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Why we need to do therapy differently

A Therapist's Guide to Working with Older People

Written by Richard Brocklehurst (Clinical Lead - Sheffield Mind)
and Gilli Cliff (Programme Co-ordinator - Age Better in Sheffield)

Introduction

Sheffield Mind were approached by the British Association of Counselling and Psychotherapy (BACP) to reflect and present at their conference "Working with Older Adults" in relation to the work done in the last 5 years as part of the Aging Better Programme. The conference represented an ideal opportunity for our learnings to be shared with a wider audience of both the counselling profession and the general public, and this paper represents our experiences and thoughts around the work we have done through our Wellbeing Practitioners service.

The case studies are presented from the perspective of therapists to enable the reader to sense how the therapist experienced the work. We felt this method best offered the opportunity to the reader to feel the work, and to see how this therapy was experienced.

Sheffield Mind Therapists who contributed towards this paper

Paula Rolston

Has an MA in Art Psychotherapy Practice and has worked as part of Well Being Practitioners project for 5 years.

Julia Pegg

Has PG Diploma in Counselling and Psychotherapy from York St. John University. She graduated in 2015 and has worked as a therapist on the Wellbeing Practitioners project since January 2018

Joe Charles

Has worked as a counsellor for the Wellbeing Practitioners project since 2016. He also supports trainee counsellors at Sheffield Mind as Student Mentor.

Richard Brocklehurst

Has a BSc Therapeutic Counselling ad Diploma in Counselling Supervision. He is the Clinical Lead and has worked on the Well Being Practitioners project for 5 years.

Age Better in Sheffield contributions to this paper

Gilli Cliff

Gill is responsible for all things learning and evaluation related within Age Better in Sheffield. She works with delivery partners to get the most learning possible out of projects and she's part of the National Age Better Programme Learning Leads group.

Context

Age Better in Sheffield (ABiS) is a partnership of organisations working to reduce loneliness and social isolation amongst people over 50 and to help them to live fulfilling lives. It is funded by the National Lottery Community Fund and is one of 14 Ageing Better pilot areas across England working to explore what works in reducing loneliness and isolation. The Ageing Better Programme is a "test and learn" initiative which allows for a research element to be included in delivery. Age Better in Sheffield services have been commissioned to focus on four target wards (Burngreave, Woodhouse, Firth Park and Beauchief and Greenhill). These wards are the ones identified as having a high percentage of the older population at risk of loneliness and isolation. The first round of Age Better in Sheffield Projects also focused on a number of hotspot areas across the city where there are significant numbers of people in groups at higher risk of loneliness and isolation (carers, people experiencing poor physical or mental health, people experiencing financial hardship and people from black and minority ethnic (BAME) backgrounds).

Well Being Practitioners is currently in its fifth year of delivery and there is now a wealth of learning and experience to be drawn upon when thinking about working in a counselling/therapeutic context with older clients. Securing funding through the National Lottery for a counselling therapy project is not a typical occurrence. In this case Sheffield Mind was initially granted in 2015 £750k over 3 years to deliver therapy to people aged 50 or more as part of Age Better in Sheffield. The project was subsequently recommissioned in 2018 by the ABiS Core Partnership and will continue until March 2021.

Can we evidence that counselling benefits lonely isolated older people?

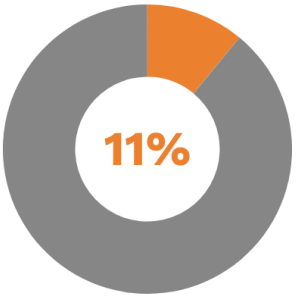
The challenge of collecting data

One of the reasons why the National Lottery do not generally award money for therapeutic counselling work is that they insist on measuring outcomes no matter what the intervention, even if measurable outcomes can be hard to get in this environment. However, although funded by the National Lottery Community Fund, Ageing Better was designated a "test and learn" programme from the outset, and this provided Sheffield Mind with a legitimate setting in which they could test the concept of measuring outcomes of therapy in new ways.

At the beginning of the project there was resistance from therapists at Sheffield Mind to using the Common Measurement Framework (CMF) questionnaires (see Appendix A) which are required by ECORYS, the national evaluators, in order to collect data from all the projects within the 14 Ageing Better Programmes across England. This method of data collection was considered to be outside the remit of mainstream counselling, even though there are forms and wellbeing questionnaires designed to assess how clients are feeling before and after therapy which are used regularly by therapists. The CMF enquires not only into how a person is feeling but also asks about the extent of their family and social networks and connectedness. It also requires the individual to rate how isolated or "left-out" they are feeling and how they imagine their amount of social activity compares to others.

The collection of CMF data has been controversial across all area of Ageing Better Programmes with many delivery partners finding the task of collecting the data arduous or even inappropriate in the context of the delivery. There has needed to be a flexibility in the system to allow those delivering interventions aimed at reducing loneliness and social isolation to know the right timing for completion of the CMF with their clients. At the start there was a tendency for therapists to feel they must complete the questionnaire right at the start of therapy which resulted in tensions. However, as the Well Being Practitioners project has progressed therapists, who struggled at the start of delivery with this task, have experienced a shift as relationships with clients were built and confidence in delivering therapy in different ways grew. Now there is a much better understanding of when to complete the forms and no longer a reliance on set timescales and agendas.

What does the data show us?



of Wellbeing Practitioners' participants have been BAME, compared to just 7% of Sheffield's 50+ population in the 2011 census

Top 3 minority ethnic groups

Asian / Asian British: Pakistani	3%
Black / Black British: Caribbean	2%
White: Irish	2%

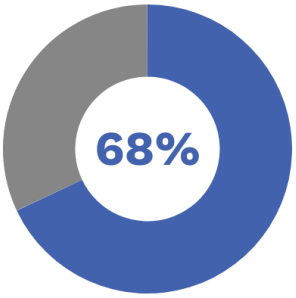
Gender of BAME participants

82% of BAME participants are female

Compared to

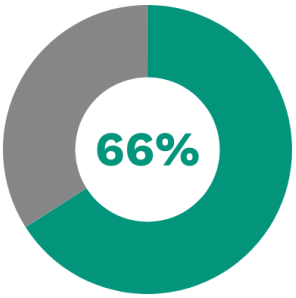
66% of White British participants

Nearly **a quarter** of female participants are aged 70 and over, compared to less than **a fifth** of male participants



of participants have been female, compared to 51% of Sheffield's 50+ population in 2019

50 - 59	40%
60 - 69	35%
70 - 79	15%
80 - 89	9%
90+	2%



of participants have been between 50 and 64 years old.

