Recovery

GROW in Ireland Recovery Outcomes in Mental Health 2017

National Report

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GROW IN IRELAND

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Contents

Executive Summary

This report presents the data findings from GROW's National Survey 2017. Surveys were completed by 389 GROWers at their Groups, Regional Weekends and the National Weekend. The survey collected information on the following:

- socio-demographic characteristics
- engagement with GROW
- profile of mental health need
- views on GROW Groups
- individual recovery outcomes and social supports

The gender of respondents was 55% (214) female and 45% (168) male, with 1% (3) selecting the 'other' category. Just over one half of participants, 54% (200), were aged 45-64 years old. Respondents came from all regions around the country. Just under one quarter of participants, 24% (93), were currently working, while another 24% (91) were not working due to illness or disability.

Three quarters of respondents, 76% (288), were attending a GROW group on a weekly basis. The majority of participants were GROW members for a number of years – 23% (85) for 3-5 years and a further 34% (128) for 6 years or more. In relation to their role in GROW, 75% (288) were members while others held a particular role, e.g. Recorder, Organiser. Almost one half, 47% (179) of respondents self-referred to GROW while 31% were referred by a professional working in the area of mental health.

In relation to current engagement with mental health services, respondents were most likely to be seeing their GP, 56% (180), followed by a Psychiatrist, 46% (146). One in ten were currently attending a support group other than GROW, 10% (32). Depression and anxiety were the two most common mental health needs reported by participants, 49% (180) and 44% (161) respectively. When asked what factors contributed to their mental health need, respondents were most likely to say childhood experience (36%), followed by poor relationships with family (31%) and bereavement (26%).

The aspects of attending GROW that were rated as most beneficial were meeting other people (55%), weekly meetings (54%) and a structured program (52%). A number of respondents said that the support they received from GROW had helped them to deal with their employer (19%) or change job/career (16%). Suggestions put forward as to how GROW could be better were more advertising/promotion (15%), more members (12%) and more social events (9%).

The results on individual recovery outcomes and social supports focus on the following indicators:

- progress towards personal goals
- social and community support
- symptoms
- coping
- relapse of symptoms and hospitalisation
- participation in community activities and physical exercise
- self-esteem and optimism about the future.

Analysis was carried out to see if there were any differences in these results by gender, age, urban/rural location and duration of GROW membership. One of the key themes emerging from this analysis was the finding that respondents who had been attending GROW for a longer period of time were more likely to report positive outcomes.

Introduction

GROW's mission is to "nurture mental health, personal growth, prevention and full recovery from all kinds of mental illness." GROW delivers a 12 Step Program of Recovery which is designed for people to take back control of their lives, overcome obstacles and start living a life full of meaning, hope and optimism. It provides a peer supported program for growth and personal development to adults with mental illness and those having trouble in coping with life's challenges. It has been working in Ireland since 1969 and currently runs approximately 120 support groups around the country. GROW's vision is to ensure that Growth, Recovery, Optimism and Well-being is possible for everyone.

This report presents the findings of a survey that was administered to GROW members over a number of months in 2017. This comprised a National Survey, which has been conducted on an annual basis over the last few years. As well as giving an insight into the characteristics of GROWers and a profile of their mental health needs, data was collected on several indicators of well-being and recovery outcomes, e.g. last relapse of symptoms, family support and participation in community activities. The findings in this report will help to inform the future development of GROW in Ireland and the services it provides to promote mental health in all aspects of its work.

Background

Recovery from mental health illness

In recent years, the concept of recovery has become more widely used in mental health research and government policy informing the development of mental health services. In Ireland, the national policy 'A Vision for Change' (2006)[1] identified recovery as a strategic priority for the Irish Mental Health Service. The growing emphasis on recovery is reflected in the development of a National Framework for Recovery in Mental Health, 2018-2020 (HSE, 2017).[2] This policy document defines recovery as follows:

"*Recovery is intrinsically about people experiencing and living with mental health issues in their lives and the personal goals they want to achieve in life, regardless of the presence or severity of those mental health issues*." (HSE, 2017: 1)

In much of the literature on mental health, recovery is deemed to be a personal process that varies from person to person. While clinical recovery refers to the absence of symptoms, personal recovery is focused on 'healing, discovery and rebuilding a worthwhile life' possibly at the same time as experiencing a varying degree of symptoms (Watts and Higgins, 2017). Based on their review of relevant literature, Leamy et al (2011) developed a conceptual framework for personal recovery known as CHIME. The presence of these factors was deemed to promote recovery from mental health illness.

- **C**onnectedness – Positive relationships with family and friends and keeping linked in to local community supports.
- **H**ope and optimism – Belief in recovery, motivation to change, positive thinking and having dreams and aspirations.
- **I**dentity – Positive sense of self, overcoming stigma and being recognised as a whole person.
- **M**eaning in life – Living a meaningful and purposeful life, importance of feeling valued and contributing as an active member of the community.

[1] HSE, Government of Ireland (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policyhttps://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf* (accessed 15th March 2018)

[2] See https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/national-framework-for-recovery-in-mental-health/recovery-framework.pdf (accessed 13th March, 2018)

- **E**mpowerment – Focusing on strengths, taking personal responsibility and control of one's life.

CHIME has been adopted in the National Framework for Recovery in Mental Health (HSE, 2017). Based on a new understanding of recovery, the National Framework sets out key principles for the development of a recovery oriented mental health service to empower and facilitate individual recovery from mental health illness. The first principle highlights the importance of the service user's lived experience and recognises that the individual must be at the centre of the recovery process. In order to support service users to avail of the resources to aid recovery, the National Framework recommends that they have access to peer support, either at group or individual level. Peer support is a unique aspect of the GROW program.

Research on GROW

The GROW program first started in Australia in 1957. Since then it has developed in many other countries and will celebrate its 50th anniversary in Ireland next year in 2019. Central to the GROW program is a weekly meeting at which members share experiences and learning, set themselves practical tasks for the week ahead and agree to take part in a particular activity which is known as '12 Step work'. This may involve supporting another member in the Group, e.g. meeting for coffee, or getting involved in the organisation, e.g. helping at a GROW event. Members are given the opportunity to play an active part in the Group by volunteering for certain roles, e.g. Recorder, Organiser or Leader. GROW groups are run by members for members with some input from a GROW staff member from time to time.

Several international research studies have been conducted on GROW. For example, Corrigan et al (2005) carried out research in America involving 57 Growers and they found that the most important aspect of GROW in providing recovery was peer support. After carrying out research in America, Rappaport (1988) described GROW as "an extended family for people. Finn et al (2009) conducted observation of Groups and interviews with GROWers in Australia to explore how GROW impacts on psychological well-being. One of their key conclusions was that attending GROW groups facilitated a process of identity transformation, whereby individuals were able to improve their interpersonal skills and build confidence within their Group, which represented a safe environment. After achieving this, they were then able to use these newly developed social skills in other settings outside of the Group."

Based on their findings, Finn et al (2009) developed a multi-dimensional model of change to describe how this process worked across three levels: individual; group; and program/community. This model proposed that attending a GROW Group facilitated

individual change in two key areas: firstly, the development of life management skills, e.g. communication skills, social skills; and secondly, a change in how members perceived themselves in terms of having an improved sense of belonging and enhanced feelings of personal value and self-worth. The second aspect refers to the 'helper' therapy principle which supports the notion that those who help others are actually helped the most themselves (Reissman, 1965). Within GROW, this principle can be applied to members agreeing to take responsibility for carrying out certain roles within the Group. These can be of a fairly informal nature, e.g. making tea/coffee, welcoming new members, as well as more formal roles, e.g. Recorder, Organiser and Leader in Groups. These roles may support other individual members in the Group and also promote the functioning of the Group itself.

In Ireland, Watts and Higgins (2017) conducted interviews with twenty six GROW leaders. Based on participants' experiences of being involved in GROW, they argue that recovery from mental illness can be seen as a 're-enchantment with life' (Watts and Higgins, 2017). This process involved three phases: a desire to escape mental illness; 'a time of healing' which was represented by becoming a GROW member and the experience of attending Group meetings; and the opportunity to be involved in all aspects of life, e.g. education, employment, community activities etc. Some participants in Watts' research described GROW as being a bridge between mental illness and life. One key theme that emerged from the experiences of participants was that at some point many accepted that they had to assume the responsibility for their own recovery rather than relying on others to get well, e.g. family, friends, professionals etc.

Much of the research on GROW has reported the benefits of attending group meetings for those experiencing mental health illness in their lives. One interesting finding from Rappaport's (1988) research in America was that GROWers who had been attending for a longer period of time were more likely to have more positive outcomes compared to those attending for a shorter period. As a result, the length of time attending GROW will be an important independent variable to explore in the analysis of the data collected here from the GROW National Survey 2017. This will be reflected in the results and findings in the rest of this report.

Methodology

This section explores how the GROW National Survey was carried out and who was involved.

Research method

The primary aim of the National Survey was to provide data on various recovery outcomes related to mental health for GROW members. For example symptoms, hospitalisation and participation in certain activities such as physical exercise and community activities. In addition, the survey aimed to compile information on the mental health needs of GROWers and their engagement in and views on GROW. As the nature of data collected was descriptive, a quantitative survey instrument was used. This made it possible to collect comprehensive data from a large number of respondents quickly and efficiently. Most questions were closed ended in that respondents could choose from a preset list of answers. This made it easier to fill in and facilitated the comparison of data across all respondents. A copy of the survey is attached at the end of this report in Appendix 1.

Confidentiality was an important consideration when collecting data and respondents were not asked to include a name on the survey unless they wished to do so for contact purposes.

Total Population and response rate

The total population for the survey comprised all GROW members who attend GROW Community groups around the country, which are typically run on a weekly basis. GROW collect data on various aspects of each Group meeting including the number of people who attend. Based on data compiled for Groups in September 2017 (when the National Weekend took place), an average of 472 individuals attended Community Groups.[3] The number of completed National Surveys was 389. Therefore, an estimate for the overall response rate is 82%.

Steps in data collection

Surveys were administered in three ways:

[3] An average figure for attendance is more appropriate than a total figure as meetings are held on a weekly basis. Therefore, the same individuals are likely to attend more than once throughout the month. This data is collected in Group Evaluation Forms that are filled in on a monthly basis for all meetings that take place that month.

- Regional Weekend events that took place in each region between April and July 2017 – 108 completed surveys (28%)
- Community Groups which took place around the country during the month of June 2017 – 199 completed surveys (51%), and
- GROW National Weekend, an annual event which took place between 29th September and 1st October, 2017 – 82 completed surveys (21%).

Therefore, data was collected at three different points in time throughout the year. At the National Weekend event, a question was included at the start of the survey to ask respondents if they had already filled in the survey at the Regional Weekend or at their Groups. If so, they were asked not to fill it in again. In addition, an announcement was made at a main session for all attendees to inform them about this. As the survey was anonymous, it is not possible to establish if more than one survey was completed by the same person. However, appropriate measures were taken to try and prevent this from happening.

Limitations of the survey

As with any research method, there are some possible limitations of the National Survey.

- The survey data provides basic information on respondents' views of their mental health at one single point in time. Therefore, it provides a snapshot of information on respondents' mental health and aspects of their lives at this point only.
- The information collected may not be fully representative of all GROW members. As the survey was confidential and anonymous, it is not possible to track non-response and to establish if any particular cohort of GROWers is not included in the survey population.
- The information provided cannot be probed for more detail as participants are anonymous.
- It is possible that some GROW members may have filled in the survey more than once as data was collected at three different points in time.

While acknowledging these potential limitations, the data from the survey provides a valuable insight into recovery outcomes for a large number of GROW members, as well as their background characteristics and views on GROW. This information can be used by GROW to help inform the future development of the organisation and the services it provides.

Data analysis

Survey data was input into Survey Monkey and exported into Excel. Data analysis was largely done in Excel using pivot tables. Further analysis was carried out to establish if there were any patterns or trends in recovery outcomes by selected criteria, e.g. gender, age, geographical location and duration of GROW membership. This was done by running cross tabulations and comparing the percentage results. While it was not possible to carry out statistical significance testing, any relationships between variables that are discussed in this report focus on consistent patterns in the results that emerged from data analysis.

Profile of respondents

This section presents the findings on socio-demographic data and provides a profile of GROWers who responded to the survey.

Gender

Chart 1 shows the gender breakdown for all respondents.

