Impact of Embedding Physical Activity into Peer Support Groups

Final Report October 2021

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Peer Researchers

16 Peer Researchers with lived experience of being severely affected by mental illness

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Project introduction and context

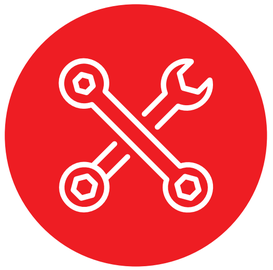
Overview of project

Rethink Mental Illness was awarded funding by Sport England to address some of the barriers which prevent people severely affected by mental illness from engaging in physical activity by embedding activities into peer support groups and local services. The aim was to support currently inactive people to start doing at least 30 minutes a week of physical activity. That could be split into 10-minute chunks of activity if that was more suitable based on individual needs. During the 3-year intervention the aim was to engage and support 46 groups to start facilitating physical activity: 6 in Year 1 (2018-19), 20 in Year 2 (2019-20), and a further 20 in Year 3 (2020-21).

The project comprised of three strands:

Steering group

A collective of experts from the mental health, physical activity, disability, and research sectors as well as people with lived experience. Membership included Rethink Mental Illness, Sport England, Richmond Group of Charities, Activity Alliance, Mind, Nottingham Trent University, and Collaboration for Leadership in Applied Health Research and Care (CLARHC) South London, and three people with lived experience of mental illness.



Co-produced toolkit

In partnership with the project steering group, Rethink Mental Illness co-produced a toolkit. This resource was aimed at peer support group coordinators and members, mental health services and anyone supporting people severely affected by mental illness who want to be more active. It was designed to be a ‘first stop shop’, a first reference point, to help on the journey to support people severely affected by mental illness to be more physically active. The toolkit was designed to be user friendly, easy to understand and provide all necessary information and guidance on how to start facilitating physical activity opportunities to benefit people’s health and wellbeing.

Evaluation

Nottingham Trent University with Newman University were commissioned to assess the impact of the project against five key outcomes – **physical wellbeing**, **mental wellbeing**, **social development**, **individual development**, and **economic development**. The outcome of the evaluation will help Rethink Mental Illness, and the wider health and physical activity sector, better understand the impact being active can have on people severely affected by mental illness.

Project introduction and context

Using the toolkit as well as personalised guidance, peer support groups and services were supported to start facilitating physical activity opportunities. The nature of activities were based on what group members and service users wanted. The level of support provided was based on need – a combination of training, equipment, signposting and advice.

Aims of evaluation

A particular interest was to investigate the impact of peer support and social interaction on physical activity behaviours for individuals severely affected by mental illness. Additionally, Rethink Mental Illness wanted to understand if there were benefits of engaging in physical activity for those severely affected by mental illness.

More broadly, there was interest in examining the impact of the peer support model on individuals' physical and mental well-being, individual, social, community and economic development, and their health. Finally, the evaluation was interested in understanding the processes which facilitated or hindered the delivery of the project.

Evaluation Methods

The evaluation adopted a mixed methodology approach. Participant questionnaires were collected at baseline, 3, 6 and 12 months wherever possible.

Physical Wellbeing	
Outcomes	1. Increased physical activity 2. Improved physical health
Tools / methods used to measure	**Questionnaire** • Sport England Short Active Lives • Behavioural Regulation for Exercise questionnaire – short version • Health status measured on a 1-100 scale, with higher scores representing a better state of health. **Focus group/individual interviews** • Specifically for reporting on changes to physical wellbeing, motivation for exercise and health

Mental Wellbeing	
Outcomes	1. Improved mental wellbeing 2. Improved resilience
Tools / methods used to measure	**Questionnaire** • Warwick Edinburgh Mental Wellbeing Scale • Conor Davidson Resilience Scale **Focus group/individual interviews**

Individual Development	
Outcomes	1. Improved confidence to approach new activities
Tools / methods used to measure	**Questionnaire** • Bespoke single line measures; • “How would you rate your quality of life” • “To what extent do you agree with the statement ‘I can achieve most of the goals I set myself’?” **Focus group/individual interviews**

Project introduction and context

Social and Community Development	
Outcomes	1. Improved confidence to approach new social activities
Tools / methods used to measure	**Questionnaire** • Bespoke single line measures in relation to; • Opportunity to be active, confidence in engaging in new activities and confidence in engaging in new social activities **Focus group/individual interviews**

Focus groups and interviews

The aim of the individual and focus group interviews was to explore participants' experiences of the project. These interviews were conducted with;

- peer support group members (3- and 12-month time points)
- peer support group leads who were responsible for coordinating the group and in some instances delivering the physical activity (3- and 12-month time points)
- Group Development Officers (GDOs) regional staff who support the peer support groups, and who were heavily involved in the recruitment of groups to take part in the physical activity project (end of project)
- Project Managers of the physical activity project (end of project)

Peer researchers

The involvement of **individuals with lived experience of being severely affected by mental illness** was a key aspect of our evaluation and aligns with the values of Rethink Mental Illness. Peer researchers were recruited through Rethink Mental Illness' existing networks and provided with **training** in the evaluation methods. This consisted of two face-to-face workshops on;

- the purpose of the evaluation
- ethical research practice
- facilitating data collection
- data analysis

The peer researchers contributed in several ways to the evaluation;

- visiting groups to collect questionnaire data
- conduct focus groups
- analysing and interpreting the data presented in this report

Peer researchers were **paid** for their contributions.

Impact of COVID-19

The COVID-19 pandemic had a significant impact on the delivery and evaluation of this project.

Delivery

The pandemic and resulting lockdowns resulted in groups not being able to meet in person. While some groups were able to continue virtually using online meetings, this was not possible for all groups.

Evaluation

Pandemic restrictions meant that it was not possible to visit groups in person. Whilst efforts were taken to continue with data collection through hosting the questionnaires online, it proved difficult to facilitate participation through these means.

Outcome

The final evaluation differed in approach from the original plans in terms of the **data** collected and the **time** that data was collected.

We were unable to collect any 12-month data from any groups, and there was little data collection from Year 3 groups due to the timing of these groups starting (i.e., around the beginning of the pandemic).

Nevertheless, we are confident that our work provides a thorough and robust evaluation of the project as it was delivered, and that the findings will be valuable for organisations looking to promote physical activity to individuals severely affected by mental illness.

2 Findings

Research Summary

This report presents data from;

- 126 participants who completed a baseline questionnaire
- 40 participants at the 3-month follow-up point
- 12 participants at the 6-month follow-up point
- 9 participants completed questionnaires at all time points

Additionally, data is presented from 26 interviews;

- five focus group interviews with peer support group members
- 16 interviews and two focus groups with group leads
- one focus group with GDOs
- interviews with the two project managers

Challenges

- Access to participants and in particular group members.
- Questionnaire data collection was completed in person, to facilitate rapport and for the researchers to be on hand to answer any questions. This appeared to be a worthwhile strategy, as questionnaire completion when groups were visited was largely successful. However, it did also present some challenges, in that group leads did not always know who would attend individual sessions.
- Due to this being a national project it was not realistic to visit every group on multiple occasions for a single time point. As a result, it was not possible to capture data from all participants at each time point.

