Supporting Beacon Day Services Review

During 2010-2011 Niamh undertook a comprehensive needs assessment within the 14 Beacon Day Support schemes across Northern Ireland, providing baseline data describing the level of wellbeing, provision of care and support needs of 306 Beacon Members with mental health problems. A summary of results along with recommendations for capturing outcomes data are presented.
Foreword

In Niamh we strive for our services to be the very best we can offer. We work hard to deliver modern services that are both safe and of a demonstrably high quality - services that are focused on meeting the needs of those who use them as well as inspiring confidence in those who have commissioned them.

We are committed to continually improving and developing what we do, so that those who use our services in helping us to improve them. Our aim is to make a positive impact on their lives, delivering positive outcomes for them through services that we know are effective because they have a credible and well researched evidence base.

As a reflection of this commitment, and for the first time in Niamh, a comprehensive review of the needs within Beacon Day Support services has been undertaken. This review seeks to help us understand better the physical, psychological, social and emotional needs of our Beacon Members.

Our vision for this document is that it can be used to support the continuous development and modernisation of services, giving reassurance to commissioners that what we deliver is relevant to the needs of those who we seek to support.

Our commitment is to offer services that are strength based, need specific, offering hope, opportunity and control, namely all the components of recovery focussed services.

While this research is primarily intended to help us develop our day support services within Niamh, we believe it is also useful as a wider commentary on the needs that remain unmet in mental health services as a whole and can be used to inform other service developments and commissioning.

Through the continued development of our services, and in our commitment to continuous improvement, we remain an organisation that is focused on listening and responding to the needs of those we seek to support. We believe that this report gives voice to some of those needs.

Billy Murphy
Director of Mental Health Services.
Acknowledgements

First and foremost, thanks to all the Beacon Members attending our Day Services who completed the interview questionnaires. We greatly appreciate your input and could not complete this work or indeed improve our services without your feedback and assistance.

Secondly, thanks to our Day Support Service managers for supporting the objectives of the review. We appreciate the time and effort you afforded your staff to help assist the review and also the time you invested in helping Beacon Members engage with the Day Service Review process.

We would like to particularly thank those staff and members who were part of the steering committee for the review, who helped in all decisions and guided us to the challenges and barriers to participation we would meet. Their input was invaluable to ensure this review was sensitive to the needs of all our members.

We have been fortunate to have the help and support of a number of volunteers on this project. In particular to all our interview volunteers who attended extensive training in conducting the DSR. Your dedication and enthusiasm is testament to the commitment of our staff and volunteers who gave up their time to ensure all Beacon Members had the opportunity to take part. Without your input this review would not have been possible.

The Niamh Research team have also benefited from the research capacity of intern Ms. Federica Massaro and volunteer Orlagh Kelly who have worked to ensure all questionnaires were inputted to the highest standards. Many thanks for your overall contribution to the project.

Day Support as an intervention or support to those experiencing mental illness. Its design was to capture detailed information about the physical, social and emotional needs of Beacon Members attending Day Centre services.

The reconfiguration of Day Services provision (From Segregation to Inclusion, 2006) has a renewed focus on the promotion of recovery, social inclusion and self-determination and the reduction of social isolation. In this way Day Services should serve to provide opportunities for social contact and support, should help people retain existing social roles, relationships and social activities that are valued; should support people to access new roles, relationships and mainstream social pursuits; and provide opportunities for mental health sufferers to run their own services.

Positive mental health has been outlined as a priority area in Northern Ireland (Investing for Health, DHSSPS, 2002); Promoting Mental Health. Strategy and Action Plan 2003-2008 DHSSPS, 2003). The recovery approach adopted will 'support people with a mental health need to plan and build a satisfying life, engaging in work or other meaningful activities and contributing to and participating in society (DHSSPS, 2009).

Executive Summary

A health-needs assessment is a systematic method for reviewing the health needs within a population, leading to a set of priorities and resource allocations to improve health and reduce inequalities.

This work, referred to as the Day Services Review (DSR) is the first step towards measuring the impact of Beacon

With the process of deinstitutionalisation sowing ‘the seeds of the recovery vision’ the idea that people with mental illness can recover and live meaningful lives within society is a growing concept (Anthony, 1993, p.521). However, there is still little knowledge of what exactly ‘person-centred recovery’ is and what it should look like in terms of service provision.

As local political structures in Northern Ireland develop and settle, the concept of evidence based commissioning has gained prominence. It is now imperative that on-going monitoring and reviewing of reconfigured services occurs to ensure the achievement of objectives, measure the effectiveness of services and inform their future development based on client needs and resource allocation.

Day Services are an integral part of community mental health services, seen as serving three main functions:

• to provide an alternative to inpatient care;
• to shorten the duration of inpatient stay; and
• to promote recovery and maintenance in the community (Marshall, 2005).

The background to the study

The reconfiguration of Day Services provision (From Segregation to Inclusion, 2006) has a renewed focus on the promotion of recovery, social inclusion and self-determination and the reduction of social isolation. In this way Day Services should serve to provide opportunities for social contact and support, should help people retain existing social roles, relationships and social activities that are valued; should support people to access new roles, relationships and mainstream social pursuits; and provide opportunities for mental health sufferers to run their own services.

Positive mental health has been outlined as a priority area in Northern Ireland (Investing for Health, DHSSPS, 2002); Promoting Mental Health. Strategy and Action Plan 2003-2008 DHSSPS, 2003). The recovery approach adopted will support people with a mental health need to plan and build a satisfying life, engaging in work or other meaningful activities and contributing to and participating in society (DHSSPS, 2009).
Beacon Day Centre services encompass two of five forms of day care provision (WHO, Marshall, 2005). Primarily Beacon Day Services take the form of traditional Day Care Centres offering continued care to patients with severe mental illness. They also offer services in line with Drop-in centres by offering a non-clinical environment for social support and activities (Marshall, 2005).

This review of Day Services across Beacon attempts to address the current lack of understanding as to the impact of services on the lives and wellbeing of its members. Not only that, it also serves to address a bigger gap of knowledge in assessing member need across a number of life domains.

This was achieved by using reliable and validated quality of life, health and social needs, and role functioning instruments that measure life domains (i.e. physical, environmental and psychological) relevant to carers and people with mental health problems in Day Support. These include the Lancashire Quality of Life and the SF-36 Health Survey alongside clinical and socio-demographic assessments. Voluntary Service Organisations (VSOs) should have accessible data on the success or failure to meet the needs of its clients and where best to target scarce resources. This internal review is the first step to achieving understanding of the degree to which the needs of service users are being met.

The questions that we wish to address:

- What are the physical, social and emotional health needs of our members?
- What sort of data would be most useful to understand the full range of service user needs (e.g. Quality of Life, physical care, recovery-based)?

Methodology

- A stratified sampling system was used to select 50% (n=504) of our entire Service user population across all Day Centres. n=101 were removed as they were non-attending (n=55) or had been discharged (n=46). n=140 did not respond to invitation, 50% point blank refused to participate, a further 10% were deemed to lack capacity at the time of review and a further 3% in hospital at the time of interviewing. 306 members from a total population of 403 were therefore recruited giving a response rate of 75.93%.

- 306 interviews were completed (75.93%) by a total number of 34 interviewers and two researchers. The interviewers were trained research volunteers recruited amongst members of staff (n=26), external volunteers (n=5) and students on placement (n=3).

We used a cross-sectional survey among people who are current users of Day Support Centres. The survey was carried out using face-to-face interviews with Beacon Members using standardised well-validated instruments relevant to health and social care needs.

Each Beacon Member was informed of the study and its aims. Participants were provided with information sheets and asked to provide written consent. All service user data was anonymised and provided with a unique ID number.

A steering committee was established comprising Service User representatives, Care Workers, Directors and Senior Managers within NIAMH. This group met with the researchers to discuss progress, potential and actual barriers to completion.
Lancashire Quality of Life Profile - EU. The interview contains socio-demographic details as well as various domains of service user satisfaction with quality of life such as leisure, finances, living situation, legal and safety, family relations, work, general wellbeing, and positive affect.

Rosenberg Self-esteem scale: a 10-item Likert scale with items answered on a four point scale—from strongly agree to strongly disagree used to assess current self-esteem of Day Service members.

Social inclusion: we explored service user’s perceptions of social inclusion using MOS Social Support Survey (measuring availability of Emotional/Informational support, Tangible support, Affective Support, and Positive Social Interaction), De Jong Gierveld Emotional and social loneliness scale (giving an indication of extent of loneliness felt by members), and King’s Stigma scale (2007) measuring stigma in relation to disclosure, discrimination and positive aspects of their mental health experience.

Assessment of education and training needs.

Physical and emotional health needs: assessment of the number and type of health problems members were experiencing if any, as well as health complaints of those they lived with. The SF-36 Health Survey to assess different health states of members (i.e. physical functioning: the extent to which mental health interferes with a variety of activities; role functioning/physical: the extent to which physical health problems interfere with usual daily activities; role functioning/emotional: the extent to which emotional problems interfere with usual daily activities; energy/fatigue: general feelings of energy and lack of fatigue; emotional wellbeing; social functioning; pain: the intensity of bodily pain experienced in the past 4 weeks; and overall perceptions of general health.

Recovery needs: The Brief Trauma Questionnaire was used to itemise the types of traumatic experiences Beacon Members have encountered. The CAGE, a three-question validated clinical tool to assess alcohol misuse was also administered.

Open ended questions: members were asked specifically to report the expectations they had of Day Services when they first attended, and any additional support they received through the Day Centres (skills/new activities engaged in, information/advice sought, signposting to other community services), and to rate how well the Day Centre met their individual needs.

Measures

1. Lancashire Quality of Life Profile - EU. The interview contains socio-demographic details as well as various domains of service user satisfaction with quality of life such as leisure, finances, living situation, legal and safety, family relations, work, general wellbeing, and positive affect.

2. Rosenberg Self-esteem scale: a 10-item Likert scale with items answered on a four point scale—from strongly agree to strongly disagree used to assess current self-esteem of Day Service members.

3. Social inclusion: we explored service user’s perceptions of social inclusion using MOS Social Support Survey (measuring availability of Emotional/Informational support, Tangible support, Affective Support, and Positive Social Interaction), De Jong Gierveld Emotional and social loneliness scale (giving an indication of extent of loneliness felt by members), and King’s Stigma scale (2007) measuring stigma in relation to disclosure, discrimination and positive aspects of their mental health experience.

4. Assessment of education and training needs.

5. Physical and emotional health needs: assessment of the number and type of health problems members were experiencing if any, as well as health complaints of those they lived with. The SF-36 Health Survey to assess different health states of members (i.e. physical functioning: the extent to which mental health interferes with a variety of activities; role functioning/physical: the extent to which physical health problems interfere with usual daily activities; role functioning/emotional: the extent to which emotional problems interfere with usual daily activities; energy/fatigue: general feelings of energy and lack of fatigue; emotional wellbeing; social functioning; pain: the intensity of bodily pain experienced in the past 4 weeks; and overall perceptions of general health.

6. Recovery needs: The Brief Trauma Questionnaire was used to itemise the types of traumatic experiences Beacon Members have encountered. The CAGE, a three-question validated clinical tool to assess alcohol misuse was also administered.

7. Open ended questions: members were asked specifically to report the expectations they had of Day Services when they first attended, and any additional support they received through the Day Centres (skills/new activities engaged in, information/advice sought, signposting to other community services), and to rate how well the Day Centre met their individual needs.

Key findings

Mental Health Conditions

- 48% (n=144) of Beacon Members were being treated from Common mental disorders (CMD: anxiety, depression, Post-Traumatic Stress Disorder, Alcohol abuse, Obsessive Compulsive Disorders, and Phobias).
- 30.3% (n=91) of members were being treated for Serious Mental Illness (SMI: schizophrenia, psychosis, personality disorder, and bipolar disorder).
- 21.7% (n=65) of members reported having a dual diagnosis.
- Members with SMI reported significantly better general wellbeing than members with CMD.
- 34.5% (n=101) of members drink alcohol of whom 41.8% (n=49) had clinically significant scores on CAGE measure indicative of addiction, while 35.2% (n=105) of members reported smoking. However only 5.1% (n=15) of Beacon Members reported currently attending addiction services.

Physical Health Concerns of Members

- A high percentage of members are being treated for medical ailments that are linked to early mortality (Blood pressure, 33% (n=94); Epilepsy/Diabetes, 21% (n=60); and heart disorders, 17%, n=48).
- Over one third of members (35.3%, n=101) are getting treated for back problems and skin disorders (15%, n=43) which are psychosomatic symptoms associated with mental illness.
- Day Service members scored on average 15.01% lower on physical functioning, 7.83% lower on physical role functioning, 25.19% lower on emotional role functioning, 13.95% lower on energy and fatigue, 20.71% lower on emotional wellbeing, social functioning, pain; the intensity of bodily pain experienced in the past 4 weeks; and overall perceptions of general health.
- Members with SMI scored better on all MOS subscales than those members with CMD.

Key findings

Members are predominantly single or unmarried (51.5%) with no children (88.7%) and a low level of educational achievement.

Members are generally of white ethnicity (99%) and are overwhelmingly unemployed (94.1%).

Only 8.4% are under the age of 35 years.
**Training, Employability and Learning**

- 67.3% (n=206) Beacon Members completed secondary level education, while 21.2% (n=65) of members have completed tertiary or further level education.
- 94.1% (n=288) of members are currently unemployed.
- On average it has been 17.4 years since members last worked.
- 25.9% (n=81) cited being dissatisfied with being unemployed.
- 95.8% (n=293) of members having previously been in employment, 13.5% (n=42) of whom within the previous 5 years.

**Technological Capabilities of Beacon Members**

- Almost one half (n=143, 46.9%) of Beacon members did not have access to or own a computer while more than a half (n=162, 52.9%) did not have access to the internet.
- Over two fifths are incapable of using a computer (41.8%, n=127) or using the internet (48.6%, n=148).

**Finances**

- The average weekly income for Beacon Members was £167.29.
- 95.8% (n=293) of members said they were in receipt of state benefits.
- The mean score for satisfaction amongst members with their financial situation was 4.13 (on a scale of 1-7) reflecting mixed satisfaction.
- 30.5% (n=93) reported low satisfaction with regards to their overall financial situation.

**Social Inclusion and the Reduction of Social Isolation**

Social inclusion in the family and the broader community and alleviation of loneliness are central issues in social wellbeing and quality of life (De Jong Gierveld & Tilburg, 2010).

- There was a high prevalence of sedentary behaviours (96.1%, n=294 watched TV or listened to radio) and low engagement with physical activities (23.5%, n=72 played or watched sport), behaviours that have been linked to comorbidities amongst the population of mental health sufferers.
- 64.1% (196) of Beacon Members when asked in the past year had there been times when they would have liked more leisure activity but were unable to do so.

To engage with social and leisure activities requires access to where they take place. For this reason members were asked about their access to transportation.

- 63.3% (n=190) of members do not drive. Of these members 31% (n=65) do not have someone to give them a lift if required.
- 46.2% (n=135) of Beacon Members reported feeling restricted to go somewhere due to a lack of transport.
- 25.4% (n=38) of those using taxi’s to Day Centres do so because of avoidance reasons such as not liking or not knowing how to use buses, feeling safer or more comfortable or because of experiencing panic attacks or anxiety in crowds.

**Religion/Spirituality – A Valued Social Activity**

Much literature exists to support the positive links between religiosity and mental wellbeing (such as life satisfaction, happiness, positive affect, lower depression, fewer suicidal thoughts and substance abuse; Moreira-Almeida, Neta & Koenig, 2006).

By asking members about the role religion or spirituality plays in their lives we can assess the need to provide support that is reflective of what is valued by members to aid their recovery.

- The majority of Beacon Members were of either Protestant (n=125, 41.3%) or Roman Catholic (n=134, 44.2%) denomination.
- The majority of members (40.8%, n=122) reported being very religious or spiritual.
- 41.1% (n=122) of members reported that their religious or spiritual beliefs influenced the way they lived their lives ‘quite a bit’ or ‘very much’ so.
- 41% (n=122) of members said their religious or spiritual beliefs helped them ‘Quite a lot’ or ‘very much’ in coping with their mental health problems.
- Praying or meditating (59.3%, n=181) and attending religious services (21.8%, n=67) were the religious activities members found most helpful.
Family Relations
- 51.6% (n=1,57) of Day Service members reported having daily contact with a relative.
- The average score for satisfaction with family relations was m=5.87 (sd=1.04) indicative that members were “mostly satisfied” or “pleased” with their family relations.
- 19% (n=58) reported mixed satisfaction in relation to the amount of contact they had with family, with a further 14.8% (n=45) reporting low satisfaction with the amount of contact they had with family.
- 30.4% (n=93) of Beacon Members reported living with people suffering from health problems.

Satisfaction with Living Situation
Research has shown that inadequate housing and support can lead to deterioration in mental health, increase risk of suicide, put strain upon family relationships, homelessness and involvement with the criminal justice system, and lead to inappropriate hospitalisation or unnecessarily long stays in hospital (Freeman 2004, Newman 2001, Wong & Solomon 2002).
- The mean score for satisfaction amongst Day Service members with their personal safety and the safety of their neighbourhood was m=5.10 (sd=1.19), indicative of being “mostly satisfied”.
- 66.6% (n=203) of Beacon Members reported a good degree of satisfaction with their safety.
- 33.5% (n=102) reported mixed or low satisfaction with their safety.
- The majority of members (93.5%, n=286) had not been the victim of an assault, beating, molestation or any other type of violence in the previous year.

Social Relations
- The mean score for satisfaction with social relations was m=5.00 (sd=1.34), indicative of members being “mostly satisfied” with their social relations.
- The majority of Beacon Members were either “mostly satisfied” (27.8%, n=85), “pleased” (25.8%, n=79) or “highly satisfied” (13.1%, n=40) with the number of friends they had.
- 17.6% (n=54) expressed dissatisfaction with the number of friends they had.

Social and Emotional Loneliness
Social loneliness is related to broader engaging in social networks (siblings, cousins, friends, and neighbours) which is either absent or considered smaller than is desirable whereas emotional loneliness is related to situations where intimacy has not been realised in relationships (partner, best friend) (Weiss, 1973).
- 65.6% (n=197) of members were intensely or quite emotionally lonely.
- Only 13.7% (n=41) were not emotionally lonely.
- 53.4% (n=160) of members were intensely or quite socially lonely.
- Over 1 quarter (28.7%, n=86) reported not being socially lonely.
- Female Beacon Members reported significantly higher emotional loneliness than their male counterparts.
- Beacon Members who were either divorced or separated reported the highest social and emotional loneliness.