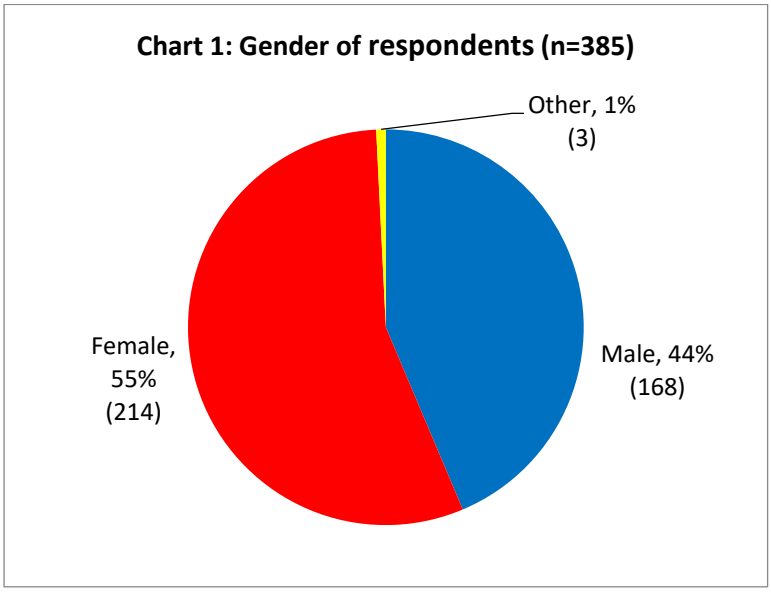
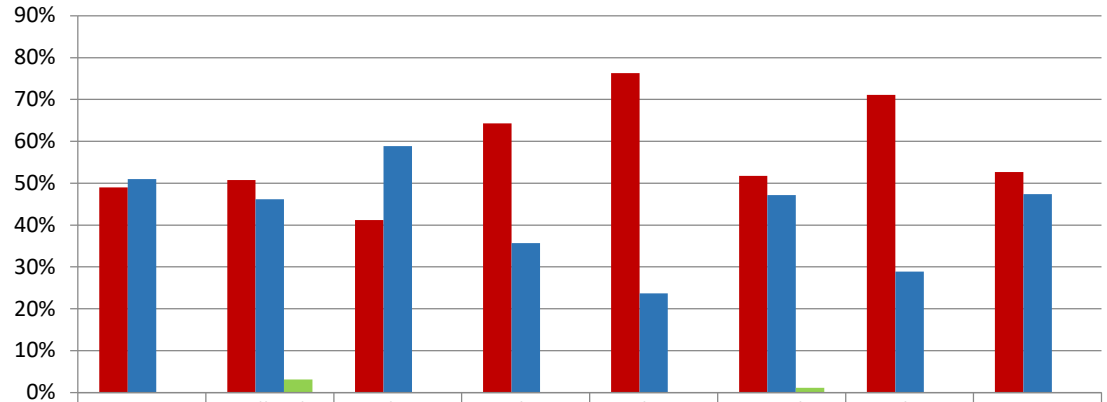


Chart 1 shows that just over one half of all respondents were female, 55% (214) and 44% (168) were male. Data for 4 respondents was missing.

Compared to 2016, there was a slight increase in the percentage of males, from 40% in 2016 to 44% in 2017.

Chart 2 shows the gender breakdown for each GROW region. Six of the eight regions followed the national trend where females were more likely to respond than males. However, in three of these regions, the percentage of females was far higher than that of males compared to the national breakdown of 55% – the North East, North West and the South East: 64%; 76%; and 71% respectively. The Midwest was the only region where the percentage of males was higher than females, 59% compared to 41%. The gender breakdown was fairly even in the East.

Chart 2: Gender breakdown by Region (n=385)



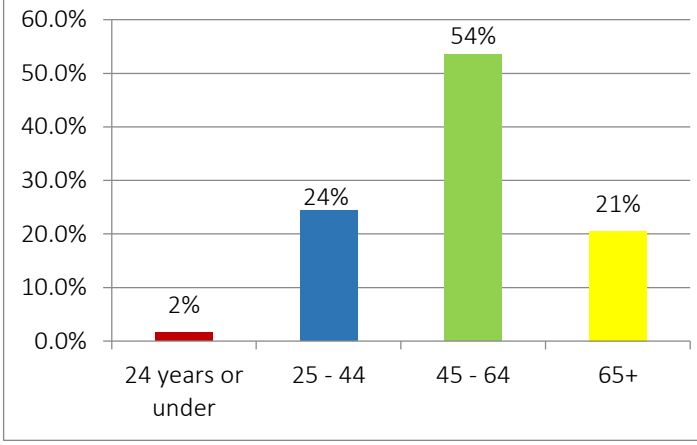
	East	Midlands	Midwest	North East	North West	South	South East	West
Female	49%	51%	41%	64%	76%	52%	71%	53%
Male	51%	46%	59%	36%	24%	47%	29%	47%
Other	0%	3%	0%	0%	0%	1%	0%	0%

Age

Chart 3 shows over one half of all respondents were aged 45-64 years old, 54% (200). Almost one quarter, 24% (91), were aged 25-44 years old. While 21% (77) were aged 65+ years old. Just 2% (6) were aged 24 years old or under. Data was missing for 15 respondents.

Compared to 2016, these results were very similar. There was a small decrease in the proportion of respondents aged 45-64 (57% in 2016) and a slight increase in those aged 65+ (18% in 2016).

Chart 3: Age group of respondents (n=374)



A breakdown by region found a similar age profile to the national figures presented in Chart 3, with some exceptions:

- the North East region had the highest proportion of respondents aged 25-44 years old at 40%, therefore having the youngest age profile of respondents[4]
- three regions – the East, Midlands and North West – had fewer respondents in the 45-64 years old category compared to the national figure (54%): 42%; 39%; and 42% respectively.
- the North West had the highest proportion of respondents aged 65 years or more at 39% followed by the East at 30%.

[4] In the North East, 56% of respondents were aged 45-64 years old and none were aged 65+ years.

Further data analysis of the results on age was done by gender and age. In the 25-44 and 45-64 age categories, the gender breakdown was similar to that nationally with a higher proportion of females compared to males. However, there was a more even gender breakdown for respondents aged 65 years or more: 47% were female, 50% were male and 3% other.

Geographical location

Data was collected on respondents' geographical location. Chart 4 shows the region that respondents were currently living in.

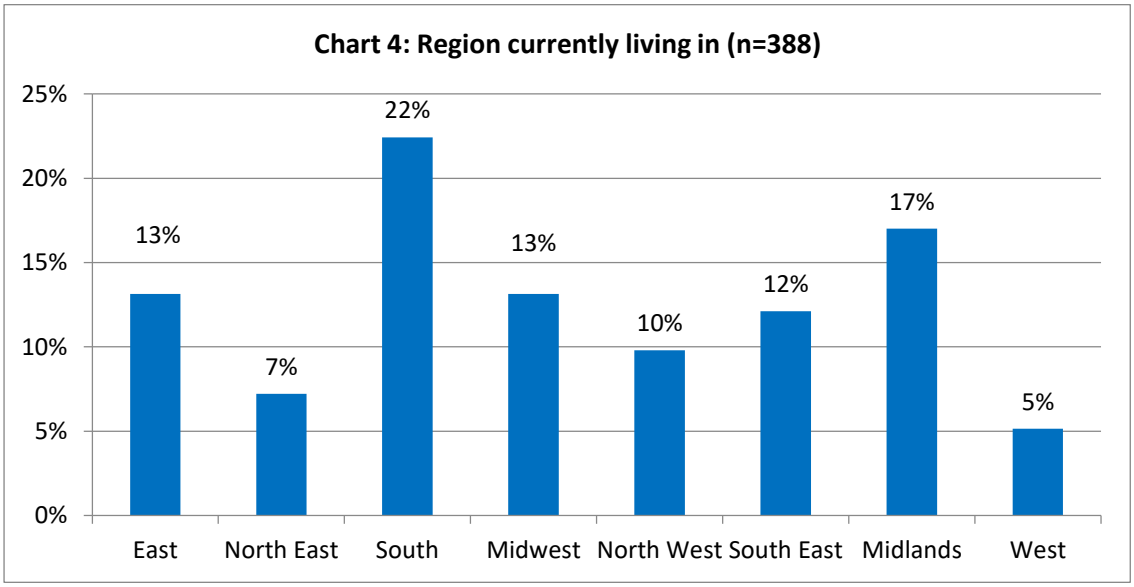


Chart 4 shows that respondents came from all regions across the country. The regions with the highest number of respondents were the South, 22% (87) and the Midlands, 17% (66). The West and North East had the lowest number of respondents: 5% (20) and 7% (28) respectively. Data on region for one respondent was missing.

One of the methods used to administer surveys was through GROW groups. The number of community groups varies in each region and this may have affected the numbers responding. Based on data for Quarter 3, 2017, the South had the highest number of community groups in all regions. However, looking at the data for other regions there was no consistent pattern in the number of groups in each region and the response to the National Survey.

Another indicator of geographical location was collected by asking respondents if they lived in an urban, suburban or rural area. The results were as follows:

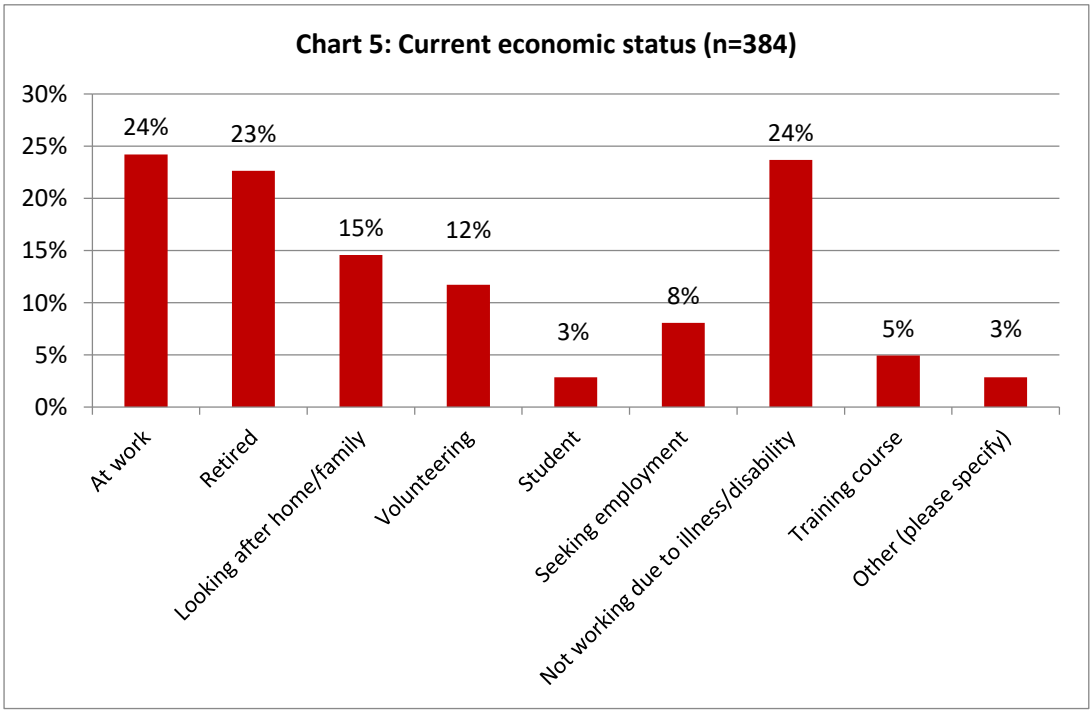
- 37% (136) lived in an urban area
- 21% (77) lived in a suburban area, and
- 43% (158) living in a rural location.[5]

[5] This result is based on 371 respondents as this question was not answered by the remaining 18 individuals.

Compared to 2016, there was a decline in the number living in an urban area, which fell from 42% in 2016 to 37% in 2017. This corresponded with a rise in those living in a suburban area from 15% in 2016 to 21% in 2017. The number of respondents living in a rural location remained unchanged.

Current economic status

Chart 5 shows the current economic status for survey respondents. It can be seen that respondents are equally as likely to be at work, 24% (93), as they are not working due to illness/disability, 24% (91). A further 23% (87) were retired. Just over one in ten, 12% (45), were currently volunteering, while another 8% (31) were seeking employment. Data on five respondents was missing.



Compared to 2016, the number of respondents who were currently at work fell from 29% in 2016 to 24% in 2017. Similarly, those seeking employment has fallen from 12% in 2016 to 8% in 2017.

