

The value of peer support on cognitive improvement amongst older people living with dementia

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Abstract

Peer support can play a critical role in improving the wellbeing, social support and practical coping strategies of older people living with dementia. This paper describes selected findings from the Mental Health Foundation's evaluation of three peer support groups for people living with dementia in extra-care housing schemes. It highlights the groups as a promising approach for maintaining cognitive faculties, reducing social isolation, increasing social networks and improving overall wellbeing. A mixed-method study design examined the impact of the groups on participants' wellbeing, managing memory, independent living skills and social support. Participants reported positive impact from taking part in the support groups for wellbeing, social support and practical coping strategies. Participants also reported positive benefits of the groups on communication abilities, managing memory and managing their lives. Peer support groups in extra-care housing schemes address the psychological, social and emotional needs of people with dementia. This evaluation adds to the literature on the effectiveness of these interventions for those with cognitive impairment.

Keywords: peer support, self-management, community services for older people, people living with dementia, extra-care housing schemes

Background

More than 800,000 people in the UK live with dementia (Alzheimer's Society, 2014a). One in fourteen people over the age of 65 experience the condition, which increases to 1 in 6 over the age of 80 and to one third of all people over the age of 95 (Alzheimer's Society, 2012). By 2021, it is estimated that there will be one million people in the UK living with dementia (Alzheimer's Society, 2013). In spite of the increasingly large numbers of people living with dementia, less than half (44%) of people with dementia in England, Wales and Northern Ireland have a formal diagnosis and as a result may not be receiving appropriate treatment and care for their condition (Alzheimer's Society, 2013).

As age is a risk factor for dementia, and as an ageing society witnessing significant increases in the number of people moving into later life, the UK economy is also witnessing a significant rise in the cost of care for people with dementia. Older people make up the biggest group whom social care services provide care for; accordingly, older people with dementia will also be frequent service users. The total cost of dementia to society in the UK is £26 billion a year with more than £10 billion of that spent on social care (Alzheimer's Society, 2014b).

Continued cuts in social care funding has meant many services, such as day centres or community support and activities may no longer exist and changes in eligibility for publicly funded social care may impact on support available for people with dementia. Funding spend in social care in parts of the UK is decreasing as demand for these services is rising (ADASS, 2014). Simultaneously, there has been a shift in social care practice to personalising support for people to enable them to live in their homes for longer (DH, 2012).

Risk factors for loneliness

It is estimated that one third of people living with dementia live in care homes (Alzheimer's Society, 2007), and more than 80% of care home residents in the UK have dementia or

significant memory problems (Alzheimer's Society, 2013). Living in residential care is a factor associated with loneliness (The Residents and Relatives Association, 2010), as is poor health (Victor *et al.*, 2005), reduced mobility (Tijhuis *et al.*, 1999) and cognitive impairment (Victor *et al.*, 2005); all of which are factors common to people with dementia and increase a person's chances of being lonely. Dementia 2014 (Alzheimer's Society, 2014a) reported that 42% of respondents from their survey said that they were not living well with their dementia, 61% felt anxious or depressed recently and 40% felt lonely.

Impact of social support, cognitive stimulation and peer support approaches

One study examining social engagement amongst older people living in the community found those without social interactions, either through social connections or activities, had an increased risk for cognitive impairment (Bassuk *et al.*, 1999). It is less clear, however, how these findings affect those who already have some level of cognitive impairment, such as the case of people with dementia. Having larger social networks is associated with reduced cognitive decline in the general older population (Barnes *et al.*, 2004) and requires further validation amongst people with dementia. Social and leisure activities are shown to have beneficial effects on maintaining functional cognitive abilities and lowering risk of dementia (Wang *et al.*, 2002), but the impact of these activities on the cognitive abilities of people who already have dementia has not been formally evaluated.

A national inquiry into the mental health of people in later life, including people with dementia, reported that social relationships and meaningful activity positively affected the mental health of older people (Age Concern & the Mental Health Foundation, 2006). In addition, a number of reports by the Joseph Rowntree Foundation (JRF, 2009; 2013) have also highlighted the importance of social wellbeing and promoting the social needs of individuals in planning purpose-built accommodation.

