

# Developing and testing a novel social coaching intervention for people with psychosis



## SCENE

Enhancing social networks,  
improving quality of life

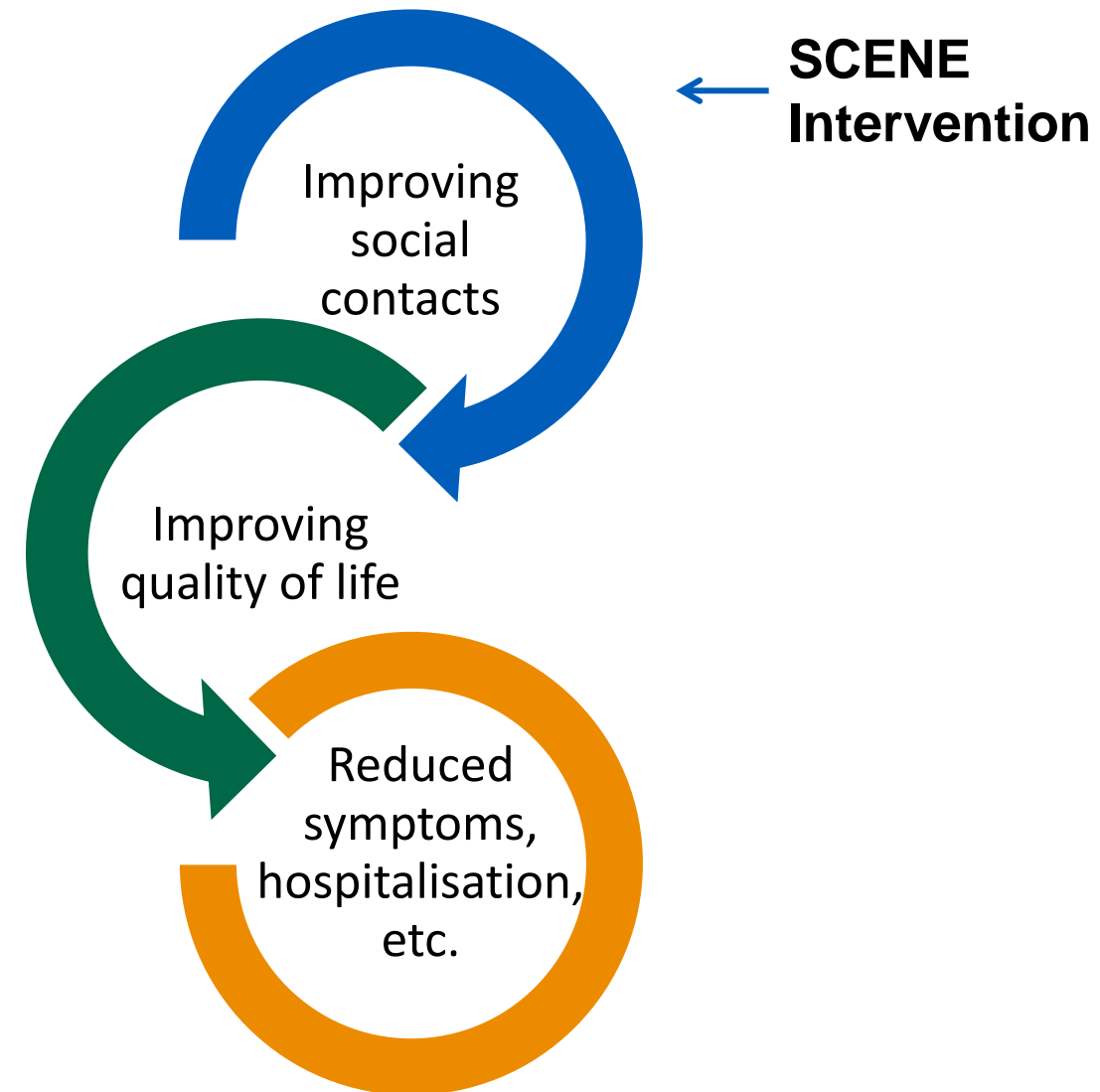
Agnès Chevalier

# SCENE: background

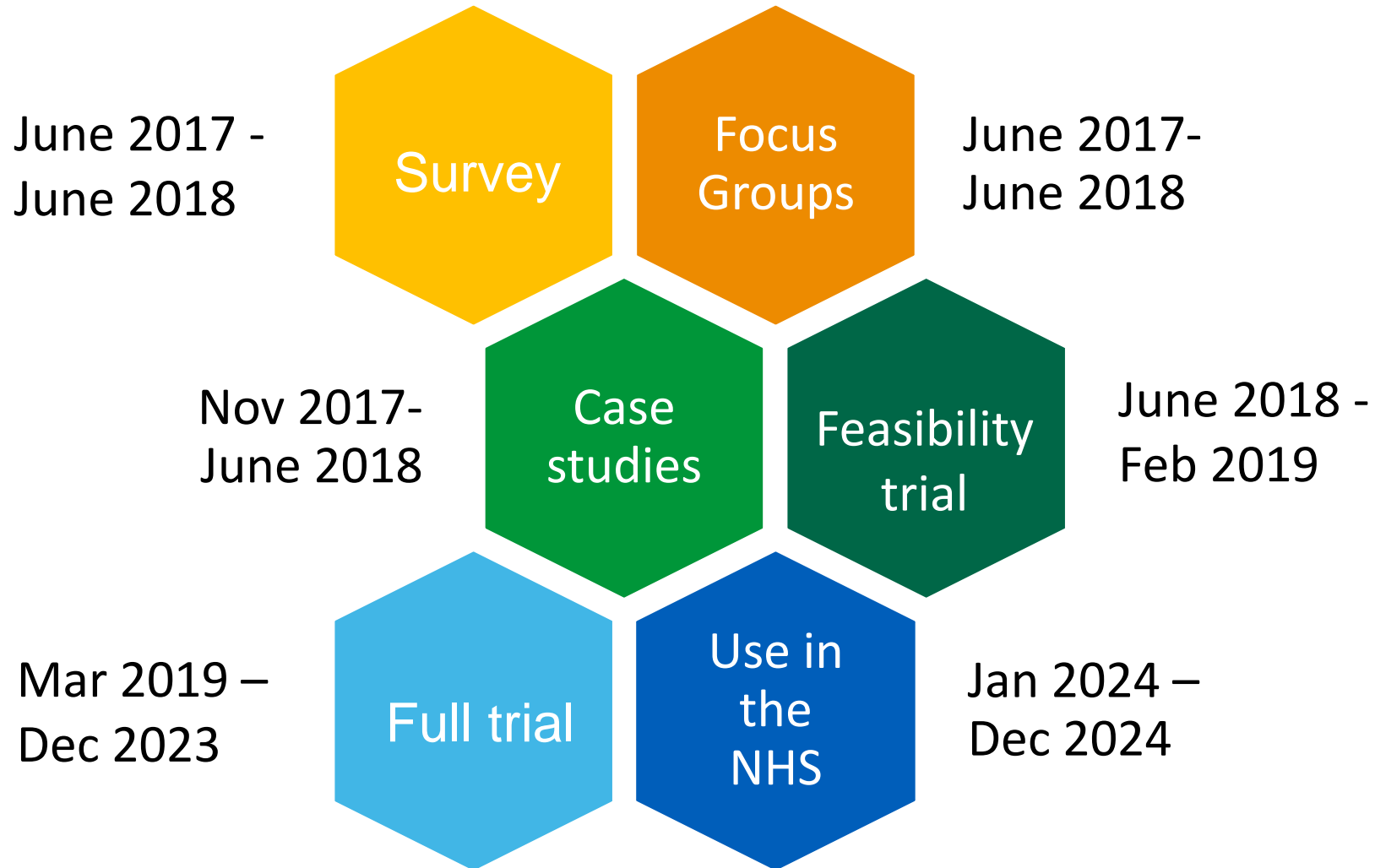
- People with psychosis are often socially isolated
- Limited social networks
- Social isolation is linked with poor outcomes
- Yet, no targeted interventions in the NHS

# SCENE: questions

- How can we support people with psychosis to increase their social contacts?
- Can increasing social contacts of people with psychosis improve their quality of life and other outcomes?