This issue was exacerbated during the COVID-19 pandemic. Group leads were the point of contact in relation to access to group members, and when groups were not meeting it became difficult to contact individual participants to capture their experience. Various methods were attempted;

- hosting questionnaires online
- asking group leads to pass on information
- requests for interviews to their groups

However, the result is that this report does not contain as much data from individual group members as we would have preferred. Nevertheless, we are confident that the findings presented are **robust**, **important** and will be **beneficial** for the design and implementation of future projects.

Demographic data

Demographic information (Figure 1) was collected in the questionnaire and includes information related to participant age, gender, and ethnicity. Overall, group members who completed questionnaires at baseline included more females (54%) than males (44%; 11% did not state), were predominantly of white ethnicity (62%). There was a relatively even spread of ages within the groups, with 39% of members being in 40-59 years age category. Thirty-nine group members (28%) reported that they offered regular support to someone with long-standing health conditions, impairments or illnesses that limit normal activities.

Figure 1. Age, gender, and ethnicity characteristics of 126 participants who completed baseline data collection.

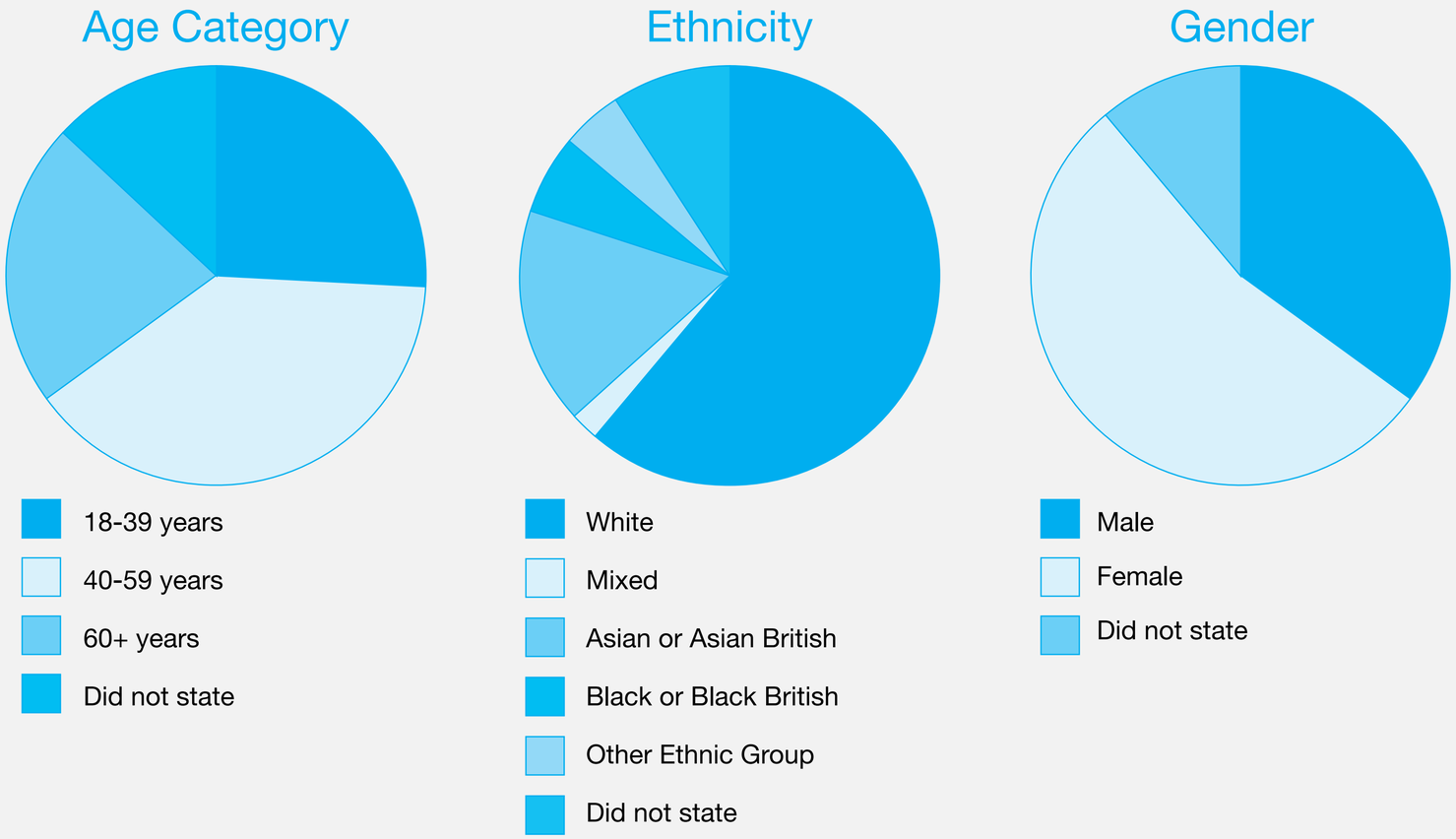
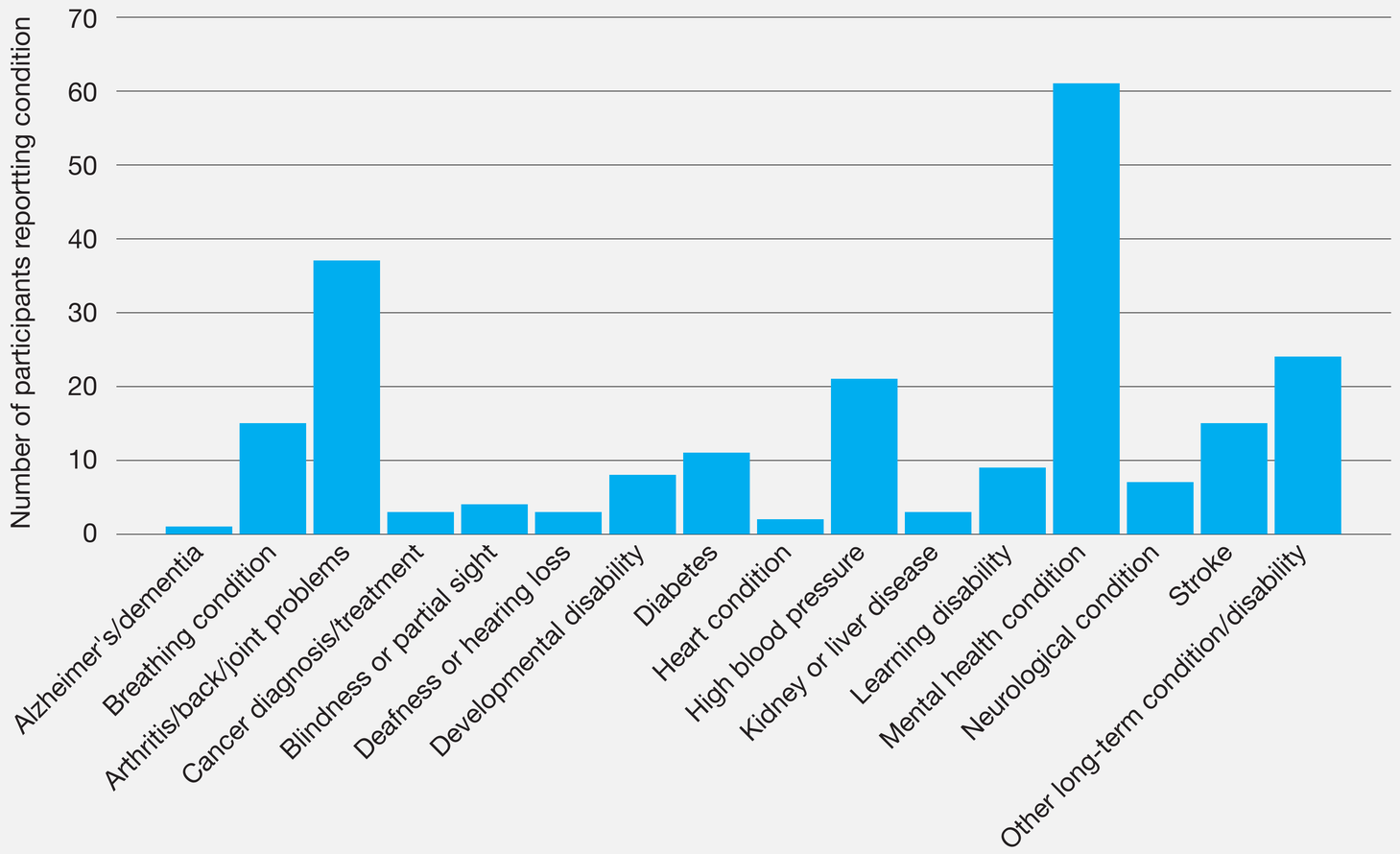


