Department for Education

Community learning mental health research project

Phase two evaluation report

October 2018

Ipsos MORI, the Centre for Mental Health and Liz Lawson

Contents

Acknowledgements

The evaluation team would like to thank everyone who made this research possible, in particular staff at the research sites for their efforts in collecting the data required for the evaluation, the learners who volunteered to contribute their data as part of the project and those learners who took part in follow-up interviews.

List of useful terms

Adult and Community Learning (ACL): adult learning, mostly non-vocational and non-accredited, delivered in a very wide range of settings and with a strong focus on reaching disadvantaged groups and individuals.

Black, Asian and Minority Ethnic (BAME): used to refer to members of these communities in the UK.

Delivery approach: one of three combinations of course topics and participant characteristics to which learning providers were assigned randomly, in order to compare differences between these approaches. The three approaches are described on pages 22-23.

Delivery model: the overall format for delivering the project courses and accompanying support to learners, specified to all participating learning providers by DfE.

GAD-7: the Generalized Anxiety Disorder scale (GAD-7) is a self-reported questionnaire for measuring the severity of symptoms of anxiety. It contains seven questions, with points for each question. These are added up to produce an overall score.

Groups A, B and C: groups to which research sites were assigned in order to deliver one of three different delivery approaches.

IAPT: the NHS Improving Access to Psychological Therapies (IAPT) programme, which provides evidence-based treatments for people with anxiety and depression.

Individualised Learner Record (ILR): the Individualised Learner Record (ILR) is a dataset about further education and work-based learning in England. The Education and Skills Funding Agency (ESFA) collects ILR data from learning providers in England's further education system that are in receipt of Education and Skills Funding Agency funding.

Information, Advice and Guidance (IAG) session: a one-to-one discussion between learning provider staff and potential learners, to understand learners' circumstances, needs and goals, assess their eligibility to participate in the project, and advise them accordingly. This discussion was also used to explain to learners the potential positives and negatives of taking part in a research study, obtain informed consent for taking part, and collect baseline data.

Learners: individuals who participated in the project by taking one of the courses. In project documentation learners were sometimes referred to as "research volunteers".

Learning providers: the 52 adult learning organisations (57 in phase one) that took part in the project.

Mild to moderate mental health problems: learners were in the target group for the project if they reported experiencing symptoms suggesting mild to moderate anxiety and/or depression, and did not report symptoms suggesting severe anxiety or depression. Mild to moderate depression is represented by a score of 5 to 19 inclusive on the PHQ-9 scale, and mild to moderate anxiety is represented by a score of 5 to 15 inclusive on the GAD-7 scale.

PHQ-9: the Patient Health Questionnaire (PHQ-9) is a self-reported questionnaire for measuring the severity of symptoms of depression. It contains nine questions, with points for each question. These are added up to produce an overall score.

Phase one: the first phase of the research project, which ran from April 2015 to August 2016.

Phase two: the second phase of the research project, which ran from September 2016 to August 2017.

Research project: the overall CLMH project taking place across England, including delivery of the project, this evaluation, and other research activities about the project carried out by DfE.

Research site: the 62 local authority areas in England (57 in phase two) where the project was delivered. Some learning providers were responsible for more than one research site.

Short WEMWBS: the Warwick-Edinburgh Mental Wellbeing Scale[1] is a questionnaire designed to monitor wellbeing in the general population, as well as among participants of particular projects aiming to improve wellbeing. The short version has seven questions, with points for each question, which are added up to produce an overall score. Questions are positively worded, so a higher score indicates greater wellbeing.

[1] https://warwick.ac.uk/fac/med/research/platform/wemwbs/

Executive summary

In February 2017, the Department for Education (DfE) commissioned Ipsos MORI[2], in partnership with the Centre for Mental Health[3] and Liz Lawson[4], to conduct the Evaluation of phase two of the Community Learning Mental Health (CLMH) Research Project.[5]

Background to the CLMH research project

Around one in six adults in England suffered from a common mental disorder[6], with significant economic implications at a national level. People who are socially and economically disadvantaged are both more likely to be affected by mental health problems, and less likely to access services offering support for these problems. This creates a gap for an intervention that can address both of these issues.

The Community Learning Mental Health (CLMH) research project aimed to identify the potential for adult and community learning courses to help people develop the tools, strategies and resilience to manage, and aid recovery from, mild to moderate mental health problems, such as anxiety and depression. This project was designed to build on the existing evidence base supporting the impact of adult and community learning on mental health and wellbeing.

Sixty-two research sites, run by adult learning providers across England were selected to develop and deliver short, part-time courses for adults experiencing mild to moderate mental health problems. The project had two phases, and this report focusses on phase two, which took place from September 2016 to August 2017. The key feature of phase two was that research sites were required to adhere to a tighter specification, and were randomly assigned to three groups:[7]

- **Group A**: Courses were focussed on managing symptoms of mental health problems (e.g. how to manage anxiety), and all participants were experiencing mild to moderate mental health problems.

[2] https://www.ipsos-mori.com/researchspecialisms/socialresearch/ourexpertise/Evaluation.aspx
[3] http://www.centreformentalhealth.org.uk/about-us
[4] A Community Learning expert who formerly led the Community Learning team within the Department for Business, Innovation and Skills (BIS).
[5] The same team, plus the Centre for Citizenship and Community, University of Central Lancashire, had previously undertaken the evaluation of Phase One of the CLMH Research Project for BIS.
[6] https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health
[7] These changes were made following phase one to improve the quality of data collection and increase the ability of the evaluation to draw robust conclusions.

- **Group B:** Courses were focussed on traditional community learning topics (e.g. yoga, digital skills, painting) and all participants were experiencing mild to moderate mental health problems.
- **Group C:** Courses were focussed on traditional community learning topics, and participants were a mix of learners with and without mental health problems.

Evaluation aims and methodology

The aim of the evaluation was to assess the potential for this educational approach to empower and support individuals with mild to moderate mental health problems, and to explore the relative impact on participants' mental health and wellbeing outcomes of the three different approaches to course delivery (group A, B and C).

The evaluation findings presented here are based on a mixed-methods approach. This consisted of:

- analysis of mental health and other outcomes for learners using validated measures of mental health symptoms, measures of wellbeing, and other information about individiual learners and their experience. This data was collected by means of a survey which learners completed before, during and after their participation;
- findings from semi-structured interviews with a sample of learners, which took place six to nine months after learners had finished their courses.

In the absence of a counterfactual who did not undertake learning, analysis focusses on exploring the differences in outcomes between learners in each of the three delivery groups[8].

Summary of key findings

Did the research project reach the intended target group?

Overall, the project was largely successful in reaching the intended target group (people with mild-to-moderate mental health problems). Almost all (96%) learners starting a course in groups A and B were in the target group. In group C, where learners should have comprised those with and without mental health problems, the figure was 63%, indicating that even people who may not consider themselves to have mental health

[8] Regression analysis was employed in order to control, as far as possible, for differences in learner characteristics between the three groups.

problems may display symptoms. More than half of learners had clinical symptoms of depression or anxiety.

While around seven in ten (69%) learners reported receiving other support for their mental health, there is evidence that the project was successful in reaching some groups who are less likely to access traditional mental health services. In particular:

- **Ethnic background:** The profile of learners in the project was more representative of the overall population in terms of ethnic background, compared to NHS mental health services
- **Employment status:** The project reached a greater proportion of people who were unemployed or unable to work (around a quarter) compared with the Improving Access to Psychological Therapies (IAPT) service. This suggests that the project was accessible to a wide range of people in different circumstances. The fact that the course was free was often a factor in learners' decision to take part.

The project, as is typical for adult and community learning, attracted a higher proportion of women than men. Men are also less likely to access NHS mental health services.

More than three-quarters (76%) of learners completed their course. Some of the reasons given by learners who were unable to complete their course included other commitments such as their caring responsibilities or medical appointments

How effective was the approach?

Analysis of evidence collected suggests that participation in the non-formal adult and community learning courses delivered as part of the CLMH research project coincided with improvements in the mental health and wellbeing of some learners. Key findings in relation to mental health and wellbeing are summarised below.

Analysis of self-reported survey data, and of qualitative follow-up interviews, indicates that learners believed participation had resulted in positive changes in their mental health and wellbeing. The majority of learners (76%) perceived some improvement in their overall mental health, although for most people the size of this improvement was small.

Analysis of validated measures of mental health and wellbeing[9] shows the following.

- **Positive mental health outcomes for a significant minority of learners in the target group.** Three in ten learners (29%) showed significant improvement in

[9] Generalised Anxiety Disorder (GAD) 7; Patient Health Questionnaire (PHQ) 9 and the Warwick-Edinburgh Mental Health and Wellbeing Scale (WEMWBS) (7-item version).

their symptoms of depression and four in ten (39%) showed significant improvement in their symptoms of anxiety.

- **Positive changes in wellbeing.** Average wellbeing of learners completing a course, compared to the overall population, moved from significantly below average to around the average following their participation.
- **Indications of recovery for over half of learners with clinically significant symptoms.** Fifty-two percent of learners who started their course with clinically significant symptoms of anxiety and/or depression no longer had clinically significant symptoms at the end of their course. While the research project and evaluation was not designed to compare the effectiveness of the CLMH approach to that of the NHS IAPT service, the recovery rate observed here was broadly similar to that of the IAPT service (49%).

While the findings outlined above highlight the positive changes during participation, two-thirds (66%) of all learners in the target group reported no significant change in their symptoms of depression over the course of their participation, and just over half had no significant change in their symptoms of anxiety (52%). It is possible, however, that in some cases taking part may have stabilised learners' mental health when it would otherwise have got worse. Ten percent of learners reported worsening symptoms of either depression or anxiety.

Findings suggest that the process of learning something new, whether focussed on mental health and wellbeing, or general community learning made a contribution to the positive effects on mental health and wellbeing. This was true both of short and longer-term effects, as outlined below.

Analysis of qualitative data suggests the courses had positive effects on mental health by giving learners an opportunity to focus on something other than day-to-day life, to make time for themselves to do something enjoyable, and to have something to look forward to. However, these positive effects were by their nature largely limited to the time period during which learners were taking part; many learners were saddened when their course ended, with some identifying this as a setback.

Those learners who identified a longer-term positive impact from participation often attributed this to having developed a new skill or interest which they could continue to pursue. Many learners reported that learning a new skill had increased their confidence, and that they were motivated to continue learning. This suggests that creating appropriate progression opportunities for learners following the end of their course is important in sustaining any positive effects from it.

Analysis of learning self-efficacy also shows an increase in the proportion of learners reporting positive attitudes towards different aspects of learning. Given the current focus

on encouraging adult learning (including efforts such as the National Retraining Scheme) this is a positive finding.

Which approach (A, B, C) was more effective?

The design of the research project allows us to compare the effectiveness of the three different approaches taken by groups A, B and C.

Of the three groups, group A had the largest proportion of learners from the target group who showed a significant improvement in their symptoms, for both depression and anxiety. Group A learners were also more likely to report improvement in their overall mental health and in other aspects of their life such as taking a positive approach to things, making progress in learning, and handling knockbacks. Group A learners also showed the greatest improvement in average wellbeing. The regression analysis shows that, all else being equal, learners in group B were less than two-thirds (0.65 times) as likely to recover from depression compared with learners in group A.

These findings collectively indicate that group A had the most positive outcomes, followed by group C, with outcomes for group B being the least positive. This may indicate that courses which are explicitly focused on managing mental health symptoms are more effective at improving mental health outcomes than general adult learning courses. Learners in group A were more likely to report feeling more optimistic and relaxed as a result of participating, while learners in groups B and C were more likely to report increased confidence and skills as the biggest change for them.

Is the approach more effective for particular groups of people?

As would be expected, outcomes varied based on learner characteristics. Learners were more likely to report signs of recovery if they were female, had higher-level qualifications, or were from a disadvantaged family background. Female learners were also more likely to say that they would go on to further learning. This apparent difference in outcomes for men and women may be due to the predominantly female environment in which the courses took place; the majority of project staff were also female.

Learners were also less likely to recover if they were unemployed, unable to work due to sickness or disability, receiving mental health support from their GP, or taking tablets for their mental health. It may be that learners who were receiving medical treatment for their mental health are more likely to have long-standing mental health problems.

Lessons learned

Overall, the findings suggest that the type of courses delivered as part of the CLMH research project may help people in a number of ways, such as improved confidence, making friends, and a range of other outcomes. While most people will not experience

significant improvement in or recovery from their mental health problem, the evidence suggests that the offer has a place in helping people to manage and/or live with their mental health problem.

A number of lessons have been identified as part of this evaluation, relating both to the future delivery of the offer tested, as well as delivery of similar pilots and evaluations in the adult and community education sector. These are detailed in section 7.2, and here we summarise the key lessons relating to policy and delivery.

Lessons for policy makers and commissioners

Support is required for continued delivery of the CLMH offer. Adult learning providers may wish to continue (or begin) to deliver this offer in future funding years. This requires support from DfE and other policy makers and commissioners to:

- Ensure Ofsted inspectors, and other organisations responsible for quality assuring delivery of adult and community learning, have access to the findings and resources from the project. This will ensure future delivery benefits from the work undertaken as part of the CLMH research project.
- Support training and maintaining a workforce that has the necessary skills to deliver the offer effectively (delivering courses focussed on mental health and wellbeing).
- Ensure the resources produced, that will support effective delivery of the offer, are shared with adult learning providers who were not involved in the research project.

Experience, and evidence, should be shared with commissioners and policy makers outside of adult learning. This can help enable joint commissioning, and increased awareness of the availability of local support for people with mild to moderate mental health problems.

Lessons for adult learning providers

Learning providers should consider how to design courses which can help people identify, share and manage symptoms of mild to moderate mental health problems. The evidence presented here suggests that courses explicitly focussed on mental health and wellbeing may be more effective than general adult learning courses in improving mental health outcomes.

Staff involved in delivery of such courses require appropriate training and support. In particular, staff should be trained and have access to support in the following areas:

- Use of the mental health self-assessment scales, if being used to assess and monitor the mental health and wellbeing of current or future adult learners.

- Safeguarding procedures, and alternative, appropriate, sources of support for people with more severe and enduring forms of mental health problem.
- Support for the mental health and wellbeing of delivery staff themselves, which the experience of this project has shown may be necessary.

A greater focus on targeting male learners would be beneficial. Learners, across the project, were more likely to be female. Tailoring of courses and marketing towards male learners would help widen access, especially as men are less likely to access NHS mental health services.

Learners would benefit from greater support at the end of courses. While the short, non-formal, nature of the course was well-received, this could also lead to a feeling of a source of support being withdrawn upon completion. Greater emphasis could be placed on supporting learners with the transition at the end of their course.

Courses should, where possible, be subsidised or free. This can help to attract learners, especially those not currently in employment. Links to initiatives such as social prescribing may help enable this.

1. Introduction

In February 2017, the Department for Education (DfE) commissioned Ipsos MORI[10], in partnership with the Centre for Mental Health[11] and Liz Lawson[12], to conduct the Evaluation of phase two of the Community Learning Mental Health (CLMH) Research Project.[13]

This report presents the findings from the evaluation of phase two. Phase two built on the delivery and evaluation work that took place during phase one. Therefore, findings from the phase one evaluation are summarised in section 1.3.

1.1 Context and rationale for the CLMH research project

The CLMH research project aimed to identify the potential for adult and community learning courses to help eligible learners develop the tools, strategies and resilience to manage[14], and aid recovery from, mild to moderate mental health problems. Up to £20m over two years (2015-2017) was made available in the Government's 2014 Autumn Statement.

In 2014, around one in six adults in England had a common mental disorder, and the estimated costs of mental health problems in the UK, largely anxiety and depression, are between £70-£100 billion each year[15]. People who are disadvantaged socially and economically are disproportionately affected by mental health problems[16] and are less likely to get access to services; at the same time, mental health problems are a major barrier to social mobility, both for those experiencing mental health problems and for their children[17].

The role of the education system in supporting good mental health through schools and colleges, was the focus of a recent Green Paper, published jointly by the Department of

[10] https://www.ipsos-mori.com/researchspecialisms/socialresearch/ourexpertise/Evaluation.aspx
[11] http://www.centreformentalhealth.org.uk/about-us
[12] A Community Learning expert who formerly led the Community Learning team within the Department for Business, Innovation and Skills (BIS).
[13] The same team, plus the Centre for Citizenship and Community, University of Central Lancashire, had previously undertaken the evaluation of Phase One of the CLMH Research Project for BIS.
[14] 'Tools, strategies and resilience' were not defined as separate concepts as part of the design of the CLMH research project, and therefore were not explored separatey as part of the evaluation.
[15] https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health
[16] Mental health and wellbeing in England: the Adult Psychiatric Morbidity Survey 2014, Health and Social Care Information Centre, 2016
[17] Elliott, I. (June 2016) Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy. London: Mental Health Foundation.

Health (DH) and DfE[18]. The Green Paper, however, focussed on supporting children and young people, and there is currently no equivalent focus on education policy for adults with mental health problems.

Research has identified a range of positive impacts on wellbeing resulting from participation in mainstream community learning courses[19][20]. It is therefore of interest to explore whether such courses can benefit people who are experiencing mental health problems.

Research has also found exploratory evidence that adult learning may be more accessible for some groups of individuals that may have been marginalised by mainstream services.[21] The research project therefore contributes to the evidence base in this area.

This research project therefore had an important role to play in helping understand whether the kind of support on offer in the CLMH project could help achieve improvements in symptoms of mild-to-moderate depression or anxiety for participating individuals, and whether it could help decrease inequalities in access.

1.2 Delivery of the CLMH research project

In early 2015, 57 learning providers operating across 62 research sites[22] were selected to develop and deliver short, non-formal part-time courses for adults aged 19 or over experiencing mild to moderate mental health problems. These aimed to help eligible learners develop the tools, strategies and resilience to manage, and aid recovery from, mild to moderate mental health problems. Learning providers were required to encourage co-production by involving people with personal experience of mental health problems, in the design and delivery of the adult education courses.

---

[18] https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

[19] The relationship between adult learning and wellbeing: Evidence from the 1958 National Child Development Study (Institute of Education, 2012)

[20] Review and update of research into the wider benefits of learning, LSE, 2012

[21] Further detail on the evidence base can be found in Annexe 11 to this report (Literature review).