# SCENE Programme ( $\approx 7$ years)



# Who wants more social contacts?

- 68% reported a desire for more social contacts
- Wanting more contacts was associated with:
  - Lower quality of life
  - Lack of confidence to increase social contacts

Reasons for wanting to	Reasons for not wanting to
<ul style="list-style-type: none"><li>• Doing more things/activities</li><li>• Being social with others</li><li>• For personal growth or wellbeing</li></ul>	<ul style="list-style-type: none"><li>• Feeling content with current circumstances</li><li>• Perceived barriers (e.g. feeling too unwell)</li></ul>

# Who is socially isolated?

Severity of symptoms

Unemployed

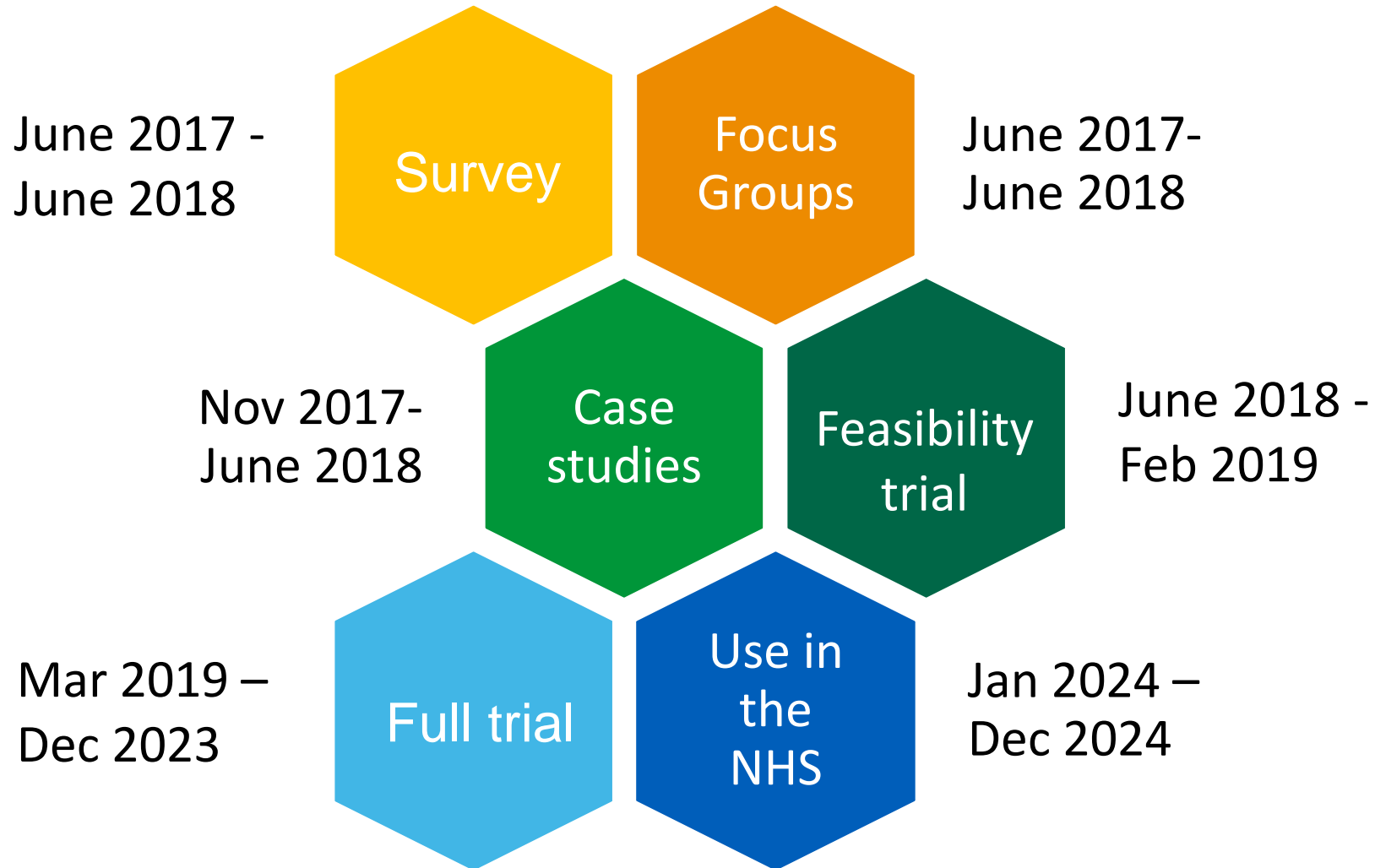
High density area

Marital status – Single

Few activities



# SCENE Programme ( $\approx 7$ years)



# What is social coaching?

- A professional with experience providing mental healthcare
- Work collaboratively with patients to increase their social contacts.
- Supports them to engage in a social activity of their choice
- Draws on motivational interviewing and solution focused therapy
- Regular sessions over 6 months