'Alzheimer's Cafés', originally a model from the Netherlands, have established roots in the UK in the last ten years. These cafés typically take place on a weekly basis in community settings and serve to provide practical support and advice to people with dementia (usually in the mild to moderate stages of the condition) and their families and friends. While these cafés are informal and don't provide clinical interventions or services, sessions are structured and can involve talks or films that are associated with living with dementia. Several organisations have adapted the model of Alzheimer's Cafés for use in sheltered housing: one, a partnership between the Sanctuary Group and the Cambridge branch of the Alzheimer's Society (Moore, 2009) and another project, a collaboration between four organisations: the South London Family Housing Association, Alzheimer's Society Southwark, South London and Maudsley NHS Trust (SLAM) and Outreach and Support in South London (OASIS) (Hough & Brims, 2009). While both sheltered housing projects have been described in the literature, neither have been formally evaluated regarding the impact of the groups on people with dementia.

A Cochrane review (Woods *et al.*, 2012) evaluating the effectiveness of cognitive stimulation interventions for people with dementia found these interventions to be beneficial to cognitive functioning, quality of life and wellbeing for people with dementia. These interventions were defined as offering a range of enjoyable activities for people with dementia that provide general stimulation for thinking, concentration and memory and typically take place in social settings and small groups.

Peer support can be defined as the help and support people with lived experience of a mental illness, learning disability or physical health condition provide to one another (Mental Health Foundation, 2014). This support can be social, emotional or practical in nature. However, key to the approach is that support is reciprocal and mutually provided. It differs from self-help approaches where individuals manage themselves by employing skills, strategies and methods to control symptoms (Crepaz-Keay & Cyhlarova, 2012).

Studies evaluating peer support methods to improve self-management of chronic conditions such as diabetes, cardiovascular disease and arthritis have examined their efficacy and effectiveness (Fisher *et al.*, 2012; Harvey *et al.*, 2008). Recently, an evaluation of a peer-led self-management training for mental health service users has shown lasting positive change in wellbeing and health-promoting lifestyle behaviours (Cyhlarova *et al.*, 2014). Two key aspects that contributed to the participants' improved outcomes were the facilitators who shared a lived experience of a mental health problem and who were also former participants of the training.

The Department of Health's Healthbridge evaluation (DH, 2013) assessed 40 services for people with dementia and their carers, including programmes modelled around peer support. The authors reported the value of peer support networks in increasing confidence for people with dementia and decreasing isolation. These networks also played a critical role with receiving a diagnosis and tackling stigma. A qualitative study conducted in 8 of the 40 services from the Healthbridge evaluation (Keyes *et al.*, 2014) showed the positive emotional and social impact of peer support for people living with dementia. A self-management programme for people in the early stages of dementia was qualitatively evaluated. The programme was attended by 6 participants and addressed wellbeing and coping strategies for handling memory changes. Participants reported enjoyment and benefits from the intervention which included spending time with others who shared a similar experience to them (Martin *et al.*, 2013).

Mental Health Foundation evaluation

The evaluation of peer support groups for people with dementia examined the impact of the groups on participants' wellbeing and learnt coping strategies to manage memory.

The aims of the peer support groups were to:

- improve people with dementia's understanding of memory loss and other issues associated with dementia;
- enable participants to learn simple, practical coping strategies to deal with memory loss and other issues associated with dementia.

It was also hoped that the groups might:

- help participants maintain or even reduce the level of care needs as practical coping improved;
- reduce social isolation and feelings of loneliness among participants by increasing social networks and interaction;
- be sustained beyond the lifetime of the project itself and become an intrinsic part of the housing provision where they were located.

The groups were modelled on a peer support approach with each group running once a week for six months and led by an experienced facilitator. The facilitator was a trained occupational therapist who did not have dementia and previously facilitated groups in the community for older people and their carers. The groups were comprised of peers, people living with dementia or those who had memory difficulties living in extra-care housing schemes. Each group also had a co-facilitator, these were: a resident living in the housing scheme who did not have dementia, the housing provider staff member and two volunteers from the Recovery Enablers programme at South London and Maudsley NHS Trust. The co-facilitators supported the role of the facilitator in leading, observing, reflecting and helping other group members to participate.

The role of the facilitator involved engaging participants to share their opinions and ideas and to draw out common issues or problems shared among members. The facilitator enabled the group to work cohesively and encouraged members to make decisions in their life.