[22] Learning providers were predominantly local authorities, with a small number of FE colleges and third-sector organisations also leading projects. The research project specification required learning providers to develop their bids in partnership with local mental health services. Across projects, joint working organisations including NHS, public health and voluntary organisations were involved with the research project at all levels, including design, delivery, management and governance, as well as referral and outreach. A map showing the location of all CLMH learning providers is available here: https://mhfe.org.uk/clmh-pilots/

Phase one

Phase one of the research project lasted 16 months and consisted of two stages. The initial stage was from April 2015 to March 2016, in which providers were funded up to £80K per project to develop and test a wide range of responses to the required delivery model. The delivery model comprised three mandatory elements, as follows:

- **Up to 3 hours of one-to-one Information, Advice and Guidance (IAG)**: before and during their course;
- **Short non-formal courses**: to help eligible learners experiencing mild to moderate mental health problems. The exact length of the courses was not specified, most were four or five weeks long, with one weekly three-hour session, although some courses ran for ten weeks or more, and others were as short as one day [23]
- **Top-up sessions:** To be available to all learners as required following completion of their course.

Across the 57 providers, around three in ten courses focussed on topics related to living with a mental health problem, such as strategies to reduce anxiety. The remainder were general-interest courses similar to those typically delivered by adult and community learning providers, such as crafts, yoga or IT skills. The majority of providers (44 of 57) offered learners a choice of both types of course. Evidence from monitoring information collected by the evaluation team about the sessions attended by each learner, and survey evidence, shows that many learning providers only started to consistently deliver the IAG and 'top-up' elements during the phase one extension period.

The purpose of the 4-month extension was to explore the potential for learning providers to meet the demands of a more robust study in 2016-17, specifically the ability of providers to improve the quality of data collection and reporting. The specification for delivery was more tightly defined, and learning providers were required to report more frequently on the volume and quality of data collected. Each project was given additional funding of £30K and required to recruit a minimum of 20 new participants each month, for whom they reported complete data sets.

Phase two

The findings from the evaluation of phase one (see section 1.3 below) were used to inform a much tighter specification for the design of phase two. This tighter specification

[23] The specification detailed that the courses should help learners 'to develop the tools, strategies and resilience: to manage and aid recovery from mental health problems; reduce their use of medical services; re-engage with their families and communities; progress to further learning/training; and/or progress to work or return to work'.

was intended to allow a small number of delivery approaches to be tested more robustly. Each research site was randomly assigned to one of three groups, each testing one of three distinct delivery approaches:

- **Group A**: Research sites delivered courses focussing on managing symptoms of mental health problems (e.g. how to manage anxiety) to participants with mild to moderate mental health problems.
- **Group B:** Research sites delivered courses focussing on traditional community learning topics (e.g. yoga, digital skills, painting) to participants with mild to moderate mental health problems.
- **Group C:** Research sites delivered courses focussing on traditional community learning topics, to participants who were a mix of learners with and without mental health problems[24].

There was no separate application process for research sites for phase two. As a result, almost all the learning providers from phase one (52) continued to take part in the project, covering 57 research sites. The delivery model for courses used the same three elements specified in phase one (IAG, non-formal courses and top-up sessions), but the duration of courses was specified as 15 hours over a period of no less than 3 taught weeks and no more than 6 taught weeks. Chapter 2 of this report provides more information on this delivery model.

In order to overcome some of the data collection challenges encountered in phase one, learning providers were required to:

- collect data using an online survey, designed and implemented by DfE. Learning providers were supplied with tablets and training in how to use them for this purpose;
- collect informed consent from participants using an information sheet and consent form designed by DfE; and
- provide a weekly update on learner numbers to DfE and to other projects in their group.

The evaluation team had access to this survey data in real time, and provided learning providers with a fortnightly update on the volume and quality of their data so that any problems could be resolved in good time.[25]

[24] Group C was intended to comprise 50% learners with mental health problems and 50% without, but in fact 63% of the group had symptoms of mild to moderate mental health problems. See section 3.2.
[25] Ongoing updates on data issues were also provided to DfE to allow escalation of any issues with data quality.

1.3 Evaluation of the CLMH research project: phase one

Phase one of the CLMH research project was subject to an independent external evaluation carried out by Ipsos MORI, the Centre for Mental Health, and the Centre for Citizenship and Community, University of Central Lancashire. The purpose of the evaluation was to:

- assess the effectiveness of this educational approach to supporting individuals with mild to moderate mental health problems;
- inform decisions about whether phase two of the research project and its evaluation should go ahead, and how phase two should differ from phase one.

In order to answer these questions, the evaluation team collected and analysed data from the following sources:

- **Monitoring information** supplied by learning providers, including details of courses delivered, workforce development, learner involvement activities, and joint working relationships;
- Learner information collected as part of the **Individualised Learner Record[26],** such as demographic information;
- **Mental health self-assessment data** completed by learners and collected and supplied by research sites. This comprised three self-assessment scales: PHQ-9 (a measure of depression); GAD-7 (a measure of anxiety) and the short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (a population-level measure of wellbeing).[27] These scales were completed at the start and end of courses, and at the mid-point of courses lasting 4 weeks or longer.
- **Surveys completed by learners[28]**. These asked questions about motivation for attending the course and referral source, learning self-efficacy, caring responsibilities, benefit status, employment status, qualifications, progression to further learning/training, learners' health, and other support received for mental health problems. Surveys were completed at the start and end of courses, and at the mid-point of courses lasting 4 weeks or longer; and

[26] The Individualised Learner Record (ILR) is a dataset about further education and work-based learning in England. The Education and Skills Funding Agency collects ILR data from learning providers in England's further education system that are in receipt of ESFA funding.
[27] Further detail on these tools and how they were used for this study can be found in the annexes of this report.
[28] Survey data was only collected between September 2015 and April 2016 inclusive. Learning providers reported that they found it too challenging to obtain survey responses from learners, limiting the utility of this data to the evaluation.

- **Case study visits** to eight research sites. During these visits the evaluation team interviewed learners; learning provider staff, volunteers, and managers; and staff from joint working organisations; as well as observing course sessions.

The evaluation highlighted substantial challenges with delivery of the project and the evaluation, which were considered and addressed in the design of both the delivery and evaluation of phase two. It was difficult to draw reliable conclusions about the impact of participation on the mental health and wellbeing of individuals, due to the lack of a comparison group, substantial gaps in data provision by the individual provider organisations, and the extremely diverse range of delivery models implemented. However, the qualitative evidence highlighted the potential for the CLMH model to have a significant impact, if delivered in a more consistent manner. Findings from the evaluation are summarised, in brief, below.

Phase one evaluation findings: participation

- Around 13,000 learners took part in the research project in phase one.
- Two in five of those who took part were outside the intended target group, because providers were reluctant to turn away learners who did not meet the criteria of experiencing mild to moderate mental health problems.
- Three in ten courses were focussed on topics related to mental health problems, whilst the rest were general adult and community courses. Learning providers were also required to offer Information, Advice and Guidance (IAG) sessions and top-up sessions, although these were not prioritised and many only started to deliver towards the end of year one.
- The research project reached a similar demographic to NHS IAPT services and to Adult and Community Learning (ACL) in terms of age and gender. It was more successful than the IAPT service in reaching people with little experience of learning and few qualifications. The majority of learners taking part were not in work and in many cases their income included welfare benefits.
- Self-referral was a key source of learners from the target group; learners reported hearing about the project through marketing activities such as leaflets and mailing lists, or from friends. Some learning providers received lower than expected referrals from health services, despite attempts to publicise the pilot to these organisations.

Phase one evaluation findings: outcomes

- Changes observed in learners' self-assessed symptoms of mental health problems were, on average, not large enough to represent a genuine improvement in mental health.
- However, one-third of learners showed a significant reduction in their anxiety, and one-quarter a significant reduction in depression.

- Learners thought these positive outcomes resulted from opportunities to discuss and learn strategies to manage mental health problems, and from participating in learning itself. Learners reported increased confidence and reduced social isolation.
- There was no noticeable large-scale impact on the quantity or type of other support that learners accessed for their mental health. Some learners compared project courses favourably with other support they had received, while others felt the project was complementary to other mental health interventions.

Phase one evaluation findings: recommendations

- Learning providers should continue to deliver courses in community settings, and consider running courses at weekends and evenings to promote accessibility.
- Approaches should be considered to help attract learners from groups that access IAPT at lower rates, such as men.
- IAG sessions should form an integral part of the delivery model, with initial and follow-up discussions documenting progress towards goals and achievements.
- Good progression opportunities such as “top up” sessions should be available to ensure learners can develop beyond their course and secure longer-term benefits from participation in the project.

1.4 Evaluation of the CLMH research project: phase two

Evaluation objectives

Building on the findings of the phase one evaluation, the purpose of the evaluation in phase two was to:

- continue to assess the potential for this educational approach to empower and support individuals with mild to moderate mental health problems
- explore the relative impact on participants’ mental health and wellbeing outcomes of the three different approaches to course delivery (group A, B and C).

To improve data quality, the evaluation team was required to supervise learning providers’ data collection throughout delivery of the project, and provide both group and one-to-one support to improve the quality of data collected.

The evaluation team also sought to identify a suitable comparison group: a set of individuals with mild to mental health problems, who had not taken part in the project and for whom data on mental health outcomes was available for analysis. This would have allowed a more robust estimation of the impact on mental health of participation in the project, compared to not undertaking learning. However, it was not possible to access this data within the evaluation timeframes (see page 19).

Evaluation methodology

Changes to the design of the evaluation approach and methodology were implemented in parallel with the changes to the Research Project delivery model. We outline the key features of the evaluation approach below, and further technical detail is available in the annexes.

Learner survey

The main source of data for the evaluation was an online survey designed by DfE and administered by learning providers using tablet devices[29]. Learners completed this survey at up to five points: at their initial IAG session; weeks 1, 3 and the final week of their course; and at any top-up sessions they attended.

The survey questions comprised demographic, equalities and social mobility information; mental health self-assessment scales (PHQ-9, GAD-7 and short WEMWBS); a self-assessment of self-efficacy in relation to learning; and a self-assessment of outcomes achieved during the course and the learner's plans for progression. The mental health self-assessment scales were used as part of every survey, while other questions were asked depending on the point at which the learner was taking the survey.

The online survey was hosted on the SmartSurvey[30] platform and went live in February 2017. Some learning providers began running courses before this point, and these learning providers collected a more limited range of information from learners using paper questionnaires. Fewer than one in five (18%) survey responses were collected on paper.

Follow-up interviews

Following the end of the project, the evaluation team invited some learners to take part in a follow-up interview to discuss their experience on their course. The purpose of this qualitative data collection was to understand learners' motivation for taking part in the project, their experience of participation, any changes (positive or negative) which they had experienced as a result of taking part, and why these had come about. Interviews took place approximately six to nine months after courses finished (in February 2018)

[29] While learning provider staff were not trained researchers, guidance, training and support was given by DfE in how to administer the survey to learners. This was intended to minimise the variation in data collected by learning providers, and to ensure that learners at different research sites had a consistent experience.
[30] https://www.smartsurvey.co.uk/

and therefore allowed the evaluation to explore whether any positive changes from participation had persisted over time.

Learners were sampled from six research sites: two in group A, two in group B and two in group C. Research sites from each group were selected on the basis of recovery rates based on MHSA assessments, with one project from each group having a high recovery rate and/or low deterioration rate, and one project from each group having a low recovery rate and/or high deterioration rate.

The evaluation team interviewed 58 learners from these six research sites, all of whom had been in the target group for the project (experiencing symptoms of mild to moderate mental health problems at the start of their course). Table 1 below shows a breakdown of the number of interviews conducted within each group. 12 of the 58 learners interviewed had not finished their course fully (six learners in group A, five in group B, and one in group C). Interviews were conducted either face-to-face (24) or over the telephone (34), and lasted around 45 minutes. They were recorded (if learners consented to this) and transcribed for analysis.

Table 1: Breakdown of interviews conducted across groups

Delivery model	Number of interviews
Group A	20
Group B	12
Group C	26
Total	**58**

Other sources of data

The evaluation team also reviewed documents relating to the project, such as the overall phase two specification and the specifications for each group; and resources produced by the central research project team and individual learning providers.

Identifying a comparison group

Building on the work of DfE analysts and the evaluation team during phase one, the evaluation team and DfE continued to seek to identify and obtain access to a suitable comparison group of individuals with similar mental health symptoms who had not taken part in the research project. This work included:

- desk-research to identify the criteria that a comparison group should meet and then search for datasets that might meet these criteria;
- consultation with stakeholders across other government departments (including Department for Health and Social Care, Ministry of Justice);

- discussions with members of the CLMH Research Project Steering Group at several time points; and,
- discussion with other experts (government analysts within and outside DfE and academics with relevant expertise) at a research panel session.

These activities resulted in the identification of data from the Clinical Practice Research Datalink (CPRD)[31] as the best available source of a comparison group. The evaluation team submitted an application to access a subset of the CPRD database. This application was submitted in collaboration with DfE and Professor Gill Rowlands (University of Newcastle).

However, unfortunately, it was not possible to gain access to the CPRD dataset within the timeframes of the evaluation, in order to further explore the feasibility of using this as a source of comparison. Therefore, while the CPRD dataset was the most promising source potentially available, we do not know whether it would have provided sufficient comparable individuals to create a comparison group for the CLMH research project.

Although it has not been possible to compare outcomes for CLMH learners with outcomes for individuals who did not participate, the delivery of phase two was designed in such a way that the evaluation has been able to compare outcomes between the three groups A, B and C, to explore potential differences in effectiveness between these approaches (in particular, differences between courses focussing on mental health and wellbeing and those focussing on traditional adult and community learning topics). More details on how the evaluation team undertook this analysis can be found in Annexe 4.

In addition to comparing within groups, some broad comparisons are made between the outcomes achieved by the CLMH research project and the latest available data for the NHS IAPT service. These comparisons should be treated as indicative only, as analysis does not account for differences between the approaches[32].

Wider support and capacity building

To facilitate both the delivery of the CLMH research project and the evaluation, the evaluation team delivered a range of wider support and capacity building activities during phase two. This support included one-to-one support from evaluation team members to help resolve data collection issues; face-to-face visits from the evaluation team if

[31] The CPRD dataset provides anonymised primary care records for public health research. More information is available online at: https://www.cprd.com/intro.asp
[32] IAPT provision typically takes place over more weeks than the CLMH offer, and the latest information indicates that IAPT patients, on average, have more severe mental health problems than those participating in the CLMH research project.

required; and delivery of workshops at termly project events (for example on interpreting data and dissemination).

Evaluation governance

A Steering Group for the research project and evaluation was convened by DfE. This group included stakeholders from across the education, health (including public health) and criminal justice sectors. This group met on two occasions during the evaluation of phase two.

Limitations of evaluation methodology

As with any evaluation of a complex intervention, this evaluation faced challenges both in collecting the necessary evidence, and in analysing it to answer the evaluation questions. These challenges are summarised below.

- The evaluation was unable to access a suitable dataset to compare outcomes for CLMH learners with outcomes for individuals with similar characteristics not taking part in the project (a counterfactual). This means that we are not able to make a robust assessment of the impact of the CLMH project compared with other mental health support or with no intervention, but rather our analysis focuses on understanding the outcomes experienced by those learners that took part, and differences in outcomes between the three different groups (A, B and C).
- While the quality of data collection in phase two was much improved compared with phase one, there were still some problems with the quality of the data, such as duplicate responses, surveys being completed in the wrong order, and inaccurate information being recorded (e.g. dates of birth recorded as 2016 or 2017). The evaluation team has corrected these errors as far as possible, but this has affected the accuracy and volume of data available for analysis.
- As described above, 18% of survey responses were completed using paper questionnaires. These responses have a much more limited range of information, although the evaluation team attempted to add to this information by matching to the Individualised Learner Record. Again, this has affected the volume of data available for analysis.
- For ethical reasons, the qualitative follow-up interviews were arranged on an opt-in basis. However, this meant that the evaluation team was unable to create as diverse a sample of participants as would have been ideal. This may have limited the ability of the qualitative research to understand the full range of participants' experiences. In particular, it may be that participants who had a more positive experience of the project are more likely to volunteer to take part in research.

- Follow-up interviews with learners were conducted later than would have been ideal: in some cases as long as nine months after learners had completed their courses. This introduces the risk of some recall bias in the qualitative findings.

The evidence presented in this evaluation report, and the conclusions reached, must therefore be considered in light of these limitations.

1.5 Report structure

The remainder of this report is structured as follows:

- **Chapter 2:** describes how the project was delivered in phase two, assesses available evidence to suggest whether the approach was delivered as intended and presents learners' views on this delivery model.
- **Chapter 3:** describes the characteristics of learners taking part in the project, and explores learners' motivation for taking part.
- **Chapter 4:** assesses whether the project helped to improve symptoms of mild to moderate mental health problems, both overall and among different groups; describes other positive outcomes from the project identified by learners; and explores the reasons for these outcomes.
- **Chapter 5:** explores what negative outcomes from participation were identified by learners, and presents their suggestions for improvement.
- **Chapter 6:** considers how challenges encountered during phase one were mitigated in phase two, and explores learners' views on taking part in the research study.
- **Chapter 7:** provides conclusions about the project, and lessons learned for policy makers, commissioners, adult learning providers and researchers.
- **Annexes:** a more detailed description of the research project and evaluation methodology is provided in the annexes, which are available as a separate document.

2. How was the project delivered?

2.1 Summary

In this chapter, we set out the CLMH research project delivery model, and present learners' views on this. We begin with a summary of the key findings, as follows.

- In phase two, the CLMH project was delivered by 52 adult learning providers across England. The project specification required all elements of the project to be delivered by community learning staff, rather than being outsourced to mental health organisations. This was a departure from phase one, during which many providers had partnered with mental health organisations to deliver the project.
- Around 10,100 adults volunteered to take part in the research project in phase two, taking part in initial information, advice and guidance sessions to assess their eligibility and consider course options. Many learners found this helpful preparation for the course.
- Based on the survey data, 7,091 learners started a course, and 76% of learners who began their course completed it. Learners reported that they were attracted to the timing and relatively short length of the courses as this appeared a manageable commitment. Learners also welcomed the non-medical setting of the courses. People who were older and/or retired, and those who were not receiving other support for their mental health problems were more likely to complete their course.
- Learners were also offered the opportunity to take part in one-off top-up sessions after their course had finished, although only 17% of learners did so, and these sessions do not appear to have been consistently offered to all learners. Learners who were not offered this opportunity remarked that they would have welcomed the chance to follow-up their participation.
- The evaluation has not rigorously assessed the extent to which research sites delivered the model as intended, and the DfE delivery team took steps to monitor this throughout phase two. However, evidence from the survey data and follow-up interviews shows that there was some deviation from the model, with not all sites offering all three elements as intended.