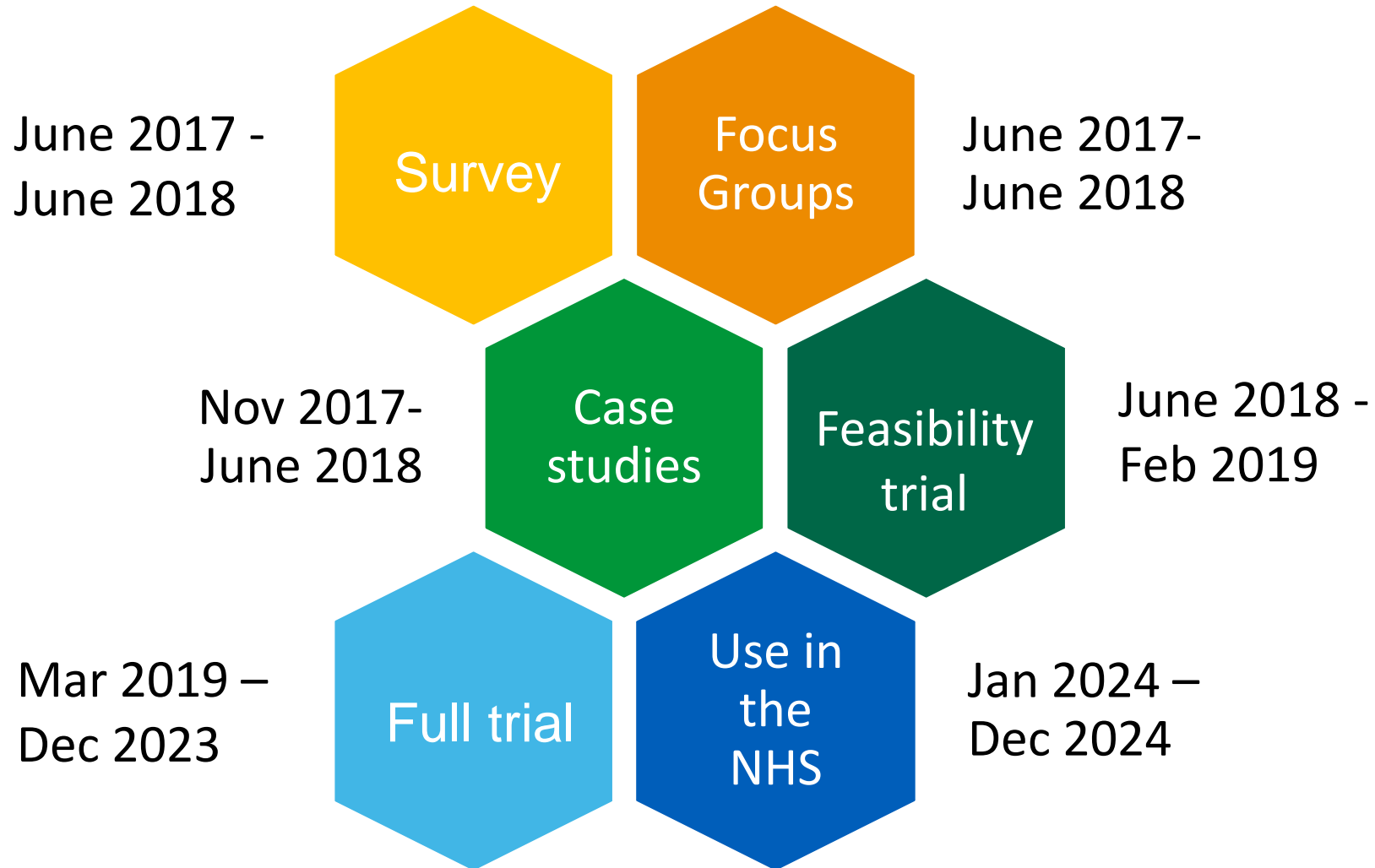


# What happens during the sessions?

- 1) Introduction
- 2) Clarification of the remit of the intervention
- 3) Exploration of past and current activities
- 4) Motivation for change
- 5) Options for activities
- 6) Information
- 7) Consideration & decision
- 8) Agreeing on actions



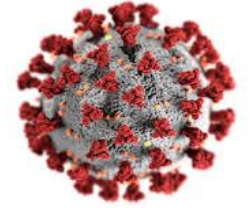
# SCENE Programme ( $\approx$ 7 years)



