

**PEER MENTORING IN RESIDENTIAL CARE:
A MIXED-METHODS STUDY**

by

KRISTINE A. THEURER

M.A. (Gerontology), Simon Fraser University, 2010
B.A., The University of British Columbia, 1995

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Rehabilitation Sciences)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

December 2018

© Kristine A. Theurer, 2018

The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

Peer Mentoring in Residential Care: A Mixed-Methods Study

submitted by Kristine A. Theurer in partial fulfillment of the requirements for

the degree of Doctor of Philosophy

in Rehabilitation Sciences

Examining Committee:

W. Ben Mortenson, Occupational Science & Occupational Therapy
Supervisor

Melinda J. Suto, Occupational Science & Occupational Therapy
Supervisory Committee Member

Robyn I. Stone, LeadingAge Long-Term Support Services Center (LTSS) @UMass
Boston (University of Massachusetts)
Supervisory Committee Member

Supervisory Committee Member

Deborah O'Connor, School of Social Work and Family Studies
University Examiner

Jennifer Lyn Baumbusch, School of Nursing
University Examiner

Additional Supervisory Committee Members:

Virpi Timonen, School of Social Work and Social Policy, Trinity College Dublin
Supervisory Committee Member

Supervisory Committee Member

Abstract

A significant number of individuals living in residential care experience loneliness and depression. People engaged in peer mentoring draw benefits from the social and emotional connection; however, this approach is rare within these settings. The objectives of this study were to develop a new model of social citizenship based on peer mentoring, describe the development of a novel peer mentoring program; and collect feasibility data associated with its implementation (e.g., assessment of recruitment and sample; outcome measures and data collection; retention, program adherence and acceptability; and residents' responses). The Peers Engaging and Empowering their Peers model, which has its foundations in social citizenship, provided the basis for a peer mentoring program in which community volunteers (community mentors) and resident volunteers (resident mentors) formed a supportive team and provided visits and guidance to other residents that were lonely or socially isolated (mentees). For the mixed-methods feasibility study, I enrolled community mentors ($n = 65$), resident mentors ($n = 48$) staff facilitators ($n = 24$) and mentees ($n = 74$) in 10 sites. Among resident mentors remaining at six months ($n = 28$), a significant reduction in loneliness scores ($p = .014$; $d = .23$) and depression scores ($p = .048$; $d = .30$) were noted. Sense of belonging, purpose in life and social identity were unchanged. In-depth interviews with a sample of resident mentors ($n = 8$) revealed positive perceptions of the program. Most of the feasibility objectives were met; however, low retention rates among resident mentors were noted as well as time and resource challenges. At six months, among the mentees from whom data could be obtained ($n = 43$), I found a significant reduction in

loneliness ($p = 0.02$; $d = .76$) and depression ($p = 0.02$; $d = .76$), and a 60% increase in the number of monthly programs attended ($p = 0.01$; $d = .37$). Interviews with mentees ($n = 32$) indicated perceptions of the program were also positive. The study findings reveal a potential role that mentorship can play in enhancing social citizenship and lay the groundwork for future research.

Lay Summary

Over half of individuals living in residential care settings report feeling lonely and depression is common. Peer mentoring, which involves emotional support and guidance provided by people sharing common experiences, has reduced loneliness and depression in other populations. I examined a novel peer mentoring program in which residents and volunteers formed a supportive team that met weekly and received training. Members of this team then paired up and visited other residents that were identified as lonely. I conducted research using this program to look at the feasibility of doing a larger experimental study. Among the resident mentors and mentees, I found significant decreases in loneliness and depression. Among people visited, I also found a significant increase in program attendance. Although retaining mentors was a challenge, I found that mentors and people visited responded positively to the program. This study and these important findings lay the groundwork for future research.

Preface

This dissertation “Peer Mentoring in Residential Care: A Mixed-methods Study” has been written to fulfill the graduations requirements of the Graduate Programs in Rehabilitation Sciences at the University of British Columbia. I was engaged in research and writing this project from September 2013 until November 2018. Peer mentoring in residential care is a revolutionary concept which has potential to change the landscape of loneliness and social isolation so common in these settings. It is my hope that this work will help to transform the role of individuals living in residential care and to improve their quality of life.

I have received personal financial support for this research and want to thank the University of British Columbia (UBC) for the UBC Public Scholars Initiative, the UBC 4YF Scholarship and the Social Sciences and Humanities Research Council of Canada for the Joseph-Armand Bombardier Canada Graduate Doctoral Scholarship [767-2014-2411].

I have had the pleasure of working with an excellent committee. I want to thank Dr. Ben Mortenson, my senior supervisor for his ongoing encouragement and his detailed and thoughtful guidance. I also want to express my gratitude to the members of the committee, Dr. Melinda Suto, Dr. Robyn Stone and Dr. Virpi Timonen for their helpful insights and edits. I am so appreciative for the support I had from each of them along the way.

Co-Authorship Statement

All the chapters of this dissertation were co-authored by the members of my committee and included edits by Susan Brown from the Schlegel-UW Research Institute for Aging. The Java Mentorship program was developed prior to 2012 by me as well as data from the associated informal pilots. The planning for this research was coordinated at the Department of Occupational Science and Occupational Therapy at the University of British Columbia, and the program and data collection were carried out in Ontario in coordination with the Schlegel-UW Research Institute for Aging and Schlegel Villages. The final study plan was developed in consultation with Dr. Ben Mortenson, supervisor, and Dr. Melinda Suto as well as consultation with Dr. Robyn Stone and Dr. Virpi Timonen (committee members). Data collection and data entry was primarily completed by Susan Brown, Kaylen Pfisterer, Amy Matharu with, in some cases, assistance from staff and/or me. I conducted a 1-day staff program implementation training, provided ongoing supervision of the study and did some qualitative data collection as needed. I also took a lead role in the data analysis. Dr. Ben Mortenson and Dr. Melinda Suto helped me coordinate all aspects of the study, data analyses, and write the first drafts and revisions of the dissertation.

Table of Contents

Abstract.....	iii
Lay Summary.....	v
Preface	vi
Table of Contents.....	viii
List of Tables	xii
List of Figures	xiii
Glossary.....	xiv
Acknowledgements.....	xv
Dedication.....	xvii
 Chapter 1. Introduction.....	 1
1.1. Introduction	1
1.2. Background.....	4
1.3. Culture Change in Residential Care	7
1.3.1. Challenges in Implementing Culture Change.....	8
1.3.2. Culture Change and Staff Issues	10
1.4. Person-Centred Care and Social Citizenship.....	12
1.5. Mental Health and Social Productivity	14
1.6. Leisure as Therapy in Residential Care	19
1.7. Parasocial Programming	21
1.8. Peer Mentoring	22
1.9. Reducing the Parasocial Programming Cycle.....	28
1.10. Statement of the Problem	33
1.11. Objectives.....	34
1.12. Mixed-Methods Design and Stance	35
1.13. Overview of Dissertation.....	36
1.13.1. Social Citizenship in Residential Care and the Development of a Peer Mentoring Program (Chapter 2)	37
Rationale.....	37
Purpose.	37
1.13.2. Peer Mentoring in Residential Care: A Feasibility Study (Chapter 3)	37
Rationale.....	37
Purpose.	38
1.13.3. “It Makes You Feel Good to Help!”: The Experience of Peer Mentoring in Residential Care (Chapter 4)	38
Rationale.....	38
Purpose.	38
1.13.4. The Impact of Peer Mentoring in Residential Care on People Visited: A Mixed-Methods Exploratory Study (Chapter 5).....	38
Rationale.....	38
Purpose.	39

Chapter 2. Social Citizenship in Residential Care and the Development of a Peer Mentoring Program	40
2.1. Introduction	40
2.2. Mental Health in Residential Care	43
2.3. Human Rights and a Disabling Society	44
2.3.1. The Complexity of Residential Care	47
2.3.2. The Institutionalization of Leisure	50
2.3.3. The Right to Respect and Dignity	52
2.4. The Practice of Social Citizenship and Relationality	54
2.5. Theoretical and Conceptual Foundations	56
2.5.1. Power and the Institutional Culture	57
2.5.2. The Phenomena of Social Death	60
2.5.3. Resident Councils	62
2.5.4. Pluralizing Modes of Representation	63
2.6. Peer Mentoring: Towards a New Model of Social Citizenship	65
2.6.1. The Development of a Mentoring Program	67
The mentoring program structure.	68
The education modules.....	70
The visits.....	73
Program sustainability and revisions.	73
2.7. Discussion	74
 Chapter 3. Peer Mentoring in Residential Care: A Feasibility Study	80
3.1. Methods.....	84
3.1.1. Recruitment and Inclusion Criteria.....	85
3.1.2. Program Structure	86
3.1.3. Measures: Resident Mentors	88
Descriptive measures and covariates.	88
Survey.....	88
Outcome measures.	89
3.2. Data Collection and Analysis	91
3.3. Results.....	92
3.3.1. Assessment of Ability to Recruit and Characteristics of the Sample	92
Resident mentors.....	93
Community mentors.....	93
Staff facilitators.	93
3.3.2. Assessment of Procedures for Collection of Data.....	94
3.3.3. Assessment of Retention, Program Adherence and Acceptability	95
3.3.4. Assessment of Resident Responses to the Program.....	97
Resident mentors.....	99
Community mentors.....	100
3.4. Discussion	101
3.4.1. Assessment of Ability to Recruit and Characteristics of the Sample	102
3.4.2. Assessment of Procedures for Collection of Data.....	102
3.4.3. Assessment of Retention, Program Adherence and Acceptability	103
3.4.4. Assessment of Resident Responses to the Program.....	105

Chapter 4. “It Makes You Feel Good to Help!”: The Experience of Peer Mentoring in Residential Care.....	113
4.1. Background.....	113
4.2. Methods.....	117
4.2.1. Study Design and Settings.....	117
4.2.2. Eligibility and Recruitment.....	118
4.2.3. Structure of the Program.....	119
4.2.4. The Program Process and Components.....	119
4.2.5. Data Collection	120
4.2.6. Data Analysis.....	121
4.3. Results.....	123
4.3.1. The Themes.....	124
Helping others, helping ourselves despite challenges.	124
Building a bigger social world.	126
Teamwork is better.	127
4.4. Discussion	129
 Chapter 5. The Impact of Peer Mentoring in Residential Care on People Visited: A Mixed-Methods Exploratory Study.....	 137
5.1. Background.....	137
5.1.1. Conceptual Foundation.....	140
5.1.2. Peer Mentoring	142
5.2. Methods.....	144
5.2.1. The Peer Mentoring Program	144
5.2.2. Study Procedures	145
5.2.3. Eligibility and Recruitment.....	146
5.2.4. Descriptive Measures and Covariates	147
Primary outcome.....	147
Secondary outcomes.	148
5.2.5. Data Analysis.....	149
5.3. Results.....	150
5.3.1. Interviews with Mentees.....	153
Caring and reciprocal relationships.....	153
A desire to connect.	154
A new lease on life.....	155
5.4. Discussion	156
 Chapter 6. Conclusion, Synthesis, and Future Directions	 162
6.1. Personal Reflections.....	173
6.2. Dissemination of Findings.....	174
6.3. Significance and Limitations	176
6.4. Future Research	179
6.5. Conclusion.....	180

References	182
-------------------------	------------

Appendices

Appendix A. Feasibility Outcomes	216
Appendix B. Observation Checklist.....	219
Appendix C. Outcome Measures	220
Appendix D. Coding Methods for Data Entry Versions A and B.....	221
Appendix E. Comparison Between Resident Mentors Who Stayed and Did Not Stay in the Study ($n = 48$).....	225
Appendix F. Mentors Interview Schedule	226
Appendix G. Mentees' Interview Schedule.....	227
Appendix H. Recruitment and Analysis Flow	228

List of Tables

Table 1.1. <i>Aspects of Peer Support Versus Peer Mentoring</i>	23
Table 2.1. <i>Delivery of the Peer Mentoring Program</i>	69
Table 2.2. <i>Education Modules</i>	73
Table 3.1. <i>Characteristics of Resident Mentors (n = 48)</i>	94
Table 3.2. <i>Resident Mentors' Post-Study Survey Results (n = 28)</i>	96
Table 3.3. <i>Descriptive Statistics for Measurements (Composite Scores) at Three Time-Points Among Resident Mentors</i>	98
Table 3.4. <i>Results of Linear Mixed-Model Analysis (n = 45)</i>	99
Table 4.1. <i>Comparison Between Subgroups of Resident Mentors: Those Not Interviewed (n = 40) Versus Those Interviewed (n = 8)</i>	124
Table 5.1. <i>Characteristics of Mentees (n = 74)</i>	150
Table 5.2. <i>Comparison Between Mentees and Resident Mentors</i>	151
Table 5.3. <i>Depression and Loneliness Scores Over Time Among Mentees (n = 43)</i>	151

List of Figures

<i>Figure 1.1.</i> Reducing the parasocial programming cycle.....	30
<i>Figure 1.2.</i> Convergent design procedure. Based on <i>Designing and Conducting Mixed Methods Research</i> (2 nd ed.), by J.W. Creswell and V. L. Plano Clark, 2011.....	36
<i>Figure 2.1.</i> A new model of social citizenship in residential care: Peers engaging and empowering their peers (PEEPS).	66
<i>Figure 2.2.</i> Model of learning cycles for mentors. Adapted from “Blended Model of Adult Learnings in Higher Education,” by E. S. Dunlap, B. Dudak, & M. Konty, 2012, <i>Kentucky Journal of Excellence in College Teaching and Learning</i> , 10(2), p. 28. Copyright 2012 by the authors; used with permission.....	70

Glossary

Continuing Care Communities provide housing, residential services and nursing care in one location and include different combinations of long-term care homes, assisted living, adult day-centers and retirement homes.

Loneliness is a discrepancy between the social relationships desired in one's life and the perception of the quality and quantity of those relationships available (Peplau & Perlman, 1982).

Long-Term Care Homes offer professional 24-hour supervision and nursing care and treatment within a residential care setting for individuals with complex health issues (Canadian Healthcare Association, 2009).

Mentors are individuals who commit (through words or action) to provide guidance and emotional support to others (Sherman, DeVinney, & Sperline, 2004).

Peer Mentoring is the action of initiating some form of empathetic guidance, social or emotional support to someone sharing a common experience or characteristic (Dennis, 2003).

Peer Support is support offered between people who share a common experience or characteristic. It often includes reciprocity of support, and shared learning based on direct experience (Keyes et al., 2014).

Purpose in Life is a motivating factor in an individual's life driven by meaning that includes making sense of life through achieving an aim (Frankl, 1963, 1978).

Residential Care is provided in settings that offer various levels of care depending on need. These settings include long-term care, assisted living, retirement and independent living homes (Schafer, 2014).

Social Identity is a sense of group belongingness—how the self is perceived by what is held in common with others (Haslam, 2014).

Sense of Belonging is the personal experience of being an important part of a social living environment (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992).

Social Productivity is the act of engaging in activities that benefit others, have a social component and are meaningful (Baker, Cahalin, Gerst, & Burr, 2005).

Acknowledgements

I have been fortunate to have support from the Schlegel-UW Research Institute for Aging and the residents, staff and volunteers from Schlegel Villages in Ontario. I cannot thank them enough—I simply could not have accomplished this large study without them.

I want to thank Susan Brown, Josie d’Avernas, and the late Dr. Michael Sharratt from the Schlegel-UW Research Institute for Aging for their extraordinary willingness to help a doctoral student from across the country launch a very large project to pilot a new program and evaluate it in so many of the Schlegel homes. Susan, thank you for putting in time in the wee hours of the night helping to launch this study, and the many hours since, editing, presenting at conferences and more.

I would like to thank those at the Schlegel Villages that took part in the research from the bottom of my heart. The residents shared their wisdom and were so willing to try something new *and* answer 1,001 questions. In the case of the questionnaires it was the same questions, not once or twice but three times. A big thank you to Melanie James for going above and beyond. Thank you to Jenny Brown for helping me present. Thank you to all the Schlegel staff who were willing to not only implement a new program but also help with the vast amounts of paperwork that was required. They put up with a lot of emails, phone calls and questions and took significant amounts of time out from their very busy work lives to respond. The volunteer *research champions* which included family members, were amazing and put in long hours helping with the project.

A thank you goes to the two research assistants from the Schlegel-UW Research Institute for Aging, Kaylen Pfisterer and Amy Matharu. Their hard work and enthusiasm for this project was remarkable. They went above and beyond, over-and-over again, to make sure that everything got done and did a superb job.

A special thank you for Dr. Deborah O'Connor and Dr. Ruth Bartlett for their extraordinary work on citizenship and dementia—it is an inspiration to me.

Finally, I'd like to thank Joanie Wolfe (joanie@3wolves.org) for her most excellent computer graphic, formatting and editing skills, and Anton Svendrovski (info@statshelp.ca) for his sense of humour and for being an immeasurable source of help throughout.

Dedicated with much gratitude to:

- Clayton MacKay, my husband, for his unfailing encouragement and support; and
- Gisela Theurer and Susanne Theurer, my sisters, for the long hours they spent editing, for keeping me grounded and for cheering me on.

Chapter 1.

Introduction

1.1. Introduction

The world's population is aging rapidly. In 2016, the United Nations estimated that people over the age of 80 will increase from 125 million in 2015 to 434 million in 2050 (United Nations, 2016). In Canada, older adults aged 65 and over increased 14.1% between 2006-2011 to almost 5 million, and 7.9% live in residential long-term care homes (Statistics Canada, 2011). These growing numbers are challenging healthcare systems to respond to the increasingly complex health needs and care is often fragmented and uncoordinated (Alzheimer Disease International, 2016). People living in these settings require assistance in performing daily activities due to physical or cognitive challenges (Kusmaul, Bern-Klug, & Bonifas, 2017). With the medical model as the common, residents tend to be characterized by a list of impairments (Power, 2017). Individuals with and without dementia in long-term care are equal citizens, and as citizens have equal rights (European Network of National Human Rights Institutions (ENNHRI), 2017, February 23), but residents are often viewed as passive recipients of care without rights (Bartlett & O'Connor, 2010). This speaks to the need to rethink

values, assumptions and practices currently in place (Brownie & Nancarrow, 2013; Canadian Healthcare Association, 2009; Canadian Institute for Health Information, 2013; Kane, 2001; Kane, 2010; Koren, 2010).

The notion of citizenship is becoming increasingly relevant for persons living in residential care settings. Citizenship is often understood in the realm of civic or political dialogues, but given the above concerns the concept of social citizenship is particularly relevant in these settings. Social citizenship has been defined as "...a set of social practices which define the nature of social members" (Turner, 1993, p. 4). Extending the concept of citizenship beyond the traditional civil or political discourses offers an opportunity to bring a different lens that considers the rights of persons living in residential care. Specifically, it allows new conversations to counter the accepted practices in a proactive way that explore social structures that enable people to become engaged in their communities (Birt, Poland, Csipke, & Charlesworth, 2017). Just as persons living with dementia can be socially discredited (World Health Organization, 2017), people moving into residential care are stripped of their social status. Individuals are then viewed as dependent on others, no longer capable of acting as citizens, and hence become easy targets of human rights abuses (Bartlett & O'Connor, 2007). While many residents need support from others to manage civic responsibilities or contribute in their communities, they need to be recognized as equal citizens (Godwin & Poland, 2015). Social citizenship offers an alternative lens to address these challenges within residential care using a relational-based or relatedness approach. Kitwood (2013) describes the importance of relatedness:

It is one of the great failures of dementia care, in the patterns that we have inherited, that the theme of relatedness has been so largely forgotten. For in the traditional institution people often lived out their lives in a kind of collective loneliness, desperately anxious in their isolation. Even today, some forms of intervention seem to have the nature of short-term fixes, without regard for lasting attachments. At the very point, then, where social being needed to be enhanced because of the lack of inner stabilizers or buffers, people with dementia often found that what remained of their social being was taken away. (Kitwood, 2013, p.3)

This broader relational perspective moves away from viewing the residents' quality of life as individualized problems to be solved, to a closer look at how societal discourses and power shape their experiences (Bartlett & O'Connor, 2010).

The social citizenship lens is particularly useful within the social, dynamic and multifaceted culture of these settings. The historic culture of long-term residential care is informed by a variety of ageist practices and beliefs (Natan, Ataneli, Admenko, & Har, 2013). Older adults in general, face societal discrimination and assumptions about their lack of productivity and usefulness. Residents in these settings also face additional discrimination from their peers, in part because of a pervasive fear of illness, in particular Alzheimer Disease (Kelson, 2013). Recognition of residents as beings with potential for contribution, growth and learning is often absent (Shura, Siders, & Dannefer, 2010). The National Advisory Council on Aging in Canada delineated negative myths of aging that influence public policy (National Advisory Council on Aging, 2003), such as "to be old is to be sick" or "seniors are too set in their ways to undertake new things." According to the National Advisory Council on Aging (2003), education for policymakers, the public, caregivers and professionals is paramount for contesting these myths. These myths and the necessity for improved quality of life in residential care highlight the need for a fundamental change in culture. To develop an

understanding of social citizenship as a potential practice within the culture of residential care, I conducted a mixed-methods research project that explored an alternative relatedness approach embedded in the complex culture of residential care.

1.2. Background

The discourse around the lives of people living in residential care settings has been dominated by a focus on an irreversible decline associated with aging and disability, instead of a rights-based focus. This discourse is tied in with the cultural stereotype held by many societies fueled by feelings, attitudes and fears about growing old (Berger, 2017). As people living in these care settings adjust to personal physical and cognitive changes, losses of privacy and former relationships, they also deal with discrimination and a loss of rights (Kusmaul et al., 2017). In Europe, a human rights-based approach to service delivery in long-term care is being developed that places standards and principles of human rights at the center of service planning, policy and practice (European Network of National Human Rights Institutions (ENNHRI), 2017, February 23). There are numerous rights identified that include the right to equality and non-discrimination, autonomy, dignity, participation and social inclusion. Concerns around resident rights are many and include excessive medicalization, mistreatment and rigid care routines and quality of life issues for residents (e.g., infantilization and suppression of residents' potentials for contribution), and have prompted legal, legislative and policy changes (Koren, 2010; Shura et al., 2010). As a substantial number of people living in residential care have dementia, their rights must be contextualized and include support to address a disease process that interferes with

intellectual functioning (Bartlett & O'Connor, 2010). Therefore, the shift in focus is an inclusive one and an opportunity to manifest the principles of rights into practice and service development (European Network of National Human Rights Institutions (ENNHRI), 2017, February 23).

Two important concepts, organizational culture and organizational climate, contribute to quality of life among residents and the ability of a home to implement and sustain making changes. These distinct, but related constructs help explain how a setting, such as a work environment, is experienced (Cassie & Cassie, 2012). Organizational culture refers to shared assumptions, values and beliefs, that helps to define why things happen within an organization, whereas climate refers to more experientially shared perceptions of the meaning attached to practices, policies and procedures, along with observed behaviors that are supported and expected (Schneider, Ehrhart, & Macey, 2013). The climate provides support for the culture of the setting (Ginsburg, Tregunno, Norton, Mitchell, & Howley, 2013). An example of a poor organizational climate observed in a care home may include unsupportive, cold or impersonal interactions between providers and the staff and between staff and residents (Cassie & Cassie, 2012). The readiness of the organization to adopt and implement change will be influenced by this climate, and this in turn, will affect residents.

Individuals moving into residential care settings are affected by the climate and culture. The challenges they face are compounded by how people living in these settings are understood in society, which influences how staff and caregivers view, position and act towards them (Bartlett & O'Connor, 2010; Daly, McCarron, Higgins, & McCallion, 2012). Although there are positive models of care and some organizations

try to provide a home-like environment and a positive organizational culture, rigid procedures and hidden power structures are common (Kane, 2001). In addition, long-held practices within the traditional medical model create numerous barriers for residents to connect in a meaningful way or have a voice in their communities (Power, 2017). Residents are frequently assumed to have little potential for productivity, contribution, growth and learning (Shura et al., 2010) and describe loss of autonomy and loneliness as major themes related to their quality of life (Choi, Ransom, & Wyllie, 2008).

Within this social environment, the loss of roles and health challenges combined with limited opportunities to engage in meaningful activities (Klinedinst & Resnick, 2014), likely has an impact on residents' mental health. Indeed, an emerging body of research highlights concerns about residents' psychosocial health and well-being, and depression and identifies that loneliness and depression are common experiences (Kemp, Ball, Hollingsworth, & Perkins, 2012; Moon, 2012; Neufeld, Freeman, Joling, & Hirdes, 2014; Schafer, 2014; Snowden, 2010a; Sun, Waldron, Gitelson, & Ho, 2012). Depression is often overlooked and undertreated (Canadian Institute for Health Information, 2010; Cohen, Hyland, & Kimhy, 2003), and efforts to improve quality of care continue to focus on safety and physiological over psychosocial health and well-being (Brownie & Nancarrow, 2013). In addition, increasing numbers of older adults entering residential care settings are older, functionally dependent and more likely to have dementia (Dobell, 2011). The concept of othering, separating individuals that are different from the norm (Doyle & Rubinstein, 2013), creates profound social isolation. In addition, people with dementia in these settings can become socially isolated for a

variety of reasons. Higher functioning residents may have difficulty connecting with individuals with dementia as it can raise concerns that they might eventually undergo similar changes (Shippee, 2012) and are generally less likely to connect with people in worse health (Iversen, Larsen, & Solem, 2009; Power, 2010; Schafer, 2014).

1.3. Culture Change in Residential Care

Concerns about the well-being of residents has spurred the culture change movement to reduce the institutional nature of the homes and enhance life for residents, and for families and staff (Shield, Looze, Tyler, Lepore, & Miller, 2014). Over the past two decades, consumer advocacy groups in the United States (US), Canada and elsewhere have been promoting a culture that de-institutionalizes services (The Association of Advocates for Care Reform, 2012; The National Consumer Voice for Quality Long-Term Care, 2013). Core values of this movement are choice, dignity, respect, self-determination and purposeful living (Pioneer Network, 2018). "Culture change" is the common name given to this American movement for the transformation of older adult services, based on values and practices where the voices of elders and people working with them are considered and respected. Culture change does not have a set definition in the literature, nor is it a prescriptive set of regulations, but rather the adoption of general principles that focus on the person. The adoption of these principles varies from organization to organization. Principles include practices such as a focus on resident preferences, a home-like atmosphere, close relationships, staff empowerment, collaborative decision-making, a relaxed hierarchical structure and systematic quality improvement processes (Cassie & Cassie, 2012; Koren, 2010; Shield et al., 2014).

Several organizations have implemented projects that piloted various aspects of culture change. Examples of culture change movements include the Green House Model, small self-contained homes with 6-10 residents (Kane, Lum, Cutler, Degenholtz, & Yu, 2007), the introduction of “neighbourhoods”—areas to increase social interactions (Boyd, 2003), on-site intergenerational centers as well as projects that involved structural changes to provide more home-like surroundings (Shura et al., 2010). Organizations such as the Wellspring Alliance advocated general approaches to improve clinical care and create better working environments (Stone et al., 2002). Evaluations of these culture change pilots show positive outcomes. One evaluation that focused on the Green House model reported improved quality of life, quality of care and staff and family satisfaction (Kane et al., 2007), and the evaluation of the Wellspring model reported lower rates of staff turnover, improved performance on the federal survey and improved staff performance (Stone et al., 2002).

1.3.1. Challenges in Implementing Culture Change

Multiple efforts of culture change within residential care have occurred over the past two decades, but organizational change is complex. According to Shield et al. (2014), successful residential care culture change requires continuous improvement on many levels, such as building revisions to create a more home-like environment, relaxed hierarchical staffing structures, a focus on resident preferences and the inclusion of staff in decision-making. Research indicates that despite the challenges, even small changes that are not expensive such as respecting choice and dignity, can improve life for residents and for staff (Koren, 2010). Shura (2011) argues, however, that culture change efforts typically overlook the residents’ experiences and changes

made come from the outside-in and the top-down. Thus, changes made often fail to address the rights of residents (Popham & Orrell, 2012).

The culture of residential care homes is influenced by a focus on medical diagnoses and treatments, often referred to as the medical or institutional model (Henderson, 1995; Power, 2010). According to Power (2010), this medical model revolves around illness and limitations and emphasizes treatment and tasks, over care of the human spirit (Power, 2010). The medical model along with discriminating ageist practices have been identified as a problem at micro-, meso- and macro-levels (Iversen et al., 2009). A focus on medical care and assessment is necessary but not sufficient to physiological well-being, as there are multiple socio-economic consequences. For example, the attention to basic physical care is driven by requirements of inspection surveys, and minimizes the evaluation of psychosocial issues (Henderson, 1995). Consequently, much time and energy are devoted to coping with illness rather than cultivating strengths (Power, 2010). This positions residents as helpless, passive recipients of care (Bartlett & O'Connor, 2010). The relative power position between staff and residents is highlighted through body work, the standardised health and social care practices that convert the bodies of residents into objects of labour (Twigg, Wolkowitz, Cohen, & Nettleton, 2011).

Long-held practices within the traditional medical model create numerous barriers for culture change. Despite wide acceptance of the need for culture change in deinstitutionalizing services, changing the organizational system and individualizing long-term care (Miller et al., 2013) only one-third of long-term care organizations in the US report adoption of some culture change practices (Koren, 2010). Prohibitive policies

and regulations are one of the most cited barriers to culture change (Pioneer Network, 2010). Examples include restrictive reimbursement policies (e.g., reimbursement for additional staff training around culture change), and lack of funds for capital improvements such as providing more socially accessible spaces for residents to meet. An excessive focus on safety is another example. The focus on safety can prevent activities that residents may find enjoyable, such as cooking in the kitchen, going for a walk outside, or woodworking. Using focus groups, Popham and Orrell (2012), examined resident experiences and found that residents were rarely allowed to take risks, even minimal ones such as cooking for one another. Indeed, one of the barriers that limits adoption is the fear by administration and staff about potential liability and regulatory exposure, e.g., if a resident suffers an injury that could be attributed to a care home condition or policy implemented (Kapp, 2012). A similar concern is incompatible state regulations, such as closed-off kitchens, that make it impossible for residents to fix a snack (Koren, 2010).

1.3.2. Culture Change and Staff Issues

Inadequate training and undervaluation of the staff at all levels, as well as the insufficient supply in types and numbers of workers, are some of the many challenges that limit implementation of new models of culture change. The World Alzheimer Report (2013), highlights the negative impact of the undervaluation of care home staff resulting in the high turnover rates and job dissatisfaction. A lack of dedicated funding, workforce shortage, low wages, workload, inadequate training, and a negative industry image are some of the challenges that affect staff (Stone & Bryant, 2012). Although the US Patient Protection and Affordable Care Act attempts to address the inadequacy of the direct

care workforce, according to Stone and Harahan (2010) overcoming the challenges requires a more focused and coordinated action. Staff report lack of time and rigid routines as ongoing problems (Knight & Mellor, 2007), as well as burnout and depression, (Post, 2011; Richardson, Lee, Berg-Weger, & Grossberg, 2013). Understaffing is a significant challenge as the quality of care depends on the ability to provide care without being rushed (Kelson, 2013). It is difficult for the direct care staff, such as the certified nursing assistants to take the time to talk with residents when they are focused on providing physical care for large numbers of residents. Given these time constraints, emotional support often happens in “stolen moments” (Baumbusch, 2008).

One of the identified barriers to culture change in practice for staff is the lack of consistent leadership and the high rates of staff turnover. In the US, the annual turnover rate in nursing homes is more than 50 percent for administrators and between 40-60 percent for nursing staff (Koren, 2010). In an evaluation of the Wellspring model of nursing home quality improvement, researchers found a successful mesh of clinical and culture change but noted the most critical finding was the need for alignment of philosophy and administrative, operational and management structures and full commitment of top administrative staff (Stone et al., 2002). In 1987, the US congress enacted the Nursing Home Quality Reform Act intended to enforce resident rights and support culture change, but according to Kapp (2012), this act only increased the focus on medical outcomes. Yet cultivating relationships and a sense of community is considered a fundamental tenet to transforming culture (Pioneer Network, 2010).

Despite the challenges, efforts to change the culture of residential are underway. In the US, for example, the basis for state nursing home regulations is the federal 1987

Omnibus Budget Reconciliation Act, and under the quality of life category, nursing homes must provide care in a way that emphasizes the residents' dignity, choice and self-determination (The National Consumer Voice for Quality Long-Term Care, 2011). In Canada, practice guidelines using a holistic approach have been established within a framework for person-centred care for people with dementia living in care homes (Alzheimer Society of Canada, 2011). Other initiatives include health promotion efforts which focus on issues such as the development of guidelines for depression, and the promotion of research through the 44 gerontology research and education centers, and three national associations for gerontology researchers (Sheets & Gallagher, 2012).

1.4. Person-Centred Care and Social Citizenship

Person-Centred Care is a philosophy of care that is linked to the rights of people living in residential care homes. In the 1960s, Carl Rogers, an influential humanistic psychologist, developed an approach to care based on acceptance, caring and empathy that paved the way for the notion of person-centred care. In his book, *A Way of Being*, Rogers (1980), writes: "As persons are accepted and prized, they tend to develop a more caring attitude towards themselves" (p. 166). He argued that capacity and the need for growth do not diminish with age. Building on Carl Rogers' work, Kitwood (1997) championed a philosophy based on a concept called "Personhood" in his seminal text *Dementia Reconsidered*. He defined personhood as ". . . a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect, and trust." (Kitwood 1997, p. 8). His work gave shape to a more holistic view that supported the idea of seeing individuals living with an

illness as whole persons rather than victims of a disease (Bartlett & O'Connor, 2010). This view brought attention to the value and the ethical obligation to treat residents with respect. The goal of person-centred care is to respect the residents' identity and autonomy in the day-to-day care practices and address their rights, preferences and goals. According to Bartlett and O'Connor (2010), although the concept of personhood has raised consciousness about the importance of the individual, it also identifies three issues: (a) The person with dementia is not necessarily positioned as a person with agency; (b) personhood is a status dependent on others for recognition; and (c) personhood focuses on the maintenance of status, allowing little room for change or growth.

Person-centred care speaks to the importance of respecting residents' autonomy as well as their rights and preferences. Yet the literature indicates that due to apprehension about potential liability, administrators tend to focus on safety (Kapp, 2012), and residents continue to struggle with frustration around their lack of influence and independence (O'Dwyer, 2013; Timonen & O'Dwyer, 2009), erosion of their identity (Baumbusch, 2008), and paternalistic communication styles (Baur & Abma, 2011). Ironically, change designed to improve the quality of life for residents is often conducted "on their behalf", which contributes to the positioning of residents in a passive role (Shura et al., 2010). An ethnographic study of person-centred care in a large care home in Canada found, for example, that the resident care conferences focused primarily on clinical issues and did not include resident input, even though the purpose of the conference was to plan their care (Kelson, 2013).

The concept of social citizenship in relation to persons living with dementia is an emerging and important idea to address the aforementioned issues. Citizenship is traditionally situated as a status that is either granted by the state or claimed by individuals, yet this definition carries with it an exclusionary drawback for persons living with later stages of dementia, unable to claim their rights or act on their responsibilities (Lister, 2007). However, social citizenship can be fostered as a practice (Brannelly, 2011). Examples of this in residential care settings might include education for staff to understand the competencies and needs of residents, individual and group coping strategies explored by residents relating to personal care decisions, or administration supporting individual coping strategies through organisational policies and procedures (Baldwin & Greason, 2016). Thus, the practice of social citizenship is a process through which individuals with dementia can gain a sense of belonging and purpose through their actions, rather than waiting for a status to be granted (Bartlett & O'Connor, 2007). This is a key distinction as it indicates a sense of agency and power, serving as an antidote to the sense of powerlessness described by residents (Thomas, 2006).

1.5. Mental Health and Social Productivity

The lack of agency and power can lead to a lack of social engagement among people in residential care settings, as is noted in the literature (Adams, Sanders, & Auth, 2004; Brownie & Horstmanshof, 2011; Canadian Institute for Health Information, 2013; Klinedinst & Resnick, 2014). Although some residents become involved in the activities provided, social isolation and loneliness are common (Drageset, Kirkevold, & Espehaug, 2011), due in part to displacement and the loss of formal social networks

(Winstead, Yost, Cotten, Berkowsky, & Anderson, 2014). The move into residential care is often a result of a decrease in health or the death of a family member, and is accompanied by several significant losses (Brownie, Horstmanshof, & Garbutt, 2014), often related to previous social engagement habits (Adams & Sanders, 2004). Previous research has associated loneliness with mental health concerns among older adults (Wilson et al., 2007), such as depression (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Heikkinen & Kauppinen, 2004).

This lack of social connection in residential care is further compounded by the issues with cognition. In the United States, close to two-thirds of nursing homes residents (Gaugler, Yu, Davila, & Shippee, 2014), and 7 out of 10 assisted living residents (Zimmerman, Sloane, & Reed, 2014) have some level of cognitive impairment. Although residents with dementia may have difficulty making social connections due to increased problems with verbal expression and memory (de Medeiros, Saunders, Doyle, Mosby, & Haitsma, 2011), similar challenges may be experienced by residents without dementia (Cipriani, Faig, Ayres, Brown, & Johnson, 2006). While persons with dementia may provide other non-verbal preference indications (Power, 2010), these cues are easily overlooked (Sherwin & Winsby, 2011). For example, the natural expressions of the body disclose social and cultural ways of being that are distinctive, yet the rigid routines and practices mean these expressions are often unrecognized (Kontos & Martin, 2013).

People living in residential care settings are not typically viewed as active contributing citizens in their communities, and this sets them apart and may have an impact on their sense of belonging and connection. The resulting sense of loneliness

can have a substantial effect on their mental well-being. It is associated with impaired mental health in this population (Wilson et al., 2007). Loneliness is a distressing feeling and a chronic subjective experience (Coyle & Dugan, 2012) but is not the same as being alone. One can be alone and not feel lonely and conversely be with people (as residents typically are) and yet experience loneliness.

Loneliness is also linked with depression (Cacioppo, 2008; Coyle & Dugan, 2012; Lynch, 2000a), and depression is a mental health concern in many parts of the world (Koopmans, Zuidema, Leontjevas, & Gerritsen, 2010; Snowden, 2010b; Yeung, Kwok, & Chung, 2012). Depression presents atypically in older adults due to comorbidity and multiple conditions that mimic depression symptoms such as fatigue and weight loss, making it difficult to diagnose (Neufeld et al., 2014). Depression and loneliness are prevalent among people with and without cognitive impairment, but it is possible that depressive symptoms increase with self-awareness of cognitive deterioration (Drageset, Espehaug, & Kirkevold, 2012; Neufeld et al., 2014). Populations with depression and people with cognitive decline both cope with major losses, disability and powerlessness, but in the later stages of dementia, depression becomes more difficult to assess (Snowden, 2010a). Longitudinal studies of depression and loneliness suggest a reciprocal relationship (Cacioppo, Hughes, et al., 2006). Individuals with dementia have trouble making connections due to increased challenges with expression and memory (Sabat & Lee, 2011), however people without cognitive impairment can also have difficulties connecting socially without adequate support (Cipriani et al., 2006). It is apparent that both loneliness and depression are important topics to address to improve mental health among older adults. In residential care settings depression is under-

recognized, and treatment is often ineffective (Snowden, 2010b). According to Snowden (2010a), many residents with depression have difficulty sharing their feelings and staff may not notice the changes as they often have little training in the recognition of depression. The Canadian Institute for Health Information (2010) found only a small proportion of residents diagnosed with depression received an evaluation for treatment. In addition, there are rising concerns regarding the availability of mental health specialists (Cruwys, Haslam, Dingle, Jetten, et al., 2014), as well as the efficacy and safety of current pharmacological treatments in residential care (Kirshner, 2011; Power, 2010).

Being socially productive offers an opportunity for social citizenship. Heavy staff workloads (Knight & Mellor, 2007) and pervasive stereotyping (Sherwin & Winsby, 2011), combined with residents' cognitive impairment and complex health conditions (Alzheimer Disease International, 2013), can interfere with the provision of good quality psychosocial programs. Residents describe feelings of uselessness and a desire for purposeful activity (Roach & Drummond, 2014). However, recreational programming provided in residential care overall tends towards entertainment and distraction, rather than opportunities for meaningful resident engagement or contribution (Theurer et al., 2015). Being socially productive can be perceived as an active form of social citizenship. Social productivity means engaging in activities that are meaningful and benefit others socially (Baker et al., 2005), and this is done in anticipation of an equivalent reciprocal recognition (Zaninotto, Breeze, McMunn, & Nazroo, 2013). This view of productivity as a model is influencing policy development on aging (Mental Health Commission of Canada, 2012). Being productive has a positive impact on overall

well-being (Jetten, Haslam, & Haslam, 2012; Jung, Gruenewald, Seeman, & Sarkisian, 2010; Kim & Ferraro, 2014; Schwartz, 2007), and loneliness and depression among individuals (Cruwys, Haslam, Dingle, Jetten, et al., 2014). The following provides a context to the above concerns relevant to this dissertation, bringing together three themes: (a) social productivity and well-being, (b) social productivity and purpose in life, and (c) social productivity and peer mentoring.

Being productive has been associated with psychological health. Older adults who volunteer have been found to report higher levels self-rated health and less depression (Morrow-Howell, Hinterlong, Rozario, & Tang, 2003). This study suggests that volunteering has an effect beyond increasing the number of friendships. With respect to the impact of volunteering on depression, one study reported that reduced levels of depression occurred only when these productive activities were perceived to be appreciated (Siegrist & Wahrendorf, 2009). Furthermore, the importance of the value of the perceived role has potential to influence the association between the volunteer work undertaken and well-being (Thoits, 2012). For residents living with dementia, being productive is possible and can affect their quality of life. A recent study examined the ability of residents living with dementia to perform productive tasks and found that not only were the residents able to perform tasks that were familiar to them (making rice balls and cakes), but that improved performance was associated with positive emotional change (Nakamae, Yotsumoto, Tatsumi, & Hashimoto, 2014).

Finding meaning and purpose in life for older adults is linked with productivity and better health. Pinquart (2002) proposed that performing meaningful activities and feeling useful produces satisfaction in later years. Conversely, purposelessness is a

characteristic of clinical depression (Cruwys, Haslam, Dingle, Jetten, et al., 2014).

Finding purpose through personally chosen activities may also be an important resource in fostering quality of life for people in residential care. Facilitating meaning-in-life, for example, may be useful in reducing associated emotional and physical symptoms (Haugan, 2014). Being a member of a volunteer group could also provide a sense of purpose in life, which, in turn, enhances well-being (Thoits, 2012). According to Cruwys et al. (2014), loneliness and depression can result from the lack of purpose in life. So being socially productive may have value for individuals in residential care, providing both a purpose in life, social connections and better health. From a larger perspective, being purposefully engaged is a means by which residents can realize their citizenship and change the discourses built around their role in these communities. Recreation therapy is a specialized form of treatment provided in most homes designed to ensure that activities meet the social interests of all residents. However it typically fails to include the perspective of people being treated and problematizes everyday life and activities (Dupuis, Whyte, et al., 2012).

1.6. Leisure as Therapy in Residential Care

Recreation therapy or activity programs provided within the medical model in the Canadian residential care home sector are problematic. This is due in part to the focus on leisure as provided by “experts” in the field, that is, the recreation staff (Dupuis, Whyte, et al., 2012). Historically, the assumption of recreation therapy is that people being helped have a deficit, problem or diagnosis that needs to be corrected or fixed by a professional (Anderson & Heyne, 2013). According to Dupuis et al. (2012), leisure

among persons with dementia within this perspective is turned into therapy that is prescribed, monitored and documented by professionals. In Canada, many provinces are moving towards regulation or licensure in recreation services (Bowtell, 2015). According to the licencing requirements, recreation staff focus on specific domains (such as physical, mental or emotional domains) to improve well-being, but not wellness as such (Lopez & Dupuis, 2014). As the assessment process for the treatment of identified problems in these domains is analytical and controlled by the recreation therapist, participants are viewed as passive and lacking in insight (Anderson & Heyne, 2013). The residents' experience of meaning is often excluded, and there is a tendency to use a combination of tradition and consensus in choosing programs rather than basing them on resident input (Kellen, 2003).