2.2 Project delivery model

Learning providers

Fifty-two adult learning providers across England took part in the project, covering 57 local authority areas[33]. Where one learning provider covered more than one local authority area, each area was considered as a separate research site. Most (39) of these adult learning providers were based in a local authority, but some were colleges (e.g. Richmond Adult Community College) and some were other types of learning organisation (e.g. Humber Learning Consortium).

The project specification required each learning provider to have a CLMH project team in place, comprising a project lead, a project manager, a data co-ordinator and a local senior strategic supporter with the ability to advocate for the project findings.

In phase one, some learning providers had outsourced significant parts of the project delivery to local mental health charities or NHS organisations. However, in phase two, the project specification stipulated that all elements of the project should be delivered by community learning staff, in order to understand the impact of community learning specifically.

Staff delivering the project were often part-time and/or temporary employees, and there were high levels of staff turnover throughout the research project. This is typical for adult and community learning, and presented some challenges to the delivery of both the research project itself and the accompanying evaluation.

Course content and structure

In phase two, the research project tested three distinct approaches. Each research site was randomly assigned to one of three groups:

- **Group A**: Research sites delivered courses focussing on managing symptoms of mental health problems (e.g. how to manage anxiety) to participants with mild to moderate mental health problems.
- **Group B:** Research sites delivered courses focussing on traditional community learning topics (e.g. yoga, digital skills, painting) to participants with mild to moderate mental health problems.

[33] A full list can be found here: https://mhfe.org.uk/clmh-pilots/

- **Group C:** Research sites delivered courses focussing on traditional community learning topics, to participants who were a mix of learners with and without mental health problems[34].

The difference between group A and groups B and C was intended to compare outcomes from participating in courses that specifically focused on mental health with outcomes from participating in general adult and community learning courses. At the same time, findings from phase one suggested that the group or peer learning aspect of CLMH courses contributed to positive outcomes for learners. Therefore, the difference between group C and groups A and B was intended to explore whether peer support from people with shared experience of mental health problems is more or less effective than peer support from other learners (where the shared experience is of being a learner).

Each of these three groups had the same number of research sites (19), and was intended to engage a similar number of learners (around 4,000[35]) with the same overall unit cost per learner (£450).

The overall focus of courses varied between the three groups, and the exact courses offered varied within the three groups. However, in order to allow the comparison of the impact of the three approaches, the format of delivery, or 'the model' across all research sites was the same, and prescribed by DfE as:

- Up to 3 hours of 1:1 pre-course guidance and assessment and on-course support and guidance to every learner. This is known as information, advice and guidance (IAG);
- Short, part-time non-formal adult education courses, lasting 15 hours over a period of no less than 3 taught weeks and no more than 6 taught weeks; and
- Non-formal 'top-up' workshops, to be offered at least once every 4 weeks, for people who had progressed from courses and needed subsequent support.

2.3 Participation and completion rates

Overall, around 10,100 learners took part in the research project in phase two[36]. This number includes 220 people who took part only in a top-up session during phase two, having taken a course in phase one of the research project.

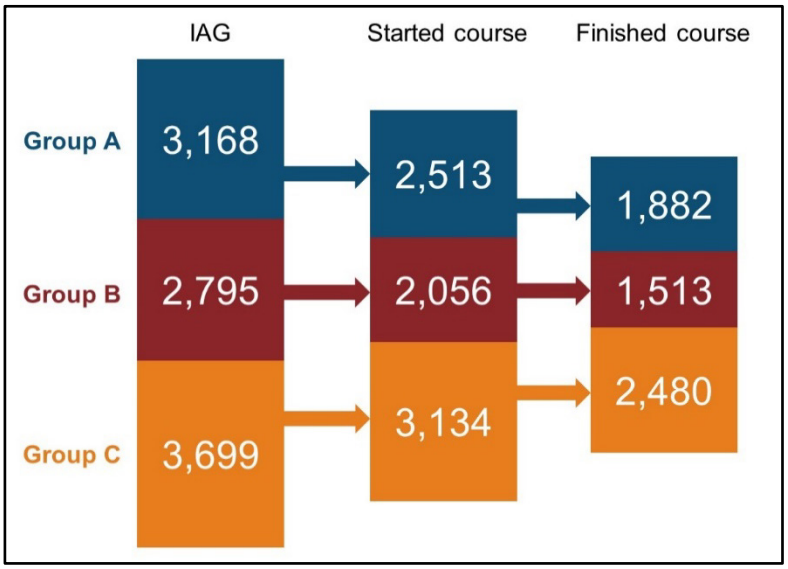
---

[34] Group C was intended to comprise 50% learners with mental health problems and 50% without, but in fact 63% of the group had symptoms of mild to moderate mental health problems. See section 3.2.See section 3.2.
[35] The target number of learners was set at this level for Phase two based on guidance by the evaluation team in Phase one. This was done in an effort to ensure that useable, pre and post course data was available for a large enough volume of learners to allow reliable impact analysis in the event that a source of data from which to create a comparison group could be found.
[36] Around 14,500 individuals took part in year one of the project.

Based on survey data, at least:

- 9,662 people had an IAG session;
- 7,703 learners started a course:
  - 2,513 in group A
  - 2,056 in group B
  - 3,134 in group C
- 5,875 finished their course – representing a 76% completion rate[37]:
  - 75% in group A
  - 73% in group B
  - 79% in group C

Figure 1: Participation and completion by group



Source: Ipsos MORI analysis of DfE survey data.

Research sites in group C were therefore most successful at recruiting and retaining learners; this may be because projects in this group were able to recruit learners without mental health problems in addition to the target group.

Data is not collected or reported for the recruitment or completion rates of general adult and community learning, and therefore comparisons are not possible. Data for IAPT can be used to provide some context. However, differences in the nature of the service and of the users of the service mean these comparisons should be treated as indicative only. In 2016/17:

[37] Completion rates in this report are worked out using the following formula: number of learners who completed a final survey divided by the number of learners who completed at least one week 1, week 3 or final survey.

- 70% of 1.39m people being referred to IAPT started a course of treatment, compared to 80% of 9,662 people who undertook an IAG session; and
- 59% of 965,379 people completed their course of treatment[38] within the year, compared to 76% of 7,703 people starting a CLMH course.

2.4 Learners' views on the delivery model

This section presents learners' views on the different elements of the CLMH delivery model, obtained from follow-up interviews with learners. The interviews explored both learners' experiences of the model and thoughts on how similar courses could be offered in future.

Information, Advice and Guidance (IAG) session

Learners explained that the IAG sessions had three objectives: a) going through different course options and discussing what they wanted to get out of the experience; b) explaining the research component and assessing their eligibility; and c) setting out expectations for the course. Learners also saw it as an opportunity to ask questions, and that this was helpful because it meant that the group could get started with the course right away in the first class.

In general, learners were relatively neutral about the session, recalling it as being 'fine', 'informative' or 'a good chat'. Learners who mentioned the session taking about 30 to 45 minutes seemed happy with this length whereas one learner who had a session that lasted 1.5 hours found it tiring. Several learners liked that the IAG session was at the same location where the course would be:

"You went to the actual building that it was going to be in which was good because it made it less scary". *Learner, Group C*

Learners generally recalled being told everything they needed to know to prepare for the course. One learner commented that they appreciated the flexibility to choose courses, though in some cases, learners reported that the CLMH course was the only one offered to them.

Regarding their experience of discussing their mental health, learners liked that the session was a one-to-one, private conversation with an IAG interviewer who was approachable and friendly but also understood mental health problems. This helped the session feel 'laid-back and easy-going', though this was also helped when learners

[38] N.B. Uncertainties about how service users whose treatment straddles two Financial Years are treated in calculating a completion rate for IAPT services may mean this figure is artificially low.

themselves felt comfortable talking about their mental health or had previous experience of doing so.

For a small number of learners, the session felt burdensome or provoked negative emotions because they found it difficult to talk about their feelings. Framing of the session was also important. For example, a learner who experienced the IAG session being introduced as an 'interview' suggested that this kind of terminology could be intimidating, and given the intended nature of the session this description is likely to be misleading.

Course structure

Learners were drawn to the short length of the course, which felt like a manageable commitment. Reflecting on the course, some learners described the length as 'ideal' while other learners also commonly said they would have liked if the course had been longer and would also have welcomed the opportunity to attend refresher sessions (see next sub-section). Learners also reported that the length of each session (2-3 hours) worked well, although this could pass too quickly when time was also taken to complete the surveys.

Top-up offer

Overall, 17% of learners who took a course in phase two also took a top-up session, which, combined with evidence from the qualitative work, suggests that these may not have been offered to learners consistently. At two learning providers there were no learners who took part in top-up sessions, and at three providers fewer than 5 learners took a top-up session. Learners taking part in the qualitative research generally reported that they were not offered any top-up sessions. Some did say that top-up opportunities were mentioned by the tutor but they did not think these happened in the end. Instead, a few learners mentioned that they were offered the opportunity to attend the same course again, a similar course that had a fee, or another course altogether; but that none of these options were right for them at that point in time. It is important to note that this may not be representative of the overall project because the learners interviewed had attended courses towards the end of the delivery period (between April and July 2017).

Despite their lack of direct experience of top-up sessions, learners were able to provide insight about why such sessions would be desirable. When asked separately about what might improve the course offer, many learners mentioned that they would have liked an opportunity to informally continue the course, for example, with drop-in sessions. Many learners were saddened when the courses finished and missed attending the course, and some learners continued practising their new skills, for example jewellery-making, at home in their own time after the course finished. In both cases, these learners stated that they would have liked a follow-up opportunity. The implications of this are considered in section 5.2.

Delivery organisation

The qualitative research also explored learners' views on what type of organisation would be best placed to deliver courses of this kind, specifically whether they should be delivered by adult education providers or the NHS. Learners emphasised that the courses should take place in a learning environment (e.g. college) rather than a medical setting, and commented that it was more important that they had the right teacher for the subject; for example, they would not want a medical practitioner delivering an art course. Learners reported that they would not want the course to become 'medicalised' or 'hospitalised' or entirely focussed on mental health as that would make them feel differently about it and potentially exclude them. This was particularly the case for learners in groups B and C, where courses were not explicitly focussed on mental health and wellbeing.

"From a personal point of view, I was on the course to learn and for the discipline. I wasn't driven by wellbeing. So if it was run by the NHS, that wouldn't do it for me. In fact I don't think I would have attended. If it was the NHS I would have thoughts about it revolving around feelings and being too focussed on mental health." *Learner, Group C*

"I think if it had been NHS it would have been more focussed on … mental health … Certainly at the stage I was at that's not what I needed. I already was seeing a therapist, I didn't need that kind of support." *Learner, Group C*

Some learners suggested a combination of both NHS and adult learning might work well, for example, having a mental health worker that attends or runs some sessions. Alternatively, learners suggested a stronger partnership could be built at the advertising or referral stages. Some learners, who had been to the NHS for their mental health and received either limited counselling offers or medication, felt that being offered a course might be a good additional offer:

"I've been to the NHS before for counselling and there's always a long waiting list and there's nowhere near enough support for people … so if they did something like offer mindfulness or assertive training in a different way I think it would work better". *Learner, Group A*

However, learners were divided on what this might mean for accessibility to the course. Some felt that going through the NHS would increase accessibility while others were concerned it might become a rigid process that would exclude some individuals.

"Everyone has heard of the NHS so everyone would know where to look for that sort of thing which would help make it accessible." *Learner, Group C*

"You would need to be referred, assessed, you might have to see a doctor and people would be more reluctant to see a doctor. Adult learning is open to everyone". *Learner, Group C*

2.5 Did research sites deliver the model as intended?

The delivery team at DfE took steps to improve the fidelity of delivery during phase two, which included:

- a more tightly defined delivery model overall, with clear instructions for research sites on the expectations for delivery;
- face-to-face visits by the project manager to all research sites during the set-up phase;
- weekly webinars throughout the delivery period to provide advice and support relating to delivery of the research project (and the evaluation);
- a series of peer observations of course sessions to allow research sites to monitor fidelity of course delivery.

The evaluation did not collect evidence with which to conduct a thorough assessment of the extent to which research sites delivered all elements of the approach for their group as intended. However, as discussed throughout this section, there is evidence that there was at least some deviation from the overall model at each stage:

- **Information, advice, and guidance:** There is evidence that in some cases this was not delivered as a separate session but rather rolled into the first session of the course. Some learners also reported this session being referred to as an "interview", which may have been misleading or discouraging.
- **Top-up sessions:** The small volume of learners taking top-ups, and qualitative evidence, suggests that top-up sessions may not have been consistently made available to learners.

Section 5.2 considers whether there is any evidence to suggest that not sticking rigidly to the project specification reduced the potential benefits learners gained from their participation.

3. Who took part in the project in year 2?

3.1 Summary

In this chapter, we present the profile of learners taking part in the project, and explore learners' reasons for taking part. The key findings of this section can be summarised as follows.

- Almost all (96%) learners starting a course were in the target group for the project, except in group C where the figure was 63%, and which was intended to be a mixed group of learners with and without mental health problems (see section 2.2).
- More than half of learners in the target group had clinically significant symptoms of anxiety or depression (55% and 51% respectively), and almost seven in ten (69%) of learners were receiving other support for their mental health at the time of volunteering to take part.
- Just over three-quarters (76%) of learners were female, and middle-aged people were over-represented compared with the overall population. This is similar to the typical profile of participants in community learning.
- Compared with users of NHS mental health services, the profile of learners in this project was more representative of the overall population in terms of ethnicity. This is largely due to a higher proportion of Asian people taking part (11% of learners).
- Compared with phase one of the project, there were more learners in employment (26%). However, the project continued to reach a greater proportion of people who were unemployed or unable to work compared with the IAPT service. This suggests that the project was accessible to a wide range of people in different circumstances. The fact that the course was free was often a factor in learners' decision to take part.
- Improving mood and confidence were key motivations for learners when deciding to sign up for the course.
- Learners were also motivated to sign up for their course because they were interested in the subject area (for example, art or yoga), either from previous experience or as a means to learn a new skill.
- The opportunity to meet new people and work within a group was also a key motivator. In some cases, learners were also reassured by knowing that others in the group would be in similar positions to themselves.

3.2 Mental health needs

The CLMH Research Project was aimed at adults with self-assessed symptoms indicating mild to moderate mental health problems (anxiety or depression).

Overall, 80% of learners attending IAG sessions were in the target group. A small proportion (5%) of people taking an IAG session had symptoms of mental health problems that were too severe for them to be eligible for the course, while 15% did not appear to have symptoms of mental health problems. Three out of four (75%) of the people who had self-assessed symptoms suggesting mental health problems that were too severe for the project, based on their symptoms, were signposted or referred elsewhere, most commonly to another course that was not part of the research project or to their GP.

Of learners who started a course in groups A and B, 96% were in the target group for the project; in group C, 63% were in the target group and the remainder did not appear to have symptoms of mental health problems. Group C was intended to comprise 50% of learners without mental health problems, but anecdotal evidence from learning providers suggests that it was difficult to recruit participants with no symptoms of mental health problems. Even if individuals did not consider themselves to have a mental health problem, at initial guidance sessions they often reported symptoms which indicated mild depression or anxiety. This may partly be due to the way in which group C courses were promoted as a potential way to improve wellbeing, which is likely to have attracted individuals with lower levels of wellbeing. All findings in this report relating to mental health outcomes are based only on learners who were in the target group for the CLMH research project, unless otherwise stated.

Of those learners who started a course and were in the target group, 51% had clinically significant symptoms of depression, 55% had clinically significant symptoms of anxiety, and 40% had both. The remainder had symptoms suggesting milder mental health problems.

Two-thirds of learners who started a course reported receiving other support for their mental health problems. The most frequently mentioned sources were: their GP (55% of those who stated they were receiving other support); medication (39%); friends and family (34%), or NHS mental health services (30%)[39]. Learners who reported receiving

[39] Participants could select multiple options.

other support for their mental health problems were less likely to complete their course (75%) than those who were not (79%)[40].

As well as measures of depression and anxiety, learners completed wellbeing assessments during their participation using the short Warwick-Edinburgh Mental Wellbeing Scale. At IAG, average wellbeing was 20.6. A person with this score would be in the bottom quarter of the population in terms of wellbeing[41].

Table 2: Average wellbeing at IAG by group

Group	Average wellbeing score at IAG (higher score represents greater wellbeing)
Group A	19.4
Group B	20.1
Group C	22.1
All	**20.6**

Source: Ipsos MORI analysis of DfE survey data. Base: 9,201 learners with wellbeing score at IAG.

3.3 Learner demographics

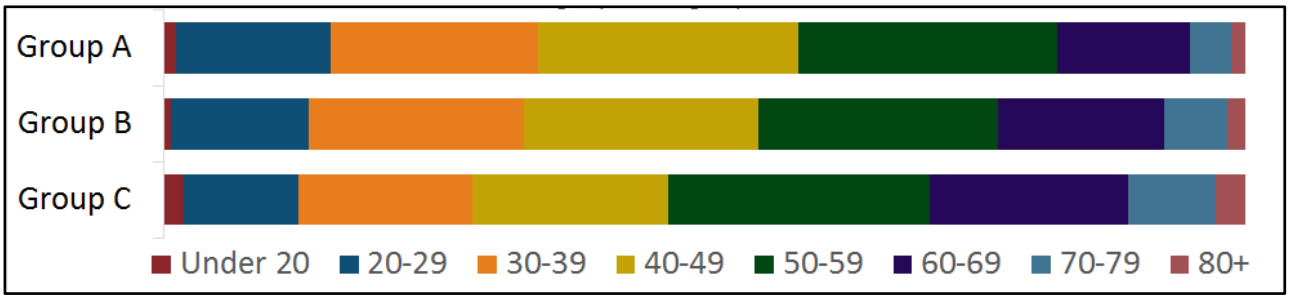
Research shows that there are demographic inequalities in who receives treatment for mild to moderate mental health problems such as anxiety and depression[42]. People who are white British, female, or aged between 35 to 54 are more likely to receive treatment[43]. There are also demographic differences in the prevalence of anxiety and depression, which are more common among Black women, adults not in employment, and those in receipt of benefits, among others[44]. As part of the research project, research sites asked learners to provide information about themselves.[45] This information allows us to explore who the learners were, and to assess whether this type of provision was able to reach people likely to be more in need of support for their mental health, and/or people from groups who access medical treatment for their mental health at a lower rate.