After six months, when the facilitator left the groups, it was hoped that the groups would become self-sustaining or be sustained through local support. Each week there was a different focus or activity, with the aim that people would learn to support themselves and one another through the challenges of living with dementia while also having fun and enjoying themselves. Group members participated in activities that included: creative writing, learning strategies to remember names and numbers, healthy living to keep minds active, preparing to go into hospital, stress and relaxation, and using technology to help.

This article draws on the selected findings from the evaluation of peer support groups for people with dementia (Chakkalackal & Kalathil, 2014), and reports on the positive benefit of the groups on participants' memory recall, orientation in time, concentration abilities and communication.

Evaluation design and methods

The evaluation was based on a mixed-methods design; both quantitative and qualitative data were collected.

Selection of participants

Participants were pre-selected by the group facilitator and assessed as suitable for the group's activities based on their cognitive and physical functioning. The group facilitator interviewed residents living in the schemes whom housing staff had indicated had a formal diagnosis of dementia or who had memory difficulties. The facilitator used an informal assessment of cognitive functioning and asked each resident whether they felt they had memory difficulties, if they had a formal diagnosis of dementia or whether they had been assessed for memory difficulties or dementia by a GP. Those who had significant physical frailty or physical disability or severe dementia were excluded from participating in the groups as there were insufficient housing and care staff to support their involvement. Participation in the group was voluntary.

Consent

All group members assessed by the facilitator were deemed to have capacity and the ability to give informed consent. Group members were introduced to the researcher by the facilitator prior to start of the groups. The researcher asked members whether they would like to participate in the evaluation using easy-read information sheets and consent forms.

Quantitative data collection

Quantitative data were collected at three time points: baseline (T1), at 6 months (T2) and at 9 months (T3). At 6 months the group facilitator withdrew; at this point, it was hoped the groups would become self-sustaining.

Quantitative data collected included measures on participants' physical functioning, social relationships, wellbeing and orientation in time. The following scales were employed:

1. The Lawton-Brody International Activities of Daily Living Scale (IADL; Lawton & Brody, 1969) to assess practical coping skills associated with independent living. The IADL is a validated instrument in the assessment of independent living skills in older adults. It is used to identify how a person is functioning at the present time across eight domains (such as food preparation, housekeeping, laundering etc.). Summary scores range from zero (low function, dependent) to eight (high function, independent). The outcomes evaluation team slightly adapted the measure to provide more complex detail about participant ability; however, the form of the scale was maintained for analysis purposes.

2. The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS; Stewart-Brown *et al.*, 2009), a measure of positive mental wellbeing. Higher scores on the SWEMWBS indicate positive wellbeing and greater psychological functioning. The SWEMWBS is a 7-item measure created from the original 14-item Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). There is high correlation between the SWEMWBS and the WEMWBS. Normative data for SWEMWBS was calculated by halving the mean WEMWBS score.
3. A participant expectations questionnaire developed by the evaluation team to collect information on participants' perception of the impact of the group on social support, loneliness, understanding memory loss and initiating new activities. Each item was ranked on a three point Likert type scale (e.g. not much, somewhat, a great deal).
4. A social relationships questionnaire developed for the purposes of the evaluation to ascertain the level of social support and social networks of participants (see **Appendix 1**).
5. A measure of orientation in time, assessed by asking participants: time, day of the week, date and season.

Qualitative data collection

Qualitative data were collected in the form of semi-structured interviews that explored topics including: strategies or approaches learnt to manage memory or memory loss; use of memory aids in daily life; and new behaviours and activities as a result of coming along to the group (see **Appendix 1**).

Ethics

Ethical approval for the study was obtained from the Social Care Research Ethics Committee (ref no: 12/1EC08/0012).

Analysis

Quantitative and qualitative data were analysed using SPSS statistical software and Excel. The Friedman test was performed on participants who completed all surveys on measures of wellbeing (SWEMWBS) and activity of daily living scores (IADL) in order to compare means of the same group of participants across the three time points. Non-parametric Wilcoxon Signed Rank Tests were performed for all group participants on wellbeing (SWEMWBS) and activity of daily living scores (IADL) given the small numbers of participants and non-normal distribution of the sample.

Findings

The small-group approach of the peer support model meant participants were divided into three groups based on the housing scheme in which they resided. The findings here, however, are presented for the sample as a whole. While there was some variation in group composition and activities in which each group engaged, which may be responsible for some differences in the findings, the small numbers of participants meant it was not possible to make comparisons of this kind.