Availability of Support for Beacon Members Attending Day Support Services (MOS Social Support)
The availability of help or emotional support may serve to protect from some of the negative consequences of major illness or stressful situations (Sherbourne, 1988).
- The mean score for MOS subscale for emotional or informational support was m=3.48 (sd=9.7) indicative that this type of support was generally available to members some or most of the time.
- 34.7% (n=105) reported having emotional or informational support available to them “most of the time” or “all of the time”.
- 10.9% (n=33) reported this support being available either “none of the time” or a “little of the time”.
- The mean score for MOS subscale for tangible support was m=3.41 (sd=1.21) indicative that this type of support was generally available to members some to most of the time.
- The majority of members (42.4%, n=129) reported having tangible support “most of the time” or “all of the time”.
- 17.8% (n=54) of members reported having tangible support “none of the time” or a “little of the time” (i.e. scores below 2).
- Males reported having significantly greater availability of tangible support than females.
- Married or cohabiting members reported greater tangible support than single/unmarried or divorced/separated members.
People with mental illness are challenged by both public and self-stigmatising stereotypes and prejudice that result from misconceptions about mental illness.
Traumatic Experiences

Unrecognised and undetected Post Traumatic Stress Disorder (PTSD) and trauma increases negative health outcomes such as substance abuse, co-morbidity and the re-victimisation of those affected (Subica, Claypoole and Wylie, 2012; O’Hare, et al., 2010; Spitzer, Vogel, Barnow, Freyberger, and Grabe, 2007).

The Brief Trauma Questionnaire (BTQ) was administered to give an indication to the types of traumatic incidents members have experienced.

A number of Northern Ireland specific questions were asked to ascertain the impact of the civil conflict upon Beacon Members’ lives.

Beacon Members experiences of traumatic events (%)

- Witnessed someone being seriously injured or killed: 27.5% (n=84)
- Close family member died violently: 23.5% (n=72)
- Seriously injured or fear of serious injury or being killed: 11.8% (n=36)
- Unwanted sexual contact: 16.3% (n=50)
- Other attack/beating/mugging: 27.1% (n=83)
- Physical punishment/beating (before 18 years old): 20.6% (n=63)
- Life-threatening illness: 10.1% (n=31)
- A serious accident (car, work or elsewhere): 19.6% (n=60)
- On average Day Service members were exposed to 1.95 (sd=1.80) types of traumatic events.
- 33.6% (n=102) of Beacon Members reported experiencing three or more traumatic events.
- 72.9% of members (n=221) were exposed to at least one traumatic event. This is higher than the 66.3% of the general population reported for N.I. (Ferry, Bolton, Bunting, Devine, McCann and Murphy, 2008).
- Day Centre members were exposed to political violence in their region to a greater extent than the general population (36.5% compared to 22.0%).
- Beacon Members also had a higher exposure to witnessing someone else being seriously injured or killed than the general population figures (27.5% compared to 19.9%).
- Almost half (47.7%) of Beacon Members had been exposed to an attack, beating or mugging, compared to 23.4% reported in the N.I. general population (Ferry et al., 2008).
- 19.6% of Beacon Members had been exposed to a serious accident (car, work or elsewhere) compared to 14% of the general population.
- 10.1% of Beacon Members had been exposed to a life threatening illness in comparison to 8.8% reported for the general population.
- 16.3% of Beacon Members had been exposed to unwanted sexual contact, which when compared to the general population figures (8.5%) was again higher (Ferry et al., 2008).
- A significant percentage (36.5%, n=100) reported “some” or “a lot” of political violence in their neighbourhood.
- 35.9% reported having personally suffered “some” (n=45) or “a lot” (n=54) as a result of the troubles.
- Similarly high percentages reported that close friends and family had suffered “some” (n=56, 20.7%) or “a lot” (n=64, 23.7%) as a result of the Northern Ireland troubles.
- 16.7% (n=46) members had to personally move due to intimidation.
- 10.9% of members (n=30) have personally experienced damage to their residency as a result of a bomb.
- 7.7% (n=21) had suffered personal injury due to cross-community violence.
- 19.3% (n=53) of members had family or friends injured in cross-community violence.

Day Centre Specific Questions

Members were asked a number of questions directly related to their expectations and experiences of the Beacon Day Centres. This was for the purposes of service delivery to assess what skills, activities, benefits and expectations members had of the services and how well current services meet their needs.
Day Centres Ability to Meet the Needs of Members

- The majority of Day Service members reported the Day Centres meeting most (50.8%, n=155) or all (36.4%, n=111) of their needs.
- N=39 (12.8%) said the Day Centres met only a few of their individual needs.

Personal Benefits of Attending the Day Centre

- 76.2% (n=186) of Beacon Members reported how attending the centre helped them manage their mental illness. The second most cited benefit members received from their attendance at the centres was the social interaction it provided (n=165, 67.6%). The help and support provided by the staff was the third most cited personal benefit (n=81, 33.2%).

Expectations of Day Services

- When asked what their expectations of the Day Centre were when they first entered the majority (n=139, 33.1%) said they had “no or low expectations” whilst 5.2% (n=22) reported being apprehensive about attending.
- Social interaction (n=90, 21.4%), social activities (n=37, 8.6%), help in managing mental health (n=45, 10.7%), general help and support (n=45, 10.7%) and education, training and employability initiatives (n=26, 6.2%) were the main expectations members held.

New Activities

Day Centre attendance has introduced members to new activities predominantly of a recreational nature (42.5%, n=204), but also educational (16.7%, n=80), social (11.2%, n=54), relaxation (n=48, 10%) and wellbeing promotion (n=55, 11.5%).

New Skills

Members reported developing new skills in: recreation (n=119, 21.8%), training and learning (n=106, 19.4%), managing physical and mental health (n=98, 17.9%), social (n=89, 16.3%) and personal development (n=78, 14.3%) that were deemed important to them and their wellbeing.

Additional Information or Advice

Additional information and advice accessed through the Day Centres deemed as beneficial included: Citizens Advice (CAB) 28.8% (n=112), mental health (12.3%, n=48) and general health (GP) (9.8%, n=38).

Signposting to Other Services in the Community

Signposting to other volunteering providers or programmes (n=49, 14.4%) and to social and recreational activities and leisure or community centres (n=34, 10%) were the most useful services in the community the Day Centre had been able to signpost members to.

Key areas for development across Beacon:

- **PHYSICAL:** Provide for physical health improvements to increase quality of life and mortality of members, integrated within mainstream society.
- **EMOTIONAL:** Need to provide therapies and interventions to members. Need to provide signposting to specific psychological services (e.g. addictions, trauma) and valued social activities i.e. religion and spirituality so members that positively impact emotional wellbeing.
- **SOCIAL:** Need to develop social skills particularly for single members who lack intimate or meaningful relationships and for those with CVD who are more vulnerable to social loneliness.

Findings highlight the importance of providing a three stranded approach to overall support and care that encompasses not only emotional wellbeing, but also the physical and social health needs of Beacon Members. Acknowledging sensitive experiences of the troubles and traumas should serve to help understand the emotional state of members and how best to deal with such experiences. By also appreciating the religiosity and spirituality of Beacon Members an additional coping technique can be explored.

Developing employment and volunteering opportunities for members serves to decrease the stigma associated with mental illness and perceptions of incapability to work or volunteer. It also serves to increase self-esteem, maintain social roles, social inclusion, give a sense of purpose and community integration.

The social needs of members are vast and range from the ability to engage in everyday social tasks such as conversations, using public transport and other public services, to the need for family based therapies to provide a support system that helps both the carer and the service user. Basic social skills are needed especially to help members formulate meaningful relationships outside of their mental-health support system.
A health-needs assessment is a systematic method for reviewing the health needs within a population, leading to a set of priorities and resource allocations to improve health and reduce inequalities.

Chapter 1 Introduction

There are a range of voluntary sector organisations in Northern Ireland providing Day Support Services to people with long-term and enduring mental health problems. However, little is known about the specific health and social needs of such people and how they can be best met?

The effectiveness of an intervention is best described in terms of improvements in symptom, disability or quality of life. Comprehensive assessment of need should be the starting point in developing psychiatric services, they should monitor whether services are needs-led, and should form an integral part of evaluating the effectiveness and efficiency of services (Hansson et al., 1995).

Organisations therefore need to establish robust information systems that efficiently gather relevant data that are easily accessible and transparent for internal and commissioning purposes. In this study, we have explored organisational information needs using validated outcome measures to help us understand and thus, address the needs of people in Day Support Services.

This work, referred to as the Day Services Review (DSR) was designed to address the above requirement by capturing detailed information about the physical, social and emotional needs of Beacon Members attending Day Centre services. It is the first step towards measuring the impact of Beacon Day Support Services as an intervention or support to those experiencing mental illness.

Data Collection Needs in Mental Health Services

In the past four decades mental health care systems in the majority of developed countries have experienced reforms spelling shifts from institutional care, to care in the community, to the current ethos of person-centred recovery (Adams, Daniels, & Compagni, 2009).

The idea that people with mental illness can recover, improve and be able to lead a meaningful life within society, is a concept that has entered popular discourse with (Adams et al., 2009) the process of deinstitutionalisation sowing ‘the seeds of the recovery vision’ (Anthony, 1993, p. 521). However, recovery is not a simple process, and there is still little knowledge of what exactly ‘person-centred recovery’ is and what it should look like in terms of service provision.

Key recommendations to aid transformation of mental health services are extensive in terms of the need to a) restructure provision to include services beyond existing buildings, b) develop workforces to meet new service requirements, and c) change progressively and to do so by monitoring and evaluating services (National Social Inclusion Programme, 2006).

It is now imperative that ongoing monitoring and reviewing of reconfigured services occurs to ensure the achievement of objectives, measure the effectiveness of services and inform their future development.

As local political structures in Northern Ireland develop and settle, the concept of evidence based commissioning has gained prominence. Thus, cultural transformation within the public sector in NI towards efficiency, value for money, transparency and accountability demands that commissioning of services from the voluntary sector is accompanied by tighter scrutiny and monitoring of quality and outcomes.

The effectiveness of an intervention is best described in terms of improvements in symptom, disability or quality of life. Comprehensive assessment of need should be the starting point in developing psychiatric services, they should monitor whether services are needs-led, and should form an integral part of evaluating the effectiveness and efficiency of services (Hansson et al., 1995).

Organisations therefore need to establish robust information systems that efficiently gather relevant data that are easily accessible and transparent for internal and commissioning purposes. In this study, we have explored organisational information needs using validated outcome measures to help us understand and thus, address the needs of people in Day Support Services.

This work, referred to as the Day Services Review (DSR) was designed to address the above requirement by capturing detailed information about the physical, social and emotional needs of Beacon Members attending Day Centre services. It is the first step towards measuring the impact of Beacon Day Support Services as an intervention or support to those experiencing mental illness.

Key recommendations to aid transformation of mental health services are extensive in terms of the need to a) restructure provision to include services beyond existing buildings, b) develop workforces to meet new service requirements, and c) change progressively and to do so by monitoring and evaluating services (National Social Inclusion Programme, 2006).

It is now imperative that ongoing monitoring and reviewing of reconfigured services occurs to ensure the achievement of objectives, measure the effectiveness of services and inform their future development.

As local political structures in Northern Ireland develop and settle, the concept of evidence based commissioning has gained prominence. Thus, cultural transformation within the public sector in NI towards efficiency, value for money, transparency and accountability demands that commissioning of services from the voluntary sector is accompanied by tighter scrutiny and monitoring of quality and outcomes.

Internally and externally there are demands for improved data collection and analysis (Review of Public Administration NI; National Inclusion Programme, 2006).

Externally, service commissioners need assurance that public money is spent on excellent care and support services where the outcomes for clients are positive. Information should therefore be driven by a finely-tuned understanding of client needs and resource allocation.

Day Support Centres and Wellbeing

Day Services are an integral part of community mental health services, seen as serving three main functions:

1. to provide an alternative to inpatient care;
2. to shorten the duration of inpatient stay; and
3. to promote recovery and maintenance in the community (Marshall, 2005).

Concerns arise around the primary functions of Day Services, in particular their capacity to promote recovery and maintenance in the community.

Such concerns are based on research findings that people with severe mental health problems experience high rates of unemployment (Lehman, 1995; McCredie, 1992) despite having the desire to work (Hatfield, Huxley, & Hadi, 1992; Lehman, 1995; Shepherd, Murray, & Muijen, 1994; Mueser et al., 2004), and that the proportion of people with mental health problems in paid work has not changed over the last decade, in contrast with an increase in the number of people with physical disabilities in employment (Social Exclusion Unit, 2003).

1 Service Users (SU) within Beacon are referred to as Beacon members, a reference decided upon by members themselves. For the remainder of this report ‘members’ will be used to refer to Beacon members who are otherwise referred to in literature as SU's.
This gives cause for concern amid the reported positive impacts of employment on quality of life through the reduction of symptoms, increased life structure, social interaction and meaningful activity (Frost, Carr, & Halpin, 2002; Van Dongen, 1996). It has even been argued that present Day Service provision encourages dependency and can hamper the road to recovery (Clark, 2001) with little support that Day Services meet the needs of young adults or ethnic minorities (National Social Inclusion Programme, 2006). Given the prominence of Day Services in the mental health care system in the UK and their potential impact on recovery, it is surprising that little has been done to date to ascertain the value of these services to service users.

Consequently, in the new vision for the transformation of mental health Day Services, from segregation to inclusion (National Social Inclusion Programme, 2006) a policy initiative was proposed to provide commissioners with a framework to enable and promote social inclusion, to bring people with mental illness into mainstream society, enabling access to opportunities for employment, leisure, and family and community life (Rankin & Institute for Public Policy Research (London, England), 2005).

Reconfiguring Mental Health Day Services (From Segregation to Inclusion, 2006)

The reconfiguration of Day Services provision has a renewed focus on the promotion of recovery, social inclusion and self-determination and the reduction of social isolation. Day Services should therefore:

1. Promote inclusion - enable people to lead full lives despite ongoing mental health problems.
2. Focus on community participation - support people to access mainstream opportunities within their communities rather than creating segregated activities.
3. Reduce social isolation - provide service users with opportunities for developing social networks with people outside the mental health system.
4. Offer service users the opportunity to provide peer support and user-led sessions.
6. Meet the needs of diverse groups.
7. Ensure that services are accessible to those with the highest needs.
8. Involve users and carers - experts by experience are better placed in designing and developing services.
9. Increase diversity of provision - maximise the contribution of the voluntary and private sector in the provision of services.
10. Improve cross-sector working - guarantee participative, integrated working beyond the mental health and social care spectrum, including providers such as faith based groups, minority ethnic community groups, libraries, employers and employment organisations, colleges and providers of sports and leisure activities.

In this way Day Services should serve to provide opportunities for social contact and support, should help people retain existing social roles, relationships and social activities that are valued; should support people to access new roles, relationships and mainstream social pursuits; and provide opportunities for mental health sufferers to run their own services.
The Northern Ireland Mental Health Agenda


The Bamford Review (DHSSPS, 2011) made a series of recommendations to improve mental health in NI, increase service provision and reform current legislation. A 10-15 year action plan (Delivering the Bamford vision, DHSSPS, 2009) following through on the recommendations of the Bamford Review (DHSSPS, 2011) focuses on the provision of a range of effective recovery-based services that help people with a mental health problem to achieve and maintain their optimum level of functioning.

The recovery approach will support people with a mental health need to plan and build a satisfying life, engaging in work or other meaningful activities and contributing to and participating in society (DHSSPS, 2009).

Models of Day Centres and their Effectiveness

The deinstitutionalisation of long-term psychiatric patients has led to the creation of a wide variety of community-based care facilities. At present however, there is no widely accepted model for day care (Boardman & Sainsbury Centre for Mental Health, 2007). Catty et al. (J.S. Catty et al., 2007) in their Cochrane review of Day Centres for severe mental illness found no Randomised Control Trials (RCTs) of non-medical Day Centres in the literature, expressing concern on how studies focused on organisational issues or delivery of programmes and not effectiveness.

Other small qualitative studies carried out across the UK have demonstrated the value of Day Centres to SU’s in providing a purpose and structure to the day, a safe and non-threatening environment, the value of a ‘a place to go’ and as having a ‘key role in preventing mental health deterioration’ (Bryant, Craik, & McKay, 2005; Rollason, Stew, & Paul, 2000).

However, there currently exists an imprecision of terminology, extensive variation in services and context of provision, and a mismatch between the focus on Day Centres and the lack of robust evidence base regarding their effectiveness in meeting clinical or social need (Catty et al., 2007; Marshall, National Coordinating Centre for Health Technology Assessment, & NHS R & D HTA Programme (Great Britain), 2001).

Consequently it is argued that funders should expect appropriate evaluation of the services before further financial support may be granted (Catty et al., 2007).

What sort of data would be most useful to understand the full range of service user needs (for example, Quality of Life, physical care, recovery-based)?

Beacon Day Services Review

Beacon Day Centre services encompass two of five forms of day care provision (WHO, Marshall, 2005). Primarily Beacon Day Services take the form of traditional Day Care Centres offering continued care to patients with severe mental illness.

They also offer services in line with Drop-in centres by offering a non-clinical environment where people with mental illness can go for social support and activities (Marshall, 2005).

This review of Day Services across Beacon attempts to address the current lack of understanding as to the impact of services on the lives and wellbeing of its members.

Not only that, it also serves to address a bigger gap of knowledge in assessing member need across a number of life domains. In this way the review will serve to inform staff of the benefits members derive from attending Day Centres and also take a more focused look at the needs of members to help shape future provision of services.

This will be achieved by using reliable and validated quality of life, health and social needs, and role functioning instruments that measure life domains (i.e. physical, environmental and psychological) relevant to carers and people with mental health problems in Day Support. Such tools provide rich information to aid the effective matching of support settings to people. These include the Lancashire Quality of Life and the SF-36 Health Survey alongside clinical and socio-demographic assessments.

Voluntary Service Organisations (VSOs) should have accessible data on the success or failure to meet the needs of its clients and where best to target scarce resources. Hence, there is a need for flexible, routine data collection that captures a comprehensive range of service user data on health and social care needs that allows a rapid and clear understanding whether or not the needs of service users are being met; if some, rather than all, which particular needs are being met. This internal review is the first step to achieving such understanding.