Comparison with Census of Population 2016

It is interesting to draw some comparisons with data from the Census of Population 2016.[6] Two key findings are of particular note:

- 53% of people aged 15 years and over were 'at work' based on the Census data[7] – the figure from the GROW survey is less than half of that at 24%
- 4% of people aged 15 years and over were 'unable to work due to permanent sickness or disability' based on the Census data – the figure from the GROW survey is 24%, which is eight times the figure for the national population.[8]

Based on this data, it can be said that the GROW survey respondents are far less likely to be currently engaged in employment and far more likely not to be working due to sickness/disability compared to the national population.

Engagement with GROW

This section presents the findings on the nature and extent of respondents' involvement in GROW. The National Survey 2017 added two new questions compared to previous years:

- how often respondents attended GROW meetings; and
- their role in GROW.

Frequency of attendance at GROW Group meetings

Respondents were asked to say how often they attended a GROW Group in the last three months.

[6] It is acknowledged that the survey data and Census data have been collected at different times – 2017 and 2016 respectively. However, Census data provides a key benchmark that can be used to consider how the circumstances of GROW survey respondents compares to that of the national population.
[7] See Table 1.1 in Census of Population 2016 – *Profile 11: Employment, Occupations and Industry*, see the link http://www.cso.ie/en/releasesandpublications/ep/p-cp11eoi/cp11eoi/pec/ (accessed 6 March, 2018)
[8] See Figure 1.1 in Census of Population 2016 – *Profile 11: Employment, Occupations and Industry*, see the link http://www.cso.ie/en/releasesandpublications/ep/p-cp11eoi/cp11eoi/pec/ (accessed 6 March, 2018)

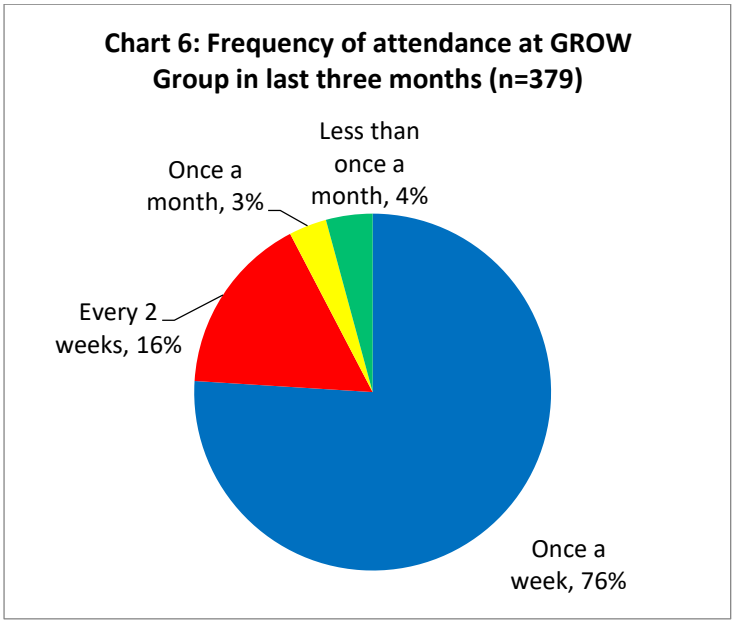


Chart 6 shows that just over three quarters of respondents, 76% (288), attended a GROW Group every week in the last three months. A further 16% (62) attended every two weeks. Therefore, the majority of respondents attended a GROW Group on a regular basis. Data was missing for ten respondents.

A gender breakdown of the category 'once a week' (n=288) showed that 57% (163) were female while 42% (122) were male (data on gender was missing for the remaining three cases). However, as the gender breakdown for all respondents was 55% female/44% male (see Chart 1), this result is similar to what would be expected. Therefore, there is no real difference in weekly attendance by female and male respondents. Similarly, an analysis was carried out by age, which found no variation in the frequency of attendance.

Duration of GROW membership

The length of time that respondents have been a member of a GROW Group is a valuable indicator as it may have some relationship with the data on recovery outcomes, which was highlighted in research by Rappaport (1988) in America. It would be reasonable to suggest that recovery outcomes might improve over time, particularly when the appropriate supports can be accessed. GROW membership might be one potential factor that contributes to an improvement in mental health outcomes. There are likely to be variations by individual based on the nature of their mental health needs and particular circumstances.

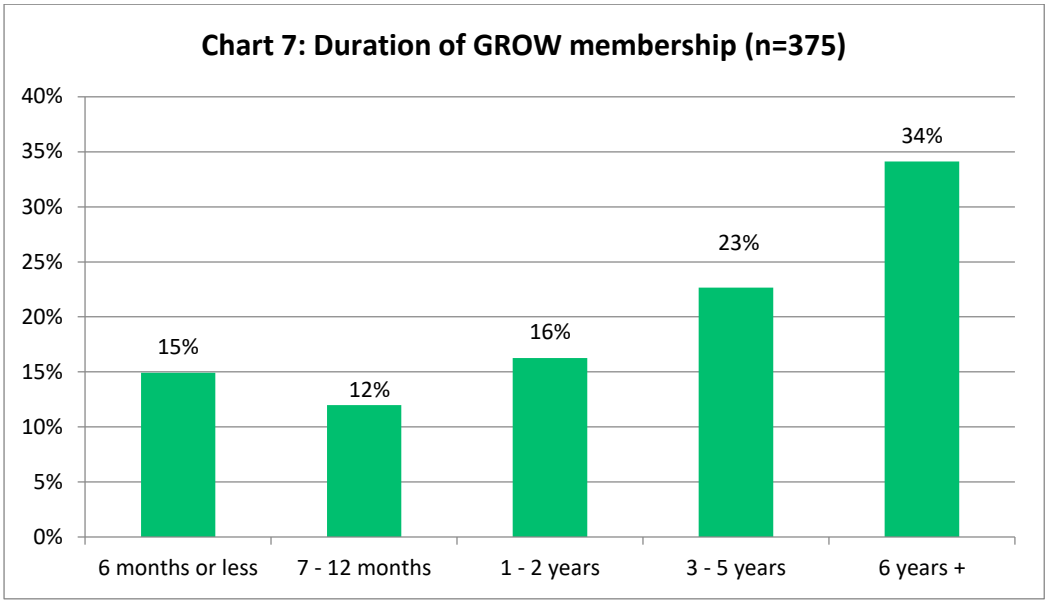


Table 7 shows that over one third of respondents, 34% (128), had been a member of a GROW Group for six years or more. A further 23% (85) had been members for between 3-5 years. Therefore, combining these two categories shows that more than one half of respondents had been attending a GROW Group for three years or more. These results were similar to those for the previous year 2016, in which 34% of respondents had been attending for six years or more and 21% for 3-5 years. The number attending for 6 months or less was also similar – 13% in 2016 and 15% in 2017. Data was missing for 14 respondents.

An analysis by gender showed little variation in duration of GROW membership compared to the overall gender distribution of respondents. There was one exception to this in the category 1-2 years (n=61) – 67% (41) were female and 31% (19) were male (the remaining respondent selected 'other' for gender). Therefore, females were more likely than males to be GROW members for between one to two years. A similar analysis by age showed no consistent patterns in the results.

It would be interesting to carry out some analysis of recovery outcomes to see if there is any relationship by duration of GROW membership. This will be covered in the findings on recovery outcomes.

Attendance at GROW events

Respondents were asked how many GROW events they had attended in the previous year 2016. The results were as follows:

- National Weekend - 37% (145)
- Regional Weekend - 42% (165)
- Group Weekend – 11% (44)
- Group social event – 37% (142)

Therefore, respondents were most likely to have attended a Regional Weekend in the last year, followed by the National Weekend and a Group social event.

Role in GROW

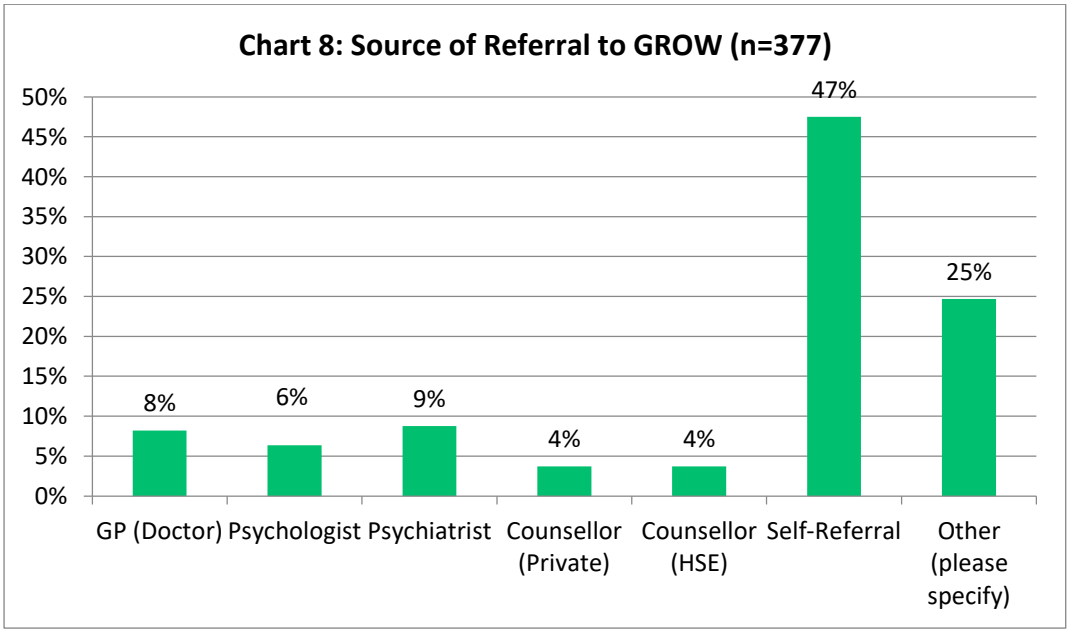
Respondents were asked to indicate what role(s) they held in GROW. The results were as follows:[9]

- Member – 75% (288)
- Recorder - 15% (59)
- Organiser – 14% (55)
- Leader – 7% (27)
- Regional team member – 5% (20)
- Staff – 2% (9)
- Board member – 1% (3)

Therefore, three quarters of all respondents were GROW Members, 75% (288). This was followed by Recorders, 15% (59), and then Organisers, 14% (55). As respondents could hold more than one role at the same time, the results added up to more than 100%.

Referral

The survey asked respondents to say how they were referred to GROW. Chart 8 shows the results.[10]



[9] Data was missing for six respondents. Therefore, the results are based on 383 cases.
[10] In some cases, respondents gave more than one answer. Therefore the total adds up to more than 100%.

Chart 8 shows that almost one half of respondents said they referred themselves to GROW, 47% (179). Compared to the previous year 2016, this fell from 69%.[11]

Looking at the different professionals, a Psychiatrist was most likely to refer respondents to GROW, 9% (33), followed by a GP, 8% (31). Other sources of referral included friends (16), family member (12), Nurse (5), GROW member (4), Social Worker (3) and Priest (3). Data was missing for 12 cases.

Profile of mental health need

This is a new section that was included in the GROW National Survey 2017. Therefore, there are no comparisons of this data with results in 2016. This section asked respondents to answer questions on the following:

- current use of mental health services
- perception of mental health need, and
- contributory factors to mental health need.

Engagement with mental health services

Chart 9 shows the mental health services that respondents were currently using.[12] Data was missing for 69 respondents. It is reasonable to suggest that many of these respondents were not engaging with any mental health service at the time although some may have chosen not to answer the question.

[11] Further analysis found that 30 respondents heard about GROW Groups through local advertising, e.g. local newspaper, church bulletin, poster in GP surgery etc. These respondents did not select 'self-referral', therefore the result in Chart 8 may be an underestimate of how many people self-referred into GROW.
[12] In some cases, respondents selected more than one mental health service. Therefore, Chart 9 adds up to more than 100%.