Figure 2. Long-term health conditions reported by group members at baseline.



Group members reported a range of long-term health conditions (Figure 2). Within this, 48% of participants reported they had a mental health condition. This included group members reporting conditions such as depression, anxiety, sadness, post-traumatic stress disorder, bipolar disorder, obsessive compulsive disorder, schizophrenia, social anxiety disorder, personality disorders, psychosis and schizoaffective disorder.

*Other participants either didn't disclose or are a carer for someone living with mental illness.

Impact of Physical Activity Peer Support Groups on Participants

Quantitative data

Overall, embedding physical activity into peer support groups was beneficial for group members. This is supported by data from both the questionnaires and interviews. In relation to the questionnaire data, we are primarily interested in the changes from baseline to 3-months as this is the period suggested to have the most health benefits (going from inactive to some activity) as well as the interview data.

Physical activity (Figure 3) and autonomous motivation (Figure 4) to be active – being motivated for reasons of enjoyment or personal importance – both increased from baseline to the 3-month time point.

Figure 3. Changes in minutes of walking, cycling, sport/other activities and total physical activity from baseline to 3-month timepoint. Data based on 27 participants who completed both time points.

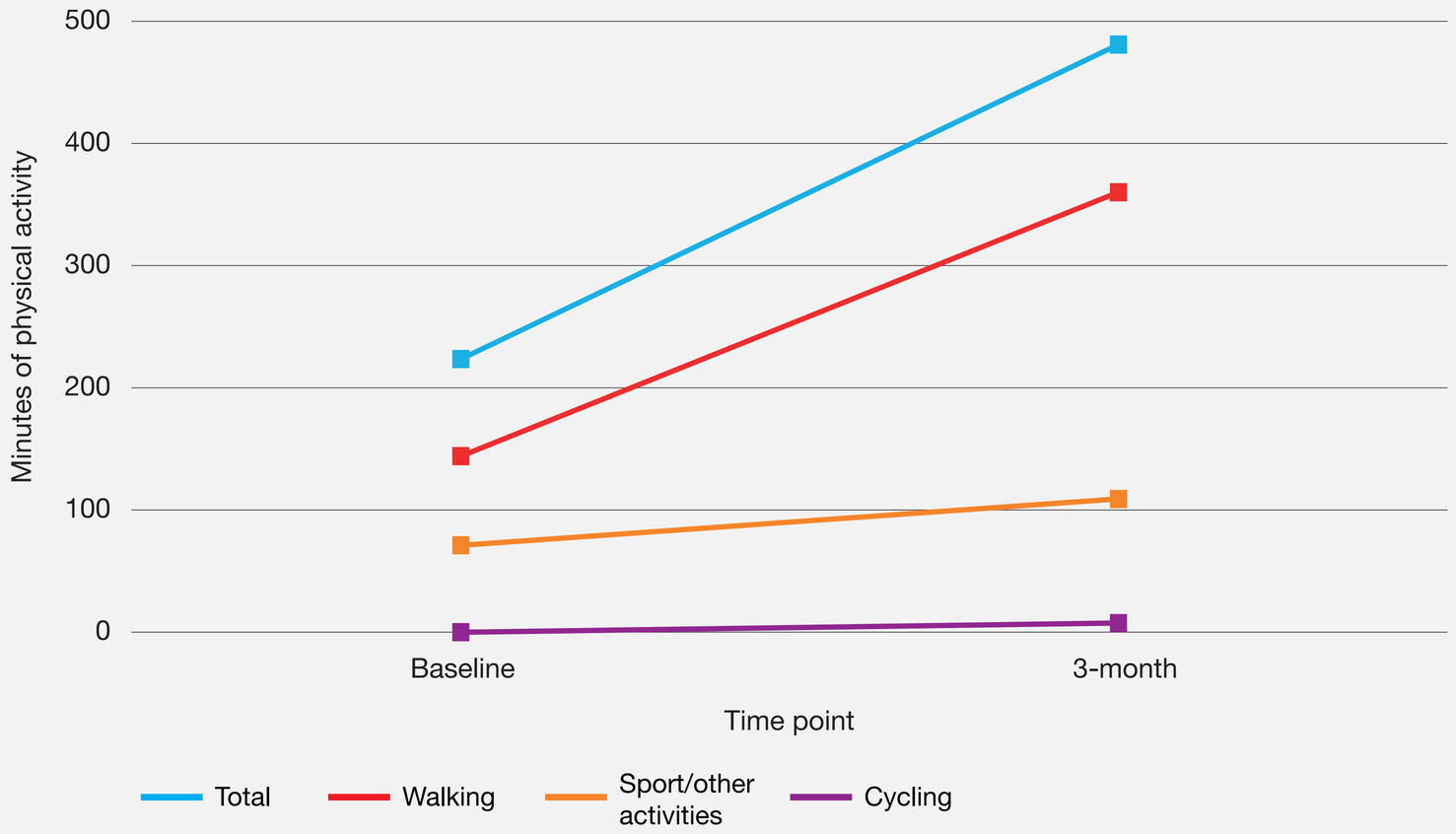
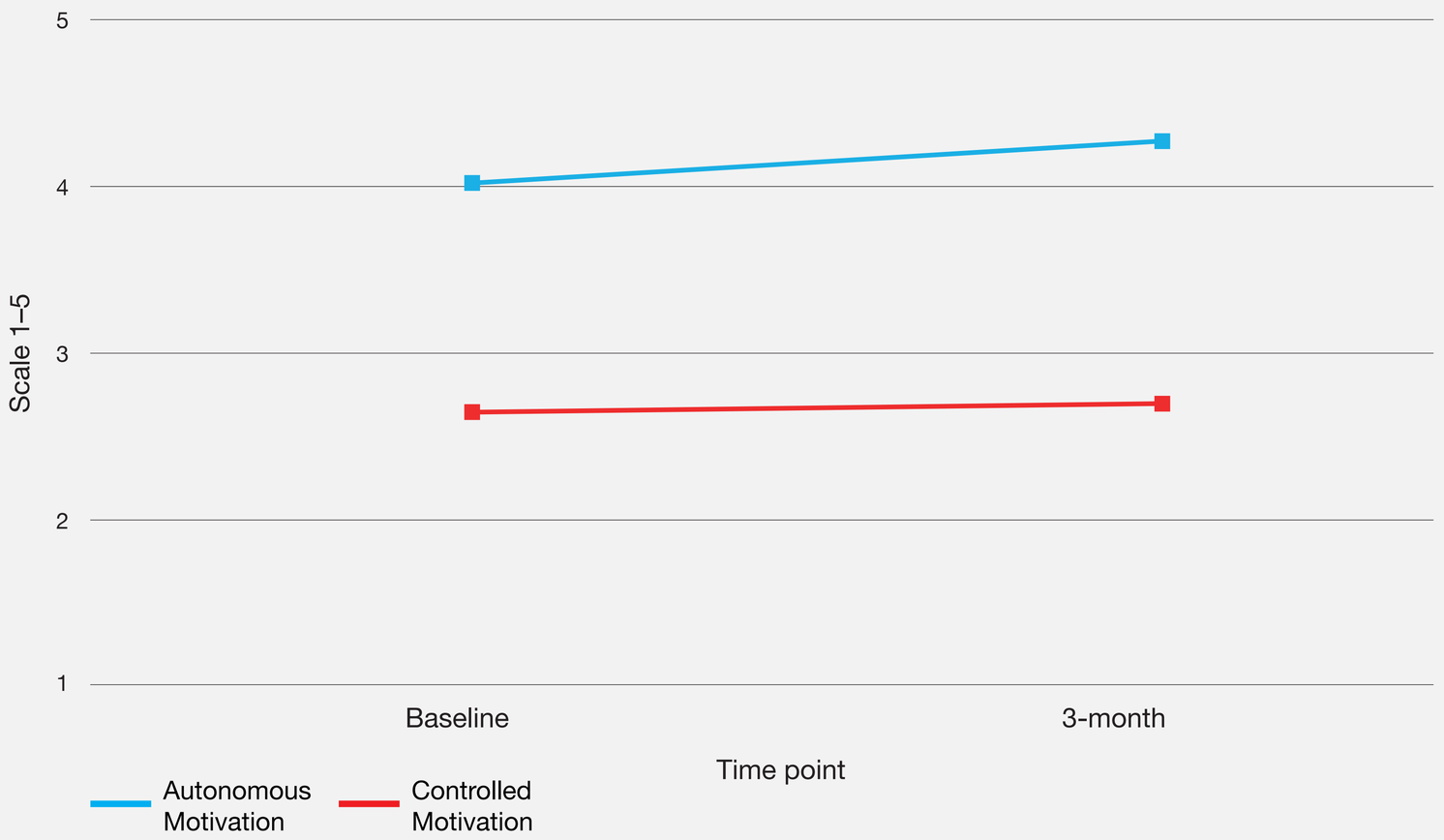