[40] Completion rates in this report are worked out using the following formula: number of learners who completed a final survey divided by the number of learners who completed at least one week 1, week 3 or final survey.
[41] Compared with Health Survey for England data, 2011, available at: https://warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/interpretations/wemwbs_population_norms_in_health_survey_for_england_data_2011.pdf
[42] For example: https://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf
[43] Adult Psychiatric Morbidity Survey 2014.
[44] Ibid.
[45] For details of the information collected about learners, please see Annex 2.

Age

Compared with the overall adult population, a higher proportion of IAG participants were aged between 30 and 60; people in their 50s were particularly over-represented (23% of course participants, compared with 15% of the adult population). Again, this reflects participation in community learning more widely: 25% of community learning participants in 2014/15 were aged between 45 and 59[46]. The 2014 Adult Psychiatric Morbidity Survey notes that rates of common mental disorders (such as anxiety and depression) have increased in those aged 55 to 64[47]. There were lower rates of participation in the research project among younger and older people. Older people (those over 65) are also underrepresented among those accessing IAPT services[48]. However, course completion rates appeared to increase with age; 73% of learners in their 20s completed their course, compared with 80% of learners over 70. Again, this is comparable to IAPT, where a greater proportion of older adults complete treatment compared to working-age people[49].

Figure 2: Learner profile by group: age



Source: Ipsos MORI analysis of learner survey data and ILR. Base: 9,951 learners with age recorded.

Disability

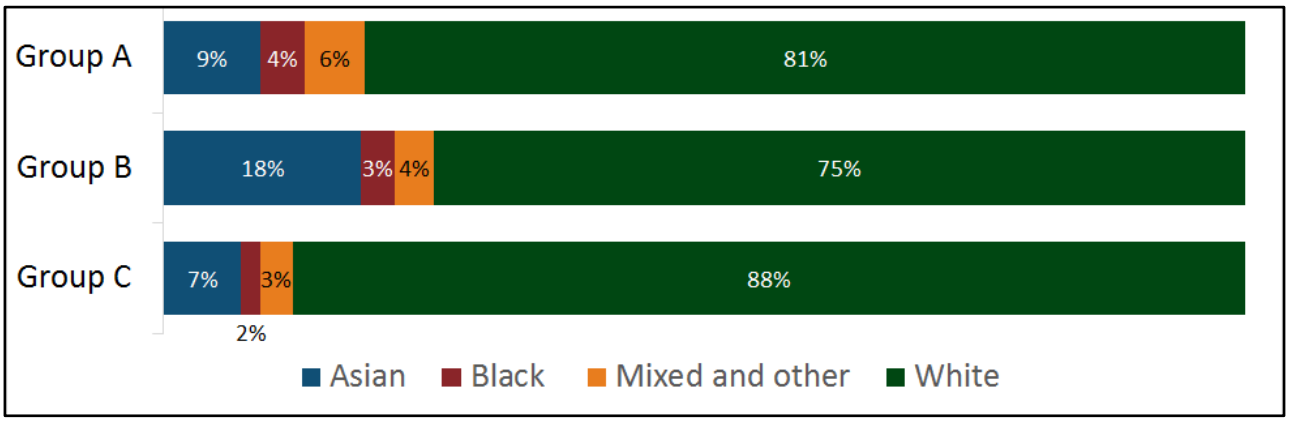
Around three in ten (31%) learners considered themselves to have a disability other than, or in addition to, a mental health problem: most commonly a long-term medical condition, mobility difficulties, learning difficulties or disabilities, or neurodiversity. 18% of learners reported receiving Employment and Support Allowance, a benefit for those unable to work due to illness or disability claimed by 6% of the working-age population in England. The Adult Psychiatric Morbidity Survey 2014 revealed that two-thirds of people claiming ESA were experiencing mental health problems.

[46] Community Learning Participation by Geography and Learner Demographics, 2014/15. Skills Funding Agency, April 2016
[47] Adult Psychiatric Morbidity Survey 2014.
[48] https://www.england.nhs.uk/mental-health/adults/iapt/older-people/
[49] Ibid.

Ethnicity

A higher proportion of Asian people and a slightly lower proportion of white people volunteered for the project compared with the overall population: 82% of learners were white, 11% were Asian, 3% were Black and 4% were from other ethnic backgrounds; 89% of learners described their nationality as British or as one of the UK nations. Group B had a larger proportion of Asian learners, due to three projects in London in this group (Harrow, Redbridge and Ealing) which had a high proportion of Asian learners, reflecting both the general population in these areas and efforts by learning providers to recruit learners from Asian communities.

Figure 3: Learner profile by group: ethnicity



Source: Ipsos MORI analysis of learner survey data and ILR. Base: 7,228 learners with ethnicity recorded.

The proportion of learners from BAME groups was higher than the proportion of IAPT patients from BAME groups (12% in 2015/16)[50]. Prevalence of anxiety and depression does not vary by ethnic group in men, but Black women are more likely to have symptoms of anxiety and depression than women from other ethnic groups[51]. Despite this, people from BAME communities have generally been less likely to be referred to psychological support[52], and white British people are most likely to receive medical treatment for mental health problems[53], so the fact that the CLMH learner cohort was more representative in terms of ethnicity is important and positive.

[50] http://digital.nhs.uk/catalogue/PUB22110
[51] Adult Psychiatric Morbidity Survey 2014. Other differences between ethnic groups were not statistically significant, which may be due to small sample sizes.
[52] http://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf
[53] Adult Psychiatric Morbidity Survey 2014

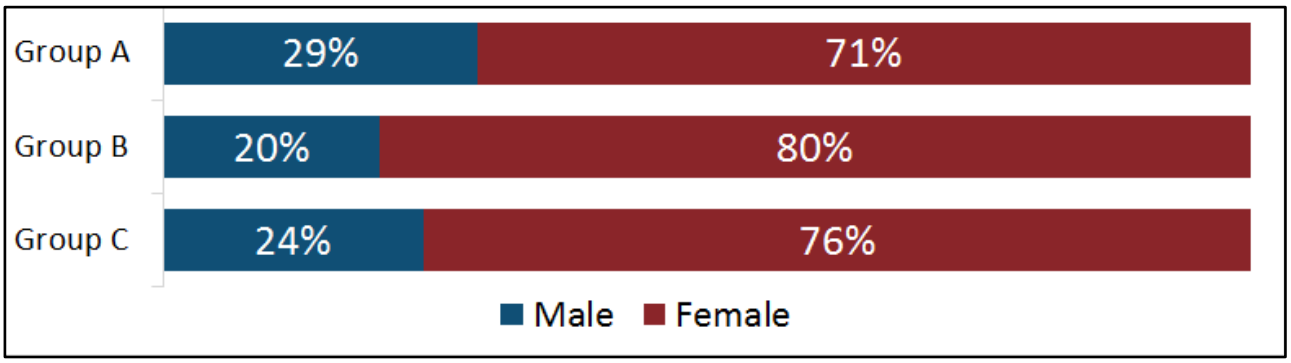
Religious beliefs

Around four in ten learners did (36%) and did not (36%) have religious beliefs; 26% were Christian, 4% were Muslim and 2% were Hindu, and smaller numbers of learners reported other religious beliefs. This is a larger proportion of people reporting no religious beliefs, and a smaller number identifying as Christian, compared with the overall UK population[54]. One-quarter (24%) of learners chose not to answer when asked about their religious beliefs.

Sex and gender identity

Three out of four learners taking part in IAG sessions[55] (76%) were female; 24% were male and 25 learners identified in a different way. This is a higher proportion of female learners than in phase one (69%), despite efforts by some learning providers to recruit more men. Women are more likely to report symptoms of mild to moderate mental health problems than men[56], and users of NHS psychological treatments for anxiety and depression (IAPT) are also predominantly female (65% in 2015/16)[57]. This profile of learners also reflects typical participation in adult and community learning, where 72% of learners were female[58] in 2014/15.

Figure 4: Learner profile by group: gender



Source: Ipsos MORI analysis of learner survey data and ILR. Base: 9,152 learners with gender recorded.

[54]https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/religioninenglandandwales2011/2012-12-11
[55] Figures this section are for learners volunteering for the project by taking IAG sessions; this is very similar to the profile of learners beginning courses (figures for the two groups are within 1 percentage point of each other).
[56] In the Adult Psychiatric Morbidity Survey 2014, 19% of women had reported CMD symptoms, compared with 12% of men: https://digital.nhs.uk/catalogue/PUB21748
[57] http://digital.nhs.uk/catalogue/PUB22110
[58] Community Learning Participation by Geography and Learner Demographics, 2014/15. Skills Funding Agency, April 2016

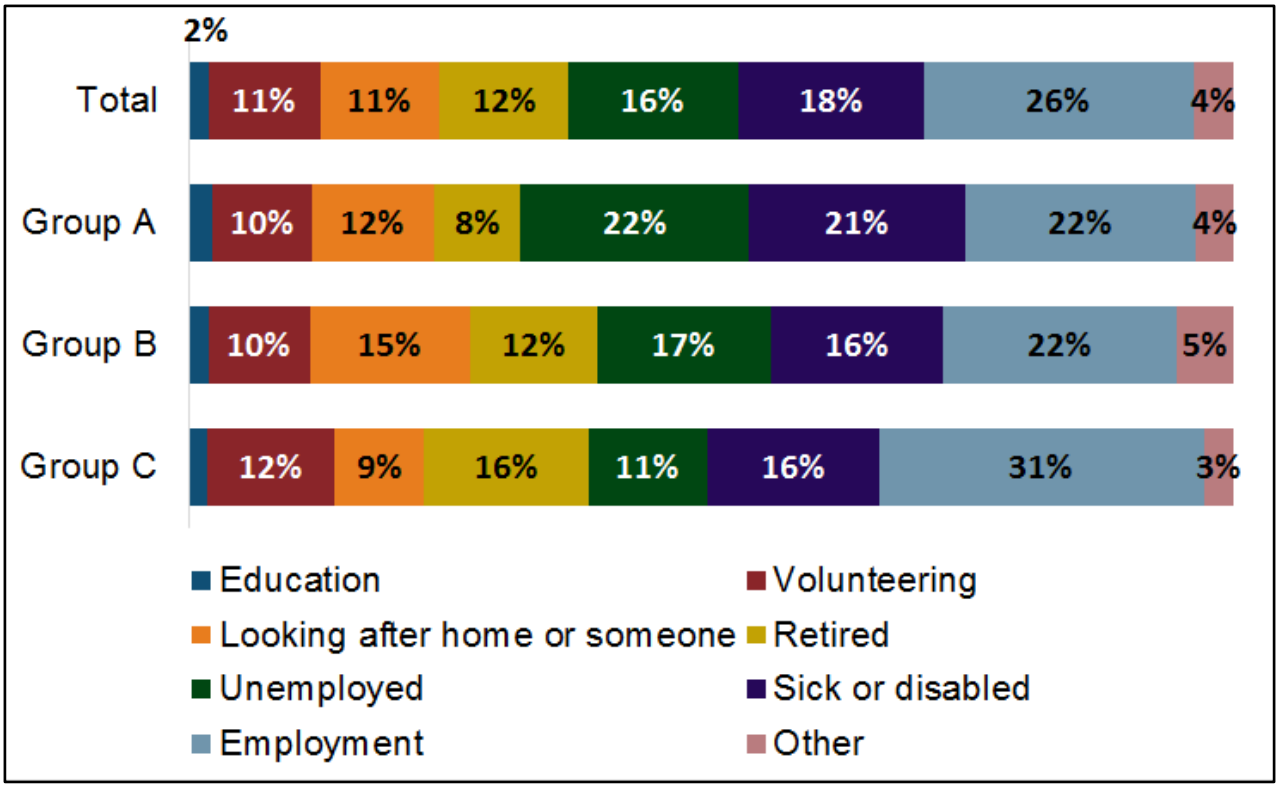
Sexual orientation

The proportion of learners identifying as lesbian, gay or bisexual (4%) was slightly higher than that of the overall UK population (2%)[59].

Occupation

Compared to the profile of learners in phase one of the research project, a higher proportion of learners taking part in phase two reported being in employment. Over a quarter (26%) of learners in year two said they were in employment (full or part-time), while 18% reported being unable to work due to illness and a further 16% being unemployed. One in eight (12%) said they were retired.

Figure 5: Learner profile by occupation



Source: Ipsos MORI analysis of learner survey data. Base: 6,731 learners with occupation recorded at IAG. Learners could only select one option.

In comparison, while people who are unemployed are twice as likely to have common mental health problems than those who are in employment[60], the majority of users of the

[59]https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016

[60] Adult Psychiatric Morbidity Survey 2014.

IAPT service (NHS talking therapies) were in employment (57%); only 12% were unemployed and 9% were long-term sick or disabled.

Caring responsibilities

Almost a quarter of learners (24%) reported that they were the primary carer for a child or children under 18, although only 12% described looking after home or caring for someone as their main occupation, and the majority (68%) said that they had no caring responsibilities. Learners who were retired or volunteering were most likely to finish their course (81%) while learners who described their main occupation as caring or who were long-term sick or disabled had the lowest completion rates (70% and 72% respectively). Qualitative research indicated that some learners were unable to finish their course, or attend all sessions, due to health-related reasons (e.g. hospital appointments) or caring responsibilities.

Social mobility

Around three in ten learners (31%) said they had received free school meals during their time at school, and just over one in five (21%) reported coming from families that had received income support when they were at school. Four out of five learners (80%) had attended a state school in the UK, with 6% attending an independent school and the remainder having attended schools outside the UK, been home-schooled, or not having been to school at all (1%).

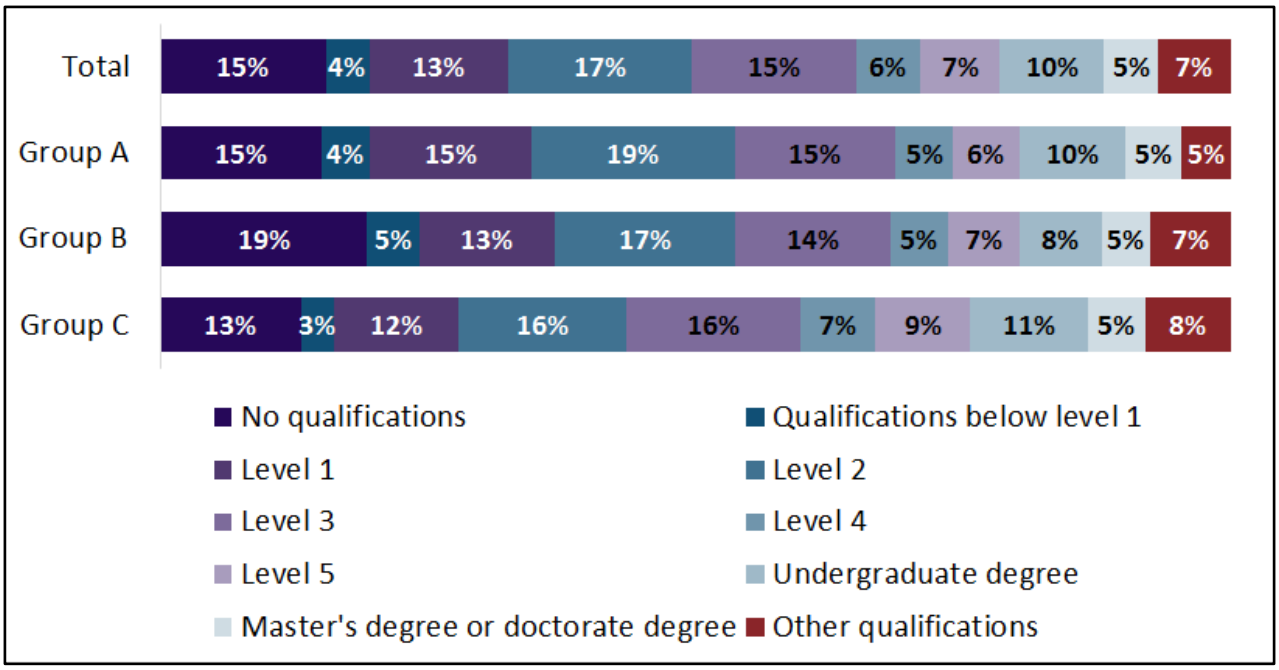
Highest level of qualification

Compared with the population, CLMH learners were more likely to have at least some qualifications, but less likely to have a degree-level qualification[61]. One in six learners (17%) had qualifications below level 2 and a further 15% had no qualifications. Around one-third (32%) had level 2 or 3 qualifications as their highest qualification and just under one in six (15%) had university-level qualifications.

This indicates that while the CLMH research project was able to attract learners with a lower-level of achievement from previous education, it was less successful at attracting those who might have less experience of formal learning.

[61] In England and Wales in 2011, 23% of people had no qualifications and 27% of people had a degree-level qualification or above: http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/local-area-analysis-of-qualifications-across-england-and-wales/info-highest-qualifications.html

Figure 6: Learner profile by highest level of qualification



Source: Ipsos MORI analysis of learner survey data. Base: 6,991 learners with highest level of qualification recorded at IAG.

Group C learners not experiencing symptoms of mental health problems

As described above, 37% of learners in group C were not experiencing symptoms of mental health problems. This group of learners had some different characteristics to other learners in group C. They were older (38% aged over 60) and more likely to be retired (23%). More learners in this group were employed (37%) and fewer were unable to work due to illness or disability (7%). They were also somewhat less likely to be from families that received income support when they were at school (15%). There were no differences between these learners and the other group C learners in terms of ethnicity or caring responsibilities.