# SCENE Trial: overview

- **Aim:** Full multi-site trial with internal pilot, economic evaluation and process evaluation
- **Design overview:**
  - Sample: 577 service users from 14 NHS sites
  - Social coaching vs. active control (activity booklet)
  - Primary outcome: MANSA at 6 months
  - Other outcomes (6, 12 and 18 months) : social contacts, social situation, symptoms, care costs, loneliness

# COVID-19



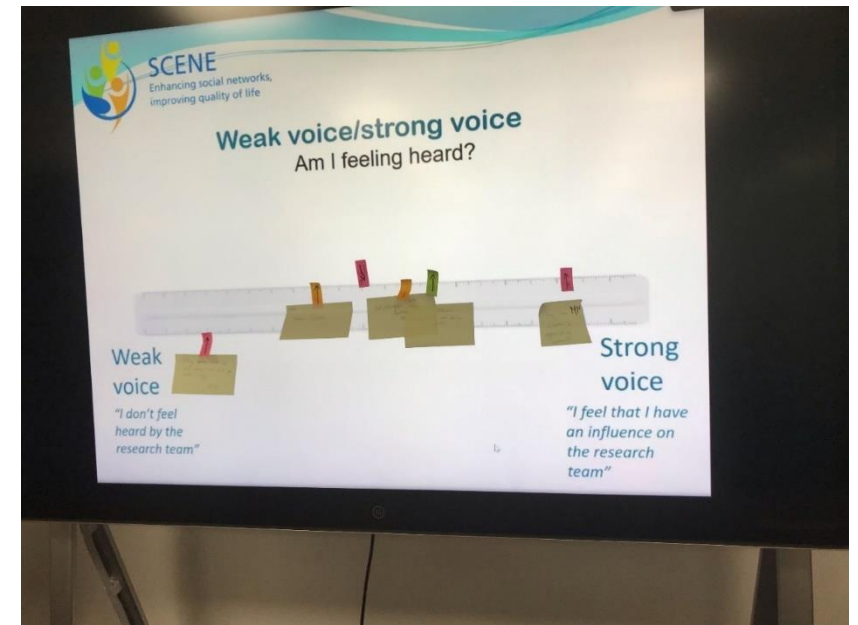
- Research meetings and intervention delivery could take place over the phone or via video-call
- Questions about online activities and remote contacts added
- Coaches to include discussions around computer access/literacy, infection control and physical distancing during the selection of the activity
- Activity booklets updated to include activities with physical distancing/online options.
- Finished 16-months later than planned

# Lived Experience Advisory Panel (LEAP)

- Contributing to the development of the intervention
- Reviewing study documents and promotional materials
- Formulating questions for the interview topic guides
- Advising on issues as they arise (e.g. restarting after Covid)
- Supporting with the interpretation of findings
- Dissemination of results

# Evaluating & improving involvement

- Cube of Involvement (Gibson, Britton & Lynch, 2012)
  - One way - many ways
  - Weak voice - strong voice
  - Their concerns - our concerns
  - Resists changes - makes change
- Ongoing evaluation



Original Article

## Patient and Public Involvement in Developing and Testing Mental Health-Care Interventions: Strategies and Reflections from Three Research Programs

### Abstract

Patient and public involvement (PPI) is valued and widely practiced in mental health research but in different ways. We present three research programs, aiming to develop and test mental healthcare interventions and we discuss their PPI strategies and activities. In all these programs, PPI has been sought from their initial conception and design and has helped their management, intervention development processes, quantitative and qualitative evaluations, and in the assessment of PPI activities themselves. The programs focus on different groups (patients with chronic depression, patients with psychotic disorders, and carers) and develop different interventions. Comparing these programs offers the opportunity to appreciate different models of involvement. These, for example, range from training lived experience collaborators to analyze qualitative data directly to asking them to comment on findings; from involving lived experience collaborators in the design of new interventions to involving them in intervention adaptation to a particular group or circumstance; and from carrying out formal PPI evaluations to collecting informal feedback during meetings. Even in the diversity of programs and PPI activities presented, common themes could be identified in relation to: specifying (and ideally co-designing) expectations and role of contributors; making bureaucratic procedures as user-friendly as possible; appropriately choosing or blending online and offline meetings; and designing flexible and inclusive arrangements to maximize participation. Our experiences contribute to a growing evidence base that can help researchers to develop meaningful, enjoyable, and constructive collaborations with people with lived experience. These collaborations will keep clinical mental health research relevant, impactful, and tailored to patients' needs.