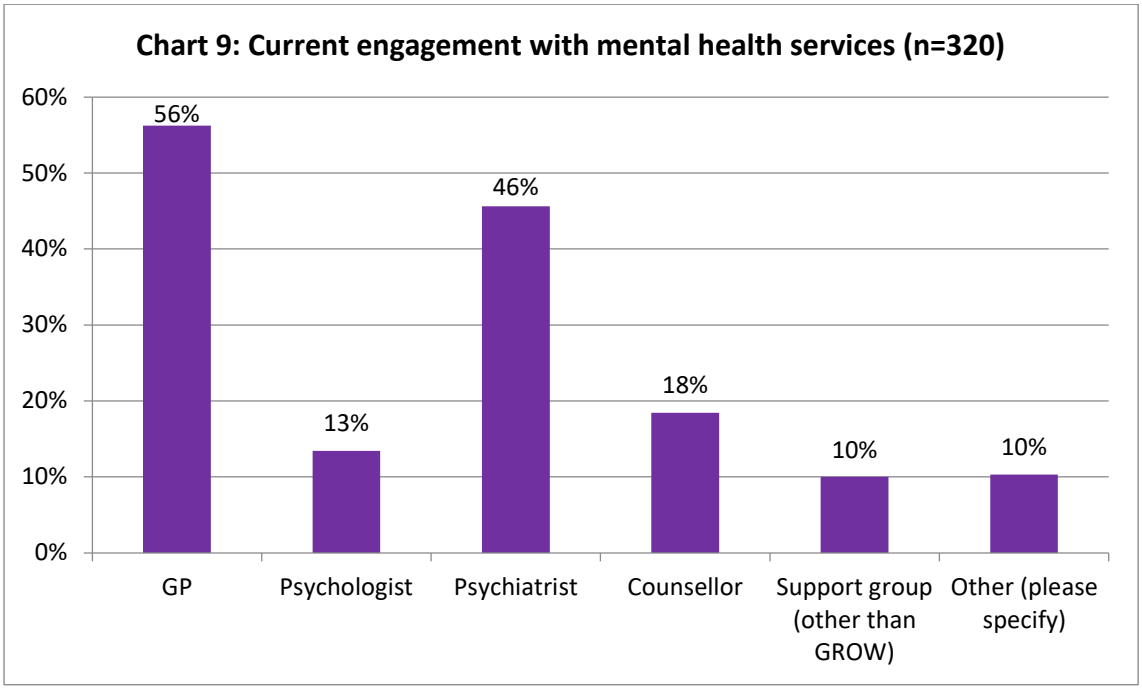


Chart 9 shows respondents were most likely to be engaging with their GP, 56% (180). This was followed by 46% (146) of respondents who were currently receiving support from a Psychiatrist. One in ten respondents, 10% (32), were attending a support group other than GROW. Other services that respondents were currently using included Alcoholics Anonymous (3), Shine (2), Aware (1), complementary therapies (e.g. acupuncture) (2), mindfulness (1), nurse (1), social worker (1), health clinic (1), Occupational Therapy group (1), local consumer panel (1) and Recovery College (1).

Variations in engagement in mental health services by gender

Table 1 shows respondents' engagement with mental health services by gender.

Table 1: Current engagement with mental health services by Gender (n=320)

	Female	Male	Total
GP	56% (100)	44% (77)	100% (177)
Psychologist	45% (19)	55% (23)	100% (42)
Psychiatrist	53% (77)	47% (68)	100% (145)
Counsellor	67% (39)	33% (19)	100% (58)
Support Group (other than GROW)	52% (16)	48% (15)	100% (31)
Other	65% (13)	35% (7)	100% (20)

Table 1 shows that females were more likely to engage with a Counsellor compared to males – 67% and 33% respectively. In relation to linking in with a GP, 56% of females were doing so compared to 44% of males. However, this result is similar to the gender breakdown of all respondents (55% female and 44% male) so a real variation by gender is unlikely here. In one category of mental health service, Psychologist, males were more likely to be accessing this service than females – 55% and 45% respectively.

Self-perception of mental health need

Respondents were asked to state the nature of their mental health need. This provides information based on the respondent's own understanding of their mental health. Chart 10 presents the results.[13]

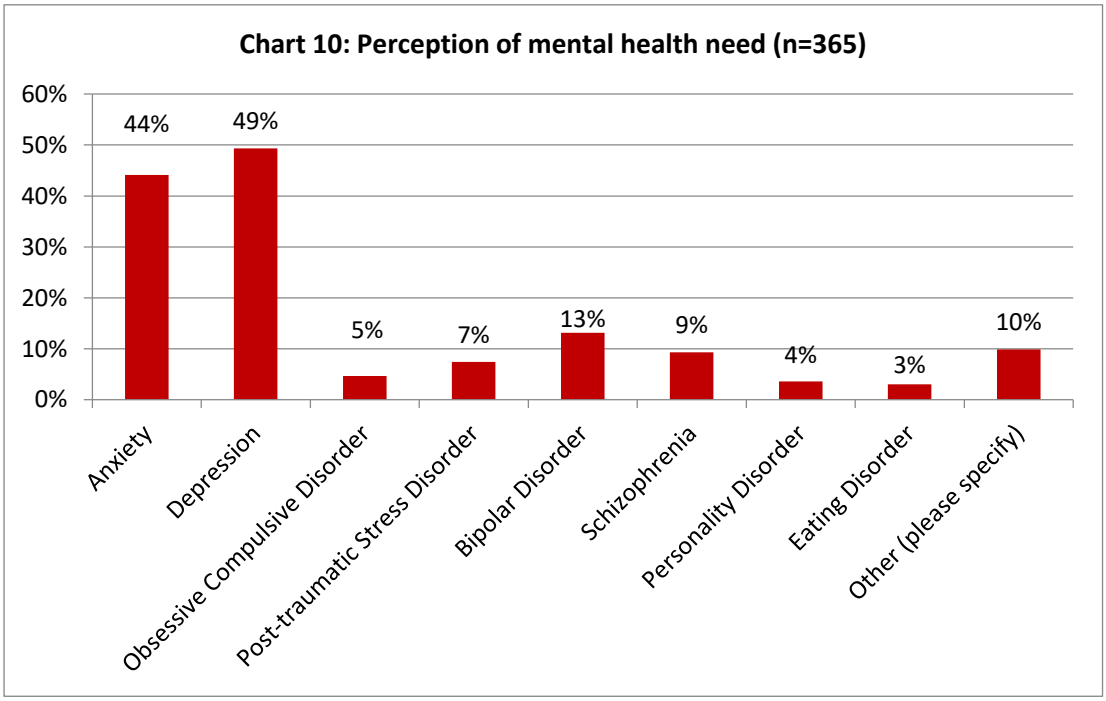


Chart 10 shows that almost one half of respondents, 49% (180), said that they experienced depression. This was closely followed by 44% (161) who stated that their mental health need was anxiety. Therefore, depression and anxiety were the two most common mental health needs identified by respondents. Just over one in ten respondents, 13% (48), said they had Bipolar Disorder and a further 9% (34) identified their mental health need as Schizophrenia.

It is not surprising that depression was the most common mental health need reported by GROW members. The Irish Health Survey 2015 (Central Statistics Office, 2015) found that 8% of all people aged 15 years or over experienced symptoms of moderate depression at least. This figure increased to 26% when mild depression was included.[14] Therefore, it is widely prevalent in the general population.

[13] In some cases, respondents gave more than one response. Therefore Chart 10 adds up to more than 100%.
[14] See Table 6 in the Irish Health Survey 2015, Central Statistics Office. See the link http://www.cso.ie/en/releasesandpublications/ep/p-ihs/irishhealthsurvey2015/ct/ accessed 12th March, 2018.

Data on mental health need was missing for 24 cases, which makes up 6% of all 389 survey respondents. Considering that this question is quite sensitive, this is a fairly low non-response rate. Missing data may also include respondents who felt they had no mental health need at the time of filling in the survey.

Variations in Mental Health Need by Gender

Table 2: Mental Health Need by Gender (n=362)[15]

	Female	Male	Other	Total
Anxiety	64% (103)	35% (57)	1% (1)	100% (161)
Depression	56% (100)	43% (77)	1% (1)	100% (178)
Obsessive Compulsive Disorder	53% (9)	47% (8)	-	100% (17)
Post-traumatic Stress Disorder	63% (17)	33% (9)	4% (1)	100% (27)
Bipolar Disorder	47% (22)	53% (25)	-	100% (47)
Schizophrenia	59% (20)	41% (14)	-	100% (34)
Personality Disorder	46% (6)	54% (7)	-	100% (13)
Eating Disorder	91% (10)	9% (1)	-	100% (11)
Other	48% (15)	52% (16)	-	100% (31)

Table 2 shows that the prevalence of some mental health needs varied by gender. In particular, where respondents said they experienced Anxiety, Post-Traumatic Stress Disorder, Schizophrenia or an eating disorder, they were more likely to be female than male.[16] For example, where people reported that they had anxiety, 64% (103) were female while 35% (57) were male. By comparison, the mental health needs of Bipolar Disorder and Personality Disorder were more likely to be reported by males than females. Some examples of 'other' mental health needs included mood disorder, autism, stress, paranoia and lack of confidence.

The figures in Table 2 add up to more than 100% as some respondents gave more than one mental health need.

[15] Gender was missing for three cases.

[16] In relation to depression, the gender breakdown (56% female/43% male) was similar to that for the survey overall (55% female/44% male). Therefore, it was deemed that there is no real variation by gender for this category.

Some of these findings correspond with other research on the diagnosis of mental health illness by gender. In particular, the Women's Health Council reported that several international research studies have found that women are more likely to be diagnosed with depression compared to men, and similarly other conditions including 'panic disorder', 'generalised anxiety disorder', 'obsessive compulsive disorder and post-traumatic stress disorder (Women's Health Council, 2004).[17]

Factors contributing to mental health need

Respondents were asked to indicate if any particular factors contributed to their mental health need. This information gives a better understanding of the life events that may have a negative impact on mental health, as experienced by those who took part in the survey. Chart 11 shows the results.[18]

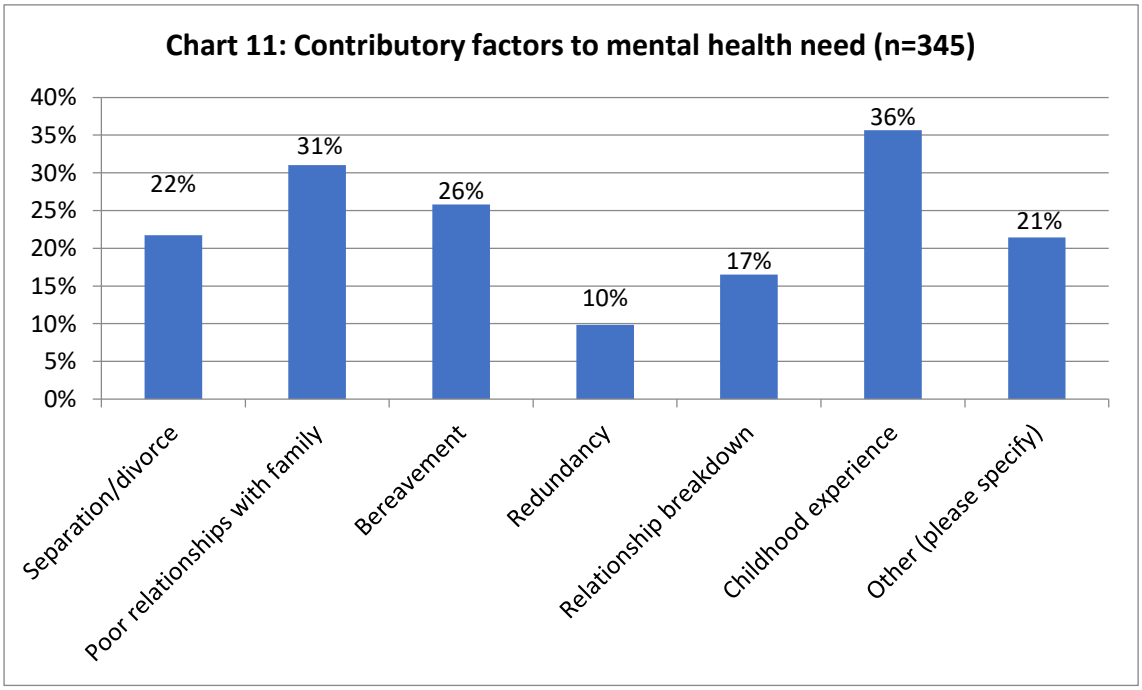


Chart 11 shows that over one third of respondents, 36% (123), said that childhood experience contributed to their mental health need. This was followed by poor relationships with family, 31% (107). Other life events also affected respondents' mental health, namely bereavement, 26% (89), separation/divorce, 22% (75) and relationship breakdown, 17% (57). Other factors were identified by 21% (74) of respondents and included work related stress (10 cases), bullying (6), ill health (6) and alcohol abuse (4). Data was missing for 44 cases.