Figure 4. Changes in minutes of walking, cycling, sport/other activities and total physical activity from baseline to 3-month timepoint. Data based on 27 participants who completed both time points.

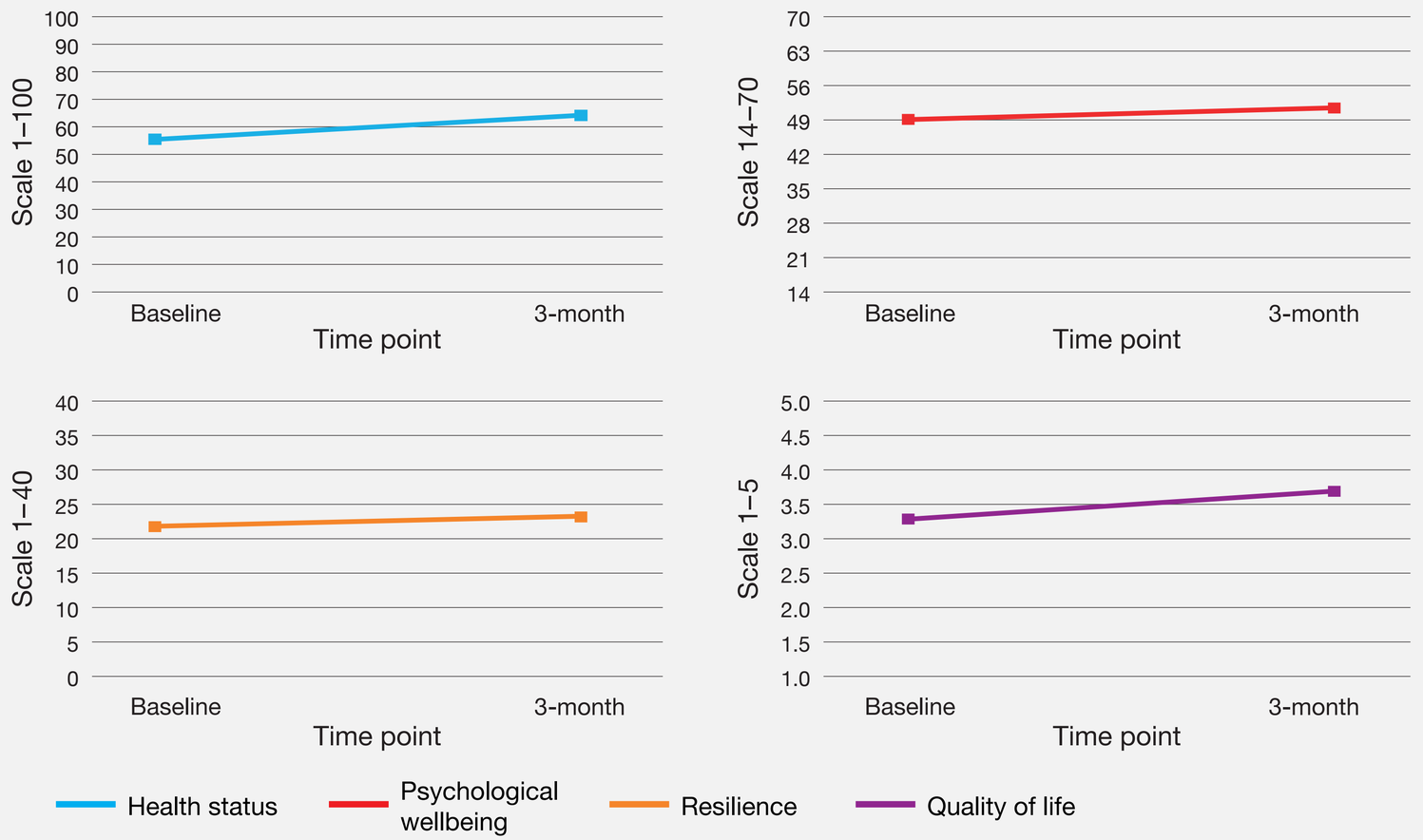


Findings

Over the same time frame, individuals also reported (Figure 5) a meaningful increase in;

- health status
- psychological wellbeing
- resilience
- quality of life

Figure 5. Changes in health status, psychological wellbeing, resilience, and quality of life in participants from baseline to the 3-month timepoint. Data based on 27 participants who completed both time points.