Characteristics of the participants

A total of 21 participants agreed to take part in the evaluation. Their mean age was 83 years (SD=9.56) with the youngest aged 66 years and the oldest aged 97 years. There were 9 participants in the first group, 6 in the second group and 6 in the third group. Across all groups, 13 females and 8 males participated.

Ethnic makeup of the groups

Based on facilitator reports, one third of (8 out of 21) participants were non-UK born. Place of ethnic origin for group attendees included: Caribbean (5), Ireland (1), South Africa (1), Nigeria (1), France (1) and India (1).

Figure 1 illustrates the high level of disability amongst participants, based on the group facilitator and researcher's reports. As can be seen from **Figure 1**, nearly half of the participants (48%) had more than one impairment (i.e. hearing and vision impairment, physical mobility issue and hearing and vision impairment, speech impairment and physical mobility issue, etc) prior to participating in the groups. Almost a quarter (24%) of participants had reduced mobility due to a physical impairment. Just over a quarter of participants (28%) had no physical impairment or disability. All participants had significant memory problems or a formal diagnosis of dementia.

Numbers of participants and attrition

Some attrition occurred over the course of the evaluation due to the following factors: participants becoming unwell; going into hospital; moving away; death; or no longer coming to the group. At baseline, there were 21 group members participating in the evaluation, 15 at T2 and 11 at T3.

Wellbeing

As can be seen from **Figure 2**, following participation in the groups (n=10), there was a minor increase in the mean wellbeing scores as measured by the SWEMWBS from T1 to T3.

The mean SWEMWBS score at T1 was 22.10 (n=10, SD=5.087) and at T3 was 22.90 (SD=3.414), though the non-parametric Wilcoxon Signed Ranks Test across all participants showed that the change was not significant (Z=-1.80, p=0.857). The mean wellbeing score increased from T2 to T3 which would indicate that there was a small benefit of the groups to members after participation which continued to increase after the facilitator departed at T2.

Figure 1. Level of disability and physical frailty of participants (n=21).

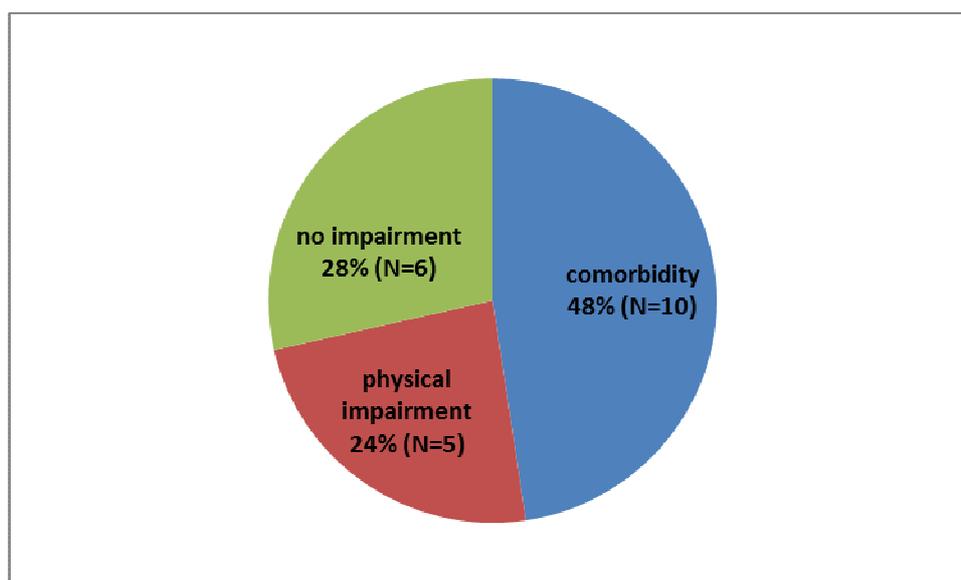
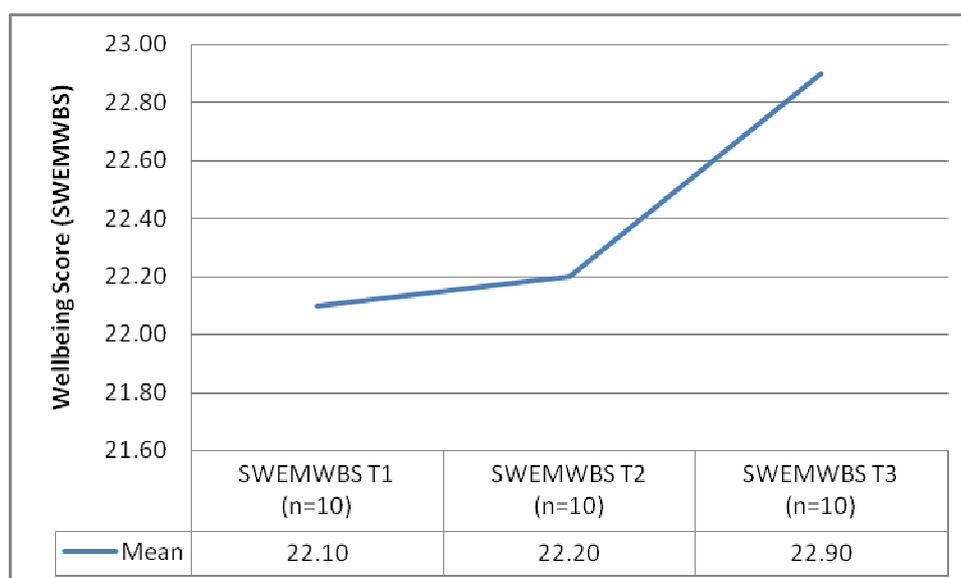