This paternalistic approach positions recreation staff as experts and denies opportunities for agency, dignity and citizenship among populations with whom they work. The activities offered tend to have a lack of mental stimulation, choice, and engagement by participants (Port, Barett, Gurland, Prerez, & Riti, 2011). Similar problems exist in other countries as well. In an evaluation done by a resident council in Ireland, residents expressed concerns about lack of mental stimulation and respect (Timonen & O'Dwyer, 2009), and in Australia, clients in an adult day group objected to the childlike activities offered (Tse & Howie, 2005). Participants in a qualitative study in Denmark, Norway and Sweden identified the importance of programs that foster meaningful participation and dignity (Slettebø et al., 2016), yet these programs are not often offered and opportunities to build close relationships or contribute are rare.

1.7. Parasocial Programming

As a result of the emphasis on treatment and light social events as therapy, residents become accustomed and sometimes resigned to keeping their connections with others superficial (Knight & Mellor, 2007). I introduce a concept called *Parasocial Programming*, which I define as a form of social programming that appears lively and engaging but creates psychological and socio-cultural barriers to the development of close relationships. An effort to keep the greatest number of residents busy (Katz, 2000) means that most programs tend to be larger gatherings. In an ethnographic study of the subtle aspects of medicalized aging, Henderson (1995) used the term *counterfeit* to depict the social activities observed. These large gatherings involved little emotional input from either the staff or the residents. While there is a place for programming such as entertainment, it is just that—not intended for any deep emotional connections. In this environment, it is rare that contribution or sharing on a deeper level is acceptable or encouraged. Effective psychosocial programming needs to balance elements of socially enjoyable events and provide opportunities for meaningful connection. As psychological barriers have a strong influence on loneliness (Cohen-Mansfield & Parpura-Gill, 2007), it is possible that parasocial programming reinforces loneliness. Broader socio-cultural factors are reflected in practices such as the stigma of residents as recipients, not givers, of care. The barriers to connecting to others and contributing in a meaningful way leads an acceptance of the status quo over time. This has the potential to produce an increase in poor health outcomes in residents (e.g., depression) which in turn fosters more loneliness. While residents resist the institutional culture and identities that are imposed by the routines (e.g., practices such as being managed by others), over time

these routines lead to a form of institutionalization and resignation (Wiersma & Dupuis, 2010).

1.8. Peer Mentoring

In reviewing the literature, peer mentoring as a form of peer support has potential to provide a vehicle through which residents can shape their social worlds in a way that reflects their agency. Peer mentoring has been used in a variety of disciplines, such as business and education (Raymond & Sheppard, 2017), as well as with older adults who have chronic health conditions (Cooper, Schofield, Klein, Smith, & Jehu, 2017). Peer mentoring is about a relationship between two individuals who share a common experience and/or characteristic to provide support (Joo, Hwang, Abu, & Gallo, 2016). While peer mentoring is not consistently defined in the literature, as indicated by the second part of the term (i.e., mentoring), it is usually thought of as a relationship in which a more experienced individual provides support to one with less experience. Importantly for residential care, a systematic literature review identified resident helping other residents as having a positive role in residents' adjustment (Brownie et al., 2014). Engaging in personally meaningful activity (e.g., volunteering through peer mentoring) further supports a sense of self and role fulfilment (Roach & Drummond, 2014).

The terms peer mentoring and peer support are often used interchangeably and while they do have similar characteristics, I have identified several features that differentiate them. Keyes et. al. (2016) identified five aspects of peer support and I focus on three of these aspects here: (a) interpersonal interaction and commonality of

experience, (b) reciprocity of support, and (c) shared learning . In Table 1.1, I compared peer support and peer mentoring and note that while all three aspects are shared, there are distinguishing characteristics.

Table 1.1. *Aspects of Peer Support Versus Peer Mentoring*

Peer Support	Peer Mentoring
“Interpersonal interaction” and “commonality of experience” (Keyes et al., 2014, p. 562).	Although resident mentors and people they visit would share some commonality of experience (e.g., both live in residential care), in the program I have implemented resident mentors would typically be more engaged in their communities and be less likely to be lonely or depressed than people they visit. This relationship is usually initiated by the mentor.
“Reciprocity of support” (p. 562).	Initially there would be limited reciprocity between a mentor and people they are supporting, but over time this may become more reciprocal as the relationship develops.
“Shared learning” (p. 562).	In the initial stages of the relationship, the learning may consist mostly of knowledge transferred from the mentor to people they are supporting (an unequal relationship). Over time this may change. As trust builds and people being supported become more engaged and connected the learning may become more of a shared experience, creating an increasingly equal relationship.

Firstly, while both peer support and peer mentoring are grounded in commonality of experience, mentors would typically be more engaged in their communities than people they mentor and would likely be the one initiating the peer relationship. Secondly, while both approaches ultimately involve reciprocity of support, in the case of mentoring, this may not be the case in the beginning. However, over time as the relationship develops, this reciprocity may increase. Thirdly, the shared learning based on direct experience may begin as knowledge transferred only from the mentor to the individual being supported, but again as the relationship grows this may become increasingly shared. Peer mentoring can be conceived of as a socially productive activity, and social productivity is a concept that has relevance in these settings. Psychosocial health centers on the optimal functioning of individuals and includes

cognitive evaluations of life purpose and meaning (Salsman et al., 2013). Peer mentoring is a potential mechanism by which these evaluations could become a learning experience shared between a mentor and a mentee.

Over the past 20 years, the meaning and conditions of mentoring have been explored by scholars across disciplines. In examining these studies, it is noteworthy that most report similar characteristics in peer mentoring. For example, in a study conducted in the UK criminal justice system, three core conditions of peer mentoring were identified: caring, listening and encouraging small steps (Buck, 2018). Buck (2018) emphasized the importance of these conditions, as they allow vulnerable people to safely share their troubles and explore new directions with their mentors. Study participants reported that the mentors were generally tolerant of slow progress, having been in similar situations themselves. Similarly, another qualitative peer mentoring study conducted within a high school in the US found that forming a caring relationship and being sincerely concerned were common themes reported among the participants (Rabe, 2018). The student mentors and those being mentored used words like open, supportive, safe and comfortable to describe their relationships.

While peer mentoring appears to be beneficial, mentoring relationships are neither static nor is the mentoring process barrier free. An autoethnographically-based approach among early career women faculty found that supporting mutual mentoring resulted in a decrease of social isolation and an increase in confidence and sense of self (Driscoll, Parkes, Tilley-Lubbs, Brill & Bannister, 2009, p. 5). This study also revealed how the traditional hierarchical approach to mentoring in universities resulted in isolation and self-doubt. Although this was a small study involving five faculty, the

relationships between the mentors were explored in depth, moving from mentoring to collaboration and offering a useful perspective on the transitions that can occur in these relationships.

Other studies on peer mentoring in academia found similar benefits and challenges. A study on training students as mentors within a large public US university explored the role of students mentoring other students within a same class (Colvin & Ashman, 2010). The students interested in mentoring took training courses on developing communication skills, using cultural sensitivity, managing time, building relationships and facilitating learning. These mentors reported positive benefits including developing connections with their peers, applying concepts learned for their own lives and being able to support others. However, they also reported a number of challenges including feelings of vulnerability and potential rejection by those being mentored, becoming overly emotionally attached, too much dependency among some students, the students not showing up or doing assignments, power struggles (students not accepting help), and anxiety around conflicting time commitments. Another study examining peer mentoring in academia suggested that mentoring was effective at reducing perceived stress and loneliness among first year university nursing students, as well as increasing their self-efficacy and sense of belonging (Raymond & Sheppard, 2017).

Researchers have also examined peer mentoring as an approach addressing wellness among older adults, such as back pain and diabetes. An exploratory qualitative study in Scotland exploring peer mentoring for management of back pain among older community-living adults, for example, also found both positive and negative experiences

(Cooper et al., 2017). Most of the mentors described a good experience related to mentoring and felt that having empathy and helping others put their back pain in perspective, which was more important than knowledge or practical advice. They also expressed that matching common interests was vital to the relationships formed, more so than age or gender. Challenges included travel barriers during winter, time barriers, and low patient expectations. Here too, there were some concerns regarding equal power relationships between mentors and those visited. A qualitative synthesis of literature examining the experience of peer support programs for people with chronic diseases, however, suggested that with careful attention and education, these relationships may become balanced over time (Embuldeniya et al., 2013). There was general agreement among the mentors in this study that the mentoring program needed to be individualized, and that recruitment, training and monitoring of the relationships was needed (Embuldeniya et al., 2013). A randomized controlled trial of African American veterans with poor diabetes control examined whether a peer mentorship model would have more of an impact than a financial incentives control group to improve control (Long, Jahnle, Richardson, Loewenstein, & Volpp, 2012). The peer mentoring group had a statistically significant effect on improvement of glucose control whereas the financial incentive group did not. The main barriers raised included difficulties getting in touch with mentors and, for some, the lack of compatibility.

Peer mentoring has also been used to improve mental well-being among older adults living in the community. A quantitative pre- and post-intervention pilot study examined the impact of peer mentorship on patient experiences (Joo et al., 2016). This study involved peer mentors supported by a mental health professional who then

delivered support to homeless older adults with depression (Joo et al., 2016). The depression scores decreased among 85% of people receiving the support. The experience of support among peers participating in depression support groups has been examined among adults living with dementia. For example, a study encompassing in-depth qualitative interviews with individuals with dementia indicated that peer support had a positive impact that was based on a commonality of experience (Keyes et al., 2014). In summary, this literature suggests that peer mentoring in the community, while not without barriers, has a positive impact on health behaviors and mental health among the participants.

Providing a program in the form of structured ongoing mentorship offers potential opportunities for individuals in residential care to build new relationships with their peers and reduce parasocial programming. Research indicates that relationships residents form with one another are a stronger predictor of loneliness and depression than already existing relationships with family and friends (Drageset, Eide, Kirkevold, & Ranhoff, 2012; Fessman & Lester, 2000). Furthermore, Cacioppo (2008) contends that loneliness is not a mental disorder even though it puts people at risk for depression, and that people who are lonely benefit from helping others. This may have particular significance for persons living with dementia. For example, a previous study examining peer support in the context of loneliness and dementia reported that finding a new valued role through supporting one's peers had an impact on the rejection of a "passive patient" role (Clare, Rowlands, & Quin, 2008, p. 27). It is not that entertainment and large social events should be removed—just that there is a need for programming that

also facilitates real connections. Thus, peer mentoring has potential as an antidote to parasocial programming and help address these concerns within residential care.

1.9. Reducing the Parasocial Programming Cycle

While parasocial programming—a form of programming that primarily focuses on light social events—offers some structure for residents to connect, these interactions provide few opportunities for meaningful relationships or contribution. Negative and limiting assumptions about residents and their potential creates a tension between the organization and institutional influences of the homes, and the people that live there (Dupuis, Gillies, et al., 2012). The expectation that residents cannot contribute and need constant entertainment stifles growth and increases the likelihood of negative psychosocial effects such as feelings of helplessness due to lack of control (Thomas et al., 2012). Feelings of helplessness and lack of perceived control have been correlated with depression (Susic, 2015). This can in turn lead to increased psychological, health and social barriers, thus creating a self-perpetuating cycle. The experience of activities depends on the meanings attached to them. For example, in a study exploring experiences of meaning and purpose in everyday life, residents reported personally treasured activities (e.g., spending time alone) as a meaning-making dimension (Drageset, Haugan, & Tranvåg, 2017). However, they also reported belonging and recognition (having someone to love and care about) as important, and opportunities for this are rare.

I propose a model based on mentoring as a program to reduce parasocial programming (Figure 1.1). In an examination of the predictors of loneliness among people living in low-income independent living sites, Cohen-Mansfield and Parpura-Gill (2007) proposed a framework that explained changes associated with loneliness and depression. This framework was adapted to build my model, as it suggests that there are multiple barriers that impact the quality of loneliness. As seen in Figure 1.1, relevant antecedents to loneliness and admission to a care home are identified at the bottom of the figure. They include predictors of admission, including health issues and cognitive impairment (Gaugler, Duval, Anderson, & Kane, 2007), as well as early life experiences (Kamiya, Doyle, Henretta, & Timonen, 2013) and personality, life-long patterns of behavior and quality of relationships (Victor, 2012).

Next in the figure, psychological, health and socio-cultural barriers (Birt et al., 2017) are identified. Psychological and health barriers contribute to the difficulties experienced by many residents resulting in a worsening of perceived quality of life, feelings of loneliness and marginalization (Scocco, Rapattoni, & Fantoni, 2006). Socio-cultural aspects such as being stigmatised and assumed to lack capacity to participate (Dupuis, Gillies, et al., 2012) are also a barrier. Then, the provision of ongoing bus trips, socials and games that are often found in social calendars in these settings, leads to loneliness and depression, which in turn lead to an increase in poor health outcomes.

development of close relationships. This new status and the opportunity to contribute could, in turn, result in better health outcomes.

In the wake of the culture change movement over the past years, there is an increasing awareness of the role social citizenship can have in shaping the experience of persons living within residential care. Peer mentoring as a practice of social citizenship has not, to my knowledge, been explored within these settings. Most care homes are structured around practices and routines set by staff that are focused on instrumental goals (Wiersma & Dupuis, 2010), impacting both people who work and live there. Thus, these concepts of active social citizenship and mentoring of residents, fly in the face of long-standing traditions of care. While many studies on social citizenship have focused on individuals living with dementia, people living in residential care have numerous health challenges, not all being related to dementia. As mentoring is a socially productive activity with potential to transform the role of individuals with and without dementia, the influence may be significant for this population. As a way of destabilizing some of the practices that rob residents of their human rights, I wanted to explore peer mentorship as an approach to improve the quality of life for people that live in residential care. To this end, I investigated peer mentoring as an approach to enhance social citizenship among residents. Peer mentoring offers opportunities for residents to become purposefully engaged as active social agents in reaching out to their peers that are socially isolated or lonely. I wanted to learn if residents would be interested in being trained as mentors. I had previously developed a peer support group for residential care (Theurer, Wister, Sixsmith, Chaudhury, & Lovegreen, 2012), and in my work noticed a significant number of residents who did not participate in their

communities—who refused invitations to attend peer support groups yet appeared to enjoy visits from their peers.

Drawing on concepts of social citizenship as a practice (Bartlett & O'Connor, 2010), I developed a peer mentoring program for residential care called the Java Mentorship Program. In the program, community volunteers and family members from outside the residential home (i.e., community mentors) and resident volunteers (i.e., resident mentors) form a supportive mentorship team within the residential community. The team meets weekly for support and education sessions. After the team meetings, pairs of team members (one community mentor and one resident mentor) visit lonely or socially isolated residents, engage in collaborative learning with them, and encourage their participation in available group programs. I pilot-tested this program in a continuing care community (with assisted living, day program, and long-term care) and two long-term care homes prior to the start of my doctoral studies.

As I developed the peer mentoring program prior to my studies and have a company that distributes peer support programs, there is a conflict of interest. This conflict of interest was declared with behavioral research ethics board at the University of British Columbia. A conflict of interest management plan was set up and carried out that included my supervisor vetting all quantitative analyses, and the committee being intimately involved in the qualitative analysis as a form of peer review.

1.10. Statement of the Problem

To evaluate the efficacy of the new mentoring program I recognized the importance of conducting a feasibility study prior to setting up an experimental study. A feasibility study has been identified as a way of providing preliminary evidence to inform a larger study and typically examines acceptability, compliance and delivery of staff conducting programs (Thabane et al., 2010). In addition, this type of a study increases the understanding of the context and methodological issues (Orsmond & Cohn, 2015). Oakley et al. (2006) also identified the importance of clearly identifying the different processes and outcomes when examining programs that consist of multiple components (such as this mentorship program), to evaluate and refine the program.

Although residential care homes ostensibly provide safe and nurturing living conditions, the way they are structured frequently infringes the rights of residents in a way that compromises their citizenship. This structure may contribute to a decline in health, quality of life and meaning in life. Persons living in residential care are entitled to experience freedom from discrimination and, as desired, to take responsibility and actively participate in caring for others (Alzheimer Society of Canada, 2018). However, residents are rarely offered this opportunity. To address these issues, my study investigated the feasibility of introducing peer mentorship into residential care as a social citizenship practice that recognizes peoples' diverse abilities and helps reframe their role in the communities in which they live. I include a list of assumptions that this work is based on:

- *The Context Matters.* Experiences of people living in residential care settings must be contextualized within a broader sociopolitical context to be fully understood and changed.
- *Including the Collective Experience.* People living in residential care settings have a collective experience as a group who have been marginalized and stigmatized. Each person, however, also has past and present experiences that influence their way of being in their communities.
- *People are Active Agents.* Although individuals are influenced by the culture around them, they are active agents in their own lives and are capable of growth.
- *There are Individual and Shared Constructed Realities.* There is a reality that many residents report chronic loneliness and depression. However as there are individual and shared constructed realities, the shared realities can only be understood in a naturalistic setting. These realities can evolve through helping others, which in turn can allow a new and important role to arise.

1.11. Objectives

The objectives of this study were: (a) to explore social citizenship as a practice and examine a new psychosocial model based on peer mentoring, (b) to collect feasibility data to inform a future experimental study, and (c) examine the resident mentors' experiences with peer mentoring and evaluate the outcomes among resident mentors and mentees produced by the program. Thus, I explored the feasibility of conducting an experimental study to: assess recruitment and the final study sample; assess the outcome measures and data collection; assess retention, program adherence and acceptability; and to assess the residents' responses. For the purposes of publication, I have divided the results into four chapters: (a) the theoretical foundation of social citizenship and development of the mentoring program, (b) the feasibility study, (c) peer mentoring from the resident mentors' perspectives, and (d) the experience of peer mentoring from the mentee's perspectives.

1.12. Mixed-Methods Design and Stance

A mixed-methods design was chosen to provide complementary and corroborative perspectives about the effects of the program. This design allowed a deeper understanding of the complex social world from multiple perspectives (Tashakkori & Teddlie, 2010). Given the exploratory nature of the study, the use of mixed-methods has the potential to provide important quantitative and qualitative data from both qualitative and quantitative perspectives, using the qualitative to contextualize and explain the findings (Creswell & Plano Clark, 2011).

I have framed this mixed-methods dissertation using a post-positivist perspective (Krauss, 2005) for several reasons. The bulk of the dissertation is quantitative, which is in keeping with that perspective. Furthermore, this stance provided a way for me to address potential concerns about bias as the developer of the peer mentoring program. A critical stance is often adopted when using critical theory, however, I thought that a post-positivist stance would resonate better with decision makers and improve the likelihood that the program would be adopted moving forward. Based on this, I thought the design was best suited in the effort to influence actions, policy and legislation improve quality of life and the culture within these settings.

This study uses a convergent mixed-methods approach. Creswell and Plano Clark (2018) describe a convergent design procedure, which includes four major steps: collecting data that is both qualitative and quantitative concurrently, analyzing the two sets of data independently, merging the results of the two sets of data and interpreting how the data results are similar or separate from one another to understand the results

as related to the purpose of the study. One of the compelling reasons this design was important was the limited time and resources available for data collection. As the study sites were geographically scattered, research assistants often collected both types of data on the same visit. Figure 1.2 outlines the basic procedures followed.

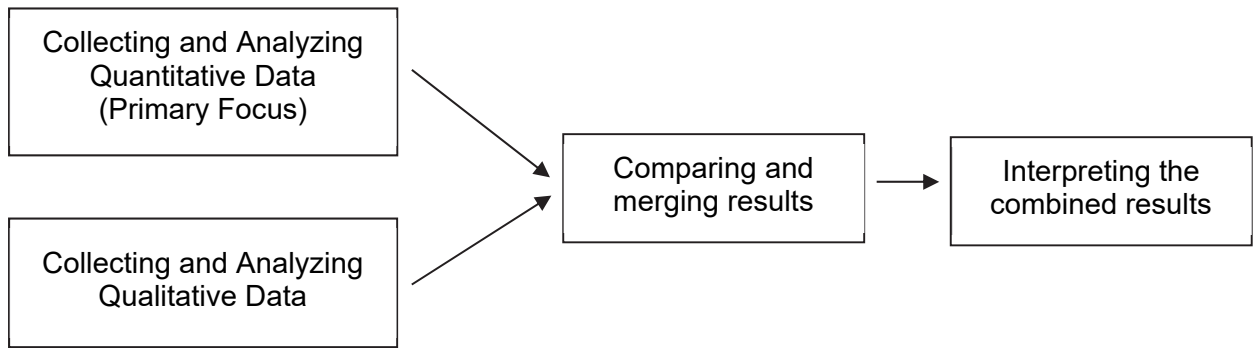


Figure 1.2. Convergent design procedure. Based on *Designing and Conducting Mixed Methods Research* (2nd ed.), by J.W. Creswell and V. L. Plano Clark, 2011.

1.13. Overview of Dissertation

The results of this research are presented in the following four chapters. A brief summary of the rationale, purpose, research questions and contribution of each of these chapters is offered below. These four chapters are followed by a concluding chapter which includes personal reflections and a synthesis of this research. As this is a manuscript-based thesis there is some intentional repetition throughout the following chapters as they are meant for publication.

1.13.1. Social Citizenship in Residential Care and the Development of a Peer Mentoring Program (Chapter 2)

Rationale. The fair and equitable treatment of persons living in residential care has considerable consequences for their well-being. In this chapter, I examined social citizenship through a relational lens and explore how these concepts can unfold in the current culture in these settings. Given that psychosocial programs in these homes are typically based on passive forms of activities, I developed a new model to increase engagement that is based on active social citizenship. I explored peer mentoring—empathetic guidance, social or emotional support to someone sharing a common experience (Dennis, 2003)—to engage residents as active social citizens within their communities.

Purpose. The purpose of this chapter is 2-fold:

1. To explore the conceptual and theoretical foundations of social citizenship and a new model called Peers Engaging and Empowering their Peers (PEEPS).
2. To report the detailed development of a new mentoring program based on this model and describe its structure and potential to transform the role of residents in these settings.

1.13.2. Peer Mentoring in Residential Care: A Feasibility Study (Chapter 3)

Rationale. To understand the peer mentoring program and to investigate whether it can be implemented as laid out is important in determining the feasibility of conducting a larger study to examine the impact of peer mentoring. Based on Orsmond and Cohn's (2015) framework, I examined four feasibility objectives among all mentors and facilitators (Thabane et al., 2010) using a post-study survey and outcomes among resident mentors (Orsmond & Cohn, 2015).

Purpose. The purpose of this chapter is to address the following four feasibility objectives: (a) assessment of ability to recruit and characteristics of the sample, (b) assessment of procedures for collection of data, (c) assessment of retention, program adherence and acceptability, and (d) assessment of resident responses to the program.

1.13.3. “It Makes You Feel Good to Help!”: The Experience of Peer Mentoring in Residential Care (Chapter 4)

Rationale. Peer mentoring provides an opportunity for people living in residential care settings to contribute in a purposeful way. Yet social support in these settings is typically planned and implemented by staff, perpetuating the role of residents as passive recipients of care (Bartlett & O'Connor, 2010). Drawing on social citizenship concepts (Haslam, 2014), I examined-peer mentoring as relational approach to addressing loneliness through residents reaching out and supporting their socially isolated peers.

Purpose. The purpose of this chapter is to explore the experience of peer mentoring among individuals living within residential care and to describe the impact of this approach from the resident mentors' perspectives.

1.13.4. The Impact of Peer Mentoring in Residential Care on People Visited: A Mixed-Methods Exploratory Study (Chapter 5)

Rationale. In considering the chronic loneliness (Victor, 2012) and depression (Snowden, 2010a) among people living in long-term care homes, I conducted an

exploratory study of the impact of peer mentoring among those being visited in these settings.

Purpose. The purpose of this chapter is to explore the impact of the peer mentoring program on mentees' loneliness, depression and social engagement and describe their perceptions of the visits.

Chapter 2.

Social Citizenship in Residential Care and the Development of a Peer Mentoring Program

2.1. Introduction

Social citizenship provides an important reformatory lens that views people living in residential care homes as equal citizens with the same rights and entitlements as everyone. Literature underscores the strategic significance of citizenship as a concept within residential care (Lister, 2003). Social citizenship is a multi-faceted concept that includes the formulation of social wellbeing, rights, growth, participation, freedom from discrimination and equality among groups of entitled citizens (Bartlett & O'Connor, 2007). Social movements such the as the one championed by people with disabilities in Canada, highlight barriers experienced by persons excluded as citizens (Government of Canada, 2017a). Bartlett and O'Connor (2010) argue that the casting of residents living in care homes as recipients of care rather than citizens compromises their rights and is exclusionary. The focus of social citizenship as a practice (Brannelly, 2011), rather than the conventional status given by the state or claimed by an individual, is significant as it has potential to be a corrective model in these settings. It shifts the discourse from individual problems experienced by residents that require therapy or treatment, to social and cultural dynamics (Bartlett & O'Connor, 2010).

Perceiving a resident in a care home as an active social citizen rather than a recipient of care challenges and undermines many assumptions about this population. Although rights for all people living in these settings need to be exercised, this can be an additional challenge for people living with dementia. The concept of citizenship has changed over time but is commonly linked to rights or equality, responsibility and the relationship that individuals have with the state (Bartlett & O'Connor, 2010). This perception excludes individuals who are unable to assume responsibility or actively claim their rights, such as persons living with dementia. From the perspective of residents within a care home, the delineation of active and passive modes of citizenship is important. As passive citizens their rights should be recognized and upheld in their day to day lives, regardless of their abilities to actively participate (Lanoix, 2007).

The citizen is located on a time continuum from birth to death; she is born a passive citizen and may become an active citizen and then again, a passive citizen or she may never be an active citizen. Nevertheless, she will always be part of a shared social space. (Lanoix, 2007, p. 126)

Thus, an active mode is played out when a resident in a care home takes on the role in making decisions not just about their own lives but also the lives of fellow residents (OARC's Mandate, 2018). This role could include participating in a resident council, lodging a complaint or offering a compliment about quality of care, or welcoming new residents. *Passive modes* of citizenship are played out with people who are no longer able to participate independently but are nevertheless entitled to and have rights of equal citizens. There is a caveat with the idea of a passive citizen, however, as it can be used as an excuse to avoid empowering people with dementia to be as active as they desire and can be.

For the purposes of this chapter, the concept of citizenship will be described using an adapted working definition proposed by Bartlett and O'Connor (2010). Their definition was focused on individuals with dementia, however, it will be used here to include all people living within a residential care setting, some of whom do not have dementia. The changes in wording are italicized: the phrase "living with dementia" is replaced with "living within a residential care setting":

Social citizenship can be defined as a relationship, practice or status, in which a person *living within a residential care setting* is entitled to experience freedom from discrimination, and to have opportunities to grow and participate in life to the fullest extent possible. It involves justice, recognition of social positions and the upholding of personhood, rights and a fluid degree of responsibility for shaping events at a personal and societal level. (Bartlett & O'Connor, 2010, p. 37)

Thus, citizenship is rights-based not participatory-based and becomes defined more as a social practice within a home rather than an active status. If a resident is denied freedom of expression because of cognitive impairment, this is an infringement of their rights as a citizen. Similarly, the administration of unnecessary psychotropic drugs to people unable to speak for themselves is an infringement of rights (Power, 2010).

Resident-to-resident peer mentoring is one of the ways that active citizenship could be expressed as a social practice. As described in the previous chapter, peer mentoring is a vehicle through which residents have opportunities to grow, nurture the emotional and social well-being of their peers and receive recognition for their social position within their communities. This chapter will address a gap in the literature concerning the concept of social citizenship from the perspective of people living in residential care and staff that care for them and the role that peer mentoring can play in

the delivery of care. To explore this, I will review the social discourses around aging and the power structures impacting the dignity and rights of residents as well as related policies in place. As proposed by Bartlett and O'Conner (2010), I draw on Michael Foucault's theory of governmentality to provide a foundation to gain insights into the social organization of power within health institutions. The objective is not only to open up and re-think the concepts and understandings we hold about social citizenship and rights within residential care, but also to examine how these concepts might be used in practice. To that end, I will conclude with an alternative approach towards a new social model of care. Ultimately, I will argue that engaging and empowering residents, staff and caregivers as a group in peer mentoring practices has potential to decrease structured dependency in long-term care, foster active citizenship and develop inclusive, thriving communities.

2.2. Mental Health in Residential Care

Mental health issues are an increasing concern in residential care. Up to 90% of people living in residential care settings have a mental health problem or illness (Public Health Agency of Canada, 2010). When staff identify more extreme situations, such as suicidal ideation, mental health professionals are contacted (Canadian Institute for Health Information, 2010). However even when an issue is identified, the focus is on the individual as the problem (Bartlett & O'Connor, 2010), and treatment does not always happen. For example, the Canadian Institute for Health Information (2010) revealed that only a small proportion of individuals identified with symptoms and a diagnosis of depression actually received an evaluation by a licensed mental health professional

(8.4%) or psychological therapy (2.6%). Loneliness too, is identified as a concern in Canada (Government of Canada, 2017b), particularly among persons living in care homes (Victor, 2015). One report has suggested that aside from care tasks, a typical resident living in a care home spent less than two minutes in conversation with staff or other residents over a six-hour period (Alzheimer Disease International, 2013).

Social quality of life is an increasing priority for the long-term sector but continues to be superseded by safety and physical health concerns (Kane, 2001). The inadequate availability of mental health services is apparent in many countries (Snowdon, 2010). For example, in the US the fragmentation of the health care system as well as multiple and competing systems of care for older adults create barriers for the provision of good mental health service delivery (Knight & Sayegh, 2011). In Canada, the Canadian Coalition for Seniors' Mental Health was established in 2002 to promote the mental health of older adults, but mental health issues such as depression continue to be a concern and are often unidentified and untreated (Canadian Institute for Health Information, 2010).

2.3. Human Rights and a Disabling Society

Human rights include an inalienable right to participate but despite advances in quality of care, people living in residential care settings are more at risk to having their rights violated. Viewing access to human rights through the social citizenship lens, disability is being created not by the individual deficits as such, but rather socially by a disabling society (Bartlett & O'Connor, 2010). Discrimination of people living with

dementia is prevalent and includes paternalism and lack of access to basic human rights such as decision making and denial of informed consent (Dupuis, Gillies, et al., 2012). Boyle (2008) examined the restricted rights afforded by the *Mental Capacity Act 2005* in the United Kingdom and applied the social model of disability in an attempt to facilitate a better understanding of citizenship for people with dementia. The author concluded that despite the Mental Capacity Act of 2005, persons with dementia face structural barriers under that act to practice citizenship. Exclusionary actions, discrimination and misguided assumptions continue to dominate care practices (Dupuis, Gillies, et al., 2012). The use of language plays a key role in keeping persons with dementia as separate in society (Bartlett & O'Connor, 2010). For example, expressions of a need from persons with dementia have been described as “behavioral excesses” and “challenging behaviors” causing problems and difficulties for the professional caregivers (Allen-Burge, Stevens, & Burgio, 1999). Exclusionary practices affect residents who do not have dementia as well. Bayne (2012), a resident without dementia living in an assisted living home, described feelings of despair experienced as a result of being excluded from decision making, a lack of true social interaction among residents and the burying of feelings and emotions. In his writings, he described frustration over being silenced by the top-down management structure and the resulting loss of autonomy—and the urgent need for reform in residential care (Bayne, 2012).

The social structures that sustain exclusion are multi-faceted and directly and indirectly affect the day-to-day lives of all older adults, especially persons in residential care. According to Spandler (2007), it is important to identify these social structures, rather than focusing on the individual. Older adults are often portrayed as lonely and

sick (Kotter-Gröhn & Hess, 2012) and the assumption is that these are a part of the ageing process which cannot be changed. According to Kelly and Innes (2012), those living with dementia are at increased risk for being discriminated against as individuals with lesser status and entitlements. Spandler (2007) argues that the rhetoric around *inclusion* can hide the social structures and practices that reproduce exclusion. Looking at these challenges from a human rights perspective is essential in examining the constraints faced by residents within the intricate social tapestry of residential care. According to Kelly and Innes (2012), the difficulties staff encounter in managing risk in addition to their lack of education and understanding of human rights, results in neglect and mistreatment of residents by staff in their social interactions. This mistreatment is often not intentional but can result in lasting psychological harm (Kelly & Innes, 2012).

People with dementia are affected not just by the disease processes but also by negative stereotyping—how they are treated by others may contribute to the erosion of self (Scholl & Sabat, 2008). In a seminal article, Sabat and Harre (1999) argued that the primary cause of the loss of self experienced by persons with Alzheimer's Disease was the way others viewed and responded to them. Individuals with dementia are vulnerable and often very aware of the negative stereotyping in their social environment, causing increased anxiety (Scholl & Sabat, 2008). The anxiety caused by this adds stress and withdrawal from social situations. Scholl and Sabat (2008) argue the importance of knowing not just that anxiety is there, but why it is there. For example, anxiety can be due to a fear or embarrassment associated with making a mistake socially.

Although anxiety around making good decisions is common, the key message is that with support, autonomy does not require physical or cognitive competence (Boyle,

2008). Assisted autonomy empowers persons with dementia and provides a practical model of citizenship. The views and wishes of residents can be and often are overridden by the decisions of others (Bayne, 2012; Kralj-Vasilj, Degmečić, Včev, & Mikšić, 2013). Assisted autonomy is referred to as the provision of material, educational and emotional resources that enable the exercise of autonomy (Boyle, 2008). In contrast, the concept of *authentic partnerships* involves and values all stakeholders in decision-making, including persons with dementia, along with formal and informal caregivers (Dupuis, Gillies, et al., 2012). This latter approach is a form of assisted autonomy but requires a safe environment, and a willingness to learn new ways of communicating with others.

2.3.1. The Complexity of Residential Care

The structure and complexity of residential care compounds issues of stereotyping and human rights. Residential care is a multifaceted structure (Baumbusch, 2008) and there are a number of barriers to translating the concept of citizenship into everyday talk and action within a care home. An example of this is the healthcare restructuring in Canada over the past decade which has resulted in facility closures and the admission of individuals with increased complex chronic health issues into long-term care (Fuller, Fuller, & Cohen, 2003). This has resulted in additional stress on the limited time available to staff. The overuse of anti-psychotics is another example. There are concerns about the use of off-label antipsychotics that is prevalent among older adults with dementia. In residential care homes these medications are used to control present and potentially future behaviors such as agitation, restlessness and even non-aggressive behaviors (Rios et al., 2017). Rios et al. (2017) argues that this

suggests a closer look at problems with provider practices and system structures, and the need for non-pharmacological interventions. That these drugs are prescribed and administered even among individuals not expressing behavioral and/or psychotic symptoms reflects a disregard for resident rights.

Criticisms of care and the overuse of antipsychotic medication led to the US Omnibus Budget Reconciliation Act, proclaimed in 1987 (Library of Congress, 1987). Pre-admission screening and annual resident reviews were mandated with the intention of restricting access of persons with mental disorders to Medicaid-funded nursing home care and ensuring they received appropriate treatment. Compliance however is generally low (Snowdon, 2010). As part of the Act, congress enacted the Nursing Home Quality Reform Act intended to enforce resident rights through development and reporting of quality indicators, which ironically increased the focus on medical outcomes rather than quality of life (White-Chu, Graves, Godfrey, Bonner, & Sloan, 2009). Supporting active citizenship in this complex culture is labour-intensive and challenging as it requires staff to have the time to establish ways of communicating with residents and supporting shared decision making.

Over the past 20 years residential care has changed, with some evidence of improvements (Wiener, Freiman, & Brown, 2007). For example, the Minimum Data Set 2.0 was implemented in 1998 in the US and in 2003-2004 in Canada and is a clinical assessment tool which provides facilities with detailed and systematic information on the status of residents to help with planning, quality improvement and accountability (Canadian Institute for Health Information, 2015). In combination of the introduction of least restraint policies that could be meaningfully tracked, trends in the right direction

are noted such as a decrease in resident restraints, an increase in nursing staff and a minimum of training requirements set for nursing aides (Simons et al., 2012). In 2010 the implementation of the new version of the MDS (3.0) in the US provided increased capacity to solicit resident feedback. It contains questions that residents are asked related to their psychosocial care. At the same time, the use of the MDS 3.0 illuminated ongoing problems. For example, even though social workers are considered the primary providers of psychosocial care, research suggests that many do not have the minimum qualifications and the caseloads far outweigh manageable levels (Simons et al., 2012). In Canada, the previous version of the MDS (2.0) is still in use. It provides little in the way of effective psychosocial assessment and treatment planning for the recreation staff.

The concept of human rights is not often applied to residents and lack of education and support for staff impacts the ability of those working closest with them to support those rights. Conventional care practices in these homes frequently violate the rights of residents, such as being denied access to a service for a family member (Kleuver, 2013). Despite the high rates of mental illness in long-term care, staff are inadequately trained and ill-prepared for working with this population. Some staff hold stigmatizing beliefs which cause them to fear or avoid these residents, thereby reducing the quality of care (Irvine et al., 2012). To help address these problems, the US Patient Protection and Affordable Care Act was implemented and was the first comprehensive federal legislation designed to change the way services and supports are paid for and delivered to the elder population (Wells & Harrington, 2013). It directly addresses the inadequacy of the direct care workforce with its attention to initiatives such as increased

education and training, payment incentives and workforce development infrastructure. In reviewing concrete actions that can be taken to improve quality of care, the World Alzheimer Report (2013) compared informal caregivers to paid staff and identifies both as undervalued and carrying out demanding roles with minimal support or training. This report identified a resistance among case managers to devoting the time, attention and interest to explore the values and preferences of the older adults in their care (Alzheimer Disease International, 2013). Their concerns centered around the practice of asking people about preferences, as this might raise unrealistic expectations that could not be met under current budgetary constraints. Other care providers (including therapists and personal care workers) cited lack of resources, time and routines as barriers to social inclusion and limited opportunities to respond to the rights of isolated residents (Knight & Mellor, 2007). Those giving care on a sustained basis (whether they are paid staff or caregivers) are also vulnerable to burnout and depression (Post, 2011; Richardson et al., 2013).

2.3.2. The Institutionalization of Leisure

Social citizenship is also constrained by the institutionalized structure of the recreation departments. Just as residential care settings are institutionalized with physical, operational and interpersonal features (Power, 2017), so are recreation departments. The institutionalization of leisure has evolved over time. It is nowhere more apparent than in the process that happens as new recreation staff and residents entering this world become acclimatized to the policies and practices around activities offered. An example of this is the way language is used, such as the use of the word “feeder” in place of a resident’s name who needs assistance with eating during a

recreation program (Rash, 2007) or references to “the smokers” when referring to a group of residents that may be harder to engage in activities. The use of these labels can lead to dehumanization, which makes it less likely that residents’ rights will be honoured. What is initially unacceptable becomes acceptable. Staff and residents allow the care home environment and the pre-existing precedent to shape the way programs are offered and accepted. In this way, institutionalization has impacted the way recreation is prepared, implemented and documented.

From my experience, leisure programming for those living in residential care is provided by mostly hardworking and well-meaning staff, however much of the programming does not honour residents as contributing social citizens. This is not to say that staff are not caring or kind. Indeed, much of the support and kindness extended to those they care for goes unnoticed (Baumbusch, 2008; Henderson, 1995). Nevertheless, according to Knight and Mellor (2007), without an informed understanding of how human rights include full participation of residents, their contribution and control over programs, most activities offered are only partially relevant. This means although the social calendars are full of activities, the planning of these programs have not included those whose rights are most impacted by the activities—the residents. A study investigating the experiences related to social activity in Australia found that although residents appreciated the care provided, they were left feeling lonely, vulnerable and not *at home* (Knight & Mellor, 2007). Staff have a mandate to address the social and emotional well-being of residents in their care, yet residents complained of loss of autonomy due to the regulations and institutional regimen (Choi et al., 2008). In an Australian study of social inclusion, however, recreation staff reported that participation

in organized activities equaled social inclusion and sense of belonging (Knight & Mellor, 2007): they also reported that the established routines and lack of resources were barriers and limited time was available to engage withdrawn and isolated residents.

2.3.3. The Right to Respect and Dignity

Social citizenship is founded on a number of core values including the rights to respect and dignity. A study examining quality of life indicators in long-term care included integrating the opinions of residents and their families, and one of the top three opinions was being treated with respect (Robichaud, Durand, Bédard, & Ouellet, 2007). Without thoughtful planning and time to assess and re-assess, activities can supersede meaning and become token programs that do not address the rights of those they are meant to serve. This raises the issue of dignity. The Centers for Medicare and Medicaid Services provides nursing home surveyors in the United States with a system to evaluate standards based on law and regulations and this system is made up of “F-Tags” which are used to identify special requirements and rights (Mollot & Butler, 2012). F-241 states:

Facilities must promote care for residents in a manner that maintains or enhances each resident’s dignity and respect in full recognition of his/her individuality.

One of the typical activities provided by recreation staff is seating residents in a circle and throwing a balloon to them one at a time. It can be argued there are physical and social benefits for residents to participate in balloon throwing. However, it is almost impossible for someone (especially persons living with advanced cognitive impairment) not to react when a balloon is thrown at them. I believe we should question the impact

this activity has on resident's dignity. While the action of hitting a balloon may have some physical benefits or provide enjoyment, merely reacting to a balloon is not a sign of meaningful participation and has questionable value. In an evaluation of a resident council in Ireland, residents expressed concerns about lack of mental stimulation and respect and a resulting loss of dignity and independence (Timonen & O'Dwyer, 2009). Residents in this home reported that they were not likely to protest for a number of reasons, one of them being fear of repercussions. In another study in an Australian home, residents described how hard the staff were working and indicated they frequently accepted invitations to programs to be polite (Knight & Mellor, 2007). Maintaining dignity is an important issue for residents and goes beyond the "gap between the rhetoric of dignity conserved" and what they are experiencing (Hall, 2014, p. 60).

The issue of dignity and respect is complicated by the drive for non-stop activity programming. Activity calendars are often filled with a multitude of social events and entertainment seven days a week. Although many enjoy more diversionary activities, they should not be denied the ability to participate in activities that might be perceived as more personally meaningful, especially productive ones. According to Katz (2000), non-stop activity programming can in some ways mask emptiness of meaning. There is a demand from family (therefore also from home administrators) that residents are kept busy. When family come to visit, they want to see their loved one occupied. This demand furthers the notion that simply being at an activity equals better quality of life (Katz, 2000). Therefore, recreation staff plan activities seven days per week and ensure that those in their care attend as many of them as possible. In a 13-month-long

ethnographic community study, Henderson (1995), described the inability of the care staff to visualize the resident's life through his or her eyes. Although they were mostly kind and attentive, the focus of their work was physical care, the gold standard by which accountability was demonstrated. Any psychosocial care provided was delegated and restricted to activities staff (Henderson, 1995).

Consequently, activities were undertaken, but they were of the simplest kind and were accompanied by the attitude that a mere charade was sufficient. It was in the psychosocial care domain that there was the greatest staff blindness to what quality of life in long term care should and could be. (Henderson, 1995, p. 38)

Henderson (1995) posits that time controls staff working within residential care. The current philosophy of care requires non-stop demands for keeping busy. More is always better—more programs, more activity. All of this, I argue, results in combination of pseudo-purpose, a facsimile of a meaningful life, and a charade of activity.