Overall, the analysis of the questionnaire data seems to show promising effects of embedding physical activity into the peer support groups, particularly in relation to the positive changes in physical activity time, autonomous motivation for exercise and quality of life. However, due to the disruption caused by the COVID-19 pandemic, we do not have enough data to fully determine if the changes experienced by participants were statistically significant, and how they may have continued to change over the 12-month period of the project. Nevertheless, the changes found in general support the notion that embedding physical activity into peer support groups has a wide range of benefits for those severely affected by mental illness.

Qualitative data

Qualitative data reinforces that there were clear benefits of embedding physical activity into peer support groups. Group members and group leads both considered the social aspects of embedding the physical activity in peer support groups to be central to the success of the project, as well as benefits from the physical activity itself.

"It's very uplifting so when I start, I don't feel, for example, energetic, but when we join in a group these phys`ical activities give me energy and positivity and I feel better in myself."

(Support group member)

"It was hugely important. I know a lot of the people who were doing the activities said, "There's no way they would've kept it going on their own". Having the group, having the chat, having the encouragement from each other was really key for them."

(Group lead)

"The social side, groups and things, the social side here is so important, it's a very, very important side of it. As well as being, because you trust each other and have a bit of banter and a bit of fun, and it just feels so at home; so free, so easy. You come in and you talk to anyone about anything you want, and you know it won't go any further, which is very important for a lot of things."

(Support group member)

"Yeah the one really big take away positive thing is that it was so hugely beneficial to our carers. Absolutely mentally and physically, emotionally, we could connect with them, they could connect with us and they could connect with each other. So it ticks so many boxes, broke down social isolation, provided peer support, provided group support, gave access to the staff, all through walking and physical activity. It was brilliant. The main thing is it might not sound very much to a lot of people but just to have a coffee bought for you that's incredible."

(Group lead)

Findings

“Oh yes, all the tai chi and that, that’s a great help. I always feel when I come in and when I leave here, I feel a much better person. I think without Rethink I don’t know where I would be actually. No, I’m really happy and they go on outings and that and I really look forward to Mondays very much. I went away last week, and I absolutely miss being here because I don’t like missing the groups and that, so no, it’s very good and as they said, they’re all lovely people. And like [name of member] said about [name of member], it’s done her good, like she can mix, she can come in and talk, like I couldn’t, I would stay in. I can go into a crowd now, I’m happy. Before I came to Rethink, I could never talk with a group like this, I’d probably just sit back, I know it’s done a lot for me.”

(Support group member)

“It’s like the body is still moving [after a session], their heads are still moving, their brain is still working. When they finish it’s like a smile on their face, they’ve done something, they’ve achieved something.”

(Group lead)

Findings

While the data is broadly supportive of embedding physical activity into peer support groups for those severely affected by mental illness, it is important to note that the majority of participants reported at all time points that they were active and meeting physical activity guidelines (i.e. at least 150 minutes of moderate intensity activity per week). This suggests that the peer support groups were attractive to those who were already engaging in physical activity. It may be worthwhile considering how to make the groups attractive to those who are not currently active or understanding the unique barriers which may prevent inactive individuals severely affected by mental illness from engaging in such groups.

In addition, from the questionnaire data, it appears that there was no impact on the ability to set goals, the opportunities to be active, or the confidence to engage in new activities. Interestingly, there was a meaningful decrease in the confidence to engage in new social activities.

Summary

- Peer support groups are successful at promoting physical activity for those severely affected by mental illness and are valued by participants.
- Peer support is a very important feature for those involved
- The groups may not be effective in attracting those who are insufficiently active

Project Delivery

Based on the interview data, there are several key themes which emerged in relation to how the project was delivered. These related to the diversity and variance across the different peer support groups, in terms of the mode and frequency of physical activity delivered and the local contexts within which they were operating. In addition, there was a theme related to the overall aims and requirements of the project, and how this was communicated across the organisation. Finally, some suggestions of how projects such as this one could be delivered in the future were provided by participants.

Diversity in peer support groups

There was considerable variation in how the peer support groups embedded physical activity into their groups. For instance, as can be seen in Table 1, there were several different activities adopted by the groups. There also existed variation in how often groups took part in these activities, and whether they were the sole focus of the group or part of a larger group meeting.

Note: This information is taken from how the groups described their own activities. Some groups engaged in multiple activities i.e., yoga and boxing, hence why the total is greater than the number of groups involved in the project.

Table 1. Types of activities that peer support groups engaged in.

Type of activity	Number of groups
Running (including Run Talk Run groups)	16
Yoga	6
Walking (including dog walking)	4
Gym based	3
Boxing (including non-contact and Boxercise)	3
Chair-based exercise	3
Table tennis	2
Badminton	2
Various	2

Type of activity	Number of groups
High Intensity Interval Training (HIIT)	1
Spinning	1
Medical Qigong	1
Individual and team sports	1
Racket sports	1
Tai chi	1
Dance	1
Cycling	1
Boccia	1
Basketball	1

Findings

The variation in how the physical activity could be delivered appeared to be popular with group leads, as it allowed them to tailor their activity to the needs of their group. Furthermore, it was acknowledged by both group members, groups leaders and the GDOs that the focus on peer support and informal physical activity, rather than organised sport was beneficial.

"Walk and talk sounds really good because it means getting out, it means social interaction both of which are major achievements but it's not got that large challenge of having to have a level of physical fitness to achieve it. It's something that you can attend then miss a few weeks and then come back to."

(Support group member)

"I go for walks, coming here, walking to the local shops, something like, I enjoy walking a lot, 'cause it's fresh air and there's sunlight and I like that a lot."

(Support group member)

"Yeah you see this obviously it's the problem we're having because obviously… because outdoors and stuff it's like if we've…so say if we have things set up for rounders, you have to have a set number of people to be able to play the game and if there's only a couple of people turn up, you can't play the game so it then turns into something else okay? So, what we do is basically we went for a coffee. So, again it's like trying to choose some sort of activity that doesn't take up massive numbers and we can you know, if only a few people turn up then we can still…still work with it."

(Group lead)

Group leads emerged as significant people to the success of the project. They were trusted members of their groups and had excellent understanding of their specific needs and contexts. As such, it was felt that they needed to be more involved in the planning and delivery of projects like this, to be successful.

"I think I mentioned it earlier that I need to pay more attention to what people want rather than just planning and expecting them to fit in with what I think will work well. I need to go to them first and do some more insight work into what they want rather than just planning and do it the other way around a bit. Because especially with groups of people that have got mental health problems, like [name of participant] said, it's not going to be everybody's going to turn up every week and follow this lovely path, life isn't like that. So yes I've learnt to talk to groups first and then plan afterwards."