Common Measurement Framework

In 4 of the 12 CMF outcomes, the majority of Wellbeing Practitioners participants improved their wellbeing throughout their time with the project, these being:

Short Warwick Edinburgh Scale	65% improved
EQ VAS (health state today)	61% improved
Co-design	59% improved
UCLA Loneliness Scale	52% improved

In no measure did less than 28% of participants record improvement

Impact of therapy

In the bespoke questionnaire, participants are asked about their thoughts about and the impact of the specific types of therapy that they have received

91%

of participants said that 1:1 Therapy helped with their self esteem

83%

of participants said that Art Therapy helped with their confidence, and

70%

said that Art Therapy helped them with social interaction

91%

of participants said that Drama Therapy helped with their confidence

95%

of participants said that Dance Therapy helped with their confidence

95%

of participants said that Storytelling Therapy helped with their confidence

Doing Therapy Differently

The challenge of collecting data

The Wellbeing Practitioners Project was introducing a more holistic approach to therapy because it was asking the clients about their experience of loneliness and connectedness and putting it in a social context.

It was also working with an entirely new client group: those who were most isolated due to age and underlying physical and mental health conditions. Suddenly the client group included not just the "worried well" but the disabled, the bedridden, the housebound and those "shut-ins" who would never have made it through the door of the Sheffield Mind building. At the start there were 3 clinical therapists involved and 50% of the therapy was taking place in people's homes. There had never been a "counselling at home" service available before and once GPs in the hot spots found out about it, they started referring patients. Then community support workers got to know about it and started making their own referrals. Loneliness and isolation were not the main guiding light for referral of clients in the beginning; the service was more concerned initially with getting people through the door to make sure they hit their delivery targets. It was promoted to the NHS as Sheffield Mind rather than as part of "Age Better in Sheffield". ABiS was an unknown brand and as such it would have been difficult to build trust with medical practitioners.

Is getting an older person out and about the gold standard for reducing loneliness and social isolation?

The demand increased as the project got better known and potential clients realised that therapy could take place in their own home and was convenient, but what were the criteria for a person being counselled at home rather than attending an appointment? If the intention was to discover ways to tackle loneliness and isolation is it possible that some clients would have been better off being encouraged to leave their own home for counselling? Maybe in the eagerness to meet targets Sheffield Mind was at times too eager to oblige clients by seeing them at home when they could have benefitted more from been seen in a more social setting.

The initial model has envisaged the first 3 sessions being delivered in the client's home setting with the intention of then "encouraging" the person to get out and attend the other sessions. This was soon seen as unworkable since many within this new client group presented multiple challenges to the idea that "getting out the house" was a central goal. Was it a failure of the project if at the end of 24 sessions the client was still in the house? The answer must be a resounding "no" and it is important to appreciate that the factors leading to a person experiencing regular loneliness and becoming socially isolated cannot simply be resolved by getting an individual to leave the house

or join a group. Neither can therapy be seen to be a failure if, at the end, the resulting score on wellbeing scales may indicate that the client appears to be in a worse position than when they began. Therapists were very aware that for this client group it was the first time that many of them were confronting certain issues and emotions. The depth and quality of therapeutic relationship will be a factor in allowing the client to come to terms their loneliness and with life as it is. By showing warmth, compassion and honesty the therapist is modelling a healthy relationship. The outcome from the final data may indicate that the person is in the same position as before but with greater inner peace and potential to change. Therapy with this client group was not aimed at "fixing problems" but rather at increasing the levels of comfort a person feels with themself and encouraging them to want to have healthy connections and build positive relationships with others. In many cases people were not simply isolated from other people but they had become isolated from themselves, from nature, from hobbies and interests. Loneliness was so much more than the absence of company. Therapy led to new levels of self-awareness for many of the clients which in turn led to the admission that they were indeed lonely and had become socially isolated.

The new client group and the home environment - how it impacted the way we do therapy

Going in as a therapist to a completely new client group brought up a range of issues that had not needed to be addressed previously. At the start therapists weren't aware of the need to do things differently with this client group. Professional training dictates how counselling should traditionally be done and initially there was reluctance to change that. Boundaries between therapist and client were too rigid for the new setting and questions arose about what the therapist was responsible for and where did the job begin and end? After a referral for therapeutic counselling at home two Sheffield Mind staff, including a therapist, carry out a risk assessment of the individual in their home. There had been no prior preparation or training for therapists to determine if they should be working in a particular home situation with a particular individual. Some of the people referred to the project were living very chaotic lives in homes that were dirty or cluttered and staff would have benefitted from training on how to assess and work specifically in those situations. There were times when it was clearly inappropriate to work in the home. For example, if the person referred was bedridden or there was no privacy or confidentiality. General conditions in the home such as evidence of hoarding or the presence of certain types of pet might also lead the therapist to feel that the risk was too great.

One Sheffield Mind therapist said the experience was a "real eye opener"

"Don't assume anything when you walk through that door; therapists are taught to be in the moment which is fine if they have control of the counselling environment, but you are incredibly vulnerable when you walk through that door. You are not in your familiar room and you could be accused of anything. It shakes the fundamental foundations of your training. You are not in control and the client has more control. You need to acknowledge your vulnerability because therapy is all about power balance and being a better therapist means being honest about the vulnerability issues and admitting what it's like to be vulnerable. Going into people's homes is a real eye opener. Therapists had never imagined working with people that people live in that way: poverty, hoarding, life limiting illness, people at a very different stage of life, maybe at the end of life and not necessarily looking for change but acceptance". **Richard**

To be or not to be: solve the problems or be preventative?

Practical problems were a constant vexation to the therapists working on the WBP project. On entering someone's home and seeing a curtain rail hanging precariously from the wall, noting that the client appears to be neglecting their physical wellbeing or that a heater is clearly unsafe what is the right response from the therapist?

"We were just not ready to go into the hellhole that is someone's home" Richard

The same boundaries do not exist as in the counselling room and a very natural response on seeing a potential hazard is to think "that needs sorting". Often the therapist's own sense of discomfort was acute and would distract initially from the therapy. Richard acknowledges that each therapist must decide what they are comfortable with and the decision to intervene to solve a problem should be a personal choice. For example, Richard felt strongly that he couldn't leave that day without addressing what he saw as a danger to the client and the curtain rail was taken down after speaking to them about it.

Hoarding is recognized as one of the most challenging circumstances that a WBP therapist may encounter in a client's home. Richard goes on to say,

"It's overwhelming. What can I actually achieve in this situation? Hoarding's about self-esteem so it's very important not to judge the person. And they can't always find their own answer. It is overwhelming but we have to start somewhere so, "my name's Richard".