2.4. The Practice of Social Citizenship and Relationality

Given that persons living in residential care settings are entitled to experience freedom from discrimination and be equally involved in their communities, it is paramount that they are supported through both organizational practices and social discourses. Relationality is defined as being socially constructed within and through relationships with others and how one is perceived within their social context (O'Connor, 2010). Being intertwined with a shared world is fundamental to the human condition (Kontos & Grigorovich, 2018). A relational citizenship model has been applied to the

field of dementia (Bartlett & O'Connor, 2007, 2010; O'Connor, 2010; Wiersma et al., 2016), and in the context of embodied selfhood (Kontos, 2011; Kontos & Martin, 2013; Kontos, 2005; Kontos & Grigorovich, 2018). Applying a citizenship lens has the potential to advance the discourse on the roles residents hold in these communities by bringing a new and important dimension to fostering capacity. O'Connor (2010) notes the contrast of a cognitive model where competence is socially constructed to a relational model where the assumption is that all people have competence, and the focus is not on *if* they are capable, but *how* they are capable.

Historically, social citizenship at its core seeks to address economic inequalities that restrict autonomy, but the concept has been critiqued. The common traditional view of citizenship among all citizens was formulated by T.H. Marshall and included civil, political and social responsibilities and equal rights (Marshall, 1949/92). Bartlett and O'Connor (2010) offer two problems inherent in this definition. Firstly, the Marshallian view focuses on the state and established systems to maintain or enhance citizenship but fails to consider citizenship from the perspective of social movements or groups seeking to promote citizenship from the ground up. Secondly, this view of citizenship assumes that all citizens are able to claim their rights and responsibilities in their communities. This means that people living with cognitive impairment and unable to vote or fulfill obligations such as work, are not considered citizens.

Ben-Ishai (2012) offers an additional critique of T.H. Marshall's definition and argued that this concept of social citizenship fails to consider that autonomy is not only hindered by economic capacity but also by the lack of well-structured social relationships. Social control (in this case, within residential care settings) overshadows

rights, and at the same time the “passive” conceptions of citizenship focus only on rights, but not the rights to services and resources needed to be capable of autonomy (Ben-Ishai, 2012). For example, in order for persons living in residential care settings to be engaged in citizenship-based practices, not only does the control need to be given to residents, but they need to be supported so that they can express their autonomy. Residents who contribute to the functioning of their home (e.g., helping to set the table at meal times), could bring about grievances from unions. Likewise, residents providing social support and care to their peers (e.g., mentoring), could threaten staff who are tasked with providing psychosocial care. Growing the notion of citizenship from a status granted by the state to a social practice in everyday life (Barnes, Auburn, & Lea, 2004) expands the definition to include persons living in residential care. The world of residential care is influenced by policies associated with the health and social care that residents receive. In the following sections, I will explore the theoretical and conceptual foundations used to build a new model of relational citizenship to help addresses these issues.

2.5. Theoretical and Conceptual Foundations

This chapter draws on a critical perspective to re-evaluate the situation of persons living in residential care. A critical perspective questions commonly accepted practices and positions (Estes, Biggs, & Phillipson, 2003). For example, in these settings the social positioning of staff as experts and residents as recipients of their expertise is an established norm. This has an impact of the lives of residents as it creates structural inequalities that limit the residents’ full participation in their

communities. The purpose of adopting a critical perspective is to examine the practices so that they can be better understood and improved.

2.5.1. Power and the Institutional Culture

One of the relevant critical schools of thought proposed by Bartlett and O'Connor (2010) is based on the work of French philosopher Michel Foucault. By viewing Foucault's theory of *Governmentality* through a critical gerontological lens it may be possible to gain insights into the oppressive culture of residential care. Foucault originally used the term governmentality during his lectures at the Collège de France in the 1970s, first to describe procedures designed to fulfill government policies and then later to describe conduct not only at administrative and political levels but also at the individual level (Dean, 1999). Powell (2009) used Foucault's concepts to analyse the power relations between health care professionals and older people. With a reliance on risk assessment, care workers problematize older people through what Foucault described as a "medical gaze" (Foucault, 1977). The role of the medical expert is a sociohistorical construction and the very process of routine assessment has potential to strip residents of their identity. This form of power is covert but pervasive and is reinforced by increasing pressures to document improved quality of care through ongoing assessment.

It is within this disciplinary duality of power/knowledge and autonomy that power operates over older people, ultimately reinforcing the fragmentation that surveillance engenders in the broken identities of many older people at the centre of the professionals' gaze. (Powell, 2006, p. 136)

Thus, practices of monitoring and assessing residents have an impact and although they are cloaked in the guise of a protective role, these practices foster dependency and helplessness (Foucault, 1977). Through the mandated documentation processes residents become a “diagnosis” or a “case” for the staff to examine and manage. The focus on continual assessment institutionalizes both the staff and the residents. There exists a constant drive to complete the agreed-upon duties correctly as dictated by professional practice guidelines and policies within residential care. These guidelines and policies are dictated by the power struggles between service providers and service users (Kelly & Innes, 2012).

The management of the residents is epitomized by what Powell (2009) has described as the managerial gaze. The managerial gaze is built on the concept of the medical gaze developed by Foucault, referring to “discourses, languages, and ways of seeing that shape the understanding of aging into questions that center on, and increase the power of, the health professions, and delegitimize other possibilities” (Powell, 2009, p. 273). Similarly, the managerial gaze is a process embedded in the power of those managing care (Powell, 2009). As experts, the role of staff is to judge, measure, compare, correct and normalize residents. When residents are established as cases to be perhaps corrected or trained by staff, their identity is eroded. Those individuals that rebel or resist face a powerful force in a society in which human services and social goods are a commodity. According to Powell (2009), this gaze is a professional institution that controls older people and, for people living in residential care settings, is a barrier to choice, empowerment and social inclusion. Foucault described the concept of dividing practices, which are played out by the exclusion of

people that are perceived as a threat to the hierarchical structure of the community (Foucault 1982: 208). Dividing practices are related to othering (Doyle & Rubinstein, 2013) which are used to make a distinction between residents living in the home and those that work there. Although this depiction of antagonistic relationships and the dispersal of power has been disputed (Svihula, 2009), it nevertheless translates into a need to keep residents dependent and socially separated. The surveillance of the medical expert, however, has also created opportunities for *resistance* from the ground up (Gilbert & Powell, 2010). This is true for both staff and residents. Foucault (1977) emphasized that the exploration of relations of power opens up the space for professionals to challenge current practices and entertain the belief that things can be different. McColgan (2005) described how residents assert their personhood and citizenship by claiming sitting spaces or escaping the gaze of surveillance by feigning sleep.

The concept of the managerial gaze can be expanded to discourses, language used and ways of seeing that give professionals power and reinforce ageist prejudices. Using a post-structuralist approach, Bartlett and O'Connor (2010) argued that discourses are not neutral. Language used in daily conversations, public policy and practice, reflect beliefs, assumptions and values held by individuals and by society. Thus, the choice of language used constructs the reality chosen. An example of this is the use of *Elderspeak*, exemplified by the use of exaggerated intonation, elevated pitch and volume, terms of endearment (e.g., “sweetie” or “dearie”), collective pronouns (e.g., “Are we ready for a bath?”, or shortened sentences (Corwin, 2018). The awareness of the use of language is important as with awareness, traditional practices can be

changed. As described by Bartlett and O'Connor (2010) language is linked to discourses that reflect assumptions, values and beliefs shared socially. A relevant example of this is the belief that it is not the role of residents to care for their peers—that this should be the exclusive role of staff.

2.5.2. The Phenomena of Social Death

Within the culture of care homes, organizational and societal practices have an impact not only on how residents are seen by staff and how they are cared for but also how residents see themselves and understand their role. Social *positioning* occurs in a myriad of ways and Kitwood (1997) contends that the positioning that occurs around residents—people with less ability and status, results in a loss of personhood. As described previously, personhood includes the importance of social relationships and the value of individual beings regardless of their disability. Society, however, places a high value on intellectual functioning and physical capabilities. Negative interactive processes, which Kitwood (1997) referred to as a malignant social psychology, have an impact on the experience of dementia further enforcing the division between the staff and residents.

The societal constructs and personal beliefs of practitioners and residents are a key aspect to understanding what needs to be changed in order to enhance and sustain citizenship in all aspects of the care processes. Loss of personhood has been conceptualized as a form of a *social death*—apparent when marginalized groups, such as persons living in residential care, are considered incapable of social participation. In an exploratory study of nurses and social workers in the community for example,

Brannelly (2011) found that practitioners who believed that individuals with dementia were incapable of social interaction conducted exclusionary practices, such as speaking about them as though they were not in the room.

In my experience as a clinician, exclusionary practices are common among staff in care homes and among unpaid caregivers. It happens in a variety of ways such as in conversations between the staff, between the staff and visitors, and among kitchen staff in the dining room as residents are being served (Corwin, 2018). Staff who socially disregard residents while giving care, may be unaware of the impact that poor social interactions have on preserving an identity of a receiver of care (Bouchard, Bannisster, & Anas, 2009). Well-meaning staff position residents through the oppressive use of labels such as “aggressive” (referring to a resident who is resisting personal care or a bath). An exploratory study conducted by Sweeting (1997) operationalized the concept of “social death” in order to assess the extent of this phenomenon of disregard among caregivers (Sweeting & Gilhooly, 1997). Social death refers to people considered figuratively “dead” even though they are alive (Sweeting & Gilhooly, 1997). Sweeting (1997) found that the treatment of those with dementia as socially dead was common among professional staff and caregiving relatives. Others have noted that staff and residents themselves refer to residents that are unable to care for themselves or engage socially as “vegetables” (Gubrium & Holstein, 1999). The habitual practices of individuals perceived as experts (i.e., staff upon whose good will and care a resident relies) can silence residents, thereby fostering a continuing cycle of helplessness and hopelessness (Timonen & O'Dwyer, 2009).

2.5.3. Resident Councils

The practice of social citizenship and rights is also reflected through resident decision making, but there are barriers to this practice. Recently, Alzheimer Disease International (2013) commissioned an analysis of long-term care and in their findings declared that “. . . governments and other stakeholders should ensure that autonomy and choice is promoted at all stages of the dementia journey”. Residents’ Councils are a purposeful gathering of residents within a home that meet regularly to promote the interests of their fellow residents (Ministry of Health, 2009). Although these councils take a variety of forms and exist in most care homes in Canada and elsewhere, many encounter numerous barriers to success and continue to struggle with ineffectiveness and inadequate representation. A number of studies have focused on this issue over the past 40 years and findings consistently highlight a range of unmet rights (Baur & Abma, 2011; Devitt & Checkoway, 1982; Meyer, 1991; Timonen & O'Dwyer, 2009; Wagner, 2008).

Two barriers to exercising resident rights through resident councils are the staff focus on safety and the lack of administrative support. Care home managers need to fulfill a duty of care that includes best practices, safety and equal treatment for all residents thereby minimizing the potential for litigation (Knight, Haslam, & Haslam, 2010). The pressure the medicalized model of care brings to managers results in a safety-first mentality and a reluctance to give too much autonomy to residents (Kapp, 2012). This appears to be the case in many westernized countries. In a Canadian study on citizenship conducted by Baumbusch (2008), residents described the erosion of identity and feelings of frustration and impotence around their lack of influence. In an

evaluation of resident councils in the Netherlands it was reported that managers' communication styles are often still paternalistic (Baur & Abma, 2011). In a study of a residents' council in Ireland, residents reported that their council was dominated by staff with inadequate skills in group facilitation and that it had a lack of independence (O'Dwyer & Timonen, 2010). In 1983, Getzel contended that without strong administrative support, councils were "an exercise in frustration and futility for staff, and most importantly for the residents who have limited time to devote to a charade" (p. 180). Although some provinces in Canada have made progress in terms of supporting and enforcing Resident Council regulations (Ontario Ministry of Health and Long-Term Care, 2007), the literature indicates a need for further research on innovative practices to enhance the existing structure of councils.

2.5.4. Pluralizing Modes of Representation

Despite these challenges, the movement away from an institutional model of care to one that embraces person-centred care is in theory becoming a standard of practice in homes. There is increasing recognition of the need for further work on the person-centred care philosophy and its translation into practice (Brownie & Nancarrow, 2013; Dewing, 2008; Venturato, Moyle, & Steel, 2013). Within care homes, staff practices usually exclude the voice of residents. I am proposing a shift in how we conceptualize structured dependency from a one-way relationship to an inter-connectiveness that recognizes the personhood of people giving and people receiving care (Fox, 1995). The approach outlined below builds on the concepts of relationship-based models of dementia care (Nolan, Davies, Brown, Keady, & Nolan, 2004) and authentic partnerships (Dupuis, Gillies, et al., 2012).

In a seminal work on inclusion, Young (2000) argued that the idea of representation of a minority group is inadequate as it assumes that the members of the minority have a set of common attributes of interest which can be represented. Within residential care homes, a resident council can be taken as an example of this, in that a council is composed of a few elected that speak for the whole. That can inadvertently result in the type of oppression that they are seeking to address. Representation is a necessary component of democracy in care homes, but it is difficult for people who show interest in being on a council as they have an unrealistic job representing the voice of many with complicated mental, physical and emotional health issues.

An alternative approach is to create a cycle of processes that involve more residents, their interests, opinions and perspectives on a more ongoing basis, rather than seeking the opinions of a few residents at the occasional council meeting. Pluralizing the modes and sites of representation strengthens the process of achieving authentic democracy (Young, 2000). Thus, residents will feel represented if interests they have shared with others are looked after and if their principles, values and priorities are voiced in discussion and heard. When differing social perspectives are honored and encouraged as starting points for discussion, they can create enriched knowledge for members of a community. This approach avoids wrongly reducing all members of a group to a common essence (Young, 2000), making this particularly relevant to people living with more advanced cognitive impairment. This raises the questions of how can residents learn what members of their community want in order to represent them better? Considering this, positioning a new approach using a social citizenship lens has the potential to enhance the rights and capabilities of people in residential care.

2.6. Peer Mentoring: Towards a New Model of Social Citizenship

Peer mentoring is the action of initiating some form of empathetic guidance, social or emotional support to someone sharing a common experience or characteristic (Dennis, 2003; Joo et al., 2016). This concept may foster the practice of social citizenship through offering structured opportunities among residents to learn, to give and to grow. For the purposes of this research, peer mentors were typically more engaged in their communities than people they visited, received training on how to mentor, and shared their knowledge with people they visited. The mentors were taught collaborative learning skills, that is, how to engage in shared learning. In this way, mentors provided people they visited with opportunities to grow together during the visits. During the visits, mentors also encouraged people they visited to attend other programs, build relationships and get involved in the community.

Peer mentoring may offer a viable form of peer support that fosters social and emotional support and close relationships between residents, particularly among individuals who are socially isolated. This approach is based on an approach called Resident Engagement and Peer Support that enhances meaningful engagement and contributions of residents (Theurer et al., 2015). I build on this approach by adding a specific mentoring component that assists fellow residents in reaching out to people that are socially isolated in their communities. This lays the foundation for a new model called Peers Engaging and Empowering their Peers (PEEPS). Laschinger (2010) described a form of empowerment derived from components of Kanter's empowerment theory that include access to information, support, resources, opportunities to grow and

power. Access to these components increases feelings of psychological empowerment among nursing staff (Laschinger et al., 2010), and I am proposing that these components can logically be extended to the residents as mentors. Through the mentoring processes, residents have new access to information (education), support (team meeting structure), resources (program components, e.g., handouts) and opportunities to learn and grow. This mentoring program and the mentoring roles within it have the potential to increase mentors' feelings of psychological empowerment within their organizations. Figure 2.1 outlines how this structure can empower resident mentors, who in turn, engage and empower their peers by providing social and emotional support.

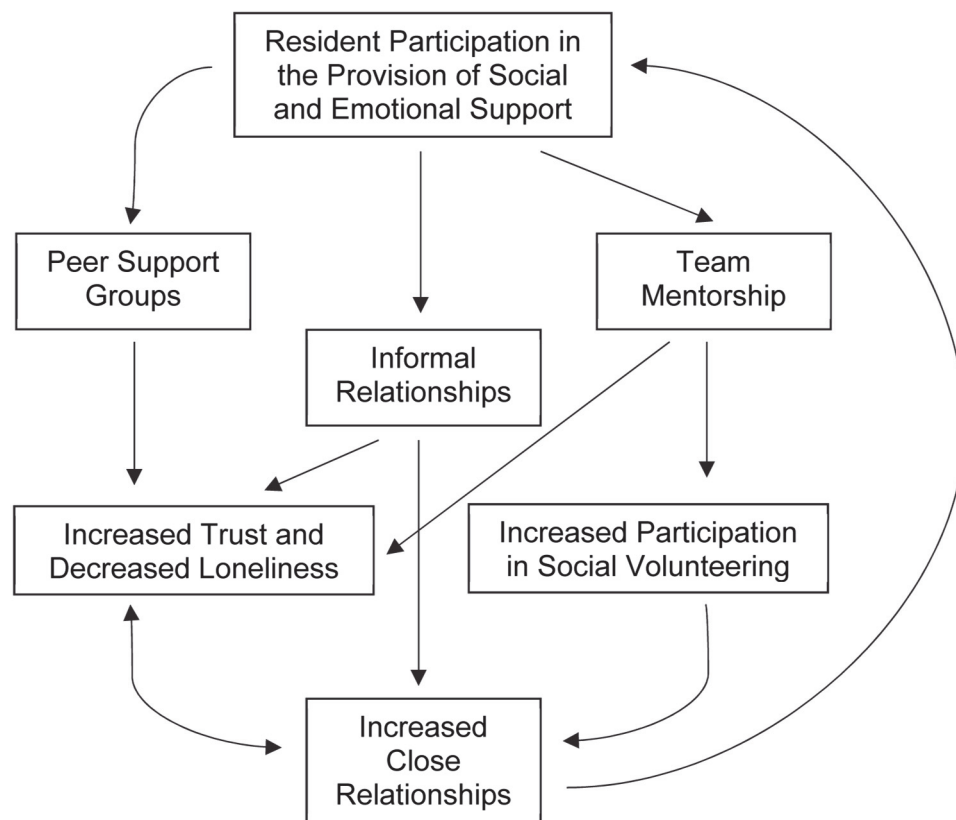


Figure 2.1. A new model of social citizenship in residential care: Peers engaging and empowering their peers (PEEPS).

The peer support and peer mentoring programs and the mentors' actions can lead to a cycle of informal relationships and increased participation in social volunteering as a form of active citizenship. This may result in increased trust, a decrease in loneliness and ultimately increased close relationships. This cycle leads back to the continued residents' participation in the provision of social and emotional support.

Having peer support and peer mentoring offered as regular programs has several benefits including the use of team-based learning that, if properly applied, shifts the focus from knowledge transmission to knowledge application (Paraprofessional Healthcare Institute, 2006). This happens by providing space for reflective learning among the participants, whether they are residents, volunteers or staff that allows them to try out new skills. Furthermore, the team-based approach offers participants additional opportunities to learn through teaching others, for example, the residents that they visit. I suggest that the structured and consistent participation of residents in peer support and peer mentoring will build new and close relationships and promote active social citizenship among residents.

2.6.1. The Development of a Mentoring Program

I developed a mentoring program called Java Mentorship, built on the peer support groups previously developed and evaluated in these settings (Theurer et al., 2012). Mentors are volunteers and due to the high resident to staff ratios, the importance of recruiting and retaining volunteers for residential care has been identified, especially for people working among residents with cognitive impairment. Damianakis

(2007) noted that community and resident volunteers can play a vital role and highlighted the need for increasing volunteer opportunities for this under-served population. Other research has pointed out that lay volunteers often do not have knowledge about how to engage residents and need education and training to develop these skills, especially when volunteering among persons living with dementia (Chung, 2009). Chung (2009) further noted that support and monitoring should be provided to support and encourage volunteers to stay motivated and deal with challenges, especially for those programs that are ongoing. The above literature helped to lay the foundation for the development of the program and its education modules.

The mentoring program structure. The mentorship program is scheduled for approximately 2 hours on a weekly basis. The program consists of a team meeting with the mentors that is facilitated by a recreation therapist or a volunteer coordinator. The role of the residents (*resident mentors*) and volunteers (*community mentors*) is to focus on developing trusting relationships with people they visit (*mentees*). Resident mentors with cognitive impairment are paired up and supported by community mentors. The first hour of the program includes a mentors' team meeting where mentors receive support and education and the second hour consists of the visits. Facilitators lead 15-minute education modules during the team meeting using a manual provided as well as facilitating a supportive check-in after the visits. The facilitator's manual includes information on how to lead the team meetings and the education sessions, how to foster peer support and how to conduct the visits.

This program was implemented as an informal pilot over a 2-year period in two long-term care homes and a continuing care community. Participants in the pilot

included residents with and without cognitive impairment. During the pilot, additional components of the program were identified. For example, staff indicated they required some education modules to train the mentors with skills such as effective communication, as well as help learning how to teach the skills. Education modules were subsequently added to the team meetings in the facilitator's manual.

To ensure and promote fidelity, Table 2.1 lays out the delivery of the program as it is designed (Saunders, Evans, & Joshi, 2005).

Table 2.1. *Delivery of the Peer Mentoring Program*

<p>The peer mentoring program is held at a residential care site with staff implementing the program. Facilitating the program is described in detail in a facilitator's guide, and staff use the guide and a group manual provided.</p> <p>The program is based on a combination of a team meeting followed by visits conducted by the mentors. The team meeting and visits happen on a weekly basis. The combination of the team meeting and visits lasts about 1.5 - 2 hours. Staff members (usually a recreation staff or volunteer coordinator) schedule the program in the social calendars and do the following in preparation:</p> <ul style="list-style-type: none"> • inform others working in the home and family members about the program and its purpose; • arrange for coffee and snacks for the team meetings; • invite potential residents and volunteers to participate as mentors; • facilitate the program; and • encourage mentors to give input into program components, future refinement and education. <p>The program components consist of the following:</p> <ul style="list-style-type: none"> • weekly meetings consisting of a team meeting <i>and</i> visits to other residents; • serving coffee and treats; • guidelines and closing affirmations; • an educational component during the team meetings; • doing a weekly check-in with the mentors; • inviting mentors to contribute their feedback and suggestions for education; • reviewing the rights of residents in the home; • debriefing time after the visits; • mentors' initiation ceremonies (at 12 weeks and periodically as new mentors join).

In the mentoring program, resident mentors offer support, guidance and advice to their peers, with support as needed from a community mentor. In addition, mentors encourage mentees to become more involved in their community by attending programs

of interest to them and to participate in the peer support groups offered in the home. Mentees who express an interest are also encouraged to consider becoming mentors themselves.

The education modules. Gierveld, Tilburg, and Dykstra (2017) argued that new approaches have a greater likelihood of being effective if they include education or training that requires active participation. Developing the education modules for the mentorship program began with a consideration of who would be receiving the education and how it should be delivered. The mentors were primarily older adults (e.g., residents and older volunteers). Adults learn best if they are actively involved in the process of learning, and Dunlap, Knowles et al. (2005) proposed four learning stages called selection (e.g., having opportunities choose what aspect of the new learning to try out), reflection (e.g., to write or discuss the new learning), application (e.g., to try something out or to teach it) and verification (after trying it out, to evaluate it and then share the evaluation with others) (Figure 2.2).

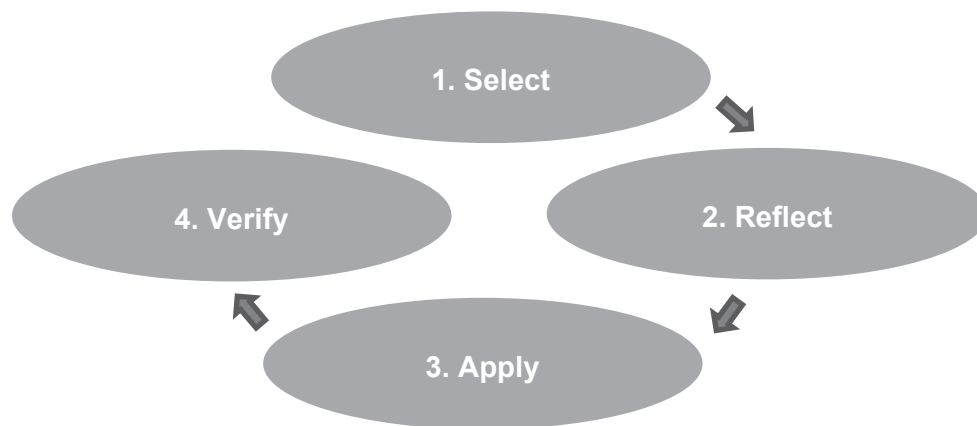


Figure 2.2. Model of learning cycles for mentors. Adapted from “Blended Model of Adult Learnings in Higher Education,” by E. S. Dunlap, B. Dudak, & M. Konty, 2012, *Kentucky Journal of Excellence in College Teaching and Learning*, 10(2), p. 28. Copyright 2012 by the authors; used with permission.

One example of an education module focuses on a commonly encountered problem titled: “What if they don’t talk much?” Facilitators use the above learning cycle to enhance the learning about this topic in the following manner:

TOPIC: “What if they don’t talk much?”

1. Select

- a. The program facilitator teaches mentors how to generate conversations (Zeisel, 2009), and how to carry a conversation in an inclusive way. They then invite one of the mentors to write out several approaches to generating a conversation on a white board, for example, using the mentees’ photos as a conversation piece, sharing a personal story, reading to them, etc.
- b. Team members are invited to share a related story from their own lives (e.g., a time spent with someone who doesn’t talk much)
- c. Then a review is done about this new skill and mentors select 1-2 approaches that they feel could be relevant to their personal or work lives and/or to their visits

2. Reflect

- a. Mentors have opportunities to write or talk about the concept as it applies to their personal life (if relevant) and/or their work with mentees, either writing (or talking for residents unable to write) about a case scenario, and/or doing a role play
- b. The team then holds a group discussion and/or brainstorm solutions

3. Apply

- a. Mentors are encouraged to experiment with selected suggestions on their visits as appropriate
- b. They are also encouraged to teach and/or share what they learned—to a friend or to a mentee if appropriate

4. Verify

- a. Finally, mentors have opportunities to evaluate the success of what they applied, either right after the visits, or during the next team meeting
- b. In addition, sharing mentoring success stories with the mentee’s permission is done within the home, for example, sharing it with a family member, or writing up a success story if it is appropriate in the home’s newsletter

A total of 26 education modules were developed. Another example is the topic of “How to help people grieving.” In this module, a discussion is held first about honouring personal grief and ways for mentors to take care of grieving in their own lives. Then mentors are invited to use a flip chart to draw up two columns: what helps people grieving and what does not. They hold a discussion and reflection time, then are given a handout called “Helping People Who Grieve” that includes tips, such as recognizing the stages of grief and offering support without imposing a timeline. This is followed by applying some of what is learned on visits when appropriate or in their personal lives. Mentors are invited to share the successes and barriers of how this application of the learning went during the team meeting in the follow week.

The education module topics provided each week during the team meetings (Table 2.2) were designed to enhance the skills of the mentors, but they also served to provide additional education for the staff. An example of this is building listening skills or improving effective communication with persons living with dementia that facilitators can use during their work in other programs.

Many of the module topics were suggested by facilitators and mentors in the pilots, thereby combining practice with evidence. The educational modules are repeated every 6 months. This trains new mentors who join the team—they also receive support from the experienced mentors who provide guidance. Existing mentors are encouraged to take on the role of an expert if they have already been exposed to the education and have used it in practice.

Table 2.2. *Education Modules*

The training modules provided each week during the mentorship team meetings are short and average about 15 to 20 minutes. During the training portion, mentors participate in adult learning cycles that include combinations of group discussions, role playing, personal reflection, etc. (Kolb, 1984).

Examples from the Introductory Month Education Modules

- Getting to know each other—introductions
- What the purpose of the program is
- What the role of a mentor is (and is not)
- Creating safety within the team (e.g., it is safe to take risks, share challenges etc.)
- Making a time commitment to the team
- Introduction to the Mentor's Initiation Ceremony (after 12 weeks)

Examples from the Training Topics in the Education Modules

- Effective communication with persons living with dementia
 - Being with persons living with dementia
 - Re-finding our life purpose
 - How to help those that worry
 - The habits of happy people
 - Building empathy
 - Building listening skills
 - What if they don't talk much
-

The visits. The residents who receive visits and the number of visits received are determined during the mentorship team meetings based on evaluated need and referrals from care staff. Mentors follow a visiting guide and use skills gained from the team meetings to engage those they visit. Mentors ask people they visit for permission to enter their rooms, and refusals are respected.

Program sustainability and revisions. The program includes a mentor's initiation ceremony for new mentors, as well as periodic appreciation activities, for example, a special newsletter highlighting the work of the mentorship team and an annual celebration. Mentors have regular opportunities to provide input and to evaluate both the program and the education modules.

2.7. Discussion

In this chapter, I reviewed social citizenship as a practice that offers residents opportunities to contribute, proposed a model of peer support and mentoring to address loneliness within the residential care context, and reported on the detailed development of a new mentoring program based on the model. I argued that reinforcing a passive role among residents in residential care can foster increasing loneliness. Peer mentoring, however, has the potential to engage residents as citizens and to lead to direct healthcare savings, which lessens the risk of potentially avoidable and expensive medical interventions. For example, research in England examined the outcomes of three dementia peer support groups and the extent of the social value produced compared to cost of investment (Willis, Semple, & De Waal, 2016). According to the authors, the social value produced (e.g., a reduction in isolation and loneliness) ranged from \$2.17 to \$9.59 (Canadian) for every dollar of investment.

The PEEPS model and the peer mentoring program have two differentiating features that are important: they foster the voice of socially isolated residents and they reflect the rights and responsibilities of residents as citizens. The first feature, fostering the voice of socially isolated residents, is significant. In 2010, the implementation of another version of the Minimum Data Set (MDS 3.0) in the US provided increased capacity to include the resident's voice. It contains questions brought to residents directly through an interview that are relevant to their psychosocial care. However, the use of the MDS 3.0 also illuminated ongoing problems. For example, even though social workers are considered the primary providers of psychosocial care, research suggests that many do not have minimum qualifications and the caseloads far outweigh

manageable levels (Simons et al., 2012). The PEEPS model has potential to address this concern as it engages an under-utilized resource of the residents themselves. Residents have much more time available to them than do the staff, and through the peer support groups and mentorship program they can join forces with the staff in reaching out to spend time with individuals who are socially isolated. In addition, staff have opportunities to learn the principles and techniques of mentoring provided in the facilitator's guide, as they teach it to the mentors. The skills they are teaching, for example, better listening skills and effective communication with persons living with dementia, are skills that may serve to give the staff better listening skills and give residents a stronger voice throughout their community.

The second feature reflects rights and responsibilities and focuses on the responsibility as a citizen to help others in the community (Government of Canada, 2016). In Canada, the rights and responsibilities of citizenship are a reflection of a history of shared traditions, identity, and values that include freedom of thought and expression (Government of Canada, 2016). As the resident mentors become providers of psychosocial support to their peers, they actively demonstrate a new role or position in their communities. This role is based on the responsibility residents have as citizens in helping their peers in need. This could have important implications for addressing the stigma for people living in these settings (Truesdell, 2016).

Putting peer mentoring into practice may not be easily accomplished but can help residents build close relationships and actively contribute within their communities. In the previously described Australian study of social inclusion, recreation staff felt that the organized activities they offered provided enough social inclusion and participation,

even though residents complained about their lack of input or contribution (Knight & Mellor, 2007). Staff acknowledged that the established routines and lack of resources were barriers and that limited time was available to include withdrawn and isolated residents. Providing a structured resident mentoring program may help address these issues by providing a previously untapped workforce to help—the residents. Concurrently, this activity can serve to reduce stigmatizing beliefs of residents' abilities to contribute. The PEEPS model proposes positioning of residents as active contributors to their community, which would offer them a new role. As staff, caregivers and the public see the resident mentors in action helping their peers, their previously entrenched identity as receivers of care can change. The choice to pair community mentors to support resident mentors with cognitive impairment means that people with more advanced dementia can participate as mentors. The role that these new relationships offer may contribute significantly to restoring the identity as a social citizen often lost as older adults move into residential care.

Focusing on residents as experts of their everyday experience and actively engaging them in reform and change processes, is a central goal of culture change (O'Dwyer, 2013). Ageist discourses, onerous policies and regulations, an undervalued workforce, change in leadership and staff turnover, and the focus on clinical assessment, are significant barriers to culture change that need to be addressed and changed. A shift in practice away from leisure as therapy and towards resident citizenship will help to create the relational culture that is being advocated. Indeed, this practice offers a form of resistance by residents to an undesirable identity imposed by others. As Kitwood (2013) has argued, even with the documented failures and

confusion surrounding the culture change movement, there is genuine social change and a growth in responsibility:

The uncertainty and lack of direction that provoke so much bewilderment also provide a space for the emergence of a new culture of care. The dismantling of some of the old structures, although deeply unsettling, has created the opportunity for a radical and more benign redistribution of power (Kitwood, 2013, p.9).

Implementing the PEEPS model will likely meet some challenges. In reviewing the quality of care provided to persons living with dementia, the World Alzheimer Report (2013) identified issues for staff including personal resistance to change and lack of time. The report compared informal caregivers to paid staff and identified both as undervalued and carrying out demanding roles with minimal support or training. It also identified the negative impact this has on the quality of care, and the resistance of case managers to giving attention to exploring values and preferences of the older adults in their care. In addition, those giving care on a regular sustained basis (whether they are paid or unpaid caregivers) are vulnerable to burnout and depression (Post, 2011; Richardson et al., 2013). However, I argue that positive social change at both an organizational and societal level is possible by fostering a culture of generosity through mentorship (Truesdell, 2016). Importantly, a positive cultural climate will likely also impact the motivation and satisfaction of community volunteers (Nencini & Romaioli, 2016). Bartlett and O'Connor (2010) offered a useful framework based on Kitwood's approach to dementia care including six key concepts of inclusion, identity, attachment, occupation, comfort, and care (Kitwood, 1997, p.82). This framework highlights the potential construction of a citizen and examines the challenges and limitations through a shift in practice in the following ways:

- **Comfort → Growth:** The concept that only providing care and comfort is not enough and that opportunities for growth as social citizens in one's community is essential.
- **Identity → Social positions:** Moving from the focus on identity of residents, especially for people with dementia, to a focus on a new social position.
- **Occupation → Purpose:** Moving from just "doing" things to roles with increased meaning and purpose.
- **Inclusion → Participation:** Moving from just being included and attending social events to active participation in them.
- **Attachment → Solidarity:** Moving from just a sense of "attachment" and relationship with others to solidarity, uniting with others to make a difference.
- **Care → Freedom from discrimination:** A shift from care that reduces self-expression and growth—which can mask controlling people who are dependent—to freedom from discrimination.

In the following chapters, I will extend these above concepts in evaluating the engagement of residents as mentors and active social citizens. In the final chapter I will apply four principles of social citizenship offered by Bartlett and O'Connor (2010) which can serve as a guide to help staff protect the rights of residents in these settings.

Defining social citizenship as a practice through peer mentoring has the potential to provide a new discourse that includes the rights, status and participation of persons living in residential care. As active social citizens, resident mentors could have a practical way to engage in building a culture of positive peer support and peer mentoring in these settings. Importantly, this offers a way for residents to build relationships and help improve quality of life among their peers through practicing a deliberate cultivation of compassion combined with action. "Social relationship—based interventions represent a major opportunity to enhance not only the quality of life but also survival" (Holt-Lunstad, Smith, & Layton, 2010, pp. 14-15). According to my proposed model, peer mentoring can be conducted with residents living with cognitive

impairment with the support of their fellow mentors and volunteers. Thus, residents have much to offer in reducing loneliness and building resident engagement in their communities, and in bringing to the fore the concept of social citizenship as a practice.

Chapter 3.

Peer Mentoring in Residential Care: A Feasibility Study

Canada's population is aging and prevention of the abuse of rights among people living in residential care is of critical importance. In 2016, 16.9% of Canadian were 65 or older and people aged 85 years or older represented 2.2% of the population, with a growth of 20% since 2011 (Statistics Canada, 2017, May 17). This growth will continue to increase by another 20% by 2024 (Statistics Canada, 2015, September 29), and by 2036 older adults will make up 25% of the population (Munro, Downie, & Stonebridge, 2011, January). The 2016 Canadian census reported that 6.8% of these individuals aged 65 years and older were living in residential care homes, and those numbers jumped to 20% among individuals aged 85 years or more (Statistics Canada, 2017, May 17). With these growing numbers there is an increased understanding of the personal and societal costs related to the abuse of rights (Hirst et al., 2016), and this issue is particularly concerning in residential care settings, such as long-term care, assisted living and retirement homes. The World Health Organization (2000) has defined abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationships where there is an expectation of trust which causes harm or distress to an older person" (World Health Organization, 2000). Abuse or mistreatment can take numerous forms and includes emotional, psychological, or systemic abuse (Hirst et al., 2016). People living in these settings, particularly individuals living with dementia, are

firmly positioned as passive recipients of care (Bartlett & O'Connor, 2010). This prevents full participation in their communities and is thus an abuse of their rights.

People living in residential care are citizens with full rights and capabilities, however both are often denied (Kelly & Innes, 2012) and this has a significant impact on mental health. Task completion and the biomedical focus in these homes dominate the culture (Doyle & Rubinstein, 2013). The staff are the designated experts and, as professionals in charge of care, are there to assess and treat the individual problems of each resident (Anderson & Heyne, 2013). This culture compromises the rights of residents to be actively engaged—and having few opportunities to contribute has an impact on their mental health. Despite calendars filled with social programs, residents report feelings of loneliness (van Beljouw et al., 2015), ongoing depression (Conn & Snowden, 2010) and a lack of purpose (Knight & Mellor, 2007). Reviews of interventions to alleviate loneliness report that few are effective (Cattan, 2005; de Jong Gierveld et al., 2017; Masi, Chen, Hawkley, & Cacioppo, 2011; Victor, 2012). Programs designed to decrease depression have also shown mixed results (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014). Given the importance of addressing these concerns, providing a critical approach to improving mental health in residential care and the development of new approaches for this population are urgently needed. Social citizenship has been defined as “...the rights and duties associated with the provision of benefits and services designed to meet social needs and enhance capabilities . . .” (Taylor-Goobe, 2008, p. 3), and is one such approach.

Social citizenship as a concept can help to build an increased understanding of the experiences of persons living in residential care. Citizenship is usually thought of in

the context of the welfare state and the promotion of civil, political and human rights (Dwyer, 2004). It was defined as a social construct and a "...status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties which the status bestows" (Marshall, 1949/92, p. 18). Exploring citizenship within a wider frame of reference in residential care provides a way to re-examine the role of society and the culture of residents as care recipients. A move from examining citizenship as a status and assumed rights to the practice of citizenship through actions—something that people do, is especially important (Bartlett & O'Connor, 2007) in these settings. There is a discourse in our culture around the miserable conditions of care homes resulting in a pervasive fear of moving into one (Kane, 2001). In a study of older adults living in the community for example, 30% of participants reported that they would rather die than live out the end of their days in a care home (Mattimore et al., 1997). The need to re-position residents as contributing citizens with equal participation and rights in their communities is critical and has potential to help reshape this discourse.

Bartlett and O'Connor (2010) described principles of social citizenship approach to dementia practice that I have adapted to all persons living in residential care, whether they have dementia or not. The authors outline four principles underpinning a social citizenship approach: (a) active participation by persons living in residential care in their own lives and their communities must be maximized and valued, (b) their potential for growth and positivity must be recognised *and* promoted, (c) individual experiences must be understood within the larger social structures of residential care and society at large, and (d) solidarity between residents through the building of a sense of community must

be nurtured. These principles require a shift of perception among residents and a shift in perception among staff, families and society in order to uphold the practice of citizenship in “ordinary places” (Bartlett, 2016, p. 456). Looking at these principles to build on and advance citizenship among residents can help to generate a greater awareness and understanding of the inequality and struggles that residents face with recognition of their rights. The principles symbolize a fundamental shift of what the term “community” means within these settings and offer residents opportunities to grow and situate themselves as equal citizens, regardless of their cognitive or physical challenges. Active participation means much more than inclusion—it means involvement at some level that is valued.

Peer mentoring among residents offers a new approach to advancing their rights and enhancing their contributions. Drawing on the concept of social citizenship as a practice, I developed a peer mentoring program for residential care, called Java Mentorship. In the program, community volunteers and family members (from outside the residential home, i.e., community mentors) and resident volunteers (from inside the home, i.e., resident mentors) formed a supportive team and visited other residents that were identified by the team as lonely or socially isolated (i.e., mentees). The mentoring program was piloted over two years at a continuing care community (with assisted living, day program, and long-term care) and two long-term care homes. With feedback from the staff and mentors, subsequent revisions were made in preparation for this feasibility study. Understanding the way in which peer mentoring can be implemented as planned is important in determining the feasibility of conducting a larger study to examine the impact of peer mentoring. A feasibility study helps to produce a set of

results that guide the decision making around determining whether a program should proceed to efficacy testing (Bowen et al., 2009). Thus, feasibility studies concentrate on the processes of implementing a program and participant responses to it. I used an adaptation of a framework for social and behavioral programs developed by Orsmond and Cohn (2015). We examined the implementation of the mentoring program, based on the following four objectives (Appendix A):

1. Assessment of ability to recruit and characteristics of the sample.
2. Assessment of procedures for collection of data.
3. Assessment of retention, program adherence and acceptability.
4. Assessment of resident responses to the program.

The aim of this study was to explore the feasibility of conducting an experimental study to evaluate a new team peer mentoring program within residential care addressing the above objectives. The mentoring program creates an environment that fosters the principles of social citizenship outlined above (Bartlett & O'Connor, 2010), and this chapter will examine the results in light of them. Due to the numbers of residents with cognitive impairment in these settings (Alzheimer Disease International, 2013), we also explored differences between the resident mentors living with and people living without cognitive impairment.

3.1. Methods

Using a mixed-methods pre-post design, I implemented the mentoring program within residential care settings in southern Ontario, Canada. I administered a post-study survey that offered an opportunity for resident and community mentors and facilitators to

rate the program, team meetings, program materials and education. Outcome data were collected at baseline, then at 3 and 6 months among resident mentors. The primary outcome measure for the resident mentors was depression. Secondary outcome measures included loneliness, purpose in life, social identity and sense of belonging. My primary interest was the effect of the program on the resident mentors, however, I also included data obtained from the community mentors' and staff facilitators' post-study survey to fully address the above objectives. Ethical approval from the Behavioural Research Ethics Board was obtained from the University of British Columbia and follow-up permission at the research sites arranged through the Schlegel-UW Research Institute for Aging.

3.1.1. Recruitment and Inclusion Criteria

Recreation and volunteer staff coordinators at each home invited eligible community and resident mentors. Residents able to speak English and understand simple instructions were eligible as resident mentors, whereas people that were bed-bound, acutely ill or on temporary respite were excluded. Both community and resident mentors were invited via personal invitations and staff also put up study advertisement posters. All community volunteers at the sites were required to obtain a successful police check prior to volunteering. Two research assistants completed the screening to ensure that residents fit the inclusion criteria and were willing to participate in the study. Legally-recognized surrogate decision-makers, e.g., the resident's spouse, close friend or guardian, provided consent for resident mentors unable to provide their own ($n = 9$). As outlined by Murphy (2015), "process consent" (p. 800) was implemented by confirming ongoing willingness of the person with dementia to participate. This

willingness was assessed by the research assistants and staff at the start of every interview for completion of the questionnaires, the survey and throughout the duration of the interviews.