(Group lead)

Project aims, requirements, perceived outcomes, and communication

In relation to the delivery of the project, the data shows several challenges that occurred over the course of the project. These largely related to the aims and requirements of the overall project, and how these were communicated to those involved ‘on the ground’, such as group leads and GDOs.

Findings

The GDOs reported that they experienced challenges in embedding physical activity into their existing groups.

“I think the thing that really has struck me more than anything else is when you’re aiming something at people to help them with their mental health and especially those who have challenges in that area, I think you have to be very careful about the level of expectation you put on people. For some people actually getting up is a big success for the day, that’s a major achievement, getting showered as well, huge step forward. So regularly attending an event I think is a big ask.”

(Group Development Officer)

Findings

Access to facilities, resources and having the right group leads were perceived to be key elements. For example, a toolkit was produced as a part of the project with the aim of providing these to group leads to support them. The data shows that group leads were not always familiar with this resource. However, there were acknowledgments that Rethink Mental Illness was providing operational support to groups, which was valued by group leads. In addition, the training opportunities provided to group leads were perceived to be useful in supporting group members.

“They (Rethink Mental Illness) have been incredible, really supportive; can’t do enough for people. I was really impressed by that. Because, for them, you know, they were also all working from home, so not easy to do that and to conduct such a nationwide job of, like, all these groups around the country, coordinating them all, when you’re sat at home, being quite cut off, not even around your colleagues; so I was really impressed by how involved they are, like a really great organisation.”

(Group lead)

“One thing that was already great, I just want to say, the mental health qualification I really enjoyed, and I think it was useful in just helping to understand how to approach conversations a bit more. The main thing I think I took from it was just the importance of sometimes just asking the question and shutting up and just letting someone else take it where they want to.“

(Group lead)

Doing things differently

Those interviewed had several suggestions on how changes could be made to make projects such as these more effective. These included how timescales and project planning could be altered, the use of resources such as toolkits to support group leads, and the sustainability of funding for practicalities. The data also suggested that recognising the diversity of groups in their local contexts, and that partnering with other organisations could be beneficial approaches.

Findings

It was felt that key elements could have been changed in the planning to facilitate the successful delivery of the project. For instances, having a longer period before delivery of the project began (i.e., before groups began embedding physical activity) would have allowed for greater co-production at the group level, and for enthusiasm for the project to be generated.

"And also the timescales that were set weren't realistic, in terms of actual delivery. So again, this is probably one of the biggest pieces of learning that we found, and that I found… you know, there was a three-year project and three years of delivery, where in hindsight there probably should have been at least a six-month initiation phase before you start delivery. It's impossible to start delivery from day one because nothing was set up prior to that. So that was a huge challenge to then work out how can we fit in three years' worth of delivery effectively within two/two and a half years, pandemic aside."

(Project Manager)

"And I think it goes back to if we'd had that collaboration and planning in the start, we might have come away with something better, I think."

(Group Development Officer)

"So the group development officers were my route into groups. And I think this is one of the big learning pieces, is, from my understanding is that they weren't heavily involved with designing and understanding the project before it got going. So when I came in I was starting from level zero. And actually there was a bit of push back from it."

(Project Manager)

"I think if we'd that better collaboration, improved collaboration in the beginning and understood that we'd have a better idea of how to approach it, how to roll it out and implement things."

(Group Development Officer)

Findings

There was also recognition within the data that a one-size-fits-all approach was not appropriate in this project, due to the differences in groups and their local context. With this diversity came challenges, at a local level (such as meeting the needs of the whole group) and more widely in ensuring that the offer in relation to physical activity was appropriate for a range of different groups.

"I think Rethink is trying to acknowledge and provide the resources that they have with the physical activities, equipment that was provided to the groups. I think that's important to note, but I think because of the unique characteristics of this group, language, background, capabilities of whether people are able to, physical capabilities, mental health capabilities, it does complicate the situation in terms of how we can support the group best."

(Group lead)

"I find the dynamics of the male and female ratio of the group is very challenging sometimes because we have predominantly more female members in the group than we do males and I think some members don't feel comfortable with that ratio of the male and female and they'd rather have just a female group. But we have to be open, flexible and that's what I keep reiterating to all the group members and it's about respecting each person's recovery journey, that might be their only time and their only group that they get from their life to feel that they're connecting with people, they're doing something of recovery for them. So yes I think that's been a challenge as well because it's maintaining other people's expectations in the group. There's a lot of dynamics because we're all different, but it's about how do we support those members in challenging situations."

(Group lead)

"Moving forward I think I would like to see the group having more discussions and open discussions. Because many of them are quite reluctant to have conversations about their own experiences of mental health. I know it sounds odd to say that and it's a mental health group and it's about recovery. But I find because of the clientele because they're Asian, from different backgrounds, not just Asian. They're in the community, some people feel reluctant to talk about their issues because they don't want the community to find out what's happening with them. I find that that's sometimes a barrier for them to talk about their own experiences and share as much as they could. But I find that when I talk to them individually or if volunteers talk to them individually they open up a bit more than they would in a group setting."

(Group lead)

However, there was also acknowledgement that there were positives of having a diverse group of people coming together as a part of peer support groups.

“With our group, we had so many different people coming, so we’d have some people coming from school, like, with their carers, coming from college, coming from work, or that didn’t work, just coming from home, and just bringing so many people together that wouldn’t normally interact with each other”

(Group lead)

Interviewees felt that the resources provided to group leads could be altered to provide more appropriate support. Group leads and GDOs considered that the toolkit and other resources could be more focussed to practical support of how to deliver sessions, rather than general information about the benefits of physical activity.

“I remember this toolkit now as you were talking, that was produced. So, a lot of things; time, effort, was spent on telling people why being fit is beneficial, when that was totally unnecessary. What we needed were the practical tools on how to get that working. So as we mentioned more than once, … how they could use the money, what type of sport they could use it on. So, this needed to be far more practical. They didn’t really need to be told the benefits of physical activity, and I think that is maybe almost like the core of it.”

(Group Development Officer)

“I think we could have probably sent out more simplified information, and actually that makes things that are easier for do, like a dog walking group, and we encourage people that way rather than maybe focus it so much on organised activities.”

(Group Development Officer)

Findings

In addition to resources like the toolkit, it was identified that support and training for group leads to enable them to deliver sessions effectively and in a way that promoted their own, and group members mental health, would be beneficial.

“We are there as a peer support group. It’s not a counselling service, but I think, maybe, even developing the resources that leaders have. So, for example, I’d love for every leader to have a bank of resources that we can direct people to. So, say, someone is struggling with grief, you can say to them this is where you can get more help. I think having a bit more of that kind of structure in place for the mental health support side of things would be really handy”.

(Group lead)

“This is a group that requires, you know, some boundaries, some kind of leadership skills, because there can be moments where there might be an anxious person or a stressed out person…and that’s good, that’s fine, that’s to be expected with the nature of what we’re doing. So it’s taught us a lot about how to facilitate a group safely, in a boundaried way and, you know, how to incorporate the physical activity, how to have a good pace, a good energy in the room; plan in advance, that’s really important. Because, if you come with no structure or real things to guide the conversation with, it’s not as appealing to the people attending, because they feel like, oh, this is a bit of waste of time. So I always make sure I plan and come with things to do, like tasks.”