The questions that we wish to address:

What are the physical, social and emotional health needs of our members?
Chapter 2 Methods

Setting

- Beacon manages 14 Day Support Schemes across Northern Ireland, currently providing support to approximately 1,000 Beacon Members experiencing long-term and enduring mental health problems. Figure 1 shows the number of SUs registered in each centre. Aspen, located in South Belfast had the highest number (n=124) of members when the DSR started, followed by Beechview (n=118) in Dungannon and Scraboview (n=97) in Newtownards. Prospects in Castlederg, one of the two centres classified as rural has the fewest number of registered members (n=23).

- For the purposes of the DSR, the centres were classified by geographical location into urban and rural, according to the official urban and rural classification for NI (NIRSA, 2005). Two Day Support Centres are located in rural Northern Ireland (Castlecroft in Lisnaskea and Prospects in Castlederg). The geographical location of all centres (n=14) is shown in Table 1.

Table 1 Location of centres

<table>
<thead>
<tr>
<th>Centre</th>
<th>Location</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbeyview</td>
<td>Armagh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspen</td>
<td>Belfast</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Beechview</td>
<td>Dungannon</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Bracken</td>
<td>Belfast</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Castlecroft</td>
<td>Lisnaskea</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Clarendon</td>
<td>Derry</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Erneval</td>
<td>Enniskillen</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Market</td>
<td>Magherafelt</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Prospect</td>
<td>Castlederg</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Rosewood</td>
<td>Omagh</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Scraboview</td>
<td>Newtownards</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Willowtree</td>
<td>Belfast</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Woodlands</td>
<td>Cookstown</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Woodvale</td>
<td>Ballymena</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
Sample

- A target sample of 504 representing 50% of our entire Service user (Beacon Member) population was approached. A stratified sampling system was used to select 50% of members across all Day centres. n=101 were removed as they were non-attending (n=55) or had been discharged (n=46). n=140 did not respond to invitation, 56% point blank refused to participate, a further 10% were deemed to lack capacity at the time of review with a further 3% in hospital at the time of interviewing. We therefore recruited 306 members from a total population of 403 which gives us a response rate of 75.93%.

- 306 interviews were completed (75.93%) by a total number of 34 interviewers and two researchers. The interviewers were trained research volunteers recruited amongst members of staff (n=26), external volunteers (n=5) and students on placement (n=3).

Methods

We used a cross-sectional survey among people who are current users of Day Support Centres. The survey was carried out using face-to-face interviews with Beacon Members using standardised well-validated instruments relevant to health and social care needs. Member interviews were arranged through the scheme managers. We sought agreement of the scheme managers in advance. Each Beacon Member was informed of the study and its aims. Participants were provided with information sheets and asked to provide written consent. All service user data was anonymised and provided with a unique ID number.

A steering committee was established comprising Service User representatives, Care Workers, Directors and Senior Managers within NIAMH. This group met with the researchers to discuss progress and potential and actual barriers to completion.

Measures

1. We used the Lancashire Quality of Life Profile-EU: The interview contains various domains of service user satisfaction with quality of life across domains such as leisure, finances, living situation, legal and safety, family relations, work, general wellbeing, and positive affect. In addition it has a section for Socio-demographic details: age, sex, religion, ethnicity, educational level and employment.

2. Rosenberg Self-esteem Scale: This scale was used to assess current self-esteem of Day Service members. The scale is a 10-item Likert scale with items answered on a four point scale from strongly agree to strongly disagree. Participants respond to a list of statements dealing with their general feelings towards themselves.

3. Social Inclusion: we explored service user’s perceptions of social inclusion using MOS Social Support Survey, De Jong Gierveld emotional and social loneliness scale and the Stigma scale (King et al, 2007). The MOS Social Support Survey measures the availability of: Emotional/Informational Support (the offering of advice, information, guidance or feedback), Tangible Support (i.e. the provision of material aid or behavioural assistance), Affective Support (i.e. expressions of love and affection), and Positive Social Interaction (i.e. the availability of others to do fun things with). The emotional and social loneliness scale gives an indication of the extent of loneliness felt by members. The Stigma scale measures stigma across three dimensions: disclosure (i.e. about mental illness), discrimination (i.e. perceived hostility by others or lost opportunities because of prejudiced attitudes), and positive aspects (of mental illness, such as becoming a more understanding or accepting person).

4. Assessment of Education and Training Needs

5. Physical and Emotional Health Needs: we assessed the number and type of health problems members were experiencing if any, health complaints those they lived with. We used the SF-36 Health Survey to assess different health states of members across: physical functioning, the extent to which mental health interferes with a variety of activities, role functioning/physical: the extent to which physical health problems interfere with usual daily activities, role functioning/emotional: the extent to which emotional problems interfere with usual daily activities, energy/fatigue: general feelings of energy and lack of fatigue, emotional wellbeing, social functioning, and pain: the intensity of bodily pain experienced in the past 4 weeks; and overall perceptions of general health.

6. Recovery Needs: The Brief Trauma Questionnaire was used to itemise the types of traumatic experiences Beacon Members have encountered. The CAGE, a three-question validated clinical tool to assess alcohol misuse was also administered.

7. Open Ended Questions: members were asked specifically to report the expectations they had of Day Services when they first attended, and any additional support they received through the Day Centres (skills/new activities engaged in, information/advice sought, signposting to other community services), and to rate how well the Day Centre met their individual needs.
Recruitment

PHASE I (April 2011 - December 2011)

• Researcher LH attended Beacon Voice (representative group of members from all centres) and all Day support scheme managers to introduce herself, her role and the proposal of a Day Services Review. Part of this process was the dissemination of the Supported Housing Needs Assessment (SHNA), the findings of which were well received.

• Researcher LH met with scheme managers to ascertain what went well in the SHNA and what we needed to do to ensure the success of the DSR. Consultation with staff was held throughout the design of the methods by which the DSR would use to be sensitive to their needs and the needs of their Beacon Members.

• Steering committee of Beacon Members, staff, Niamh management and the research team was established to effectively plan the study.

• Information sheet and consent form was sent to staff to proof read.

• Information fliers were sent to each centre for members and staff to see and read.

• Managers were asked to discuss the DSR with their staff and ensure all members knew it was happening.

• Managers were asked to promote the opportunity of building research capacity across Niamh by offering extensive training in interviewing to interested members of staff.

• Staff and volunteer researchers were recruited and underwent a 2 day intensive training programme to prepare them for undertaking interviews.

• All material (i.e. information sheets, consent forms and questionnaires) were posted directly to each centre and secured in a lock-filing cabinet.

• Random selections of 50% of members from across the 14 Day Centres were invited to participate in the review. Those who agreed to participate had a time and date for interview arranged via their scheme manager. A researcher then met them at the centre as agreed to undertake the interview.

• Written consent was obtained prior to any interview, following a briefing on the DSR aims and objectives.

• Face-to-face interviews with Beacon Members were undertaken within the Day Centres and ranged from 1-3 hours in length, the average lasting around 1.5 hours.

• Questionnaires were assigned a unique identifier to assure all personal identifiers of members were removed. Codes were used to identify each participant and to ensure no one was approached twice.

• Each BM was provided with the option to have a KW or other person in attendance throughout the interview and could withdraw at any stage.

PHASE II (February 2012 - April 2012)

• Given the capacity of the research team and the geographical location of some centres February 2012 began the second phase of recruitment for centres previously not approached.

• For those centres with a low response rate amongst BMs, further consultation with Scheme Managers was undertaken, and a second invitation to participate was extended to participate. This allowed members who were initially unsure to have time to reconsider their decision following discussion with other BMs who had already taken part.

• This final recruitment phase helped ensure all Beacon Day Centres were approached and represented in the study.

The response rate for the DSR was high at 75.93% of our total population available to participate. The individual response rate varied from centre to centre. The response rate by centre is shown in Table 2.

Chapter 3 Results

Table 2 Response rate per centre

<table>
<thead>
<tr>
<th>Centre name</th>
<th>Centre Code</th>
<th>Response Rate N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbeyview</td>
<td>ABU</td>
<td>28 (87.5)</td>
</tr>
<tr>
<td>Ernevale</td>
<td>ERU</td>
<td>20 (88.9)</td>
</tr>
<tr>
<td>prospects</td>
<td>PRR</td>
<td>12 (100)</td>
</tr>
<tr>
<td>Rosewood</td>
<td>ROU</td>
<td>20 (71.4)</td>
</tr>
<tr>
<td>Bracken House</td>
<td>BRU</td>
<td>24 (62.3)</td>
</tr>
<tr>
<td>Scrabbleview</td>
<td>SCU</td>
<td>43 (88.7)</td>
</tr>
<tr>
<td>Castlecroft</td>
<td>CAR</td>
<td>18 (90)</td>
</tr>
<tr>
<td>Willowtree House</td>
<td>WHU</td>
<td>12 (54.5)</td>
</tr>
<tr>
<td>Beechview</td>
<td>BEU</td>
<td>40 (67.8)</td>
</tr>
<tr>
<td>Aspen</td>
<td>ASU</td>
<td>36 (58.1)</td>
</tr>
<tr>
<td>Clarendon Street</td>
<td>CIU</td>
<td>19 (42.7)</td>
</tr>
<tr>
<td>Woodlands</td>
<td>WLU</td>
<td>15 (31.3)</td>
</tr>
<tr>
<td>Woodvale</td>
<td>WOU</td>
<td>12 (28.6)</td>
</tr>
<tr>
<td>Marketstreet</td>
<td>MSU</td>
<td>7 (25.9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>306 (75.9)</strong></td>
</tr>
</tbody>
</table>
Reasons for refusal to participate in the DSR are displayed in Figure 2. Over half of respondents first invited to participate refused to do so. 13% were either unwell or in hospital at the time of interviewing. 5% of Beacon Members cited not wanting to participate because of intellectual disabilities.

Table 3 gives a picture of the Beacon Members currently attending Beacon Day Services.

- The male to female ratio recruited for the DSR is reflective of the existing breakdown of Beacon members across gender (male: 44.4%, n=449; female: 55.6%).
- The average age of members who took part was 52 years (ranging from 23-90 years of age) with the majority of members aged between 36 and 55 years old.
- 9.5% of members attending Day Centres are aged 65 years or older while just 6.4% are under the age of 35 years.
- Members are mainly single or unmarried with no children and a low level of educational achievement.
- Members are generally of white ethnicity and are overwhelmingly unemployed. The ethnic breakdown of Beacon Membership is reflective of the National Inclusion Programmes (2006) concerns that day services are not meeting the needs of ethnic minorities (National Inclusion Programme, 2006).
- Beacon Day Centres are predominantly providing services for individuals suffering from depression (40% of members).

Table 3 An overview of Beacon Members attending current Day Support Services

<table>
<thead>
<tr>
<th>Classification</th>
<th>Category</th>
<th>Number of Members</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>148</td>
<td>48.4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>158</td>
<td>51.5</td>
</tr>
<tr>
<td>Age</td>
<td>Under 35</td>
<td>19</td>
<td>6.4</td>
</tr>
<tr>
<td></td>
<td>36-55</td>
<td>165</td>
<td>55.2</td>
</tr>
<tr>
<td></td>
<td>&gt; 56</td>
<td>115</td>
<td>38.3</td>
</tr>
<tr>
<td></td>
<td>Males of working age (i.e. &lt;65 yrs)</td>
<td>126</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>Females of working age (i.e. &lt;60 yrs)</td>
<td>112</td>
<td>70.9</td>
</tr>
<tr>
<td>Education (age left school)</td>
<td>15 and under (prior to formal examinations)</td>
<td>83</td>
<td>27.9</td>
</tr>
<tr>
<td></td>
<td>Aged 16</td>
<td>129</td>
<td>43.4</td>
</tr>
<tr>
<td></td>
<td>Aged 17-18</td>
<td>54</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>19 or over</td>
<td>31</td>
<td>10.4</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single/unmarried</td>
<td>157</td>
<td>51.5</td>
</tr>
<tr>
<td></td>
<td>Married/living with partner</td>
<td>65</td>
<td>21.3</td>
</tr>
<tr>
<td></td>
<td>Divorced/separated</td>
<td>66</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>16</td>
<td>5.2</td>
</tr>
<tr>
<td>Number of Children</td>
<td>No Dependent (&lt;18yrs)</td>
<td>261</td>
<td>86.7</td>
</tr>
<tr>
<td></td>
<td>1-2 dependent children</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3-4 dependent children</td>
<td>8</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>No Independent (&gt;18yrs)</td>
<td>170</td>
<td>56.3</td>
</tr>
<tr>
<td></td>
<td>1-2 independent children</td>
<td>69</td>
<td>22.9</td>
</tr>
<tr>
<td></td>
<td>3-4 independent children</td>
<td>48</td>
<td>15.9</td>
</tr>
<tr>
<td></td>
<td>5-7 independent children</td>
<td>11</td>
<td>3.6</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White</td>
<td>297</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Chinese</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Black African</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Employment</td>
<td>Paid employment</td>
<td>12</td>
<td>3.9</td>
</tr>
<tr>
<td></td>
<td>Voluntary employment</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Unemployed/retired</td>
<td>289</td>
<td>94.1</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Depression</td>
<td>120</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td>48</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Bipolar Disorder</td>
<td>31</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>46</td>
<td>15.3</td>
</tr>
<tr>
<td></td>
<td>Phobias (mainly social)</td>
<td>5</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Personality Disorder</td>
<td>14</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Psychosis</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>PTSD</td>
<td>7</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>OCD</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Alcohol Abuse</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other (includes self-harm, nervous breakdown, Parkinson’s, learning difficulties)</td>
<td>14</td>
<td>4.7</td>
</tr>
</tbody>
</table>

NB: percentages add up to more than 100% since some members have dual diagnosis.

Figure 2 Reasons for non-response
Beacon Member Diagnosis

- The mean number of years since the onset of mental health diagnosis of members was 18.2 years ranging from 0-48 years.
- The vast majority of members have been enduring their mental illness for over 10 years (65%).
- Only 17% (n=38) of members have had a diagnosis within the last 5 years.

86% (n=240) of Beacon Members had been given a specific mental health diagnosis while 14% (n=39) had not.

Over one fifth (21.1%, n=65) of members reported having two diagnoses.

Common Mental Disorders (CMD), Serious Mental Illness (SMI) and Dual Diagnosis

Diagnosis was further classified as being either CMD or SMI. Common mental disorders refer to: anxiety, depression, PTSD (Post-Traumatic Stress Disorder), Alcohol abuse, Obsessive Compulsive Disorders (OCD) and Phobias. Serious Mental Illness refers to: schizophrenia, psychosis, personality disorder, and bipolar disorder.

Table 4 breaks diagnosis of Beacon Members into Common Mental Disorders (CMD) and Serious Mental Illness (SMI) and those members who have a dual diagnosis.

Table 5 provides a centre-by-centre breakdown of the mental health diagnosis of members attending the Day Support Centres. The most common mental health problem that centres are helping members deal with is depression.

CMD Versus SMI:
- Members with CMD did not differ from members experiencing SMI in terms of stigma.
- Findings reflect better physical functioning, greater energy and less fatigue, greater emotional wellbeing, less pain, and lower social loneliness reported amongst those with SMI than those suffering from CMD.
- There were no differences across diagnosis in terms of the traumas members were exposed to or levels of distress and unease with engaging with the environment (positive and negative affect).
- Members with SMI reported significantly better general wellbeing than members with CMD.
Table 4 Common Mental Disorders and Serious Mental Illness Across Centres

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Centre Codes</th>
<th>Diagnosed</th>
<th>SMI</th>
<th>Dual Diagnosis</th>
<th>Mean no. of years since onset of illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Of members with CMD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. Of members with SMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. Of members with dual diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centre Codes</th>
<th>No.</th>
<th>CMD</th>
<th>SMI</th>
<th>Dual Diagnosis</th>
<th>Mean no. of years since onset of illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABU</td>
<td>13</td>
<td>19</td>
<td>2</td>
<td>4</td>
<td>20.43</td>
</tr>
<tr>
<td>ASU</td>
<td>2</td>
<td>14</td>
<td>14</td>
<td>6</td>
<td>17.45</td>
</tr>
<tr>
<td>BEU</td>
<td>15</td>
<td>14</td>
<td>5</td>
<td>15</td>
<td>16.69</td>
</tr>
<tr>
<td>ERU</td>
<td>12</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>17.33</td>
</tr>
<tr>
<td>ROU</td>
<td>12</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>25.62</td>
</tr>
<tr>
<td>SCU</td>
<td>20</td>
<td>5</td>
<td>14</td>
<td>17.85</td>
<td></td>
</tr>
<tr>
<td>WHU</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>12.27</td>
<td></td>
</tr>
<tr>
<td>WLU</td>
<td>16</td>
<td>3</td>
<td>3</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>BRU</td>
<td>19</td>
<td>6</td>
<td>4</td>
<td>21.06</td>
<td></td>
</tr>
<tr>
<td>CAR</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>CLU</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>MSU</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>17.57</td>
<td></td>
</tr>
<tr>
<td>PRR</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>19.82</td>
<td></td>
</tr>
<tr>
<td>WOU</td>
<td>14</td>
<td>3</td>
<td>2</td>
<td>16.17</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>91</td>
<td>65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Area of need:

- Provision of early interventions for those recently diagnosed (i.e. within the previous 5 years) that will help them retain existing social roles and maintain integration in the community.
- Given the diagnostic variations across centres, Beacon should source interventions and therapies that are diagnosis specific and proven to help aid recovery to ensure a person-centred recovery approach.
- To open up volunteering and employment opportunities for members, existing staff will need to develop new skills to facilitate engagement of people with expertise beyond the mental health field as is expected in the policy document From Segregation to Inclusion (2006).
- Current services are meeting the needs of a diverse population in terms of diagnosis, however they are not serving the needs of young adults and ethnic minorities, a concern raised in the National Inclusion Programme (2006). More targeted work with such populations is required.
- Findings reflect differences between those members diagnosed with CMD and SMI. Staff need to be aware that those with CMD require extra support to promote better physical functioning, increase energy and control pain, promote emotional wellbeing, and lower social loneliness.