3.1.2. Program Structure

The mentoring program was scheduled for two hours each week and facilitated either by a staff recreation therapist or a volunteer coordinator. Resident mentors with moderate or severe cognitive impairment were paired up with community mentors for the visits. The first hour of the program consisted of the mentorship team meeting and the second hour consisted of two mentors visiting one resident. Some mentor pairs visited more than one resident. Mentoring during visits consisted of providing emotional support or empathy, collaborative learning (described below) and encouragement for mentees to attend other programs offered in the home. After the visits, debriefing sessions were offered by the staff facilitators to celebrate what went well and to address any challenges that arose.

Team meetings facilitated by the staff included a supportive check-in, 15-minute education modules, a review of which mentees were visited and any new potential mentees. Staff used a group manual which consisted of a facilitator's guide and 26 educational modules, a team meeting guide and standardized program materials such as handouts. The manual and guides outlined group formation, number of participants, approaches for the team meetings and the mentors' visits. The foundation of the educational modules was based on collaborative learning (Driscoll, Parkes, Tilley-Lubbs, Brill, & Pitts Bannister, 2009). This approach focused on avoiding 1-way

teaching or 1-way giving, and instead, used a reciprocal learning approach. Mentors explored new concepts during the team meetings such as the differences between normal worry and habitual worry. They then practiced what they learned, trying out different approaches on how to support people who habitually worried, using compassion and cultivating calmness. If the concept was appropriate to the mentee, then during the visits in the following hour, mentors and mentees explored the concept together using handouts provided (e.g., “Three Keys to Calmness”). Mentors shared their own related experiences with worry and invited the mentees to share theirs as well. Following this, the mentees were invited to practice the suggested three keys to calmness along with the mentors. The sharing of personal stories and the collaborative learning were designed to build strong relationships and reduce the sense of inequality between mentors and mentees. To foster retention of the mentors, an initiation ceremony was performed for new mentors that included reading of guidelines and a pledge, at which point they would receive a name badge. In addition, a quarterly team celebration was held where mentors were honoured and given a certificate of appreciation. Mentors were also invited to evaluate the program on a regular basis and contribute educational session ideas.

A complete description of a program is essential so that future studies can reliably implement the program. Key features such as duration and the mode of delivery can influence efficacy and replicability, therefore we used a Template for Program Description and Replication checklist as a guide for both the above description of the program and modifications made during the study (Hoffmann et al., 2014). An initial training session for the staff facilitators was held, with the standardized program

materials providing a consistent structure for the implementation of the program. Using an observation checklist, the consultant who oversaw recreation in homes observed the staff conducting the program once during the second month to document adherence to the study protocols (Appendix B). Observations were held once only due to limited time and resources available.

3.1.3. Measures: Resident Mentors

Descriptive measures and covariates. I extracted demographic data about resident mentors including sex, age, education, number of programs attended per month and Cognitive Performance Scale levels (Paquay et al., 2007) using Resident Assessment Instrument-Minimum Data Set scores (Canadian Institute for Health Information, 2010) from resident charts. Although one review suggests that evidence for the reliability and validity of the Resident Assessment Instrument-Minimum Data Set is mixed (Hutchinson et al., 2010), it is commonly used to assess residents in these settings within Canada (Poss et al., 2008). The cognitive performance scale shows substantial agreement with the Mini-Mental State Examination (Hartmaier et al., 1995) and an average inter-rater reliability of 0.85 (Morris et al., 1994).

Survey. To help address feasibility objectives three and four, resident and community mentors as well as the staff facilitators completed a 7-item survey. They were asked to rate the program, team meetings and program materials, if the education impacted their confidence levels as mentors, if they felt the program should be continued and if they would recommend the program to others. The survey also included an open-ended question at the end: “What has your experience been like with

the Java Mentorship Program?” Responses to this question supplemented the quantitative information obtained (Thabane et al., 2010).

Outcome measures. With my primary focus on resident mentors, outcome measures (Appendix C) were completed by these mentors at baseline, 3 months and 6 months. Higher scores indicated higher rates.

Primary outcome. The primary outcome measure depression was assessed using the Geriatric Depression Scale Short Form (GDS-SF) that consists of 15 questions requiring “yes” or “no” answers, with scores greater than five suggestive of depression (Sheikh & Yesavage, 1986). Internal consistency of this scale is high with Cronbach’s $\alpha = 0.94$ and a split-half reliability 0.94, test–retest reliability has been reported at 0.84-0.85 at 1-2 weeks retest, and sensitivity = 0.814, specificity = 0.754 at a cut-off score of six (Friedman, Heisel, & Delavan, 2005). The GDS-SF has been found to be highly correlated with the Geriatric Depression Scale long form (Friedman et al., 2005) and successful in differentiating people with depression from people without depression (Sheikh & Yesavage, 1986). Friedman, Heisel and Delavan (2005) examined the GDS-SF among older primary care patients and found moderate internal consistency (with a Cronbach α coefficient of 0.75). The GDS-SF has been validated for people living with early-stage dementia, but due to challenges in comprehending questions it has not been validated among people with moderate to severe dementia (Sheehan, 2012).

In reviewing the sensitivity to change of this outcome measure, I found there was little responsiveness data available; however, a study among patients with rheumatoid

arthritis found the full version of the Geriatric Depression Scale (30 items) needed 6-11 points for 80-90% reliable change (Smarr & Keefer, 2011). As the GDS-SF version of this scale has only 15 items, I estimated a minimum clinically important difference of 3-6 points change (half) may be needed for 80-90% reliable change. I also examined the minimal detectable change (MDC) for this measure. Based on results from a validation study by Friedman (2005) performed in a sample of 960 cognitively intact adults in the US, I estimated that the MDC for the GDS-SF was 4.17. This value suggests that a change in GDS-SF scores smaller than 4.17 cannot be detected by the instrument and therefore would not be considered clinically significant. However, the fact that this validation was performed on a different population of adults needs to be factored in interpreting these values.

Secondary outcomes. Loneliness was assessed by the UCLA Loneliness Scale (ULS-6), a 6-question scale with a rating on a 4-point Likert scale (1 = never, 4 = always). Purpose in life was assessed by the Life Engagement Test (LET), a 6-question scale with a rating on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). This scale included questions such as: “There is not enough purpose in my life” and “I have lots of reasons for living.” Social identity was assessed using an adapted version of the Single-item Measure of Social Identification (SISI) (Postmes, Haslam, & Jans, 2013) with a rating on a 7-point Likert scale (strongly disagree to strongly agree). Sense of belonging was measured by an 18-question psychological subscale of the Sense of Belonging Scale (SOBI-P) with a rating on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree) (Hagerty & Patusky, 1995). As 20% of the resident mentors had mild to severe cognitive impairment, I created adapted versions of all outcome measures,

except the GDS for administration to mentors with cognitive impairment (Appendix D). Questions that had potential to be confusing were changed, for example, from “There is not enough purpose in my life,” to “Do you have enough purpose in your life?”. I also changed multiple category responses options to “Yes” or “No.” Participants received either Version A or Version B depending on their cognitive abilities. Versions A and B were scored together, and I calculated one composite score per person (per time point) regardless of which version was used.

3.2. Data Collection and Analysis

Data were collected by two trained research assistants from the research institute with support from staff. Training for the research assistants was provided through the research institute and I developed a manual for their use that included information such as the purpose of the study, informed consent details, confidentiality, how to interview people with dementia and a data collection schedule overview. With my primary focus on resident mentors, I summarized the survey results using a descriptive analysis, and for the open-ended question I conducted a content analysis on the resident mentors’ responses (Hsieh & Shannon, 2005). I also provided brief summaries of the community mentors’ and staff descriptives and quotes to address the feasibility objectives. Answers to the last open-ended question were written as the interviews took place (Pelto, 2013). I used descriptive statistics to characterize all study variables among resident mentors. For continuous outcomes I reported mean, standard deviation and ranges, and for categorical variables I reported frequencies and percentages. Scores on the outcome measures for these mentors were compared

within participants over a 6-month period during three time-points. A linear mixed-model regression analysis was used to explore the effect of time on outcome measures. I observed that the baseline scores were significantly different for each individual in the baseline model and therefore used a linear mixed-model with a random intercept. The effect of the program was similar for all participants, and I consequently included that as a fixed effect. However, since the effect of the program did not demonstrate a linear pattern, I included time as an independent categorical factor with three levels: T1, T2, T3. The clustering effect of the sites was explored in the linear mixed-model by examining the intra-cluster correlations as an indication of how similar participants were within each study location.

3.3. Results

The findings below are structured according to the feasibility objectives above with a primary focus on the resident mentors: after each objective I present detailed results on the resident mentors first, followed by a brief summary of related data from the community mentors and staff facilitators. For the community mentors and staff facilitators I also add several quotes to contextualize the data.

3.3.1. Assessment of Ability to Recruit and Characteristics of the Sample

Regarding recruitment, 13 residential care homes were invited and 10 signed up (77%). Half of these sites were continuing care communities (with long-term care, assisted living and retirement services) and half were long-term care homes. Study

participants recruited included community mentors ($n = 65$), resident mentors ($n = 48$), and staff facilitators ($n = 24$). Regarding recruitment of mentors, 9 out of 10 sites (90%) were able to recruit three or more resident mentors and three or more community mentors. There was a range of three to 10 resident mentors ($n = 48$) recruited across the 10 homes, with an average of five per home. Mentorship teams ranged from six to 20 mentors in total.

Resident mentors. The majority of resident mentors ($n = 48$) were 85 and over and female with a high school education (Table 3.1). Most did not have significant cognitive impairment and attended over 10 activity events within the home on a monthly basis.

Community mentors. A total of 65 community mentors participated across the 10 sites. The majority of these mentors were female (83%) with an average age of 40.88 (SD = 23.09) and median age of 42.50. Of these mentors, 41% were students, 19% worked part-time, and 19% were retired; 34% had completed high school and 63% had an undergraduate degree or higher levels of education. Some participated in three or more months of mentoring sessions (26%) and 63% participated for six or more months.

Staff facilitators. A total of 24 staff facilitators participated across the 10 sites. Most of the staff facilitators were female (92%) with an average age of 35.36 (SD = 3.48) and median age of 34. Of these facilitators, 46% completed a 2-year college program and 50% completed a 4-year undergraduate program, and most were full time staff (83%) and had worked for an average of 9 years in long-term care settings.

Table 3.1. *Characteristics of Resident Mentors (n = 48)*

Resident Mentors' Characteristics	N (%) or Mean \pm SD [Range]
Age, years	80.24 \pm 12.58 [39 to 100]
Sex	
Male	6 (12%)
Female	42 (88%)
Level of Education	
Elementary School	9 (19%)
High School	20 (43%)
College	10 (21%)
Undergraduate	6 (13%)
Masters/Doctorate	2 (4%)
Number of Activities Attended per Month	
0-1	3 (7%)
2-6	0 (0%)
7-8	6 (13%)
9-10	2 (4%)
More than 10	35 (76%)
Cognitive Performance Scores (CPS)	
Intact – mild	36 (80%)
Mild – moderate	8 (18%)
Severe – very severe	1 (2%)

Note. Sex $n = 48$, Education $n = 47$, Activities $n = 46$, CPS $n = 45$.

3.3.2. Assessment of Procedures for Collection of Data

All the 48 resident mentors required assistance in completing the questionnaires as did 3 of the 65 community mentors (5%). This support consisted of research assistants or staff reading the questions aloud to the mentors and helping them write the responses. In addition, five of the resident mentors at baseline (10%) were given the Questionnaire Version B, adapted for people with more advanced cognitive impairment. Regarding the completion rates for measures from retained participants, 52% of resident mentors had all three time-points for all the data. Out of 48 resident mentors I had complete data at all three time-points for 23 participants (48%) on GDS-SF, 22

participants (46%) on ULS-6, 22 participants (46%) on LET, 20 participants (42%) on SISI, and 21 participants (44%) on SOBI-P. For descriptive measures, missing data from resident mentors ranged from 4% for three variables (GDS-SF, ULS-6, SOBI-P) at baseline to 46% for SISI variable at the end of the study.

3.3.3. Assessment of Retention, Program Adherence and Acceptability

All 10 residential care homes that enrolled completed the study. With respect to retention, among the 65 community mentors 42 remained at the end of the study (65%), and among the resident mentors 48 started the program and 20 dropped out, leaving 28 in total at the end of six months (58%). Of the 20 resident mentors who left the study, four died, four left due to poor health, two had scheduling issues, four lost interest, two were identified by staff as not comfortable visiting unfamiliar people, and one was not able to understand the program. The reasons for the remaining three who left the study are unknown.

Observations revealed that 80% of the sites conducted the program as laid out in the facilitator's manual. Facilitators at one of the sites conducted only one team meeting per month (rather than weekly) and used only one of the education modules over a 6-month period. At another site, community mentors only were invited to participate on the team and facilitators did not invite residents to be mentors until the last month. In their surveys, most resident mentors rated the mentorship program and the team meetings as good to excellent (Table 3.2).

Table 3.2. *Resident Mentors' Post-Study Survey Results (n = 28)*

Survey Questions (Truncated)	n (%)
How would you rate the program overall?	
Poor	0 (0%)
Fair	3 (11%)
Good	8 (30%)
Excellent	16 (59%)
How would you rate the team meetings?	
Poor	0 (0%)
Fair	2 (7%)
Good	12 (45%)
Excellent	13 (48%)
Did you feel increased confidence due to the education?	
Not at all	0 (0%)
A little bit	4 (14%)
Quite a bit	16 (57%)
A great deal	8 (29%)
Were the program materials easy to use?	
Poor	0 (0%)
Fair	5 (18.5%)
Good	17 (63%)
Excellent	5 (18.5%)
Were the program materials helpful during visits?	
Poor	0 (0%)
Fair	4 (15%)
Good	18 (67%)
Excellent	5 (18%)
Would you recommend the program to others?	
Yes	28 (100%)
No	0 (0%)
Should the program be offered on an ongoing basis?	
Yes	28 (100%)
No	0 (0%)

All the staff facilitators completed the study. The majority of staff facilitators (80%) reported that they had sufficient resources overall to facilitate the program but there were several challenges encountered. Some reported a lack of enough time to

facilitate the program (2%) and some found the paperwork associated with the study too much (2%). Despite these challenges, the facilitators rated the program as good (55%) or excellent (45%). All the resident and community mentors (100%) and 95% of staff facilitators indicated their preference for the mentoring program to be offered on an ongoing basis in their home after the study completion.

Most of the homes facilitated the program as intended. However, one facilitator reported that visiting lonely residents was something they already did at their home, and therefore only held team meetings once per month. As a result, this site maintained regular weekly visits but rarely used the educational resources. Staff reported that the mentors loved the visiting but did not appear to need the team meetings as much. The second home used community mentors on the team only during the last month. Observations documented by mentorship teams at both sites suggested that community mentors had bonded and enjoyed the visits and being part of a team. As these sites conducted the program differently than the other sites, the three mentors at these sites still participating at 6 months were removed from the linear mixed-model analysis below.

3.3.4. Assessment of Resident Responses to the Program |

examined the quantitative data at a participant level to see if there were changes in key outcome variables. Table 3.3 shows descriptive characteristics of the sample for each of the five measurements among resident mentors at each of the three time-points, baseline, 3 and 6 months.

Table 3.3. *Descriptive Statistics for Measurements (Composite Scores) at Three Time-Points Among Resident Mentors*

Measure (possible range)	T1: baseline	T2: 3 months	T3: 6 months
Depression Scale (0-15)	3.15 ± 3.05 (n = 46)	2.78 ± 2.59 (n = 27)	2.36 ± 2.70 (n = 28)
Loneliness Scale (6-24)	10.63 ± 3.95 (n = 46)	10.70 ± 3.07 (n = 27)	9.41 ± 4.24 (n = 27)
Life Engagement Test (6-30)	18.78 ± 2.77 (n = 45)	18.07 ± 3.43 (n = 27)	18.41 ± 2.26 (n = 27)
Social Identity Measure (1-7)	5.36 ± 1.66 (n = 44)	5.12 ± 2.03 (n = 25)	5.81 ± 1.44 (n = 26)
Sense of Belonging Scale (18-72)	51.15 ± 12.94 (n = 46)	51.52 ± 7.59 (n = 26)	54.54 ± 11.60 (n = 27)

Note. Reported values are Mean ± SD.

Linear mixed-models were used to explore change over time in dependent variables. Two of the five models showed statistically significant effects over time. I observed small values in the intra-cluster correlations (Table 3.4) with the highest being 0.11, which suggests participants are not clustered and show uncorrelated outcomes within the same location.

Time was included as a categorical variable here allowing for a non-change in scores over time. As a result, I ended up with a comparison between baseline and 3 months and a separate comparison at baseline and 6 months. At 6 months compared to baseline, I observed a significant decrease of 0.97 units in the GDS-SF Depression Scale scores ($p = .048$; $d = .30$) and a 1.66 unit significant decrease in the ULS-6 Loneliness Scale scores ($p = .01$; $d = .23$). In examining the primary outcome measure, I found a potential floor effect. Among resident mentors, GDS-SF scores ranged from 0 to 12 (7 out of 48, 15% of resident mentors had GDS-SF scores of 0 at baseline). No significant differences were found for other outcomes at six months: life engagement,

social identity measure, or sense of belonging ($p = .33$; $d = .14$, $p = 0.24$; $d = .18$, $p = .17$; $d = .21$ respectively).

Table 3.4. *Results of Linear Mixed-Model Analysis (n = 45)*

Outcome	ICC Coefficient	Linear Mixed-Model Results	
		Baseline vs. 3 months	Baseline vs. 6 months
Geriatric Depression Scale (GDS-SF)	$p < 0.001$	-0.64 (0.50), $p = .20$	-0.97 (0.49), $p = .048$
Loneliness scale (ULS-6)	$p < 0.001$	-0.86 (0.63), $p = .17$	-1.66 (0.62), $p < .01$
Life Engagement Test (LET)	$p = 0.144$	-1.27 (0.67), $p = .059$	-0.65 (0.67), $p = .33$
Social Identity Measure (SIS)	$p < 0.001$	-0.25 (0.44), $p = .57$	0.51 (0.43), $p = .24$
Sense of Belonging Scale (SOBI-P)	$p < 0.001$	0.07 (2.44), $p = .98$	3.27 (2.36), $p = .17$

Note. LMM results reported as coefficient B (SE) and p -value; ICC = Intra-cluster correlation.

Finally, I performed two sub-group analyses. The first was to identify any potential change in outcomes among people without cognitive impairment (assessed as intact to mild) who completed Version A ($n = 36$ at baseline) and I found no statistical differences. The second was to identify any potential change in outcomes between resident mentors who dropped out of the study versus those who did not, and here I also found no statistical differences (Appendix E).

Resident mentors. In their surveys, some resident mentors indicated an increase in confidence due to the education provided during team meetings. They also rated helpfulness and ease of use of the program materials positively and an increase in confidence in their role due to the education provided at team meetings. The range of these increases were described as a little bit (14%), quite a bit (57%), to a great deal (29%). I identified three inter-related themes from our analysis of the resident mentors' open-ended survey question (as explained in the earlier Data Collection and Analysis).

Positive feelings connected with program participation described the residents' reactions to being involved with the program. Mentors described good feelings associated with the team meetings, the camaraderie, social aspects and the visits: "I like the people and I can hardly wait to come every week" and "Loved it—enjoyed both the visits and the meetings." They also described some challenges encountered such as the mentees not being available or not talking much during visits, and how the team meetings and education helped address these challenges. *Perceived personal benefits* revealed the mentors' perceptions of associated benefits: "It helped me with my confidence. It made me feel like I was needed," and, ". . . it helped me to make close friendships. It has been rewarding." They described how they enjoyed being involved in the initiation ceremony, receiving a certificate and the quarterly celebrations. *Perceived benefits of helping others* described the mentors' enjoyment related to aiding others: "I like being able to help people," and, "When I was first signed up . . . I was very excited and still continue to be excited to make a difference in someone's life."

Community mentors. In the post-study survey, the community mentors rated their satisfaction with the program from good (43%), to excellent (57%). The team meetings were rated fair (5%), good (40%); to excellent (55%). In response to the open-ended survey question, some community mentors commented on the team meetings: "I like hearing from others, what they are doing." and "I'm actually really excited about it. It really helped because instead of just coming here blindly, and saying "Ok, just go and be with them," they give you lots of tips and tricks for building rapport." Their reports of an increase in confidence in their role due to the education provided ranged from a little bit (14%), quite a bit (31%) to a great deal (55%). When asked about the usefulness of

the program resources provided, the results were mixed. Ratings on the helpfulness of the program materials during visits ranged from poor (2%) to fair (12%), good (41%), and excellent (45%). Some mentors noted in the open-ended survey question that they preferred to use materials they brought from home, for example, readings and photographs.

3.4. Discussion

This study was undertaken to explore the feasibility of conducting a larger experimental study about peer mentoring within residential care as a practice of social citizenship. In reviewing the results, I found that most of the mentors and facilitators were satisfied overall with processes and resources of this mentoring program and felt the program should be continued. Facilitators did encounter some challenges—some of which were addressed over time once the program was implemented—and both mentors and facilitators offered suggestions for program improvements. In the evaluation of the outcomes, the resident mentors reported that the program contributed to their overall well-being, and I found statistically significant changes in their loneliness and depression scores. In the following assessment of feasibility, I discuss the findings in more detail and then review the implication of the results and potential impact on the rights, status and participation of residents as social citizens.

3.4.1. Assessment of Ability to Recruit and Characteristics of the Sample

The findings indicate that despite some challenges, successful recruitment of appropriate residential care sites and participants for a mentoring program is possible. Almost two-thirds of the community mentors participated in the program over six months. As most of the resident mentors were female and socially active, I do not know if acting as a peer mentor may be acceptable to all residents. For example, it may be that this program does not appeal to residents who are male, or reclusive individuals. Many of the community mentors were also female but were a much younger group with over a third being college and high school students. This may mean going forward, future studies might be successful in recruiting students as a support network for this program.

3.4.2. Assessment of Procedures for Collection of Data

When evaluating how appropriate the data collection procedures and measures were for residential care, I had anticipated some of the challenges but also encountered some surprises. For example, I wanted to include persons living with dementia as mentors. Others have noted that people with dementia can give meaningful and essential feedback (Span et al., 2017) and should be included in research in these settings. I designed a separate questionnaire with the four revised outcome measures to facilitate their participation but did not need it for most of the participants. Future studies will need to consider whether to include people with more advanced dementia as mentors. While including these residents is important, it may impact mentors that can learn at a faster rate—and may even cause higher functioning study participants to

leave. As persons living with dementia have much to contribute, one approach may be to consider having them participate in the program, with the exception of the research component. I also developed training documents to help the research assistants and staff with the data collection including “Interviewing Residents with Dementia” and “How to Choose Questionnaires Versions A or B.” I found that most of the residents were able to answer the questions presented in the questionnaires without adapting them. However, given people who needed Version B consisted of only 10% of the resident mentors, they represent statistical outliers who likely increase the heterogeneity of the sample. This would make finding differences between treatment groups more challenging in future experimental studies.

3.4.3. Assessment of Retention, Program Adherence and Acceptability

All the sites completed the study, however only 58% of the resident mentors were retained over the 6-month study period. The loss of that many study participants is noteworthy, and I offer three points to consider respecting these high attrition rates. First, the significant mental and physical health issues of residents and resulting attrition rates during studies in long-term care has been noted by others (Murfield, Cooke, Moyle, Shum, & Harrison, 2011). Second, retaining residents as volunteers is challenging due to high cognitive impairment rates and increasing mental and physical health challenges facing these residents (Alzheimer Disease International, 2013). Third, the student mentors participated as part of their academic program requirements and therefore most were not available for more than three months of their school term. Further research could explore different retention strategies and build them into the

program. Based on the feedback from the mentors, some of these suggestions might include scheduling the program during the day so that residents who go to bed immediately after dinner can be involved, adding games to the education modules to enhance interest, and exploring alternative ways for the mentors to meet prospective mentees in casual social events so that they would not be complete strangers on the initial visits. Although some evaluation scales recommend retention rates of 85% or higher, this is likely unrealistic given the nature of this population, where even rates of 70% might be challenging to achieve (Maher, Sherrington, Herbert, Moseley, & Elkins, 2003). Issues have been identified around recruitment and retention of homes, scheduling and workload pressures on staff, complications related to obtaining consent among people with cognitive impairment, and retention of older residents with multiple health issues (Murfield et al., 2011). Although I would like to achieve rates closer to 70% for sample size calculations, a conservative estimate of retention would likely be 50%. Finally, data from the observations and field notes taken with a focus on the fidelity and uptake of the program over the course of the six months indicated that it was important to conduct observations early on to ensure fidelity to the program. For example, two of the homes made some changes early in the study on how the program was facilitated. One home included only community mentors on the team and one of the homes chose to hold team meetings once a month rather than weekly as they felt that was enough. While this allowed them the flexibility to facilitate the program as they felt best suited the care home, it negatively affected the fidelity of the program. Therefore, I removed the participants from these homes from the analysis to ensure that the results were not impacted by these changes.

3.4.4. Assessment of Resident Responses to the Program

I assessed the participants' responses to the program through the survey questions and the responses to the open-ended question at the end of the survey. Overall, mentors and mentees responded positively to the program. Prior studies examining peer mentoring underscored that peers respond to the lived experience of others in similar situations (Joo et al., 2016). My findings highlight that the training and support during team meetings were helpful to ensure that mentors felt confident that their support was helping—or at least not providing a negative experience, the possibility of which has been identified in previous research (Cooper et al., 2017). For example, previous research highlighted the potential for an uneven power relationship to develop between people providing support and their peers (Embuldeniya et al., 2013), but the survey findings suggest, to the contrary, that mentors reported these relationships often felt more like friendships.

Causality cannot be determined without a control group, and other factors, such as attention bias, differential attrition and the high dropout rates, may have contributed to the study findings. While I did not anticipate how difficult it would be to enroll and retain residents as volunteers, it is important to acknowledge the many challenges listed above that future efficacy studies might encounter. For example, it is important to note that we may have artificially improved outcomes because people who were more depressed or became depressed were the ones who dropped out. In my analysis, I found no significant difference between the baseline characteristics of resident mentors who dropped out of the study and participants who remained in the program. However, as this analysis only tells us about the differences at baseline, there is potential for

differential attrition. With differential attrition the concern is that the study participants who do not return for follow-up are the ones likely to have the worst outcomes (Dumville, Torgerson, & Hewitt, 2006).

I anticipated that residents with depression would benefit from volunteering and found support for this in the results. These findings are congruent with previous research that suggests that while depression can be a barrier to volunteering, it can also act as a motivating catalyst among older adults experiencing losses (Li & Ferraro, 2006). Volunteering has been noted to decrease depression and increase well-being among older adults (Jenkinson et al., 2013). A study in France examining characteristics and depression among a sample of 2,000 care home residents, noted that feelings of depression reported by the residents were influenced to a larger extent by friendships developed within the home than visits from family or friends (Wolff, 2013). Thus, the results may be due to the relationships that mentors developed with their peers, not the mentoring as such. The change scores in the GDS-SF were below the values obtained in other populations, however, I had moderate effect sizes and the difference was almost significant. The results were below the MDC and MCID found in other populations, which emphasizes the need for further research with a control group.

Among the secondary outcomes, there was a significant change in loneliness scores. This is a novel finding as reviews of the effectiveness of programs addressing loneliness, such as structured discussion groups over morning coffee or computer courses, repeatedly report that many are not effective (de Jong Gierveld et al., 2017). Common findings from these reviews suggest that these programs are lacking strong theoretical foundations, education and training requiring active participation of

individuals participating and do not target specific groups. Both mentors and mentees were involved in shared learning experiences and were most enthusiastic about the closeness of the relationships that developed. This is consistent with prior research indicating that the need for belonging and development of close relationships is psychological (Cacioppo, 2008). The lack of connection and belonging to a community for example, is associated with loneliness and depression (Choenarom, Williams, & Hagerty, 2005; Kissane & McLaren, 2006). For the mentors the connections developed with one another were also noteworthy. This finding is consistent with Cattani et al. (2005), who argued that it is the connectedness found in groups that is a vital component in reducing loneliness. It is also important to note that the changes in the loneliness scores may have impacted the changes in the depression scores and vice versa, as has been identified by others (Cacioppo, Hawkley, et al., 2006). The quantitative findings were congruent with the qualitative findings, which provides some corroboration, although once again there is the potential issue of differential attrition. In addition, although the change was significant, and the effect size was moderate, no information about the MCID is currently available.

I did not find any significant changes in the other secondary outcome measures for sense of belonging, purpose in life or social identity. It may be that the program did not have an impact on these constructs. However, it is also possible that the measures may not be sensitive to change (no responsiveness information is known), and there are potential issues with a Type II error. Another possibility is that a longer duration of follow-up may be required to capture changes in these constructs. For example, relationships that build a sense of belonging enhance the sense of having a meaningful

life (Lambert et al., 2013), but trust in relationships takes time. A sense of *not* belonging is associated with worsened mental health (Bhatti & Haq, 2017), loneliness (Prieto-Flores, Fernandez-Mayoralas, Forjaza, Rojo-Perez, & Martinez-Martin, 2011) and increased depression (McLaren, Gibbs, & Watts, 2012). Furthermore, seeing oneself as a valued member of a group, such as a member of a mentoring team, may be different from the development of friendships and individual connections, as the literature indicates (Cruwys, Haslam, Dingle, Jetten, et al., 2014).

The purpose in life score as measured by the Life Engagement Test decreased, but not significantly. This is an unexpected result and there are a few possible explanations. It may be that this test is not the best outcome measure for this population or it may be too much to assume that this relatively modest program would affect this high level of an outcome. I also found no change for social identity, although it too moved in the expected direction. In this case, it may be that as a single-item measure, it was not sensitive enough to pick up changes (Reysen, Katzarska-Miller, Nesbit, & Pierce, 2013), or I may not have had a large enough sample size to achieve statistical significance.

These preliminary results are important and have a potential impact on the practice of social citizenship in residential care. In the conceptual framework developed by Bartlett and O'Connor (2010), the authors identified six key ideas to expand thinking and practice around social citizenship, and I will discuss two relevant to the above results: (a) moving from inclusion to participation, and (b) moving from identity to social positions. The first notion—moving from inclusion to participation—focuses on the importance of mattering—that it is not enough to include residents in social events.

Merely having residents present at events does not address their right to participate at whatever level they wish and is possible for them (Bartlett & O'Connor, 2010). The idea of mentorship, however, does offer this right. Persons living in residential care settings are physically and mentally capable of participating in meaningful work. Their participation in civic duties, in this case actively helping to address loneliness and social isolation, challenges a deficits discourse. These ideas destabilize the traditional deficits-based discourse in these settings and begins to adopt an understanding that many residents are still capable and have the inalienable right as a citizen to help others. The results emphasize that despite significant physical and cognitive challenges, residents enjoyed and benefitted from their role as a mentor.

The second notion, moving from identity to social positions, challenges the idea of a fixed identity or set of characteristics and acknowledges the multiple identities or positions that residents may have. Identity has frequently been portrayed as a fixed sense of self, rather than a fluid and layered selfhood that allows for change (Sabat, 2001). Sabat (2001) describes the loss of self experienced by people with dementia, not as a result of the disease, but by their social world and how they are treated by others around them. The concern around the concept of a fixed identity is that all people have the right to change, grow and adapt. However, the status of people living in residential care as equal citizens is downgraded once they are labeled as a resident in these settings (Bartlett & O'Connor, 2010). For people with dementia, the diagnosis can supersede all other parts of their identity (Milne, 2010). The positive impact of the shift that residents made, from a receiver of care to a mentor involved in the giving of care, is reflected in their reports of feeling needed and the excitement of making a difference in

the lives of their peers. Mentors reported that being a mentor was much more than an identity, it was a social role visible to others in their community. Thus, the resident mentors were claiming their right to establish a new role alongside the staff—a role that is defined by caring for others.

There are several challenges from the staff and mentors' perspectives that would be worth addressing in future studies. Some of the reported challenges for staff were due in part to the limited resources available for this project, resulting in substantial paperwork for them. The support of staff in fostering peer mentoring is essential for the sustainability of a program based on volunteers, such as this (Persson, 2004). Other challenges included lack of time and help to facilitate the program adequately, especially for the larger mentorship teams. Thus, for a larger trial, one of the most important challenges may be providing adequate time and support for the facilitators of the program and additional research assistants to collect the data. From a pragmatic perspective, the amount of time and effort involved in facilitating the program may even be a deterrent for some long-term care homes. From the mentors' perspective, it would be useful to examine scheduling issues that were reported, explore in more depth the reasons why 20% of the mentors lost interest in mentoring, and what strategies might mitigate residents not comfortable visiting unfamiliar people. This may include finding ways to exclude residents disinterested from enrollment. Some flexibility in how the program is facilitated may be helpful in increasing the uptake among the mentors. An example would be to encourage the mentors to choose the next education module that is of most interest to them after the introductory module.

There are several limitations to this study including the lack of a control group, a small sample size, a social desirability and response shift bias for the survey questions, and a mostly highly active, female sample. As I did not have a control group, I was not able to eliminate other factors that may have impacted the change in our scores. The sample size was smaller than it could have been, and that potentially increases the Type II error and decreases the power. The positive survey findings may reflect a social desirability bias (Gittelman et al., 2015) because of the subjective nature of the measure. Although the lack of a control group raises a question about whether participants would have done better on their own naturally (maturation bias), some research has suggested that depression scores increase following admission to residential care. For example, a study investigating the changes in depressive symptoms and diagnoses after admission into long-term care found depressive symptoms were present in approximately 54% of residents at initial assessment, and that increased to 61% at three months' follow-up (Neufeld et al., 2014). Thus, the decreasing trend in the depression scores found in my study may have increased statistical significance if a control group were present. The ULS-6 scale has not been validated among people with dementia and the GDS-SF has not been validated among people with moderate to severe dementia. As most of the participants were socially active females with little or no cognitive impairment, this limits generalizability of the findings to men or people with more advanced cognitive impairment within this population.

To my knowledge this is the first study to explore the feasibility of delivering of peer support using a resident-focused team mentoring approach. The results point to a

potentially beneficial role that peer mentoring may serve in elevating citizenship among residents in these settings. The findings of this study are promising and lay the groundwork for more definitive experimental research that I hope will demonstrate a causal link between peer mentoring and mental health. Mentors, mentees and staff responded positively to the program, even while some challenges were encountered. Taken together, the significant decreases in loneliness and depression scores among mentors, and the increase in program attendance among mentees highlight the potential of this program. Indeed, these findings are consistent with previous studies that suggest being socially productive has a positive impact among older adults (Siegrist & Wahrendorf, 2009). Activities that promote socially productive roles also promote healthy aging, and this is particularly true when combined with autonomy and perceived control (Wahrendorf, Ribet, Zins, & Siegrist, 2008). As noted in the literature, losses of role in social networks and roles, reduced physical and/or cognitive abilities are significant when moving into residential care (Coyle & Dugan, 2012). The positive impact of the mentoring role on citizenship and on loneliness and depression among residents may have implications for future studies. More research exploring the role of mentoring is indicated, as this role has potential to compensate for substantial losses experienced by this population.

Chapter 4.

“It Makes You Feel Good to Help!”: The Experience of Peer Mentoring in Residential Care

4.1. Background

The aging population within residential care is growing and people living in these settings are often excluded from equal involvement in their communities. Residential care settings such as long-term care homes, assisted and retirement living, offer support for the increasing numbers of older adults living with a variety of diagnoses and health conditions. The 2016 Canadian census revealed the largest increase in older adults since the first census after Confederation in 1867, and 20% of people aged 85 years or older live in residential care, (Statistics Canada, 2017, May 17). For many older adults, the loss of independence and control is an inevitable consequence of getting older (Brownie et al., 2014). A sociological lens of social citizenship offers a unique contribution to understanding the residents' role in these congregate social environments. Citizenship as a practice is defined by relationships with others (Brannelly, 2011), and these relationships often position residents in ways that exclude them from equal involvement in social practices, equal positions and equal rights to decision making (Birt et al., 2017). In a study examining the transitions to care, residents described key determinants that impacted their relocation experience and included being able to exert control over their decisions, preserve their autonomy and

retain meaningful social relationships. However, the combination of the challenging health conditions along with the consequences of being allocated to a new lower status socially (Milne, 2010) made this difficult for residents to realise.

The impact of the negative societal responses to residents in these sittings may profoundly undermine the social and emotional well-being of residents. The mental health among persons in residential settings is of considerable concern. A Canadian Institute for Health Information study of long-term care homes (2010) found nearly half (44%) of residents had a diagnosis and/or symptom of depression. Only a small proportion of these residents received an evaluation (8.4%) or psychological therapy (2.6%) by a licenced mental health professional. Depression is linked with a list of negative health outcomes including decline in self-sufficiency and cognitive impairment (Canadian Institute for Health Information, 2010) and increased mortality (Cuijpers et al., 2013). Similarly, the prevalence of loneliness in care homes is also high. For example, in Europe the rates range from 37% to 56% (Victor, 2012), in many cases affecting over half of people living in these settings (Nyqvist, Cattan, Conradsson, Näsman, & Gustafsson, 2017). Loneliness has a strong correlation with health, even after controlling for depression and other covariates (Rico-Urbe et al., 2016). Interventions designed to increase social interactions to address depression have mixed results (Cruwys, Haslam, Dingle, Haslam, et al., 2014), and have had little effect on loneliness (Victor, 2012). Citizenship includes the ability to be connected and socially productive as an adult (Brannelly, 2011), but opportunities to do this in residential care homes are rare (Theurer et al., 2015).

Depression and loneliness have been linked with a lack of purpose and poor health, and one of the ways to increase purpose is through uniting with others. Cruwys et al. (2014) argue that loneliness and depression can result from lack of purpose. A study among community-dwelling older people found that feelings of uselessness were associated with increased mortality (Curzio, Bernacca, Bianchi, & Rossi, 2017). Conversely, a literature review on purpose and older adults found that a higher sense of purpose is associated with improved well-being and noted that fostering a sense of purpose is a particularly important but often ignored aim within aged care contexts (Irving, Davis, & Collier, 2017). A deeply entrenched tradition of providing social programs in residential care settings that are based on games, socials and bus trips designed and facilitated by staff continues (Theurer et al., 2015), and contributions by residents are often lacking (Slettebø et al., 2016). Recognizing the importance of relationships with others in solidarity to make a difference has also been noted in the literature (Bartlett & O'Connor, 2010). Consequently, uniting with others to contribute has potential to enhance a sense of purpose and meaning among residents.

There is an increasing recognition of peer mentoring as an approach to improving mental health and this approach may provide a useful structure to build the practice of social citizenship in these settings. The Mental Health Commission of Canada (2012) published a report that identified peers helping one another is an important factor to consider in the provision of mental health services (Institute of Medicine, 2012; Mental Health Commission of Canada, 2012; Pinquart, 2002). The health benefits of helping others are significant (Vaillant, 2007). In a sample of older Canadians living in the community, Theurer and Wister (2010) found that sense of

belonging was increased by helping others. Conversely, not contributing or helping others resulted in increases of impairment of activities of daily living or even death (Post, 2011; Sladowski, Hientz, & MacKenzie, 2013; Victor, 2012). Peer mentoring, particularly using a group or team approach, may have potential to fill the gap between limited mental health services (Stone & Bryant, 2012) and honour the rights of people living in residential care.

The terms *peer support* and *peer mentoring* both refer to developing empathy and support amongst peers, but our approach differs from other peer support studies in the following ways. We conceptualized peer support as an umbrella term and peer mentoring as one form that peer support can take. Peer support is defined by aspects that: (a) are based on interpersonal interactions grounded in a common experience, (b) are based on reciprocity, (c) consist of a positive social structure, and (d) include mutual sharing based on personal experience (Keyes et al., 2014). Peer mentoring has been described as empathetic peer support offered on a one-to-one basis that includes a form of guidance or advice (Dennis, 2003). Peer mentoring can include instrumental support (e.g., driving someone to a doctor's appointment or teaching someone a skill), practical advice or help, and/or social support. However, a recent study exploring the perceptions of peer mentoring amongst older adults with pain found that experiencing empathy in the encounter with the peer supporter was more important to people being supported than the practical advice given (Cooper et al., 2017).

The purpose of this study was to explore the experiences of being a mentor from the perspective of people living within residential care. The use of peer support and peer mentoring has mostly been focused on people living in the community with severe

mental illness (Joo et al., 2016), and other illnesses such as dementia (Keyes et al., 2014) or physical health challenges such as low back pain (Dennis, 2003) or chronic kidney disease (Taylor, Gutteridge, & Willis, 2016). To my knowledge, no research has explored peer mentoring in a team structure to address the rights of people living in residential care. Drawing on concepts of social citizenship, I developed a peer mentoring group approach called the Java Mentorship program that used a team focus to assist residents in reaching out and supporting their socially isolated peers. Prior to the current study, the program was piloted in a continuing care community (with assisted living, day program and long-term care) and two long-term care homes over a 2-year period, which resulted in subsequent revisions and the addition of the educational modules (see details below). This chapter describes the impact of this mentoring program from the resident mentors' perspectives.

4.2. Methods

4.2.1. Study Design and Settings

This qualitative study design consisted of individual interviews conducted with resident mentors to explore their perspectives. We examined outcomes associated with a peer mentoring program and collected the data through semi-structured, in-depth interviews. Ethics approval was obtained from the University of British Columbia Behavioural Research Ethics Board with additional permission at the research sites through the partner organization, the Schlegel-University of Waterloo Research Institute for Aging. Regarding settings, of the 13 homes invited to participate in the current study, 10 for-profit residential care homes located across Ontario, Canada agreed to

participate in this project. Of these, five were long-term care homes and five were continuums of care that included long-term care, assisted living and retirement services.

4.2.2. Eligibility and Recruitment

Residents who were able to speak and understand English and comprehend simple instructions were eligible to participate in the study as resident mentors. Exclusion criteria included residents on temporary care respite stays and people who were acutely ill. Recruitment of the mentors at each site was facilitated by research assistants and staff. Study advertisements were posted, and staff made personal invitations to residents. Once residents agreed to participate, research assistants checked to ensure that they fit the criteria. Interested residents were asked to commit to: (a) participating in the weekly mentorship team meetings and conducting supportive visits with their peers over a 6-month period; and (b) completing the consent process and questionnaires over three time-points and doing a survey at the end of the study. In addition, among the 48 participating mentors a subsample ($n = 8$) were asked to complete an individual interview at three months after the start of the program to understand the workability and sustainability of the program and gain insight into mentors' experiences and perceptions (Appendix F). This time period was chosen as I thought that after three months the attrition rate would be less than at six months, but the resident mentors would still have gained enough experience with the program to share their experiences. This was primarily a convenience sample selected because of the resident mentors' availability, accessibility and ability to participate in a longer interview. Staff members at each site who were familiar with the residents' cognitive abilities determined which residents were able to provide their own consent and which

residents were willing and able to participate in the in-depth interviews. Institutionally recognized surrogate decision makers (e.g., the resident's spouse, adult son, daughter, brother, sister, adult grandchild, close friend or guardian) provided consent for the resident mentors deemed unable to provide informed consent independently. Assent was obtained for residents whose consent had been obtained from a surrogate decision maker.

4.2.3. Structure of the Program

Java Mentorship is a program in which volunteers (e.g., volunteers and family from outside the residential setting, i.e., community mentors) and resident volunteers (from the home, i.e., resident mentors) met regularly as a team and provided visits to residents who were lonely or socially isolated (i.e., mentees). Some of the resident mentors had dementia and these mentors were paired up with community mentors who provided needed support.