[17] Women's Health Council (2004) *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision*, see http://health.gov.ie/wp-content/uploads/2014/03/Womens-Mental-Health-Promoting-a-Gendered-Approach-to-Policy-and-Service-Provision.pdf (accessed 12th March, 2018)

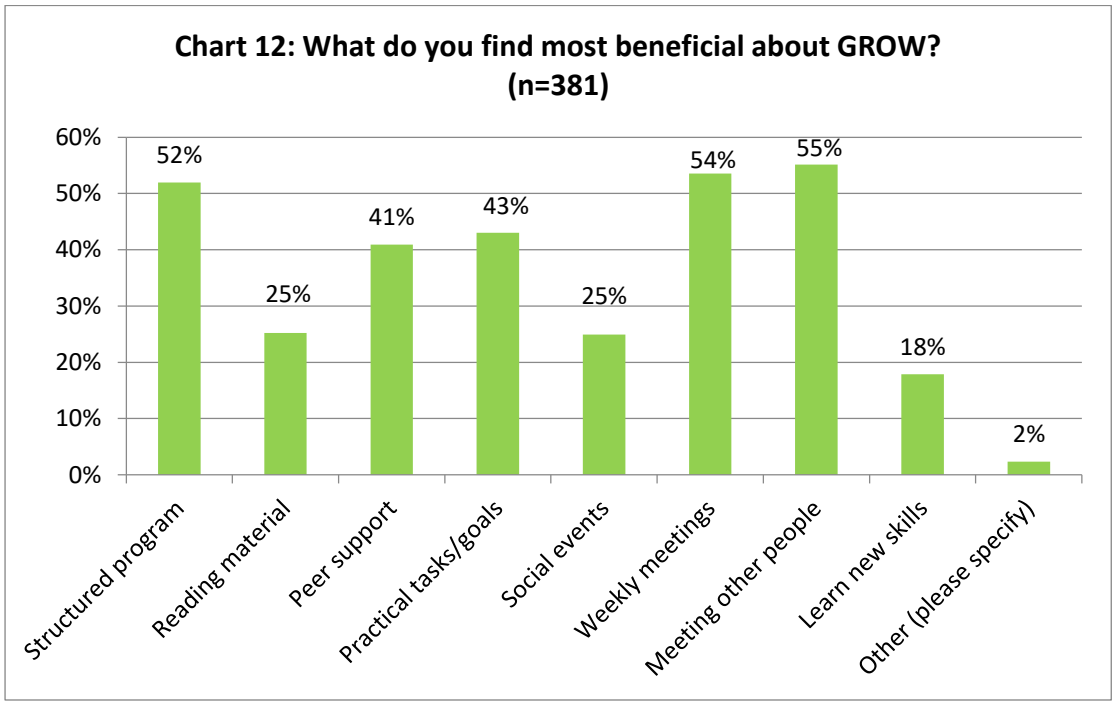
[18] In some cases, respondents gave more than one response. Therefore, Chart 11 adds up to more than 100%.

Views on GROW

Respondents were asked to give their views on GROW, which was a new section in the survey. They were invited to state the benefits of attending GROW and what could be improved.

Benefits

Chart 12 shows the benefits that attending GROW had for respondents.[19]



The benefit that was rated highest by respondents was meeting other people, which was chosen by 55% (210) of those who took part. This was closely followed by weekly meetings, 54% (204), which is a feature of most of GROW's Community Groups. Having a structured program was selected by 52% (198) of respondents as being most beneficial.

Support with employment

Survey respondents were asked if the support they received from GROW helped them with different aspects of employment. Chart 13 shows the results.

[19] Respondents were asked to name the top three benefits from a pre-defined list of possible answers. Therefore, Chart 12 adds up to more than 100%.

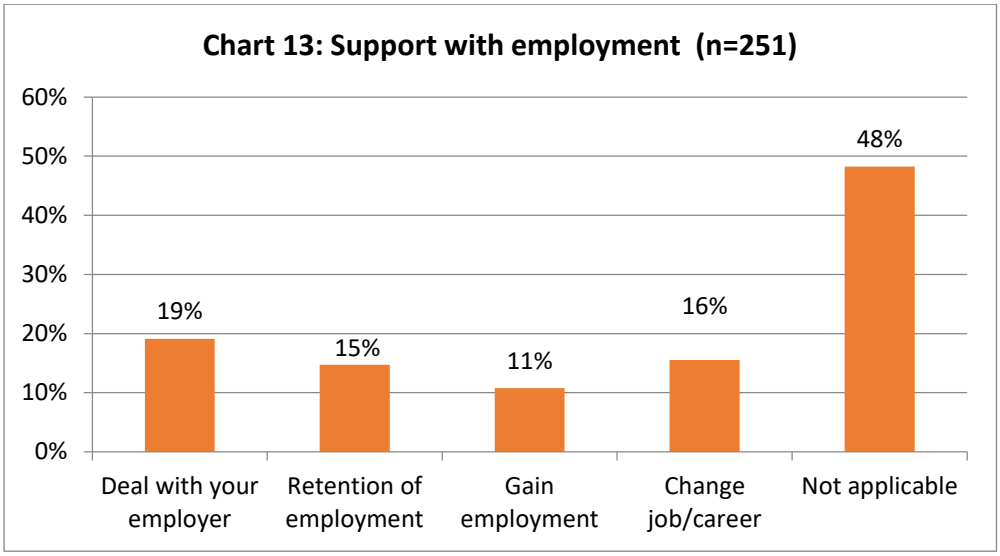


Chart 13 shows that 19% (48) of respondents said the support they received from GROW had helped them to deal with their employer. This was followed by a change of job/career, 16% (39), which had fallen from 27% in the previous year 2016.

The data in Chart 13 is based on a relatively small number of respondents as the question was not applicable to all, e.g. many people were retired or looking after home/family.

What could be better

Respondents were asked to say what could be better about GROW? It was answered by 208 people. The most popular comments were as follows:

- More advertising/promotion – 15% (32)
- Nothing – 14% (30)
- More members – 12% (24)
- More social events – 9% (10)
- Better organisation/communication – 5% (11)
- Updated material – 5% (10)
- More support – 5% (10)
- New skills/training – 4% (9)

Data on Recovery Outcomes and Social Supports

The final section of results in this report presents data on twelve questions which attempt to measure recovery outcomes for respondents at the time of doing the survey. These questions were all asked in the previous year's survey in 2016. Therefore, some comparisons can be made in the results for both years. However, the data only gives a snapshot of respondents' well-being at one particular point in time.

Progress towards personal goals

Respondents were asked if they had made progress towards personal goals in the last three months. The results were as follows:

- 30% (105) said they had a personal goal and had achieved it
- 25% (90) said they had a personal goal and had gotten pretty far in achieving it
- 31% (110) said they had a personal goal and made a little way towards achieving it
- 6% (21) said they had a personal goal but had not done anything to achieve it, and
- 8% (28) said they had no personal goals.[20]

Therefore, more than half of respondents, 55% (195), said they had a personal goal and had either achieved it or were near to achieving it. This had increased from 49% in the previous year 2016. There was a noticeable increase in the percentage of respondents who said they had a personal goal and had achieved it – from 12% in 2016 to 30% in 2017.

Further analysis by gender and duration of GROW membership

An analysis by gender found that female respondents were more likely than males to say they had achieved a personal goal (n=105) – 61% (64) and 38% (40) respectively.[21] The category of having a personal goal but doing nothing to achieve it yet (n=21) was selected by more males than females – 57% (12) and 43% (9) respectively. Therefore, based on these findings it would seem that female respondents are making more progress in terms of working on their personal goals than males.

It would be reasonable to expect that recovery outcomes would improve the longer an individual has been a GROW member. Therefore, further analysis was carried out on the recovery outcomes data to explore this question. To facilitate this analysis, the categories for the variable duration of GROW membership were reduced from five to three: <1 year; 1-5 years; and 6 years or more. Table 3 presents the results for the outcome on personal goals.

[20] These results are based on 354 respondents as data was missing for 35 cases.
[21] Data on gender was missing for one case.

Table 3: Personal Goals by duration of GROW membership (n=343)

	<1 year	1-5 years	6 years+	Total
A personal goal and have achieved it	19% (19)	42% (43)	39% (40)	100% (102)
A personal goal and have gotten pretty far in achieving it	24% (21)	51% (44)	25% (22)	100% (87)
A personal goal and made a little way toward achieving it	36% (39)	34% (37)	30% (32)	100% (108)
A personal goal but have not done anything to achieve it	15% (3)	35% (7)	50% (10)	100% (20)
No personal goals	23% (6)	23% (6)	54% (14)	100% (26)

Table 3 shows that the two most positive categories of having a personal goal and achieving it or 'gotten pretty far in achieving it' were more likely to be selected by respondents who had been GROW members for one to five years compared to those who had been attending for less than one year.[22] In addition, it was interesting that the response for these categories was lower for those who had been GROW members for six years or more compared to one to five years, which indicates that the motivation to work on personal goals may decrease for those who have been GROW members for a very long period of time.

Similarly, the two least positive categories of 'a personal goal but have not done anything to achieve it' and 'no personal goal' have the highest response from those who were GROW members for six years or more. However, these two results are based on a relatively small number of cases (n=20 and n=26 respectively). Nonetheless, it would be interesting to explore the data on other recovery outcomes to see if any similar pattern in relation to duration of GROW membership emerges.

Social and community support

Two questions in the National Survey looked at the importance of social and community supports to recovery outcomes. These were as follows:

- how much are family members, friends, partner and other people important to you (outside of GROW) involved in your recovery? and
- have you support from your neighbours and other people in your community? In a normal week, how much support would you receive?

[22] The percentage results for the top two categories for respondents who had been GROW members for 1-5 years was higher than the overall percentage of that group amongst all survey respondents, i.e. 39% (see Chart 7).

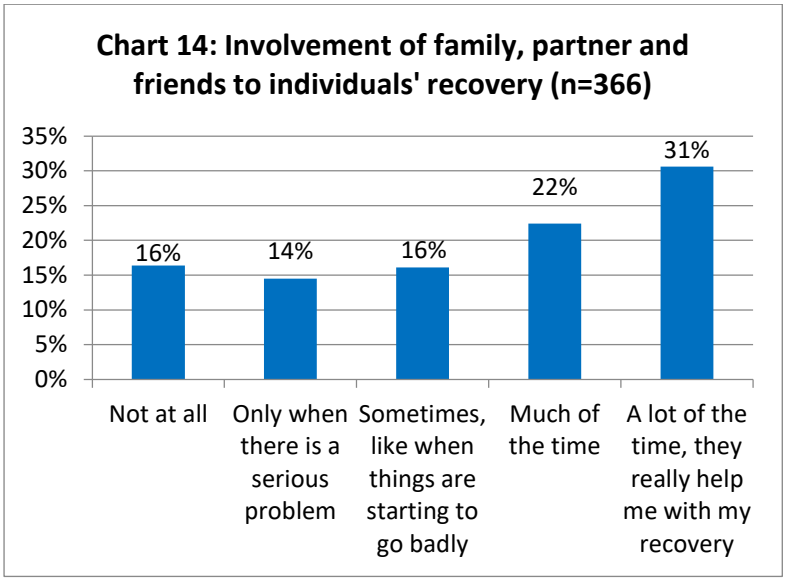


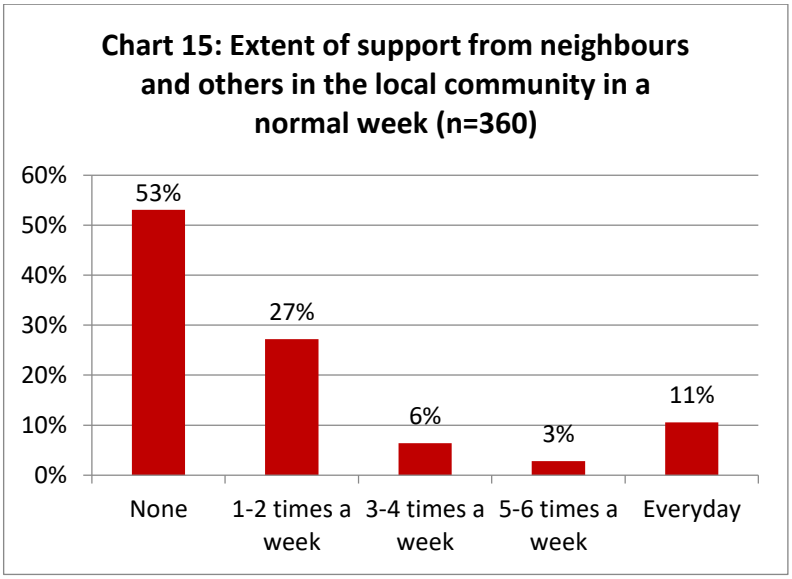
Chart 14 shows more than half of respondents, 53% (194), said that family, partner and friends were involved in their recovery much of the time (22%) or a lot of the time (31%). By comparison, 30% of respondents said that family and friends were not involved in their recovery (16%) or only when a serious problem arose (14%). Compared to 2016, these results were very similar.