The therapist is there to be nurturing and not to be the critical parent chiding a client for the hazards or the mess. The aim is to increase a client's self-awareness, so they come to appreciate the dangers for themselves. Going into someone's home means that at times you will be confronted with personal neglect; the person is not eating properly and fails to get dressed in an appropriate manner. It is important to remember that the therapist is not a rescuer and that the client has survived up until this point.

There have been occasions when physical conditions have been too chaotic for therapy to continue and honesty is required in stating that the environment is just not conducive. There must be what Richard refers to as "mutuality of respect" and he stresses the importance of starting off on "the right foot":

"Lots of therapists struggle with internalizing so they aren't open with the client. We are told that self-disclosure and self-revelation are to be avoided but being real and admitting frustration is simply being genuine and it's not a mistake. It's important to own the frustration, the uncertainty and the all "unsaids". Richard

Richard observes how the age of this client group also changes the dynamic and that older people are more prepared to be blunt and "tell it how it is". Terminal illness or chronic ill health mean that "the clock is ticking" and the "now" becomes more important. A client may be approaching therapy with the view, "I want to process my life before I die".

When you walk through that door into an older client's home keep in mind:

- It's not all about "you" the therapist
- You are not being deskilled as a human being but instead you are being reskilled
- One size doesn't fit all in therapy. As students we are given a modality and then we try to fit that to the client; this doesn't always work.
- Therapy is co-created; it is a joint venture and it can go wrong. You think the client "wasn't ready" but were you ready?
- Model the behavior you want to see.. Be real. Be honest, show respect and empathy.
- Be genuine; we are disingenuous when we won't talk to clients about death.

Losing my Religion - What are we learning as therapists?

"So, what is my identity if I am not on the other side of the counselling room and you are the client? There are therapists who may not be prepared to face the issues that arise when working in a home environment with older clients. The project was not one that every therapist could get on board with. Not all the clients wanted a therapeutic intervention, some just wanted a chat, but not all therapists wanted to "belittle" themselves a professional by taking on such a humble role. Yet it was in that place of chit chat that trust was built, and people began to open up, like the woman who admitted after several weeks that she had an illegitimate child when she was 16 and the baby was then adopted". Richard Clinical Lead on the WBP project

Joe Charles is a therapist at Sheffield Mind who has worked on the project since in 2016. When he began, he was a newly qualifies therapist working 50% of his time on WBP and the other 50% on "traditional" counselling. "I didn't know what I was going into at the start" he said; these are his reflections.

"What really stands out for me is the variety of settings in which I have worked. In these environments I am surrounded by the objects of the client's life. At times this presented a challenge to therapeutic work as there were more distractions than there would be in a traditional counselling room. However, as my experience grew, I recognised the value of engaging with what was around us, helping to build trust and the 'therapeutic alliance'. Working in a project that categorises people by age lends itself to generalisations. In counselling it is essential to see the individual rather than the label. By physically entering the client's world I was able to experience firsthand something of how the client lived. The traditional counselling settings can reinforce the power imbalance between therapist and client. Therapist as expert professional and client as vulnerable person in need of support. In this dynamic the perception can be that the organisation and therapist hold the power. Working with people who would not normally have accessed therapy in a setting where they were perhaps more comfortable than I was helped to challenge that perception before it became part of my subconscious thought process.

Congruence is something that therapists talk about a lot. They also talk about avoiding self-disclosure in order to keep the focus on the client. There is a conflict here and it is still something I am working on. Am I choosing not to share my vulnerability because I don't want it to be all about me or is it because I don't feel comfortable exposing myself? This is hopefully a conversation which therapists have regularly in supervision or in their own heads.

I think that working in this way at the start of my life as a qualified therapist meant that I was able to apply the training I had received over the previous 5 years rather than being influenced by previous experience. I entered the clients' worlds without a pre-conception of what counselling 'should' look like. Supervision and conversations with other Wellbeing Practitioners also supported me with any doubts that I experienced." Joe Charles

Julia Pegg started working as a therapist for WBP in January 2018. She admits that in the beginning she thought of it as "counselling with elderly people" and was probably influenced by stereotypes but says her assumptions have changed over time. She is very aware that many older people never get the chance to tell their story, "I wanted to be part of allowing them to have their voices heard". In this reflection Julia talks about "finding her groove".

"I always felt very held and supported by Sheffield Mind and I got to observe a counselling assessment in an older client's home before going in alone. Obviously, it's not a controlled environment like working in a GP's surgery or a counselling room and there's lots you can't control like doorbells, phones ringing and the TV. When you go in and the TV is on what should be my response? Do I ask the client to turn off their TV in their own home? It's all about boundaries and needing to negotiate those boundaries. It's also about honesty and trust. Pets, now that's an interesting one and I've had some experiences around this since I started with WBP. Birds in particular; I don't like birds very much, certainly not flying round my head or landing on me. But clients who are socially isolated and fearful of travelling anywhere rely absolutely on their pets for company: dogs, cats and birds.

You don't necessarily see lives change dramatically but somethings can change. For example, one client had a deep-seated mistrust of the GP, the care givers and me, well all professionals really and she has softened her approach. Therapy has helped some people feel more comfortable with themselves so they could connect with community support. It's helped some to address difficult relationships and to be able to say, "I have needs too". People don't always know they are very isolated until they get into therapy, but they are. If you have no one at all in your life but then you start to open up in therapy, and you get heard and validated then that person feels more able to reach out and get support.

Working on WBP I have certainly gained a great deal of experience and I've had brilliant support from Sheffield Mind. It's impacted my personal development through increasing my confidence, enabling me to feel more comfortable with taking a risk and asking difficult questions. I'm more secure and feel better able to challenge clients when necessary." **Julia**

More than just "talking"therapy

One to one therapy in people's homes has remained the core element of WBP throughout the delivery of the project but other types of therapy have also been part of the service.

Art therapy was there from the start of the WBP project both for groups and individuals Individual art therapy took place in the Sheffield Mind office while groups could also be run in a community settings, at venues in the project "hotspots" and linked with partners who were known to Sheffield Mind. Art therapy is seen as a very useful intervention for trauma work and can be helpful if the person has difficulty verbalising their feelings or if English is not a language they feel comfortable with. Art therapy also allowed older people to express feelings that perhaps otherwise would have seemed unacceptable to express.

Reducing Isolation through Group Art Therapy
A reflection from Paula Rolston – art therapist working on WBP project

Well Being Practioners' Art therapy groups at Sheffield Mind generally run for 12 weeks. Therapeutic groups are 'closed' to provide a safe and confidential space where clients come together with the same people each week. In my experience, this enables folk to overcome anxiety about meeting new people, to gradually connect with one another, and to develop confidence as they experiment with something new; whether this be with the art-making, or with new ways of being in the presence of others. During the main activity, the group explore a common theme, often through paint, pastels or 3D materials. The theme of 'isolation' is often significant. For this group, the pressures of being a carer, the loss of loved ones and a longing for support seemed to have been significant factors in their sense of isolation.