Staff need to be aware that those with common mental disorders require extra support to promote better physical functioning, increase energy and control pain, promote emotional wellbeing, and lower social loneliness.
Table 5 Mental Health Diagnosis by Centre

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Centre Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABU</td>
</tr>
<tr>
<td>Depression</td>
<td>7</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2</td>
</tr>
<tr>
<td>Phobias (mainly social)</td>
<td>0</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
</tr>
<tr>
<td>PTSD</td>
<td>1</td>
</tr>
<tr>
<td>OCD</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>


Table 6 Centre-by–centre comparisons across SF–36 Health Survey

<table>
<thead>
<tr>
<th>SF36 Social functioning subscales Means:</th>
<th>Centre Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ABU</td>
</tr>
<tr>
<td>Physical functioning</td>
<td>75.54</td>
</tr>
<tr>
<td>Physical role function</td>
<td>77.68</td>
</tr>
<tr>
<td>Emotional role function</td>
<td>74.1</td>
</tr>
<tr>
<td>Energy fatigue*</td>
<td>50.89</td>
</tr>
<tr>
<td>Emotional well-being</td>
<td>59.71</td>
</tr>
<tr>
<td>Social functioning</td>
<td>67.86</td>
</tr>
<tr>
<td>Pain *</td>
<td>77.68</td>
</tr>
<tr>
<td>General health</td>
<td>56.96</td>
</tr>
</tbody>
</table>

NB: High scores define a more favourable health state. Each item is scored on a 0–100 range.
Scores represent the % of total possible scores. *High scores represent high energy and low fatigue and low pain for these items.
Substance use Amongst Beacon Members

Beacon Members were asked to complete CAGE, a measure for alcohol misuse where a total score of 2 or greater is considered clinically significant (Brown & Rounds, 1995). Members were also asked questions in relation to other substances they use. It is important if members have an addiction that they receive specific help for that as part of their recovery plan.

• Just over one third of members (34.5%, n=101) drink alcohol, of whom 41.8% (n=49) had clinically significant scores on CAGE measure indicative of addiction.

• Only 2.7% (n=8) DS members reported having used illicit substances in the previous 6 months, 3 of whom however reported using them 4 or more times per week.

• The majority of those using illicit drugs reported using cannabis (n=6).

• n=105 (35.2%) of DS members reported smoking. The majority (54.4%, n=56) reported smoking between 10-20 cigarettes per day. Almost one quarter (23.3%, n=24) reported smoking between 21-40 cigarettes per day.

• 16.1% (n=48) of DS members reported gambling with a mean spending of £16.95 per week.

• 5.1% (n=15) of DS members reported currently attending addiction services, the majority of whom reported attending the AA (n=10) or other NHS services (n=3).

Physical Health Concerns of Members

In terms of service provision, a full understanding of medical health concerns of members is needed to ensure Beacon is fit for purpose. Beacon Members attending the Day Centres were asked about current treatment they were in receipt of for physical health ailments.

• A high percentage of members are being treated for medical ailments that are linked to early mortality (Blood pressure, 33%; Epilepsy/diabetes, 21%; and heart disorders, 17%). Each of which can be controlled by lifestyle and dietary factors.

• Over one third of members (35.3%, n=101) are getting treated for back problems and skin disorders (15%, n=43) which are psychosomatic symptoms associated with mental illness.
Members were also given the RAND 36-Item Health Survey to assess different health states of members across:

- Physical functioning: the extent to which health interferes with a variety of activities
- Role functioning/physical: the extent to which physical health problems interfere with usual daily activities
- Role functioning/emotional: the extent to which emotional problems interfere with usual daily activities
- Energy /fatigue: general feelings of energy and lack of fatigue
- Emotional wellbeing
- Social functioning
- Pain: the intensity of bodily pain experienced in the past 4 weeks
- General health

High scores define a more favourable health state with each item scored on a 0-100 range. Scores represent the percentage of total possible score achieved and are shown in Table 8 for Beacon Day Service members.

Day Service members scored on average 15.01% lower on physical functioning, 7.83% lower on physical role, 25.19% lower on emotional role functioning, 13.95% lower on energy and fatigue, 20.71% lower on emotional wellbeing functioning, 27.45% lower on social functioning, 11.62% lower on general health, and experienced 13.18% more pain than the central tendency in the Medical Outcomes Study (MOS).

Table 8 RAND SF36- Health Survey

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean (sd)</th>
<th>MOS central tendency M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical functioning</td>
<td>55.6 (sd=30.97)</td>
<td>70.61 (sd=27.42)</td>
</tr>
<tr>
<td>Role functioning/physical</td>
<td>45.9 (sd=42.75)</td>
<td>52.97 (sd=40.78)</td>
</tr>
<tr>
<td>Role functioning/emotional</td>
<td>40.9 (sd=44.45)</td>
<td>65.78 (sd=40.71)</td>
</tr>
<tr>
<td>Energy /fatigue</td>
<td>*38.2 (sd=23.67)</td>
<td>52.15 (sd=22.39)</td>
</tr>
<tr>
<td>Emotional wellbeing</td>
<td>49.67 (sd=24.62)</td>
<td>70.38 (sd=21.97)</td>
</tr>
<tr>
<td>Social functioning</td>
<td>51.32 (sd=28.67)</td>
<td>78.77 (sd=23.43)</td>
</tr>
<tr>
<td>Pain</td>
<td>*57.59 (sd=33.08)</td>
<td>70.77 (25.46)</td>
</tr>
<tr>
<td>General health</td>
<td>45.37 (sd=22.88)</td>
<td>56.99 (sd=21.11)</td>
</tr>
</tbody>
</table>

NB: High scores define a more favourable health state. Each item is scored on a 0-100 range. Scores represent the % of total possible scores. *High scores represent high energy and low fatigue and low pain for these items.

Area of need:

- Given the prominence of physical ailments amongst members, lifestyle and dietary advice/interventions should form part of members support plans. In particular lifestyle and physical interventions that are diagnosis specific should be adopted to ensure they meet the needs of members. This should help manage comorbidities associated with early mortality amongst those with mental illness.
- High clinical scores on the alcohol measure CAGE amongst those who do drink indicate a need for further support and signposting to addiction agencies.
- Similarly healthy lifestyle interventions should focus on reducing cigarette smoking amongst members, given the inherent health risks of doing so (e.g. cancers, CHD, heart attacks and stroke, www.nhs.co.uk).

• Establishing links with community leisure centres, leisure groups, personal trainers etc, should help integrate members back into the community and increase physical functioning, social functioning, reduce pain and promote better general health amongst members.

• Recovery for Beacon Members should involve a strategic effort to improve physical, emotional and social functioning to promote a better quality of life.

Establishing links with community leisure centres, leisure groups, personal trainers etc, should help integrate members back into the community and increase physical functioning, social functioning, reduce pain and promote better general health amongst members.
Training, Employability and Learning

The Northern Ireland mental health agenda proposes a recovery approach that will support those with mental illness in engaging in work, meaningful activities and participating in society (DHSSPS, 2009). In light of this, members were asked questions on their educational levels, employment status (current and past), their financial situation including who covers the cost of their travel to the Day Centres, and internet and computer capabilities.

The average age for Beacon Members on leaving full-time education was 16 years of age, the equivalent to 12 years in education. Over one fifth have completed tertiary or further level education indicating potential for employability. Almost one quarter of Beacon Members have returned to formal education. This would be indicative of ongoing training and skills development which could aid future employment. Members with a diagnosis of CMD (Common Mental Disorder) left full-time education at a younger age than those members with a diagnosis of SMI (Serious Mental Illness).

Unemployment figures for members do not read well with 94.1% currently unemployed. Whilst work need not be paid, only 1% of members are engaged in voluntary work. Of the high number of members currently unemployed the mean score for satisfaction with being unemployed was m=3.5 (sd=1.226) which could make return to work difficult. Positively however, 13.5% (n=42) had been in employment within the previous 5 years which could bode well for future back to work schemes. There was no difference between the length of time since last employment between members with diagnoses of CMD or SMI.

Of the 15 members currently engaging with work (either paid or voluntary) the mean score for satisfaction with being employed was m=5.5 (sd=1.226) which would reflect members being “mostly satisfied” or “pleased” with employment. The mean number of hours worked per week by this group was 14.5, with a mean hourly rate of payment of £5.85 for those in paid employment which is below the minimum wage in the UK at present (£6.19 for those aged 21 and over).

Members were not always unemployed with 95.8% having previously worked (see Figure 3 for a breakdown on the previous occupations held by members). Of the high number of members currently unemployed the mean score for satisfaction with being unemployed was m=3.5 (sd=1.226) which could make return to work difficult. Positively however, 13.5% (n=42) had been in employment within the previous 5 years which could bode well for future back to work schemes. There was no difference between the length of time since last employment between members with diagnoses of CMD or SMI.

Of the 15 members currently engaging with work (either paid or voluntary) the mean score for satisfaction with being employed was m=5.5 (sd=1.226) which would reflect members being “mostly satisfied” or “pleased” with employment. The mean number of hours worked per week by this group was 14.5, with a mean hourly rate of payment of £5.85 for those in paid employment which is below the minimum wage in the UK at present (£6.19 for those aged 21 and over).

Members were not always unemployed with 95.8% having previously worked (see Figure 3 for a breakdown on the previous occupations held by members). Female members worked predominantly in production occupations, the food industry, personal care services and sales. Male members worked predominantly in the construction and extraction industry, production occupations, transportation and material moving or in sales. On average however it has been 17.4 years since members last worked, with some having never worked (4.2%, n=13) and others not having worked in over 40 years (4.1%, n=13) which could make return to work difficult. Positively however, 13.5% (n=42) had been in employment within the previous 5 years which could bode well for future back to work schemes. There was no difference between the length of time since last employment between members with diagnoses of CMD or SMI.

Of the 15 members currently engaging with work (either paid or voluntary) the mean score for satisfaction with being employed was m=5.5 (sd=1.226) which would reflect members being “mostly satisfied” or “pleased” with employment. The mean number of hours worked per week by this group was 14.5, with a mean hourly rate of payment of £5.85 for those in paid employment which is below the minimum wage in the UK at present (£6.19 for those aged 21 and over).

Members were not always unemployed with 95.8% having previously worked (see Figure 3 for a breakdown on the previous occupations held by members). Female members worked predominantly in production occupations, the food industry, personal care services and sales. Male members worked predominantly in the construction and extraction industry, production occupations, transportation and material moving or in sales. On average however it has been 17.4 years since members last worked, with some having never worked (4.2%, n=13) and others not having worked in over 40 years (4.1%, n=13) which could make return to work difficult. Positively however, 13.5% (n=42) had been in employment within the previous 5 years which could bode well for future back to work schemes. There was no difference between the length of time since last employment between members with diagnoses of CMD or SMI.

Of the 15 members currently engaging with work (either paid or voluntary) the mean score for satisfaction with being employed was m=5.5 (sd=1.226) which would reflect members being “mostly satisfied” or “pleased” with employment. The mean number of hours worked per week by this group was 14.5, with a mean hourly rate of payment of £5.85 for those in paid employment which is below the minimum wage in the UK at present (£6.19 for those aged 21 and over).

The average age for Beacon Members on leaving full-time education was 16 years of age, the equivalent to 12 years in education. Over one fifth have completed tertiary or further level education indicating potential for employability. Almost one quarter of Beacon Members have returned to formal education. This would be indicative of ongoing training and skills development which could aid future employment. Members with a diagnosis of CMD (Common Mental Disorder) left full-time education at a younger age than those members with a diagnosis of SMI (Serious Mental Illness).

Unemployment figures for members do not read well with 94.1% currently unemployed. Whilst work need not be paid, only 1% of members are engaged in voluntary work. Of the high number of members currently unemployed the mean score for satisfaction with being unemployed was m=3.5 (sd=1.226) which could make return to work difficult. Positively however, 13.5% (n=42) had been in employment within the previous 5 years which could bode well for future back to work schemes. There was no difference between the length of time since last employment between members with diagnoses of CMD or SMI.

Of the 15 members currently engaging with work (either paid or voluntary) the mean score for satisfaction with being employed was m=5.5 (sd=1.226) which would reflect members being “mostly satisfied” or “pleased” with employment. The mean number of hours worked per week by this group was 14.5, with a mean hourly rate of payment of £5.85 for those in paid employment which is below the minimum wage in the UK at present (£6.19 for those aged 21 and over).

Finances

Members were asked about their current financial situation and to rate their satisfaction with it. The average weekly income for Beacon Members was £167.29. 95.8% of members said they were in receipt of state benefits, while 4.2% (n=13) said they did not know if they received any state benefits. Table 9 indicates the types of state benefits members said they received.

The majority of members were in receipt of disability living allowance, income support and housing benefit. The mean score for satisfaction amongst members with their financial situation was 4.13 (on a scale of 1-7) reflecting mixed satisfaction.

Whilst 44.1% (n=135) reported a good degree of satisfaction with the amount of money they have, 30.5% (n=93) reported low satisfaction with regards to their overall financial situation, that is how well off they are and the amount they have to spend on enjoyment.

The vast majority of Beacon Members (82.8%, 221) personally cover the cost of transport to the Day Centre. On average members spend £9.59 going to and from the Day Centre however, 13.1% (n=19) of members spent between £20 and £63 per week. 12.8% (n=28) have free travel and were not out of pocket for transportation to the Day Centre.
Area of need:

- Those members out of work (particularly within the last 5 years) will need to receive training and education opportunities (e.g. interview skills training, IT training to fill in electronic forms etc) that will help them return to work and maintain existing social roles in the workplace.
- Considering the average length of time since being employed, much support will be required to ease members back into the workplace.
- More emphasis should be placed on getting members involved in volunteering or paid employment initiatives to help promote social inclusion, engage members in meaningful activity, reclaim aspects of identity lost through the experience of mental illness and give members a sense of purpose.
- Knowledge of previous employment helps understand what may have been lost through mental illness that members may wish to try and reclaim. This type of information could be routinely collected as part of member’s induction.

- For members who are in paid employment, support is needed to ensure they are paid the legal wage for their age.
- Almost one third (28.8%) of members reported receiving advice from the Citizens Advice Bureau (CAB) which was deemed beneficial. Continued financial advice from the CAB will help assure all members receive the benefits they are entitled to.
- Low levels of income have been associated with fewer opportunities to engage in joyful activities with confidants and other members of the social network, and with emotional and social loneliness (Hawkley et al. 2008). Beacon needs to be aware of those members for whom financial deprivation could lead to social isolation and loneliness.
- Almost one half (46.9%) of Beacon Members did not have access to or own a computer while more than a half (52.9%) did not have access to the internet.
- Almost one quarter of members cited having access to a computer (26.2%, 80) while a further 26.9% (n=82) owned their own computer.
- Over two thirds of members are very capable of using a computer (22.3%, 68) and the internet (22.7%, 69).
- There were no differences between sufferers of CMD and SMI in their capabilities to use computers or the internet.

<table>
<thead>
<tr>
<th>Type of State Benefit</th>
<th>Number of Members in Receipt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income support</td>
<td>154 (50.3%)</td>
</tr>
<tr>
<td>Housing benefit</td>
<td>119 (38.9%)</td>
</tr>
<tr>
<td>State pension</td>
<td>58 (19%)</td>
</tr>
<tr>
<td>Tax credits</td>
<td>14 (4.6%)</td>
</tr>
<tr>
<td>Child benefit</td>
<td>16 (5.2%)</td>
</tr>
<tr>
<td>Job seekers allowance</td>
<td>8 (2.6%)</td>
</tr>
<tr>
<td>Disability living allowance</td>
<td>242 (79.1%)</td>
</tr>
<tr>
<td>Statutory sick pay</td>
<td>22 (7.2%)</td>
</tr>
<tr>
<td>Incapacity benefit</td>
<td>35 (11.3%)</td>
</tr>
<tr>
<td>Pension credit or private pension</td>
<td>14 (4.3%)</td>
</tr>
<tr>
<td>ESA (Employment Support Agency)</td>
<td>5 (1.6%)</td>
</tr>
</tbody>
</table>

Table 9 Benefits Receipt of Beacon Members

Computer and Internet Competencies of Beacon Members

- There were no differences between sufferers of CMD and SMI in their capabilities to use computers or the internet.
On a scale of 1-7 ranging from 1, “not at all true” through to 7, “very true”, the average score for Day Service members in terms of being capable of using a computer was 3.48 and using the internet was slightly lower at 3.22. Capability of using a computer and using the internet both decreased with age.

Area of need:

- Training in IT is required for all members to feel socially included and integrated into society. This should have the focus of providing typing and internet skills to help members gain confidence in using online forms, applications, programmes etc that could be of benefit to them.

- The IT infrastructure across Beacon needs to include online evaluation and monitoring forms.

- IT literacy will also open opportunities for members to engage with online programmes such as moodgym, Beat the Blues, INSPIRE, the Recovery Context Inventory etc that will help them in their recovery journey.

- IT literacy of staff is imperative to help with future evaluation and monitoring of interventions and services. This will do much to reduce the paper workload of staff and members.

- There is potential opportunity for members highly capable in internet and computers to help staff in their training in this area which would involve users in the developing of Beacon services, a recommendation in the National Inclusion Programme (2006).

Social inclusion and the reduction of social isolation

Social inclusion in the family and the broader community and alleviation of loneliness are central issues in social wellbeing and quality of life (De Jong Gierveld & Tilburg, 2010). The renewed focus on promoting social inclusion and reducing social isolation requires that services provide opportunities for social contact and support, help retain existing social roles, relationships and social activities that are valued and should provide opportunities for mental health sufferers to run their own services (From Segregation to Inclusion, 2006).

Beacon Members were asked numerous questions in relation to leisure activities, access to transport, family and social relations, health problems for themselves and those they live with, satisfaction with living conditions, safety and legal issues, and available social support to get a picture of how or not Beacon Day Centres are promoting social inclusion.

Leisure Activities and Accessibility

Beacon Members were asked about their leisure activity in the previous fortnight. Over three quarters (75.5%, 231) of members had not been out to play or watch a sport in the previous fortnight however 96.1% reported watching television or listening to the radio, an indication of sedentary lifestyle behaviours that have been linked to comorbidities amongst the population of mental health sufferers.

Whilst the majority of members had been shopping and used a bus, train or car in the previous fortnight (20.6%, 63 and 22.2%, 68% respectively) over one fifth had not engaged with such social activities.

Social inclusion and the reduction of social isolation

Social inclusion in the family and the broader community and alleviation of loneliness are central issues in social wellbeing and quality of life (De Jong Gierveld & Tilburg, 2010). The renewed focus on promoting social inclusion and reducing social isolation requires that services provide opportunities for social contact and support, help retain existing social roles, relationships and social activities that are valued and should provide opportunities for mental health sufferers to run their own services (From Segregation to Inclusion, 2006).

Beacon Members were asked numerous questions in relation to leisure activities, access to transport, family and social relations, health problems for themselves and those they live with, satisfaction with living conditions, safety and legal issues, and available social support to get a picture of how or not Beacon Day Centres are promoting social inclusion.