Figure 2. Mean wellbeing scores (SWEMWBS) over three time points.

Independent living skills

From the findings on the IADL (n=10), physical functioning of participants deteriorated slightly at T2, and stayed around this level at T3 (**Figure 3**).

The mean IADL score at T1 was 3.00 (SD=2.31) and at T2 it was 1.80 (SD=1.81); the non-parametric Wilcoxon Signed Ranks Test across all participants showed this change was significant ($Z=-2.99$, $p=0.003$). One possibility for the deterioration may be explained by pre-existing high levels of physical frailty among participants, which was unlikely to improve over time, although the mean IADL score stayed roughly the same between T2 and T3.

Participants' orientation in time

Figure 4 shows the numbers of participants at T1 and T3 who gave correct responses when asked questions on orientation in time.

Following participation in the groups (n=11), participants at T3 improved on most measures of orientation in time (e.g. time, month, season and date) compared with responses at T1. The same numbers of participants at T1 and T3 (n=8) were using aids (e.g. clock, watch, calendar) to keep them orientated in time, indicating there was a positive change on measures of orientation in time as a result of participation in the groups.

Memory recall and perceived social support

Although memory recall was not directly tested in this evaluation, participants were asked how many tenants they knew in the housing scheme where they lived and how many friends they had outside the scheme, to gauge their level of social support.

Equal numbers of participants recalled names of tenants at T1 and T2, however, participants at T2 could recall *more names* of people living in their scheme, and in particular they recalled more names of group members including the facilitator. Participants also reported noticing improvements in recall after participation in the groups. One participant reported using the photo book album, an item created in the group, to help them remember names. From these findings it would appear that participants were more cognisant of others and reported better recall of others as a result of participation in the group.

Figure 3. Participants' change in IADL scores over time.