4.2.4. The Program Process and Components

The program consisted of two components: weekly team meetings and dyadic visits with mentees. The mentorship team meetings followed a structured format that included ongoing education provided by the program facilitators, discussion of residents who would potentially benefit from visits, and support and recognition activities for the mentors. There were 26 education modules that included topics such as how to be an effective mentor, how to engage passive mentees who did not speak much or did not want to leave their room, and how to support someone who was grieving. The mentors received large shoulder bags for the visits that contained materials such as a visiting

guide, themes for discussion, readings and treats. During the visits, mentors offered support and encouraged mentees to participate in programs that would help enhance social connections with their peers. Examples of specific mentoring actions mentors learned during the team meetings included creating a brief life story to build rapport with the mentee, identifying values that matter to the mentee and any related barriers to those values, helping them re-frame a problem, and most importantly, inviting them to a peer support group being offered in the home to build connections with other residents.

The program was structured to be sustainable and provide ongoing support for both the mentors and the facilitators. To strengthen sustainability, the program included periodic appreciation activities, such as quarterly mentors' celebrations along with the presentation of a mentor's certificate. The team meetings were led by recreation staff or a volunteer coordinator (i.e., the facilitator) who offered 15- to 20-minute education modules using a guide and program materials provided (e.g., handouts for mentors). The facilitator's guide outlined suggestions on how to recruit mentors, how to match mentors and mentees and different approaches for the mentors' visits. Facilitators were trained before the project began to keep the structure of the program and the education modules consistent across the participating sites.

4.2.5. Data Collection

Resident demographic data (sex, age, education) and clinical background data including functional abilities (visual and hearing impairment and mobility assessed by staff), social attendance (number of programs attended per month) and Cognitive Performance Scale levels (Paquay et al., 2007) were extracted from resident charts.

Two trained research assistants from the research institute collected data with assistance from staff, completed data entry and conducted five of the eight interviews. I conducted the remaining three interviews.

The interview guide included questions that encouraged residents to describe their experience. Question examples included: What has it been like for you being a participant in the mentorship program? What do you think about the education portions of the team meetings? What has it been like for you to go on the visits? Have you had any challenges during the visits? Do you have any suggestions about how we could improve this program? Interview questions described above were intended as a probe to generate conversation and were intentionally open-ended. I held monthly project meetings with the research assistants and staff throughout the data collection process to provide support and answer questions.

4.2.6. Data Analysis

The mentor interviews were recorded and transcribed verbatim and lasted an average of 45 minutes to an hour each. Data analysis proceeded inductively, starting with the mentor's experiences, and through an iterative process moved towards a bigger picture in the form of important commonalities and patterns that emerged across the interviews. Using a framework established by Ritchie and Spenser (1994), I conducted a thematic analysis. These stages included becoming familiar with the interview transcript data, identifying a thematic framework (beginning development of categories and coding), and making comparisons within and between themes, identifying or lifting quotes and re-arranging them, and finally, interpreting the overall

data. A 4-member analysis team¹ reviewed a sample of transcripts independently, then employed a consensus-based process to identify codes and final themes.

The analysis team used triangulation and reflexivity to provide a well-developed account—robust approaches that have been identified in the literature (Denzin & Lincoln, 2005). I used more transcendent standards not associated with a specific paradigm as suggested by Morrow (2005), including social validity, subjectivity and reflexivity, adequacy of data and interpretation. The first approach, triangulation, involved the use of multiple analysts to review the findings and compare and check data collection and interpretation. Having four team members interpret the findings provided a check on selective perceptions and helped to clarify the analyses. The second approach, reflexivity, helped me as the first author to examine how my bias, values, beliefs and experiences may have influenced the research. I kept a reflexive diary, documented insights, assumptions (see below) and prior beliefs using interview notes that influenced the way data were read, analysed and written up (Hesse-Biber & Leavy, 2006). One assumption I held was that people living in residential care are capable of growth, and that they strengthen their own well-being when they support and encourage others. The program materials reflected this assumption. To deal with this, I actively looked for negative cases, probed for alternative explanations rather than only accepting those that were congruent with the assumptions. As I developed the program and worked as a therapist for many years in these settings, it was important to be aware of the relationships between the residents and my dual roles as a staff and a

¹ Kristine Theurer, with Drs. Ben Mortenson, Melinda Suto, and Dr. Virpi Timonen, who have expertise in qualitative methodology.

researcher. For example, the advantage of this experience is that I had an insider's trust and understanding. The disadvantage is that at times I made personal assumptions. For example, because I had already informally piloted the program, I assumed that staff and mentors would implement the program as it was laid out in all the sites. In analyzing the data, it was a challenge to not force fit what happened to what I hoped would happen. In addition, I recognized the need to consider both sides when presenting findings, rather than focusing on positives. Other research team members corroborated or refuted the conclusions reached. Thus, the use of multiple analysts to review the findings, reflexivity and interview notes, all strengthened the analytical process and helped support the trustworthiness of these findings (O'Brien, Harris, Beckman, Reed, & Cook, 2014).

4.3. Results

Eight resident mentors across eight different homes agreed to be interviewed at the 3-month time line. I examined these mentors interviewed versus mentors not interviewed (Table 4.1) and found no statistically significant difference between two subgroups in any characteristics except for level of education ($p = 0.04$). People interviewed had a higher level of education (the majority have college) compared to people who were not interviewed (mostly high school and elementary school).

I identified three overarching, inter-related themes from my analysis of the mentors' interviews. *Helping others, helping ourselves despite challenges* described the residents' experiences of adopting the new role of a mentor. *Building a bigger social world* revealed how the mentors developed connections and fostered new peer

relationships within their communities. *Teamwork is better* described developing relationships among the mentors and illustrated how mentors learned as a team to deal with challenges encountered. I begin each theme below with a description of the interview findings. The quotes below are verbatim except where clarification is needed. Pseudonyms have been given to preserve anonymity of the participants.

Table 4.1. *Comparison Between Subgroups of Resident Mentors:
Those Not Interviewed (n = 40) Versus Those Interviewed (n = 8)*

Resident Mentors' Characteristics	Not Interviewed (n = 40)	Interviewed (n = 8)	Comparison Test
Age, years (Mean \pm SD, range)	81.52 \pm 11.55, 50 to 100	77.86 \pm 18.05, 40 to 94	$t(44) = 0.71, p = 0.48$
Sex			$\chi^2(1) = 1.37, p = 0.24$
Male	4 (10%)	2 (25%)	
Female	36 (90%)	6 (75%)	
Level of Education			MW $U = 31.50, p = .47$
Elementary School	8 (21%)	1 (12%)	
High School	18 (46%)	2 (25%)	
College Program	5 (13%)	5 (63%)	
Undergraduate	6 (15%)	0 (0%)	
Master/Doctorate	2 (5%)	0 (0%)	
Number of programs attended per month, at baseline (estimated Mean)	10.29	12.00	MW $U = 98.00, p = .12$
0-1	3 (8%)	0 (0%)	
2-4	0 (0%)	0 (0%)	
5-6	0 (0%)	0 (0%)	
7-8	6 (15%)	0 (0%)	
9-10	2 (5%)	0 (0%)	
More than 10	28 (72%)	7 (100%)	

Note. MW = Mann-Whitney.

4.3.1. The Themes

Helping others, helping ourselves despite challenges. Mentors reported a variety of personal benefits that ranged from personal positive feelings arising from their

service to benefits they noticed in people visited. Cheryl, an 81-year-old resident living with mild dementia, for example, noted positive changes in herself: “It helped me with my confidence. It made me feel like I was needed. It makes you feel good to help!” This feeling of being needed was in marked contrast to the experience that Liza, a much younger 40-year-old resident with cerebral palsy, had with other programs:

The rest [other programs]—I’m not taking part in them, I’m listening to somebody else [the staff] do it [run the programs]. So, I appreciate that, um, and plus I feel I’m adding something with this program, I’m helping them. It makes me feel like I’m a different person.

Some mentors described the benefits of being a mentor as reciprocal. Cheryl stated, “Well, and what feels so good about it . . . I feel like we’re adding to their [other residents’] experience and it makes it better for them. And by doing that it makes it better for me.” Mentors indicated that through tending to their peers, they felt they were receiving help themselves. For example, Melody, an 81-year-old resident pointed out, “It’s important [helping them] and helping people that are lonely—including me.”

Mentors encountered challenges from time to time in connecting with people they visited. For example, occasionally mentees were not interested in a visit or were asleep. William, one of the few male mentors commented, “One of the challenges is always being engaged in conversation and if the mentee doesn’t want you to come in and stay with them.” Being prevented from carrying out a visit by staff when a mentee was asleep, resulted in a strong emotional reaction in Liza:

Sometimes when I go there the nurses tell me he is asleep. But I don’t know. I know he needs his rest, but I want them to realize that I have to take care of him when it’s his day, right. So, he stays in his room and he doesn’t do nothing about me. He doesn’t know nothing about me.

In addition, mentors shared similar concerns that sometimes mentees were passive during the visits, either watching TV or not actively participating. Although the mentors expressed some frustration around these challenges, they also talked about finding solutions to these challenges during the team meetings. Mentors gave one another suggestions and advice for alternative approaches during the meetings (e.g., changing the scheduled time to when the mentee's favorite TV show was not on).

Mentors also expressed a sense of enjoyment and gratitude that came from participation in the program. Hillary, a 60-year-old resident with multiple sclerosis spoke of her participation in the following way: "I was very flattered that they asked me. I'm just . . . thankful that I was asked to do it." Liza, who had lived at home for over 10 years, expressed a sense of pride, "He [the mentee] makes me happy each time I do it—'cause I am his mentor." Ella, a 77-year-old mentor with early stage dementia stated, "It's the best thing to do. It's very good—I love it. I like the people and I can hardly wait to come every week." The role appeared to enhance the resident mentors' sense of pride and appreciation through the connections built within the team and people visited.

Building a bigger social world. In their interviews, mentors talked about new connections developed with people they visited—how it broadened their world. Karen, a 91-year-old resident, noted her excitement about the developing friendship with people she did not previously know and stated: "It's been a thrill . . . when you first go in, they're, we're strangers . . . [and now], they're like our old friends." She continued, "I think it benefits them in that it opens up their world a little bit. Um, it's not just their world, it's ours. They share with us their family and their kids and it just makes it a bigger world." Mentors observed positive responses of the mentees during the visits.

These responses from mentees had an impact on them. Cheryl stated, “. . . they’ve been happy to have us there. Uh, seem to be happy to share their room and happy to know that we’re coming in to visit them.” Mentors expressed enjoyment in these connections and being able to help people they visited. For example, Hillary, commented, “I enjoy sort of pulling them out of themselves. You know they’re sometimes mentally in a small space. And when you, somebody goes in to visit, it pulls them out of that little small space.”

Mentors broadened their world with people they visited outside of the mentorship program times. Liza pointed out, “I really like it. It’s good, in fact he [a mentee] eats at the next table from us. So, every time we go by him we’ll say hi.” In this way mentors described how their social world became larger and that the connections with people they visited also extended beyond the formal visits, even with people that were not *their* mentees. Karen, for example, hesitantly described to me the regret she felt concerning a table-mate with dementia that she had sat beside at mealtimes for several years—that in the past she rarely made an effort to speak to her. She elaborated in her interview:

I’ve been at lonely stages in my life. And I could feel for them. I practice at my table, this one resident . . . I practice on her too. Because, just to have her respond, she’s there, she’s not going to keep her eyes shut [and not speak with us]. And . . . so I use it [mentoring skills learned] separately.

Since becoming a mentor, Karen found it fulfilling to practice her newly-learned communication skills with her long-time table-mate.

Teamwork is better. This theme revealed developing bonds between mentors and illustrated how mentors learned as a team to deal with challenges encountered.

Mentors described team meetings as a combination of camaraderie, a space for learning that benefitted them personally and on visits, and a place to address problems that arose. Hillary noted the strong bonds that formed between mentors and her enjoyment of the learning processes that happened during the meetings.

It's being like family. And we have a time of learning something about ourselves. Oh, I do [enjoy the meetings]! I think they're a good draw that they put us into focus before we go to visit the people. And it's nice, it's always nice to learn something new.

The initiation ceremony of new incoming mentors and some of the specific educational techniques had a positive impact on Hillary. "The role-playing . . . I find the best. And I thought it [the initiation ceremony] was very encouraging. I was really excited." Although mentors experienced difficulties, they felt they could safely share these challenges during the team meetings. Mary, who had early stage dementia, stated, "You discuss everything and, and maybe a problem hit [you encounter a challenge], that you know, you lost contact . . . everything was discussed." Thus, the mentors' reports indicate that teamwork was better than doing it alone in terms of learning mentoring techniques, receiving support and in finding solutions to problems.

Mentors also encountered challenges regarding scheduling, visiting spaces, and health issues. Karen found the evening time for team meetings selected by her home difficult as she was often tired after dinner. However, she continued to participate and explained that the evening time was chosen as volunteer mentors from outside the home were not able to come during the day for team meetings. She stated, "I just . . . I just wish we had a different time schedule, but it's impossible. Right now, anyway." The small spaces in private rooms were challenging for some to negotiate during the visits.

Karen described her own health as a barrier to visits as she suffered from rheumatic fever, saying that she was not always able to participate in the team meetings on Saturdays. However, Karen stated that she compensated for this by conducting additional visits during the week when she felt stronger. Thus, these three themes highlight the benefits of engaging residents as active contributors, the potential this role has in advancing their social identities and bringing connection and purpose to their lives.

4.4. Discussion

The aim of my study was to explore peer mentoring as a form of active social citizenship among people living in residential care and describe the impact from the resident mentors' perspective. To my knowledge this is the first study to explore a peer mentoring approach using a team structure and the practice of two-to-one visits—that is, two mentors pairing up to visit another resident. It appears the challenges the mentors experienced did not detract from the satisfaction the role brought them. The beneficial effects of giving have been described by others examining the ability of residents to contribute (Yeung et al., 2012), and finding meaningful social roles (Skrajner et al., 2014). Mentors described the importance of their shared experiences as mentors and how being a mentor brought meaning to their lives, as has been identified by others (Greenaway, Cruwys, Haslam, & Jetten, 2015). One of the unique aspects of the program was that mentoring took on a variety of forms including offering empathy and emotional support, as well sharing of wisdom and experience, guidance and learning opportunities—but did not extend to instrumental support (e.g., shopping).

This study illuminated three themes in the interviews with the resident mentors. First, the theme titled *Helping others, helping ourselves despite challenges* detailed the residents' experiences of adopting a new role of a mentor. It was clear that the overall impact of the role was positive and affected the residents on a personal level. Research suggests that purposeful social interaction in groups brings meaning to social life (Knight et al., 2010). It is possible that the adoption of a role that is focused on helping others within a group setting may be particularly important to residents, as it offers them a new identity. Indeed, there were specific activities built into the team meetings to strengthen this identity, such as receiving name badges that identified them as a mentor, receiving certificates and participating in ceremonies. The mentors described the ceremonies as enjoyable and having a sense of pride in their role. Furthermore, mentors talked about feeling different as they took on the role, and how they experienced personal benefits, such as feeling less lonely. There were challenges encountered during the visits, however, sharing the challenges at team meetings and finding solutions during the team meetings was helpful to them. Prior studies indicate that having a purposeful role and helping others is influential in how well individuals adjust to living in residential care (Brownie et al., 2014), and thus the impact of this role may be worthy exploring in future research.

Despite challenges encountered, the second theme *Building a bigger social world* revealed how mentors used their role to connect with and support their peers in new ways. Staff as experts often assume that residents are incapable of providing care and this habitual practice can silence residents (Timonen & O'Dwyer, 2009). The findings reveal how mentors actively used their role to be a provider of social support

and to develop mutually beneficial relationships. Witnessing the resident mentors in action, particularly persons with dementia, has the potential to influence how staff, family and the community view them, thereby having potential to combat the stigma associated with being a recipient of care. In my study, persons with dementia were able to participate as mentors as they were supported by another resident or a volunteer. This is an important finding. Residents as active contributors, caring and nurturing their peers, reflects a new role and may help to reduce associated ageist stigma in these settings.

The third theme, *Teamwork is better* illustrated how mentors learned together and as a team worked through challenges encountered as they sought to build trusting relationships with the people they visited. The value of providing opportunities for growth and connectedness for people living in residential care has been identified (Wilby, DuMond Stryker, Hyde, & Ranson, 2016). As mentors were trained to share what they learned in team meetings with the mentees, the program also offered participants additional opportunities to learn through teaching during the visits. This provides support for the value of offering authentic and practical opportunities for residents to identify and live their desired social identities (Haslam et al., 2017), such as becoming a mentor and offering support to others. Indeed, becoming actively engaged within a community can impact life transitions of residents when a loss of identity is experienced, such as moving into a care home (Knight & Sayegh, 2011). Providing a structured format for residents to engage in learning and helping others may be a way to meet a significant unmet need among people living in these settings. There are two key concepts within the conceptual framework offered by Bartlett and O'Connor (2010)

that are useful in discussing the above results: (a) moving from a sense of attachment and relationship with others, to solidarity—uniting with others to make a difference; and (b) moving from doing things to stay occupied, to doing things with meaning and purpose. The first concept, uniting with others, is illuminated by the reports of the mentors describing their enjoyment of the bonding that occurred among them during the team meetings. Attachment to others is an important component of a good quality of life (Kurusu et al., 2016), yet is not in and of itself enough in the context of residents as active social citizens (Bartlett & O'Connor, 2010). However, this attachment helped to move the mentors from a focus on positive relationships to solidarity—a shift in focus to their self-identified role as a group of united citizens to help others. The idea of solidarity has been identified as a necessary component of healthy communities that requires united action to help society progress (Thake, 2008). Despite being recognized as an important way to improve well-being, residents are less likely to be offered opportunities to unite and participate in civic engagement (Leedahl, Esllon, & Gallopyn, 2017). Civic engagement has been defined as “activities of personal and public concern that are both individually life-enriching and socially beneficial to the community” (Cullinane, 2006, p. 66). A denial of opportunities to participate in these activities is a denial of rights. While civic engagement such as voting is not feasible for some residents, other forms are possible. One example is participation in resident councils. While many homes have resident councils empowered to promote standards of care (O'Dwyer & Timonen, 2010), residents may find themselves dealing with complex communication barriers and struggle to make changes due to power differences and symmetric relationships (Baur & Abma, 2011). Civic engagement, however, can also happen on a grass roots level among residents, such as the formation of a mentoring team.

Participation in the mentorship program may facilitate a sense of solidarity among the mentors more broadly—through relationships among the mentors and relationships between the mentors and people they visited.

The second concept, doing things to stay occupied versus doing things with meaning and purpose, played an important role in what motivated the mentors. Mentors described their gratitude for being needed and having a sense of pride in their role. Activities that focus on simply doing things to keep busy can drive artificial social environments (Bartlett & O'Connor, 2010). The focus of recreation therapy in the biomedical residential care environments is on prescribing, assessing, monitoring and documenting the leisure time of residents using the expertise of the recreational therapists (Dupuis, Whyte, et al., 2012). Thus, the treatment prescribed is often based on little or no input from the residents. While some of these activities offer enjoyment, they are narrowly defined. Supporting meaning and purpose has been identified as an important aspect of everyday life (Drageset et al., 2017). Yet many activities focus on receiving rather than giving. In addition, typical social calendars do not offer opportunities to engage in purposeful activity (Theurer et al., 2015). Giving or volunteering has been associated with mental health benefits such as higher levels of mental well-being, particularly among older adults above the age of 70 years (Tabassum, Mohan, & Smith, 2016). Consequently, the purposeful helping behaviour exhibited by the mentors may have provided a sense of meaning and contributed to mentors' sense of well being. When residents are helping their peers, they are likely providing the psychosocial support that staff often do not have the time to give.

There are three major study limitations to consider: (a) researcher and social desirability bias, (b) sampling limitations, and (c) reliability of the data collected from people with cognitive impairment. First, as I developed the peer mentoring program and conducted some of the interviews, a researcher bias and social desirability bias of the mentors may have influenced both the interviews and the analysis. Second, the small convenience sample is due in part to challenges and lack of resources encountered in collecting the data. The 10 sites were scattered across a large geographical region and data were collected over the winter months when travel was difficult. Therefore, due to pragmatic reasons saturation could not be achieved, and the interviews were completed by the research assistants and me as needed. It would have been helpful to interview more of the residents who were male and/or who had dementia in order to gain greater insight into their perspectives. Thus, the interviews only included residents who stayed on as mentors rather than residents who withdrew, which is an identified sampling limitation. Third, there is evidence that people living with mild to moderate dementia are able to reliably answer questions relating to feelings (Trigg, Jones, & Skevington, 2007), and we took a variety of steps to present the questions to achieve maximum opportunities for participation. For example, the text (e.g., answer categories) was presented to participants in clearly written language and in large font-sizes, and participants were given extra time to consider and provide answers.

This study lays the ground for future research in this area. Future research could include comparisons within and across sub-groups (e.g., different cultural groups, dementia-non-dementia, women-men), which may help us understand what is unique to or transferrable across groups of residents. In addition, future ethnographic studies

could help to capture the emotional connections that are made as well as identify possible differences between what mentors say they do and what they do. It is noteworthy that people interviewed had higher levels of education than people who were not, and future research could explore the impact of the potentially different mentoring styles between these two groups. Finally, experimental research is needed to evaluate the efficacy of this approach within residential care.

Despite the study limitations, findings indicate that it is possible for residents to engage as a team of social citizens in solidarity to provide support to their lonely or socially isolated peers. My research suggests that with a consistent, structured mentoring program in place that includes education, residents may feel more prepared and confident to contact their peers. By providing staff with training and education modules, peer mentoring can be fostered even among resident mentors with moderate cognitive impairment. This lends support to previous research that found that residents with cognitive impairment are capable of engaging in supporting their peers within peer support groups (Theurer et al., 2012). The current study expands on that concept of peer support with an innovative structure that enables residents to focus on actively engaging in peer mentoring by reaching out to residents that do not typically attend programs.

With a growing older adult population and increasing mental health issues, finding alternative approaches to supporting the social citizenship of residents is critical within residential care. Although further research is required, peer mentoring then may be an approach that can help to reduce the substantial medical and human costs associated with loss of purpose, loneliness and depression. Enhancing the social roles

of residents as citizens has considerable potential to mitigate the ageist social discourses surrounding people living in these settings. Importantly, it can provide residents with opportunities to use their skills and build a life with value, purpose and meaning.

Chapter 5.

The Impact of Peer Mentoring in Residential Care on People Visited: A Mixed-Methods Exploratory Study

5.1. Background

The terror of sickness and old age is not merely the terror of losses one is forced to endure but also the terror of isolation. As people become aware of the finitude of their life, they do not ask for much. They do not seek more riches. They do not seek more power. They ask only to be permitted, insofar as possible, to keep shaping the story of their life in the world—to make choices and sustain connections to others according to their own priorities. In modern society, we have come to assume that debility and dependence rule out such autonomy. (Gawande, 2014, p. 146-147)

Lillian (a pseudonym) is a 94-year-old retired art history teacher living with dementia in a large long-term care home. This home appears to be a lively place—the entrance wall features a social calendar filled with events for every day of the week. Residents are often found sitting and chatting in the entrance way and bingo happens three times a week in the next room. As a study participant, Lillian was asked how she was doing, and she shared her feelings of loneliness and depression. Lillian said she had no interest in the activities offered and that she preferred to stay alone in her room. In the basket of her wheelchair sat a black stuffed dog, whom she introduced as her only friend. She claimed that, as a teacher, the activities in the home were beneath her, and went on to say that she was keeping all this to herself—“But no-one should suffer alone like this, no-one.” Lillian’s description of loneliness highlights growing concerns

about social isolation and exclusion experienced by people living in residential care settings. I will reflect on her story later in the chapter.

The aging population is growing rapidly and the opportunity to engage as a citizen on one's community has been identified as an important way to improve quality of life. Globally approximately 11% of the population between the ages of 80-89 years of age are living in residential care settings, such as long-term care, assisted living and retirement homes (Malmedal, 2014). People living in residential care, such as Lillian, are thought to be recipients of services (Leedahl et al., 2017). Consequently, these homes provide limited opportunities for meaningful social engagement (Meeks & Looney, 2011) or civic duties such as helping one's neighbour. Age discrimination and the stigma of being a resident represents an important part of the story. For residents living with dementia, there is the impact of negative responses to the diagnosis by people around them along with self-stigmatization absorbed by the residents, resulting in a withdrawal from social life (Milne, 2010).

Loneliness and social isolation are complex constructions and have been defined in many ways throughout the literature. While loneliness has been described as a subjective emotional state, social isolation is described as a more objective state of few social contacts (Ong, Uchino, & Wethington, 2016). Loneliness has also been defined as a mismatch between the social needs of an individual and what their social environment seemingly offers (Hawkey & Capitanio, 2015). Thus, one may have frequent social contact with others and still experience loneliness (Theurer et al., 2015). A group living setting does not necessarily mean that the need for meaningful social connections is guaranteed—at the same time, a person who appears isolated might not

experience loneliness (Newall & Menec, 2017). Loneliness in residential care homes continues to be of significant concern. Loneliness is common in care homes (Nygqvist, Cattan, Andersson, Forsman, & Gustafson, 2013), assisted living (Tremethick, 2001) and in retirement homes (Bekhet & Zauszniewski, 2012). Admission to residential care is often preceded by changes in health, loss of a spouse, increased cognitive impairment or the need for help with things like bathing, meal preparation and ambulation (Gaugler et al., 2007). These losses can be profound and impact the ability of residents to adapt to a new way of life and a new social network. As an example, in a study that examined the association between loneliness and social support among people living in care homes in Norway, 56% reported that they sometimes felt lonely (Drageset, Espehaug, et al., 2012). Although the rates vary from country to country, reports of severe loneliness are more frequent for care home residents than for community-dwelling older adults (Victor, 2012). Residential care homes can be difficult places to build friendships and maintain relationships that move beyond casual greetings. In a study examining residents' relationships with others, Bonifas et al. (2014) found that while the care home offered programming to foster social connections, residents reported that these connections were superficial and unsatisfactory as the programs did not allow them to build solid relationships with their peers. Slettebø (2010) explored the experiences of people living in care homes in Norway: residents reported the worst part of living there to be loneliness and lack of companionship. The impact of the lack of meaningful social connections on health is severe. Loneliness has been linked to a number of mental and physical outcomes. As loneliness and depression are linked (Barg et al., 2006), these outcomes are of critical concern. Social isolation is associated with dementia, depression and cognitive decline (Global Council on Brain

Health, 2017) and with early mortality (Holt-Lunstad, Smith, Baker, Harris, & Stepheson, 2015). Lack of social connections, lack of participation in groups and fewer friends are risk factors for loneliness (Holt-Lunstad et al., 2015) and this is particularly concerning within residential care. Slettebø (2010) explored the experiences of people living in care homes in Norway, and residents reported the worst part of living there to be loneliness and lack of companionship.

5.1.1. Conceptual Foundation

Social citizenship is a relevant construct that has been increasingly used to understand the experience of dementia (Wiersma et al., 2016), but can be applied to the experience of all persons living in residential care. Social citizenship has been described as “the rights and duties associated with the provision of benefits and services designed to meet social needs and enhance capabilities...” (Taylor-Gooby, 2008, p. 3). However, a tendency to deal with safety first due to fear of litigation prevails (Park, Zimmerman, Sloane, Gruber-Bladini, & Eckert, 2006) and as management in these settings take responsibility and control over residents, their sense of independence and autonomy erodes (Haslam et al., 2010). Turner’s (1993) contention that citizenship is a “dynamic social construction” (p. 3) is a useful notion that can help re-shape the helplessness discourse prevalent around people living in these settings. Utilizing the concept of citizenship beyond the political sphere provides an opportunity to explore ways in which citizenship as a practice can enhance the lives of people who are socially disengaged in these communities (Birt et al., 2017).

One of the ways that social citizenship can enhance the lives of residents is through an opportunity to grow. Residents who typically spend a lot of time in their rooms are often offered comfort care. While being comfortable and having a sense of security is vital (Ryan, Nolan, Reid, & Enderby, 2008), having a structure that fosters development, growth and learning opportunities matters (Bartlett & O'Connor, 2010). Caring and compassion are common traits exhibited by staff (Thomas, 2006). Yet Bartlett and O'Connor (2010) describe the discrimination associated with the concept of caring and comfort and the closely related concept of love, which can manifest as control. The very actions of caring for someone can contribute to disempowerment. There is a need to provide care while at the same time allow residents to look after themselves (Haslam et al., 2010) and one another (Theurer et al., 2012). To be free from discrimination and to have opportunities to grow and support is the right of all citizens, including people who stay isolated in their rooms. Activity calendars in residential care homes offer social programming designed to address social domains, but other than resident councils, rarely offer opportunities for residents to contribute. Activities are typically light social events based on entertainment and distraction (Theurer et al., 2015). Light social events refer to large gatherings such as socials, entertainment, games such as bingo and scenic bus trips. Conversations at these group events tend to be kept on a surface level. While these programs are enjoyable for some, they are not a place where individuals can easily contribute as a citizen, share concerns or develop meaningful relationships. Indeed, it is possible that the ongoing activity programming that focuses on entertainment and large social events actually contributes to loneliness, as it masks an emptiness of meaning (Katz, 2000).

Having relationships with friends who share similar experiences has a significant impact on loneliness for residents that are physically dependent as well as people living with cognitive impairment. Moving into a residential care home—whether long-term care, assisted living or retirement—conceivably offers multiple opportunities for increased relationships with others. However, literature suggests that developing quality relationships in these settings is difficult. Despite the available social programs and support from staff, many residents are still lonely (Drageset, Espehaug, et al., 2012). For example, a study in a care home in Italy revealed that admission to the home resulted in a worsening of perceived quality of life, feelings of loneliness and marginalization (Scocco et al., 2006). Victor (2012) posited that the failure of loneliness interventions reflects the gaps in our understanding of specific factors linked with changes in loneliness. Gatherings without long-term obligations do not result in reduced loneliness (de Jong Gierveld et al., 2017). Protective factors may be not the number of social contacts but the quality and length of engagement with these contacts. In the following section we review the systematic development of long-term supportive peer relationships—an approach to enhancing social citizenship and both loneliness reduction and loneliness prevention.

5.1.2. Peer Mentoring

The concept of mentoring is typically understood as a relationship in which an individual with more experience provides support for someone with less experience. Traditional mentoring, however, can unintentionally foster hierarchical power relationships. An example might be a resident with a medical background (e.g., a former nurse) coaching another resident on specific wellness activities. While the activities may

be helpful, this unequal relationship has potential to result in feelings of self-doubt and loneliness (Driscoll et al., 2009). Driscoll et al. (2009) proposed that peer mentoring, where the relationships are equal and collaborative, may be a useful alternative. Peer mentoring may vary in format, such as small groups, one-to-ones or by telephone, and can take many forms, for example, support for new students in academic settings (Raymond & Sheppard, 2017) or as a support system for people living with a chronic disease (Embuldeniya et al., 2013). Peer mentoring and peer support are used interchangeably and are inconsistently defined in the literature. For the purposes of my study, peer mentoring is support offered to peers that includes the provision of ongoing emotional support or empathy as well as guidance or advice between peers (Dennis, 2003). Unlike traditional mentoring, the objective is not to achieve a goal and then end the relationship, but rather the development of close meaningful relationships and increased connectedness within a community (Raymond & Sheppard, 2017). While peer mentoring (Institute of Medicine, 2012) has been examined among older adults in the community (presented earlier in this dissertation), to my knowledge this approach has not been examined among people living in residential care settings. This chapter will explore the impact of the mentoring program on mentees' loneliness, depression and social citizenship and describe their perceptions of the visits. I hypothesized that by participating in this mentoring program, people being visited would report reduced loneliness and depression, and an increase in social engagement as citizens in their communities. I used qualitative data to illuminate processes involved.

5.2. Methods

A mixed-methods approach was selected that included collecting, analysing and integrating quantitative surveys and qualitative interviews to help me provide a better understanding of this mentoring approach and a more robust overall explanation of results (Clarke, 2009). I partnered with the Schlegel-UW Research Institute for Aging to facilitate access to these research sites and received ethical approval from the University of British Columbia Behavioural Research Ethics Board to conduct the study.

5.2.1. The Peer Mentoring Program

I developed the mentoring program as a structured way for residents to engage in active citizenship by participating in a team that meets regularly to engage and provide support to their peers. The program consisted of a 2-hour activity that included: (a) weekly supportive team meetings with short educational sessions for residents and volunteers (mentors); and (b) visits conducted by mentors in pairs with people identified by the team as needing support (mentees), examples include a new resident, people socially isolated who do not typically attend programs, or people just back from the hospital. Recreation or volunteer staff led the program using a facilitator's guide that included instructions on how to set up a mentorship team, a guide to leading team meetings and education or training modules.

The training offered at the team meetings consisted of 26 education modules that ranged from learning communication skills to topics such as "What if They Don't Talk Much," or "Supporting People Grieving." As an example, the "How to Move from Pity to Partnership" learning module included a review called "Is our helping, helping?" in which

mentors explored how to support their peers in a collaborative way that moved from one-way giving to reciprocal learning approaches. Another example of this collaborative form of mentorship was an education module on how to use a *practice of gratitude* to maintain well-being (Killen & Macaskill, 2015). Mentors learned about the benefits of discussing and writing down three things they were thankful for during the team meetings, and then offering a gratitude practice at the end of each visit. During these visits, mentors invited mentees to complete the gratitude practice along with them, thus learning and growing together as equals. Visiting in pairs made it possible for resident mentors living with dementia to participate (as community mentors assisted resident mentors as needed) and was designed to increase the chances of positive relationships developing between the mentors and mentees. Visiting times were flexible, as were the number of visits conducted each week (i.e., some mentors visited more than one resident each week). Visits were usually conducted immediately after the team meetings, but also at other times when mentors were available.

5.2.2. Study Procedures

Quantitative outcome data for mentees were collected at baseline and after 6 months of participating in the program. (In the previous chapters we examined the outcomes of the peer mentoring primarily among mentors, and this chapter focuses on the mentees.) The primary outcome measure for mentees was loneliness, and secondary outcomes included measures of depression and program engagement. A record of attendance by the mentees at other activity programs was kept by staff facilitators. Due to limited resources, structured interviews with targeted questions were conducted by research assistants of a smaller convenience sub-sample of mentees

after four visits (Appendix G). This short time frame was chosen due to the anticipated high attrition rates among this population. The mentees were selected based on availability and ability to participate verbally in an interview. Questions were asked about their perceptions of the visits, the kinds of things that were done (e.g., readings or discussion), whether the mentors shared about themselves or issued invitations to attend a program with them, and if they wanted the visits to continue. Most questions were intended to be used as probes to generate conversation, for example, “What was it like for you to have [name of mentors] come and visit you?” and “What kinds of things did you do during the visits?” Staff assisted by providing prompts to answering the interview questions for mentees who had difficulty communicating verbally. For example, they would remind the mentees of who the mentors were that had visited them.

5.2.3. Eligibility and Recruitment

The facilitating recreation or volunteer staff along with the mentorship team created a list to recruit mentees for this study. Inclusion criteria consisted of residents with a specific need (e.g., a recent bereavement or change in health status), people bedridden, and/or people with lower levels of social engagement, i.e., people with lower than average programs attended per month (defined as six programs or fewer by these homes). People on temporary respite were excluded. Research assistants assisted with signing consents. During the informed consent process, mentees agreed to: (a) visitation from two mentors on a weekly basis, (b) a brief interview after four visits, and (c) questionnaires at baseline and at 6 months. For residents unable to provide their

own consent and people that required ongoing assent, surrogate decision makers—typically family members—were used.

5.2.4. Descriptive Measures and Covariates

For descriptive purposes, I collected demographic characteristics and functional abilities for all participants, including age, sex, education, number of activity programs attended and functional status. The participants' Cognitive Performance Scale levels (Paquay et al., 2007) were extracted from resident charts at the beginning of the study.

Primary outcome. Loneliness was evaluated using a brief version of the UCLA Loneliness Scale (Russell, 1996), called the ULS-6 (Neto, 2014). The scale consists of six questions with a rating on a 4-point Likert scale (1 = never, 4 = always) with one item reverse scored. Higher scores on this scale indicate greater loneliness. While this scale has not been tested among people with cognitive impairment, a previous study using the ULS-6 in a cohort of older Portuguese adults (aged 60-90) supported the one-factor model and confirmed that this brief measure was appropriate for this population (Neto, 2014). The correlation between the ULS-6 and the longer UCLA loneliness scale was reported at 0.87 with an internal consistency Cronbach's $\alpha = 0.82$. There is not a lot of responsiveness data on this measure. However, the validation was performed by Neto (2014) using a sample of 1,154 Portuguese adults, and those findings allowed us to estimate the minimal detectable change for the ULS-6 as 4.58. Any change below this can be considered noise that the instrument is not able to detect. Considering the validation was done using the Portuguese version of UCL-6, cautious interpretation of the results is recommended when applied to a different population.

As with the mentors in the previous chapters, adapted versions of outcome measures excluding the GDS were created for use with mentees with cognitive impairment (see Appendix D). An example of an item changed was “There is not enough purpose in my life,” to “Do you have enough purpose in your life?” Multiple category responses options were changed to “Yes” or “No” categories and like the mentors, mentees received either Version A or Version B. These two versions were scored together, and one composite score per person (per time point) was calculated for both.

Secondary outcomes. Secondary outcomes included depression and program attendance. Depression was assessed using the Geriatric Depression Scale Short Form (GDS-SF) (Sheikh & Yesavage, 1986). The GDS-SF has 15 questions and uses “yes” or “no” responses with five items reverse scored. Test–retest reliability was measured at 0.84-0.85 at 1-2 weeks, specificity = 0.754 and sensitivity = 0.814 with a cut-off score of 6 (Friedman et al., 2005). Scores higher than five are suggestive of depression. Sheikh and Yesavage (1986) found that both the long and short form of the assessment scales were successful in distinguishing adults who were depressed from those who were not ($r = 0.84$, $p = .001$). High internal consistency has been reported with Cronbach’s $\alpha = 0.94$ and a split-half reliability 0.94 (Friedman et al., 2005). Although limited work of the use of this scale has been done in screening persons living with dementia, a study of residents with and without dementia reported an acceptable Cronbach’s alpha coefficient of 0.68 (Lach, 2010).

5.2.5. Data Analysis

I used descriptive statistics to summarize outcome measure scores, demographic characteristics and functional abilities. For numerical variables I reported means, standard deviations and ranges. For categorical variables I reported frequency and percentages. Scores on the outcome measures were compared within subjects at two time-points over a 6-month period. I reviewed the data to ensure it did not violate the tolerance of statistical tests used. Effect sizes were calculated using Cohen's criteria with a minimum level of power of 0.80 (Cohen, 1988). The number of programs attended by participants monthly at baseline and 6-months did not have a normal distribution. Thus, paired-samples *t*-tests were used to explore change in loneliness and depression and a non-parametric equivalent Wilcoxon Signed Rank test for program attendance. This analysis was performed using independent samples *t*-test (for numerical variables, like age) and chi-square tests (for categorical variables, like sex). An additional secondary analysis was conducted to compare the subgroups of mentees interviewed versus not interviewed, in terms of their demographics. I also examined the differences between the resident mentors and the mentees in terms of loneliness, depression and program attendance at baseline.

For the qualitative analysis, I conducted a thematic analysis of the subgroup of mentees interviewed ($n = 32$) and summarized the results. After reading all the data several times an initial coding scheme was developed, and these data were then sorted into increasingly more defined categories or themes. To ensure trustworthiness, other research team members corroborated, or refuted, conclusions made (O'Brien et al., 2014).

5.3. Results

Ten residential care homes in Ontario, Canada took part in this study. Most of the participating mentees ($n = 74$) were female (72%), and the majority had a high school education (52%) and were 85 and over with one notable exception of a resident age 26 (Table 5.1). With respect to cognition, 42% had mild-moderate cognitive impairment and 7% severe to very severe cognitive impairment. I noted that among these mentees, 36 used Version A (68%) of the questionnaires, and 17 used Version B (32%) at six months.

Table 5.1. *Characteristics of Mentees ($n = 74$)*

Mentees' Characteristics	<i>N</i> (%) or Mean \pm SD [Range]
Age, years	83.99 \pm 12.47 [26 to 100]
Sex ($n = 71$)	
Male	20 (28%)
Female	51 (72%)
Level of Education ($n = 56$)	
Elementary School	9 (16%)
High School	29 (52%)
College	9 (16%)
Undergraduate	4 (7%)
Masters/Doctorate	5 (9%)
Number of Activities Attended per Month ($n = 71$)	
0-1	19 (27%)
2-4	15 (21%)
5-6	5 (7%)
7-8	5 (7%)
9-10	5 (7%)
More than 10	22 (31%)
Cognitive Performance Scores (CPS) ($n = 71$)	
Intact – mild	36 (51%)
Mild – moderate	30 (42%)
Severe – very severe	5 (7%)

I then examined the differences at baseline between the mentees and the resident mentors. Mentees showed significantly higher depression ($p = .013$) and loneliness scores ($p = .004$) compared to resident mentors, suggesting mentees were more depressed and lonelier (Table 5.2).

Table 5.2. *Comparison Between Mentees and Resident Mentors*

Factor	Mentees ($n = 65$)	Resident mentors ($n = 46$)	Comparison test
Depression Scale (0-15)	4.63 ± 3.03	3.15 ± 3.05	$t(109) = 2.52, p = .013$
Loneliness Scale (6-24)	13.03 ± 4.31	10.63 ± 3.95	$t(108) = 2.98, p = .004$
Number of Activities Attended per Month	6.07 ± 4.74 , Median = 5.5	10.55 ± 3.11 , Median = 12	MW test $p < .001$

Note. Depression and Loneliness scores are reported as *Mean \pm SD*; number of activities reported as *Mean \pm SD*, *Median* as well as *frequency (%)* for categories; Mann-Whitney = MW.

As noted in Table 5.3, after 6 months mentees ($n = 43$) showed a statistically significant reduction in depression and loneliness with a medium to large effect size. Although a variety of measures were taken to minimize attrition, 31 mentees dropped out of the study. Of these, five were deceased, two dropped out due to poor health, one had scheduling issues, four expressed no interest in visits and three were identified as unresponsive (usually asleep or showed no response to mentors' visits). The reasons for 16 of the dropouts are unknown.

Table 5.3. *Depression and Loneliness Scores Over Time Among Mentees ($n = 43$)*

	T1: baseline	T2: 6 months follow-up	Change
Depression	4.74 ± 2.99	3.65 ± 3.15	$t(42) = 2.47, p = .02, d = .76$, $M = 1.09$ (30% reduction)
Loneliness	12.77 ± 4.36	11.19 ± 4.22	$t(42) = 2.47, p = .02, d = .76$, $M = 1.58$ (12% reduction)

In examining the primary outcome measure, I found mentees' data showed 5 out of 74 participants (7%) that showed floor effect (LS-6 score of 6). In calculating the missing data, I found that 43 cases had no missing data, 21 cases had GDS-SF T1 and ULS-6 T1 data, but missing GDS-SF T2 and ULS-6 T2. One case had GDS-SF T1 only (missing ULS-6 T1, GDS-SF T2, ULS-6 T2); two cases had all four variables missing and seven cases had GDS-SF T2/ULS-6 T2 data, but missing GDS-SF T1/ULS-6 T2 data.