From week 7, as this art therapy group began to share their feelings around the group coming to an end, I could already sense deep sadness around letting go. Just as they were beginning to feel safe in one another's company, relaxed within a room that had begun to feel familiar and permitted to share difficulties and painful realities, this experience would soon have to end, and they would say goodbye.

For me as the therapist, it was important to share my observations; in the context of this group, what we'd seen emerge in the artwork and shared conversations around isolation, peoples' stories had really resonated with one other. Could it be that allowing oneself to be vulnerable in the company of strangers, could also happen outside of the space at Sheffield Mind? What was it that people had done differently that they could try outside of the therapeutic space? Perhaps that same courage to face initial anxiety and stick with a new situation, could reap rewards.

In the weeks that followed, the group worked towards their ending. They shared advice around other creative groups and possibilities in the community. One member decided to become a befriending volunteer with Age Better. Another talked about having contacted an old friend.

'Group Art Therapy has been invaluable. It has helped me to learn that it is good to socialise and meet new people after years of being isolated. With it being therapy based, it gave me time to explore some complex emotions that I had been unable to verbalise - to have this with Paula in a safe setting has changed my life for the better.' WBP client
(Written permission has been given for the anonymous use of clients' words and images)

Dance and Movement Therapy was added in year 3 just before recommissioning and was offered on group only basis. This type of therapy can greatly help older people to work with their pain; They learn how to hold the body so as not to exacerbate the pain. It can also be about helping people to release or reconnect with their body and emotions, for example anxiety influences the way we hold ourselves. Dance Movement therapy emphasizes the body as a tool we use and as we get older the tool seems less effective and can lead to frustration and limitation.

Mindfulness began 2019 as group therapy in community settings and was as a direct result of clients who has gone through therapy completing the WBP bespoke questionnaire (see appendix A) indicating that they would be interested in taking part in different and creative forms of therapy. It was therefore aimed at people who had already experienced therapy and was not seen as an appropriate intervention for people who were in trauma or grief.

Bringing a more openminded attitude to therapy has been essential in developing the project. Previously a therapist may have judged that some of the above interventions were not relevant to the age group. Now therapists see these as very useful for clients in the older age range and to reach older people in BAME communities. As a direct result of the evidence showing the effectiveness of these interventions within WBP, National Mind have funded a project at Sheffield Mind to use creative therapies to work with asylum seekers.

Exit via the Gift shop
How long is long enough and when is enough ever enough?

The WBP model is 24 sessions x 50 mins per client which can be delivered over any period and is reviewed every six weeks. 75% of clients have completed the full programme but the total number of sessions offered to a client is decided on a case by case basis. For some clients it can be more productive not to know that they have the possibility of a full 24 weeks as this may mean the client feels no sense of urgency and the therapy tends to meander rather than have a clear focus. There is a "perception" that people need long term therapy, but this comes more the therapist's point of view rather than the clients. Short term therapy can be empowering for the client who then moves on rather than getting stuck in a long-term relationship. The empirical evidence says statistically that 6 week's intervention can be just as effective as very long-term therapy. Therapists tend to think 6 months must be the gold standard and that they can do better work over a longer term. However, co-dependency can build

up over 24 sessions as the lonely isolated person becomes more and more reliant on the therapeutic relationship. The client will want to hook the therapist into a longer intervention and in some cases the relationship was extended by a further 6 sessions.

The exit from therapy is always well planned and the client receives plenty of notice. Lots of clients are ready to finish and will have found a natural conclusion. However, it's important to start the process by being very clear that there will be an end; not mentioning the possibility of 24 sessions and reviewing every 6 weeks does make it easier to find a natural ending.

Is it worth the money?
What does a good outcome look like and have we reduced loneliness and social isolation?

The classic exit from therapy would be, wrap up and review followed by the client telling the therapist how much they got from it. But with this new client group it was harder to exit if the person was still identifying as lonely and isolated but had stopped being lonely while the therapist was visiting them. Sheffield Mind were focused on delivery of therapy and not primarily on the issues of loneliness isolation; that is to say, the funding of £250,000 was to be spent on delivering therapy rather than on reducing loneliness and isolation. Would it even be possible to see a link between a therapeutic intervention and a reduction in loneliness, or an improvement in wellbeing which led to greater social connectedness? Can therapy of itself address loneliness and isolation? The answer appears to be yes, it can do, by empowering the individual and making them more aware.

"Setting out to solve loneliness was not the goal and it certainly isn't a linear process that starts with ABC and end in XYZ".

"That the person feels, in the end ok, not necessarily "cured", but has arrived at a point of awareness and acceptance is a very positive outcome for the intervention; that maybe you've helped them towards a bit of acceptance and peace." **Richard**

This generally follows from acceptance of things as they, for example, a life limiting health condition is something that is not going to change. "Fighting the battle" is a frequently used metaphor and yet acceptance is often the better course of action and is more realistic. The therapist will need to stop digging into the past and accept that not all present distress relates to the past. In fact the reason why the majority of people in this age group are suffering poor mental health is not related to stuff that happened years ago but is because something happened recently: the death of someone they had been with for a long time, retirement, son/daughter moved away, a hip operation went wrong. Much of the help that is needed is practical and

immediate, so was it right to spend all immediate, so was it right to spend all the money on the therapy? Maybe half could have been spent on counselling and half on support work so that the test and learn model would have been to study the relationship between the two forms of support.

The Ripple Effect which is also delivered by Sheffield Mind and was commissioned by Age Better in Sheffield in 2019, was in fact conceived as a way of testing the idea that people need two different kinds of support: emotional and practical. We already have evidence from this new project to indicate that we would be wrong to underestimate the power of practical help, and the likelihood of it leading to someone opening up to emotional support, just as we know from our experience as WBP therapists that mere "chit chat" is a valuable way of building trust and allowing an older person to feel comfortable with disclosing personal or painful things.

There remains the question in our minds as to how do you give people a therapeutic intervention if their basic needs aren't being met? If the is curtain hanging off the wall, the heater poses a danger and there's no food in the 'fridge, isn't there something more important here that the clients therapeutic needs? This is a tension that exists between a frontline delivery person, such as a therapist, and "the project". It is a tension that will remain because funding does not allow us to be all things to all people. We are part of a national programme which has explored different ways of reducing loneliness and social isolation to help people reconnect and as we come towards the end of our delivery we can say for certain that therapy does have a valid part to play in that process.