Further analysis by gender and urban/rural location

A breakdown by gender found little difference in the survey results for the two categories 'a lot of the time' and 'much of the time' compared to the overall gender distribution. However, where respondents said that family and friends had no involvement ('not at all') (n=60), 60% (36) were female compared to 40% (24) male. Similarly, where respondents said that family and friends were only involved 'when there is a serious problem' (n=52), 62% (32) were female and 38% (20) were male. This indicates that where family were less involved in individual's recovery, this was more likely to be the experience of females compared to males.

Some analysis was done by whether respondents lived in an urban or rural location. There were mixed results. Where respondents said that family and friends were not involved in their recovery ('not at all'), 50% (29) lived in a rural area compared to 29% (17) from an urban area. This might be due to those living in rural areas having family and friends living further away from them compared to those in urban areas. However, where respondents said that family and friends had a lot of involvement in their recovery, the rural/urban breakdown was similar to the overall distribution of rural and urban respondents in the survey results - 45% (47) and 34% (36) respectively. Based on the first result, it might be expected that a lower percentage of those from a rural area would have had a lot of family involvement, but this was not the case.

Chart 15 shows that more than half of respondents, 53% (191), said they had no support from neighbours or others in their local community during a normal week. Where such supports were available, respondents were most likely to receive them once or twice a week, 27% (98). One in ten respondents said they accessed these supports every day, 11% (38).



Compared to 2016, it appears that support from neighbours and the local community has fallen slightly. The percentage of respondents who said they received no such support was 45% in 2016, which increased to 53% in 2017. The categories for 1-2 times a week and 3-4 times a week have also reduced somewhat (35% and 11% in 2016).

Further analysis by gender and urban/rural location

An analysis by gender found that where more frequent support from neighbours and the local community was reported, this was more likely for females compared to males. For example, where respondents said they received such support 'everyday' (n=38), 63% (24) were female and 37% (14) were male. Similarly, females were more likely to say they received supports 3-4 times a week (78%) and 5-6 times a week (89%) compared to males (22% and 11% respectively).

A breakdown of urban/rural geographical location found that where respondents said they received support from neighbours and the local community 'everyday', they were more likely to be living in rural areas than urban – 51% (18) and 37% (13) respectively. The results for the other categories of extent of support showed few differences by rural/urban location.

Symptoms

Respondents were asked two questions about the symptoms they experienced as a result of a mental health need. These were as follows:

- how much do your symptoms bother you? and
- how much do your symptoms get in the way of doing things that you would like to or need to do?

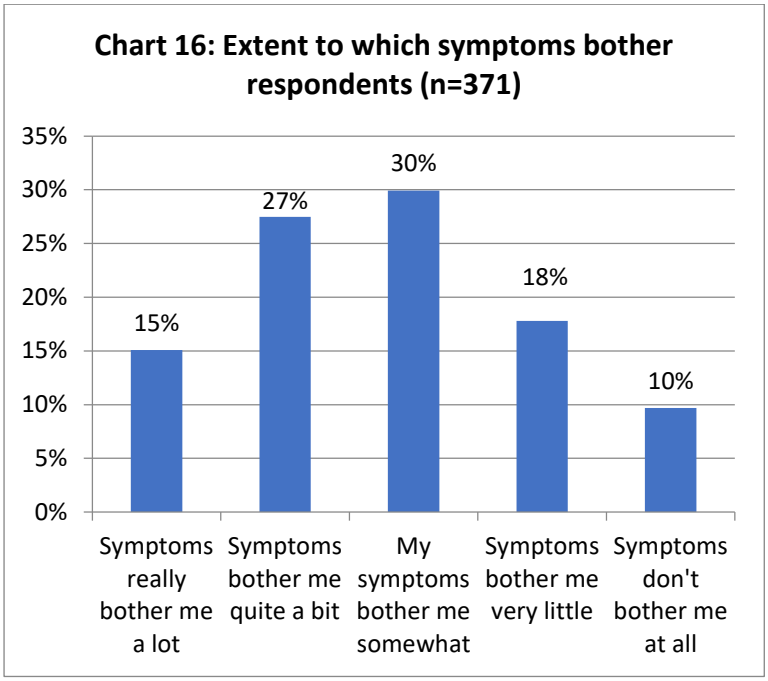
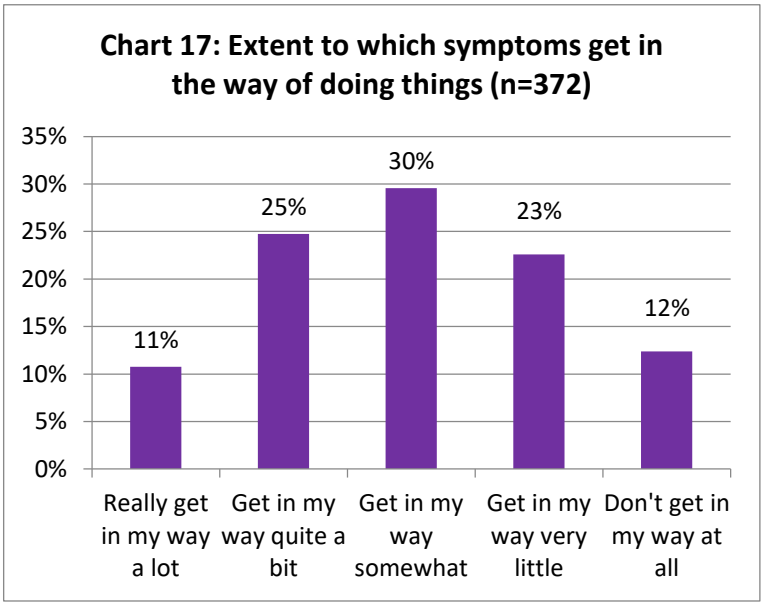


Chart 16 shows that almost one third of respondents, 30% (111), said that their symptoms bothered them somewhat. This was followed by 27% (102) who said their symptoms bothered them quite a bit.

More than one out of ten respondents, 15% (56), said that their symptoms bothered them a lot, which had increased from 9% in 2016. In 2017, one in ten respondents, 10% (36), said their symptoms did not bother them at all. This had increased slightly from 8% in 2016.

Chart 17 shows that 30% (110) of respondents said that the symptoms of their mental health need got in their way somewhat. This was followed by 25% (92) who said they got in their way quite a bit. One in ten respondents, 11% (40), reported that symptoms got in their way a lot.

By comparison, almost one quarter, 23% (84), said symptoms got in their way very little and another 12% (46) reported that symptoms did not get in their way at all.



The results for both questions relating to symptoms are very similar, which shows some consistency in the findings. The majority of respondents said that their symptoms bothered them to some extent, 72% (269) (the sum of the first three categories in Chart 16). In addition, two thirds of respondents, 66% (242), said their symptoms got in their way to varying degrees (sum of the first three categories in Chart 17). By comparison between one quarter and one third of respondents said their symptoms bothered them little or not at and did not have a negative impact on their ability to do things.

Further analysis – gender, age and duration of GROW membership

Further analysis looked at the results on symptoms by three variables: gender; age; and duration of GROW membership. In general, it was found that respondents who were less affected by their symptoms (selecting the 'very little' or 'not at all' response categories) were more likely to be:

- female compared to male
- older than younger, and
- a GROW member for a longer period of time.

Looking at the findings by gender, where participants said that their symptoms did not bother them at all (n=36), 67% (24) were female and 33% (12) were male. In relation to the second question on the extent to which symptoms got in the way of doing things, where 'don't get in my way at all' was selected (n=46), 59% (27) were female compared to 41% (19) who were male.

Turning to age, where respondents said their symptoms bothered them 'a lot' (n=56): 16% (9) were aged 25-44 years old; 59% (33) were aged 45-64 years old; and 14% (8) were 65+ years old. Similarly, the likelihood of older participants (65+) reporting that their symptoms bothered them 'very little' (32%) or 'not at all' (31%) was higher than the proportion of 65+ year olds who took part in the survey (21%).

Table 4: Response to question 'How much do your symptoms bother you?' by duration of GROW membership (n=371)

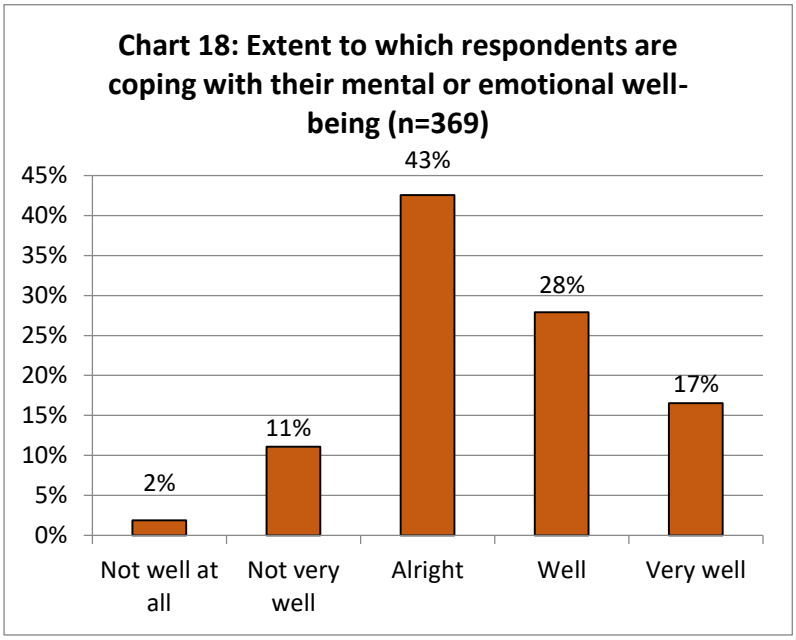
	<1 year	1-5 years	6 years+	Missing	Total
My symptoms bother me a lot	43% (24)	32% (18)	21% (12)	4% (2)	100% (56)
My symptoms bother me quite a bit	27% (28)	43% (44)	25% (26)	4% (4)	100% (102)
My symptoms bother me somewhat	23% (26)	36% (40)	37% (41)	4% (4)	100% (111)
My symptoms bother me very little	15% (10)	47% (31)	38% (25)	-	100% (66)
My symptoms don't bother me at all	17% (6)	22% (8)	58% (21)	3% (1)	100% (36)

Table 4 shows that where respondents said their symptoms bothered them a lot (n=56), almost one half, 43% (24), had been attending GROW for less than one year. This result was far higher than the proportion of all respondents who had been GROW members for less than one year, 27% (see Chart 8). Respondents who were GROW members for longer were less likely to say their symptoms bothered them a lot – 32% (18) were attending for 1-5 years and 21% (12) for 6 years or more. Similarly, where participants reported their symptoms did not bother them at all (n=36), almost two thirds, 58% (21) had been attending GROW for 6 years or more.

It is important to say that these findings are not based on statistically significant results. However, the percentage results on symptoms were compared to the proportion of these groups in the overall response to the survey. The differences found indicate some extent of variation in the results on symptoms by the variables of gender, age and duration of GROW membership.

Coping

Respondents were asked how well they felt they were coping with their mental or emotional well-being on a day to day basis. Chart 18 shows the results.



It can be seen that almost one half of respondents, 43% (157), felt they were feeling 'alright', which had increased from 39% in 2016. In 2017, a further 45% (164) said they felt 'well' (28%) or 'very well' (17%). This had fallen from 51% in the previous year 2016. In 2017, just over one in ten respondents, 13% (48), said they felt 'not very well' (11%) or 'not well at all' (2%), which had increased from 9% in 2016. Therefore, overall there was a slight worsening in respondents' coping skills between the years 2016-17.