Leisure Activities and Accessibility

Beacon Members were asked about their leisure activity in the previous fortnight. Over three quarters (75.5%, 231) of members had not been out to play or watch a sport in the previous fortnight however 96.1% reported watching television or listening to the radio, an indication of sedentary lifestyle behaviours that have been linked to comorbidities amongst the population of mental health sufferers.

Whilst the majority of members had been shopping and used a bus, train or car in the previous fortnight (20.6%, 63 and 22.2%, 68% respectively) over one fifth had not engaged with such social activities.

64.1% (196) of Beacon Members when asked said in the past year there had there been times when they would have liked more leisure activity but were unable to do so. The average score for satisfaction amongst members with the pleasure they get from leisure activities was 4.85 (on a scale of 1-7) indicative of members being “mostly satisfied”.

The majority of Beacon Members (56.4%, n=173) reported a good degree of satisfaction with the amount of pleasure they get from leisure activities. Over one third (36.9%, n=113) of members however reported ‘mixed’ satisfaction with regards to pleasure derived from leisure activities, with a further 6.6% (n=20) reporting low satisfaction with the amount of pleasure they get from leisure activities.

To engage with social and leisure activities requires access to where they take place. For this reason members were asked about their access to transportation.
Almost two thirds (63.3%, n=190) of members do not drive. Of these 67.6% (n=142) do have someone who can give them a lift to where they need to go. However 31% (n=65) of those who do not drive, do not have someone to give them a lift to where they need to go.

Over one third of Beacon Members (36.7%, n=110) do drive. Of those who do drive, 77.7% (n=94) do have access to a car, the remaining 22.3% (n=27) do not.

Not being able to drive negatively impacts upon members ability to be involved in leisure and social pursuits as was evidenced with 46.2% (135) reporting feeling restricted to go somewhere due to a lack of transport.

A wide variety of transportation methods are used by Beacon Members to attend the centres.

- Beacon Members most commonly drive (19.6%, 63) or walk (16.5%, 53) to the centres themselves.
- Taxi’s (16.5%, 53), getting a lift with friends, family or neighbours (14.6%, 47) or public transport (13.7%, 44) are the next most used mode of transport.
- Only a small percentage of members are reliant on community transport services (7.1%, 23), door to door services (6.5%, 21) or Beacon provided transport (2.2%, 7).
- It is encouraging that 16.5% of members live within close enough proximity to walk to the Day Centres to receive support.

- Members who used taxis as opposed to public transport cited reasons of accessibility (24.1%, 19), convenience (17.7%, 14) and mobility (11.4%, 9).
- Worryingly though was the fact that over one quarter (25.4%, 38) of these were using taxis’ because of avoidance reasons such as not liking or not knowing how to use buses (7.6%, 6), feeling safer or more comfortable (10.2%) or because of experiencing panic attacks or anxiety in crowds (7.6%, 6).

Area of need:

- Beacon Members need to become more involved in physically active leisure activities to challenge sedentary lifestyle behaviours. This should involve outreach to community based activities not simply activities within the Day Centre.

Basic leisure activities such as using public transport, going shopping and learning to drive could form part of a person-centred recovery ethos that would challenge avoidance behaviours, encourage community involvement, reduce social isolation and promote self-determination amongst members.
Religion/Spirituality – a Valued Social Activity

Much literature exists to support the positive links between religiosity and mental wellbeing. Higher levels of religious involvement are positively associated with indicators of psychological wellbeing (life satisfaction, happiness, positive affect) and less depression, suicidal thoughts and substance abuse (Moreira-Almeida, Neto & Koenig; 2006).

For this reason, and in light of Northern Ireland being a predominantly Christian region, members were asked about how religious or spiritual they were and to report the related activities they found beneficial to their wellbeing. For years the discussion of religion has been avoided in Northern Ireland in light of the civil conflict and unrest.

In a period of relative peace it was decided to explore the importance of religion or spirituality in the lives of members with the view to meeting Commission requirements of exploring cross-sector work by engaging with providers such as faith based groups (From Segregation to Inclusion, 2006).

By asking members about the role religion or spirituality plays in their lives we can assess the need to provide support that is reflective of what is valued by members to aid their recovery.

The majority of Beacon Members were of either Protestant (n=125, 41.3%) or Roman Catholic (n=134, 44.2%) denomination. 10.2% of members reported being of ‘other’ religion, whilst a further 4.0% reported having no religion. Only one person in the sample (0.3%) was of Hindu faith.

When asked if they considered themselves to be spiritual or religious, the majority (40.8%, n=122) reported being very religious or spiritual. A further 20.1% (n=60) reported being ‘somewhat’ religious with the remaining two fifths (n=117, 39.2%) of Day Service members being either ‘not at all’ or ‘a little’ religious.

41.1% (n=119) of members reported that their religious or spiritual beliefs influenced the way they lived their lives ‘quite a bit’ or ‘very much’ so. 14.3% reported that their beliefs ‘somewhat’ influenced the way they lived their lives.

41% (n=122) of members said their religious or spiritual beliefs helped them ‘Quite a lot’ or ‘very much’ in coping with their mental health problems. A further 14.8% (n=44) said their beliefs helped them cope ‘somewhat’ with their mental health problems, whilst 44.3% (n=132) felt their beliefs either did not help them cope at all or only helped them a little in coping with the mental illness.

There were no significant differences between CMD and SWI sufferers in how religious or spiritual they were.

By asking members about the role religion or spirituality plays in their lives we can assess the need to provide support that is reflective of what is valued by members to aid their recovery.
Table 10 reports the spiritual and religious activities Beacon Members found helpful. Praying or meditating (59.3%) and attending religious services (21.8%) were the religious activities members found most helpful. A significant minority reported discussing their beliefs with others (21.8%) or with religious or spiritual leaders (21.1%) as helpful whilst 29.1% found reading religious texts of benefit.

Table 10 Religious and Spiritual Activities Found Helpful by Beacon Members

<table>
<thead>
<tr>
<th>Religious or Spiritual Activity Found Helpful</th>
<th>No. Of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Praying or meditating</td>
<td>N=169 (59.3%)</td>
</tr>
<tr>
<td>Attending religious services</td>
<td>N=117 (41.1%)</td>
</tr>
<tr>
<td>Discussing beliefs with others (formally or informally)</td>
<td>N=62 (21.8%)</td>
</tr>
<tr>
<td>Discussing beliefs with religious or spiritual leaders</td>
<td>N=60 (21.1%)</td>
</tr>
<tr>
<td>Reading religious texts</td>
<td>N=83 (29.1%)</td>
</tr>
<tr>
<td>Other religious or spiritual activity</td>
<td>N=19 (6.2%)</td>
</tr>
</tbody>
</table>

Area of need:

- Findings highlight the importance of religion or spirituality in the lives of Beacon Members. In particular, the way their beliefs influence the way they live their lives and helps them cope with their mental illness.

- Religion and spirituality have been reported by Beacon Members as an important coping technique to their mental illness. Religious patients tend to use more positive than negative religious coping which involves trying to find a lesson from God in an event, doing what they can do and leaving the rest in God’s hands, seeking support from church/clergy (Moreira-Almeida et al., 2006).

- The religious and spiritual activities reported as important to members, highlight their social value to members. Religion may provide social cohesion, sense of belonging, and continuity in relationships (Moreira-Almeida et al., 2006). Public and private religious practices can help cope with anxiety, fears, frustration, anger, inferiority, despondency and isolation (Schell, 1979; Schumaker, 1992). It is therefore important to establish links with faith-based groups, and link in with community groups and individuals who can help support members from a faith perspective.

- Assessing the religiosity or spirituality of new members as well as current members will help ensure a person-centred recovery ethos that is grounded in what members deem important to them and their recovery. Staff competencies in asking questions about the importance of religion or spirituality of members must be achieved to ensure a person-centred recovery approach.

- There is also an avenue for faith based literature to be made available in the centres for members to avail of. This would help promote self-determining behaviour amongst members for whom religion or spirituality is important.

- However over one fifth 20.6% (63) reported mixed satisfaction with their family, while a further 11.4% (35) reported low satisfaction with their family relations (“couldn’t be worse”, “displeased” or “mostly dissatisfied”).

- Almost half (47.7%) of Beacon Members reported times in the past year they would like to have participated in family activities but were unable to do so.

- 19% (58) reported mixed satisfaction in relation to the amount of contact they had with family, with a further 14.8% (45) reporting low satisfaction with the amount of contact they had with family.

Family Relations

- Over half (51.6%, n=157) of Day Service members reported having daily contact with a relative.

- 33.2% (n=101) of Day Service members reported having weekly contact with a relative.

- 7.6% (n=23) reported having monthly contact with relatives.

- 1.6% (n=5) reported having contact with relatives annually and a further 3.9% (n=12) reported having contact less than annually with relatives.

- The average score for satisfaction with family relations was m=5.87 (sd=1.04) indicative that members were “mostly satisfied” or “pleased” with their family relations.

Beacon Members Accessibility to Transport

- However over one fifth 20.6% (63) reported mixed satisfaction with their family, while a further 11.4% (35) reported low satisfaction with their family relations (“couldn’t be worse”, “displeased” or “mostly dissatisfied”).

- Almost half (47.7%) of Beacon Members reported times in the past year they would like to have participated in family activities but were unable to do so.

- 19% (58) reported mixed satisfaction in relation to the amount of contact they had with family, with a further 14.8% (45) reporting low satisfaction with the amount of contact they had with family.
Health Problems of Member’s Relatives

30.43% (n=93) of Beacon Members reported living with people suffering from health problems.

Health Problems of Relatives

A further breakdown of this figure informed us that:

- 24.24% (n=24) of whom lived with parents who have health problems. The majority (n=20) had physical health complaints, n=2 had mental health problems, while one member lived with a parent who suffered from both mental and physical health problems. N=1 was not specified.

- 34.34% (n=34) reported living with a spouse or partner who had health problems. Such health problems were of a physical (n=17) and mental (n=7) nature or both (n=6). N=4 were not specified.

- 18.37% (n=18) of Day Service members indicating living with children who had health problems. This equates to n=7 physical, n=2 mental, n=1 both physical and mental.

- 18% (n=18) of members live with other family or relatives who suffer from health problems of which n=12 were cited as mental, n=3 were both being physical and mental, and one was of physical nature. n=2 were not specified.

- n=5 of Day Service members reported living alongside siblings who suffered health problems. This translates to n=2 physical, n=2 mental, n=1 both physical and mental.

Area of need:

- A sizeable percentage of members are not happy with the amount of contact they have with family, the relations they have with family or their ability to participate in family activities. This indicates a need to engage with the family networks of members. Such engagement could help mend or build upon family relations, help communicate the need members have for contact and the challenges their mental illness present to their involvement in family activities.

Satisfaction with Living Situation

Research has shown that inadequate housing and support can lead to deterioration in mental health, increase risk of suicide, put strain upon family relationships, homelessness and involvement with the criminal justice system, and lead to inappropriate hospitalisation or unnecessarily long stays in hospital (Freeman 2004, Newman 2001, Wong & Solomon 2002). In light of links to wellbeing, members were asked about their current living situations.

Table 11 Current Living Residence of Beacon Day Support Members

<table>
<thead>
<tr>
<th>Current living residence</th>
<th>No. of members</th>
<th>% of members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostel</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Housing association</td>
<td>77</td>
<td>25.4</td>
</tr>
<tr>
<td>Group home</td>
<td>5</td>
<td>1.7</td>
</tr>
<tr>
<td>Sheltered housing</td>
<td>26</td>
<td>8.6</td>
</tr>
<tr>
<td>Private house (owned)</td>
<td>101</td>
<td>33.3</td>
</tr>
<tr>
<td>Private house (rented)</td>
<td>53</td>
<td>17.5</td>
</tr>
<tr>
<td>Flat</td>
<td>20</td>
<td>6.6</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>5.6</td>
</tr>
</tbody>
</table>

The majority of members of Day Service members live in a privately owned home (n=101, 33.3%).

However a significant minority of Beacon Members reported mixed to low of satisfaction with their living situation (38.9%, n=119), the people they live with (14.5%, n=44), the prospect of staying there a long time (46.4%, n=142), the independence (20.6%, n=63), influence (25%, n=77), and privacy of their residence (15.9%, n=49).
Safety and Legal Issues

- The mean score for satisfaction amongst Day Service members with their personal safety and the safety of their neighbourhood was $m=5.10$ (sd=1.19), indicative of being “mostly satisfied”.

- The majority of Day Service members (66.6%, n=203) reported a good degree of satisfaction with their safety, however a significant minority (33.5%, n=102) reported mixed or low satisfaction with their safety.

- Only 3.9% of members had been accused of a crime in the previous year.

- The majority of members (93.5%, n=286) had not been the victim of an assault, beating, molestation or any other type of violence in the previous year. A small minority (n=19, 6.2%) had however been the victim to such violence and would need appropriate support.

- Over 10% (10.8%, n=33) of Beacon Day Service members had been unable to get police or legal help in the previous year despite wanting such.

Area of need:

- Over 10% (10.8%, n=33) of Beacon Day Service members had been unable to get police or legal help in the previous year despite wanting such.

Social Relations

The mean score for satisfaction with social relations was $m=5.00$ (sd=1.34), indicative of members being “mostly satisfied” with their social relations.

- 14.7% (n=45) reported the highest satisfaction (“couldn’t be better”) with how well they get on with other people.

- Almost one third (31%, n=95) said they were “pleased” with how well they get on with other people, while a further 25.8% (n=79) reported being “mostly satisfied” with the way they get on with other people.
The majority of Beacon Members were either "mostly satisfied" (27.8%, n=85) or "pleased" (25.8%, n=79) with the number of friends they had. A sizeable percentage (17.6%, n=54) indicated dissatisfaction with the number of friends they had with a further 15.7% (n=48) reporting having mixed satisfaction with the number of friends they have. Positively though 13.1% (n=40) indicated the highest level of satisfaction (i.e. "couldn’t be better") with the number of friends they had.

Table 12 gives a centre-by-centre breakdown of member’s satisfaction with life across the LQoLP (Lancashire Quality of Life Profile). Higher scores represent greater satisfaction with an area of life.

### Table 12: Satisfaction with Life Domains (LQoLP) – Centre by Centre Comparisons

**Lancashire Quality of Life Profile Domains**

Satisfaction was measured on a 7-point Likert scale ranging from 1 = “couldn’t be worse” to 7 = “couldn’t be better”. Higher scores reflect greater satisfaction in each life domain. Mean scores for each centre are displayed.

<table>
<thead>
<tr>
<th>Centre</th>
<th>Work</th>
<th>Leisure</th>
<th>Finance</th>
<th>Living Situation</th>
<th>Legal &amp; Safety</th>
<th>Family Relations</th>
<th>Social Relations</th>
<th>Perceived Quality of Life</th>
<th>General Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABU</td>
<td>5.56</td>
<td>5.37</td>
<td>4.95</td>
<td>5.33</td>
<td>5.77</td>
<td>6.14</td>
<td>5.16</td>
<td>5.47</td>
<td>4.25</td>
</tr>
<tr>
<td>ASU</td>
<td>6.00</td>
<td>4.69</td>
<td>4.07</td>
<td>4.57</td>
<td>4.92</td>
<td>5.56</td>
<td>4.83</td>
<td>4.95</td>
<td>4.08</td>
</tr>
<tr>
<td>BEU</td>
<td>6.59</td>
<td>4.89</td>
<td>3.89</td>
<td>5.05</td>
<td>5.21</td>
<td>5.76</td>
<td>5.24</td>
<td>5.23</td>
<td>4.44</td>
</tr>
<tr>
<td>ERU</td>
<td>5.65</td>
<td>4.73</td>
<td>3.45</td>
<td>4.84</td>
<td>4.95</td>
<td>5.53</td>
<td>4.18</td>
<td>4.76</td>
<td>4.13</td>
</tr>
<tr>
<td>ROU</td>
<td>6.48</td>
<td>4.38</td>
<td>3.50</td>
<td>4.83</td>
<td>4.93</td>
<td>5.50</td>
<td>4.93</td>
<td>4.93</td>
<td>4.05</td>
</tr>
<tr>
<td>SCU</td>
<td>5.99</td>
<td>4.60</td>
<td>3.99</td>
<td>5.27</td>
<td>4.83</td>
<td>5.77</td>
<td>4.78</td>
<td>5.03</td>
<td>3.60</td>
</tr>
<tr>
<td>WHU</td>
<td>6.83</td>
<td>4.75</td>
<td>3.79</td>
<td>4.61</td>
<td>5.08</td>
<td>5.69</td>
<td>5.00</td>
<td>5.11</td>
<td>4.08</td>
</tr>
<tr>
<td>WLU</td>
<td>6.16</td>
<td>4.58</td>
<td>4.30</td>
<td>5.01</td>
<td>5.03</td>
<td>5.18</td>
<td>5.17</td>
<td>5.20</td>
<td>4.27</td>
</tr>
<tr>
<td>BRU</td>
<td>6.25</td>
<td>5.35</td>
<td>4.40</td>
<td>5.32</td>
<td>5.31</td>
<td>6.21</td>
<td>5.46</td>
<td>5.47</td>
<td>5.02</td>
</tr>
<tr>
<td>CAR</td>
<td>5.85</td>
<td>4.91</td>
<td>4.19</td>
<td>5.66</td>
<td>5.39</td>
<td>6.24</td>
<td>5.06</td>
<td>5.33</td>
<td>4.22</td>
</tr>
<tr>
<td>CLU</td>
<td>6.51</td>
<td>4.49</td>
<td>4.21</td>
<td>4.48</td>
<td>4.66</td>
<td>5.86</td>
<td>4.42</td>
<td>4.95</td>
<td>4.05</td>
</tr>
<tr>
<td>MSU</td>
<td>6.43</td>
<td>4.67</td>
<td>4.29</td>
<td>4.88</td>
<td>4.57</td>
<td>5.90</td>
<td>5.57</td>
<td>5.19</td>
<td>4.43</td>
</tr>
<tr>
<td>PRR</td>
<td>6.92</td>
<td>5.33</td>
<td>4.25</td>
<td>5.75</td>
<td>5.21</td>
<td>6.03</td>
<td>5.67</td>
<td>5.59</td>
<td>4.38</td>
</tr>
<tr>
<td>WOU</td>
<td>6.38</td>
<td>5.33</td>
<td>4.96</td>
<td>5.68</td>
<td>5.42</td>
<td>6.53</td>
<td>5.33</td>
<td>5.69</td>
<td>4.67</td>
</tr>
</tbody>
</table>

Social and Emotional Loneliness

Social loneliness is related to broader engaging in social networks (siblings, cousins, friends, and neighbours) which is either absent or considered smaller than is desirable whereas emotional loneliness is related to situations where intimacy has not been realised in relationships (partner, best friend) (Weiss, 1973).