Appendix 1

case studies

Case study 1

Barbara

Why does satnav never work? A bit of a script there, I say to myself as I approach my new client's address. I am going to be late; they don't tell you about these problems on your counselling course. It's all eye contact, posture reflective practice none of this of "oh my god I am going to be late and it's raining".

Barbara was a new client as part of our Well-being Practitioners project, where we saw clients in their own home if they couldn't make it to the office. She had been assessed and, due to her illness, was a clear case of being seen at home.

I finally find the flat number and press the buzzer to be let in, "stay in the now they say", but hard to do when you are wet and flustered.

Come on answer the buzzer. Is she there? How long do I wait? Finally, a voice comes over the intercom, "Hello", I reply, "It's Richard from Sheffield Mind". Barbara buzzes me in after delivering very complicated directions on how to reach her flat. I can follow numbers I thought; so much for being non-judgmental.

As I enter the building and walk down the corridor, a voice shouts "where's the loo?" Are they talking to me? I had just gone past the sign for the toilet. I look around and there's no one else, so they must be talking to me, I thought. In the same instant I think: should I engage with this person because I'm already tight for time and those boundaries matter? But I'm a human being and it will only take a second so point to the toilet. The gentleman takes an age to respond. I feel my frustration rising, but he needs help and it's the right thing to do. Eventually he finds his way and now I'm definitely late. Barbara will think I can't even follow simple directions. I need to make a good impression, that's my inner voice.

I press the buzzer and wait conscious of being five minutes late. This is what you get for being kind; next time I'll just walk on. Where is she? This is turning into the worst session ever and it's not started yet!

After what feels like a long wait, Barbara answers attached to a feeding drip and using a walking frame and I fail on non-judgmental again. Richard, great therapist!

"Sorry for being late", I say and think about offering an excuse but then I reflect on being real and genuine. Instead I tell Barbara about my encounter on the way to her flat,

"Oh that's Frank" says Barbara, "He does that to everyone to get their attention". In that moment a relationship was formed, I was congruent and genuine Barbara had showed me empathy. I can see this client is going to teach me a lot and if we both stay real, I hope we can learn a lot from each other. It feels very different from those staged triads that I remember from classes at college but then this is "real" therapy.

Case study 2

Bill

I like Bill: first call in the morning near to home, cup of tea, nice house, no real issues, what could be a better start to the day? Don't think I'm missing anything, therapy is going well, Bill's opening up slowly, he's just a bit lonely and needs company and to re-connect following the death of his wife.

I arrive at 9 am and my tea's ready as usual, just how I like it as well. Perhaps the boundaries are getting a bit blurred, but we are moving things forward and we are only 4 sessions from ending; I think our work here is done. Good work Richard.

The session progresses as usual, talk about loss and how my visits have been really helpful; note to self: positive feedback is always good, I don't think he is trying to please me and fit in. I glace at the clock, 10 minutes left, need to be at next one, time is tight and it's a new client so I can't be late. Perhaps, I could wrap it up 5 minutes early, Bill won't mind, after all he says my visits have helped and our work here is pretty much done.

I start to look for a window in our conversation to wrap things up early when Bill states "I know we have only got three more after today but there's something I would like to tell you. I was adopted when I was a baby and have never told my family or wife and I think I need to tell them". My complacency is immediately shattered, I think, "Richard, what have you been doing for 20 weeks that you didn't see this coming?" and "There I go again, thinking about me when what I should be thinking about why Bill hasn't told anyone that for 75 years".

I am suddenly at a loss and don't know what to say or how to say it. Perhaps this is how Bill has felt all his life? I know though, that whatever I say, it should acknowledge what has just happened and Bill's present vulnerability and openness, so I reply with honesty, "Wow Bill that caught me by surprise, but I'm honoured that you felt you could tell me". Bill's response is, "I knew I could trust you, you kept coming and listened to me without looking bored". The therapeutic relationship comes in many forms.

Case study 3

Colin

I had never offered counselling in a client's home before this project, but in spite of my initial concerns I was starting to get the hang of it. The 'rules' were a bit different of course, and the environment played a big part in terms of boundaries, dynamics and therapeutic interventions. I'd reflected heavily on my initial concerns (as counsellors we reflect on everything, it's ingrained into us from training onwards) and after over a year of working in this way I felt secure in the counselling I was offering. When Colin opted for counselling at home due to struggling with agoraphobia and anxiety, I was happy to offer it.

That was until I walked into Collin's apartment. He politely greeted me at the door and showed me through to the living room, where the television blared out a snooker game. He then proceeded to sit in front of it and watch. I sat down on the chair in the corner and rummaged my papers around, giving him an opportunity to press the off button. He didn't.

"Now what?" I thought to myself. The "parent" in me wanted to tell him off for being rude, the "child" wasn't about to tell someone what to do in their own home and the "adult" tentatively suggested addressing the issue with the client. I ignored my experience, wisdom and gut and opted for avoidance, and ploughed on with my first session blurb whilst in competition with Ronnie O'Sullivan. Colin reached for the remote – hurrah – to turn the volume down. Ah well little victories.

By session two the television was on mute when I arrived, playing an old Manchester United game. I was thankful at this point than mine and Colin's hobbies differed greatly, so I didn't get any more distracted by this than I already was. By session three the TV was on pause and by session four I had mustered up the courage to ask how Colin would feel about turning it off. He felt OK, and off it went; it didn't come back on for the remainder of the sessions we had.

It wasn't until around session 8 that we discussed this unorthodox start to the process. I had suspected that the television wasn't about what programme was on but instead it was a way in which Colin could keep me at a distance. The things he wanted to talk about were hard: historical abuse, rock bottom self-esteem and feeling unworthy of love. These are not subjects you can reel off easily, especially as Colin had never had an opportunity to discuss them before. But as the therapy went on, he started to share himself with me. We reflected on how difficult the counselling process was for him, and how unusual it was for him to have his voice heard and

respected. We talked about the television, and how it had made Colin feel safe to have a barrier to protect himself in those first few sessions. But as we progressed, he had realised that I wasn't someone he needed to protect himself from.

Counselling clients in their own home has taught me to expect the unexpected: pets, noisy neighbours and World Snooker Championship Semi-Finals. They are a part of my clients' reality and they provide me with an insight into their world that would otherwise be lost in the four walls of the counselling room.

Case study 4

David

As I pulled up at David's house for our first session, I was excited, curious and a little bit nervous.
I had recently qualified as a counsellor and this was my chosen vocation in life. I had gained my experience volunteering at Sheffield Mind and they had now offered me a permanent role. They rated me as a therapist, and I was confident in my practice.