(Group lead)

Finally, it was acknowledged that there may be benefits in future projects engaging with organisations within the local area who could support or share the delivery of physical activity within peer support groups.

“So, what helped was having another organisation involved. So, the walking group was actually... well, part of the [name of group and location], so they supplied the framework that we could use, and also a member of staff to support in that way. And then the badminton group, that really is under the umbrella of Badminton England, so it’s in [location], it’s the [name of group] under Badminton England. So, again, there was that understanding, as [name of interviewee] talked about, we can see a future that it would be sustainable and so the money was used from Sports England to hire courts, a lump sum, but then they started collecting money straight away so that they could move it forward”.

(Group Development Officer)

“If I did it again a lot of work, which wasn’t in the original scope, but there was a need for it to engage with [partners and] local authorities that know about what we were doing, and potentially help us find community groups and organisations or individuals that would be interested in the project and get involved with it. So yeah, I think I had to do a lot more stakeholder relationship building than maybe anticipated.”

(Project Manager)

Summary

- Co-production and communication across all levels of the project (i.e. groups, GDOs, project managers, organisation) a vital ingredient
- Important to ensure the group leaders are well-supported with the right training and resources
- Timescales and objectives should be realistic
- Diversity in activities is a strength, but need to consider what constitutes physical activity

Impact of COVID-19

It was clear from the data that the COVID-19 pandemic had a profound impact on the delivery of the project, and those involved in groups. Many groups ceased to meet, and some did not start meeting again after the pandemic. While some groups were able to maintain contact using online services and communication apps, the lack of face-to-face contact had considerable impact. It further reinforced the importance of peer support for many individuals severely affected by mental illness.

"I believe that the pandemic has really literally changed the whole way of how we function and especially how groups are functioning and the moment. We've not been able to do WhatsApp or use online formats at this point because when asked collectively to the group members, "What is your preference to stay in touch?" Most of them don't have the skills and they feel comfortable by just having that phone call to have that conversation about how they're coping during the pandemic without the group meeting for face to face activities. So it's hit them hard and it's hit me hard because we're all part of the group."

(Group lead)

"I think they've realised that maybe we've taken for granted but this has been a really good experiment in a sense, where we've recognised what really makes peer support, what makes that up, and that human presence and all the non-verbal cues and that human presence is what does contribute to being a supportive group face-to-face."

(Group Development Officer)

"A lot of the groups when they could meet were given the exemption and started to go out walking and meet in green spaces, because it is something they could do in small groups. That's really helped in terms of increasing or addressing some of the loss of confidence in going out, reducing the social isolation, things like that, and that's worked well."

(Group Development Officer)

Findings

Individuals' experiences during the pandemic reinforced that for those severely affected by mental illness, groups could be a vital way of avoiding social isolation. The social aspect of the groups was felt to be at least as beneficial and important as the physical activity itself. It was clear from several interviews that the groups were perceived to be an important aspect in maintaining social connections as well promoting physical activity.

"I think having the group there is probably a good thing and I know one of the runners he stopped running over the pandemic period but remained involved with the group just because he was getting the benefits of the social aspect of the group which is really good. I think it's all about isolation isn't it."

(Group lead)

"Obviously the exercise has got to be good for everyone, but I think especially with the pandemic and the isolation and that as a social group it's really paid dividends and I think it's a shame we didn't get a walk and talk group up and running before the pandemic because I think that would've been a good social connection as well for people."

(Group lead)

"Yeah, because especially for this group as well, alongside the physical wellbeing, it's the social side a lot of people got on board with, and we'd have carers and people coming, sitting on benches and just talking to other people, like, not taking part, they're just there to support whoever, but just they were getting involved as well by talking to us all. So, I think physical activity and social activity together is so important."

(Group lead)

Findings

There was a clear sense that the pandemic resulted in reduced levels of physical activity for all involved. This appeared to both be due to the impact of lockdown on individuals, but also the lack of contact with peer support groups who would facilitate physical activity. However, for some individuals, there was a sense that there had been a change in the importance of physical activity.

"So many of our carers were literally locked down and if they did go out it was either on their own or in the bubble it wasn't really appropriate at the time. Our problem is trying to get carers to carve that time out for themselves, it's very, very difficult for them to get any time away on their own from someone that they're caring for. So when they are on their own it's absolutely brilliant that that time is as brilliant a time as possible and that's where that funding just made such a difference to our carers."

(Group lead)

"Yes, it definitely dropped, definitely dropped during the pandemic and I think that was linked to the drop in social contact. I think for me with less of a face to face contact with people it dropped my natural energy levels and I found it quite hard to motivate myself to do things. I think getting back out now, starting to build those levels of contact I'm definitely seeing my motivation to do things pick up."

(Group lead)

"I think as well, it's gone to show how important physical activity is, so especially in the first month or so when the very toughest lockdown, when exercise was the one exemption out of your house, other than shopping really, I think that showed how important it is to be grateful for what you can do, and no matter your disability or not, then exercise is just so important, physically and mentally. So I definitely think that's highlighted the importance of this group specifically."

(Group lead)

Findings

There were wide variations in the use of technology to maintain contact. While there were some exceptions, overall it seems that using technology offered different or decreased support for most groups. This was due to the difference in meeting online versus face to face, as well as barriers due to access to technology. Additionally, the pandemic made communication across different levels of the project (i.e., project managers, GDOs, group leaders) challenging; for instance a number of group leads were unfamiliar with initiatives such as a winter activity pack sent out to groups during the pandemic.

"it was mostly just emailing people on the mailing list. We bounced around the idea of online groups, but it didn't really ever get off the ground. I don't know if it would have been well received with our particular sort of membership, because a lot of people are older or disabled or don't have internet access."

(Group lead)

"I think people have missed being in a room with others face-to-face, having a laugh in a circle with others, people have missed just human contact, people have missed the sort of spontaneity of a meet up. You know, with Zoom and all the rest of it, I don't know about it for you, but I found everything I've done on Zoom and Teams that's group related has been quite, like structured and regimented. Like, right, you unmute, say your name, then mute, you unmute, say your name, then mute. And it's just like…it's so sort of soulless".

(Group lead)

"Well it was really the pandemic because it's that face to face contact that was a problem. So it was the digital isolation, the digital exclusion and in terms of cost and finances but also in terms of intelligence, know-how and training. So that hindered some people, yes, because not everybody's able to access online services and if they are able to they need an awful lot of support to do that. Rethink did make some support available and there is support out there but it's still difficult for some people."

(Group lead)

Findings

“Obviously, technology is making the job a little bit easier, but it is a little bit more confined being in the same four walls all the time. But I think from our groups, I’ve got one group that seems to have moved from meeting face-to-face to digitally, but that’s just a very niche group and I think it’s because they can get a wider group with their national base online. But mainly I think people will look forward to doing face-to face meetings again and it’ll be a mix, it’ll be a hybrid of technology for some groups and face-to-face. I don’t think anyone’s embracing technology fully.”