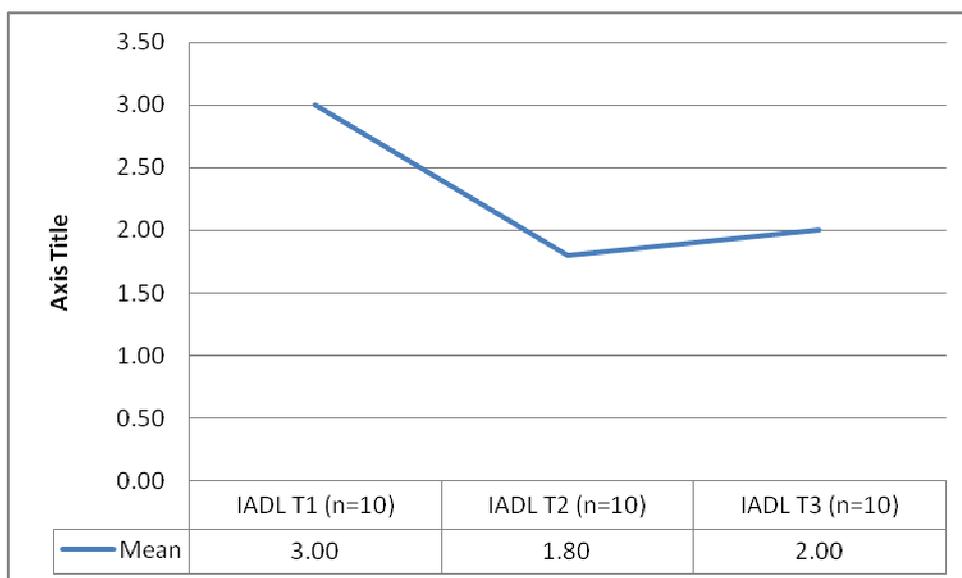
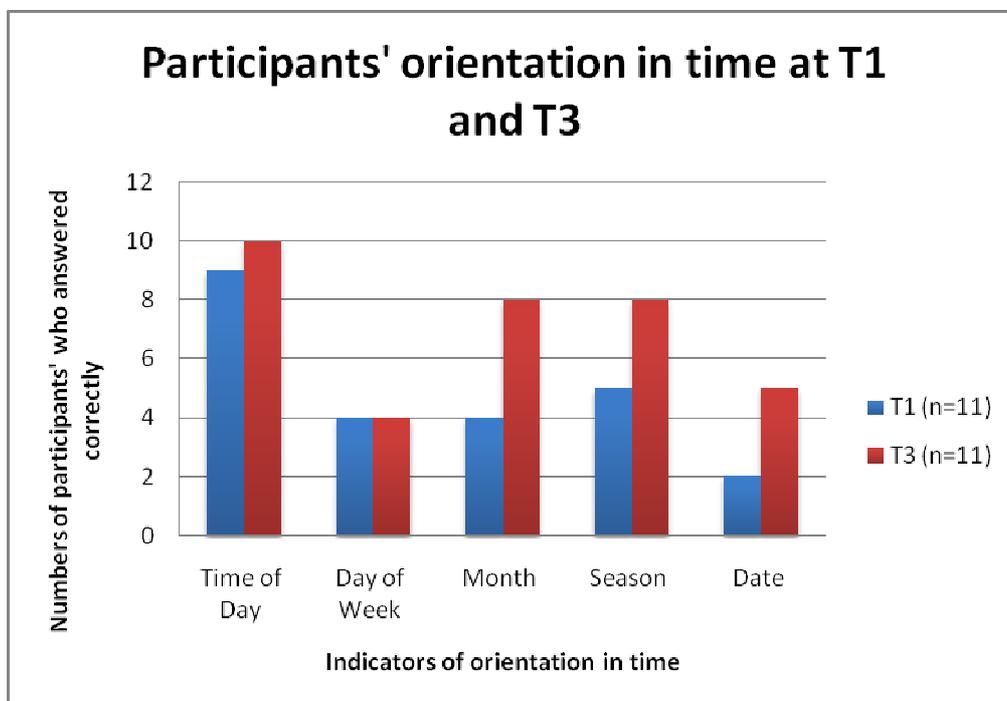


Figure 4. Number of participants with correct response on measures of orientation in time at T1 and T3.



Qualitative interviews with participants provided additional findings indicating improved memory recall. Interviewees spoke of how participation in the groups had helped them understand more about the brain and increased their understanding of memory and memory loss. Members spoke about using different cognitive strategies, which they had learnt through taking part in their support group, to help them remember things such as names, dates and numbers.

You learn more through association. Like the telephone, if you want to remember numbers like the pin number, you make a number on the telephone keyboard like the L shape on the left or right. (Participant #7)

I'm remembering more things now because I'm thinking more about it. What I'm doing at the time and what I should say. (Participant #8)

Participants spoke of realising from strategies learnt during the group, the importance of keeping the brain 'active' to keep the mind alert and to improve their concentration abilities. They spoke of doing activities such as Sudoku puzzles, word searches and reading books to help keep their mind sharp.