As far as emotional loneliness is concerned, the presence of an intimate partner is of crucial importance (Dykstra and Fokkema 2007; Stevens and Westerhof 2006; Waite and Gallagher 2000). The experience of social loneliness is primarily related to the evaluation of deficiencies in the broader network of social relationships, having no children is a major risk factor for social loneliness (Buber and Engelhardt 2008; Pinquart 2003).

Age and loneliness are correlated in Western countries. Social or emotional loneliness, especially at ages of 60 and above, is to a large extent mediated by health, financial pressures, and absence of a partner in the household (De Jong Gierveld et al. 2009).

Emotional Loneliness of Beacon Day Services Members

- 65.6% (n=197) of members were intensely or quite emotionally lonely.
- Only 13.7% (n=41) were not emotionally lonely.
- Findings indicate high levels of emotional loneliness amongst Beacon Members attending Day Support Services.

Social Loneliness of Beacon Day Services Members

- 53.4% (n=160) of members were intensely or quite socially lonely.
- Over 1 quarter (28.7%, n=86) reported not being socially lonely indicative of satisfaction with engaging in social networks.
- Overall findings indicate high levels of social loneliness amongst Beacon Members.

- Female Beacon Members reported higher social and emotional loneliness than their male counterparts, however differences were only significant across emotional loneliness.
- Beacon Members who were either divorced or separated reported the highest social and emotional loneliness.
- Over half (51.5%, 157) of members are single and never married indicating an absence of an intimate partner which may contribute to their social and emotional loneliness.
- Of the 21.3% of Beacon Members who are married, the majority (41.4%, n=29) reported that satisfaction with their marriage “couldn’t be better” and a further 22.9% (n=16) reported being “pleased” with their marriage with a mean satisfaction for marriage of 5.71 (on a Likert scale of 1-7) indicative of high satisfaction. This finding may highlight a protective aspect of being married and having an intimate partner.

- 42.4% (n=128) of Beacon Members have adult children who are not dependent upon them, who could form part of a vital support network in their care.
- The mean number of close friends and relatives Beacon Members reported having was m=6.85 (sd=8.23) with no differences between males and females. There were no differences between those with diagnoses of CMD and SMI and the number of close friends they had.
- Members with diagnoses of Common Mental Disorders (CMD) scored higher on social loneliness than members with diagnoses of Serious Mental Illness (SMI) however no differences were found between diagnosis and emotional loneliness experienced.
Over one third (36%, n=105) of Day Service members had 3 or less close friends or relatives, 3.1% (n=9) of whom reported having no close friends or relatives.

35.4% (n=103) of Beacon Members reported having more than 7 close friends or family who they would feel at ease with to talk about what was on their mind. This finding appears to contradict the level of social and emotionally loneliness reported.

There may be a stark contrast to the number of friends and close relatives reported and the quality of such relationships in the lives of members.

It is also worth noting that many members included the Day Support staff, Social Workers and CPN (Community Psychiatric Nurse) in their count of close friends and relatives which may give an indication of the closeness of relationships and also potential dependency of members upon the support network they have within mental health services.

Area of need:

- A high percentage of members reported mixed satisfaction or dissatisfaction with how well they get on with others (25.4%) and with the number of friends they have (33.3%). Basic social skills need to be implemented into the person-centred recovery approach in Beacon to build confidence in social interaction with others especially with those outside of their mental health network.

- The number of close friends, availability of emotional/informational and tangible support, and emotional loneliness were the biggest contributors to members feeling socially lonely. Interventions to reduce social loneliness should therefore seek to increase the number of close friends members have, improve the emotional/informational and tangible support available to members, and reduce emotional loneliness.

- Social loneliness, the amount emotions impact upon role-functioning, the discrimination aspect of stigma and emotional wellbeing, the extent to which ones religious/spiritual beliefs influences the way one lives one’s life, and marital status (married versus not) were the biggest contributors to feeling emotionally lonely. Interventions to reduce emotional loneliness need to focus on reducing member’s social loneliness, engaging in programmes that help members control their emotions and perceptions of stigma, building upon the extent one’s religious or spiritual beliefs influence the way one leads one’s life (for those who have religious and spiritual beliefs), and providing support for those married to maintain relationships and to build upon relationships of those not married.

- Being divorced/separated or being female is a risk factor for being both socially and emotionally lonely. Suffering from CMD is a risk factor for social loneliness. Basic demographic information such as marital status and diagnosis can help inform staff of vulnerabilities for members.
Availability of Support for Beacon Members Attending Day Support Services (MOS Social Support)

People seek and receive help as a major form of coping activity (Wilcox, B.L. and Vernberg, 1985). The availability of help or emotional support may serve to protect from some of the negative consequences of major illness or stressful situations (Sherbourne, 1988). Beacon Members were asked to inform us of the types of support that was available to them should they need it, on a scale of: 1 = none of the time, 2 = a little of the time, 3 = some of the time, 4 = most of the time and 5 = all of the time.

Emotional/Informational Support

Emotional support refers to the expression of positive affect, empathetic understanding and the encouragement of expressions of feelings. Informational support refers to the offering of advice, information, guidance or feedback (Sherbourne & Stewart, 1991).

The mean score for MOS subscale for emotional or informational support was $m=3.48$ $(sd=.97)$ indicative that this type of support was generally available to members “some” or “most of the time”. No significant differences were found between males and females and the amount of emotional or informational support available, however Beacon Members who are married report having greater emotional/informational support than those members who are divorced.

The majority of members (34.7%, $n=105$) reported having emotional or informational support available to them “most of the time” or “all of the time”, however a significant minority (10.9%, $n=33$) reported this support being available either “none of the time” or a “little of the time” (i.e. scores below 2). There were no significant differences between rural and urban Day Centre members or members with diagnoses of CMD or SMI across MOS emotional and informational support available.

Tangible support

Tangible support measures the provision of material aid or behavioural assistance available (Sherbourne & Stewart, 1991). The mean score for MOS subscale for tangible support was $m=3.41$ $(sd=1.23)$ indicative that this type of support was generally available to members “some” to “most of the time”. The majority of members (37.3%, $n=113$) reported having tangible support “most of the time” or “all of the time”. However, a sizeable percentage of members (17.8%, $n=54$) reported having tangible support “none of the time” or a “little of the time” (i.e. scores below 2).

Males reported having significantly greater availability of tangible support than females, whilst Protestant members reported higher tangible support than their Catholic counterparts.

Married or co-habitating members reported greater tangible support than single/unmarried or divorced/separated members. There were no significant differences between rural and urban Day Centre members, or members with CMD or SMI diagnoses across MOS tangible support available.

Affectionate Support

Affectionate support involves measuring the availability of expressions of love and affection when needed (Sherbourne & Stewart, 1991).

The mean score for MOS subscale for affectionate support was $m=3.3$ $(sd=1.23)$ indicative that this type of support was generally available to members “some of the time”. The majority of members (37.3%, $n=113$) reported having affectionate support available to them “most of the time” or “all of the time”. However over one fifth (20.8%, $n=63$) reported the availability of affectionate support “none of the time” or a “little of the time”.

Married member’s reported significantly higher affectionate support available to them than members who were single/unmarried or divorced/separated. There were no significant differences between rural and urban Day Centre members or members with diagnoses of CMD or SMI across MOS affectionate support availability.
Positive Social Interaction

Positive social interaction measures the availability of other persons to do fun things with (Sherbourne & Stewart, 1991). The mean score for MOS subscale for positive social interaction was $m=3.10$ ($sd=1.14$) indicative that this type of support was generally available to members some of the time. Almost one quarter ($n=71, 23.4\%$) of members reported the availability of positive social interaction “none of the time” or “a little of the time”. 30.7\% ($n=93$) however, reported having positive social interaction available to them “most of the time” or “all of the time”. There were no significant differences between rural and urban Day Centre members or between CMD and SWI sufferers across MOS positive social interaction.

Overall Support

The mean score for overall support on the MOS was $m=63.89$ ($sd=17.41$) which reflects lower overall support available to our members than was found in patient samples with a mixture of physical and psychological health concerns (Sherbourne & Stewart, 1991). $n=86$ (28.3\%) of Day Service members reported having good overall availability of support with a small number ($n=27$, 8.9\%) reporting poor overall support. There were no differences between members at rural or urban centres, or between members with diagnoses of CMD or SWI and the overall support reported. Table 13 provides a centre-by-centre comparison across the types of social support available to members.

Area of need:

- Being married is linked to having greater emotional/informational support than those members who are divorced and greater affectionate support available than members who were single/unmarried or divorced/separated. Members who are not married are more vulnerable to having less available support and may need greater assistance.

- Being male, protestant or married/co-habiting was reflective of having greater availability of tangible support. Provision of material aid or behavioural assistance could help increase tangible support for female, Catholic and single/unmarried/divorced/separated members.

Table 13 Centre–by–Centre Comparisons on Availability of Support

<table>
<thead>
<tr>
<th>Centre Codes</th>
<th>Emotional/informational support</th>
<th>Tangible support</th>
<th>Affectionate support</th>
<th>Positive social interaction</th>
<th>Overall support</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABU</td>
<td>3.96</td>
<td>3.94</td>
<td>3.42</td>
<td>3.88</td>
<td>3.86</td>
</tr>
<tr>
<td>ASU</td>
<td>3.36</td>
<td>3.31</td>
<td>3.33</td>
<td>3.30</td>
<td>3.32</td>
</tr>
<tr>
<td>BEU</td>
<td>3.46</td>
<td>3.53</td>
<td>3.33</td>
<td>2.90</td>
<td>3.19</td>
</tr>
<tr>
<td>ERU</td>
<td>2.90</td>
<td>2.72</td>
<td>2.19</td>
<td>2.90</td>
<td>3.43</td>
</tr>
<tr>
<td>ROU</td>
<td>3.43</td>
<td>2.89</td>
<td>2.98</td>
<td>2.72</td>
<td>3.59</td>
</tr>
<tr>
<td>SCU</td>
<td>3.59</td>
<td>3.81</td>
<td>3.55</td>
<td>2.84</td>
<td>3.08</td>
</tr>
<tr>
<td>WHU</td>
<td>3.03</td>
<td>3.38</td>
<td>3.69</td>
<td>2.67</td>
<td>3.13</td>
</tr>
<tr>
<td>WLU</td>
<td>3.19</td>
<td>3.17</td>
<td>3.02</td>
<td>2.77</td>
<td>3.08</td>
</tr>
<tr>
<td>BRU</td>
<td>3.77</td>
<td>3.67</td>
<td>3.75</td>
<td>3.60</td>
<td>3.70</td>
</tr>
<tr>
<td>CAR</td>
<td>3.25</td>
<td>3.17</td>
<td>3.04</td>
<td>2.90</td>
<td>3.14</td>
</tr>
<tr>
<td>CLU</td>
<td>3.25</td>
<td>3.17</td>
<td>3.17</td>
<td>3.02</td>
<td>3.17</td>
</tr>
<tr>
<td>MSU</td>
<td>3.38</td>
<td>3.54</td>
<td>3.10</td>
<td>3.19</td>
<td>3.52</td>
</tr>
<tr>
<td>PRR</td>
<td>3.86</td>
<td>3.54</td>
<td>3.97</td>
<td>3.69</td>
<td>3.72</td>
</tr>
<tr>
<td>WOU</td>
<td>3.59</td>
<td>3.44</td>
<td>3.50</td>
<td>3.47</td>
<td>3.54</td>
</tr>
</tbody>
</table>

Quality of Life, General Wellbeing and Happiness

Beacon Members were asked questions in relation to their quality of life, general wellbeing, and things that would improve quality of life. This was to understand better what service users feel are important to them leading a higher quality of life.

Members were also asked about the happiness of their life to date, their self-esteem, positive and negative affect, and their experiences of trauma. The answers to such questions give an indication to the things that may be impacting upon the quality of life for members and give direction for future provision of services.

- The mean score for perceived quality of life amongst Day Service members was $m=5.17$ (sd=.76) indicative of members being “mostly satisfied” with their quality of life.
- The mean score for general wellbeing was lower ($m=4.21$, sd=1.43) reflective of “mixed” satisfaction amongst members.
- The primary things Beacon Members cited that would improve their quality of life were improved mental and physical health (35.5%, n=179).
- 13.9% (n=70) of Day Service members did not report anything they thought would improve their quality of Life.

Area of need:
- Improved physical health emerged as a salient factor perceived by members that would improve overall quality of life. Interventions and services in the future should move towards improving both the mental and physical wellbeing of members.

When asked how happy they rated their life overall the mean score was $m=2.79$ (sd=0.97) on a scale of: 1 = “very happy” to 4 = “not happy” reflective of average happiness amongst the majority of members (36.8%, n=103). A further breakdown of this showed that:

- Only 11.8% (n=33) reported their life as having been “very happy”
- 24.3% (n=68) reported their life as having been “pretty happy”
- 27.1% (n=76) reported their life as having been “not happy”.

Day Service members were asked to mark on a ladder ranging from 1 = “worst outcomes you could have expected to have had in life” to 10 = “best outcome you could have expected to have had in life”.

The mean score was 5.71 (sd=2.29) indicative that out of a score of 100% members scored 57%. 30.3% of members (n=91) scored between 10-40%. Encouragingly, 40.7% (n=122) of members scored between 70-100% in terms of outcomes for their lives.

### Table 14 Centre-by-Centre Comparisons on Social and Emotional Loneliness

Scores range from $0 = \text{not socially or emotionally lonely}$ to $3 = \text{intensely socially or emotionally lonely}$

<table>
<thead>
<tr>
<th>Centre Codes</th>
<th>ABU</th>
<th>ASU</th>
<th>BEU</th>
<th>ERU</th>
<th>ROU</th>
<th>SCU</th>
<th>WHU</th>
<th>WLU</th>
<th>BRU</th>
<th>CAR</th>
<th>CLU</th>
<th>MSU</th>
<th>PRR</th>
<th>WOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social loneliness</td>
<td>1.15</td>
<td>1.49</td>
<td>1.99</td>
<td>2.10</td>
<td>2.00</td>
<td>1.60</td>
<td>1.42</td>
<td>1.47</td>
<td>1.17</td>
<td>2.02</td>
<td>1.67</td>
<td>2.00</td>
<td>1.93</td>
<td>1.57</td>
</tr>
<tr>
<td>Emotional loneliness</td>
<td>1.81</td>
<td>1.86</td>
<td>1.80</td>
<td>2.10</td>
<td>2.16</td>
<td>2.07</td>
<td>1.85</td>
<td>2.07</td>
<td>1.67</td>
<td>1.43</td>
<td>2.25</td>
<td>2.57</td>
<td>1.83</td>
<td>1.42</td>
</tr>
</tbody>
</table>
Self-Esteem, Positive and Negative Affect

“To esteem a thing is to prize it, to set a high mental valuation upon it; when applied to persons, esteem carries also the warmer interest of approval, cordiality, and affection” (Williams, 1979, p.309). Self-esteem is therefore the extent to which one prizes, values, approves, or likes oneself. Members were asked questions in relation to their self-esteem. Scores range from 0-30, a score of 30 indicating the highest possible score for self-esteem.

Negative affect (NA) and Positive Affect (PA) reflect dimensions of an individual’s character. High NA represents subjective distress and un-pleasurable engagement with the environment and low NA by the absence of these feelings. PA represents the extent to which an individual experiences pleasurable engagement with the environment and is depicted by emotions such as enthusiasm and alertness (Crawford and Henry, 2004).

Self-Esteem Amongst Beacon Members

- The average score for self-esteem was $\bar{m}=16.38$ (sd=2.78) which equates to being moderate.
- The majority of members (78%, n=218) reported moderate self-esteem.
- Only 3.6% (n=10) of members reported low scores on self-esteem.
- 18.3% (n=51) reported having high self-esteem.

Positive affect contains the sub-dimensions of joviality (e.g., cheerful, happy, lively); self-assurance (e.g., confident, strong, daring); and attentiveness (e.g., alert, concentrating, determined). Positive affectivity is correlated with being extraverted in personality, greater job satisfaction and marital satisfaction (Carr, 2004, p.3).

Negative affectivity is correlated with the personality trait of neuroticism and a wide range of psychological disorders (Carr, 2004, p.3). Negative affectivity is one aspect of the avoidance-oriented behavioural inhibition system, which serves to make people avoid situations that may entail danger, pain or punishment. Positive affectivity is part of the behavioural facilitation system which lends an individual towards potentially rewarding situations that yield pleasure. Positive affectivity is associated with regular physical activity; adequate sleep; regular socialising with close friends; and striving for valued goals (Carr, 2004, p6). Scores range from 0 -1 with higher scores reflecting higher affect.

Mean scores for positive affect amongst members was $\bar{m}=0.54$ (sd= 0.33) and for negative affect was $\bar{m}=0.55$ (sd= 0.35).

- 42.4% (n=130) scored below 0.4 therefore reported low pleasurable engagement with the environment, of whom 15% (n=46) reported the lowest possible score on positive affect. This figure depicts a significant percentage of members who do not experience emotions such as enthusiasm and alertness, joviality, self-assurance, and attentiveness.

- Encouragingly 37.2% (n=114) of members reported high positive affect which may be indicative that a sizeable percentage of members have a behavioural facilitation system which lends towards potentially rewarding situations that yield pleasure.

- High scores on negative affect by almost half of Beacon Members (49.6%, n=152) reflect high levels of distress and un-pleasurable engagement with the environment. Encouragingly however was the absence of distress and presence of pleasurable engagement by 34% (n=104) members who scored low on negative affect.

Area of need:

- Given the figures for low positive affect and high negative affect future interventions need to focus on reducing subjective distress and un-pleasurable engagement with the environment around them.
Stigma

People with mental illness are challenged by both public and self-stigmatising stereotypes and prejudice that result from misconceptions about mental illness (Corrigan & Watson, 2002). Such misconceptions are commonly accepted by people with mental illness which negatively impacts their self-confidence, self-esteem, relationships, and job opportunities (Rach, Angermeyer & Corrigan, 2005; Lai, Hong, & Chee, 2000). Challenging mental illness stigma is essential in helping individuals accomplish recovery-related goals (Corrigan & Wessel, 2008).

