and Planning D: Society and Space*, 25, 537-561

Pawson, R. and Tilley N. (2003) *Realistic Evaluation.* London: Sage.

Rebeiro, K.L. and Cook J.V. (1999) Opportunity, not prescription: an exploratory study of the experience of occupational engagement. *Canadian Journal of Occupational Therapy*, 66, 176-187

Rebeiro, K. (2001) Occupational spin-off. *Journal of Occupational Science*, 8, 33-34

Rishbeth, C. and Finney, N. (2006) Novelty and nostalgia in urban greenspace: Refugee perspectives. *Tijdschrift voor Economische und Social Geografie,* 97, 3, 281-295

Sempik, J., Aldridge, J. and Becker, S. (2005) *Health, well-being and social inclusion: therapeutic horticulture in the UK.* Bristol: Policy Press

Sheffield City Council. (2004) *Indices of Deprivation Scores for Sheffield Neighbourhoods.* Sheffield: Sheffield City Council

Simson, S. and Straus, M.C. (1998) *Horticulture as therapy: Principles and practice.* Binghampton NY: The Food Products Press

Strauss, A. and Corbin, J. (1998) *Basics of qualitative research: Grounded theory, procedures and techniques.* Newbury Park, CA: Sage

Tilley, N. (2000) *Realistic evaluation: an overview.* Presented at the founding conference of the Danish Evaluation Society, September. [Accessed 12 September 2011 at http://evidencebasemanagement.org/research_practice/articles/nick_tilley.pdf]

Trevithick, P (2005) The knowledge base of groupwork and its importance within social work. *Groupwork*, 15, 2, 80-107

Watkins, P. (2009) *Compassionate care: A guide for mental health practitioners.* Philadelphia: Butterworth Heinemann/Elsevier

Wood, C. (2011) *Tailor made*. London: Demos.

Yalom, I.D. (1995) *The theory and practice of group psychotherapy (4th edition).* New York: Basic Books

Appendix: Questions used for data collection.

Members

1) Since you first started with PMHCP/SAGE can you tell me about any changes in your physical and mental well-being?
2) Since you first started can you describe any changes in your relations with other people – both the number of people you interact with on a daily basis and the quality of those interactions.
3) Since first starting with us can you remember being connected by either the staff, volunteers or other members to other sources of support (including leisure activity). Please could you list them and comment on how helpful you found them. Were you aware of them before joining the project?
4) Since joining the project can you comment on your relationship with your GP and/or other health services? Do you see them more or less often? Are those visits useful or not? Please explain.
5) How long do you anticipate wanting to continue to be involved with the project's activities? Why?

GP Referrers

1) Please describe what you know about the aims and activities of the 2 projects: SAGE Greenfingers and the Primary Mental Health Care Project.
2) From your experience what aspects of patients' mental, physical and social well-being do you think are promoted by the work of SAGE &/or PMHCP? Have you any anonymised evidence of this?
3) Can you comment on any significant changes in the quantity and quality of your appointments with patients subsequent to them taking up activities with SAGE &/or PMHCP?
4) Can you describe the nature of your ongoing relationship with either SAGE and/or PMHCP subsequent to referral? Over what period would you like to see them extending support to any specific referral and why?
5) What other local non-clinical support services for people experiencing mental and physical health problems are you aware

of? Would you consider referring patients to them? Why? Why not?
6) Looking at your partnership work with PMHCP and/or SAGE overall, what do you think are the keys to its success (in areas where it is successful!)?
7) Have you any suggestions for improving it?

PMHCP / SAGE workers

1) To the extent that this project is successful at meeting the needs of marginalised people, what do you think are the keys to that success?
2) How do you foster relationships with referral agencies &/or other health care services?
3) Can you suggest ways in which these relationships may be improved?
4) Can you list any local non-clinical support services supporting people's mental, physical and social well-being that you are aware of? Have you ever linked members to those services? What has been the outcome?
5) How long do you think a referral should be involved in your project and why?
6) Can you describe what motivates you in your own role? What enables you to do your job?