I would be working on the Well Being Practitioners project with older people, often in their own homes, delivering a free service for people who would otherwise have been unlikely to access therapy. Reaching these people meant working in a non-traditional way and it would bring new challenges. I would be outside the consistency and safety of the therapy room, but I was relishing the opportunity.

David was the first client I would be seeing at home and for me this was unknown territory. All my previous clients had been seen in a counselling room which I was familiar with and where I felt in control of the process. The balance shifts as soon as you enter someone else's home.

As I walked up to the door and heard barking I thought, 'Great, I like dogs". My affection for David's pet would help us to establish an early bond.

"Nice to meet you Joe, do you want a cuppa?" "Erm..." (I'd love one I thought but something tells me I shouldn't), "No thank you David" I replied.

David brings his coffee over, "You don't mind if I smoke do you?" he asks. Well yes, I do as it happens, but I also don't want to start by telling him what to do in his own home, "Could you smoke it in the back yard?" I suggested. And this is the way our 6

month relationship began: me going through the therapy agreement while a border terrier lay at my feet and her owner stood nervously smoking at the door.

My instincts told me that this was OK, but back in the Sheffield Mind office I didn't share this with any of my more experienced colleagues and I didn't take it to supervision. Why not? Because I was afraid that they would tell me I was doing it wrong.

But David didn't think it was wrong. We came to an agreement about his smoking that kept me safe and I started accepting his offer of tea. He didn't feel I was judging him but rather that I treated him like an adult. He felt safe enough in his surroundings and the relationship to be able to express and explore things that had been buried for 50 years.

Case study 5

Helen

As I pulled into the street, I just knew it would be the most run-down house. Yes, I was right, however much we say "stay in the moment" our minds can't help running forward and creating an image we either fear or hope. "Come on Richard. Focus, every client is new and different, and we must be the core conditions, even if that bin really does smell awful".

The door looked like an original, a 1950s original and I could not quite understand how it was still on. I knocked gently and waited. What greeted me, was not what I expected, and I wondered and would ask later, was I not what Helen had expected either. Helen presented herself at the door dressed immaculately. My inner voice said, "When will you learn Richard? Be in the moment". Easy to say, much harder to practice.

If Helen had come to the office, I would have seen a version of her that she felt comfortable presenting, but by entering her home, I was seeing her world. It's one thing empathising in the office with that "version" of the client and it's another empathising with the "whole client", mouldy wallpaper and all. I thought, "I must chat to my supervisor about this", and then I thought, "And there I go again, not being in the moment".

We make our way into the front room and I am immediately struck by the curtain dangling from its rail over the fire. Now here's the challenge: talk about it and potentially be judgemental or leave it and wonder is it's going to set on fire at some point? Safety first so I enquire tentatively, "Does the fire work?"

Helen knows exactly what I am saying and replies "Sorry yes, I know it's a bit of problem, but I can't get anyone to put the curtain back up". Notice that "sorry", as if she had to apologize to me, and yet I am the one who had made a clumsy and non-too congruent statement of, "That curtain is going to set on fire." You didn't need to be a therapy genius to recognize this relational pattern.

As a chance to redeem myself, (to myself at least), I could look to work with Helen to fix the problem. Don't be looking for the self-actualizing tendency when there is a fire risk, I'm sure there's a CPD course in that. We mutually agreed to contact someone to fix the curtain and then began our work together. I had catching up to do. I had seen Helen, now it was my turn to let her see Richard.

Case study 6

Paul

I was working with Paul who was stuck at home and had an alcohol dependency. He had been referred into the Wellbeing Practitioners project by an alcohol support worker and in the past I would have felt it was my role to focus on this issue and trying to get him to reconnect socially. But in the four years I had been working as a therapist I had learnt to trust in the relationship and to focus on building the connection in the room. Trying to encourage the client to join social groups that they aren't ready for often raised anxiety.

Still, Paul wasn't easy to connect to. He was erratic. Some weeks he would barely talk, others the floodgates opened. I was on my guard. I suspected that he was only opening up when he had been drinking but he wouldn't admit to it. My frustration built and we couldn't connect in this atmosphere of mistrust.

So, I asked him– "Paul, have you been drinking?"

He said he had and so we talked about it. Alcohol was his security, his safety blanket. He didn't have much else, it gave him a sense of control. He knew it was unhealthy but resisted sobriety because he was scared. When he was sober he avoided connection which might unearth pain from the past. He couldn't engage in society unless it was through alcohol, so stayed safe at home.

The mutual understanding that I was not trying to stop him drinking and I was not there to get him out of the house was the basis of our work together.

He sometimes had a drink during our sessions, I didn't judge. Neither of us was at imminent risk. He had explained why and I respected his honesty. If I wasn't there he'd be alone and probably drinking more.

As we ended therapy, life for Paul didn't appear to be much different. But it was. He had talked about things he had never spoken about. He was less isolated, not because he was going out and seeing people, but because he had experienced connection to another person. Most significantly he was more connected to himself.

Case study 7

Tom

Tom described himself as "in a bit of a mess" when he came to see me, but he didn't look like he was in a mess at all to the casual observer. He came to his first session in a nicely ironed shirt, tailored trousers and polished shoes. In my jeans and trainers, I felt like I could have tried harder.

Tom's wife had sadly been diagnosed with dementia and was living in a care home. Tom had wanted to take care of her at home but had realised early on that he didn't have the physicality, either in himself or in the space at home. He visited her every day and spoke of finding life difficult without her. He wasn't used to being alone or looking after himself. He was polite, considered and courteous. I warmed to him quickly.

However, I realised that although Tom was open and forthcoming about his life, everything from what had happened in his early years right up to present day, he rarely spoke about his feelings. As a counsellor, this soon bothered me. "Feelings" are our bread and butter. Thoughts, yeah OK. Behaviours? I guess. But feelings are where the process is at for us. I found myself on more than one occasion pushing my 'feelings agenda' with Tom.

"And how does that make you feel?"

"Well the situation was an inconvenience, but we managed to make it work."

"But how does that make you feel?"

"I don't think he should have behaved in that way."

"HOW DOES THAT MAKE YOU FEEL?!?!?"

"It wasn't a very good experience to be honest."

After a few sessions, my sense of curiosity and frustrations finally lead me to enquire about Tom's relationship with his feelings in a more direct way: simply observing that it seemed he was uncomfortable engaging with them. He again skirted around this. I then shared some of my feelings about the things he was talking about, and again I got a dismissive response. I decided to leave it at that. This was Tom's space, and if he wanted to tell me the ins and outs of his life in a factual way, that was up to him.