3.4 Why did learners decide to take part?

How did learners find out about the research project?

In interviews, learners reported that they first heard about the courses through a range of channels, for example:

- GP referral or a leaflet in the GP surgery
- Recommendation from mental health support worker or via group therapy

- JobCentre Plus, careers advisor or through a work programme open day
- Brochure or poster in the local library
- Recommendation from a friend or family member
- Social media e.g. Facebook
- Previous adult education courses (e.g. mailing list; recommendation from previous teacher)
- Letter from college or website advertisement

It is likely that different channels are more suitable for recruiting different types of learner. Therefore, the breadth of channels used is important in making this offer accessible to a diverse range of learners. For example, if targeting people with mild-to-moderate mental health problems who are not accessing support from the NHS, then referral routes outside of GPs/mental health support workers will be vital.

What motivated learners to take part?

The qualitative research identified a range of different reasons why learners decided to sign-up. While there are common themes, as discussed below, motivations also often related to a learner's individual circumstances at that time.

Some learners, especially those who had completed previous courses, were actively looking for courses to join because they liked the learning environment, whereas others only signed up for the course as a one-off.

Across all three delivery groups, improving mood and mental health was a key reason for joining courses. This was especially true for learners at research sites in group A, where courses were advertised with a more explicit focus on improving wellbeing. Often, learners had experienced significant life changes or personal circumstances that had negative impacts on their wellbeing, for example, becoming ill, experiencing relationship difficulties or breakdown, or employment problems.

These learners described wanting to de-stress, relax and lift their spirits. They were attracted to the wellbeing element of the course and some specifically mentioned that they wanted to learn or refresh their wellbeing skills or take practical steps to improve wellbeing. Learners were also looking for ways to improve their confidence and self-esteem, to 'become braver' and feel a sense of achievement. An opportunity to 'focus on me' or 'do something for myself away from home' was also important and this was typically linked to having something that could help them clear their mind and focus:

"It made me join because I thought that doing something creative, and something with my hands, would make me feel better and more concentrated on something because I

couldn't concentrate on anything…To improve my mood, and to make me feel active as well because I was made redundant and I didn't have a job." *Learner, Group A*

Among those with long-term physical conditions, some hoped the course would take their mind off the pain or saw aspects of the course (e.g. exercise, meditation, breathing techniques) as a means to improve their symptoms.

Another important reason for learners deciding to take part was that they were drawn to the course because they were interested in the subject area, for example yoga, jewellery-making, or creative writing. While some learners said they had long-standing interests in the subject and wanted to improve their skills, others were looking to learn a new skill and challenge themselves:

"I wanted to put myself outside my comfort zone a little bit" *Learner, Group C*

Learners also commented that they thought the wellbeing angle of the courses would mean the class would include others in a similar position to themselves, and that the course would have more flexibility and be low-pressure, where 'everyone could be a beginner together':

"I just assumed that because it was wellbeing they would be people like me who had never done it, whereas the classes I do now, apart from me they have all been doing it for years". *Learner, Group C*

It is important to note that class composition was not always viewed positively by learners reflecting back on the course, and this is discussed further in section 5.1.

The social element of taking part was a key attraction. For example, one learner mentioned that she had made a group of close friends on a previous course and continued signing up for courses together. Another learner, who had recently moved to the local area, liked the opportunity to meet people and become more social. Several learners also noted that they were more likely to do certain activities in a group than on their own, or that the activity was made better by taking place in a group.

Some learners did not, however, specifically mention improving their wellbeing as a reason for signing up for the course. Learners from research sites in group B and C were more likely to say that they were interested in the subject area, the desire to learn or improve their skills, and/or the social aspect of the courses, rather than in improving their wellbeing. For example, several learners mentioned wanting to gain practical skills that might be helpful for employment or volunteering opportunities, or that it was something they could put on their CV while they were off work. This is perhaps less surprising given that research sites in group B and C provided courses with more traditional community learning topics so their promotion may have had a reduced emphasis on wellbeing. However, many of these learners later reflected that the courses did in fact help improve their wellbeing:

"The main reason for signing-up was to improve my writing skills. It wasn't about mental health. I wasn't in tune with the idea that it could boost confidence and help me cope with things at the time of signing up." *Learner, Group B*

Finally, some of the practical details of the course encouraged learners to sign up. For example, if the course was at a time and location that suited their circumstances. Multiple learners also mentioned that the course length seemed 'doable' and 'not a huge commitment'.

The reasons learners interviewed cited for taking part can help learning providers who are continuing this offer understand the range of likely motivations of learners.

Learners appreciated that the course was free; a common remark was for learners to say that they would not have joined the course if it had involved a fee, due to their circumstances at the time and not being sure what they would get out of the course. It was only in retrospect that they were able to assign a value that they would be willing to pay, knowing what they would be getting out of it:

"At that point in time I was very, very low and I didn't have the finances to sign up for anything that I would have to obviously pay a lot of money for, so to just have something like that that was free" *Learner, Group C*

"In hindsight having done the course I would have been happy to pay for it, but I don't think, I didn't have the money to pay for it at the time as I wasn't working. That [being free] was obviously a big incentive". *Learner, Group A*

When asked how much they thought it would be reasonable to charge for similar courses, some learners provided estimates from other courses they had been on (usually £100 or more) but many learners were unsure what a typical rate would be. The most common response was £3 to £5 per session (£20-30 for whole course) as learners felt this would be enough to cover the costs of course materials. Several learners also mentioned that they would prefer to pay weekly rather than in one lump sum at the beginning. It should be noted that people on low incomes or in receipt of some benefits are often eligible for free or discounted adult and community learning courses.

4. How effective was the approach?

4.1 Summary

In this chapter we present findings from the analysis of the mental health outcomes for learners participating in the CLMH Research Project, measured using the three mental health self-assessment scales. We only consider mental health outcomes for learners who were in the target group for the project (experiencing symptoms of mild to moderate mental health problems at the start of their participation). Outcomes for learners in Group C who reported no symptoms are not part of this evaluation.

We also explore other positive outcomes identified by learners, and the ways in which the approach might be contributing to these positive outcomes. We summarise the key findings below, before discussing these in detail in the remainder of the chapter.

- Overall, rates of recovery (52%) for those with clinical depression and/or anxiety were broadly similar to those for patients using the IAPT service.
- More than two in five learners who had clinically significant symptoms of depression (41%) or anxiety (46%) at the start showed reliable recovery over the course of their participation.
- Learners' average wellbeing, measured using the Short Warwick-Edinburgh Mental Wellbeing Scale (sWEMWBS) also improved during participation, with the average at the end of the course close to average wellbeing in the wider population.
    - The size of these changes in wellbeing was similar for learners without symptoms of mental health problems (in group C). These learners started their courses with higher than average wellbeing, and at the end of their participation their wellbeing had also improved.
- The findings collectively indicate that group A had the most positive outcomes, followed by group C, with outcomes for group B being the least positive. This may suggest that courses which are explicitly focused on managing mental health symptoms are more effective than general adult learning courses; it may also suggest that general adult learning courses are more effective at improving mental health outcomes when delivered to a mixed group of learners rather than only to learners with mental health problems.
- Regression analysis found that:

    - Learners were more likely to recover if they were female, had higher-level qualifications, or were from a disadvantaged family background[62].
    - Learners were less likely to recover if they were unemployed, unable to work due to sickness or disability, receiving mental health support from their GP, or taking tablets for their mental health. On average, learners in these groups had more severe symptoms at the start of their course.
    - Learners in group B were less likely to recover from depression, but there were no other differences between the three delivery approaches (groups A, B and C).
- Learners attributed these improvements in wellbeing to a supportive and relaxed learning environment; to having a routine and something to look forward to; and to the opportunity to focus on something other than day-to-day life. Some learners also mentioned feeling pride in learning a new skill, especially where they were able to see tangible evidence of their progress.
- At the end of their course, learners reported feeling more confident, positive and relaxed; that they had made progress with their learning; and that they had made new friends or improved their social skills. Learners' increased confidence had also increased their motivation to try new things in future or to continue learning.
- More than half (52%) of learners said that they intended to go on to further learning following their CLMH course, most commonly more community learning. Slightly fewer than one in five (19%) learners expressed interest in going on to more formal learning.
- For group A learners, the greatest benefits of the courses appeared to be in learners' outlook: taking a more positive, optimistic attitude and becoming less stressed or anxious. This is likely to reflect the group A courses' focus on mental health and wellbeing. Learners in groups B and C, on the other hand, were more likely to identify improvements in their skills, learning and confidence, and to say that they would go on to further learning.
- Learners generally felt that the wellbeing benefits of their participation had been limited to the time period during which they were taking the course. However, those learners who had been able to continue with the activity they started on their course, or who had progressed to other learning opportunities, had found it easier to maintain positive changes to their wellbeing.

[62] Defined by whether the respondents came from families that received income support at some point during the respondent's school life.

4.2 Mental health outcomes: overall findings

The findings in this section, section 4.3 and section 4.4 relate to mental health outcomes for learners that:

- were in the target group for the research project; in other words, those who showed symptoms of mild to moderate mental health problems at the start of their participation; and
- completed at least one mental health self-assessment (MHSA) before the start of their course and at least one MHSA after the start of their course. If they completed more than two MHSAs, the earliest and latest assessments were compared.[63,64]

The overall findings provide a descriptive analysis of changes in self-reported mental health symptoms for learners across all three delivery approaches. We discuss differences in outcome for learners in each of the three delivery groups in section 4.4.

Explanation of terms used

Learners reported their symptoms of depression or anxiety using the PHQ-9 and GAD-7 self-assessment scales, which produce a numerical score. These scales are used in the NHS, for example by GPs and the IAPT service, to diagnose mental health problems and assess their severity. A clinically significant score means that the learner's self-report of their symptoms produced a score which, in the NHS, would diagnose them as experiencing depression or anxiety. These scales are also designed to be used to monitor an individual's mental health over time, and are used in the NHS to determine how a patient is responding to treatment.[65]

To understand whether changes in scores are likely to be a genuine sign of improvement, there are several criteria that can be used:

- **Significant improvement:** Research has identified the minimum change in scores which can be interpreted as a genuine sign of recovery, rather than day-to-day variation. Learners whose scores improved by this amount or more were said to have shown significant improvement in their symptoms.

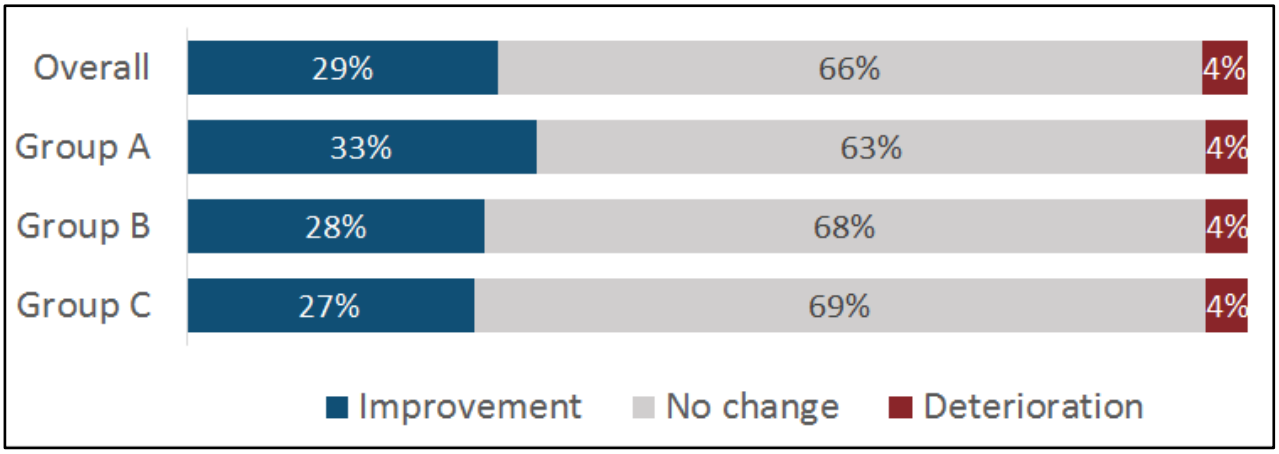
[63] For example, where a learner does not have an assessment at the point of IAG in the dataset, their assessment from the first week of their course is used.
[64] This approach means that the time period between the scores being compared may vary. This time period over which change is observed could be significantly longer than the length of the course if learners took an IAG session a long time before the start of their course, and/or attended a top-up session a long time after the end of their course.
[65] For example, patients accessing NHS IAPT services would complete the scale(s) relevant to their diagnosis at every session.

- **Recovery:** Learners whose scores suggested clinically significant symptoms of depression at the start of their course, but not at the end of their course, were considered to have recovered.
- **Reliable recovery:** Learners who experienced both significant improvement and recovery were said to have shown reliable recovery.

Depression (measured by PHQ-9)

- 29% of learners showed a significant improvement in their symptoms of depression.
- 4% of learners showed a significant deterioration in their symptoms of depression.

Figure 6: Distance travelled on PHQ-9 scale, by group



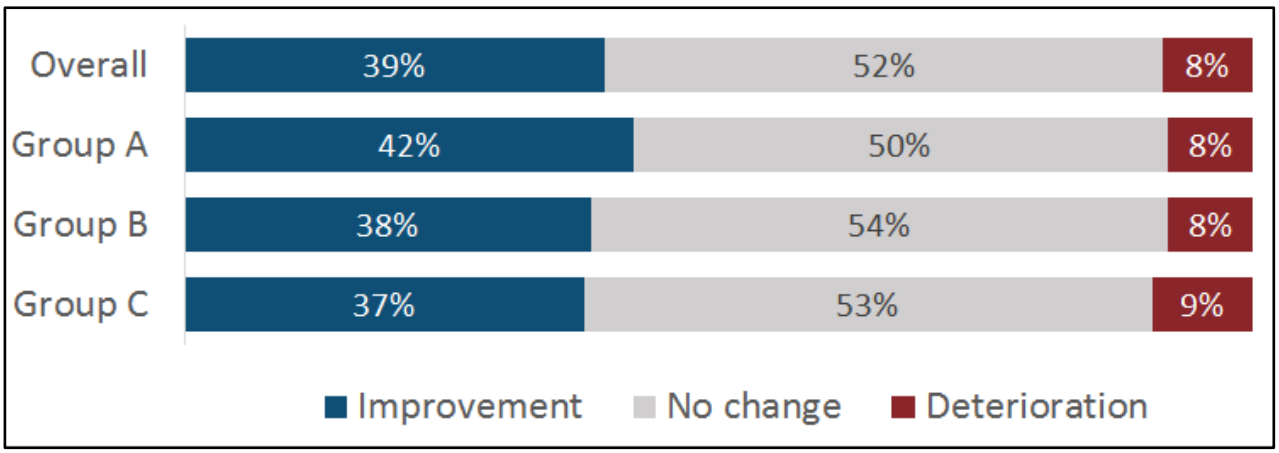
Base: 5,570 learners in target group with distance travelled measure for PHQ-9. Group A: 2,086, Group B: 1,710, Group C: 1,774

- 41% of 2,938 learners who had clinically significant symptoms of depression showed reliable recovery in their symptoms of depression.

Anxiety (measured by GAD-7)

- 39% of learners showed a significant improvement in their symptoms of anxiety.
- 8% of learners showed a significant deterioration in their symptoms of anxiety.

Figure 7: Distance travelled on GAD-7 scale, by group



Base: 5,567 learners in target group with distance travelled measure for GAD-7. Group A: 2,085, Group B: 1,710, Group C: 1,772

- 47% of 3,132 learners who had clinically significant symptoms of anxiety showed reliable recovery in their symptoms of anxiety.

Learners experiencing symptoms of both depression and anxiety

- 54% of 2,160 learners who had clinically significant symptoms of both depression and anxiety showed reliable recovery for at least one of these.
- 32% of these learners showed reliable recovery for both depression and anxiety.

Overall recovery

In comparison with the IAPT service, overall rates of significant improvement are lower. However, people using the IAPT service usually have clinically significant symptoms and are experiencing moderate, rather than mild, mental health problems. When looking only at learners from the CLMH project with clinically significant symptoms, rates of recovery are broadly in-line with those for the IAPT service. Fifty-two percent of 3,633 CLMH learners who had clinically significant symptoms of depression, anxiety, or both, did not

have clinically significant symptoms of either depression or anxiety at the end of their course[66]. The equivalent figure for the IAPT service was 49% in 2016-17[67].

One in ten learners (10%) showed a significant deterioration in their symptoms of anxiety, depression, or both, which was not accompanied by an improvement on either MHSA scale. The equivalent figure for the IAPT service was 6% in 2016-17[68].

Wellbeing

As well as measures of depression and anxiety, learners completed wellbeing assessments during their participation using the short Warwick-Edinburgh Mental Wellbeing Scale[69].

Looking only at learners from the target group who completed a course, at IAG, average wellbeing was 20.0; a person with this score would be in the bottom quarter of the population in terms of wellbeing[70]. At the time of final surveys, average wellbeing had increased to 22.4. A person with this score would have close to average wellbeing. Learners in group C who were not experiencing mild to moderate mental health problems also demonstrated an improvement in wellbeing. This group of learners had, on average, levels of wellbeing that were higher than the population average. Their wellbeing also improved by around 2 points on the scale, meaning that at the end of their courses, learners in this group were, on average, in the top quarter of the population for wellbeing.

---

[66] This figure is higher than the figures presented above for depression and anxiety because it is a figure for recovery (not reliable recovery): this includes all learners moving from above to below caseness, without considering the size of the change in their scores (distance travelled). Figures for reliable recovery only include learners if they have moved from above to below the caseness threshold and showed a significant improvement in their scores. We have chosen to report overall recovery (not overall reliable recovery) as recovery is the main measure used by IAPT.

[67] https://files.digital.nhs.uk/publication/s/n/psyc-ther-ann-rep-2016-17_add.pdf. Figures for the IAPT service are included here for context; it is not within the remit of the evaluation to provide a like-for-like comparison between these two interventions as there are a number of differences between them. For example, an IAPT intervention is typically longer than the CLMH courses: 6 to 8 sessions over 9 to 12 weeks, as recommended here: https://pathways.nice.org.uk/pathways/depression#path=view%3A/pathways/depression/step-2-recognised-depression-in-adults-persistent-subthreshold-depressive-symptoms-or-mild-to-moderate-depression.xml&content=view-node%3Anodes-low-intensity-interventions-or-group-cbt
Moreover,the analysis has not attempted to control for any differences in profile between those accessing IAPT and the CLMH research project.