Certainly keeping the brain active, I'm a great word searcher, learning to keep your brain much more active. (Participant #3)

Improvements in perceived social support was also seen when comparing participants' experiences following participation in the group, with their initial expectations as reported on the participants' expectations form. When asked whether the groups would help members support each other (item 1) or feel less lonely (item 2), participants reported they had benefitted more than they expected. The mean difference in expectations between T2 and T1 on the item of supporting one another was 0.36 and for feeling less lonely 0.15. A positive integer reflects on average participants benefitted more from the group (T2) than they expected to at T1. This illustrates how the groups helped to alleviate isolation for people with dementia in the scheme and reduce loneliness.

Confidence to do new things

Many participants reported increased confidence and a greater sense of self as a result of participation in the groups. The group setting, based on supportive relationships, set the foundation for group members to try to plan to do new things, such as talking to more people, going out on their own and using the communal tenants' room where previously some had been afraid to use on their own.

I'm feeling much more determined with how I want to do things. Before I went to the group I always thought I was going to have an addled brain, but it's not like that at all. Going to the group and listening and learning, they've shown me how to point myself to the future. (Participant #3)

I never used to go downstairs till the group started. (Participant #21)

Coping skills and self-management

Group members spoke about learning practical coping strategies, which helped them improve their communication with others. These included:

- allowing people to finish when they are speaking and minimising interruptions;
- patience;
- listening to one another;
- accepting that all people are different and behave differently.

Group members also spoke of learning methods, skills and strategies to manage their memory. Other specific learning during the groups included sessions on relaxation techniques, and planning and preparing for end of life issues, such as going into hospital. This helped ease participants' anxieties and gave them a greater sense of control over their lives.

[The group] seemed like nothing at all, but in the last few meetings I noticed how useful the group could be in getting things done, teaching people how to manage themselves [their memory]. (Participant #18)

Relaxation was so useful. We had a lady come in to teach us relaxation and breathing techniques, I found that very useful. (Participant #3)

Going into hospital with a picture board with your name on it, with what you like and what you want to be called as, and what your favourite food is. That was excellent, that was a good idea. (Participant #3)

Positive supportive relationships

Participants reported meeting and interacting with others who shared a similar experience to them to be the most important and meaningful aspect of the groups. Participants spoke about how much they enjoyed going to the group each week and how supported they felt by one another.

Oh yeah, I get along with the group. 'Cause it helps, you know, and you're not lonely and you listen to them and it's very nice. It's nice being talked to. (Participant #4)

It [the group] livens you up. (Participant #6)

I remember the most the talking and the friends I've made. As it is going now, it's lovely. I want that to continue, it keeps us all together. (Participant #9)

Meaningful activity

It was also extremely important for participants, that the group activities reflected things that were of interest and had meaning to them.

I thoroughly enjoyed the film we had, it was to do with the Old Kent Road and life in the 1900s, it's called 'Say it With Flowers'. 'X' (participant's name) was brought up on the Old Kent Road and she was singing away with gusto and she really enjoyed it. (Participant #3)

[Facilitator] would always ask what you would like to happen in the group; all that was put down by us. (Participant #12)

Discussion and conclusions

The trend in health and social care services has been towards person-centred care and personalisation since the 1990 NHS and Community Care Act (DH, 1990). In recent years, the value of peer support and self-management programmes has garnered interest from health and social care commissioners who are keen to invest in interventions which support people living independently longer. Despite interest, however, there is relatively little research examining the effectiveness of these interventions and none that has been applied within supported accommodation such as in extra-care housing schemes. Studies that have evaluated programmes have tended to focus on chronic physical health conditions, for example, cancer, diabetes, chronic pain and arthritis (Harvey *et al.*, 2008). More recently, peer-led self-management programmes for people with serious mental illness have been evaluated (Druss *et al.*, 2012; Cyhlarova *et al.*, 2014) and have shown positive improvements in patient self-efficacy, emotional wellbeing and healthy living.

The aim of this paper has been to describe the effectiveness of peer support groups for people with dementia living in supported housing. This article offers additional evidence to support claims about the value of peer support and self-management among older people with dementia. The paper suggests that peer support can have a positive benefit on the cognitive functioning of people living with dementia.

The study examined the impact of the groups on: managing memory and memory loss; wellbeing; learning practical coping strategies; maintaining or reducing care needs; and reducing social isolation. Positive findings were reported in wellbeing, memory recall, time orientation, concentration abilities and communication from qualitative interviews following participation in the groups.