(Group Development Officer)

“There’s a huge number of members in our groups and the coordinators that don’t have access to technology. And there’s a number of barriers, whether that be affordability, confidence in using it, or just through their own wellness, aspects of their being unwell that they won’t use it. And we’ve got a lot in areas where it’s really difficult, particularly in a lot of rural areas where you’ve stuck to only using one provider and it not being great”

(Group Development Officer)

Findings

There were some examples of where using online communication helped to facilitate support, and in some cases encourage group members to be physically active. This seemed to be particularly for those groups who might have struggled to engage in face-to-face group meetings, as well as for supporting individuals back into the groups following a period of absence.

"I think having the WhatsApp group maybe helps, and just a bit of communication between sessions. Once a month, when possible, we've done a pub meet afterwards, so that might inspire people. Also if one of my regulars hasn't shown up for a while, I do just reach out and ask if everything's okay, and I think that has encouraged people to come back when they've taken a break and they've maybe lost confidence in their running, that kind of thing."

(Group lead)

"If they talk to me on the phone and go for a little walk, it's encouraging them to do something and just put it on, put their earphones on and just talk to me and do something. One lady she said, "I'm cleaning my windows now because you told me to do something". It's like helping them to just do something when sometimes they're just sitting down".

(Group lead)

"Very few of them [carers in a carers group] ever did any group work because they were caring for someone who's vulnerable. So they were in a very high risk group so we ran online movement therapy classes with the movement therapist from the mental health trust and that was very well attended, so that was once a week."

(Group lead)

Summary

- Pandemic impacted upon groups being able to meet,
  but reinforced the value of social connections
- Drops in physical activity reported
- Technology to meet online was useful for some groups,
  but not all

3

Recommendations

Based on our evaluation, there are several recommendations for organisations trying to use peer support groups to encourage people severely affected by mental illness to be more active.

Groups

- The social element of peer support groups is vital and highly valued by those involved.
- Group leads are key to facilitate the success of groups. Support is needed for their own development, and to ensure that they have the confidence and skills to facilitate physical activity sessions.
- Consideration should be given to what constitutes physical activity, as informal activities seem to be preferred to formalised “sport” by some groups.
- Funding needs to be sustainable, with the focus being on the right people to do the right tasks. Supporting the development of group lead seems to be have been effective.
- Co-production is vital across all aspects of projects, recognising local contexts and variations in the needs of groups.

Timescales and flexibility

- Timescales for projects need to be realistic, with adequate lead in time prior to groups beginning activity. This would allow for more time for planning and communication.

- Consultation across all levels of organisations such as Rethink Mental Illness is crucial. This would involve groups engaging in physical activity, group leads delivering activities, individuals supporting groups and leader such as Group Development Officers and Project Managers, and those in the organisation involved with fundraising and campaigns.

- Flexibility in expectations would help group leads to facilitate physical activity in their location and context.

Connecting and collaborating

- Working collaboratively with other organisations seems to be beneficial but needs to be facilitated and support from organisational level.

- Consideration should be made in relation to “ownership” of these groups, particularly during times of challenge such as the COVID-19 pandemic. Clarity is needed around who will support and communicate with such groups.

Key Principles for future work

- Social elements of peer support groups should be highly valued.
- Group leads with some confidence and experience in physical activity but also expertise in the needs of their groups.
- Co-production at all levels of and throughout a project – from project conception, to development, implementation, and evaluation.
- Regular communication between organisations running projects and those practically delivering them.

4

Reflections from the research team

Reflections from the research team

In this section, we wish to provide some reflections on our evaluation.

We have included this section for two primary reasons;

1. Highlight some of the strengths of our evaluation approach, whilst also acknowledging how some challenges experienced through the course of the work might limit the scope of the findings.

2. Provide some broad recommendations to those conducting similar evaluations of physical activity programmes aimed at promoting health and wellbeing with individuals severely affected by mental illness.

Strengths of the evaluation

Mixed methods approach

By utilising a mixed methods approach with a combination of quantitative and qualitative research methods, we have been able to capture;

a. a broad overview of the impact of the project on key outcomes such as physical activity, mental health and wellbeing and physical health

b. the in-depth experiences of those involved in the project.

It has also provided multiple ways for individuals to be involved in the evaluation – for instance, some participants may feel more comfortable answering questionnaires than speaking in a group, and vice versa.

While we always intended to use a mixed-methodological approach, the impact of COVID-19 on the evaluation further validates this strategy and shows the benefits of including multiple sources and methods of data collection.

Collecting data from individuals involved in all 'levels' of the project

Gathering learning from peer support group members and leads, to organisational staff from Rethink Mental Illness, we have been able to provide wide-ranging recommendations to facilitate the delivery of projects such as these in the future.

Peer researchers

The expertise they brought from their own lived experience of being severely affected by mental illness was invaluable to the collection and interpretation of the data. Their contribution to the data analysis and particularly comments related to how the data resonated with them, allows us to have confidence that our findings could be generalised to other projects conducted within similar contexts to the one delivered by Rethink Mental Illness.

Challenges and considerations for future evaluations

There were some distinct challenges that we experienced during the evaluation process that we wish to acknowledge, with a view to being transparent on the limitations that these present and to provide thoughts on how to overcome such challenges in future projects.

Access to and engagement of group members

Within this project, access was almost exclusively facilitated through group leads and most data collection was completed at support group sessions. Support from group leads was vital in supporting data collection. However, if access could have been maintained more directly with individual group members this would have allowed us to engage participants regardless of their attendance at support groups.

This issue was amplified with the onset of the COVID-19 pandemic, as without contacts for support group members attempts to collect data relied on information being trickled down through groups leads, which ultimately was unsuccessful in collecting any further information from group members. While the situation caused by the global pandemic might be unique, it is still our opinion that both teams conducting evaluations, and the organisations commissioning them, should consider how to maximise opportunities to access participants to capture the experience of a wide range of individuals involved in such projects.

Data collection methods

Due consideration should be given to the data collection methods and tools adopted within evaluations. Based on our experience, there needs to be a balance between;

- these being appropriate for the questions being addressed
- the context of the evaluation
- how acceptable measures and methods are to participants.

Reflections from the research team

Within our evaluation, we relied upon self-report measures that could be completed within the settings of the group meetings. However, a limitation of this is that group members may have overreported the amount of physical activity they took part in. Using objective measures, such as smart watches or accelerometers, to assess physical activity could be used in conjunction with these self-report measures, but consideration should be given to how participants might feel about wearing such devices, as well as the associated cost implications.

In addition, while digital technologies could be used, for instance, hosting the questionnaires online to reduce travel time for researchers and time spent in group meetings completing questionnaires, it is important to consider whether this might exclude people from being participants due to a lack of access, confidence, or skills.

Capturing data over time

Even without the impact of the COVID-19 pandemic, maintaining contact with participants across a 12-month period creates challenges in collecting data from everyone at all timepoints. It would have been worthwhile to try and engage with those who started attending a group but did not continue to the 3-month period, although again this was hindered by access to individual participants.

It is our view that longitudinal research designs are important for addressing key questions in this area and feel that using a mixed methodological approach helped to mitigate some of the challenges created by participant drop out.

However, this is something that should be considered in future evaluations in this context, to try and maintain direct contact with as many participants as possible throughout the length of the evaluation.

Rethink Mental Illness.

Leading the way to a better quality of life for everyone severely affected by mental illness

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