[68] https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/psychological-therapies-annual-report-on-the-use-of-iapt-services-england-further-analyses-on-2016-17 (Table 7A in data tables)

[69] This scale is scored from between 7 to 35. Half of the population recorded scores between 21.5 and 26.0 (Health Survey for England, 2011) with one-quarter of the population recording scores between 7 and 21.5 and one-quarter recording scores between 26 and 35.

[70] Compared with Health Survey for England data, 2011, available at: https://warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/interpretations/wemwbs_population_norms_in_health_survey_for_england_data_2011.pdf

Table 3: Average wellbeing scores before and after participation, by group

Group	Average wellbeing score at IAG	Average wellbeing score at final survey
Group A	19.4	22.1
Group B	20.3	22.6
Group C (mild to moderate mental health problems)	20.2	22.5
Group C (without mild to moderate mental health problems)	25.5	27.4
All (mild to moderate mental health problems)	**20.0**	**22.4**

Source: Ipsos MORI analysis of DfE survey data. Base: 5,784 learners who completed short WEMWBS assessment at IAG and final survey

This suggests that participation in the project had a positive effect on learners' wellbeing, on average. This positive effect was largest for learners in group A, although differences between the groups are small.

4.3 Mental health outcomes: differences between demographic groups

The findings in this section relate only to learners who were in the target group for the research project and who had clinically significant symptoms of depression or anxiety.

We have analysed pre- and post-course MHSA scores for these learners using a logistic regression analysis[71]. The results of this analysis show that the overall model of adult and community learning being tested by this research project was more likely to work for learners with certain characteristics.

Specifically, the analysis found that, all other things being equal:

- women were 1.58 times more likely than men to show reliable recovery from depression, but there was no significant difference between men and women in recovery from anxiety;
- learners who were unable to work due to sickness or disability, and learners who were unemployed, were half as likely (0.53 times and 0.58 times respectively) to

[71] Explanation of the approach used, and data tables from the analysis, can be found in Annex 4.

recover from depression or anxiety compared with learners in full-time employment;

- learners who had a university qualification were more (1.71 times as) likely to show reliable recovery from depression than learners who had no qualifications;
- in terms of social mobility, learners whose families had not received income support during their time at school were one-third less (0.70 times as) likely to recover from depression than learners whose families had received income support;
- learners who reported taking medication for their mental health were around half (0.55 times) as likely to recover from depression or anxiety than those who were not receiving this additional support. This was also true of learners who reported receiving support from their GP (0.53 times as likely to recover from depression) compared with those who were not.[72]

The analysis explored, but did not find significant differences in likelihood of recovery:

- between ethnic groups;
- between learners with an additional disability and those without;
- relating to age;
- relating to caring responsibilities;
- relating to other kinds of support for mental health; and,
- relating to other social mobility questions:
    - type of school attended
    - whether the learner's parents attended university
    - whether the learner had received free school meals as a child.

The analysis did not compare rates of recovery by sexual orientation or religion, as the number of learners within individual sub-categories was too small to allow a statistically robust comparison between groups.

[72] Learners who received these kinds of additional support had very slightly higher PHQ-9 scores on average at the start of their course, compared with those who did not, but these differences were small and unlikely to fully explain the observed differences in outcomes. Learners receiving support from their GP had an average PHQ-9 score at IAG of 14, while learners who did not receive support from their GP had an average score of 13.5. Learners taking tablets for their mental health had an average PHQ-9 score at IAG of 14.1, while learners who did not take tablets had an average score of 13.5.

4.4 Mental health outcomes: differences between delivery approaches

At the end of their course, learners were asked to identify whether certain areas of their life had got worse, stayed the same or improved. Overall, around three-quarters of learners (76%) self-reported an improvement in mental health when asked this question. This was reported by 82% of group A learners, 74% of group C learners and 71% of group B learners. This suggests that many learners perceived an improvement in their mental health even though they did not report a significant improvement in their symptoms of anxiety and/or depression based on the clinical assessment scales.[73]

Of the three groups, group A had the largest proportion of learners from the target group who showed a significant improvement in their symptoms, for both depression and anxiety. Group A learners also showed the greatest improvement in average wellbeing.

The regression analysis also found some differences in rates of recovery between the three groups A, B and C, but these were largely not significant once differences in the make-up of the groups were taken into account.

One significant difference was identified. Adjusting for differences in the characteristics of learners in each group, learners in group B were found to be less likely to recover from depression than learners in group A and group C. Learners in group B were less than two-thirds (0.65 times) as likely to recover from depression compared with learners in group A. These findings collectively indicate that group A had the most positive outcomes, followed by group C, with outcomes for group B being the least positive. This suggests that, based on the evidence collected by this research project, courses which are explicitly focused on managing mental health symptoms are more effective than general adult learning courses; and that general adult learning courses are more effective at improving mental health outcomes when delivered to a mixed group of learners rather than only to learners with mental health problems.[74] While we can compare outcomes between groups, it is not possible to say *how much* difference the intervention, overall, made to mental health outcomes for participating learners compared to not participating.

---

[73] Measures of 'improvement' on the clinical scales are based on a movement of a minimum number of points. The fact that more learners self-reported improvements than the clinical scales picked-up may indicate several things, for example: Learners are reporting changes in their mental health that are not measured through the scales, or learners are self-reporting changes that are not yet significant (as measured by PHQ9 and GAD7).

[74] While regression analysis is intended to control for differences in learner characteristics, as with any such analysis, there remains the possibility that differences in observed outcome are driven by unobservable differences between the groups of learners.

4.5 What can we say about longer-term trends in outcomes relating to mental health and wellbeing?

Research sites only collected self-reported symptoms of mental health problems from learners during courses, and at any top-up sessions they attended. Therefore, there is no quantitative data available through which to measure longer-term trends in learners' mental health outcomes. The follow-up interviews with learners, however, allow us to make an assessment of changes in learners' mental health in the period following completion of their course.

Learners noted that the benefits relating to their wellbeing were generally time-bound to their participation in the course, and, in particular, the sessions themselves:

"It was a really good course and for the few hours on the day it made me relax and lift my mood." *Learner, Group C*

Overall, learners tended to attribute the status of their mental health and wellbeing, and their ability to cope, to their previous and current circumstances rather than to the effects of their participation in the course:

"It was a distraction for the time it was happening, but it didn't change anything. I needed everything to work out with the family moving over before I would stop being anxious". *Learner, Group B*

Learners who explained that they were doing better now compared with when they were on the course typically felt this was because their circumstances had changed. For example, at the time of signing up for the course, they were ill, unemployed or had recently experienced bereavement and now those situations had either changed (e.g. physical health improved, started work or volunteering) or they had more time to accept or come to terms with their circumstances.

Learners also sometimes mentioned that they were feeling more positive since the course ended despite new challenging circumstances. In general, learners did not attribute this to their participation on the course, and for some people this change may just reflect changes in mental health and wellbeing over time. As the project intended to empower learners to move towards recovery, the fact that learners did not attribute longer-term improvements to their participation in the course may be a positive finding, as it suggests that learners are better able to self-manage their mental health:

"Although I have been suffering from back problems since October [after the course finished], I do feel I have felt happier more. Not all the time, but more than I was. And more able to perhaps get myself out of feeling a bit down in the dumps a bit more quickly... I try not to let things dwell in my mind ever so much". *Learner, Group A*

Learners generally felt that their participation had limited long-lasting impacts on their mental health and wellbeing. It was a common theme for learners to attribute this to a

lack of routine. Learners explained that the regularity of the weekly sessions gave them something to look forward to each week, which helped them stay positive. Learners also felt that the course schedule, and the fact that they were part of a group, helped them stay accountable to a routine that dedicated time for themselves. Section 4.8 explores additional aspects of the course that learners identified as helping them achieve positive outcomes, including improvements in their mental health and wellbeing.

Learners sometimes explained that without the course they struggled to dedicate this time in their normal routine, though they occasionally noted trying to use their learning with some success:

"I'm not as upbeat as I was when I was doing the course, because I had something to look forward to and be able to relax doing some artwork." Learner, Group A

"I did try to repeat the techniques and the exercises but I am the kind of person who needs to be told. I can't do something at home, I need to go somewhere and for somebody to say 'do this, do that'. But the breathing techniques helped a lot and I actually use them every now and then when I get anxious, but I still have a lot of problems." *Learner, Group A*

Learners who were better at managing their mental health and wellbeing often noted that this was because they were successful at making 'me time'. For example, learners emphasised finding time to read, exercise or socialise more regularly. Learners who went on to other learning courses also felt that this helped them maintain a more focussed routine. In some cases, these learners continued the subject of their course as a personal hobby. These learners explained that they were currently not feeling as stressed because they still had something to look forward to and something they enjoyed doing, which made them feel better about themselves:

"The course definitely helped in terms of giving me an outlet, because … I wouldn't have given myself time. [Doing the course] gave me a taste of just how great it [the subject] can be and relaxing, creative and the sense of achievement I get from it. I'm really rigid about making the time". *Learner, Group C*

These learners sometimes felt like the course was a turning point or 'kick-start' and the main thing they could attribute positive changes in their life and wellbeing to:

"It's [the course subject] given me a new side of life really that I couldn't now imagine being without to be honest ". *Learner, Group C*

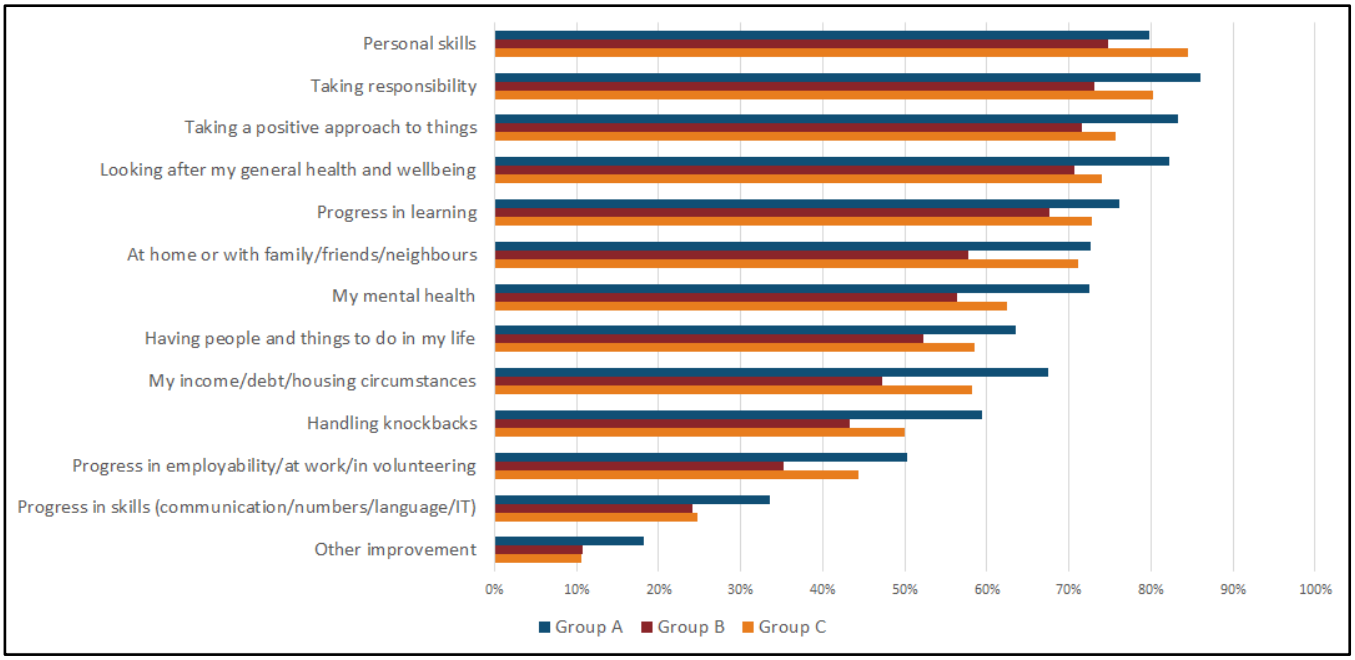
"I would say that the main change was from doing the course. I didn't do anything in the evenings but now I look forward to going out in an evening [to do a hobby]… I still make time to do something for me, and that makes a difference I think." *Learner, Group C*

4.6 What other positive outcomes from participation did learners identify?

At the end of their course, learners were asked to identify whether certain areas of their life had got worse, stayed the same or improved. The areas covered related both directly to mental health and general wellbeing, and other aspects of life more generally . The areas in which improvements were most commonly reported were personal skills, taking responsibility, and adopting a more positive approach to things. These are things that might be associated with improvements in mental health and wellbeing.

Group B learners were least likely to report improvement on all the categories except for "other". Group A learners were most likely to report improvement on every category except "improvement in personal skills", where group C learners (including those not in the target group) had the biggest proportion of reported improvement. However, group A learners were more likely to report an improvement in basic skills (communication, numbers, language or IT), which indicates that even though these courses were focussed on mental health, they were still seen as delivering skills-related outcomes.

Figure 8: Self-reported improvements at end of course, by group



Source: Ipsos MORI analysis of DfE survey data (learners' self-reported improvements). Base: 1,591 learners in group A, 1,223 in group B, 1,988 in group C.

Learners were also asked to identify, in their own words[75], the biggest single change in their life since taking the course[76]. A wide range of answers were provided, with no single answer being given by more than one in five learners. The most common answer, given by one in six learners (17%), was that they had become more confident or improved their self-esteem. This was also a common theme in the qualitative follow-up interviews with learners across all three delivery groups. Confidence appeared to mediate other positive outcomes as well, for example, in learners' willingness to try something new or be more social:

"It gives you the confidence to do things where you might have been a bit too scared to do them before…every week you were building on your confidence each time and building on your skills." *Learner, Group C*

Around one in ten learners (9%) reported that the biggest single change for them had been learning a new skill or making progress with their learning. Again, the qualitative evidence supports this and learners felt that learning a new skill or progressing their learning helped build their confidence:

"I definitely learned a new skill, learned things I hadn't done before, and was quite surprised by what you could do*." Learner, Group B*

Smaller volumes of learners reported each of three other positive changes, each of which was supported to some extent by the qualitative research:

- become more positive or optimistic in their thinking (7%)

"It made me try things that I wouldn't have done, it made me put myself out of my comfort zone … it made me think 'oh yeah, I can do this'". *Learner, Group C*

- made new friends or met new people (5%)

"The class made me have to make an effort to go somewhere and I met people and I met strangers that I actually could talk to and enjoy being with and it just made me more sociable". *Learner, Group C*

- become more relaxed, or less anxious or stressed (6%).

[75] Responses given have been coded by Ipsos MORI to allow outcomes to be quantified.
[76] Despite the wording of this question, some learners supplied more than one answer.

"Even if I arrived and I was still anxious about things, during the course I definitely relaxed and I think the effect certainly lasted for the rest of the day, and a few days after". *Learner, Group A*

There were some differences in the outcomes reported here between learners in each of the three delivery groups. Learners who had taken one of the group A courses, which focussed on mental health and wellbeing, were more likely to say that they had become more relaxed and/or more optimistic compared with learners who had taken a group B or C course. Meanwhile, learners who had taken a group B or C course, focussed on a traditional community learning topic, were more likely to say that they had learned a new skill or made progress in learning[77] and that they had become more confident.

Table 4: Positive outcomes from participation by group

Group	A	B	C	Overall
Progress in learning, new skills	5%	7%	12%	9%
More confident	11%	19%	22%	17%
Made friends, met people	6%	3%	4%	5%
Optimistic/ positive	8%	6%	7%	7%
Relaxed/less stressed	10%	4%	36%	6%

Source: Ipsos MORI coding of DfE survey data (learners' self-reported progression outcomes). Base: 1,352 learners in group A, 811 in group B, 1,810 in group C.

The evaluation team explored whether there are any differences here amongst learners based on other characteristics (e.g. gender), but found no differences of significance.[78]

The qualitative follow-up interviews highlighted several other positive outcomes worth noting. Firstly, courses could have a significant influence on learners' motivation, in terms of day-to-day life as well as looking towards the future and making goals:

[77] Learners taking group C courses were particularly likely to identify learning outcomes as the single biggest change for them, but this may be because some learners on group C courses were not experiencing mental health problems.
[78] Base sizes for some other demographics are too small to allow analysis of differences.