Beacon Members were asked to complete the Stigma scale (King et al’s 2007) to assess levels of perceived stigma. This measure was developed amongst a mental health service user population and was therefore able to give us a comparison of scores. King et al’s Stigma scale assessed three dimensions of stigma:

1. **Disclosure**: concerns about disclosing one’s mental illness
2. **Discrimination**: perceived hostility by others or lost opportunities because of prejudiced attitudes
3. **Positive aspects**: of the mental illness journey such as becoming more understanding or accepting as a person.

Table 15 provides a comparison of Beacon Members and those mental health service users in King et al’s (2007) sample. Beacon Members scored lower on Global stigma than those service users in King et al’s study. Results provide a baseline for Beacon Members in terms of stigma and will help shape and guide anti-stigma campaigns in the future.

Findings indicate lower stigma perceived by Beacon Members in terms of disclosing their mental illness or in terms of the negative reactions of other people (discrimination) towards them.

High scores on the positive aspects subscale reflect respondents perceiving few positive outcomes from the illness. Our sample scored higher (12.24 out of a possible 20) on this subscale than King’s sample, which would indicate they perceived fewer positive outcomes from their experience of mental illness. This dimension of the Stigma scale taps into how people accept their illness and make positive changes as a result. Findings would indicate that Beacon Members have not accepted their illness well. Table 16 provides a centre-by-centre comparison across stigma scores.

### Table 15 Perceived Stigma Across Two Mental Health Service User Populations

<table>
<thead>
<tr>
<th>Stigma Dimensions</th>
<th>Beacon Day Support Members Mean (sd)</th>
<th>King Mean (sd)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure subscale</td>
<td>22.37 (8.21)</td>
<td>24.7 (8.0)</td>
</tr>
<tr>
<td>Discrimination subscale</td>
<td>21.38 (8.58)</td>
<td>29.1 (9.5)</td>
</tr>
<tr>
<td>Positive aspects subscale</td>
<td>12.24 (2.88)</td>
<td>8.8 (2.8)</td>
</tr>
<tr>
<td>Global stigma score</td>
<td>56.51 (13.80)</td>
<td>62.6 (15.4)</td>
</tr>
</tbody>
</table>

### Table 16 Stigma Across Centres

Higher scores across disclosure, discrimination and global stigma reflect higher perceived stigma related to one’s mental illness. Higher scores on Positive aspects reflect the perception of few positive outcomes from the experience of mental illness.

<table>
<thead>
<tr>
<th>Centre Codes</th>
<th>Stigma means:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disclosure</td>
</tr>
<tr>
<td>ABU</td>
<td>21.71</td>
</tr>
<tr>
<td>ASU</td>
<td>21.89</td>
</tr>
<tr>
<td>BEU</td>
<td>20.55</td>
</tr>
<tr>
<td>ERU</td>
<td>24.84</td>
</tr>
<tr>
<td>ROU</td>
<td>23.75</td>
</tr>
<tr>
<td>SCU</td>
<td>27.65</td>
</tr>
<tr>
<td>WHU</td>
<td>24.92</td>
</tr>
<tr>
<td>WLU</td>
<td>22.20</td>
</tr>
<tr>
<td>BRU</td>
<td>19.63</td>
</tr>
<tr>
<td>CAR</td>
<td>17.53</td>
</tr>
<tr>
<td>CLU</td>
<td>23.78</td>
</tr>
<tr>
<td>MSU</td>
<td>21.43</td>
</tr>
<tr>
<td>PRG</td>
<td>22.45</td>
</tr>
<tr>
<td>WOU</td>
<td>14.42</td>
</tr>
</tbody>
</table>


### Area of needs:
- The biggest contributors to overall stigma amongst Beacon Members were satisfaction with legal and safety issues, satisfaction with living situation, age, emotional loneliness and the extent of violence experienced in your neighbourhood. Anti-stigma initiatives should therefore focus on increasing support and satisfaction with legal and safety issues, supporting members in accessing satisfactory living accommodation and reducing emotional loneliness. Staff should be aware that younger members experience higher stigma than older members so special efforts should be made to tackle stigma as early as possible.
Trauma Experiences

In a recent report compiled for the Northern Ireland Community Relations Council (CRC), it was found that amongst those with Serious Mental Illness (SMI), there are high rates of unrecognised trauma exposure (Daly, Hughes, and Leavey, 2012).

Unrecognised and undetected Post Traumatic Stress Disorder (PTSD) and trauma increases negative health outcomes such as substance abuse, co-morbidity and the re-victimisation of those affected (Subica, Claypoole, and Wylie, 2012; O’Hare, et al., 2010; Spitzer, Vogel, Barnow, Freyberger, and Grabe, 2007).

Negative health outcomes are confounded by the fact that overlapping symptoms make it difficult to differentiate between SMI and PTSD. The overall conclusion from the CRC report indicates a significant need to conduct trauma assessments and identify PTSD within service delivery to ensure appropriate interventions are used.

Beacon Members attending the Day Centres were asked to report on whether they had experience of particular traumatic events (e.g., serious accident, life-threatening illness, physical punishment/beating, unwanted sexual contact, serious injury, and witness to a serious incident).

It is important to highlight that the Brief Trauma Questionnaire (BTQ) used does not quantify the number of times each member experienced a traumatic event. For example, some members cited having unwanted sexual contact that occurred on numerous occasions over a period of time. The BTQ merely gives an indication to the types of traumatic incidents members have experienced.

Table 17 Trauma Experiences Across Centres

<table>
<thead>
<tr>
<th>Centre Codes</th>
<th>Mean Number of Traumas Experienced by Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABU</td>
<td>1.11</td>
</tr>
<tr>
<td>WLU</td>
<td>1.80</td>
</tr>
<tr>
<td>ASU</td>
<td>2.56</td>
</tr>
<tr>
<td>BRU</td>
<td>2.17</td>
</tr>
<tr>
<td>BEU</td>
<td>2.10</td>
</tr>
<tr>
<td>CAR</td>
<td>1.00</td>
</tr>
<tr>
<td>ERU</td>
<td>1.53</td>
</tr>
<tr>
<td>CLU</td>
<td>2.33</td>
</tr>
<tr>
<td>ROU</td>
<td>1.21</td>
</tr>
<tr>
<td>MSU</td>
<td>4.14</td>
</tr>
<tr>
<td>SCU</td>
<td>2.14</td>
</tr>
<tr>
<td>PRR</td>
<td>1.58</td>
</tr>
<tr>
<td>WHU</td>
<td>2.33</td>
</tr>
<tr>
<td>WOU</td>
<td>2.17</td>
</tr>
</tbody>
</table>

On average Day Service members were exposed to 1.95 (SD=1.80) types of traumatic events.

50.9% (n=156) of members reported experiencing two or more traumatic events, therefore above the average for the population sampled.

Over one third of Beacon Members (33.6%, n=102) reported experiencing three or more traumatic events.

Over one quarter (27.1%, n=83) did not report experiencing any traumatic events in their lives.

72.9% of members (n=221) were exposed to at least one traumatic event. This is higher than the 66.3% of the general population reported for N.I. (Ferry, Bolton, Bunting, Devine, McCann, and Murphy, 2008).

Almost half of all members (47.7%) reported having been physically punished, beaten, mugged or attacked. Off this number 20.6% had been beaten before the age of 18 years by a parent, caretaker or teacher.

Being a witness to someone else being seriously injured or killed or where you feared they would be (27.5%), and the experience of the violent death of a family member (23.5%) were traumas commonly experienced amongst our member population.

Almost one fifth (19.6%, n=60) of Beacon Members had experienced a serious accident in a car, at work or elsewhere.

Almost one quarter (27.1%, n=82) did not report experiencing any traumatic events in their lives.

Witnessed someone being seriously injured or killed

Close family member died violently

Seriously injured or fear of serious injury or being killed

Unwanted sexual contact

Other attack/beating/mugging

Physical punishment/beating (before 18 years old)

Life-threatening illness

A serious accident (car, work or elsewhere)
• Compared to general population statistics for Northern Ireland (Ferry et al., 2008) Day centre members had a lower lifetime exposure to the unexpected/violent death of a loved one (23.5% compared to 28.8%).

• Day Centre members were exposed to political violence in their region to a greater extent than the general population (36.5% compared to 22.0%). Beacon Members also had a higher exposure to witnessing someone else being seriously injured or killed than the general population figures (27.5% compared to 19.9%).

• Almost half (47.7%) of Beacon Members had been exposed to an attack, beating or mugging, compared to 23.4% reported in the N.I. general population (Ferry et al., 2008).

• 19.6% of Beacon Members had been exposed to a serious accident (car, work or elsewhere) compared to 14% reported for the general population.

• 10.1% of Beacon Members had been exposed to a life threatening illness in comparison to 8.8% reported for the general population.

• 16.3% of Beacon Members had been exposed to unwanted sexual contact, which when compared to the general population figures (8.5%) was again higher (Ferry et al., 2008).

Northern Ireland Specific Questions

Given the historical context of Northern Ireland, members were asked specific questions in relation to how they or their family had been affected by the “troubles”. The civil conflict has impacted the mental health of the population of Northern Ireland with prevalence of mental illness greater in Northern Ireland than in neighbouring countries (Bunting, Murphy, O’Neill and Ferry, 2011; Bamford Review, 2007; Appleby, 2005). The vast majority of Beacon Members attending Day Services were raised in Northern Ireland (91%, n=274) with an even spread across members brought up in segregated (n=9, 39%), partially integrated (n=76, 29.9%) and completely integrated (n=79, 31.1%) neighbourhoods.

• The majority of members reported no political violence in the neighbourhoods they were raised (46.4%, n=127).

• A significant percentage (36.5%, n=100) however reported “some” or “a lot” of political violence in their neighbourhood.

Beacon Members also had a higher exposure to witnessing someone else being seriously injured or killed than the general population figures (27.5% compared to 19.9%).
Members were asked to report on the extent they or close friends and family had suffered as a result of the N.I. troubles and on such related events.

The majority of members had not personally suffered as a result of the troubles (47.5%, n=131), nor had their families or friends (45.2%, n=122).

A significant percentage (35.9%, n=99) did however report having personally suffered “some” (n=45) or “a lot” (n=54) as a result of the troubles.

Similarly high percentages reported that close friends and family had suffered “some” (n=56, 20.7%) or “a lot” (n=64, 23.7%) as a result of the Northern Ireland troubles.

The majority of members and their family or friends had not experienced troubles related intimidation, residence damage or injury through cross-community violence. However a significant minority of members had been directly affected by such events.

16.7% (n=46) members had to personally move due to intimidation.

10.9% of members (n=30) have personally experienced damage to their residency as a result of a bomb.

7.7% (n=21) had suffered personal injury due to cross-community violence.

Similar experiences were had by members close family and friends, in particular 19.3% (n=53) of members had family or friends injured in cross-community violence.
Area of need:

- Trauma experiences of members highlight the need to conduct trauma assessments and identify PTSD within service delivery. Findings highlight high prevalence of political violence, experience of troubles related disruption, and a lot of suffering for members and their family as a result of the N.I. troubles. Based on need, Beacon could establish links with the Victims commission and link members into their trauma specific services.

- Findings indicate the need for trauma specific interventions. Proven interventions for PTSD include: Critical Incident Debriefing, EMDR (Eye Movement Desensitisation Reprocessing), VK (Visual Kinaesthetic) association or rewind technique, Hypnotherapy, and CBT trauma intervention. Findings also indicate a possibility for the retraining and skilling of existing staff to ensure a wide provision of interventions that would be center-based.

Day Centre specific questions

Members were asked a number of questions directly related to their expectations and experiences of the Beacon Day Centres. This was for the purposes of service delivery to assess what skills, activities, benefits and expectations members had of the services and how well current services meet their needs.

Sessions Attended at the Day Centre Per Week

The average number of sessions members attend per week is $m=3.51$ (sd=2.22). A session was classified as a half day attendance at the Day Centre.

- 16.4% (n=50) of members attend only one session per week.
- Over one quarter (27.1%, n=83) of members attend two sessions per week.
- Almost one third (29.6%, n=90) attend between 3 and 4 sessions per week (13.5%, n=41 and 16.1%, n=49 respectively).
- 26.6% (n=81) attend 5 or more sessions per week, with the maximum number of sessions attended per week being 10 (n=8 service members).
Expectations of Day Services

When asked what their expectations of the Day Centre were when they first entered the majority (n=139, 33.1%) said they had “no or low expectations” which could be reflective of not enough information being received about the Day Centres, or indeed their own state of wellbeing at the time of entry into services. A further 5.2% (n=22) reported being apprehensive about attending the Day Services.

- Over one fifth (n=90, 21.4%) expected “social interaction” through coming to the Day Services with a further 8.8% (n=37) expecting to engage in social activities.
- n=45 (10.7%) expected the services to help them “manage their mental health”

A further 10.7% (n=45) expected “help or support” through the services.

- n=26 (6.2%) expected to engage with “education, training and employability” initiatives.

Over two fifths (42.5%, n=204) of Day Service members reported recreational activities offered through the Day Centres as being important to them and their wellbeing.

New Activities

Day Service members were asked to report on the new activities they have engaged with or tried through the Day Centre they felt were important to them and their wellbeing.

- Over two fifths (42.5%, n=204) of Day Service members reported recreational activities offered through the Day Centres as being important to them and their wellbeing.
- Other activities associated with relaxation (n=48, 10%) and wellbeing promotion (n=55, 11.5%) were also reported as being important to Day Service members.
- 8.1% (n=39) of Day Service members reported none of the activities provided through the Day Centres as important to them or their wellbeing.

- 16.7% (n=80) cited the educational activities offered through the Day Centres as being important to them and their wellbeing, while 11.25% (n=54) cited the social activities offered as being important to them and their wellbeing.
New Skills
Day Service members were asked what skills they have developed through attending the Day Centres that they felt were important to them and their wellbeing.

- Recreational skills (n=119, 21.8%) developed through their attendance at Day Centres emerged as the most important skills to members wellbeing.
- Skills related to training and learning (n=106, 19.4%) were the second most frequently reported skill of importance to Day Service members.
- Skills developed to help manage physical and mental health (n=98, 17.9%) also emerged as important skills to members and their wellbeing, as were social skills.

Additional Information or Advice
Day Service members were asked about other information or advice they were able to access through the Day Centre that was personally beneficial.

- Almost one third (n=119, 30.6%) reported no information or advice accessed through the day centres as beneficial to them.
- 28.8% (n=112) reported information received from the CAB through the Day Centres as being beneficial to them.
- Mental health information accessed through the Day Centre was deemed beneficial by 12.3% (n=48) members.
- 9.8% (n=38) reported receiving information or advice related to the doctor or health as personally beneficial.
Signposting to Other Community Services Through the Day Centres

Day Service members were asked to state other services in the community the Day Centre had been able to signpost them to which they found useful.

- Over half (57.4%, n=195) reported no signposting received through the Day Centres to other existing community services.
- Signposting to other volunteering providers or volunteering programmes was most frequently reported as being of benefit (n=49, 14.4%).
- Signposting to social and recreational activities and leisure or community centres (n=34, 10%) was the second most reported beneficial service.
- Signposting to further education (6.2%, n=21), CAB (6.5%, n=22) and other mental (n=16, 4.7%) and physical health (n=3, 0.9%) services also deemed to be of benefit to members.

Day Centres Ability to Meet the Needs of Members

Beacon Members were asked to rate how well the Day Centres met their individual needs. Positively no members reported the centres as being unable to meet their needs. Members were also asked to report on how satisfied they would be with the prospect of having to return to live in a hospital environment given that Day Centres have been set up to reduce inpatient psychiatric care numbers.

- The majority (50.8%, n=155) of Day Service members reported the Day Centres as meeting most of their needs.
- Over one third (36.4%, n=111) reported that the Day Centres met all of their needs.
- n=39 (12.8%) said the Day Centres met only a few of their individual needs.

Almost half (46.9%, n=90) of Day Service members expressed very low levels of satisfaction with the prospect of returning to live in a hospital. These members felt such an outcome “couldn’t be worse”. For over one fifth (21.4%, n=41) of Day Service members this question was either unanswered or not applicable.

Only 5.8% (n=11) expressed a good degree of satisfaction with the prospect of returning to live in a hospital, reporting being “mostly satisfied”, “pleased” or “couldn’t be better”. The remaining 5.2% (n=11) reported “mixed” satisfaction with regards to returning to live in a hospital.

Ability of the Day Centre to Meet Members Needs
Personal Benefits of Attending the Beacon Day Centres

Beacon Members were asked to report how attending the Beacon Day Centre has personally benefitted them.

- Overwhelmingly from a response of 244 members, 186 (76.2%) reported attending the centre helped them manage their mental illness.
- The second most cited benefit members received from their attendance at the centres was the social interaction it provided them with (n=165, 67.6%).
- The help and support provided by the staff was the third most cited personal benefit (n=81, 33.2%).

Chapter 4 Conclusions and Recommendations

To ensure Niamh Beacon services meet the recommendations of Commissioners and remain therefore fit for purpose, priority areas are to ensure Day Services:

- Promote inclusion - enable people to lead full lives despite ongoing mental health problems.
- Focus on community participation - support people to access mainstream opportunities within their communities rather than creating segregated activities.
- Reduce social isolation - provide service users with opportunities for developing social networks with people outside the mental health system.
- Offer service users the opportunity to provide peer support and user-led sessions.
- Ensure that services are accessible to those with the highest needs.
- Maximise choice and self-determination.

- Involve users and carers - experts by experience are better placed in designing and developing services.
- Increase diversity of provision - maximise the contribution of the voluntary and private sector in the provision of services.
- Improve cross-sector working - guarantee participative, integrated working beyond the mental health and social care spectrum, including providers such as faith based groups, minority ethnic community groups, libraries, employers and employment organisations, colleges and providers of sports and leisure activities.

(National Social Inclusion Programme, 2006).
Key areas for development across Beacon:

**PHYSICAL:** Provide for physical health improvements to increase quality of life and mortality of members. Need to challenge sedentary lifestyles and focus on the existing comorbidities amongst members. Need to link with GP’s for health indicators (e.g. Body Mass Index, BP, cholesterol) to mark physiological changes as a result of interventions. Need to establish links with community physical activity programmes or groups to promote physical activity in mainstream society.

**EMOTIONAL:** Need to provide talking therapies and interventions to members. Use of free online programmes/literature should be promoted for recovery. Need to provide signposting to specific psychological services (e.g. Addictions, trauma) and valued social activities (i.e. religion and spirituality for members) that positively impact emotional wellbeing.

**SOCIAL:** Need to implement basic social skills into support plans (e.g. conversational skills, volunteering programmes and initiatives) that positively impact emotional wellbeing.

Acknowledging existing skills base and strengths and building upon what has been lost through the experience of mental illness.