Further analysis – gender, age and duration of GROW membership

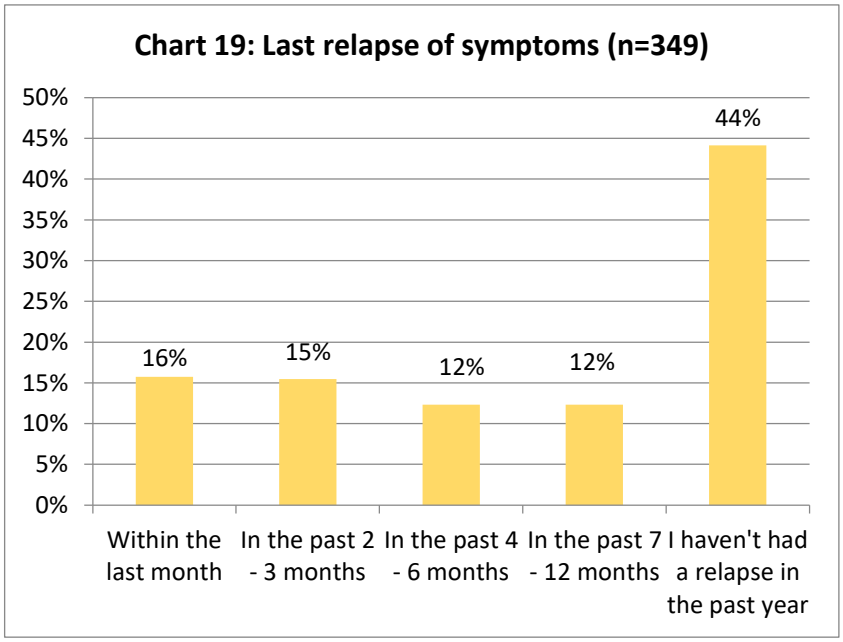
Similar to the results for symptoms above, respondents were more likely to say they were coping 'very well' with their mental or emotional well-being when they were:

- female (62%) compared to male (36%)
- aged 65+ years old (31%) compared to aged 25-44 years old (16%), and
- a GROW member for 6 years or more (51%) compared to less than one year (18%) or 1-5 years (28%).

Relapse of symptoms and hospitalisation

Respondents were asked to say when they last had a relapse of symptoms and the most recent time they had been hospitalised for mental health reasons. Charts 19 and 20 show the results.

Chart 19 shows that just under half of respondents, 44% (154), had no relapse in the last year. Whereas more than half of respondents, 56% (195), did have a relapse in the last year (sum of first four bars). Looking at the timeframe for a relapse, the results were fairly similar in each category. These results were similar to the findings for 2016, where there was a 46% no relapse/54% breakdown for relapse in the last year.



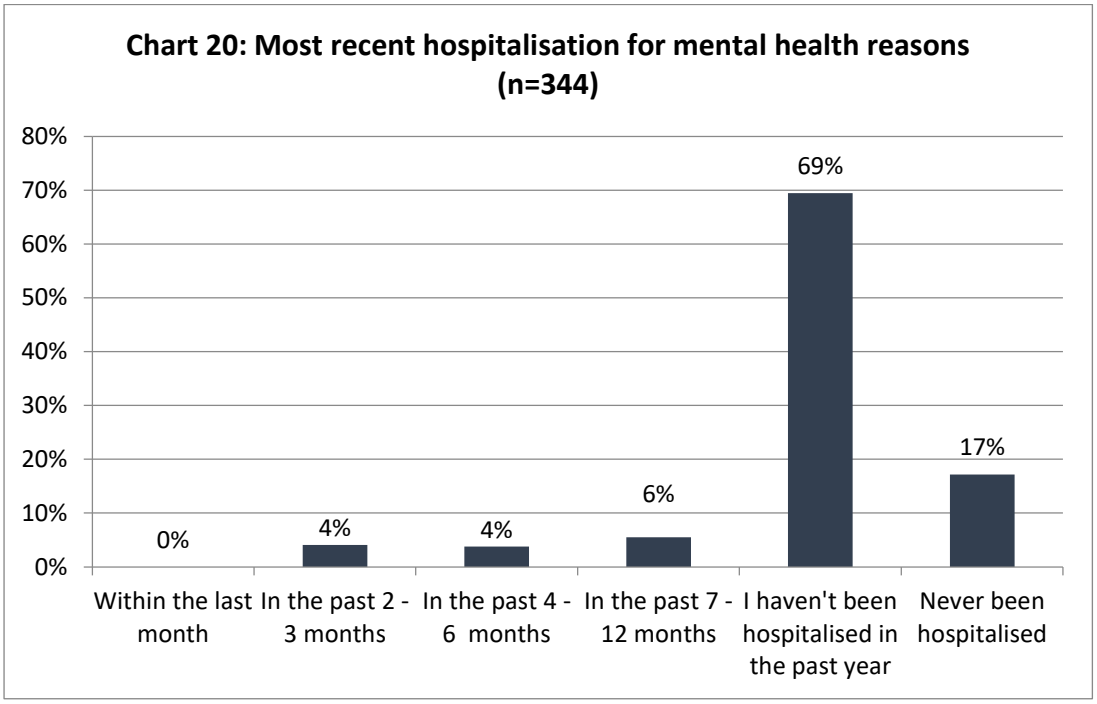


Chart 20 shows that more than two thirds of respondents, 69% (239) had not been in hospital for mental health reasons in the last year. A further 17% (59) had never been hospitalised. Just over one in ten had been in hospital in the past year, 14% (46) in total.

These results were very similar for 2016 when 68% had not been in hospital in the last year and 13% had been hospitalised.

Further analysis – gender, age and duration of GROW membership

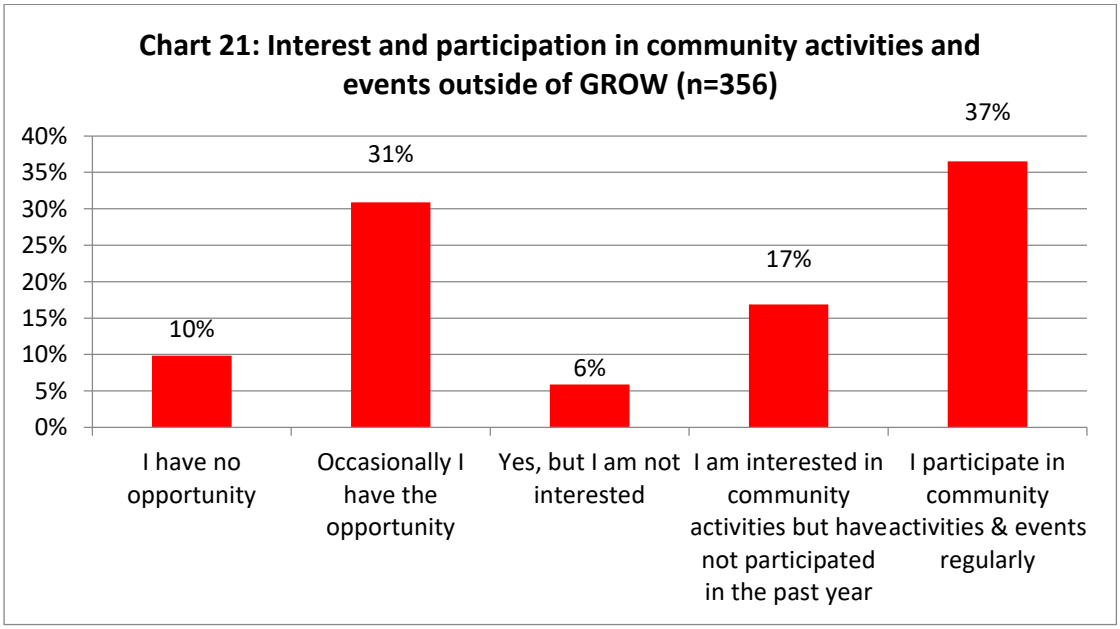
Looking at the results on the last relapse of symptoms, there was little difference by gender but those respondents who had no relapse in the last year (n=154) were more likely to be:

- older – 28% (43) were aged 65+ years old compared to 20% (31) aged 25-44 years old, and
- a GROW member for a longer period of time – almost one half of all respondents who had no relapse in the last year had been GROW members for 6 years or more, 48% (74), which compared to 32% (50) who had been members for 1-5 years and 18% (28) who had been attending GROW for less than one year.

Further analysis of the results on hospitalisation by gender, age and GROW membership did not show any consistent trends.

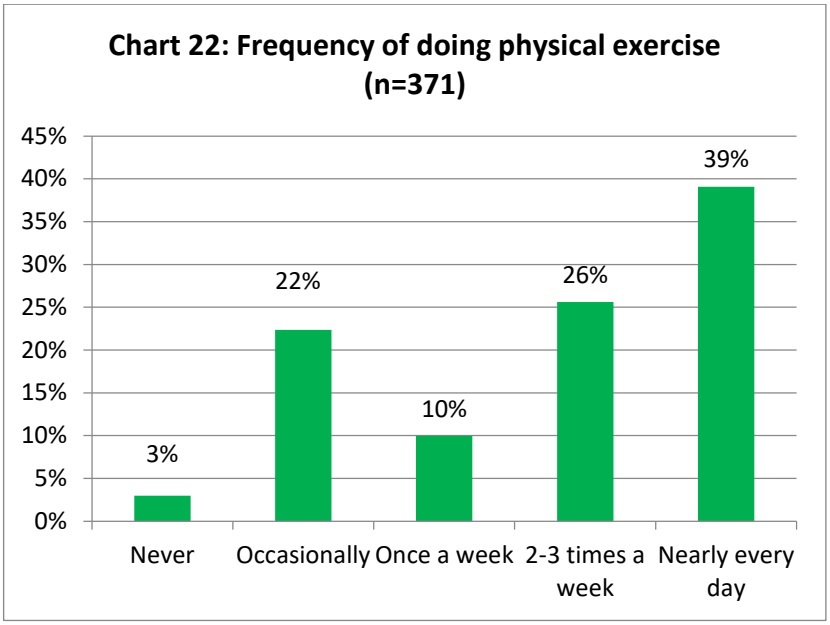
Participation in community activities and physical exercise

Respondents were asked if they had the opportunity to be involved in community activities and events outside of GROW. Chart 21 shows the results.



It can be seen that more than one third of respondents, 37% (130), said they took part in community activities on a regular basis. Compared to the previous year 2016, this has fallen from 50%. Chart 21 shows that a further 17% (60) of respondents said they were interested in community activities but had not participated in the last year. One in ten respondents, 10% (35), said they had no opportunity to take part in community activities, which increased from 5% in 2016.

Chart 22 shows that almost 4 out of 10 respondents did some physical exercise nearly every day, 39% (145), which fell from 54% in 2016. In 2017, a further 26% (95) said they exercised 2-3 times a week. Just 3% (11) said they never exercised, which was the same result in the previous year 2016.



Further analysis – gender, age, geographical location and duration of GROW membership

In relation to participation in community activities, there were two findings of note:

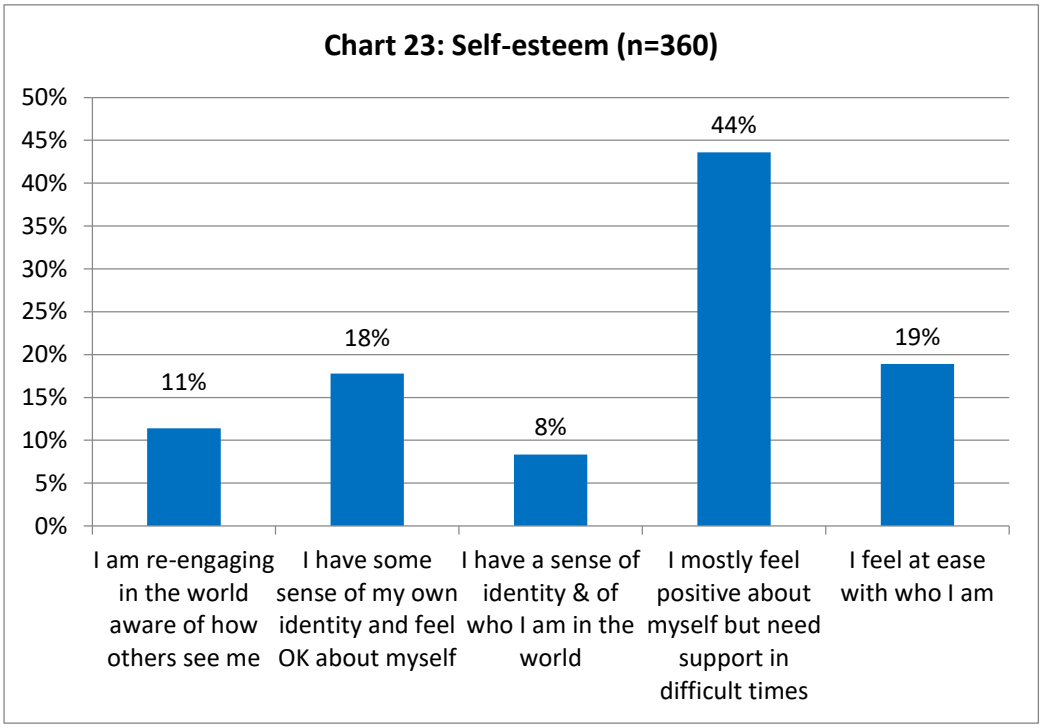
- respondents living in rural areas were more likely to say they had no opportunity to be involved, 71% (25), which compared to 20% (7) in suburban and just 6% (2) in urban areas, and
- respondents who were GROW members for six years or more were more likely to participate in community activities and events regularly, 42% (55), which compared to 18% (23) who were members for less than one year. The corresponding result for those who had been attending GROW for one to five years was 39% (51).