"I started to make more of an effort with myself, I wanted to get up and get things done. Previously I hadn't worried about if my hair looked alright or if I had showered, silly little things, but things I had struggled with for quite a while." *Learner, Group C*

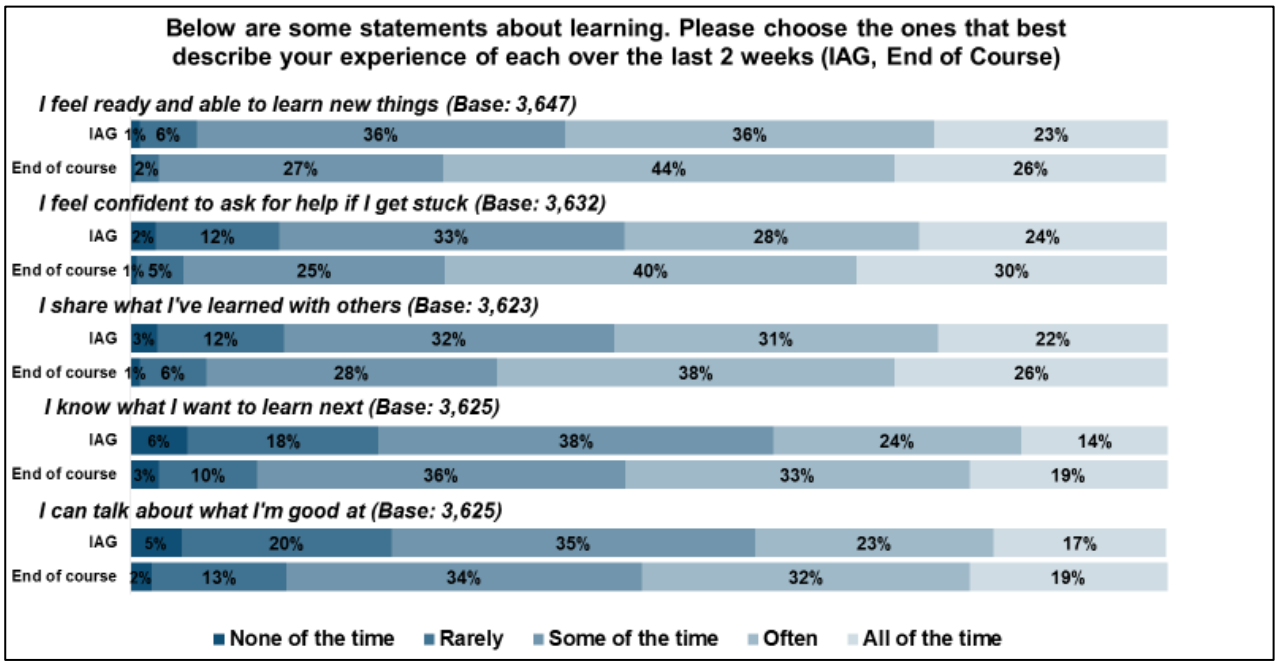
Secondly, learners sometimes mentioned that not only did they learn a new skill or progress their learning, but that they felt proud of this. These learners also said that they enjoyed being able to share this sense of achievement with others:

"In the case of depression, you feel like you can't do anything … the fact that you are doing it [the course], that makes you just feel better with yourself in every single way … I was really proud to share with everyone that I was doing this." *Learner, Group A*

Learning outcomes

Learners were asked to complete assessments of their self-efficacy and competencies with regard to learning, both at their initial IAG session and on completion of their course. For all questions, there was an increase in the proportion of learners reporting positive attitudes towards learning "often" or "all of the time". This is shown in the graph below. The biggest change was in the number of learners who reported that they often or always felt confident to ask for help if they got stuck.

Figure 9: Responses to 'About Learning' statements before and after participation

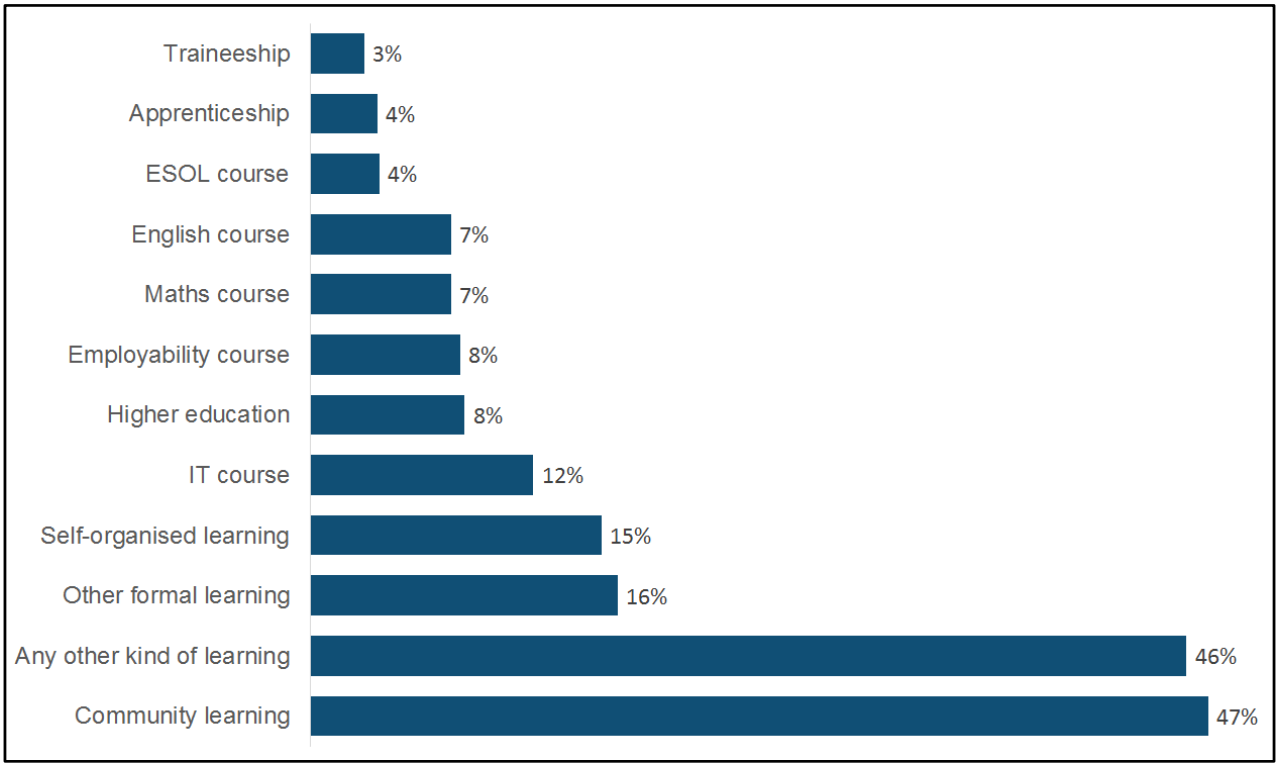


Base: all phase two learners in the CLMH target group providing responses both at IAG and at the end of their course. Individual base sizes in brackets. Source: Ipsos MORI analysis of DfE survey data.

Further participation in learning or training

When asked what they intended to do following the course[79], just over half of learners (52%) said that they intended to go on to further learning. This was most commonly more community learning or self-directed learning, but 37% of this group (19% of learners overall) also expressed interest in more formal learning. The types of courses learners intended to progress to are shown in the chart below.

Figure 10: Proportion of learners intending to progress to further learning



Base: 3,123 learners intending to go on to further learning. Source: DfE survey data

After this, the next most common response was that learners were going to go on holiday (17%) or take a break (7%). Some learners reported that they would go on to work (13%), return to work after being off sick (3%) or attend a work trial (2%). Eleven percent of learners said they would get more support with their mental health. However, many learners (21%) were not sure what they would do next.

Learners from group C were most likely to say that they would go on to further learning, while learners from group A were least likely to say this. This suggests that courses focussed on more traditional adult and community learning topics may be more likely to act as a stepping-stone to other formal learning. It is also possible that the presence of learners without symptoms of mild-to-moderate mental health problems in group C

[79] Learners were also able to select more than one answer to this question.

contributes to this finding. Women and people from an Asian ethnic background were also more likely to say that they would go on to further learning.

4.7 What can we say about longer-term trends in these other positive outcomes?

Although learners typically found it difficult to attribute longer-term improvements in their mental health and wellbeing specifically to their participation on the course, learners often identified other benefits that continued to positively impact their lives. Some of the positive changes mentioned most frequently were extensions of the short-term outcomes noted in section 4.6, including feeling more confident, being more social and having a more positive outlook. This suggests that these benefits persisted over time since the courses finished. As with the positive outcomes described in section 4.5, this lack of attribution to the course by learners may reflect increased self-management and independence.

Improved confidence was mentioned frequently as a key longer-term benefit. Learners typically felt that their improved confidence and self-esteem led to other benefits because they were more willing and motivated to try things that they would not have done previously.

"[The course] has given me the ability to go 'well, I'll try it!' … I will keep up this way of thinking, I'm not going to go backwards because I'm now at that stage". *Learner, Group C*

"The fact that I did this one and it was okay … That improves your self-esteem and your confidence to do something new, and that doesn't need to be a course, it could be a Master's or new sports. I'm definitely more willing to join new things now." *Learner, Group A*

Continuing education and training, through both formal or non-formal channels, was a common interest among learners interviewed. Learners often reported that they were interested in going on other courses in the future, while others had already been on one or more courses since finishing the CLMH course. For those who went on to do additional learning or training, learners sometimes felt they would not have done this if they had not gone on the CLMH course first:

"I don't think I would have had that confidence to go and do [another] training and then do the course at school if I hadn't gone on the [CLMH] course that I did to start off with". *Learner, Group A*

Furthermore, it was often the case that trying something new following the course helped learners maintain positive changes they experienced in the short-term:

"It was a confidence boost when you've just done it [the CLMH course], but then you can go back a bit … then I did a new course, and got another boost". *Learner, Group A*

Learners who explained that they were unemployed at the time of the course felt positive about having the course to put on their CV during that time. Furthermore, these learners sometimes mentioned that the confidence gained during the course helped them to pursue employment or volunteering opportunities, and in some instances, they were successful in securing new positions. For learners who were jobseeking at the time of being interviewed, they explained that, while the process was still difficult, they had been feeling more relaxed during application and interview processes:

"This was a stepping-stone for me. I was out of work for three years, I'd been going for interviews and finding it very, very daunting … I was going for non-qualified jobs and not getting them, and finding it mortifying … then I decided to go for a job I was actually qualified for … I don't think I would have been able to go to the interview if I hadn't had something to relax me at the same time. The course was like some sort of relaxation therapy." *Learner, Group C*

Learners also noted that some opportunities came directly from their participation in the course, for example, meeting another learner on the course who introduced them to a volunteering opportunity. Such opportunities were also identified as helping learners maintain positive changes:

"Because the course led on to the volunteering I have been doing, that filled the gap that would have been left, and has helped maintain positive changes." *Learner, Group C*

In other cases, learners were already using or considering using the skills they learned on their course as a small self-employment opportunity, particularly in cases where the subject involved creating jewellery or art.

However, it is important to note that positive changes in confidence and motivation did not persist for all learners. In some instances, learners felt they were unable to stay motivated without the course, or something similar, giving them something to do:

"I was really motivated during the course, felt like I wanted to do things. My motivation is now not that hot, dwindling, as I haven't been doing things." *Learner, Group B*

Another longer-term benefit noted by learners was having a more positive outlook on life. In some cases, this was directly attributed to learning from the course:

"You think that maybe sometimes you're doing things wrong [in life] but actually, as in art, you're just doing things your way and we all have a different perspective and we see things differently. The art teacher helped us to realise that". *Learner, Group C*

The extent to which learners felt more positive and hopeful varied. For example, learners who were more engaged with other activities (as above) tended to feel more positive.

However, feeling more hopeful and thinking about the future was also an important benefit for learners who continued to struggle within their personal circumstances:

"It is baby steps, I am still struggling to pick myself back up but I suppose it [the course] sort of opened my mind to the future again". *Learner, Group C*

A final theme of key long-term benefits that emerged was based on improvements to learners' social lives. Learners discussed how making new friends on the course or developing their social skills more generally continued to positively impact their lives. This benefit varied across learners. In some cases, it was simply giving learners more confidence to walk into a room of people they did not know. In other cases, learners felt that they had a better support network following the course, for example, through continuing to meet up with other learners from the course. Learners also sometimes mentioned that they had joined new clubs or local groups, some of which were signposted to them by the course tutors.

4.8 What did learners identify as helping them to achieve these outcomes?

Learners across all three delivery groups identified tutor characteristics and the teaching style as key facilitators that helped them achieve positive outcomes. For example, learners valued tutors who were patient, demonstrated a positive attitude and were led by learners' needs. These characteristics were reported by learners to raise their mood and build their confidence:

"[The tutor] had such a good way of putting things across, very positive about everything and I found that a help…it was quite an uplifting experience". *Learner, Group A*

"[The tutor] was there when you needed her but she kind of let you get on with it, so that helped build your confidence as well". *Learner, Group C*

A flexible and relaxed teaching style was also important to learners. Learners felt this created a safe environment where they did not feel under pressure to progress their learning at a certain rate or get things right the first time:

"If everybody wanted to have a chat or we were having a laugh about something, [the tutor] made space for that, and I think that was what was good". *Learner, Group C*

"I think [what made the difference] was expanding my boundaries, and pushing myself, but in a safe environment. If the people had been intimidating, it could have made it worse*". Learner, Group A*

The social environment with other learners was also mentioned as an aspect that helped them achieve positive outcomes:

“Some people might say, ‘well I’ll go home and I won’t see a soul until next week’ … I do feel that mixing with other people and mixing with members of the community is the most important thing and I feel more confident.” *Learner, Group B*

Learners mentioned that finding common ground with other learners helped make them more comfortable and confident in the group. For example, this may have been because their reasons for attending the course were similar or because they were experiencing similar difficulties with managing their mental health and wellbeing. As a result, learners felt there was mutual support:

"It’s like a support network – you’re all there for roughly the same reasons, and you become a little group and it can open so many doors." *Learner, Group C*

The regularity of the weekly classes was also appreciated. It gave learners a routine and something to look forward to. Learners sometimes noted that the consistency of the other learners from week to week was also important, because the familiarity of faces each week made them more comfortable and confident about communicating within the group. In some instances, learners felt encouraged by improvements among other learners in the group:

"As other people got their confidence up and asked questions it kind of helps you voice things that you’re stuck with." *Learner, Group C*

Learners across all three delivery groups also identified the course as an opportunity to be in the moment, take time for themselves, and be distracted from other aspects of their life. This was sometimes related to the physicality of doing the course activities, because it gave learners something to focus on. In these cases, learners felt they were not actively trying to support their wellbeing, but that having something enjoyable to focus on was important:

"It helps you to really focus on that thing you’re doing and you forget about anything that might be worrying you, or that you might be thinking about ... so it does actually give, I think, your mind a break from kind of every day worries and that is why I particularly like it a lot." *Learner, Group C*

"I think it was just about understanding that it's OK to take time out". *Learner, Group C*

Learners mostly said they enjoyed their course and found it relaxing, but that sometimes it also helped them express their emotions better. Learners also felt that trying out and learning a new skill was important for their confidence, especially when they were able to see tangible or physical results of their progress (e.g. jewellery pieces they had made):

“You feel like you’re developing and learning something and making progress, it kind of helps you feel that it’s less of a downward spiral and helps you feel more positive about things". *Learner, Group C*

Learners who had attended group A courses had sometimes continued to use practical techniques they had learned on these courses to improve their mental health and wellbeing. For example, learning breathing techniques, lying still, and other mindfulness and relaxation activities helped learners with their anxiety and sleep.

5. What aspects of participation were viewed negatively by learners?

5.1 Summary

As well as a range of positive outcomes, the qualitative research with learners also explored what aspects did not work as well as learners had hoped or expected, and what improvements, if any, learners would suggest to the delivery model. Key findings on these topics include:

Readiness for learning and learning efficacy

- Learners in group B and C courses sometimes reported feeling under pressure to produce “good” work or a sense of competition with other learners on the course. This could make them feel more anxious, especially if they were unable to progress or develop their skills as much as they had hoped.

- Among learners at research sites in group A, some learners were uncomfortable sharing their circumstances as part of the discussions of a personal nature that could take place during sessions.

Course structure and resources

- In all three groups, some learners commented that they found it difficult to learn alongside others who had severe mental health problems, or other needs such as significant learning difficulties and/or disabilities. They commented that sometimes these learners disrupted the class or 'took up too much of the tutor’s attention'.

- While the short nature of the course was identified as a positive aspect, learners also reported being saddened when the course ended because they had just started to become comfortable with the topic and other learners. In some cases, these learners also thought that the positive benefits of the course would not last after it had finished.

- Learners interviewed were not, on the whole, offered the opportunity to take part in the top-up sessions. This may be because they took part in courses in the final few months of delivery.

- Among learners interviewed who did not finish their course, reasons for not finishing were primarily health-related or due to other personal circumstances, rather than due to reasons related to the course itself.

5.2 What did learners identify as negative aspects of the model?

Learners were often motivated to sign up to their course because they hoped to try something new or improve their skills, and hoped that this might also lead to a new hobby. However, some learners reflected that the course may not have been right for them at that time. For example, taking on something new may have, in hindsight, been too big a step for them at the time. This was especially seen to be the case when learners were facing challenges in their personal lives. This may have contributed to some learners feeling somewhat overawed by the tasks and becoming frustrated by their lack of progress. Rather than having a positive effect on their mental health and wellbeing, this could adversely affect self-esteem and anxiety, and in some cases, this meant learners disengaged with the course and felt discouraged from trying something new in the future:

"This [lack of progress] led to me being very anxious about it, and then mentally pulling down the shutters and stopped engaging with the tutor." *Learner, Group B*

At times, this could be exacerbated when learners felt a sense of competition with other learners. For example, learners reported feeling self-conscious about how they were perceived by other learners, worrying that others might have a negative view of them if they made slower progress. Learners also thought that comparing themselves with other learners who they perceived to be doing better, in terms of their learning progression, damaged their self-esteem and enjoyment of the course:

"Some of the other people there were really good at [course subject]. I felt I had to perform better – though the tutor said just do what you want to do. It would have been better to clarify the purpose a bit. I wasn't there to become a professional, just to relax". *Learner, Group C*

As might be expected, these issues seemed to be more prevalent for learners at research sites in group B and C, where the content was more traditional community learning courses, and particularly in the case of group C where classes included a mixture of learners with and without mental health problems.

Some learners would have preferred smaller groups and a slower pace. Smaller groups were preferred by learners who felt they needed more support to complete the course tasks. These learners felt that the number of people in the class meant they could not ask all of their questions, which hindered their progress:

"There was only one instructor, and I felt like some people were faster than me and I'm just asking their questions…I would do things wrong and I would have to do it again and again, and that was a bit frustrating…you can't just jump the queue to ask more questions." *Learner, Group A*

Learners felt that this kind of negative experience sometimes related to the teaching style. For example, in some cases the tutor was described as explaining how to do multiple tasks at once and then expecting learners to do them independently. Learners who found this problematic sometimes said they would have preferred a slower pace where the tutor explained one task at a time or spent longer on each topic. Learners thought that some tutors could be trained to be more understanding of learners' needs and make it easier by repeating instructions or writing steps out for the class.

Learners also sometimes struggled to connect with other learners on the course. Some learners across the three delivery groups (A, B, C) mentioned difficulties connecting with others on the course and felt this negatively affected their overall experience. One learner reported that this made them feel anxious before attending course sessions. A common theme for explaining this disconnect was the fact that learners in a single group could be at very different points in being able to manage any mental health problems they might have. For example, some learners felt they had less severe mental health problems than others on the course. Other learners felt that a single learner with more severe mental health problems was sometimes disruptive. Learners felt this affected their ability to focus on the course because other learners required more attention from the tutor.