- Back to work schemes (IT training, interview skills, volunteering programmes and initiatives).
- Targeting young people, those out of work within last 5 years.

**Staff training:** In IT, collaboration with expertise beyond the Mental Health field, interventions and psychotherapies to build professional capacity of Day Centres to meet client need.

- To increase staff competencies in assessing need of all new members.
- Provide training, learning and employment initiatives that promote social inclusion and community integration of members.

Findings highlight the importance of providing a three stranded approach to overall support and care that encompasses not only emotional wellbeing, but also the physical and social health needs of Beacon Members. This will provide a more holistic approach to wellbeing that will help promote greater recovery. Acknowledging sensitive experiences of the troubles and traumatic experiences of members and signposting to specific services or therapies should serve to help explore and understand the emotional state of members and how best they can move on from such experiences.

By also appreciating the religiosity and spirituality of Beacon Members an additional coping technique can be explored and provided for. The training, learning and employability needs of members serve to increase self-esteem, the maintenance of social roles, social inclusion and sense of purpose, community integration and skills based learning that will open job and social opportunities for Beacon Members who live with severe and enduring mental illness.

**Training, learning, employment:**

Widening of social support networks for members outside of their mental health care team to build upon amount and quality of social engagement with non-mental health populations.

**Family based work:** Family based therapies, carers support, with the focus of improving amount and quality of contact with members, availability of support and reducing barriers for members in engaging with family activities.

- Build upon social skills of members to help them establish meaningful relationships, articulate their mental health experience to be able to challenge stigma of self and society, to reduce disengagement from the environment.
- Provide support to those members living with other people who have mental and physical health problems.
- Provide assistance to enhance safe living conditions and legal support.

By developing employment and volunteering opportunities for members, we serve to decrease the stigma associated with mental illness and perceptions of incapability to work or volunteer. This also serves to decrease self-stigma amongst our Beacon Member population and instil confidence in their ability to move beyond their mental illness.

The social needs of members are vast and range from the ability to engage in everyday social tasks such as conversations, using public transport and other public services, to the need for family based therapies to provide a support system that helps both the carer and the service user. Basic social skills are needed especially to help members formulate meaningful relationships outside of their mental-health support system. The focus should be upon building confidence in speaking about their mental illness, to help challenge stigma and build upon the quality of relationships held by members.

Presentations of the findings were conducted to Beacon Members, Service managers and Day Centre managers. Interactive workshops were then carried out with the managers groups to assess what staff themselves felt were priority areas for the future.

The findings of these are presented in Appendices i and ii and serve to provide guidance on how the findings from the Day Services Review can be implemented centrally and at scheme level.
Immediate Actions (Centrally): Collated From Service Managers Workshop

The feedback was collated and is presented below. The numbers in brackets 1-4 reflect the feedback given from each of the four groups of service team managers.

A  What immediate actions need to be made centrally to help implement the findings?

B  What actions are needed to be taken at scheme level?

Appendix I: Service Managers Interactive Workshop Feedback

Services managers were separated into 4 groups and asked to discuss what they felt were the priority areas for Day Support Services based on the findings of the Day Services Review (DSR) in terms of:

Recovery Focus:

The unanimous view was that as an organisation recovery as the main focus and outcome of service provision needs to be highlighted. An operational definition of recovery is required to ensure consistency of communication across the organisation.

It was acknowledged that this will be a challenge in terms of changing communication for existing members whilst trying to promote a recovery ethos amongst new members. There will also be a need to develop appropriate recovery focused materials and tools (e.g. literature and data collection processes) that will support relationships between staff and members.

The use of INSPIRE and QPR as data collection tools have been discussed in terms of collecting information on members that is recovery focused. Prior to use with members, staff will require adequate training and briefing to ensure they are comfortable using it with members.

Such measures will ensure a recovery focus and ethos that will guide and shape individual support plans with the added benefit of being able to track changes in wellbeing for members.

Training:

It was felt in light of the DSR findings there is a need to clarify and align current training and recreational course provisions with the needs of centre members.

In particular the need to tackle the emotional needs of members as well as the overall physical health concerns that are present. To help facilitate this as an organisation the development of standards across schemes is required that also acknowledges the inherent differences of each centre.

Based on the emotional, psychological and physiological needs of members, Service Members felt there is a need to review current staff training so that it provides highly skilled staff to meet the needs of their members.

For example based on the emotional needs of members the training of one member of staff per centre in emotional therapies such as CBT could be explored. Based on physical health needs there could be an avenue for a staff member of each centre to be trained in motivational techniques and physical activities to ensure the physical health needs of members are being met.

Specific targeted training would ensure capacity of centres to deliver services onsite that would promote recovery. It could also reduce the amount of time members of staff are currently out of centres to attend generic training thus providing more face-to-face contact for members.

Other training is required in overall staff competencies. These include:

• Asking questions in terms of religion and spirituality as part of member support plans;

• Ability to collect information on IT systems, and overall knowledge of what to collect to ensure evidence based practice and monitoring.

Recovery Focus:

- Highlight recovery as focus and main outcome (1)
- Communicate being recovery focused (2)
- Develop appropriate and relevant recovery focused materials and tools to support relationships between staff and members which support an overall core recovery message (4)

Training:

- Clarify and align training and recreational course provision with mental need and recovery focus (4)
- Review of training to support what we do or need to do in Day Support e.g building competency amongst staff to ask questions of religion/spirituality (1)
- Develop standards across schemes whilst acknowledging centre differences based on DSR findings (3)
- Identify and develop skills of staff in presenting research findings and monitor the development of action plans across centres to ensure best practice and evidence based practice is being collated (3)
- Training and learning: need for staff re-training and focus on members training initiatives (2)
- Training: need for staff retraining and focus on members training initiatives (4)
- Review existing programmes of activities: need for physical health resources (2)
- Emotional wellbeing programmes: need to engage with effective tools, programmes and interventions to address emotional needs of members.

Develop resources:

- For work on internalised stigma, and mental and physical wellbeing (4)
- Physical health issues of members need addressed through risk management and pain, through support plans, to be included in policy and procedures and new documentation needed to support changes (1)
- Physical health concerns and seeing how we can link in with existing services e.g. linking in with PHA (Public Health Agency) and smoking cessation programmes (3)
- Need to identify and develop specific wellbeing programmes across centres and have staff trained to deliver such especially with the view to management of specific mental health conditions (3)
- Develop capacity across centres for young members and ethnic minorities (2)
- Review existing programmes of activities: need for physical health resources (2)
- Emotional wellbeing programmes: need to engage with effective tools, programmes and interventions to address emotional needs of members.

External use of findings:

- Use DSR findings to identify and attract adequate funding (4)
- Share findings with external groups: trusts, funders, conferences, use for marketing of services etc (1)
- Establish priorities and action plan to focus on easy wins from findings (3)
Development of Resources:

Service managers felt the physical health issues of members need to be addressed through the inclusion of new documentation that would record risk management and pain. There was also a desire to link in with existing services such as the PHA to draw in funding and signpost members into existing programmes that would be cost effective.

Such programmes include the current PHA smoking cessation initiative. There is a current drive to tackle the obesity problem in Northern Ireland so using the findings of the DSR should position Beacon to apply for money for interventions of a physical nature to reduce co-morbidities. Given the inherent barriers to physical activity for those suffering from mental illness, there may be added resources and training needed that will help manage specific mental health conditions and motivate particular groups of members.

It was acknowledged that a more active philosophy should be adopted across schemes to ensure members are physically active. More resources in terms of equipment and time may be needed to endorse this.

Given the emotional vulnerability of members that emerged from the DSR findings, there is a need to develop and engage with emotional wellbeing programmes, interventions and tools.

This would allow the effective assessment of emotional need of members, the tracking of personal and organisational progress, and the provision of a forum where members can talk about and work through their emotional wellbeing needs. An overall need was highlighted to engage more with young members to ensure their needs (educational, training, emotional, physical and psychological) are met in an engaging manner that ensures person-centred recovery.

External Usage of Findings:

It was felt amongst Service managers that the DSR findings could be effectively used to identify and attract funding that is supported by evidence-based need.

It was also felt that the DSR itself was evidence of good practice for the organisation.

There was also a strong desire to share the findings with trusts, commissioners, for marketing of services, other potential funders and at academic and health focused conferences.

Overall the managers felt a need to establish priority areas and action plans to focus on changes that could be made quickly and effectively.

Immediate Actions (Scheme Level): Collated From Service Managers Workshop

- Each centre to get to know the findings as they apply to their centre members (1)
- Active engagement with and participation of members in identifying solutions in terms of being recovery focused and identifying training needs (1)
- Scheme action plans to be agreed with members (2)
- Baseline findings to be fed into GOS system and used to track improvements of members quality of life (2)
- Sharing of DSR findings with other local stakeholders (1)
- Use findings for service development (Compton-Innovation) (2)
- Local links to be renewed and developed to strengthen signposting of members to services (2)
- Establish local need and influences over services offered and use findings to bolster tenders (2)
- Identify physical health programmes and links locally that members can be linked into (4)
- Review current provision of life skills and activities offered and compare to the needs assessment findings to establish a focused approach to service delivery (2)
- Evaluate training and service provision that can be delivered by staff in centres. Needed to build competencies in religion and spirituality, recovery ethos (2), dealing with family/carer relationships (3), tackling of internalised stigma and external stigma perceived from families and communities (4)
- Identify physical health needs of members and the relevant support programmes that help e.g. relaxation, smoking cessation, diet/diabetes etc.
- Develop a resource library for members (2)
- It was acknowledged that a more active philosophy should be adopted across schemes to ensure members are physically active.

Understanding DSR findings

External use of findings for service development

Internal use of findings for service development

• Each centre to get to know the findings as they apply to their centre members (1)
• Active engagement with and participation of members in identifying solutions in terms of being recovery focused and identifying training needs (1)
• Scheme action plans to be agreed with members (2)
• Baseline findings to be fed into GOS system and used to track improvements of members quality of life (2)
• Sharing of DSR findings with other local stakeholders (1)
• Use findings for service development (Compton-Innovation) (2)
• Local links to be renewed and developed to strengthen signposting of members to services (2)
• Establish local need and influences over services offered and use findings to bolster tenders (2)
• Identify physical health programmes and links locally that members can be linked into (4)
• Review current provision of life skills and activities offered and compare to the needs assessment findings to establish a focused approach to service delivery (2)
• Evaluate training and service provision that can be delivered by staff in centres. Needed to build competencies in religion and spirituality, recovery ethos (2), dealing with family/carer relationships (3), tackling of internalised stigma and external stigma perceived from families and communities (4)
• Identify physical health needs of members and the relevant support programmes that help e.g. relaxation, smoking cessation, diet/diabetes etc.
• Develop a resource library for members (2)
Understanding of DSR Findings:

There was an overwhelming consensus that each centre should take the time to become familiar with the DSR findings for both internal and external purposes. Internally it was felt necessary that staff engage with members in sharing the findings and working towards scheme-based action plans that feed into the Niamh strategy. This process should help in the communication of being recovery-focused by displaying a desire to engage with members to ensure services meet their needs. This will also serve to strengthen member involvement and participation in the provision of services across Beacon.

It was felt that the DSR findings need to be fed into the new GOS IT system as baseline results that can then be used to track improvements of members’ quality of life overtime and for continued development of evidence-based practice across the organisation. This will then serve as the platform for sharing findings with other stakeholders.

Use of Findings for External Service Development:

Service managers felt the DSR findings could be used by centre staff to renew, develop and strengthen local links to services and organisations that would aid integration of members into the wider community and thus help tackle current levels of social isolation.

Signposting to existing services and organisations such as trauma or addiction services will ensure person-centred recovery that promotes community involvement. The DSR findings have also helped identify the need for physical health programmes many of which staff can source locally and link members into. The findings can also be used to allow innovation and creativity across schemes in meeting the specific needs of their members and also for information sharing of good practice across schemes.

In particular, the centre-specific findings have established local need and can be used to influence and bolster current service provision and also tenders for new services that are required by Beacon. Tenders for locally sourced funding will be strengthened by evidence-based findings.

Use of Findings for Internal Service Development:

It was deemed necessary to review the current provision of activities that centres currently offer and compare these to the DSR findings to establish their relevancy and to help plan for future provision that is based on the needs of members. Service managers highlighted the need to address the physical health needs of members by providing relevant, targeted and focused support programmes that would challenge sedentary lifestyles and help combat co-morbidities associated with early mortality.

A need was also highlighted in terms of developing a resource library for members’ self-help through for example literature, books, videos, online psychological programmes that help with emotional wellbeing etc.

It was also deemed necessary for centre staff and managers to evaluate current training initiatives and service provision provided to members. Services need to provide opportunities for skilling, training and education of members to help them reintegrate into the community and secure either voluntary or paid opportunities for work.

Given the DSR findings it is also necessary that staff are trained to competently assess what recovery is for each individual member (including asking about religion and spirituality), are able to help tackle stigma members perceive and work with family members if necessary to an individual’s recovery.

Appendix ii: Day Centre Managers Interactive Workshop Feedback

Day Centre managers were separated into 2 groups and asked to discuss what they feel are the priority areas for Day Support Services based on the findings of the Day Services Review (DSR) in terms of:

A What immediate actions need to be made centrally to help implement the findings?

B What actions are needed to be taken at scheme level?

Immediate Actions (Centrally): Collated From Day Centre Managers Workshop
Investment in Resources:

There was consensus amongst all Day Centre managers that the key priority for developing services was reliant upon investments in resources on the ground. Managers highlighted the challenges in meeting member's needs due to current restrictions upon member's sessions and staff capacity.

In terms of staff abilities and the skills base of staff, managers felt staff training was essential to providing better quality services for members. With this in mind managers felt centres would benefit from at least one staff member being fully trained in CBT (Cognitive Behavioural Therapy) to undertake group or one-to-one work with members. This would be in contrast to the current training where all staff receive introductory training in CBT.

The cost of specific training to a smaller pool of staff could be offset with savings of time for all staff to attend all training, which would also help staff capacity issues. Given the high incidence of traumatic experiences of members this therapy as a resource within each centre could be used to promote recovery. Trauma-specific CBT was employed post Omagh bomb with victims and was reported to have had beneficial outcomes.

Managers cited the need for more staff on the ground to help provide more face-to-face contact with members. There was an acknowledgement that current training schedules result in staff being away from the centres frequently. This has a negative impact upon the availability of staff for members needs. Again specific and focused training would remedy much of staff absence from centres as well as providing continual professional development (CPD) opportunities for staff that would enhance the skills base of each centre and therefore the quality of services provided.

Caution was aired in terms of ensuring any training was in keeping with the overall services Beacon is paid to provide members. Not all members of staff need to be therapists however with Live and Learn coming to a close there is a need for staff to provide continuation of services.

Centre managers highlighted training needs in terms of staff being able to both deliver courses and carry out assessments (OCN assessors). Training therefore might take many forms for e.g. flower arranging, arts and crafts, meditation and relaxation, pottery. Centre managers also felt there was need for more support with funding applications to ensure continuation of services.

Recovery Focus:

Centre managers felt there was a need for clear direction for staff on “Recovery” tools and resources for this. This view is in line with Service Team managers call for an operational definition of recovery to be used across Beacon.

Similarly Day Centre managers highlighted a need to be sensitive towards members in the terminology used when communicating this new ethos with a need to dispel fears of members in relation to their benefits.

There is a need to realise that current members have been part of a very different system compared to that which will be introduced in line with Niamh’s recovery ethos. This process needs managed carefully to create positive change amongst staff and members.

With changes imminent in terms of the provision for community care, managers felt they need time allocated specifically to network for local community groups, to build links and create partnership opportunities.

Centre managers also highlighted the need for centre specific action plans to be drawn up in consensus with their respective Services Team managers to allow creative freedom in planning services to meet their own member’s needs, many of which were highlighted in the findings of the DSR.

Across Group Sharing:

Day Centre managers felt there was an opportunity for across group sharing given the high level of skill across the entire Niamh group. In particular there was a call for more joint working with Carecall, the counselling arm of the group, for members to have greater opportunity to avail of talking therapies. Day Centre managers also felt there were unexplored opportunities for sharing of staff and training across the organisation to be cost effective and to provide better quality and range of services.
Immediate Actions (Scheme Level): Collated From Day Centre Managers Workshop

Individual Centres

- Each centre to get to know the findings of the DSR as they apply to their centre members.
- Each scheme needs to review their current services alongside existing members, to identify areas for development.
- Each scheme needs to get programmes accredited.
- Each scheme according to their individual needs need to make action plans.

Across Schemes

- Joint inter-scheme working and sharing of information.

Understanding and Application of DSR Findings:

Day Centre managers were in agreement that each centre should take the time to become familiar with the DSR findings, in particular how they apply to their own particular setting. Managers felt it necessary to review their current services alongside existing members, to identify areas for development and to ensure action plans were in keeping with the DSR findings and the specific needs of their centre members.

In light of continuation of services, centre managers felt it was important for each scheme to get the programmes they deliver accredited. The involvement and copartnership between staff and members in the review of services will help dispel fears of change expressed by members and strengthen member involvement and participation in line with the Niamh strategy.

Inter-scheme Sharing

There was an acknowledgement amongst managers that much great work and innovation in terms of recovery is currently ongoing across centres however there is little room or time for joint work and sharing of information and initiatives that work well.

Managers therefore felt that the sharing of resources, information, staff skills and innovation across centres was mutually beneficial. This could be economically viable in bringing centre members together for social and recreational pursuits and courses, as well as pushing the social boundaries of members to potentially develop friendships with other members. Given the high levels of social and emotional loneliness reported by members, any initiative that could generate social interaction and inter-sharing would help towards recovery.


Catty, J. S., Burns, T., Comas, A., & Paole, Z. (2007). Day Centres for severe mental illness. Cochrane Database of Systematic Reviews, (1)


Ferry, F., Bolton, D., Bunting, B., Devine, B., McCann, S., and Murphy, S. (2008). Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual. The Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster. NICTT THCNI.


Marshall, M., National Coordinating Centre for Health Technology Assessment., & NHS R & D HTA Programme [Great Britain]. (2001). Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation ; (3) day hospital versus outpatient care. Alton: Care Research on behalf of the NICE-HTA.


Ferry, F., Bolton, D., Bunting, B., Devine, B., McCann, S., and Murphy, S. (2008). Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual. The Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster. NICTT THCNI.


Thanks to all the Beacon Members attending our Day Services who completed the interview questionnaires. We greatly appreciate your input and could not complete this work or indeed improve our services without your feedback and assistance.