I remember being taken aback when Tom said to me, out of the blue one session, "I've shared things with you I've never told anyone else before." But what have you shared? I thought to myself. I realised that Tom and I had different expectations and perspectives of the counselling process. I wanted him to engage with his inner most feelings and process them to develop a deeper understanding of his edge of awareness on the path towards self-actualisation. He simply wanted to talk about his life, with someone who would listen. He had always been the strong one, the confident one, the in control one of the family. I thought a little more about my first impressions, and the impressions he perhaps leaves with others. For him to say, "It wasn't a very good experience to be honest", or to even acknowledge that the situation was "a bit of a mess" was a big deal for him, even if it didn't seem it to me. For a long time after I finished working with Tom, I was left thinking about perspectives and expectations, I still think of him when I need to give myself a reminder to watch mine.

Appendix 2

www.agebettersheff.co.uk

Age Better Questionnaire

Age Better Questionnaire

Customer ID number:

Thank you for taking the time to fill in this questionnaire. Please fill in as much as you can. The questionnaire helps us to measure the impact the programme has in reducing loneliness and isolation in older people.

For further information please refer to your Evaluating Age Better Booklet which should have been given to you by your local project.

I consent voluntarily to be a participant in this questionnaire (please tick below if you agree)

I have read the Evaluating Age Better Booklet, or it has been read to me and I understand it.	☐ Yes, I agree	☐ No, I don't agree
I have had the opportunity to ask questions about the Evaluating Age Better Booklet and any questions I have asked have been answered to my satisfaction.	☐ Yes, I agree	☐ No, I don't agree
I consent voluntarily to be a participant in this questionnaire.	☐ Yes, I agree	☐ No, I don't agree

About you

Name and title:

Address:

Signature:

Date:

D	D	M	M	Y	Y	Y	Y

If anyone is helping you to complete this questionnaire, what help are they giving?

Reading out questions? ☐ Support/companionship? ☐

Other (please specify)

You can withdraw your consent at any time by contacting Vic Stirling, Programme Lead on Age Better in Sheffield by emailing agebettersheff@syha.co.uk, by calling us on 0114 2900 294 or by writing to us at Age Better in Sheffield, 43-47 Wellington Street, Sheffield, S1 4HF.

Project name:

Delivery Partner:

A bit about you

There are a number of topics in this questionnaire, but the first questions are about your background.

If you have completed the Consent and Personal Information form, please skip to question 4.

1. Who do you live with?

Alone	☐	In residential accommodation	☐
With a spouse or partner	☐	Prefer not to say	☐
With family	☐	Other	☐

2. Do you have any longstanding limiting health conditions that have troubled you over a period of at least 12 months or that are likely to trouble you over a period of at least 12 months? This could include physical conditions, sensory impairments and dementia.

Yes ☐ No ☐ Prefer not to say ☐

If yes, please tick all that apply to you

- ☐ Ability to hear – profound to mild deafness
- ☐ Speech impairment
- ☐ Ability to see – blind or partially sighted
- ☐ Mobility or physical impairment – limits or restricts physical movement, coordination or manual dexterity
- ☐ Long-standing illness or diagnosed health condition – eg. Cancer, HIV, diabetes, chronic heart disease, rheumatoid arthritis
- ☐ Learning or development disability – eg. Downs syndrome, autism or dyslexia
- ☐ Impaired memory/concentration or the ability to understand – eg. Stroke, dementia, dyslexia, head injury
- ☐ Dementia
- ☐ Other, please state

3. Do you have any longstanding mental health conditions that have troubled you over a period of at least 12 months or that are likely to trouble affect you over a period of at least 12 months? This could include mental health conditions such as depression, bi-polar disorders and schizophrenia.

Yes ☐ No ☐ Prefer not to say ☐

4. Is there anyone who is sick, disabled or elderly who you look after or give special unpaid help or care to (for example a sick, disabled or elderly relative, wife, husband, partner, child or friend)?

Yes, to a relative ☐ Yes, to another ☐ No ☐ Prefer not to say ☐

5. Overall, how satisfied are you with your life nowadays?

Please tick one number (1 = Not Satisfied, 10 = Very Satisfied)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. Below are some statements about feelings and thoughts. Please tick the one that best describes your experience of each over the last 2 weeks.

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	☐	☐	☐	☐	☐
I've been feeling useful	☐	☐	☐	☐	☐
I've been feeling relaxed	☐	☐	☐	☐	☐
I've been deeling with problems well	☐	☐	☐	☐	☐
I've been thinking clearly	☐	☐	☐	☐	☐
I've been feeling close to other people	☐	☐	☐	☐	☐
I've been able to make up my own mind about things	☐	☐	☐	☐	☐

7. Not counting the people you live with, how often do you do any of the following with children, family or friends?

	3 times a week or more	1–2 times a week or more	1–2 times a month	Every few months	1–2 times a year	Less than once a year or never
Meet up in person	☐	☐	☐	☐	☐	☐
Speak on a phone (including FaceTime and Skype)	☐	☐	☐	☐	☐	☐
Email or write	☐	☐	☐	☐	☐	☐
Text message	☐	☐	☐	☐	☐	☐

8. By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility:

I have no problems in walking about	☐	I have some problems in walking about	☐	I am confined to bed	☐

Self-Care: (looking after yourself)

I have no problems with self-care	☐	I have some problems washing or dressing myself	☐	I am unable to wash or dress myself	☐

Usual activities (e.g. work, study, housework, family or leisure activities):

I have no problems with performing my usual activities	☐	I have some problems with performing my usual activities	☐	I am unable to perform my usual activities	☐

Pain / Discomfort:

I have no pain or discomfort	☐	I have moderate pain or discomfort	☐	I have extreme pain or discomfort	☐

Anxiety / Depression:

I am not anxious or depressed	☐	I am moderately anxious or depressed	☐	I am extremely anxious or depressed	☐

9. In the last 3 months, how many times have you visited or accessed the following: (Please give a number for each line or enter 0 if none)

Hospital		**Other healthcare**	
Accident and Emergency (A&E)	☐	GP	☐
Hospital day case (surgery)	☐	Nurse	☐
Hospital outpatients (non-surgery)	☐	Mental health worker	☐
Hospital inpatients	☐	Psychotherapist	☐
If you have visited as an inpatient, how many nights was it for (in total)	☐	Social care	☐

10. Please read the statements that follow and tick the box for the statement that best describes your situation.

	Yes	More or less	No
I experience a general sense of emptiness	☐	☐	☐
There are plenty of people I can rely on when I have problems	☐	☐	☐
There are many people I can trust completely	☐	☐	☐
There are enough people I feel close to	☐	☐	☐
I miss having people around	☐	☐	☐
I often feel rejected	☐	☐	☐