The estimated mean of monthly programs attended at baseline was 5.94 ($SD = 4.66$) and follow-up at 6 months was 9.22 ($SD = 3.50$). In addition, I found a statistically significant increase in the number of monthly programs attended by mentees (60%) at 6 months compared to baseline ($p = 0.01$) with a small to medium effect size ($d = .37$). The comparison was performed using independent samples t -test as the scores followed normal distribution. Number of activities attended per month was collected categorically, but I also used midpoints to perform comparison. Based on numerical representation (midpoints), I observed significantly higher number of activities attended by resident mentors ($mean = 10.55$, $median = 12$) compared to mentees ($mean = 6.07$, $median = 5.5$). The difference is statistically significant according to Mann-Whitney test ($p < .001$). Next, I move on to reporting the analysis of the interviews conducted with the mentees to help make sense of the processes behind these quantitative findings.

5.3.1. Interviews with Mentees

A total of 32 mentees were interviewed. Many of the mentees had difficulties overall in communicating their thoughts, due to cognitive impairment or fatigue. The answers were often short, and I did not have as much data as I did with the resident mentors. I examined mentees interviewed compared with mentees not interviewed and found no statistically significant differences between the two subgroups with regards to age, sex, education, number of programs attended, mobility, visual impairment, cognition or depression. I identified three inter-related themes from the analysis of interviews conducted with the mentees. *Caring and reciprocal relationships* illustrated how mentees reported the relationships with mentors to be meaningful and reciprocal. *A desire to connect* described the interest mentees had in connecting with their community. *A new lease on life* revealed a change in mentees' perception on their life and perceived role in their community.

Caring and reciprocal relationships. Caring and reciprocal relationships described a number of positive feelings mentees noted in their relationships with the mentors. The following quotes are from different study participants. One mentee described the impact of these visits: "I look forward to it every week. We always find something to laugh about." As over a third of the mentees had GDS scores suggestive of depression, the importance of these connections with their peers and the pleasure they derived from these connections was noteworthy. Lillian reported that the relationships were reciprocal in nature, in that the mentors shared about themselves while offering learning tools such as the gratitude practice that revealed their personal stories. She indicated a desire for the mentors to talk more about themselves. Another

mentee stated: “I look forward to it every week—it’s nice to have a familiar face. We have lots of interests in common.”

Mentees also shared how their experiences of the visits helped to reduce a sense of isolation. Most spent the majority of time in their rooms, therefore these relationships were clearly important to them: “I like to feel that someone cares. I can be lonely at night” and “I enjoy that—that someone likes me that I never suspected would like me.” The sharing of experiences in the safety of their rooms—a non-threatening environment—meant that the feelings of being alone for some were lessened by the visits.

A desire to connect. A desire to connect revealed the mentees’ interest in getting to know more about what was going on in their community through the mentors’ eyes. Some reported an interest in what was happening around them: “I enjoy getting to know what is happening [in the home] through [name of mentor].” This theme overlaps to some extent with the development of caring relationships in that these connections have potential to reduce the sense of alienation—in this case though the mentors acting as a window into their community. Mentees talked about how they enjoyed personally getting to know the mentors better on their visits. “I especially like getting to know [name of mentor].” The desire to connect was met for one mentee through the gratitude practice conducted at the end of each visit: “One of the things I like is the gratitude practice—it made me feel like I’m more part of the world. I used to feel that I’m old and dried up. Sometimes I thought I would go crazy.” The following theme is also inter-related to some extent as all three themes are based on the impact of the new relationships.

A new lease on life. A new lease on life described the positive impact of the visits on the lives of the mentees and their perceived role. One mentee described this change in the following way: “It makes my life worthwhile. Before they [the mentors] came I was feeling lost and depressed.” Another stated: “It brightens my whole day—that they think of it to see me.” Two of the mentees chose to become mentors and joined the mentorship team. As a mentee, Lillian, the art history teacher living with dementia whom we referred to at the beginning of this chapter, talked about the impact of this on her life. After a month of receiving visits from two mentors, she asked if she could join the mentorship team and conduct visits herself. She became initiated as a mentor and regularly attended the weekly team meetings. Lillian requested to be assigned mentees that had depression like herself and reported that she often visited these residents throughout the week, not just once after the team meetings. She described her new role: “It gives me a new lease on life. It makes my life worthwhile.”

For some mentees, however, there was ambivalence around the visits. One shared that at times the visits interfered with bingo, and another stated: “I don’t know if I am enjoying it yet.” Some had specific preferences around timing or frequency of the visits. For example, one expressed a preference to have visits at a different time of day: “I’m not a morning person,” and one stated a preference to have a visit only “Once in a blue moon.” Despite the ambivalence however, all the mentees interviewed indicated they would like regular visits to continue with the exception of one who preferred only occasional visits. When asked if the visits should continue, one mentee described it in the following manner: “If they don’t mind [continuing the visits]? It makes me very happy when I think about my new friends. I look forward to Wednesday evenings.”

5.4. Discussion

In this chapter, I explored mentorship as a potential program for reducing loneliness and depression and increasing engagement and social citizenship of residents who are isolated in residential care homes. Although the study design does not permit causal inferences to be made, the findings suggest that mentoring may be a useful approach for engaging people that are typically not involved. Although the quantitative findings were consistent with the qualitative findings, future studies are needed to demonstrate the efficacy of the program. My first finding, a decrease in loneliness, makes an important contribution to knowledge in this field. This result is supported by prior research that indicates the importance of relationships and reciprocity in social support (Brownie & Horstmanshof, 2011). Cohen-Mansfield & Parpura-Gill (2007) proposed that psychosocial factors have the strongest influence on loneliness and that preventative programs that include multiple opportunities for engagement will have the greatest effect. The mentorship program structure enabled mentors to use a variety of approaches during visits and to visit throughout the week as their schedules allowed. As detailed in the results, one mentee described that her loneliness was most intense in the evenings and that she valued a chance to talk at that time of day. Consequently, having flexible times for the mentors' visits was useful and may have contributed to the decrease in loneliness outcomes scores overall. These positive outcomes are consistent with a review of factors impacting residents' adjustment to long-term care that pointed out the importance of meaningful social relationships (Brownie et al., 2014).

My second finding, reduced depressive symptoms, is also a vital contribution to the literature. It suggests the importance of meaningful social relationships between residents living in these settings. People experiencing depression do not always want to use professional mental health services, even though these services may be helpful (Joo et al., 2016). Residential care residents often have fewer friends and family contacts (Meeks & Looney, 2011), and relationships with peers may help residents cope with the many losses they experience. Given how common depression is within care homes (Snowden, 2010a) it is important to highlight the toll these outcomes take on the health of older adults, which include increased cognitive decline and dementia, and reduced functioning and quality of life (Hawkley & Capitano, 2015). Many residents suffering from depression also experience loneliness, and this has implications for severe mental health consequences (van Beljouw et al., 2014). This finding is consistent with previous research that has found peer mentoring as a promising model of depression care delivery for older adults (Joo et al., 2016).

My third finding, increased engagement in other programs, is also important. Although this would need to be confirmed in future experiment research, the finding suggests a potentially significant impact of residents helping their peers to connect socially and emotionally in their communities. As noted in their interviews, mentees did have an interest in what was going on in their community, and the mentors' visits offered them an opportunity to develop new relationships, build a new identity and try new things. Prior research indicates that the consequences of loneliness are not adequately addressed in many existing programs and that there is a lack of evidence on how to improve the outcomes (Cohen-Mansfield, 2014). A study examining how

loneliness influences mortality among people without dementia in nursing homes highlighted the importance of emotional support from someone who is close (Drageset, Eide, et al., 2012). Therefore, it is significant that mentees expressed an interest in their peers during their interviews and began attending more programs. Residents who participated in a qualitative study examining the personal views of people living in a care home noted that it was a “safe but lonely” experience (Slettebø, 2016, p. 23). Although I was unable to determine whether the visits, the increase in program attendance, or the combination of the two contributed to the results, taken together the findings of this study suggest that the role of peer mentoring may prove to be a useful avenue to pursue for improving late-life well-being. In examining the missing data, our analysis suggests that it was missing at random. Most of the missing data were due to dropouts at 6 months or mentees that did not complete baseline assessment.

I return to Lillian, and the parasocial programming model discussed in Chapter 1. Previously, Lillian had no interest in the social programming within her home. After developing relationships with the mentors, she was one of two mentors who chose to participate in the social fabric of their home in a way that worked for them. Lillian wanted to help others like herself, who were suffering from loneliness and depression. In keeping with the social citizenship approach, it may be that Lillian was able to internalize her own relevance and meaning within the community through building relationships with her peers (Cruwys et al., 2016). Sharing of common experiences may have had a positive impact on balancing the relationship of helper and those helped over time. The role of a mentor does have potential to be hierarchical and this can have negative consequences as has been noted by others (Embaldeniya et al., 2013).

However, in a study using peer mentors to deliver depression care in collaboration with a mental health professional found that the benefits of peers offering *experience* rather than *treatment* contributed to strong trusting relationships, and these relationships may have contributed to a decrease in depressive symptoms (Joo et al., 2016). In Lillian's case, it is significant as she was able to shift her role from being a mentee to becoming a mentor and active social citizen, thereby increasing her previous level of engagement and changing her relationship with others in her community in a positive way. The emotional and social impact of supportive peer relationships has been pointed out by others (Keyes et al., 2014). Thus, for mentees, the new relationships enabled some that felt isolated to regain a lost sense of community.

Lillian's transformation from a socially isolated resident to an active social citizen is noteworthy. Her role moved from one of being at the receiving end of comfort to one who gives comfort to others. Being at the receiving end of visits from her peers appeared to give Lillian an opportunity to consider changing her identified role within her community and building relationships beyond that of her stuffed dog. Such findings are consistent with Gardner, Pickett, and Knowles (2005) who argue that some individuals that are lonely look for opportunities for connection. Applying the framework of social citizenship to this situation can help build understanding about how supporting the strengths of residents enables a re-shaping of the deficit narrative (Birt et al., 2017). I ultimately hope that these visits can promote citizenship not just among the mentors, but also among those they visit, as was the case with Lillian. A positive social structure such as a mentorship team can re-position residents as mentors and citizens with a unique way to exercise their rights and responsibilities. The agentic role taken on by

Lillian allowed her to change her place within her social world, despite the emotional challenges she was facing. As a resident suffering from loneliness and depression, her right to be free from discrimination as a social citizen was constrained by being at the receiving end of care and concern. Her transformation to an active social citizen contributes to the restricting narrative that inhibits people living in these settings from their inherent rights as citizens.

My analysis is limited in several important ways but does provide direction for future research. The lack of a control group limited the generalizability of my results to a larger population and my conclusions do not suggest causality. The high attrition rates of mentees in this study is also a limitation. Challenges in research amongst persons living with dementia have long been identified (Maas, Kelley, Park, & Specht, 2002), which includes the many recruitment and logistical difficulties of conducting research in these settings (Murfield et al., 2011), and one of these is attrition due to the fragility of residents. As most of mentees had little or no cognitive impairment, the sample should not be considered generally representative of the long-term care population. Despite this, during the interviews mentees often gave short answers, limiting my ability to look deeper into issues presented. Further research is needed to explore the reasons for the ambivalence described by some of the mentees. In addition, the positive responses provided by mentees in the interviews may reflect a social desirability bias (Gittelman et al., 2015). Finally, as only residents who agreed to be visited were included there is a selection bias. People less likely to participate were also more likely to be lonely or socially isolated.

There are some potentially important impacts of this research. Loneliness and depression are common in care homes (Snowden, 2010a; Victor, 2012) and the peer-mentorship program brings residents to the forefront in my efforts to provide new approaches to social citizenship and emotional support. Interrupting the prevailing form of group programs in residential care and adding opportunities to engage as citizens encompasses a fundamental change. This change is a shift from the provision of light social events to one of building resident-to-resident close relationships and access to equal opportunities to exercise rights and responsibilities. Peer support has helped people with early-stage dementia living in the community connect with their peers (Mason, Clare, & Pistrang, 2005) and peer mentoring within residential care homes may provide similar needed support to people who are socially isolated. To my knowledge, this study is the first to use a team approach to peer mentoring as a strategy to enhance social citizenship and reduce loneliness in these settings. However, further research is crucial before peer mentoring can become a viable alternative approach to social and emotional support within these settings. As mentoring programs can be led by existing staff, residents and volunteers, this model offers a potential means to address the recalcitrant problem of loneliness and depression in residential care and to empower residents as active social citizens in their communities.

Chapter 6.

Conclusion, Synthesis, and Future Directions

This mixed-methods research project offers valuable insights into the use of a new psychosocial model of peer mentoring as a practice of social citizenship in residential care. It represents a marked departure from the a-theoretical nature of many programs which can result in failure in achieving the best health outcomes (Michie et al., 2005). Having a strong theoretical foundation guiding the development of peer mentoring as a program helped me to structure this research. It allowed me to make links between the abstract and concrete concepts I presented and provided a context for the outcomes. In the model reducing the parasocial programming cycle (see Figure 1.1), for example, I argued that the provision of a structured, ongoing peer mentoring program has potential to increase citizenship as a practice. Adding meaning and fostering close relationships (thereby decreasing loneliness and depression and increasing engagement), were quantitative outcomes supported by this model. The qualitative findings also lent support with overall consistently positive perceptions of peer mentoring among the mentors, mentees, and staff. Although I had some contradictory outcomes, this theory became stronger as more supporting evidence was gathered, providing a context for predictions and future research. I synthesize the results of our research below as I discuss social citizenship as a practice, some of the challenges encountered, the significance and health implications associated with the

mentoring, personal reflections on the research, dissemination of findings, limitations and future directions.

In addition to the six concepts discussed previously chapters that provided a broader conceptual framework, Bartlett and O'Connor (2010) offered four guiding principles of social citizenship as an approach to practice that resonate with the findings of my research. These principles include: (a) "maximizing and valuing participation," (b) "facilitating growth and creativity in the dementia experience," (c) "connecting personal experiences to broader sociopolitical and cultural contexts", and (d) "promoting solidarity by constructing a 'we' community" (pp. 75-78). I will discuss these principles in the context of people living with and without dementia in residential care setting communities and will make the case for them below. The principles combined with empowerment-oriented practices suggested by the authors, I argue are useful for staff seeking to foster citizenship among residents (Bartlett & O'Connor, 2010).

The first principle, maximizing and valuing participation, is a societal responsibility and focuses on full participation over the notion of mere inclusion (Bartlett & O'Connor, 2010). Mentors were not just included on the mentorship team but were explicitly tasked with engaging and supporting their peers. To support engagement among the mentors required thoughtful consideration of conditions that would be conducive to full participation and I addressed these principles by building the following features into the mentorship program:

1. *Ensuring adequate time.* To support full participation, it was important to ensure that residents had the time they needed. The team meetings were structured so that each mentor was recognized on the team and had a voice during the weekly check in time. This meant that setting

aside enough time in the busy social schedules for this to happen. The team meetings required anywhere from 45 minutes to an hour and a half, depending on the size of the team. This structure was crucial, particularly for people with dementia, as it recognized the contributions of each mentor and ensured that each had a voice.

2. *Ensuring a welcoming space.* The team meetings were held in a comfortable room with refreshments that made it a welcoming environment. This meant, for example, scheduling a room for the meetings that provided enough space to maneuver a wheelchair, allowing room for people to come and go as needed to use the washroom.
3. *Supporting mentors with health challenges.* Residents that expressed interest in being a mentor were provided with support as needed to participate. For example, ensuring that printed materials were in large font sizes, enough time was allocated to repeat instructions, understanding of the mentoring actions being discussed was increased by modeling them (e.g., knocking on the door, asking before giving someone a hug).
4. *Supporting people that are isolated.* The bridging task of the team was to examine the links between individual areas of difficulty among the mentees as well, and the interactional environment in order to maximize and value their contributions. The team discussed and debated the barriers to participation among people who may be isolated in their rooms and how they could empower change. For example, were there ways in which residents could participate even when they did not feel comfortable leaving their rooms? An example might be to write a get-well card to a resident just returning from the hospital, helping to choose music for an event, or exhibiting their artwork in the hallways.

Based on the mentor's reports, reaching out to help their peers was important and vital work. Mentors described a number of personal benefits from this volunteer role that ranged from an increase in confidence to a sense of pride. Other research supports these outcomes. For example, a study exploring volunteer preferences among older adults in a continuing care retirement community found that common reasons for volunteering included perceived personal benefits such as being able to interact with others, learn new things and altruistic reasons such as doing something to help others (Resnick, Klinedinst, Dorsey, Holtzmna, & Abuelhiga, 2013).

During their visits, mentors in this research offered suggestions to mentees to reframe issues that were brought up. The mentors learned a variety of activities that could expand the social world of the mentees without telling them what to do. For example, Lillian as a mentee, was invited to participate in the gratitude practice each week during the visits. After about four visits, she was able to reframe her experience of depression and take up the idea of becoming an active contributing social citizen. This desire of hers to connect with others in her community is noteworthy as up until that point, she was disconnected with others living there and spent most of her time in isolation. As described in Chapter 5, mentees indicated in their interviews that they looked forward to the visits and that it reduced their sense of isolation. Research has suggested that this vulnerable group may be most likely to benefit from support and assistance (Newall & Menec, 2017). The positive impact of participating in peer mentoring among both the mentors and mentees indicates that this type of intervention has potential to alleviate some of the loneliness and depression in these settings. This supports the argument that programs to reduce loneliness that include education and focus on social networks maintenance are likely to be effective (Cohen-Mansfield, 2014). Moreover, and perhaps most importantly, it elevated the resident mentors' status (and some of the mentees) from recipients of care to a conscious, contributing social citizens.

The second principle for practitioners to consider is facilitating growth and creativity, and this can take many forms. To facilitate growth, Bartlett and O'Connor emphasized the importance of avoiding the notions of "maintaining" or "preserving" (p. 75) and focusing instead on fostering existing strengths. The education modules were

one source of growth and creativity. Mentors were able to try out new skills and approaches during the meetings using learning tools such as role-playing. Another source of growth and creativity was the sharing of knowledge gained by the mentors with the mentees. For most mentors these were new skills and they shared their excitement about trying out tips and strategies. Mentoring was also an opportunity for residents to build on innate altruistic tendencies. The enjoyment that came from these helping activities was a recurring theme in the mentor's interviews, as noted in Chapter 4. This is in keeping with the results of a study examining the influence of altruistic attitudes and prosocial behaviors, and the resulting increase of life satisfaction and positive affect (Kahana, Bhatta, Lovegreen, Kahana, & Midlarsky, 2013). From my perspective, supporting growth and creativity among residents is an important consideration for staff.

The third principle, connecting personal experiences to broaden sociopolitical and cultural contexts, may seem unrealistic at face value for people living in residential care. Societal discourses and practices influence the experiences of residents. Bartlett and O'Connor (2010) point out that our attempts to understand and respond to the issues in these settings must include changes at a societal level. These changes must be multidimensional and include an individual level, interpersonal levels and societal levels. I offer three questions for staff to consider in order to foster social citizenship:

1. At the individual level: How can all resident be encouraged and supported in every day social citizenship practices?
2. At an interpersonal level: How can staff better assist the community (including residents, family and staff) in reducing the associated stigma through education, policy and practice?
3. At the societal level: How can staff and residents better communicate these changes at a societal and political level?

Although it might seem difficult to challenge current practices such as stigmatizing language and silencing practices that marginalize residents, communicating the positive experience of residents in the role of mentor and contributing social citizen, can influence change. An example of this might be offering support to residents to tell their stories through the media or at aging conferences. These actions have potential for changing this discourse. Similar work is being done by the Ontario Residents' Council Association. This council is made up of residents from different homes who promote new legislation to raise the voice of resident in long-term care homes with their provincial government (OARC's Mandate, 2018),

The fourth principle, promoting solidarity by constructing a “we” community, focuses on unity. This is a form of midi-citizenship, defined as action taken by a group at an organisational level to improve something (Baldwin & Greason, 2016). In this case, it is to increase sense of belonging in residential care homes. Midi-citizenship was exemplified by the mentorship team as they took on a collaborative, consulting role as a group to uphold the rights of people isolated in their community. They had the opportunity to engage in problem solving during their team meetings, assessing the needs of their peers during the meetings and during the visits, addressing their immediate discomfort (e.g., being disconnected) and building relationships with them. In this way, they took on the role of a social citizen, practitioner, peer supporter and friend. However, they did not do this work in isolation. The positive benefits of these actions and enjoyment of working together as a team reported by mentors is consistent with an identified gap in what Canadian volunteers are looking for and what is available—volunteer opportunities that operate in groups (Sladowski et al., 2013). Together, the

above four principles have potential to foster social citizenship and contest the deficits discourse on a broader national level.

The positive perceptions of mentoring role as described by mentors across the chapters along with the positive outcomes, suggests that this program may be worth exploring further. The combination of a structured mentoring program, team meetings and training, may be key to helping residents feel more prepared and confident in engaging in the practice of social citizenship. One of the themes identified in my research involved the reciprocal benefits identified by the mentors, especially in addressing loneliness. Both mentors and mentees reported positive feelings associated with being needed and useful, as well as new developing friendships with their peers. This finding is important, as people moving into residential care face many losses (e.g., loss of a spouse or health), and this increases their vulnerability to illness. An analysis of a national longitudinal sample of US adults, for example, reported that older adults who maintain higher levels of purposeful life engagement experience numerous health benefits including fewer disease outcomes and extended longevity (Ryff, Heller, Schaefer, van Reekum, & Davidson, 2016). As purpose declines with age, this suggests that providing meaningful activities that sustain social value through a contributing role, such as the mentoring program I evaluated, may be a key factor to consider in the development of future programs (Irving et al., 2017).

Engaging people that are socially isolated and lonely in this program is significant as the roles and responsibilities of citizenship. Older adults that are lonely do not always respond to invitations to engage (Pieters, 2013). In residential care settings, residents who do not attend programs on their own initiative often refuse invitations to

attend programs. After repeated invitations, staff may give up on inviting them and their presence in the community becomes invisible. Due to low staffing and limited time, attending to these residents is difficult for staff. The mentorship program is key to this issue as it specifically targets this group. One of the opportunities related to the socially isolated and lonely group has been highlighted by Cacioppo et al. (2006). From an evolutionary perspective, some who lack a desired social network may be particularly motivated to change. Thus, residents who have had few opportunities to engage with their peers may have welcomed the mentors' visits and a chance to become involved in programs. Conversely, some residents may not be interested in being a mentor or in being visited, and this should be respected. In consideration of the development of the best possible program for future deployment and research, it is important to acknowledge that there is likely a group of residents who are particularly ready and willing for an program like this—and another group who are not.

In reviewing the above results of the mentees in Chapter 5, four dimensions of social isolation and loneliness offered by Newall and Menec (2017) are useful. Residents who refuse invitations to participate in activities in their communities may appear to be socially isolated, but that does not necessarily mean they are experiencing loneliness. It is possible that these residents may have chosen not to retain previous relationships or build new ones upon moving into a home or may simply have stronger personal preferences for being alone. There are two considerations that have relevance to future studies. Firstly, although the isolated but not lonely group may not appear to need support, research indicates a closer look is warranted. For example, Capitanio, Hawkey, Cole and Cacioppo (2014) examined loneliness as an outcome of perceived

choice among older adults. The authors found that people who felt they had control over their social activities reported lower levels of loneliness. In residential settings, it is possible that some residents who state they are not lonely, may not actually be choosing to be alone. For example, residents who are not able to attend activities when they wish (e.g., persons living with dementia who are not able to remember times or location of activities), may be not be able to express this clearly, or the people they are communicating with lack the ability to understand their expressions both orally or through body gestures (Kontos & Martin, 2013). Although these residents may not be able to describe how loss of control effects them, it might have a negative effect on their well-being. Secondly, although some residents may be content to be left alone, there are residents who are vulnerable and want help but have lowered their expectations of their desires for more contact due to their prior negative experiences (Newall & Menec, 2017). This may or may not be linked with a fear of failure. Trained peer mentors may be able to build trusting relationships with these residents and help them become connected in their communities.

As I explored the feasibility of conducting an experimental study to evaluate this mentoring program, I found that although the results provided enough initial support to inform a larger trial there were problematic areas, such as the retention rates (see Appendix H for the recruitment and analysis flow). According to the PEDro scale (Physiotherapy Evidence Database), a criteria list for quality assessment of trials, retention rates should be around 80% and are critical to address before considering a larger trial (Verhagen et al., 1998). However, I was dealing with a very fragile population and it may not be realistic to expect higher retention rates among residents. Future

research on mentoring in these settings will need to take this into account. The intra-cluster correlational coefficients were small, but the sample size for a future randomized controlled trial needs to be adjusted for the high dropout rate (Cohen, 1988). I conducted a sample size estimate for the primary outcome measures using 42% dropout and 50% dropout (more conservative) rates. I calculated that I would need 126 (50% dropout) or 109 (42% dropout) participants to power a study for GDS-SF (depression) and ULS-6 (loneliness).

In considering the best primary outcome to use moving forward, the GDS-SF may be a good option as there is an estimated minimal clinically important difference for this measure and it does not need to be modified for participants with cognitive problems. There were significant changes in the ULS-6 scores among participants, however I was not able to find responsiveness data on this measure. No significant differences were found for purpose in life, social identity, or sense of belonging scores. These findings, while unexpected, suggest further research is needed into the impact of adopting this new role for residents. The positive trend noted in the sense of belonging scores are, however, consistent with the work of others who have reported that citizenship enables individuals to achieve a sense of belonging (Barnes et al., 2004).

There were unanticipated challenges that came up during this research. These challenges included things like the extent of the difficulties we encountered collecting data from the sites and the dropout rates. As we were collecting data over the winter months, travel was especially challenging for the research assistants. In addition, the busy work schedules of the staff made it difficult to collect data in a timely fashion and hence some data were not fully collected, e.g., the reasons for the dropouts. We had

planned to collect all the data within a six-month period, but it took almost nine months. Some of the study sites began a bit later than planned and some homes had a flu outbreak and had to cancel sessions as the community mentors were not able to enter the home.

The use of both quantitative and qualitative methods in the study provided valuable insights into the use of mentorship as a model and as an approach to psychosocial care in residential settings. These combined methods allowed for a better understanding of the study outcomes and the program itself, as the results from each could be considered independently and then together. The use of multiple perspectives to collect and interpret data can provide corroborating evidence of findings (Tashakkori & Teddlie, 2010). For example, the quantitative data of the mentees, such as a decrease in loneliness and an increase in program attendance was supported by the mentee interviews, as well as the staff and mentor observations. However, these methods also revealed a discordance with the other outcome measures which showed no significant changes, e.g. purpose in life, social identity and sense of belonging. Despite the lack of significance in these measures, mentors reported a number of benefits, including feeling more connected and having a stronger sense of purpose. This discrepancy raises new questions that future researchers can explore. For example, it may be that there were outside factors that we were not able to control for, and thus a trial design may reveal different outcomes on these measures.

6.1. Personal Reflections

With some exceptions, the study went as planned and the findings resonated with my work experience in these settings, however, there were some unanticipated results and challenges. As an accredited music therapist, I have over 20 years of experience working directly with residents in long-term care homes. According to Mulhall (2003) it is not possible to separate what is being observed from a researcher's experience and it is important to keep an accounting of how the observations are filtered through the researcher's experiences. Over the years of working in these settings, I experienced an increasing concern about the loneliness and social isolation I observed among residents. They often spoke of feeling lonely, and I encountered numerous residents who, when I tried to invite them to my groups, stated they preferred to stay in their rooms. Thus, one challenge I had as a researcher was keeping an awareness of an investment in a positive outcome of this research and taking care to avoid overselling positive findings (given issues with the study design and potential threats to validity). Consequently, I kept reflexive notes and held frequent discussions regarding bias during analysis with the research team members. An example of this bias was that I anticipated both the staff and residents would enjoy a structured program that involved education and helping others, and they did. However, I also anticipated that the impact of mentoring would have a significant effect on the outcome measures of purpose in life, social identity and sense of belonging, but it did not. This raises several questions for future research, such as was this due to lack of impact of the program or was it due to the high attrition rates?

This insider knowledge I had from my work experience, was both an asset and a disadvantage. As I had developed and piloted the program before I began my doctoral studies, I had experiences that were helpful in setting up the research. I knew from the pilots and my work as a therapist, some of the challenges that would be encountered. This knowledge also served as an asset as I understood the context clearly at the beginning and my comfort level had a positive impact on participation levels of the research institute and the staff at the homes. A disadvantage was the potential for unintentionally analyzing data in ways that fit with my assumptions, experiences and expectations. I conducted some of the interviews, and so researcher bias may have influenced both the interviews and the analysis. Furthermore, residents may have had a response bias and have answered in a way that would be viewed favorably by me. Finally, despite having a vested interest as the developer of the program I feel that, with the expert guidance of my committee, I presented this research to the best of my ability in an objective way.

6.2. Dissemination of Findings

I hope that the findings from this collaborative research contributes new knowledge and identifies further questions about peer mentoring in residential settings. Although more research is needed to study its efficacy and effectiveness, my findings indicate that this potentially transformative model of peer mentoring can be used by residents, volunteers and staff. It can also serve long-term care advocates to better understand and challenge the existing social and political forces in continuing care. The mentoring program was structured in a way that lay people (e.g., volunteers) could

easily help facilitate it and persons with dementia could actively participate. For example, the modules were short, followed by a series of graduated steps, and for ease of reading the font-size of the handouts was large (e.g., Arial 18-24 font). These are important considerations when disseminating this program within residential care, particularly long-term care homes. These education modules were carefully developed and tested to enhance the learning cycles of the mentors.

To translate the knowledge gained for academic and non-academics I have developed a three-part dissemination plan. The first part of the plan includes disseminating the research results to the participating research sites and interested participants, the wider public audience through media reports and to the research and professional community through journal publications and presentations at conferences. Findings will also be disseminated to educators, administrators, and policy makers who design and implement programs in residential care, as well as family and resident advocacy groups, for example, resident council associations. The second part of the dissemination plan includes seeking funding for production of a series of professional videos about the concept of peer mentoring in residential care for education and knowledge mobilization. These videos will include an introduction to the concept, short trainings for staff with limited time or who may not prefer reading, and feature interviews with resident and community mentors, family, staff, and mentees. Presenting residents as active contributors within their communities will help to dispel ageist stereotypes and inspire people within other residential settings. Interested study participants will also be invited to help to develop the video content. The third part of the dissemination plan includes partnering with organizations to provide and educational webinars. To enhance

the understanding of the significance of this approach to psychosocial care, free online seminars will be offered in collaboration with other organizations. Examples are already existing collaborations I have with organizations such as the Alzheimer's Society of Canada, the Ontario Association of Residents' Councils, the Centre for Aging and Brain Health Innovation, and professional associations such as the Canadian Association of Recreational Therapy and senior living associations.

6.3. Significance and Limitations

This study is significant on policy, theoretical and practical levels. Loneliness and depression in residential care is an important topic of interest for policy (Snowden, 2010b; Victor, 2012), and the proposed program is a marked departure from the traditional standards of psychosocial care. Considering the high resident-to-staff ratios, this novel program offers the possibility of providing an economically viable and sustainable approach to improving psychosocial care. In addition, it offers a nonpharmacological alternative to the treatment of loneliness and depression. Policy makers can be approached to lobby for initiating, standardizing and changing the ways that peer mentoring programs are provided and funded.

Theoretically, the use of social citizenship as a foundation for this study is significant as people living in residential care setting may feel dislocated from the social world around them (Cruwys, Haslam, Dingle, Jetten, et al., 2014). This is of importance throughout residential care, but especially in long-term care homes where residents need support making connections and maintaining autonomy (Riedl, Mantovan, &

Them, 2013). Forced relocations and processes to re-establish social relationships in new settings likely impacts most residents. Some residents may remain connected to previous identities when they enter residential care, e.g., remain members of the same church, but may also become involved in their new community. Theoretically, this study lays the groundwork for future work to extend social citizenship by considering the importance of the roles of residents or any patients as contributors within the greater health care system. As identified above, an enhanced sense of contribution may be linked with a stronger sense of belonging and purpose in life. A stronger sense of belonging, in turn, may be linked to a decrease in loneliness and depression and a wide range of health outcomes, including better physical and mental health and a lower mortality risk.

This research project is to my knowledge the first that examines the impact of a structured program giving people living in residential care a means by which they can actively engage in the practice of social citizenship. Changes designed to de-institutionalize residential care often reinforce residents' passive roles (Shura et al., 2010), but this research has the potential to foster active contributing roles and change practice. For residents with and without dementia, having a valued role and a perceived sense of belonging through helping others can foster a positive change in self-perception. Furthermore, the shift from resident care to resident engagement in this study lays the empirical groundwork for new knowledge and additional research that identify more ways of achieving a stronger social identity for residents (Brownie & Nancarrow, 2013; Canadian Healthcare Association, 2009; Kane, 2001; Koren, 2010). Most importantly, by strengthening the contributing role among residents, it is

anticipated that mentoring can have a significant effect on the mental health and quality of life of people living in residential care.

Limitations include the lack of a control group, which limits our ability to state that the changes experienced by the participants were due to the mentorship program and not to other factors. This argument cuts both ways. Potentially, participants in the control group could have exhibited similar improvements in scores in which case the change would not be significant between groups. However, scores in a control group could have potentially decreased (as was the case in our purpose in life variable), in which case the maintenance of scores in the experimental group might be significantly better. From a quantitative perspective, there was potential for social desirability bias given the self-report nature of measures and the lack of blinding. Future studies could use blinded raters and participants could be blinded to the study hypothesis, however blinding presents challenges for clinical trial investigators (Page & Persch, 2013). The program could also be taken up differently in samples of non-English speaking participants from different areas that are more diverse regarding ethnicity, country of origin, religion and socioeconomic status. Although the concepts should apply across these groups, empirical verification would be necessary. This was a relatively small sample based within one organization and one geographical region. Finally, from a qualitative perspective, one of the limitations is that the program materials and training were developed by me and I already have a positive close relationship with this organization and many of the staff. Hence, it is difficult to ascertain whether the impact of the program will change if taken out of this context, as future facilitators may not follow the protocols laid out in the training.

6.4. Future Research

The results of my research present mixed findings, which have implications for future research. There is a need for future experimental studies to look at different retention strategies and to look at the efficacy, to determine whether this program works under ideal circumstances, and effectiveness, to determine the degree to which this program provides benefits in real world settings (Singal, Higgins, & Akbar, 2014). Additional research could also explore the impact of the training and support offered to resident mentors and what types of education have the potential to increase their comfort levels in conducting visits. As some of the resident mentors lost interest in mentoring, future research could examine what part of the program did not interest them and whether there is a possible adaptation to the program that would retain their interest. As indicated in Chapter 3, it would also be useful to conduct a comparison within and across sub-groups, for example different cultural groups, to understand what works best for diverse groups of residents. Finally, it would be fruitful to further quantify the benefits of peer mentoring. An example of this is conducting a social return on investment analysis, as has been done with peer support for people with dementia (Willis et al., 2016). This research took place in England and examined the outcomes of three dementia peer support groups and how much social value they produced compared to the cost of investment. Using a Social Return on Investment analysis, Willis (2016) found that the social value produced was much greater than the cost of investment. This may also be true for peer mentoring and worthy of investigation.

This study provides support and guides planning for future experimental trials. Previous research has identified reciprocity as an indicator of quality of social

relationships (Pope, Miller, Wolfer, Mann, & McKeown, 2013); however, there is little evidence about peer mentoring as a form of reciprocity within residential care. The growing body of research identifying loneliness, social isolation and associated mental health issues highlight these issues as a significant public health risk among older adults and highlights the need for new interventions (Holt-Lunstad et al., 2015). Contributing to the well-being of their peers has potential to reduce loneliness and enhance the social engagement of the resident mentors through an increased sense of purpose and meaning (Klinedinst & Resnick, 2014), and the social and emotional impact of reciprocity of support (Resnick et al., 2013).

6.5. Conclusion

I believe the concept of social citizenship, when put into practice through peer mentoring, offers residents opportunities to grow and participate fully in community life. I argue that using this approach to reduce loneliness and increase engagement is novel and important within residential care for two reasons. First, from the perspective of the resident mentors, the helping role has potential to address an identified barrier to social citizenship. This barrier centers on recreational programming based on a culture of entertainment. In this culture, residents are considered passive recipients of care and offered ongoing light social events and distraction organized by staff. The resident mentoring role breaks through that barrier by modeling a different social value associated with generosity and giving back.

The second reason is the helping role may provide a new role for residents—one that offers them a purpose. Residents in long-term care homes have largely been discounted as potential volunteers. Although the concept of offering residents formal volunteering roles is not new (Sellon, Chapin, & Leedahl, 2017), offering a formal role that includes extensive mentoring education and training is, to my knowledge, unique. The education provided during the team meetings may serve additional purposes. For example, observing residents as active, educated mentors may help to ameliorate the stigma that exists associated with being a recipient of care. The PEEPS model has significance for persons living with dementia. The practice of pairing community mentors with persons living with dementia for needed support means that individuals can feel confident adopting a helping role. Thus, having a new purposeful identity and role may have important ramifications for all people living in residential care settings and help to improve their quality of life as equal social citizens in their communities.

References

- Adams, K. B., Sanders, S., & Auth, E. A. (2004). Loneliness and depression in independent living retirement communities: Risk and resilience factors. *Aging & Mental Health, 8*(6), 475-485. doi:10.1080/13607860410001725054
- Allen-Burge, R., Stevens, A. B., & Burgio, L. D. (1999). Effective behavioral interventions for decreasing dementia-related challenging behavior in nursing homes. *International Journal of Geriatric Psychiatry, 14*(14), 213-232. doi:10.1002/(SICI)1099-1166(199903)
- Alzheimer Disease International. (2013). *World Alzheimer Report 2013: Journey of caring: An analysis of long-term care for dementia*. Retrieved March 10, 2018 from <https://www.alz.co.uk/research/WorldAlzheimerReport2013.pdf>
- Alzheimer Disease International. (2016). *World Alzheimer Report 2016: Improving healthcare for people living with dementia: Coverage, quality and costs now and in the future*. Retrieved October 4, 2018 from <https://www.alz.co.uk/research/world-report-2016>
- Alzheimer Society of Canada. (2011). *Guidelines for care: Person-centred care of people with dementia living in care homes*. Retrieved March 10, 2018 from http://www.alzheimer.ca/sites/default/files/files/national/culture-change/culture_change_framework_e.pdf
- Alzheimer Society of Canada. (2018). *The Canadian charter of rights for people with dementia*. Retrieved September 6, 2018 from <http://alzheimer.ca/en/Home/Get-involved/The-Charter>
- Anderson, L. S., & Heyne, L. A. (2013). A strengths approach to assessment in therapeutic recreation. *Therapeutic Recreation Journal, 47*(2), 89-108.
- Baker, B. (2007). *Old age in a new age: The promise of transformative nursing homes*: Vanderbilt University Press.
- Baker, L. A., Cahalin, L. P., Gerst, K., & Burr, J. (2005). Productive activities and subjective well-being among older adults: The influence of number of activities and time commitment. *Social Indicators Research, 73*(3), 431-458.
- Baldwin, C., & Greason, M. (2016). Micro-citizenship, dementia and long-term care. *Dementia, 15*(3), 289-303. doi:10.1177/1471301216638762

- Barg, F. K., Huss-Ashmore, R., Wittink, M. N., Murray, G. F., Bogнар, H. R., & Gallo, J. J. (2006). A mixed-methods approach to understanding loneliness and depression in older adults. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 61(6), S329-S339.
- Barnes, R., Auburn, T., & Lea, S. (2004). Citizenship in practice. *British Journal of Social Psychology*, 43(2), 187-206. doi:10.1348/0144666041501705
- Bartlett, R. (2016). Scanning the conceptual horizons of citizenship. *Dementia*, 15(3), 453-461. doi:10.1177/1471301216644114
- Bartlett, R., & O'Connor, D. (2007). From personhood to citizenship: Broadening the lens for dementia practice and research. *Journal of Aging Studies*, 21(2), 107-118. doi:10.1016/j.jaging.2006.09.002
- Bartlett, R., & O'Connor, D. (2010). *Broadening the dementia debate: Towards social citizenship*. Portland, OR: The Policy Press.
- Baumbusch, J. L. (2008). *Decommissioning Citizenship: The organization of long-term residential care* (Doctoral Dissertation, University of British Columbia, Vancouver, Canada)
- Baur, V. E., & Abma, T. A. (2011). Resident councils between lifeworld and system: Is there room for communicative action? *Journal of Aging Studies*, 25(4), 390-396. doi:10.1016/j.jaging.2011.03.001
- Bayne, M. (2012). A room with a grim view: The 'ambient despair' that marks life in assisted living. *Health Affairs*, 31(7), 1633-1635. doi:10.1377/HLTHAFF.2011.0440
- Bekhet, A. K., & Zauszniewski, J. A. (2012). Mental health of elders in retirement communities: Is loneliness a key factor? *Archives of Psychiatric Nursing*, 26(3), 214-224. doi:10.1016/j.apnu.2011.09.007
- Ben-Ishai, E. (2012). *Fostering autonomy: A theory of citizenship, the state, and social service delivery*. University Park, PA: Pennsylvania State University Press.
- Berger, R. (2017). Aging in America: Ageism and general attitudes toward growing old and the elderly. *Open Journal of Social Sciences*, 5(8), 183-198. doi:10.4236/jss.2017.58015
- Bhatti, A., & Haq, A. (2017). The pathophysiology of perceived social isolation: Effects on health and mortality. *Cureus*, 9(1), e994-e1004. doi:10.7759/cureus.994

- Birt, L., Poland, F., Csipke, E., & Charlesworth, G. (2017). Shifting dementia discourse from deficit to active citizenship. *Sociology of Health and Illness*, 39(2), 199-211. doi:10.1111/1467-9566.12530
- Bonifas, R., Simons, K., & Biel, B. (2014). Aging and place in long-term care settings: Influences of social relationships. *Journal of Aging and Health*, 26(8), 1320-1339. doi:10.1177/0898264314535632
- Bouchard, R. E., Bannister, K. A., & Anas, A. P. (2009). The dementia narrative: Writing to reclaim social identity. *Journal of Aging Studies*, 22(3), 145-157.
- Bowen, J. B., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., . . . Fernanadez, M. (2009). How we design feasibility studies. *American Journal of Preventative Medicine*, 36(5), 452-457. doi:10.1016/j.amepre.2009.02.002
- Bowtell, D. (2015). *Therapeutic recreation regulation in Canada 2015: Comparison of Canada's health professions acts*. Retrieved October 22, 2018 from <https://www.alberta-tr.org/media/1410/therapeutic-recreation-regulation-in-canada-2015-report-2.pdf>
- Boyd, C. K. (2003). The Providence Mount St. Vincent experience. *Journal of Social Work in Long-Term Care*, 2(3/4), 245-267.
- Boyle, G. (2008). The Mental Capacity Act 2005: Promoting the citizenship of people with dementia. *Health and Social Care in the Community*, 16(5), 529-537. doi:10.1111/j.1365-2524.2007.00775.x
- Brannelly, T. (2011). Sustaining citizenship: People with dementia and the phenomenon of social death. *Nursing Ethics*, 18(5), 662-671. doi:10.1177/0969733011408049
- Brownie, S., & Horstmanshof, L. (2011). The management of loneliness in aged care residents: An important therapeutic target for gerontological nursing. *Geriatric Nursing*, 35(5), 318-325. doi:10.1016/j.gerinurse.2011.05.003
- Brownie, S., Horstmanshof, L., & Garbutt, R. (2014). Factors that impact residents' transition and psychological adjustment to long-term aged care: A systematic literature review. *International Journal of Nursing Studies*, 51(12), 1654-1666. doi:10.1016/j.ijnurstu.2014.04.011
- Brownie, S. N., & Nancarrow, S. (2013). Effects of person-centered care on residents and staff in aged-care facilities: A systematic review. *Clinical Interventions In Aging*, 8(1), 1-10. doi:10.2147/CIA.S38589