The mean SWEMWBS score of our sample at T1 was 22.10. Participants reported minor improvements in wellbeing after the groups, despite the change not being statistically significant. These findings are consistent with improved wellbeing reported from participation in cognitive stimulation interventions for people with dementia and participation in peer-led self-management programmes (Woods *et al.*, 2012; Cyhlarova *et al.*, 2014).

There was some deterioration in the independent living skills over time of participants, as measured on the IADL scale. It may be that the high level of physical frailty and impairment in the sample made it unlikely that practical coping would improve. This is consistent with findings from the English Longitudinal Study of Ageing which found that prevalence in reporting one or more limitations in activities of daily living increased with age (Zaninotto & Steptoe, 2012).

Qualitative feedback at T2 and T3 suggested that participants are more cognisant of each other and had improved memory recall, possibly as a consequence of the increased socialisation opportunities and the cognitive activities they completed in the group. Certainly one of the greatest reported positive benefits were the opportunities to socialise and interact with others with a shared experience. While studies have looked at the relationship between social activities and social engagement and cognitive decline/impairment and dementia, results are mixed (Wang *et al.*, 2011).

The study had several limitations. The small sample size of the groups meant findings from quantitative measures were limited and therefore overall findings must be treated with caution. Drop out was high in the groups as many participants became unwell, went into hospital or passed away during the evaluation. Another limitation was the study did not use a control group of residents living in the housing scheme who were not participating in the groups and who did not have dementia. Though this was planned, through the housing provider's care databases, obtaining data on changes in resident care or wellbeing was not possible during the timeframe of the study.

The value of peer support and self-help approaches in housing schemes should be encouraged by housing providers as interventions like these address the psychological, social and emotional needs of residents living in these schemes. These approaches also support a shift from a supported housing culture that focuses on maintaining individual independence to one which supports individuals' inter-dependence, by encouraging mutual support and sharing coping strategies among people using social care services. A culture of inter-dependence supports community engagement, meaningful activity and supportive relationships, which increases an individual's social support, positively impacts on their wellbeing and reduces isolation and feelings of loneliness.

The findings from this study offer support for claims about the value of peer support groups for people with mild to moderate dementia in supported housing. The evaluation reported improvements in wellbeing, concentration, memory recall, orientation in time and communication abilities following participation in the support groups. The study adds to the research on peer support and self-management programmes and suggests interventions like

these are meaningful and beneficial for people with dementia in extra-care housing settings. Future research is needed to address the impact of these groups on formal measures of cognitive functioning.

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Notes on Contributor

Lauren Chakkalackal is an experienced research scientist with over five years' mental health experience in the UK and Canada. Her research includes evaluations both in the public and voluntary sector working with vulnerable and excluded groups, including: people with dementia, veterans, and gang affected youth. Her research interests lie in examining self-management and peer support interventions for improving wellbeing and resilience. She is a Yoga Alliance Accredited yoga teacher leading workplace yoga sessions with interests in mind body approaches in mental health. She holds an MSc in Mental Health Studies from King's College London and a BSc in Psychology from McGill University.

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Appendix 1: Social relationships questionnaire

1. If you are really worried about something do you have someone you can call/contact/talk to?

- A relative? A staff member? A friend? Anyone inside the home? Anyone outside the home?

2. How many people do you know living here?

- Can you name them?
- Do you consider any of them to be your friends?

3. How many people in the home would you feel comfortable to speak to if something was bothering you?

4. Do you do an activity outside the home? Inside the home?

- If yes, what and how often?

6 month (T2) interview schedule

- What strategies/approaches have you learnt in the group that would help them to manage their memory or memory loss? *Ask them to specify*
- Were you given any equipment from Cindy? – (Date clock, photo book of names, magnifier, calendar, hospital bag, preference sheets, information on planning for the future... power of attorney) Do you use any of the new equipment? Has it made a difference in your day-to-day life? How?
- Have you started doing new things as a result of coming to the group? If so, what things have you started doing?

9 month (T3) interview schedule

- Are you doing anything differently since starting the group?
Prompt: think back to a year ago and now
- Have things changed over the last three months? (Since facilitator left)
Prompts: socializing more, interacting with others in the home, started any new activities, feeling more content with themselves
- What do you remember MOST from the group?
- Do you use any memory strategies in your day-to-day life that you learnt in the group?