There was little difference in the results for participation in community activities by gender and age.

Looking at the results on physical exercise, there was one difference worth mentioning. Respondents who lived in rural areas were slightly less likely to take physical exercise nearly every day, 37% (53), while they made up 43% of all survey respondents. This compares to 40% (58) of respondents who exercised nearly every day from an urban location, whom represented 37% of respondents overall.

Self-esteem and optimism about the future

Respondents were asked to say how they felt about themselves and whether they were optimistic about the future. Chart 23 presents the findings.



It can be seen that almost one half of respondents, 44% (157), said they felt positive about themselves but needed support in difficult times. This had increased slightly from 40% in 2016, and was still the most popular choice over 2016-17. One in five respondents, 19% (68), felt at ease with themselves, which was similar to 20% in 2016.

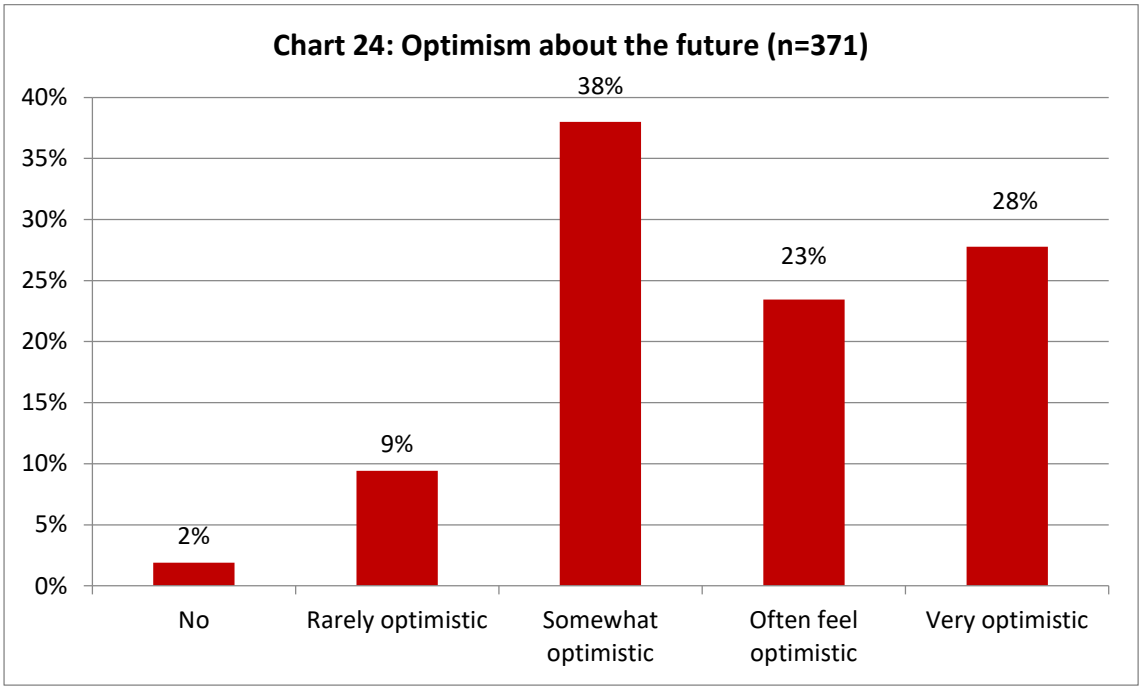


Chart 24 shows respondents' feelings about the future. Just over one quarter of respondents, 28% (103), said they felt very optimistic about the future. A further 23% (87) said they often felt optimistic. Therefore, five in ten respondents, 51% (190), said they often felt optimistic or were very optimistic about the future. This compares favourably to one in ten respondents who said they did not feel optimistic about the future (2%) or rarely felt optimistic (9%). The percentage of respondents who felt very optimistic about the future increased from 22% in 2016 to 28% in 2017.

Further analysis – gender, age, geographical location and duration of GROW membership

Looking at the results on self-esteem and optimism about the future, respondents were more positive where they were:

- female – where respondents said they felt 'very optimistic' (n=103), 64% (66) were female compared to 35% (36) who were male[23]
- living in a rural location – where respondents said they felt at ease with who they were (n=68), 47% (32) were from a rural area compared to 21% (14) who lived in a suburban area and 28% (19) in urban locations, and
- GROW members for six years or more – where respondents said they felt 'very optimistic' about the future (n=103), 42% (43) had attended GROW for six years or more, which compared to 24% (25) who had been attending GROW for less than one year and 33% (34) for one to five years.

These trends were found for both outcomes on self-esteem and optimism about the future. There was no consistent pattern in the results found by age.

Conclusions

This report has presented the main findings from the GROW National Survey 2017. It gives an insight into the socio-demographic characteristics of the 389 GROWers who took part. It also provides some understanding of the nature of their mental health needs and views on GROW – both of which have been asked for the first time in the National Survey.

Depression was found to be the most common mental health need identified by nearly one half of all respondents (49%). The key life events that were reported to contribute to their mental health need were childhood experiences, poor relationships with family and bereavement. The survey data also contributes to a better understanding of what aspects of GROW were deemed to be most beneficial to members. Having the opportunity to meet other people was closely followed by the routine of going to a weekly meeting.

The survey findings also shed some light on the differences in life chances taken up by GROWers compared to the national population. In particular, just under one quarter of respondents were currently engaged in employment, which was less than half of that in the national population (53%) based on Census data.

[23] Data for one respondent was missing here.

Data on recovery outcomes give a valuable insight into the well-being of respondents at the time of completing the survey. Overall, results were fairly positive with the majority of GROWers reporting that their current symptoms were not stopping them from getting on with every day activities just over one in ten being hospitalised in the last year. However, 56% of GROWers said that they had experienced a relapse within the last year, which shows cyclical nature of mental wellness and mental illness.

One of the key themes to emerge from the data analysis carried out for this report was that where respondents reported more positive recovery outcomes, they were more likely to be long term GROWers. This finding was consistent for many of the recovery outcomes measured in the survey – from a feeling of being able to cope with everyday life to being less likely to have had a relapse in the last year. Similarly, the results on participation in community activities outside GROW showed that where such engagement was more frequent, this was more likely to be amongst respondents who had been GROWers for six years or more. In relation to having positive self-esteem and being optimistic about the future, respondents who were long term GROWers were more likely to express these views. Hopefully this bodes well for the future of GROW and the valuable contribution it can make towards positive mental health.

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GROW in Ireland National Survey 2017

Please answer the following questions – your feedback is important to GROW. All the data is anonymous and confidential.

Background characteristics

1. Are you…. Male ☐ Female ☐ Other ☐

2. How old are you? 24 years or under ☐ 25-44 years old ☐ 45-64 years old ☐ 65+ years old ☐

3. Which county do you live in? _____

4. Region: East ☐ North East ☐ South ☐ Midwest ☐ North West ☐ South East ☐ Midlands ☐ West ☐

5. Would you describe the area you live in as: Urban ☐ Suburban ☐ Rural ☐

6. What is your current status? At work ☐ Retired ☐ Looking after home/family ☐ Volunteering ☐ Student ☐ Seeking employment ☐ Not working due to illness/disability ☐ Training course ☐ Other ☐ (specify) _____

Engagement with Grow

7. In the last 3 months did you attend your GROW group……. Once a week ☐ Every 2 weeks ☐ Once a month ☐ Less than once a month ☐

8. How long have you been a member of your GROW group? 6 months or less ☐ 7-12 months ☐ 1-2 years ☐ 3-5 years ☐ 6 years+ ☐

9. In 2016, how many of the following did you attend? National weekends _____ Regional weekends _____ Group weekends _____ Group social events _____

10. What is your role in GROW? *(tick as many that apply)* Member ☐ Recorder ☐ Organiser ☐ Leader ☐ Regional team member ☐ Board member ☐ Staff ☐

11. Who referred you to GROW? GP (Doctor) ☐ Psychologist ☐ Psychiatrist ☐ Counsellor (Private) ☐ Counsellor (HSE) ☐ Self-referral ☐ Other professional (specify) _____

12. At the moment are you engaging with any of the following? GP ☐ Psychologist ☐ Psychiatrist ☐ Counsellor ☐ Support group (other than GROW) ☐ Other ☐ (specify) _____

13. How would you define your mental health need? *(tick one)* Anxiety ☐ Depression ☐ Obsessive Compulsive Disorder ☐ Post-traumatic Stress Disorder ☐ Bipolar Disorder ☐ Schizophrenia ☐ Personality Disorder ☐ Eating disorder ☐ Other ☐ (specify) _____

14. Did any of the following contribute to your mental health need? Separation/divorce ☐ Poor relationships with family ☐ Bereavement ☐ Redundancy ☐ Relationship breakdown ☐ Childhood experience ☐ Other ☐ (specify) _____

15. What do you find <u>most</u> beneficial about GROW? *(tick up to 3)* Structured program ☐ Reading material ☐ Peer support ☐ Practical tasks/goals ☐ Social events ☐ Weekly meetings ☐ Meeting other people ☐ Learn new skills ☐ Other ☐ (specify) _____

16. Has the support you have received from GROW helped you with any of the following? Deal with your employer ☐ Retention of employment ☐ Gain employment ☐ Change job/career ☐

17. What could be better about GROW? _____ _____ _____

GROW in Ireland National Survey 2017

Outcomes

18. In the past 3 months, I have come up with……..

No personal goals ☐ | A goal but have not done anything to achieve it ☐ | A goal and made a little way towards achieving it ☐

A goal and have gotten pretty far in achieving it ☐ | A goal and have achieved it ☐

19. How much are family members, friends, boyfriend/girlfriend, and other people who are important to you (outside of GROW) involved in your recovery?

Not at all ☐ | Only when there is a serious problem ☐ | Sometimes, like when things are starting to go badly ☐

Much of the time ☐ | A lot of the time, they really help me with my recovery ☐

20. Have you support from your neighbours and other people in your community? In a normal week, how much support would you receive?

None ☐ | 1-2 times a week ☐ | 3-4 times a week ☐

5-6 times a week ☐ | Every day ☐

21. How much do your symptoms bother you? My symptoms…

Really bother me a lot ☐ | Bother me quite a bit ☐ | Bother me somewhat ☐

Bother me very little ☐ | Don't bother me at all ☐

22. How much do your symptoms get in the way of you doing things that you would like to or need to do?

Really get in my way a lot ☐ | Get in my way quite a bit ☐ | Get in my way somewhat ☐

Get in my way very little ☐ | Don't get in my way at all ☐

23. How well are you coping with your mental or emotional well-being from day to day?

Not well at all ☐ | Not very well ☐ | Alright ☐ | Well ☐ | Very well ☐

24. When was the last time you had a relapse of symptoms (that is, when your symptoms had gotten much worse)?

Within the last month ☐ | In the last 2-3 months ☐ | In the last 4-6 months ☐

In the last 7-12 months ☐ | I haven't had a relapse in the last year ☐

25. When were you last hospitalised for mental health reasons?

Within the last month ☐ | In the last 2-3 months ☐ | In the last 4-6 months ☐

In the last 7-12 months ☐ | Haven't been hospitalised in the last year ☐

26. Have you the opportunity to be involved in community activities and events outside of GROW?

I have no opportunity ☐ | Occasionally I have the opportunity ☐ | Yes but I am not interested ☐

I am interested in community activities but have not participated in the last year ☐ | I participate in community activities/events regularly ☐

27. Do you take regular physical exercise?

Never ☐ | Occasionally ☐ | Once a week ☐ | 2-3 times a week ☐ | Nearly every day ☐

28. How do you feel about yourself?

I am re-engaging in the world aware of how others see me ☐ | I have some sense of my own identity and feel OK about myself ☐ | I have a sense of identity and of who I am in the world ☐

I mostly feel positive about myself but need support in difficult times ☐ | I feel at ease with who I am ☐

29. Do you feel optimistic about the future?

No ☐ | Rarely optimistic ☐ | Somewhat optimistic ☐

Often feel optimistic ☐ | Very optimistic ☐

Would you like to sign up to GROW's monthly newsletter? If yes, give your email address:_____

Thank you for your participation