- Buck, G. (2018). The core conditions of peer mentoring. *Criminology & Criminal Justice*, 18(2), 190-206. doi:10.1177/1748895817699659
- Cacioppo, J. T. (2008). *Loneliness: Human nature and the need for social connection*. New York, NY: W.W. Norton & Company.
- Cacioppo, J. T., Hawkley, L. C., Ernst, J. M., Burleson, M., Berntson, G. G., Nouriani, B., & Spiegel, D. (2006). Loneliness within a nomological net: An evolutionary perspective. *Journal of Research in Personality*, 40(6), 1054-1085. doi:10.1016/j.jrp.2005.11.007
- Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging*, 21(1), 140-151. doi:10.1037/0882-7974.21.1.140
- Canadian Healthcare Association. (2009). *New directions for facility-based long term care*. Retrieved March 26, 2018 from https://www.advantageontario.ca/oanhssdocs/Issue_Positions/External_Resources/Sept2009_New_Directions_for_Facility_Based_LTC.pdf
- Canadian Institute for Health Information. (2010). *Depression among seniors in residential care*. Retrieved March 29, 2018 from https://secure.cihi.ca/free_products/ccrs_depression_among_seniors_e.pdf
- Canadian Institute for Health Information. (2013). *When a nursing home is home: How do Canadian nursing homes measure up on quality?* Retrieved March 10, 2018 from https://secure.cihi.ca/free_products/CCRS_QualityinLongTermCare_EN.pdf
- Canadian Institute for Health Information. (2015). *Data quality documentation, continuing care reporting system, 2013–2014*. Retrieved October 15, 2018 from https://secure.cihi.ca/free_products/CCRS_Data_Quality_Report_2013-2014_EN.pdf
- Capitanio, J. P., Hawkley, L. C., Cole, S. W., & Cacioppo, J. T. (2014). A behavioral taxonomy of loneliness in humans and Rhesus monkeys (*Macaca mulatta*). *PLoS ONE*, 9(10), e110307. doi:10.1371/journal.pone.0110307
- Cassie, K. M., & Cassie, W. E. (2012). Organizational and individual conditions associated with depressive symptoms among nursing home residents over time. *The Gerontologist*, 52(6), 812-821. doi:10.1093/geront/gns059

- Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Aging & Society*, 25, 41-67. doi:10.1017/S0144686X0400259
- Choenarom, C., Williams, R. A., & Hagerty, B. M. (2005). The role of sense of belonging and social support on stress and depression in individuals with depression. *Archives of Psychiatric Nursing*, 19(1), 18-29.
- Choi, N. G., Ransom, S., & Wyllie, R. J. (2008). Depression in older nursing home residents: The influence of nursing home environmental stressors, coping and acceptance of group and individual therapy. *Aging & Mental Health*, 12(5), 536-547. doi:10.1080/13607860802343001
- Chung, J. C. C. (2009). An intergenerational reminiscence programme for older adults with early dementia and youth volunteers: Values and challenges. *Scandinavian Journal of Caring Sciences*, 23(2), 259-264. doi:10.1111/j.1471-6712.2008.00615.x
- Cipriani, J., Faig, S., Ayres, K., Brown, L., & Johnson, N. C. (2006). Altruistic activity patterns among long-term nursing home residents. *Physical & Occupational Therapy in Geriatrics*, 24(3), 45-61. doi:10.1080/J148v24n03_04
- Clare, L., Rowlands, J. M., & Quin, R. (2008). Collective Strength: The impact of developing a shared social identity in early-stage dementia. *Dementia*, 7(1), 9-30.
- Clarke, P. (2009). Understanding the experience of stroke: A mixed-method research agenda. *The Gerontologist*, 49(3), 293-302. doi:10.1093/geront/gnp047
- Cohen-Mansfield, J. (2014). Interventions for alleviating loneliness among older persons: A critical review. *American Journal of Health Promotion*, 29(3), 109-125. doi:10.4278/ajhp.130418-LIT-182
- Cohen-Mansfield, J., & Parpura-Gill, A. (2007). Loneliness in older persons: A theoretical model and empirical findings. *International Psychogeriatrics*, 19(2), 279-294. doi:10.1017/S1041610206004200
- Cohen, C. I., Hyland, K., & Kimhy, D. (2003). The utility of mandatory depression screening of dementia patients in nursing homes. *American Journal of Psychiatry*, 160(11), 2012-2017. doi:10.1176/appi.ajp.160.11.2012
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

- Colvin, J. W., & Ashman, M. (2010). Roles, risks, and benefits of peer mentoring relationships in higher education. *Mentoring & Tutoring: Partnership in Learning*, 18(2), 121-134. doi:10.1080/13611261003678879
- Conn, D., & Snowden, J. (2010). Optimizing mental health in long-term care homes. *International Psychogeriatrics*, 22(7), 1023-1024. doi:10.1017/S1041610210001389
- Cooper, K., Schofield, P., Klein, S., Smith, B., H., & Jehu, L., M. (2017). Exploring peer-mentoring for community dwelling older adults with chronic low back pain: A qualitative study. *Physiotherapy*, 103(2), 138-145. doi:10.1016/j.physio.2016.05.005
- Corwin, A. I. (2018). Overcoming elderspeak: A qualitative study of three alternatives. *The Gerontologist*, 58(4), 724-729. doi:10.1093/geront/gnx009
- Coyle, C. E., & Dugan, E. (2012). Social isolation, loneliness and health among older adults. *Journal of Aging Health*, 24(8), 1346-1363. doi:10.1177/0898264312460275
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Cruwys, T., Haslam, A., Dingle, G. A., Haslam, C., & Jetten, J. (2014). Depression and social identity: An integrative review. *Personality and Social Psychology Review*, 18(3), 215-238. doi:10.1177/1088868314523839
- Cruwys, T., Haslam, S. A., Dingle, G. A., Jetten, J., Hornsey, M. J., Chong, E. M. D., & Oei, T. P. S. (2014). Feeling connected again: Interventions that increase social identification reduce depression symptoms in community and clinical settings. *Journal of Affective Disorders*, 159(20), 139-146. doi:10.1016/j.jad.2014.02.019
- Cruwys, T., Steffens, N. K., Haslam, A. S., Haslam, C., Jetten, J., & Dingle, G. (2016). Social Identity Mapping: A procedure for visual representation and assessment of subjective multiple group memberships. *British Journal of Social Psychology*, 55(4), 613-642. doi:10.1111/bjso.12155
- Cuijpers, P., Vogelzangs, N., Twisk, J., Kleiboer, A., Li, J., & Penninx, B. W. (2013). Differential mortality rates in major and subthreshold depression: Meta-analysis of studies that measured both. *British Journal of Psychiatry*, 202(1), 22-27. doi:10.1192/bjp.bp.112.112169

- Cullinane, P. (2006). Late-life civic engagement enhances health for individuals and communities. *The Journal on Active Aging*, 5(6), 66-73.
- Curzio, O., Bernacca, E., Bianchi, B., & Rossi, G. (2017). Feelings of uselessness and 3-year mortality in an Italian community older people: The role of the functional status. *Psychogeriatrics*, 17(5), 300-309. doi:10.1111/psyg.12238
- Daly, L., McCarron, M., Higgins, A., & McCallion, P. (2012). Sustaining Place - A grounded theory of how informal carers of people with dementia manage alterations to relationships within their social worlds. *Journal of Clinical Nursing*, 22(3-4), 501-512. doi:10.1111/jocn.12003
- Damianakis, T. (2007). Volunteers' experiences visiting the cognitively impaired in nursing homes: A friendly visiting program. *Canadian Journal on Aging*, 26(4), 343-356. doi:10.3138/cja.26.4.343
- de Jong Gierveld, J., Van Tilburg, T. G., & Dykstra, P. A. (2017). New ways of theorizing and conducting research in the field of loneliness and social isolation. In A. L. Vangelisti & D. Perlman (Eds.), *Cambridge Handbook of Personal Relationships* (2nd ed., pp. 391-404). Cambridge, NY: Cambridge University Press.
- de Medeiros, K., Saunders, P. A., Doyle, P. J., Mosby, A., & Haitsma, K. V. (2011). Friendships among people with dementia in long-term care. *Dementia*, 11(3), 363-381. doi:10.1177/1471301211421186
- Dean, M. (1999). *Governmentality: Power and rule in modern society*. London: Sage.
- Dennis, C. (2003). Peer support within a health care context: A concept analysis. *International Journal of Nursing Studies*, 40(3), 321-322. doi:10.1016/S0020-7489(02)00092-5
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Devitt, M., & Checkoway, B. (1982). Participation in nursing home resident councils: Promise and practice. *The Gerontologist*, 22(1), 49-53. doi:10.1093/geront/22.1.49
- Dewing, J. (2008). Personhood and dementia: Revisiting Tom Kitwood's ideas. *International Journal of Older People Nursing*, 3, 3-13.
- Dobell, G. (2011). *Residential long-term care for Canada's seniors: Nonprofit, for-profit, or does it matter?* Retrieved March 10, 2018 from http://irpp.org/wp-content/uploads/2011/01/commentary_dobell_03_08_2011.pdf

- Doyle, P. J., & Rubinstein, R. L. (2013). Person-Centered dementia care and the cultural matrix of othering. *The Gerontologist*, 54(6), 952-964. doi:10.1093/geront/gnt081
- Drageset, J., Eide, G. E., Kirkevold, M., & Ranhoff, A. H. (2012). Emotional loneliness is associated with mortality among mentally intact nursing home residents with and without cancer: A five-year follow-up study. *Journal of Clinical Nursing*, 22(1), 106-114. doi:10.1111/j.1365-2702.2012.04209.x
- Drageset, J., Espehaug, B., & Kirkevold, M. (2012). The impact of depression and sense of coherence on emotional and social loneliness among nursing home residents without cognitive impairment – A questionnaire survey. *Journal of Clinical Nursing*, 21(7-8), 965-974. doi:10.1111/j.1365-2702.2011.03932.x
- Drageset, J., Haugan, G., & Tranvåg, O. (2017). Crucial aspects promoting meaning and purpose in life: perceptions of nursing home residents. *BMC Geriatrics*, 17, 254-263. doi:10.1186/s12877-017-0650-x
- Drageset, J., Kirkevold, M., & Espehaug, B. (2011). Loneliness and social support among nursing home residents without cognitive impairment: A questionnaire survey. *International Journal of Nursing Studies*, 48(5), 611-619. doi:10.1016/j.ijnurstu.2010.09.008
- Driscoll, L. G., Parkes, K. A., Tilley-Lubbs, G. A., Brill, J. M., & Pitts Bannister, V. R. (2009). Navigating the lonely sea: Peer mentoring and collaboration among aspiring women scholars. *Mentoring & Tutoring: Partnership in Learning*, 17(1), 5-21. doi:10.1080/13611260802699532
- Dumville, J. C., Torgerson, D. J., & Hewitt, C. E. (2006). Reporting attrition in randomised controlled trials. *British Medical Journal*, 332(7547), 969-971. doi:10.1136/bmj.332.7547.969
- Dunlap, E. S., Dudak, B., & Konty, M. (2012). A synthesized model for integrating principles of adult learning in the higher education classroom. *Kentucky Journal of Excellence in College Teaching and Learning*, 10(2), 19-35.
- Dupuis, S. L., Gillies, J., Carson, J., Whyte, C., Genoe, R., Loiselle, L., & Sadler, L. (2012). Moving beyond patient and client approaches: Mobilizing 'authentic partnerships' in dementia care, support and services. *Dementia*, 11(4). doi:10.1177/1471301211421063

- Dupuis, S. L., Whyte, C., Carson, J., Genoe, R., Meschino, I., & Sadler, L. (2012). Just dance with me: An authentic partnership approach to understanding leisure in the dementia context. *World Leisure Journal*, 54(3), 240-254. doi:10.1080/04419057.2012.702454
- Dwyer, P. (2004). Understanding social citizenship: Themes and practices for policy and practice. Bristol, England: The Policy Press.
- Embuldeniya, G., Veinot, P., Bell, E., Bell, M., Nyhof-Young, J., Sale, J. E. M., & Britten, N. (2013). The experience and impact of chronic disease peer support interventions: A qualitative synthesis. *Patient Education and Counseling*, 92(1), 3-12. doi:10.1016/j.pec.2013.02.002
- Estes, C., Biggs, S., & Phillipson, C. (2003). *Social policy, social theory and ageing*. Berkshire, England: Open University Press.
- European Network of National Human Rights Institutions (ENNHRI). (2017, February 23). *Human rights of older persons in long-term care*. Retrieved October 17, 2018 from <http://ennhri.org/Human-Rights-of-Older-Persons-in-Long-Term-Care-164>
- Fessman, N., & Lester, D. (2000). Loneliness and depression among elderly nursing home patients. *International Journal of Aging and Human Development*, 51(2), 137-141.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans. Second Vintage Books ed.). New York: Pantheon Books.
- Foucault, M. (1982). The subject and power. In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (pp. 16-49). Amherst, MA: University of Massachusetts press.
- Fox, N. (1995). Postmodern perspectives on care: The vigil and the gift. *Critical Social Policy*, 15(44-45), 107-125. doi:10.1177/026101839501504407
- Friedman, B., Heisel, M. J., & Delavan, R. L. (2005). Psychometric properties of the 15-item Geriatric Depression Scale in functionally impaired, cognitively intact, community-dwelling elderly primary care patients. *Journal of the American Geriatrics Society*, 53(9), 1570-1576. doi:10.1111/j.1532-5415.2005.53461.x
- Fuller, S., Fuller, C., & Cohen, M. (2003). *Health Care Restructuring in BC*. Retrieved October 14, 2018 from https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/health_restructuring.pdf

- Gardner, W. L., Pickett, C., & Knowles, M. L. (2005). On the outside looking in: Loneliness and social monitoring. *Personality and Social Psychology Bulletin*, 31(11), 1549-1560. doi:10.1177/0146167205277208
- Gaugler, J. E., Duval, S., Anderson, K. A., & Kane, R. L. (2007). Predicting nursing home admission in the U.S: A meta-analysis. *BMC Geriatrics*, 7(13), 13-27. doi:10.1186/1471-2318-7-13
- Gaugler, J. E., Yu, F., Davila, H. W., & Shippee, T. (2014). Alzheimer's Disease and nursing homes. *Health Affairs*, 33(4), 650-657. doi:10.1377/hlthaff.2013.126
- Getzel, G. S., & Mellor, J. M. (1983). *Social work with older people*. New York: Haworth Press.
- Gilbert, T., & Powell, J. L. (2010). Power and social work in the United Kingdom: A Foucauldian excursion. *Journal of Social Work*, 10(1), 3-22. doi:10.1177/1468017309347237
- Ginsburg, L. R., Tregunno, D., Norton, P. G., Mitchell, J. I., & Howley, H. (2013). 'Not another safety culture survey': Using the Canadian patient safety climate survey (Can-PSCS) to measure provider perceptions of PSC across health settings. *BMJ Journal*, *In press*. doi:doi:10.1136/bmjqs-2013-002220
- Gittelman, S., Lange, V., Cook, W. A., Frede, S. M., Lavrakas, P. J., Pierce, C., & Thomas, R., K. (2015). Accounting for social-desireability bias in survey sampling. *Journal of Advertising Research*, 55(3). doi:10.2501/JAR-2015-006
- Global Council on Brain Health. (2017). *The brain and social connectedness: GCBH recommendations on social engagement and brain health*. Retrieved March 26, 2018 from https://www.aarp.org/content/dam/aarp/health/brain_health/2017/02/gcbh-social-engagement-report-english-aarp.doi.10.26419%252Fpia.00015.001.pdf
- Godwin, B., & Poland, F. (2015). Bedlam or bliss? Recognizing the emotional self-experience of people with moderate to advanced dementia in residential and nursing care. *Quality in Ageing and Older Adults*, 16(4), 235-248. doi:10.1108/QAOA-08-2015-0038
- Government of Canada. (2016). *Rights and responsibilities of citizenship*. Retrieved September 5, 2018 from <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/discover-canada/read-online/rights-responsibilities-citizenship.html>

- Government of Canada. (2017a). *Rights of people with disabilities*. Retrieved August 17, 2018 from <https://www.canada.ca/en/canadian-heritage/services/rights-people-disabilities.html>
- Government of Canada. (2017b). Who's at risk and what can be done about it?; A review of the literature on the social isolation of different groups of seniors. Retrieved March 10, 2018 from <https://www.canada.ca/en/national-seniors-council/programs/publications-reports/2017/review-social-isolation-seniors.html>
- Greenaway, K., Cruwys, T., Haslam, A. S., & Jetten, J. (2015). Social identities promote well-being because they satisfy global psychological needs. *European Journal of Social Psychology*, 46(3), 294-307. doi:10.1002/ejsp.2169
- Gubrium, J. F., & Holstein, J. A. (1999). The nursing home as a discursive anchor for the ageing body. *Ageing & Society*, 19(5), 519-538. doi:10.1017/S0144686X99007448
- Hagerty, B. M., & Patusky, K. (1995). Developing a measure of sense of belonging. *Nursing Research*, 44(1), 9-13.
- Hagerty, B. M. K., Lynch-Sauer, J., Patusky, K. L., Bouwsema, M., & Collier, P. (1992). Sense of belonging: A vital mental health concept. *Archives of Psychiatric Nursing*, 6(3), 172-177.
- Hall, S., Dodd, R. H., & Higginson, I. J. (2014). Maintaining dignity for residents of care homes: A qualitative study of the view of care home staff, community nurses, residents and their families. *Geriatric Nursing*, 35(1), 55-60. doi:10.16/j.gerinurse.2013.10.012
- Hartmaier, S. L., Sloane, P. D., Guess, H. A., Koch, G. G., Mitchell, M., & Phillips, C. D. (1995). Validation of the Minimum Data Set Cognitive Performance Scale: Agreement with the Mini-Mental State Examination. *Journals of Gerontology: Series B, Psychological Sciences and Social Sciences*, 50(A), M128-M133.
- Haslam, A. S., Haslam, C., Cruwys, T., Jetten, J., Dingle, G., & Greenaway, K. (2017). Applying the social identity approach in clinical and health domains: Key principles and insights. In S. A. Buckingham & D. Best (Eds.), *Addiction, behavioral change and social identity* (pp. 14-33). New York, NY: Routledge.
- Haslam, C., Haslam, S. A., Jetten, J., Bevins, A., Ravenscroft, S., & Tonks, J. (2010). The social treatment: The benefits of group interventions in residential care settings. *Psychology and Aging*, 25(1), 157-167. doi:10.1037/a0018256

- Haslam, S. A. (2014). Making good theory practical: Five lessons for an applied social identity approach to challenges of organizational, health, and clinical psychology. *British Journal of Social Psychology*, 53(1), 1-20. doi:10.1111/bjso.12061
- Haugan, G. (2014). Meaning-in-life in nursing-home patients: A correlate with physical and emotional symptoms. *Journal of Clinical Nursing*, 23(13-14), 1830-1844. doi:10.1111/jocn.12402
- Hawkey, L. C., & Capitanio, J. P. (2015). Perceived social isolation, evolutionary fitness and health outcomes: A lifespan approach. *Philosophical Transactions B*, 370. doi:0.1098/rstb.2014.01114
- Heikkinen, R. L., & Kauppinen, M. (2004). Depressive symptoms in late life: A 10-year follow-up. *Archives of Gerontology & Geriatrics*, 38(3), 239-250. doi:10.1016/j.archger.2003.10.004
- Henderson, J. N. (1995). The culture of care in a nursing home: Effects of a medicalized model of long-term care. In J. N. Henderson & M. D. Vesperi (Eds.), *The culture of long term care: Nursing home ethnography* (pp. 37-54). Westport, CT: Bergin & Garvey.
- Hesse-Biber, S. N., & Leavy, P. (2006). In-depth interview. In S. N. Hesse-Biber & P. Leavy (Eds.), *The practice of qualitative research* (pp. 119-148). Thousand Oaks, CA: Sage.
- Hirst, S. P., Penney, T., McNeill, S., Boscart, V., M., Podnieks, E., & Sinha, S. K. (2016). Best-practice guideline on the prevention of abuse and neglect of older adults. *Canadian Journal on Aging*, 35(2), 242-260. doi:10.1017/S0714980816000209
- Hoffmann, T., Glasziou, P., Boutron, I., Milne, R., Perera, R., Moher, D., . . . Michie, S. (2014). Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *British Medical Journal*, 348(g1687), 1-12. doi:10.1136/bmj.g1687
- Holt-Lunstad, J., Smith, T., B., Baker, M., Harris, T., & Stepheson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, 10(2), 227-237. doi:10.1177/1745691614568352
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288. doi:10.1177/1049732305276687

- Hutchinson, A. M., Milke, D. L., Maisey, S., Johnson, C., Squires, J. E., Teare, G., & Estabrooks, C. A. (2010). The Resident Assessment Instrument-Minimum Data Set 2.0 quality indicators: A systematic review. *BMC Health Services Research*, 10(1), 166-180. doi:10.1186/1472-6963-10-166
- Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Retrieved March 29, 2018 from <https://www.ncbi.nlm.nih.gov/books/NBK201410/>
- Irvine, A. B., Billow, M. B., Eberhage, M. G., Seeley, J. R., McMahon, E., & Bourgeois, M. (2012). Mental illness training for licensed staff in long-term care. *Issues in Mental Health Nursing*, 33(3), 131-194. doi:10.3109/01612840.2011.639482
- Irving, J., Davis, S., & Collier, A. (2017). Aging With purpose: Systematic search and review of literature pertaining to older adults and purpose. *The International Journal of Aging and Human Development*, 85(4), 403-437. doi:10.1177/0091415017702908
- Iversen, T. N., Larsen, L., & Solem, P. E. (2009). A conceptual analysis of ageism. *Nordic Psychology*, 61(3), 4-22. doi:10.1027/1901-2276.61.3.4
- Jenkinson, C. E., Dickens, A. P., Jones, K., hompson-Coon, J., Taylor, R. S., Rogers, M., . . . Richards, S. H. (2013). Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Health Services*, 13(1), 773. doi:10.1186/1471-2458-13-773
- Jetten, J., Haslam, C., & Haslam, S. A. (2012). *The social cure: Identity, health and well-being*. New York, NY: Psychology Press.
- Joo, J. H., Hwang, S., Abu, H., & Gallo, J. J. (2016). An innovative model of depression care delivery: Peer mentors in collaboration with a mental health professional to relieve depression in older adults. *The American Journal of Geriatric Psychiatry*, 24(5), 407-416. doi:10.1016/j.jagp.2016.02.002
- Jung, Y., Gruenewald, T. L., Seeman, T. E., & Sarkisian, C. A. (2010). Productive activities and development of frailty in older adults. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 65B(2), 256-261. doi:10.1093/geronb/gbp105
- Kahana, E., Bhatta, T., Lovegreen, L. D., Kahana, B., & Midlarsky, E. (2013). Altruism, helping, and volunteering: Pathways to well-being in late life. *Journal of Aging and Health*, 25(1), 159-187. doi:10.1177/0898264312469665

- Kamiya, Y., Doyle, M., Henretta, J. C., & Timonen, V. (2013). Early-life circumstances and later-life loneliness in Ireland. *The Gerontologist*, 54(5), 773-783. doi:10.1093/geront/gnt097
- Kane, R. A. (2001). Long-term care and a good quality of life: Bringing them closer together. *The Gerontologist*, 41(3), 293-304. doi:10.1093/geront/41.3.293
- Kane, R. A., Lum, O., Cutler, L. J., Degenholtz, H. B., & Yu, T. (2007). Resident outcomes in small-house nursing homes: A longitudinal evaluation of the initial green house program. *Journal of Geriatrics Society*, 55, 832-839.
- Kane, R. L. (2010). Reimagining nursing homes: The art of the possible. *Journal of Aging & Social Policy*, 22(4), 321-333. doi:10.1080/08959420.2010.507509
- Kapp, M. B. (2012). Nursing home culture change: Legal apprehensions and opportunities. *The Gerontologist*, 53(5), 718-726. doi:10.1093/geront/gns131
- Katz, S. (2000). Busy bodies: Activity, aging and the management of everyday life. *Journal of Aging Studies*, 14(2), 135-152. doi:10.1016/S0890-4065(00)80008-0
- Kellen, M. J. (2003). How do you know activities make a difference? Practice-based research and evaluation. *Activities, Adaptation and Aging*, 27(3-4), 65-78.
- Kelly, F., & Innes, A. (2012). Human rights, citizenship and dementia care nursing. *International Journal of Older People Nursing*, 8(1), 61-70. doi:doi:10.1111/j.1748-3743.2011.00308.x
- Kelson, E. E. (2013). *Challenges of person-centred dementia care: A critical ethnography of culture change in long-term care* (Doctor of Philosophy, University of British Columbia, Vancouver, BC). Retrieved March 10, 2018 from <http://hdl.handle.net/2429/44261>
- Kemp, C. L., Ball, M. M., Hollingsworth, C., & Perkins, M. M. (2012). Strangers and friends: Residents' social careers in assisted living. *Journals of Gerontology: Series B, Psychological Sciences and Social Sciences*, 67(4), 491-502. doi:10.1093/geronb/gbs043
- Keyes, S. E., Clarke, C. L., Wilkinson, H., Alexjuk, E. J., Wilcockson, J., Robinson, L., . . . Cattan, M. (2014). "We're all thrown in the same boat...": A qualitative analysis of peer support in dementia care. *Dementia*, 15(4), 560-577. doi:10.1177/1471301214529575

- Killen, A., & Macaskill, A. (2015). Using a gratitude intervention to enhance well-being in older adults. *Journal of Happiness Studies*, 16(4), 947-964. doi:10.1007/s10902-014-9542-3
- Kim, S., & Ferraro, K. F. (2014). Do productive activities reduce inflammation in later life? Multiple roles, frequency of activities, and C-Reactive Protein. *The Gerontologist*, 54(5), 830-839. doi:10.1093/geront/gnt090
- Kirshner, H. S. (2011). Efficacy and safety of antidepressant with dementia. *Current Neurology and Neuroscience Reports*, 11(6), 520-522. doi:10.1007/s11910-011-0222-y
- Kissane, M., & McLaren, S. (2006). Sense of belonging as a predictor of reasons for living in older adults. *Death Studies*, 30(3), 243-258.
- Kitwood, T. (1997). *Dementia reconsidered: The person comes first*. Philadelphia, PA: Open University Press.
- Kitwood, T. (2013). The concept of personhood and its relevance for a new culture of dementia care. In G. M. M. Jones & B. M. L. Miesen (Eds.), *Care-Giving in Dementia 2*. New York, NY: Routledge.
- Kitwood, T., & Bredin, K. (1992). Toward a theory of dementia care: Personhood and well-being. *Ageing and Society*, 12(3), 269-287. doi:10.1017/S0144686X0000502X
- Kleuver, L. D. (2013). Human rights: Meaningless to those with mental health issues. *Australian Nursing Journal*, 20(7), 1.
- Klinedinst, N. J., & Resnick, B. (2014). Volunteering and depressive symptoms among residents in a continuing care retirement community. *Journal of Gerontological Social Work*, 57(1), 52-71. doi:10.1080/01634372.2013.867294
- Knight, B. G., & Sayegh, P. (2011). Mental health and aging in the 21st century. *Journal of Aging & Social Policy*, 23(3), 228-243. doi:10.1080/08959420.2011.579494
- Knight, C., Haslam, S. A., & Haslam, C. (2010). In home or at home? How collective decision making in a new care facility enhances social interaction and wellbeing amongst older adults. *Ageing & Society*, 30(08), 1393-1418. doi:10.1017/S0144686X10000656
- Knight, T., & Mellor, D. (2007). Social inclusion of older adults in care: Is it just a question of providing activities? *International Journal of Qualitative Studies in Health and Well-being*, 2(2), 76-85. doi:10.1080/17482620701320802

- Kontos, P. (2011). Rethinking sociability in long-term care: An embodied dimension of selfhood. *Dementia*, 11(3), 329-346. doi:10.1177/1471301211421073
- Kontos, P., & Martin, W. (2013). Embodiment and dementia: Exploring critical narratives of selfhood, surveillance, and dementia care. *Dementia*, 12(3), 288-302. doi:10.1177/1471301213479787
- Kontos, P. C. (2005). Embodied selfhood in Alzheimer's disease. *Dementia*, 4(4), 553-570. doi:10.1177/1471301205058311
- Kontos, P. C., & Grigorovich, A. (2018). Rethinking musicality in dementia as embodied and relational. *Journal of Aging Studies*, 45(1), 39-48. doi:10.1016/j.jaging.2018.01.006
- Koopmans, R. T. C. M., Zuidema, S. U., Leontjevas, R., & Gerritsen, D. L. (2010). Comprehensive assessment of depression and behavioral problems in long-term care. *International Psychogeriatrics*, 27(7), 1054-1062. doi:10.1017/S1041610210000736
- Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, 29(2), 1-6. doi:10.1377/hlthaff.2009.0966
- Kotter-Grühn, D., & Hess, T. M. (2012). The impact of age stereotypes on self-perceptions of aging across the adult lifespan. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 67(5), 563-571. doi:10.1093/geronb/gbr153
- Kralj-Vasilj, M., Degmečić, D., Včev, A., & Mikšić, Š. (2013). Loneliness, grieving process and depression affecting people of old age. *South Eastern Europe Health Sciences Journal*, 3(1), 19-25.
- Krauss, S. E. (2005). Research paradigms and meaning making: A primer. *The Qualitative Report*, 10(4), 758-770.
- Kurusu, K., Terada, S., Oshima, E., Horiuchi, M., Imai, N., Yabe, M., . . . Yamada, N. (2016). Comparison of QOL between patients with different degenerative dementias, focusing especially on positive and negative affect. *International Psychogeriatrics*, 28(8), 1355-1361. doi:10.1017/S1041610216000491
- Kusmaul, N., Bern-Klug, M., & Bonifas, R. (2017). Ethical issues in long-term care: A human rights perspective. *Journal of Human Rights and Social Work*, 2(3), 86-97. doi:10.1007/s41134-017-0035-2

- Lach, H. W. (2010). Can older adults with dementia accurately report depression using brief forms. *Journal of Gerontological Nursing*, 36(5), 30-37. doi:10.3928/00989134-20100303-01
- Lambert, N. M., Stillman, T. F., Hicks, J. A., Kamble, S., Baumeister, R. F., & Fincham, F. D. (2013). To belong is to matter: Sense of belonging enhances meaning in life. *Personality and Social Psychology Bulletin*, 39(11), 1418-1427. doi:10.1177/0146167213499186
- Lanoix, M. (2007). The citizen in question. *Hypatia*, 22(4). doi:10.1353/hyp.2007.0053
- Laschinger, H. K. S., Gilbert, S., Smith, L. M., & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: Applying Kanter's empowerment theory to patient care. *Journal of Nursing Management*, 18(1), 4-13. doi:10.1111/j.1365-2834.2009.01046.x
- Leedahl, S. N., Esllon, A. M., & Gallopyn, N. (2017). Factors predicting civic engagement among older adult nursing home residents. *Activities, Adaptation and Aging*, 41(3), 197-219. doi:10.1080/01924788.2017.1310581
- Li, Y., & Ferraro, K. F. (2006). Volunteering in middle and later life: Is it a health benefit, barrier, or both? *Social Forces*, 85(1), 497-519. doi:10.1353/sof.2006.0132
- Library of Congress. (1987). *H.R.3545: Omnibus Budget Reconciliation Act of 1987*. Retrieved October 15, 2018 from <https://www.congress.gov/bill/100th-congress/house-bill/3545>
- Lister, R. (2003). *Citizenship: Feminist perspectives*. London: Macmillan.
- Lister, R. (2007). 'Inclusive citizenship: Realizing the potential. *Citizenship Studies*, 11(1), 49-61. doi:10.1080/13621020601099856
- Long, J. A., Jahnle, E. C., Richardson, D. M., Loewenstein, G., & Volpp, K. G. (2012). Peer mentoring and financial incentives to improve glucose control in African American veterans. *Annals of Internal Medicine*, 156(6), 416-424. doi:10.7326/0003-4819-156-6-201203200-00004
- Lopez, K. J., & Dupuis, S. L. (2014). Exploring meanings and experience of wellness from residents living in long-term care homes. *World Leisure Journal*, 56(2), 141-150. doi:10.1080/16078055.2014.903724
- Lynch, J. J. (2000a). *A cry unheard: New insights into the medical consequences of loneliness*. Baltimore, MD: Bancroft Press.

- Lynch, J. J. (2000b). Living together, Dying alone. *A cry unheard: Medical consequences of loneliness* (pp. 79-115). Baltimore: Bancroft Press.
- Maas, M. L., Kelley, L. S., Park, M., & Specht, J. P. (2002). Issues on conducting research in nursing homes. *Western Journal of Nursing Research*, 24(4), 373-389.
- Maher, C. G., Sherrington, C., Herbert, R. D., Moseley, A. M., & Elkins, M. (2003). Reliability of the PEDro Scale for rating quality of randomized controlled trials. *Physical Therapy*, 83(8), 713-722.
- Malmedal, W. (2014). Norwegian nursing home: A care facility or a home? *Open Journal of Nursing*, 4(1), 337-342. doi:10.4236/ojn.2014.45039
- Marshall, T. H. (1949/92). Citizenship and social class. In T. H. Marshall & T. Bottomore (Eds.), *Citizenship and social class* (pp. 3-51). London, UK: Pluto Press.
- Masi, C. M., Chen, H. Y., Hawkey, L. C., & Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review*, 15(3), 219-266. doi:10.1177/1088868310377394
- Mason, E., Clare, L., & Pistrang, N. (2005). Processes and experiences of mutual support in professionally-led support groups for people with early-stage dementia. *Dementia*, 4(1), 87-112.
- Mattimore, T. J., Wenger, N. S., Cesbiens, N. A., Teno, J. M., Hamel, M. B., Liu, H., . . . Oye, R. K. (1997). Surrogate and physician understanding of patients' preferences for living permanently in a nursing home. *Journal of the American Geriatrics Society*, 45, 818-824.
- McColgan, G. (2005). A place to sit: Resistance strategies used to create privacy and home by people with dementia. *Journal of Contemporary Ethnography*, 34(4), 410-433. doi:10.1177/0891241605275574
- McLaren, S., Gibbs, P. M., & Watts, E. (2012). The interrelations between age, sense of belonging, and depressive symptoms among Australian gay men and lesbians. *Journal of Homosexuality*, 60(1), 1-15. doi:10.1080/00918369.2013.735933
- Meeks, S., & Looney, S., W. (2011). Depressed nursing home residents' activity participation and affect as a function of staff engagement. *Behavior Therapy*, 42(1), 22-29. doi:10.1016/j.beth.2010.01.004

- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Retrieved March 10, 2018 from https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf
- Meyer, M. H. (1991). Assuring quality of care: Nursing home resident councils. *Journal of Applied Gerontology*, 10(1), 103-116. doi:10.1177/073346489101000108
- Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D., & Walker, A. (2005). Making psychological theory useful for implementing evidence based practice: A consensus approach. *Quality and Safety in Health Care*, 14(1), 26-33. doi:10.1136/qshc.2004.011155
- Miller, S. C., Looze, J., Shield, R., Clark, M. A., Lepore, M., Tyler, D., . . . Mor, V. (2013). Culture change practice in U.S. nursing homes: Prevalence and variation by state medicaid reimbursement policies. *The Gerontologist*, *In press*. doi:10.1093/geront/gnt020
- Milne, A. (2010). The 'D' word: Reflections on the relationship between stigma, discrimination and dementia. *Journal of Mental Health*, 19(3), 227-233. doi:10.3109/09638231003728166
- Ministry of Health. (2009). Resident Bill of Rights. Retrieved November 26 from http://www.health.gov.bc.ca/ccf/residents_bill_of_rights.html
- Molloy, R. J., & Butler, D. (2012). Federal requirements & regulatory provisions relevant to dementia care & the use of antipsychotic drugs.
- Moon, H. (2012). Risk factors for depression among the oldest-old in urban congregate housing: Contribution of grief. *International Social Work*, 56(4), 516-533. doi:10.1177/0020872811429954
- Morris, J. N., Fries, B. E., Mehr, D. R., Hawes, C., Phillips, C. D., Mor, V., & Lipsitz, L. A. (1994). MDS Cognitive Performance Scale. *Journal of Gerontology*, 49(4), M174-M182.
- Morrow-Howell, N., Hinterlong, J., Rozario, P. A., & Tang, F. (2003). Effects of volunteering on the well-being of older adults. *Journal of Gerontology*, 58B(3), S137-S145.
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counselling Psychology*, 52(2), 250-260. doi:10.1037/0022-0167.52.2.250

- Mulhall, A. (2003). In the field: Notes on observation in qualitative research. *Journal of Advanced Nursing*, 41(3), 306-313.
- Munro, D., Downie, M., & Stonebridge, C. (2011, January). Elements of an effective innovation strategy for long term care in Ontario (Report): Ottawa, Ontario, Canada: The Conference Board of Canada. Retrieved October 22, 2018 from <http://neltoolkit.rnao.ca/sites/default/files/Elements%20of%20an%20Effective%20Innovation%20Strategy%20for%20Long%20Term%20Care%20in%20Ontario%202011.pdf>
- Murfield, J., Cooke, M., Moyle, W., Shum, D., & Harrison, S. (2011). Conducting randomized controlled trials with older people with dementia in long-term care: Challenges and lessons learnt. *International Journal of Nursing Practice*, 17(1), 52-59. doi:10.1111/j.1440-172X.2010.01906.x
- Murphy, K., Jordan, F., Hunter, A., Cooney, A., & Casey, D. (2015). Articulating the strategies for maximising the inclusion of people with dementia in qualitative research studies. *Dementia*, 8(6), 800-824. doi:10.1177/1471301213512489
- Nakamae, T., Yotsumoto, K., Tatsumi, E., & Hashimoto, T. (2014). Effects of productive activities with reminiscence in occupational therapy for people with dementia: A pilot randomized controlled study. *Hong Kong Journal of Occupational Therapy*, 24(1), 13-19. doi:10.1016/j.hkjot.2014.01.003
- Natan, M. B., Ataneli, M., Admenko, A., & Har, R. (2013). Nurse assessment of residents' pain in a long-term care facility. *International Nursing Review*, 60(2), 251-257. doi:10.1111/inr.12006
- National Advisory Council on Aging. (2003). *The myths of aging*. Ottawa: NACA.
- Nencini, A., & Romaioli, D. M., A. (2016). Volunteer motivation and organizational climate: Factors that promote satisfaction and sustained volunteerism in NPOs. *Voluntas: International Journal of Voluntary and Non Profit Organizations*, 27(2), 618-639. doi:10.1007/s11266-015-9593-z
- Neto, F. (2014). Psychometric analysis of the short-form UCLA Loneliness Scale (ULS-6) in older adults. *European Journal of Aging*, 11(4), 313-319. doi:10.1007/s10433-014-0312-1
- Neufeld, E., Freeman, S., Joling, K., & Hirdes, J. P. (2014). "When the golden years are blue": Changes in depressive symptoms over time among new admitted to long term care facilities. *Clinical Gerontologist*, 37(3), 298-315. doi:10.1080/07317115.2014.885919

- Newall, N. E. G., & Menec, V. H. (2017). Loneliness and social isolation of older adults: Why it is important to examine these social aspects together. *Journal of Social and Personal Relationships*. doi:10.1177/0265407517749045
- Nolan, M. R., Davies, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond person-centered care: A new vision of gerontological nursing. *International Journal of Older People Nursing*, 13(3a), 45-53.
- Nyqvist, F., Cattan, M., Andersson, L., Forsman, A. K., & Gustafson, Y. (2013). Social capital and loneliness among the very old living at home and in institutional settings. *Journal of Aging and Health*, 2(1), 1013-1035. doi:10.1177/0898264313497508
- Nyqvist, F., Cattan, M., Conradsson, M., Näsman, M., & Gustafsson, Y. (2017). Prevalence of loneliness over ten years among the oldest old. *Scandinavian Journal of Public Health*, 45(4), 411-418. doi:10.1177/1403494817697511
- O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine*, 89(9), 1245-1251. doi:10.1097/ACM.0000000000000388
- O'Connor, D. (2010). Personhood and dementia: Toward a relational framework for assessing decisional capacity. *The Journal of mental Health Training, Education and Practice*, 5(3), 22-30. doi:10.5042/jmhtep.2010.0501
- O'Dwyer, C. (2013). Official conceptualizations of person-centered care: Which person counts? *Journal of Aging Studies*, 10(1), 233-242. doi:10.1016/j.jaging.2013.03.003
- O'Dwyer, C., & Timonen, V. (2010). Rethinking the value of Residents' Councils: Observations and lessons from an exploratory study. *Journal of Applied Gerontology*, 29(6), 762-771. doi:10.1177/0733464809348002
- Oakley, A., Strange, V., Bonell, C., Allen, E., & Stephenson, J. (2006). Process evaluation in randomised controlled trials of complex interventions. *British Medical Journal*, 18(1), 413-416. doi:10.1136/bmj.332.7538.413
- OARC's Mandate. (2018). Ontario Association of Residents' Councils. Retrieved August 17, 2018 from <http://www.ontarc.com/index.html>
- Ong, A. D., Uchino, B. N., & Wethington, E. (2016). Loneliness and health in older adults: A mini-review and synthesis. *Gerontology*, 62(4), 443-449. doi:10.1159/000441651

- Ontario Ministry of Health and Long-Term Care. (2007). Long-Term Care Homes Act. Retrieved November 7, 2012 from <http://www.health.gov.on.ca/en/common/legislation/litcha/default.aspx>
- Orsmond, G. I., & Cohn, E. S. (2015). The distinctive features of a feasibility study: Objectives and guiding questions. *OTJR: Occupation, Participation and Health*, 35(3), 169-177. doi:10.1177/1539449215578649
- Page, S. J., & Persch, A. C. (2013). Recruitment, retention, and blinding in clinical trials. *The American Journal of Occupational Therapy*, 67(2), 154-161. doi:10.5014/ajot.2013.006197
- Paquay, L., Lepeleire, J. D., Schoenmakers, B., Ylief, M., Fontaine, O., & Buntinx, F. (2007). Comparison of the diagnostic accuracy of the Cognitive Performance Scale (Minimum Data Set) and the Mini-Mental State Exam for the detection of cognitive impairment in nursing home residents. *International Journal of Geriatric Psychiatry*, 22(4), 286-293. doi:10.1002/gps.1671
- Paraprofessional Healthcare Institute. (2006). *Adult learner-centered training: An introduction for educators in home and residential care*. Retrieved March 10, 2018 from [https://phinational.org/wp-content/uploads/legacy/clearinghouse/PHI-386%20ALCT%20Guide%20\(small\).pdf](https://phinational.org/wp-content/uploads/legacy/clearinghouse/PHI-386%20ALCT%20Guide%20(small).pdf)
- Park, N. S., Zimmerman, S., Sloane, P. D., Gruber-Bladini, A. L., & Eckert, J. K. (2006). An empirical typology of residential care/assisted living based on a four-state study. *The Gerontologist*, 46(2), 238-248. doi:10.1093/geront/46.2.238
- Pelto, P. J. (2013). *Applied ethnography: Guidelines for field research*. New York, NY: Routledge.
- Peplau, L. A., & Perlman, D. (1982). Perspectives on loneliness. In L. A. Peplau & D. Perlman (Eds.), *Loneliness: A source book of current theory, research and therapy* (pp. 1-18). New York, NY: Wiley-Interscience.
- Persson, D. I. (2004). Volunteer ombudsmen in the nursing home: Obstacles to retention. *Journal of Aging Studies*, 18(2), 205-214. doi:10.1016/j.jaging.2004.01.003
- Pieters, R. (2013). Bidirectional dynamics of materialism and loneliness: Not just a vicious cycle. *Journal of Consumer Research*, 40(1), 615-631. doi:10.1086/671564
- Pinquart, M. (2002). Creating and maintaining purpose in life in old age: A meta-analysis. *Ageing International*, 27(2), 90-114.