11. Are you a member of any clubs, organisations or societies? (Please tick)

- ☐ Political party, trade union or environmental group
- ☐ Tenants groups, neighbourhood groups, Neighbourhood Watch
- ☐ Church or other religious groups
- ☐ Charitable organisation
- ☐ Education, arts or music groups or evening classes
- ☐ Social clubs
- ☐ Sports clubs, gyms or exercise classes
- ☐ Any other organisations, clubs or societies
- ☐ No, I am not a member of any organisations, clubs or societies
- ☐ Prefer not to say

Any other organisation, clubs or societies

12. Do you agree or disagree that you personally can influence decisions affecting your local area?

☐ Definitely agree ☐ Tend to agree ☐ Tend to disagree ☐ Definitely disagree

☐ Don’t know

13. Have you ever been involved in volunteering?
(This is an activity that involves providing unpaid help or work that benefits the community, individual or the environment, excluding close relatives)

☐ Yes, in the last 12 months ☐ Yes, but not in the last 12 months ☐ Never

14. In the last 12 months, have you given unpaid help in any of the ways shown below? Please tick all that apply.

- Raising or handling money/taking part in sponsored events ☐
- Leading a group/member of a committee ☐
- Organising or helping to run an activity or event ☐
- Visiting people ☐
- Befriending or mentoring people ☐
- Giving advice/information/ counselling ☐
- Secretarial, admin or clerical work ☐
- Providing transport/driving ☐
- Representing ☐
- Campaigning ☐
- Other practical help (e.g. helping out at school, shopping) ☐
- Any other help ☐
- None of the above ☐

15. Do you intend to provide unpaid work or volunteer in the future?

Yes ☐ No ☐ Maybe ☐ Don't know ☐

16. Compared to other people of your age, how often would you say you take part in social activities?

Much less than most ☐ Less than most ☐ About the same ☐ More than most ☐ Much more than most ☐

17. This question is about how you feel about different aspects of your life. For each statement, please say how often you feel that way.

	Hardly ever or never	Some of the time	Often
How often do you feel you lack companionship?	☐	☐	☐
How often do you feel left out?	☐	☐	☐
How often do you feel isolated from others?	☐	☐	☐
How often do you feel in tune with the people around you?	☐	☐	☐

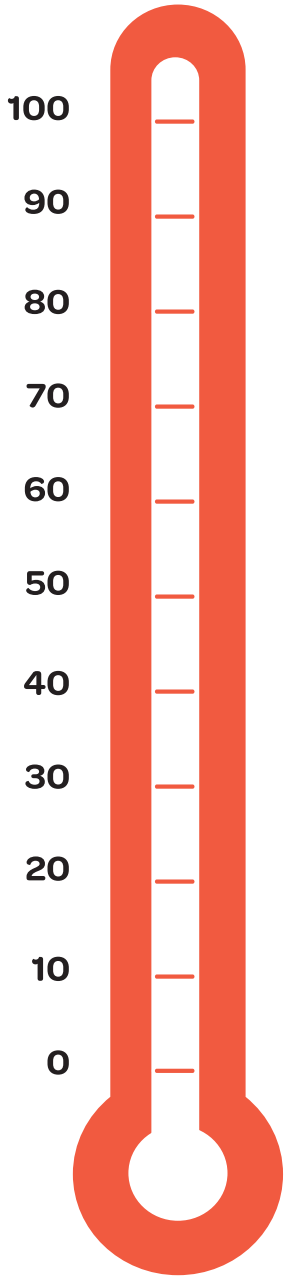
18. Thinking about people in your local area, how often do you speak to anyone who isn't a family member? Please include local friends, neighbours, acquaintances, people who come in to help you, people you see if you go out, and so on. Please tick one box only.

- Every day or almost every day ☐
- Three or more times a week ☐
- Once or twice a week ☐
- A few times a month ☐
- Once a month ☐
- Once every two months ☐
- Every few months ☐
- Once or twice a year ☐
- Less than once a year or never ☐

19. To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



Delivery Partners to complete

For project use only. This questionnaire has been completed at:

Entry into the project ☐

Six months into the project ☐

When exiting the project ☐

Follow up when no longer in the project ☐

Wellbeing Practitioners Bespoke Questionnaire

1. Are you

- ○ Just starting your therapy with Wellbeing Practitioners (**please go to question 8**)
- ○ Part way through your therapy with Wellbeing Practitioners
- ○ At the end of your therapy with Wellbeing Practitioners

2. Where have you received your therapy from Wellbeing Practitioners?

(Tick as many as apply)

- ☐ Initial assessment in my own home
- ☐ Initial assessment in a venue in my local community (not the Sheffield Mind Wellbeing centre)
- ☐ Initial assessment at the Sheffield Mind Wellbeing Centre
- ☐ Therapeutic sessions (e.g. individual counselling) in my own home
- ☐ Therapeutic sessions (e.g. individual counselling, group therapy) in my local community (not the Sheffield Mind Wellbeing Centre)
- ☐ Therapeutic sessions (e.g. individual counselling, group therapy) at the Sheffield Mind Wellbeing Centre
- ☐ Somewhere else (please specify) _____

3. If you have been involved in receiving therapy with Wellbeing Practitioner, please state how each therapy that you have engaged in through Wellbeing Practitioners has helped you.

	1 to 1 counselling	Group talking therapy	Art therapy	Drama therapy	Dance therapy	Storytelling therapy	Any other therapy
Helped with confidence							
Helped with social interac-							
Helped with self-esteem							
Helped with social confi-							
Didn't help with any of							
Not applicable							

4. Is there anything else you would like to say about your experience of therapy with Wellbeing Practitioners?

5. Is supporting another person something that you would consider for yourself?

- ○ **Yes**
- ○ **No**

6. How else have you been involved in Wellbeing Practioners?

	None of the time	Seldom	Sometimes	Often	Always
I was given the opportunity to be involved in the design of the project					
I was given the opportunity to be involved in the delivery of the project					
I was given the opportunity to be involved in the evaluation of the project					
Any input I had into the design, delivery or evaluation of the project was valued					

7. Is there anything else you would like to say about your experience of therapy with Wellbeing Practitioners?

8. To what extent have you done the following things in the last week?

	None of the time	**Seldom**	**Sometimes**	**Often**	**Always**
Been in regular contact with people such as family, friends, work colleagues or neighbours					
Been physically active by walking, dancing or just keeping moving					
Taken the time to notice the world around you in a way that makes you appreciate the things in your life					
Learnt or tried something new, or rekindled a previous interest					
Given time or done something nice for someone else					

Age Better in Sheffield

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