**Keywords:** *Healthcare, interventions, lived experience, mental health, patient and public involvement*

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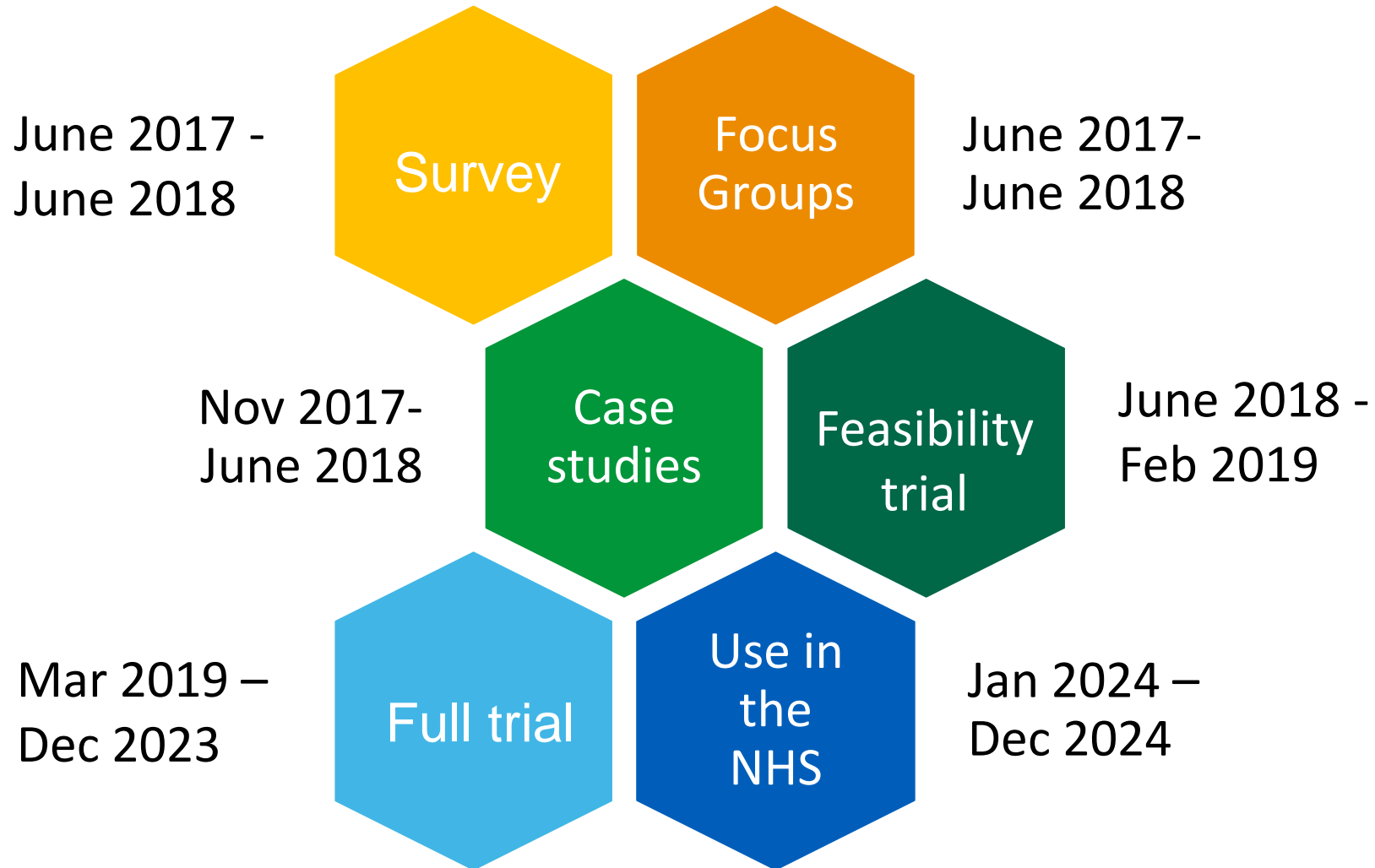
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**What do you think  
about the issue of  
social isolation in SMI?**

*vimeo*



# SCENE Programme ( $\approx 7$ years)



# Questions?



@study\_scene

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