- Pioneer Network. (2010). Continuum of Person-Directed Culture. Retrieved December 7, 2013
- Pioneer Network. (2018). Defining cultural change: Inspiring innovation and transformation. Retrieved March 10, 2018 from <https://www.pioneernetwork.net/culture-change/what-is-culture-change/>
- Pope, H. C., Miller, M. C., Wolfer, T. A., Mann, J. R., & McKeown, R. E. (2013). Psychometric analysis of a scale to assess norms of reciprocity of social support in community-base and congregation-based groups. *Sage Open*, 3(4), 1-12. doi:10.1177/2158244013516771
- Popham, C., & Orrell, M. (2012). What matters for people with dementia in care homes? *Aging & Mental Health*, 16(2), 181-188. doi:10.1080/13607863.2011.628972
- Port, A., Barrett, V. W., Gurland, B. J., Prerez, M., & Riti, F. (2011). Engaging nursing home residents in meaningful activities. *Annals of Long-Term Care*, 19(12), 20-26.
- Poss, J. W., Jutan, N. M., Hirdes, J., Fries, B. E., Morris, J. N., Teare, G. F., & Reidel, K. (2008). A review of evidence on the reliability and validity of Minimum Data Set data. *Healthcare Management Forum*, 21(1), 33-39. doi:10.1016/S0840-4704(10)60127-5
- Post, S. G. (2011). It's good to be good: 2011 fifth annual scientific report on health, happiness and helping others. *The International Journal of Person Centered Medicine*, 1(4), 814-829. doi:10.5750/ijpcm.v1i4.154
- Postmes, T., Haslam, A. S., & Jans, L. (2013). A single-item measure of social identification: Reliability, validity and utility. *British Journal of Social Psychology*, 52(4), 597-617. doi:10.1111/bjso.12006
- Powell, J. L. (2006). *Social theory and aging*. New York: Rowman and Littlefield.
- Powell, J. L. (2009). Social theory, aging, and health and welfare professionals: A Foucauldian "toolkit". *Journal of Applied Gerontology*, 28(6), 669-682. doi:10.1177/0733464809335596
- Power, A. G. (2010). *Dementia beyond drugs: Changing the culture of care*. Baltimore, MA: Health Professions Press.
- Power, A. G. (2017). *Dementia beyond drugs: Changing the culture of care* (2nd ed.). Baltimore, MA: Health Professions Press.

- Prieto-Flores, M.-E., Fernandez-Mayoralas, G., Forjaza, M. J., Rojo-Perez, F., & Martinez-Martin, P. (2011). Residential satisfaction, sense of belonging and loneliness among older adults living in the community and in care facilities. *Health and Place*, 17(6), 1183-1190. doi:10.1016/j.healthplace.2011.08.012
- Public Health Agency of Canada. (2010). *The Chief Public Health Officer's report on the state of public health in Canada, 2010: Growing older – Adding life to years*. Retrieved August 22, 2018 from http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2010/fr-rc/pdf/cpho_report_2010_e.pdf
- Rabe, K. S. (2018). *Cross-age peer mentoring: A case study of resiliency building relationships* (Doctoral dissertation). Available from ProQuest Dissertations Publishing database. (UMI No. 10831526)
- Rash, E. M. (2007). Social support in elderly nursing home populations: Manifestations and influences. *The Qualitative Report*, 12(3), 375-396.
- Raymond, J. M., & Sheppard, K. (2017). Effects of peer mentoring on nursing students' perceived stress, sense of belonging, self-efficacy and loneliness. *Journal of Nursing Education and Practice*, 8(1), 16-23. doi:10.5430/jnep.v8n1p16
- Resnick, B., Klinedinst, J., Dorsey, S., Holtzman, L., & Abuelhiga, L. S. (2013). Volunteer behavior and factors that influence volunteering among residents in continuing care retirement communities. *Journal of Housing for the Elderly*, 27(1-2), 161-176. doi:10.1080/02763893.2012.754820
- Reysen, S., Katzarska-Miller, I., Nesbit, S. M., & Pierce, L. (2013). Further validation of a single-item measure of social identification. *European Review of Social Psychology*, 43(6), 463-470. doi:10.1002/ejsp.1973
- Richardson, T. J., Lee, S. J., Berg-Weger, M., & Grossberg, G. T. (2013). Caregiver health: Health of caregivers of Alzheimer's and other dementia patients. *Current Psychiatry Reports*, 15(7), 367-374. doi:10.1007/s11920-013-0367-2
- Rico-Uribe, L. A., Caballero, F. F., Olaya, B., Tobiasz-Adamczyk, B., Koskinen, S., Leonardi, M., . . . Miret, M. (2016). Loneliness, social networks, and health: A cross-sectional study in three countries. *PLoS ONE*, 11(1), e0145264. doi:10.1371/journal.pone.0145264
- Riedl, M., Mantovan, F., & Them, C. (2013). Being a nursing home resident: A challenge to one's identity. *Nursing Research and Practice*, 65(5), 280-285. doi:10.1155/2013/932381

- Rios, S., Perlman, C. M., Costa, A., Heckman, G., Hirdes, J. P., & Mitchell, L. (2017). Antipsychotics and dementia in Canada: A retrospective cross-sectional study of four health sectors. *BMG Geriatrics*, 17(1), 244-252. doi:10.1186/s12877-017-0636-8
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analysing Qualitative Data* (pp. 173-194). London: Routledge.
- Roach, P., & Drummond, N. (2014). 'It's nice to have something to do': Early-onset dementia and maintaining purposeful activity. *Journal of Psychiatric and Mental Health Nursing*, 21(10), 889-895. doi:10.1111/jpm.12154
- Robichaud, L., Durand, P. J., Bédard, R., & Ouellet, J.-P. (2007). Quality of life indicators in long term care: Opinions of elderly residents and their families. *The Canadian Journal of Occupational Therapy*, 73(4), 245-251. doi:10.2182/cjot.06.003
- Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.
- Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity and factor structure. *Journal of Personality Assessment*, 66(1), 20-40.
- Ryan, T., Nolan, M. R., Reid, D., & Enderby, P. (2008). Using the senses framework to achieve relationship-centred dementia care services. *Dementia*, 7(1), 71-93. doi:10.1177/1471301207085368
- Ryff, C. D., Heller, A. S., Schaefer, S. M., van Reekum, C., & Davidson, R. J. (2016). Purposeful engagement, healthy aging, and the brain. *Current Neurology and Neuroscience Reports*, 3(4), 318-327. doi:10.1007/s40473-016-0096-z
- Sabat, S. R. (2001). *The experience of Alzheimer's disease: Life through a tangled veil*. Oxford, UK: Blackwell Publishers Ltd.
- Sabat, S. R., Fath, H., Moghabghab, R., & Harré, R. (1999). The maintenance of self-esteem: Lessons from the culture of Alzheimer's sufferers. *Culture & Psychology*, 5(1), 5-31. doi:10.1177/1354067X9951001
- Sabat, S. R., & Lee, J. M. (2011). Relatedness among people diagnosed with dementia: Social cognition and the possibility of friendship. *Dementia*, 11(3), 315-327. doi:10.1177/1471301211421069

- Salsman, J. M., Lai, J.-S., Hendrie, H. C., Butt, Z., Zill, N., Pilkonis, P. A., . . . Cella, D. (2013). Assessing psychological well-being: Self-report instruments for the NIH Toolbox. *Quality of Life Research*, 23(1), 205-215. doi:10.1007/s11136-013-0452-3
- Saunders, R. P., Evans, M. H., & Joshi, P. (2005). Developing a process-evaluation plan for assessing health promotion program implementation: A how-to guide. *Health Promotion Practice*, 6(2), 134-147. doi:DOI: 10.1177/1524839904273387
- Schafer, M. H. (2014). On the locality of asymmetric close relations: Spatial proximity and health differences in a senior community. *Journals of Gerontology: Series B, Psychological Sciences and Social Sciences*, 70(1), 100-110. doi:10.1093/geronb/gbu043
- Scheier, M., C., W., A., B., S., C., L.M., M., K.A., M., . . . B., Z. (2006). The Life Engagement Test: Assessing purpose in life. *Journal of Behavioral Medicine*, 29(3), 291-800.
- Schneider, B., Ehrhart, M. G., & Macey, W. H. (2013). Organizational climate and culture. *Annual Review of Psychology*, 64, 361-388. doi:10.1146/annurev-psych-113011-143809
- Scholl, J. M., & Sabat, S. R. (2008). Stereotypes, stereotype threat and ageing: Implications for the understanding and treatment of people with Alzheimer's disease. *Ageing & Society*, 28(1), 103-130. doi:10.1017/S0144686X07006241
- Schwartz, C. (2007). Altruism and subjective well-being: Conceptual model and empirical support. In S. G. Post (Ed.), *Altruism and Health* (pp. 70-81). New York, NY: Oxford University Press.
- Scocco, P., Rapattoni, M., & Fantoni, G. (2006). Nursing home institutionalization: A source of eustress or distress for the elderly? *International Journal of Geriatric Psychiatry*, 21(1), 281-287. doi:10.1002/gps.1453
- Sellon, A. M., Chapin, R. K., & Leedahl, S. N. (2017). Engaging nursing homes residents in formal volunteer activities: A focus on strengths. *Ageing International*, 42(1), 93-114. doi:10.1007/s12126-016-9252-8
- Sheehan, B. (2012). Assessment scales in dementia. *Therapeutic Advances in Neurological Disorders*, 5(6), 349-358. doi:10.1177/1756285612455733
- Sheets, D. K., & Gallagher, E. M. (2012). Aging in Canada: State of the art and science. *The Gerontologist*, 53(1), 1-8. doi:10.1093/geront/gns150

- Sheikh, J. I., & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version *Clinical Gerontology: A guide to assessment and intervention*. New York, NY: The Haworth Press.
- Sherman, J. E., DeVinney, D. J., & Sperline, K. B. (2004). Social support and adjustment after spinal cord injury: Influence of past peer-mentoring experiences and current live-in partner. *Rehabilitation Psychology*, 49(2), 140-149. doi:10.1037/0090-5550.49.2.140
- Sherwin, S., & Winsby, M. (2011). A relational perspective on autonomy for older adults residing in nursing homes. *Health Expectations*, 14(2), 182-190. doi:10.1111/j.1369-7625.2010.00638.x
- Shield, R. R., Looze, J., Tyler, D., Lepore, M., & Miller, S. C. (2014). Why and how do nursing homes implement culture change practices? Insights from qualitative interviews in a mixed methods study. *Journal of Applied Gerontology*, 33(6), 737-763. doi:10.1177/0733464813491141
- Shippee, T. P. (2012). One the edge: Balancing health, participation, and autonomy to maintain active independent living in two retirement facilities. *Journal of Aging Studies*, 26(1), 1-15. doi:10.1016/j.jaging.2011.05.002
- Shura, R., Siders, R. A., & Dannefer, D. (2010). Culture change in long-term care: Participatory action research and the role of the resident. *The Gerontologist*, 51(2), 212-225. doi:10.1093/geront/gnq099
- Siegrist, J., von dem Knesebeck, O., & Pollack, E. (2004). Social productivity and well-being of older people: A sociological exploration. *Social Theory & Health*, 2(1), 1-17. doi:10.1057/palgrave.sth.8700014
- Siegrist, J., & Wahrendorf, M. (2009). Participation in socially productive activities and quality of life in early old age: Findings from SHARE. *Journal of European Social Policy*, 19(4), 317-326. doi:10.1177/1350506809341513
- Simons, K., Connolly, R. P., Bonifas, R., Allen, P. D., Bailey, K., Downes, D., & Galambos, C. (2012). Psychosocial assessment of nursing home residents via MDS 3.0: Recommendations for social service training, staffing, and roles in interdisciplinary care. *Journal of American Medical Directors Association*, 13(2), 190.e199-190.e115. doi:10.1016/j.jamda.2011.07.005
- Singal, A. G., Higgins, P. D. R., & Akbar, K. W. (2014). A primer on effectiveness and efficacy trials. *Clinical and Translational Gastroenterology*, 5(1), e45. doi:10.1038/ctg.2013.13

- Skrajner, M. J., Haberman, J. L., Camp, C. J., Tusick, M., Frentiu, C., & Gorzelle, G. (2014). Effects of using nursing home residents to serve as group activity leaders: Lessons from the RAP project. *Dementia*, 13(2), 274-285. doi:10.1177/1471301213499219
- Sladowski, P. S., Hientz, M., & MacKenzie, R. (2013). Volunteering: A catalyst for citizen engagement, social inclusion, and resilient communities. *The Philanthropist*, 25(1), 37-44.
- Slettebø, A., Sæteren, B., Caspari, S., Lohne, V., Rehnsfeldt, A. W., Heggestad, A. K. T., . . . Naden, D. (2016). The significance of meaningful and enjoyable activities for nursing home resident's experiences of dignity. *Scandinavian Journal of Caring Sciences*, 31(4), 718-726. doi:10.1111/scs.12386
- Smarr, K. L., & Keefer, A. L. (2011). Measures of depression and depressive symptoms. *Arthritis Care and Research*, 63(S11), S454-S466. doi:10.1002/acr.20556
- Snowden, J. (2010a). Depression in nursing homes. *International Psychogeriatrics*, 27(7), 1143-1148. doi:10.1017/S1041610210001602
- Snowden, J. (2010b). Mental health service delivery in long-term care homes. *International Psychogeriatrics*, 27(7), 1063-1071. doi:10.1017/S1041610210000773
- Snowdon, J. (2010). Mental health service delivery in long-term care homes. *International Psychogeriatrics*, 22(7), 1063-1071. doi:10.1017/S1041610210000773
- Span, M., Hettinga, M., Groen-van de Ven, L., Jukema, J., Janssen, R., Vernooij-Dassen, M., . . . Smits, C. (2017). Involving people with dementia in developing an interactive web tool for shared decision-making: experiences with a participatory design approach. *Disability & Rehabilitation*, 12(1), 1-11. doi:10.1080/09638288.2017.1298162
- Spandler, H. (2009). From social exclusion to inclusion? A critique of the inclusion imperative in mental health. *Medical Sociology*, 2(2), 3-16. doi:10.1007/978-1-349-92322-9_18
- Statistics Canada. (2011). *The Canadian population in 2011: Age and sex*. Retrieved July 16, 2018 from <http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011001-eng.pdf>

- Statistics Canada. (2015, September 29). *Canada's population estimates: Age and sex, July 1, 2015*. Retrieved September 10, 2018 from <http://www.statcan.gc.ca/daily-quotidien/150929/dq150929b-eng.pdf>
- Statistics Canada. (2017, May 17). *Age and sex, and type of dwelling data: Key results from the 2016 census*. Retrieved September 10, 2018 from <http://www.statcan.gc.ca/daily-quotidien/170503/dq170503a-eng.pdf>
- Stone, R., & Harahan, M. F. (2010). Improving the long-term care workforce serving older adults. *Health Affairs*, 29(1), 109-115.
- Stone, R. I., & Bryant, N. (2012). The impact of health care reform on the workforce caring for older adults. *Journal of Aging & Social Policy*, 24(2), 188-205. doi:10.1080/08959420.2012.659144
- Stone, R. I., Reinhard, S. C., Bowers, B., Zimmerman, D., Phillips, C. D., Catherine Hawes, . . . Jacobson, N. (2002). *Evaluation of the Wellspring model for improving nursing home quality*.
- Sun, F., Waldron, V., Gitelson, R., & Ho, C.-H. (2012). The effects of loss of loved ones on life satisfaction among residents in a southwest retirement community: The mediating roles of social connectedness. *Research on Aging*, 34(2), 222-245. doi:10.1177/0164027511417594
- Susic, P. (2015). *Learned helplessness and depression: Comparison of skilled nursing and assisted living facilities* (Doctoral Dissertation, Walden University St. Louis, MI). Retrieved October 14, 2018 from <https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1311&context=dissertations>
- Svihula, J. (2009). Gerontological theory: A commentary on Powell's Foucauldian toolkit. *Journal of Applied Gerontology*, 28(6), 690-696. doi:10.1177/0733464809333885
- Sweeting, H., & Gilhooly, M. (1997). Dementia and the phenomenon of social death. *Sociology of Health and Illness*, 19(1), 93-117.
- Tabassum, F., Mohan, J., & Smith, P. (2016). Association of volunteering with mental well-being A lifecourse analysis of a national population-based longitudinal study in the UK. *British Medical Journal*, 6(e011327). doi:10.1136/bmjopen-2016-011327
- Tashakkori, A., & Teddlie, C. (Eds.). (2010). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: SAGE Publications.

- Taylor-Gooby, P. (2008). *Reframing social citizenship*. Oxford, England: Oxford University Press.
- Taylor, F., Gutteridge, R., & Willis, C. (2016). Peer support for CKD patients and carers: Overcoming barriers and facilitating access. *Health Expectations*, 19(3), 617-630. doi:10.1111/hex.12348
- Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L. P., . . . Goldsmith, C. H. (2010). A tutorial on pilot studies: The what, why and how. *BMC Medical Research Methodology*, 10(1). doi:10.1186/1471-2288-10-1
- Thake, S. (2008). *Individualism and consumerism: Reframing the debate*. York, England: Joseph Rowntree Foundation.
- The Association of Advocates for Care Reform. (2012). Advocacy and education. Retrieved December 5, 2013 from <http://www.acrbc.ca/about-us-what.html>
- The National Consumer Voice for Quality Long-Term Care. (2011). Nursing Home Reform Law (OBRA '87). Retrieved December 2 from <http://www.theconsumervoice.org/advocate/issueindex/archivedissues/obra>
- The National Consumer Voice for Quality Long-Term Care. (2013). About the consumer voice. Retrieved December 5, 2013 from <http://www.theconsumervoice.org/about>
- Theurer, K., Mortenson, B., Stone, R., Suto, M., Timonen, V., & Rozanova, J. (2015). The need for a social revolution in residential care. *Journal of Aging Studies*, 35, 201-210. doi:10.1016/j.jaging.2015.08.011
- Theurer, K., & Wister, A. (2010). Altruistic behavior and social capital as predictors of well-being among older Canadians. *Ageing & Society*, 30(1), 157-181. doi:10.1017/S0144686X09008848
- Theurer, K., Wister, A., Sixsmith, A., Chaudhury, H., & Lovegreen, L. (2012). The development and evaluation of mutual support groups in long-term care homes. *Journal of Applied Gerontology*, 33(4), 387-415. doi:10.1177/0733464812446866
- Thoits, P. A. (2012). Role identity salience, purpose and meaning in life, and well-being among volunteers. *Social Psychology Quarterly*, 75(4), 360-384. doi:10.1177/0190272512459662

- Thomas, W., Fox, N., Rashap, A. W., Angelelli, J., Tellis-Nyak, V., Tellis-Nyak, M., . . . Brostoski, D. (2012). The Eden Alternative domains of well-being. Retrieved from <http://library.constantcontact.com/download/get/file/1101511475155-750/EdenAltWellBeingWhitePaperv5.pdf>
- Thomas, W. H. (2006). *In the arms of elders*. Acton, MA: VanderWyk & Burnham.
- Timonen, V., & O'Dwyer, C. (2009). Living in institutional care: Residents' experiences and coping strategies. *Social Work in Health Care*, 48(6), 597-613. doi:10.1080/00981380902791267
- Tremethick, M. J. (2001). Alone in a crowd: A study of social networks in home health and assisted living. *Journal of Gerontological Nursing*, 27(5), 42-47. doi:10.3928/0098-9134-20010501-10
- Trigg, R., Jones, R. W., & Skevington, S. M. (2007). Can people with mild to moderate dementia answer questions about their quality of life? *Age and Ageing*, 36(6), 663-669. doi:10.1093/ageing/afm077
- Truesdell, T. M. (2016). *Motivation for volunteer with older adults in a rural community* (Doctoral dissertation, Waldon University, Minneapolis, MN). Retrieved March 30, 2018 from <http://scholarworks.waldenu.edu/dissertations/2625/>
- Tse, T., & Howie, L. (2005). Adult day groups: Addressing older people's needs for activity and companionship. *Australasian Journal on Ageing*, 24(3), 134-140. doi:10.1111/j.1741-6612.2005.00117.x
- Turner, B. S. (1993). Contemporary problems in the theory of citizenship. In B. S. Turner (Ed.), *Citizenship and social theory*. London, England: Sage Publications.
- Twigg, J., Wolkowitz, C., Cohen, R. L., & Nettleton, S. (2011). Conceptualising body work in health and social care. *Sociology of Health and Illness*, 33(2), 171-188. doi:10.1111/j.1467-9566.2010.01323.x
- United Nations. (2016). *The growing need for long-term care: Assumptions and realities*. Retrieved October 6, 2018 from https://www.un.org/esa/socdev/ageing/documents/un-ageing_briefing-paper_Long-term-care.pdf
- Vaillant, G. E. (2007). Generativity: A form of unconditional love. In S. G. Post (Ed.), *Altruism and health* (pp. 219-229). New York, NY: Oxford University Press.

- van Beljouw, I.M., Heerings, M., Abma, T. A., Laurant, M. G., Veer-Tazelaar, P. J., Baur, V. e., . . . Van Exel, V. E. (2015). Pulling out all the stops: What motivates 65+ year olds with depressive symptoms to participate in an outreaching preference-led intervention programme? *Aging & Mental Health*, 19(5), 453-463. doi:10.1080/13607863.2014.944090
- van Beljouw, I.M., van Exel, E., de Jong Gierveld, J., Comijs, H. C., Heerings, M., Stek, M. L., & van Marwijk, H.W. (2014). "Being all alone makes me sad": Loneliness in older adults with depressive symptoms. *International Psychiatrics*, 26(9), 1541-1551. doi:10.1017/S1041610214000581
- Venturato, L., Moyle, W., & Steel, A. (2013). Exploring the gap between rhetoric and reality in dementia care in Australia: Could practice documents help bridge the great divide? *Dementia*, 12(2), 251-267. doi:10.1177/1471301211421837
- Verhagen, A. P., de Vet, H. C., de Bie, R. A., Kessels, A. G., Boers, M., Bouter, L. M., & Knipschild, P. G. (1998). The Delphi list: A criteria list for quality assessment of randomized clinical trials for conducting systematic reviews developed by Delphi consensus. *The Journal Clinical Epidemiology*, 51(12), 1235-1241.
- Victor, C. (2015). Is loneliness a cause or consequence of dementia. *The Gerontologist*, 55(Suppl_2), 593. doi:10.1093/geront/gnv306.02
- Victor, C. R. (2012). Loneliness in care homes: A neglected area of research? *Aging Health*, 8(6), 637-649. doi:10.2217/ahe.12.65
- Wagner, J. A. (2008). *Nursing home resident councils: Development of an instrument to evaluate their effectiveness* (Doctoral Dissertation, University of Wisconsin-Madison, Ann Arbor, MI) (3328007)
- Wahrendorf, M., Ribet, C., Zins, M., & Siegrist, J. (2008). Social productivity and depressive symptoms in early old age—results from the GAZEL study. *Aging & Mental Health*, 12(3), 310-316. doi:10.1080/13607860802120805
- Wells, J., & Harrington, C. (2013). The Kaiser Commission on Medicaid and the uninsured: Implementation of the Affordable Care Act provisions to improve nursing home transparency, care quality, and abuse prevention.
- White-Chu, E. F., Graves, W. J., Godfrey, S. M., Bonner, A., & Sloan, P. (2009). Beyond the medical model: The culture change revolution in long-term care. *Journal of American Medical Directors Association*, 10(6), 370-380. doi:10.1016/j.jamda.2009.04.004

- Wiener, J. M., Freiman, M. P., & Brown, D. (2007). Nursing home care quality: Twenty years of the Omnibus Budget Reconciliation Act of 1987.
- Wiersma, E., & Dupuis, S. L. (2010). Becoming institutional bodies: Socialization into a long-term care home. *Journal of Aging Studies*, 24(4), 278-291. doi:10.1016/j.jaging.2010.08.003
- Wiersma, E. C., O'Connor, D., Loiselle, L., Hickman, K., Heibein, B., Hounam, B., & Mann, J. (2016). Creating space for citizenship: The impact of group structure on validating the voices of people with dementia. *Dementia*, 15(3), 414-433. doi:10.1177/14713012116642339
- Wilby, F., DuMond Stryker, C., Hyde, D., & Ranson, S. (2016). Plotting the course of well-being: The Eden Alternative Well-Being Assessment Tool. *Sage Open*, 6(2), 1-9. doi:10.1177/2158244016646147
- Willis, E., Semple, A. C., & De Waal, H. (2016). Quantifying the benefits of peer support for people with dementia: A social return on investment (SROI) study. *Dementia*, 0(0), 1-13. doi:10.1177/1471301216640184
- Wilson, R. S., Krueger, K. R., Arnold, S. E., Schneider, J. A., Kelly, J. F., Barnes, L. L., . . . Bennett, D. A. (2007). Loneliness and the risk of Alzheimer disease. *Archives of General Psychiatry*, 64(2), 234-240. doi:10.1001/archpsyc.64.2.234
- Winstead, V., Yost, E. A., Cotten, S. R., Berkowsky, R. W., & Anderson, W. A. (2014). The impact of activity interventions on the well-being of older adults in continuing care communities. *Journal of Applied Gerontology*, 33(7), 888-911. doi:10.1177/0733464814537701
- Wolff, F.-C. (2013). Well-being of elderly people living in nursing homes: The benefits of making friends. *KYKLOS*, 66(1), 153-171. doi:10.1111/kykl.12015
- World Health Organization. (2000). *Elder abuse*. Retrieved October 21, 2018 from http://www.who.int/ageing/projects/elder_abuse/en/
- World Health Organization. (2017). *Reducing stigma and discrimination against older people with mental disorders: A technical consensus statement (WHO/MSD/MBC/02.3)*. Retrieved August 29, 2018 from <http://apps.who.int/iris/handle/10665/67380>
- Yeung, D. Y., Kwok, S. Y. C., & Chung, A. (2012). Institutional peer support mediates the impact of physical declines on depressive symptoms of nursing home residents. *Journal of Advanced Nursing*, 69(4), 875-885. doi:10.1111/j.1365-2648.2012.06076.x

Young, I. M. (2000). *Inclusion and Democracy*. Oxford: Oxford University Press.

Zaninotto, P., Breeze, E., McMunn, A., & Nazroo, J. (2013). Socially productive activities, reciprocity and well-being in early old age: Gender-specific results from the English Longitudinal Study of Ageing (ELSA). *Journal of Population Ageing*, 6(1-2), 47-57. doi:10.1007/s12062-012-9079-3

Zeisel, J. (2009). *I'm still here: A breakthrough approach to understanding someone living with Alzheimer's*. New York, NY: Penguin Group.

Zimmerman, S., Sloane, P. D., & Reed, D. (2014). Dementia prevalence and care in assisted living. *Health Affairs*, 33(4), 658-666. doi:10.1377/hlthaff.2013.1255

Appendix A. Feasibility Outcomes

Objective	Data Sources/ Measurement	Analysis	Outcomes
1. Assessment of Ability to Recruit and Characteristics of the Sample			
Recruitment of sites	Site recruitment numbers	Calculate % scores based on number of sites invited vs number participated	77%, 10 out of the 13 sites invited signed up
Recruitment of all mentors	Mentors' recruitment numbers	Calculate % scores based on number of mentors participated	Resident Mentors <i>and</i> Community Mentors: 90%, 9 out of 10 sites recruited 3 or more resident and community mentors with a range of 6 to 20 mentors.
Potential and actual eligible <i>resident mentors</i>	Total number of residents at each site	Calculate scores based on number of residents at each site and number participated	Among the resident mentors recruited (48) there was a range of 3 to 10 that participated across the 10 homes, with an average of 5 per home
2. Assessment of Procedures for Data Collection			
Ability to complete questionnaires	Completion of Version A or B Questionnaires	Calculate %-scores based mentors using Version B	5 of 48 resident mentors required questionnaire Version B (10%); 17 of 43 mentees required Version B (32%)
Ability to complete questionnaires independently	Number of mentors assisted by research assistants or staff	Calculate % scores based on numbers needing assistance	All resident mentors (100%) needed assistance and 3 of the 65 community mentors (5%)
Feasibility of data collection	Missing data	Analysis of missing data for each measure on three time-points	Complete data at all three time-points for 23 participants (48%) on GDS-SF, 22 (46%) on ULS-6, 22 (46%) on LET, 20 (42%) on SIM, and 21 (44%) on SOBI-P. ^a

^a GDS-SF Geriatric Depression Scale Short Form; ULS-6 UCLA Loneliness Scale; LET Life Engagement Test; SISI Single-item Measure of Social Identification; SOBI-P Sense of Belonging.

(Appendix A continued next page)

Objective	Data Sources/ Measurement	Analysis	Outcomes
3. Assessment of Retention, Program Adherence and Acceptability			
Retention of sites	Site recruitment numbers	Calculate % scores based on number of sites retained until end of study	100% (10 out of 10 participating sites completed the study)
Retention of mentors	Mentors' attrition rates	Calculate % scores based on number of mentors retained until end of study	Resident Mentors: 58% (28 out of 48); Community Mentors: 65% (42 out of 65)
Retention of staff	Staff attrition rates	Calculate % of staff retained	100% (All staff completed the study)
Program adherence	Observations	Calculate % scores of observations of facilitators facilitating as per group manual	80% (2 out of 10 sites conducted the program differently: one had only one team meeting a month and used only one education module; one used only community mentors)
To what extent would the mentors recommend the program to others?	Mentors' post-study survey	Calculate % scores	Resident Mentors <i>and</i> Community Mentors: 100% indicated that they would recommend the program to others
To what extent would the facilitators recommend the program continue?	Facilitators' post-study survey	Calculate % scores	95% of facilitators recommended the program to continue

(Appendix A continued next page)

Objective	Data Sources/ Measurement	Analysis	Outcomes
4. Assessment of Resident Responses to the Program			
What were the outcomes of the measures and effect sizes among resident mentors?	Outcome measurements pre- and post-program	Linear mixed-model regression analysis	Statistically significant differences in scientific outcomes noted for loneliness ($p = 0.014$) and depression ($p = .048$). Effect sizes ranged from small to medium: Depression $d = .30$; Loneliness $d = .23$; Purpose in Life $d = -.13^b$; Social Identity $d = .29$; Sense of belonging $d = .29$
To what extent was the program satisfactory for mentors?	Mentors' post-study survey	Calculate % scores based on rating of the program	Resident Mentors: fair (11%), good (30%); excellent (59%); Community Mentors: good (43%); excellent (57%)
To what extent were the team meetings satisfactory for mentors?	Mentors' post-study survey	Calculate % scores based on rating of the team meetings	Resident Mentors: fair (7%), good (44%); excellent (48%); Community Mentors: fair (5%), good (40%); excellent (55%)
To what extent did the mentors feel more confident in their role due to the education?	Mentors' post-study survey	Calculate % scores and analysis of themes generated from open-ended question	Resident Mentors: a little bit (14%), quite a bit (57%); a great deal (29%); Community Mentors: A little bit (14%), quite a bit (31%), a great deal (55%)
To what extent did mentors find the program materials helpful during visits?	Mentors' post-study survey	Calculate % scores based on rating of the helpfulness of program materials	Resident Mentors: fair (15%), good (67%); excellent (19%); Community Mentors: poor (2%); fair (12%), good (41%); excellent (45%)
To what extent did the mentors find the program materials easy to use?	Mentors' post-study survey	Calculate % scores based on rating of ease of use of program materials	Resident Mentors: fair (19%), good (63%); excellent (19%); Community Mentors: poor (2%); fair (2%), good (36%); excellent (60%)
To what extent did facilitators find the program resources sufficient	Facilitators' post-study survey	Calculate % of facilitators reporting sufficient resources to facilitate the program	80% (2 reported lack of enough time and 2 found study paperwork too much)

^b Negative effect size indicates that this measure moved in a negative (unexpected) direction, meaning that purpose in life decreased.

Appendix B. Observation Checklist

Site: _____
 Name of Program: The Java Mentorship Program
 Start Date of Program: _____
 Date of Observation: _____
 Number of Resident Mentors: _____ Number of Community Mentors (e.g., family/volunteers): _____
 Number of Staff: _____

A. The Java Mentorship Program Team Meeting

	Yes	No
1. <i>The Set Up:</i>		
1a. Was the Java Mentorship Program sign displayed?		
1b. Were coffee/tea and treats served?		
2. <i>The Team Meeting:</i>		
2a. Were the guidelines read by a team member?		
2b. Were new mentors welcomed? (please indicate how many, if any, were present: _____)		
2c. Was an education module presented? (please indicate how much time was spent on it: _____)		
2d. Was a check-in done (i.e., sharing of successes and challenges)		
2e. What the "Good News" option carried out? (i.e., a team member brought a good news story to share)		
2f. Were the mentorship bags reviewed and restocked?		
2g. Were the needs of the home reviewed and who was going to visit who?		
2h. Was the closing affirmation read by the team members?		
2i. Was the team reminded about the debrief opportunity after the visits?		
3. Did all the participants have an opportunity to share? (if not, please indicate how many didn't: _____)		

B. General Observations: (what did you notice, what stood out for you - turn over if you need more space)

Appendix C. Outcome Measures

Name of Measure	Construct	Items and Domains	Time	Individual who will complete	Reliability: Validity Data
Geriatric Depression Scale Short Form	Screening measure for depression	15-item self-report measure with yes/no answers	10 min	Mentors and mentees (with assistance from staff as needed)	Sheikh & Yesavage (1986)
ULS-6 Loneliness Scale	Scale for assessing loneliness	6-item scale	5 min	Mentors (with assistance from staff as needed)	Neto (2014)
Sense of Belonging Instrument (SOBI-P)	Measure of belonging in adults	33-item self-report measure with 2 separately scored scales: psychological (SOBI-P; 18 questions) and antecedents (SOBI-A; 14 questions)	20 min	Mentors and mentees (with assistance from staff as needed)	Hagerty (1995)
Single-Item Measure of Social Identification	single item measure of social identification	1-item question with a rating on a 7-point Likert scale	1 min	Mentors (with assistance from staff as needed)	Postmes et al. (2012)
Life Engagement Test	Measure of purpose in life	6-question scale with a rating on a 5-point Likert scale	3 min	Mentors (with assistance from staff as needed)	Scheier (2006)

Appendix D. Coding Methods for Data Entry Versions A and B

	Reverse Scoring on Version B from Version A
	Only for Version A

Questionnaires (Versions A and B) | Baseline, 3 Months and 6 Months

As a number of residents (20%) had mild to severe cognitive impairment, adapted versions of all outcome measures below (except the GDS) were created for administration to mentors with cognitive impairment. Questions that had the potential to be confusing, for example, were changed from “There is not enough purpose in my life,” to “Do you have enough purpose in your life?” We also changed multiple category responses options to “Yes” or “No.” Participants received either Version A or Version B depending on their cognitive abilities. Versions A and B are scored together, and we calculated one composite score per person (per time-point) regardless of what version was being used.

Geriatric Depression Scale

Coding (for both Versions A and B)

- Yes=1
- No=0

Loneliness Scale

Coding

Version A	Version B
Never=0	No=0
Occasionally=1	n/a
Sometimes=2	n/a
Always=3	Yes=3

Life Engagement Test

How Versions A and B correspond to one another

Version A	Version B
1. There is not enough purpose in my life.	1. Do you have enough purpose in your life? (Reverse coded)
2. To me, the things I do are all worthwhile.	2. Are all the things you do worthwhile?
3. Most of what I do seems trivial and unimportant to me.	3. Does most of what you do seem important? (Reverse coded)
4. I value my activities a lot.	4. Do you value your activities?
5. I don't care very much about the things I do.	5. Do you care about the things you do? (Reverse coded)
6. I have lots of reasons for living.	6. Do you have lots of reasons for living?

Coding

Version A	Version B
Strongly disagree=-2	n/a
Disagree=-1	No=-1
Neutral=0	Neutral=0
Agree=1	Yes=1
Strongly agree=2	n/a

Social Identity Measure

How Versions A and B correspond to one another

- Version A: scale only
- Version B: Yes or No, scale if possible. Whenever scale provided, will record that number (consistent with Version A). If only yes or no is indicated will be coded as follows:

Coding

Version A	Version B
Strongly disagree=-3	n/a
Disagree=-2	Disagree=-2
Somewhat disagree=-1	n/a
Neutral=0	n/a
Somewhat agree=1	n/a
Agree=2	Agree=2
Strongly agree=3	n/a

Sense of Belonging Scale

How Versions A and B correspond to one another

Version A	Version B
1. I often wonder if there is any place on earth where I really fit in.	1. Do you feel like you fit in?
2. I am just not sure if I fit in with my friends.	n/a
3. I would describe myself as a misfit in most social situations.	n/a
4. I generally feel that people accept me.	2. Do you feel people accept you?
5. I feel like a piece of a jig-saw puzzle that doesn't fit into the puzzle.	n/a
6. I would like to make a difference to people or things around me, but I don't feel that what I have to offer is valued.	3. Do you feel what you have to offer is valued?
7. I feel like an outsider in most situations.	4. Do you feel like an outsider?
8. I am troubled by feeling like I have no place in this world.	5. Do you feel you have a place in this world?
9. I could disappear for days and it wouldn't matter to my family.	6. If you disappeared do you think it would matter to anyone?
10. In general, I don't feel a part of the mainstream of society.	7. Do you feel you are part of society? (Reverse coded)
11. I feel like I observe life rather than participate in it.	8. Do you observe rather than participate in life?
12. If I died tomorrow, very few people would come to my funeral.	n/a
13. I feel like a square peg trying to fit into a round hole.	9. Do you feel you are different from others?
14. I don't feel that there is any place where I really fit in this world.	
15. I am uncomfortable that my background and experiences are so different from those who are usually around me.	
16. I could not see or call my friends for days and it wouldn't matter to them.	10. If you could not see your friends, would it matter to them?
17. I feel left out of things.	11. Do you feel left out of things?
18. I am not valued by or important to my friends.	12. Do you feel important here? (Reverse Coded)

Coding

Version A	Version B
Strongly disagree=-2	n/a
Disagree=-1	No=-1
Agree=1	Yes=1
Strongly Agree=2	n/a

How averages were made

- Version A was summed and divided by 18
- Version B was summed and divided by 12

If you helped someone complete this questionnaire . . .

Coding for both Versions A and B

- Did the participant need assistance?
 - Yes=1
 - No=0
- If Yes . . .
 - Assistant asked questions as written = 1
 - Assistant rephrased questions to increase understanding = 2
 - Participant was not able to answer (i.e., this data is missing) = 3

Appendix E. Comparison Between Resident Mentors Who Stayed and Did Not Stay in the Study ($n = 48$)

Resident Mentors' Characteristics	Stayed in study ($n = 28$)	Did not stay in study (dropouts) ($n = 20$)	Comparison test
Age, years	80.46 \pm 13.22 [40 to 100]	81.66 \pm 11.88 [50 to 96]	$t(44) = 0.32, p = 0.75$
Sex			$\chi^2(1) = 0.20, p = 0.66$
Male	3 (11%)	3 (15%)	
Female	25 (89%)	17 (85%)	
Level of Education			MW test $p = .87$
Elementary School	5 (18%)	4 (20%)	
High School	11 (41%)	9 (45%)	
College	7 (26%)	3 (15%)	
Undergraduate	3 (11%)	3 (15%)	
Masters/Doctorate	1 (4%)	1 (5%)	
Number of Activities Attended per Month			MW test $p = .29$
0-1	1 (4%)	2 (11%)	
7-8	3 (11%)	3 (16%)	
9-10	1 (4%)	1 (5%)	
More than 10	22 (82%)	13 (68%)	
Cognitive Performance Scores (CPS)			MW test $p = .82$
Intact – mild	22 (81%)	14 (78%)	
Mild – moderate	4 (15%)	4 (22%)	
Severe – very severe	1 (4%)	0 (0%)	
Depression Scores (GDS-SF 15) at baseline	3.38 \pm 3.24 [0 to 12]	2.85 \pm 2.85 [0 to 9]	$t(44) = 0.58, p = 0.56$
Loneliness Scale at baseline	10.96 \pm 3.61 [6 to 21]	10.20 \pm 4.42 [6 to 18]	$t(44) = 0.64, p = 0.52$
Life Engagement Test at baseline	18.64 \pm 2.56 [12 to 24]	18.95 \pm 3.07 [10 to 26]	$t(43) = -0.37, p = 0.71$
Social Identity Measure at baseline	5.15 \pm 1.67 [1 to 7]	5.67 \pm 1.65 [1 to 7]	$t(42) = -1.01, p = 0.32$
Sense of Belonging Scale at baseline	51.29 \pm 11.71 [17 to 69]	50.98 \pm 14.70 [20 to 69]	$t(44) = 0.08, p = 0.94$

Note. Reported values represent N (%) or Mean \pm SD [Range]; MW = Mann-Whitney.

Appendix F. Mentor Interview Schedule

Site:

Type of Mentor (e.g. Resident Mentor, Volunteer or Family Mentor, Student Mentor etc.):

Date of Evaluation:

Number of Times Attended (if known):

1. What has it been like for you being a participant in the Java Mentorship Program?

Probes: What has stood out for you about the program? Do you enjoy it? If so, what is it about the program you like...

2. How have those you visited responded?

Probes: Did those you visited appear to enjoy the visits? What did you notice?

A. The Mentorship Team Meetings

1. What is it like for you to participate in the Mentorship Team meetings?

2. What do you like most about the team meetings? *Use Team Meeting Guide to review components with them*

3. What do you think about the education portions of the program? *Probe: What do you like/not like about the education?*

4. What do you think about the Mentor's Initiation Ceremony?

B. The Java Mentorship Program Visits

1. What has it been like for you to go on the visits? *Probe: Did you enjoy the visits?*

2. Have you had any challenges during the visits? (Circle yes or no)

Yes

No

Probe: If yes, please describe...it is very helpful to know as we can help others who might be having similar challenges.

3. What do you think about the visiting guides? *Use the Visiting Guide to review components with them*

4. What do you think of the log books?

5. What do you think about the Mentorship Bags? *Look in the bags to review components with them*

C. General Questions

1. How is this program different from other programs that you are involved in?

2. Do you have any suggestions about how we could improve this program?

Appendix G. Mentees' Interview Schedule

1. What is it like for you to have _____ (name of mentors) come visit you? (or . . . What is it like having fellow residents and volunteers come and visit you?)
Probe: Did you enjoy the visits?
 - a. If so, what did you like most about the visits?
 - b. If not, what did you not like about the visits?
2. What kinds of things do you do during the visits?
 - a. Probe: Did your visitors bring anything in with them?
 - b. Probe: Did they bring any readings or poetry?
 - c. Probe: Did they share about themselves at all?
 - d. Probe: Did they end visits talking about gratitude?
3. Did your visitors share anything about themselves during the visits?
4. Did your visitors invite you to attend a program with them?
 - a. Probe: If so, did you accept?
 - b. Probe: If not, why not?
5. Did your visitors talk about you contributing something to your community, for example sharing a special gift you have, or even becoming a mentor yourself?
6. Would you like your visitors to continue visiting you?