"I did find it difficult because I have always been a really social person, so to go somewhere in a social setting and not be very sociable is not like me". *Learner, Group A*

Learners were unsure how this could have been managed better, because they also understood that the course should be open to anyone who could benefit from it. It was thought that different courses might be appropriate for learners with different levels of mental health problems, and therefore different support requirements.

Another issue raised by learners was the lack of the consistent group of people attending some courses. For example, as the course went on, class sizes, which in some cases were very small to begin with, could dwindle and this could negatively affect the overall experience.

Course objectives and learner expectations were not always aligned. In group A, finding the right approach to cover strategies to improve mental wellbeing appeared to have been a challenge on some courses. Some learners were uncomfortable sharing personal circumstances with people they were unfamiliar with and would have preferred more private conversations or one-to-one time with the tutor. For others, the content was seen as being insufficient to have a real impact on their mental health and wellbeing. Similarly, some learners said they had expected the course to have more therapy-like elements

rather than a learning focus, which might reflect a degree of miscommunication or misunderstanding.

Some learners in groups B and C would have liked courses to be more tailored around wellbeing. Suggestions made by learners included: the facilitation of a ‘self-help’ group; allowing more time and space for learners to talk about their experiences (e.g. in coffee breaks); or having someone present at the sessions who would be willing to talk with learners about their mental health.

The location and accessibility of courses presented challenges for some learners. For example, learners across all three delivery groups who had longer distances to travel or who were unfamiliar with the area reported finding this stressful.

“I wasn’t so keen on the travel as it was on the other side of [the town], and it was two buses for me. Luckily where it was I used to live there … if it had been somewhere really unfamiliar, I probably wouldn’t have gone as wouldn’t have felt safe or confident that I would find the place.” *Learner, Group B*

Some learners identified issues with facilities. These included:

- classroom space did not suit the needs of the course, or the number of people, with negative impacts on the way the course was delivered; and,
- accessibility could be problematic, for example, requiring learners to go up multiple flights of stairs to get to the classroom, which was difficult for some.

Learners with disabilities that limited their mobility thought that additional support for the tutor was important.

Learners were disappointed when the course ended. Although learners liked the short length of the course at the time of signing up because it seemed like a manageable commitment, when looking back after completing the course, many learners said they would have liked if the course had been longer and that they felt disappointed when the course ended:

"It's like losing a friend. You think, ‘oh, it's a shame it's got to end’, it really is". *Learner, Group A*

Learners identified several reasons for this. A major theme was that learners related this to the course having a positive influence in their lives on a consistent basis which was harder to maintain when it finished. This was consistent learners in all three delivery groups:

"Time-wise once you get in the routine of going and you get that first week out the way you do start to feel like, 'god there's only three weeks left, what am I going to do after that?'" *Learner, Group A*

A less common theme was learners feeling they had only just become comfortable with attending the course, both in terms of becoming more familiar with the topic as well as with the other learners:

"If you'd done 10 or 12 weeks, you would have got more friendly with the people there and made more friends. You'd have got more close with the people on the course and it would have had a bit more of a community feel to it." *Learner, Group A*

The final theme related to the short course length was that some learners thought their course was too short for them to fully explore their new skills; for example, the course only covered the basics and they wanted to take it to the next step. This was not confined to courses focussing on skills, but also those focussing on improving mental health and wellbeing, where learners felt that a longer course might have had greater benefits:

"It was short enough to be inspiring, but I think that if you were slightly further behind in the process of recovering than I was at the time, you probably wouldn't have quite got to the point that I did before it ended". *Learner, Group C*

Among learners interviewed who did not complete their course, reasons for non-completion were largely health-related (e.g. conflicting hospital appointments) or due to personal circumstances (e.g. caring responsibilities) rather than reasons relating to the course itself. In some cases, the final session was also delayed by one week and learners had already made other plans. However, it is worth noting that in a very few cases, learners explained that they stopped attending their course because they did not think they were benefitting from it and did not enjoy the course content.

5.3 What potential improvements to the approach did learners suggest?

Interviews with learners also included an exploration of potential improvements to the approach to improve learner experience. Generally, the improvements suggested by learners align with the negative aspects they identified, which are discussed above. These include the following improvements:

- The short length of the course was important in encouraging learners to sign up initially. However, learners would also have liked the opportunity to continue courses or progress to longer courses once they knew what they would achieve from the course.
- Accessible locations that are easy to get to for learners, with instructions on how to get there provided at IAG sessions.

- Appropriate classrooms for the course subject and the number of people attending.
- Ensuring the pace and teaching style of the course is suitable to the group of learners, and if necessary, including additional teaching support to meet additional needs.
- Setting out clear expectations about what learners will take away from the course so they are not disappointed if their personal expectations are not met.
- Several learners felt that the courses could be better promoted, for example, through social media or local town groups. One learner felt this was especially important for individuals with disabilities or other accessibility needs.
- Weekly reminders to attend the class were recommended to improve attendance given that inconsistent attendance could be disruptive to the flow of the course.

As noted in section 2.4, the evidence suggests that learning providers did not consistently offer top-up sessions. This was a particular issue for learners taking part in follow-up interviews, potentially because their courses happened in the final stage of the delivery window (April – July 2017). Learners from across the three delivery groups highlighted that they would have liked follow-up opportunities.

"It was a shame when it ended, so maybe a follow-up session or an offer to come back and do the next level at a reduced rate or something would be good. I was a bit lost once it had finished, I kind of got used to it and then that was it". *Learner, Group C*

Learners suggested that top-up sessions would be important, to allow learners to carry on with the subject, to reflect on what they gained from the course and think about goals for the future. Learners suggested that learning providers could perhaps provide takeaway packs of information to help learners continue their skills, leaflets with information on other free or subsidised courses in the local area, or facilities for the group to continue informally on a self-organised basis.

6. What can be learned from the research project and the evaluation about conducting research in the ACL sector?

6.1 Summary

- The research project and evaluation activities from both phase one and phase two have provided useful learning about conducting research in the adult and community learning (ACL) sector. The qualitative follow-up interviews with learners also explored their experience being part of a research study, including whether they had any concerns about taking part and what this meant on a practical level for their experience during the course. Some of the key lessons are summarised below, and section 7.2 sets out lessons for future ACL research projects. Overall, building in evaluation considerations from the beginning, and framing the programme as a research project, is fundamental to the success of such programmes.
- Requirements for learning providers to screen learners for eligibility led to improvements in reaching the target group.
- Fortnightly monitoring reports improved the quality of data across learning providers.
- In general, learners felt the research was explained well and they did not have any concerns about taking part in the study. Although the nature of the research was not a factor in learners' decision to sign up for the course, learners often remarked that they felt their participation in the research was important to improve future courses for other people. However, learners who opted to take part in interviews may have had a more positive attitude towards research than CLMH learners overall.
- Learners reported some challenges with survey collection. This included the surveys taking time away from the course and learners sometimes finding the nature of the questions upsetting or difficult to answer.

6.2 Which challenges from phase one were mitigated and which persisted in phase two?

The challenges faced by the evaluation team during the first phase of the CLMH research project led to a number of recommendations for the setup of future research projects. These recommendations were aimed at both funders (e.g. DfE and other departments) and researchers planning to undertake research and evaluation in the ACL sector. Many of these recommendations were implemented in phase two. This section provides a summary of how well the changes made in phase two helped to reduce the problems encountered in phase one, and highlights persisting challenges for conducting research

in the ACL sector. The following chapter details recommendations based on these findings.

Set-up, design and communications

Although the need for a robust evaluation was identified in the original business case for the CLMH research project, the evaluation team was not in place until learning providers and research sites had already been selected in phase one, and it was not possible to include the key requirements of the evaluation in the funding specification. As such, an overarching challenge in phase one was that many learning providers did not fully grasp the nature of their successful bid as a research project, and viewed the data collection as burdensome “paperwork” that interfered with their ability to deliver courses, rather than a core part of the research and vital to the evaluation.

This also led to issues with data quality, including problems with matching surveys completed by the same learner over time. Although learning providers were asked to supply unique learner numbers (ULNs) for participating learners, these were often unavailable or recorded inconsistently, and names were often spelled differently. As a result, the evaluation team spent a significant amount of time identifying and correcting matching errors one-by-one; this increased resource demands and delayed the analysis process, and led to some data being disregarded.

As there was no separate application process for phase two, and almost all the learning providers from phase one continued to take part, the evaluation team leveraged the relationships built and lessons learned during phase one to ensure learning providers were aware of expectations and responsibilities for participating in the research project. This involved regular engagement with research sites, including one-to-one support from a named member of the evaluation team, termly meetings to discuss data collection and fortnightly monitoring reports on the quality of their data.

However, as detailed elsewhere in this report, evidence suggests that the three components of the delivery model were not consistently delivered, and some issues with data quality remained.

Another challenge encountered in phase one was that many learning providers were reluctant to screen learners for eligibility on the basis of their mental health scores. Consequently, many learning providers accepted learners who did not meet the criteria for the research project, and as a result only 60% of phase one participants were in the intended target group. This led to a smaller volume of relevant data being available for the evaluation, significant additional work for the evaluation team, and unnecessary data collection efforts for learning providers.

In phase two, learning providers were required to screen learners for eligibility in the IAG session. This dramatically improved the proportion of learners starting courses who fell in the target group (as detailed in section 3.2).

Learning providers in phase one also reported that learners had concerns about privacy and data sharing, including a worry that sharing information about themselves might affect their entitlement to benefits. This led to some learners refusing to provide information and a large number taking part anonymously, which reduced the usefulness of their data to the research.

In phase two, learning providers were required to dedicate more time to explaining to learners the value of their data, the benefits of sharing information and how it would and would not be used, in order to allay learners' concerns, gain informed consent and enable people to participate. This involved the development and use of materials to introduce the research to staff and learners, including an accessible information sheet and consent form. Learners' views on this, detailed in section 6.3 below, suggest that learners generally felt they had enough information about the research and felt comfortable taking part.

A practical challenge identified in phase one was that much of the delivery of the research project took place in small community venues and in some cases outdoors, where there was no access to IT facilities. This caused greater demand for paper versions of data collection tools than had initially been anticipated, which increased the resource needed for data processing, and the risk of errors and breaches of data security.

Responding to this challenge, learning providers were equipped by DfE with tablets and MiFi mobile network dongles to facilitate survey collection in phase two. Although this was successful at reducing the number of paper surveys used, some learning providers continued to use paper surveys even after the online survey was available.

Finally, in phase one, the delivery model specification for the three elements of the learning offer (one to one IAG, short non-formal courses, and top-up sessions) was intentionally broad, allowing a wide variety of delivery models (e.g. course/session length and subject) to be explored. However, the volume and variety of courses delivered presented challenges for data analysis, and the number of variables involved meant that it was not possible for the evaluation team to robustly identify which models were more successful than others.

Although phase two still required the delivery of the three course elements (IAG, short non-formal courses, and top-up sessions), learning providers were allocated to one of three delivery groups (groups A, B, C), and course duration and length were more tightly specified (see chapter 2 of this report). This ensured more consistent delivery within each group, enhancing comparability for the evaluation.

Delivery and workforce

In phase one, learning providers experienced a high turnover of staff during the delivery of the research project, and many staff worked on a part-time or casual basis. Furthermore, many learning providers sub-contracted the delivery of part or all of their courses to other organisations, who were then also responsible for data collection. Information about the research project and evaluation requirements was not always passed on in full to sub-contractors or when a key member of staff moved on. Some learning provider staff also had low levels of IT skills; for example, some providers found it challenging to complete and return monitoring information in a spreadsheet form. These workforce challenges often resulted in poor quality data collection.

In phase two, some of these challenges were mitigated by limiting the options for sub-contracting and using an online survey that facilitated data collection and collation. In general, the online survey minimised errors in recording data and the level of data editing required. This meant that a greater proportion of the data provided by learners was usable.

The evaluation team also continued to provide one-to-one support to individual projects, enhanced by fortnightly monitoring reports, and including a small number of face-to-face visits. This helped learning providers to identify data quality issues and resolve these promptly.

In phase one some learning providers reported concerns about using the mental health self-assessment scales with learners, believing them to be a “clinical” assessment that they were not qualified to undertake. Some providers were also concerned about asking learners about suicide risk in particular. These concerns were significantly reduced following mental health awareness training, which increased tutors’ confidence, and extensive guidance incorporated into the online survey for learning provider staff when administering the data collection (e.g. what to do if a learner’s response to the MHSAs indicated they had mental health problems that were too severe for inclusion in the CLMH project).

6.3 How did learners feel about being part of a research study?

The following sub-section looks at learners’ views on being part of the research study and evaluation, based on the qualitative follow-up interviews. Topics covered included whether learners had enough information about the research study, how they felt about taking part and whether the fact that it was a research study discouraged or motivated them to join the course, any concerns they had, and whether they felt that research and evaluation activities had any impact on the course delivery.

It is important to note that the evaluation team spoke to learners who had opted-in to take part in follow-up interviews. Therefore, it is possible that the learners interviewed for the evaluation were more likely than the overall cohort of CLMH learners to have positive views about the value of taking part in research and were more likely to have had a positive experience of the research element of the course.

Were learners satisfied with the information provided about the research study?

Learners typically said that they were told about the research element during the IAG session when they also completed the first survey. In most cases, learners felt it was sufficiently clear at the outset what the research would entail, though there were several instances where learners would have liked more information at this point. In general, learners did not have any concerns about being part of research and they accepted that this meant they had to complete surveys. For learners who did have initial concerns about how their information would be used and whether it would be kept private and anonymous, they explained that once a staff member answered their questions, they felt comfortable taking part:

"I didn't want my employer to see me taking part in a mental health course. But [the IAG interviewer] said they wouldn't pass the information on to anyone, so that was fine."
Learner, Group A

Despite this, learners sometimes did not appear to have been aware at the outset of the purpose of the research project, deducing this later from the nature of the MHSA questions; whilst others explained that they were not sure exactly how the research findings would be used to make a tangible difference. A few were interested in learning about the research results, asking how they could find this information.

Did being part of a research study motivate learners to join the course?

In general, learners said they were more motivated by the course itself and that being part of research did not influence their decision to sign up or continue with the course. In some cases, learners noted that being part of research meant the courses were free, a sort of 'trade-off'. When asked separately about whether they would have signed up for the course if it had involved a fee, learners mostly said they would not have.

Although learners would have still signed up for and attended the course without the research component, they were often very interested in the research and felt it was important and encouraging. These learners explained that it felt like they were contributing to the continuation and improvement of similar courses in the future and consequently, helping other people:

"I think it's important because you don't know that something works until you try it and if I can try it and it helps and it can be used again for other people, if they can get out of it what I got out of it, fab." *Learner, Group C*

Learners also liked being part of research that increased awareness about mental health and could potentially help people manage their mental health in different ways:

"Anything that will help the mental health of people, and it is a growing problem, has got to be good because it's not drug related, it's a different approach." *Learner, Group C*

What were the practical implications of the survey collection on learners' experience during the course?

In general, learners found the survey completion to be relatively quick and non-burdensome, but there were also several mentions about survey completion taking time away from the course. This was especially problematic or frustrating if there were internet connectivity problems, for example, one learner explained that she had to do one of the surveys twice as a result. Learners occasionally also mentioned that they did not like filling out the survey using tablet screens which made it take longer and more disruptive to their time on the course:

"There was only one actual iPad, one man with an iPad who had to go around everybody, and it took quite a long time for each person to fill it in, and sometimes it cut quite a lot into the session or it was at the end of the session. It wasn't a big deal I suppose but if we'd had like a sheet of paper we could have taken it home or if we'd all had a sheet we could have just ticked the things and give it back, you wouldn't have had to have hung around waiting for the iPad to come around to you." *Learner, Group A*

In some instances, learners felt completing the MHSAs helped them take time to acknowledge how they had been feeling, and in some cases see improvements. Getting the opportunity to speak with the staff member while going through the questions was also mentioned as being helpful. In contrast, some learners said that completing the MHSAs was difficult, or provoked negative emotions given the sensitive and personal nature of the questions:

"[I found completing the MHSAs] quite difficult really because it makes you think about the past two weeks and you think, 'oh my goodness, yeah, I didn't realise I was getting anxious about that' so it's quite a good self-reflection tool really ... It may not work for everybody, but for me, it makes me think, actually I need to do something. It made me take a step back rather than whizzing around at a million miles an hour. I definitely think being part of the project was important to me." *Learner, Group C*

On a related point, learners occasionally mentioned that they found the MHSA scales difficult to use because they were 'forced into a box' that they may not have fully agreed with, or because it was difficult for them to reduce everything down to one option.

Furthermore, one learner felt the questions were not always a fair representation because they lacked context:

“There’s no opportunity for me to say that I’m scoring on the scales a certain way just because of my physical health. I was actually getting more depressed during my time on the course but the scales probably don’t show that. It doesn’t reflect real life. There’s no ability to say what it means to me.” *Learner, Group C*

Some learners in Group C were not experiencing difficulties with their mental health and wellbeing. These learners felt that some of the questions did not apply to them and were unclear about the purpose of gathering this information, beyond assessing eligibility:

"I thought it was a big waste of time. I understand why they have to do it, they have to check people are able to do the course and that they don’t have major problems, but I already knew that about myself, so... It wasn’t an obstacle, but it was a waste of time". *Learner, Group C*

One learner (Group C) felt the questions were negatively framed overall and would have preferred some more positive questions, for example, 'do they feel positive some days' or 'how many days do they feel good about themselves'.

7. Conclusions and lessons learned

7.1 Conclusions

How effective is the CLMH approach?

Analysis of learners' end-of-course survey responses, and of qualitative follow-up interviews with learners, indicates that learners believed participation had resulted in positive changes in their mental health and wellbeing. On average, wellbeing across the learner cohort had improved by the end of their course, from significantly below average to around the average for the overall population.

A majority of learners (76%) perceived some improvement in their overall mental health. The absence of a comparison group who received no learning means that we cannot confidently assess how effective the CLMH offer piloted is compared to doing nothing. However, based on analysis of the clinical assessment scales, three in ten learners (29%) showed significant improvement in their symptoms of depression and four in ten (39%) showed significant improvement in their symptoms of anxiety. Of those learners who started their course with clinically significant symptoms of anxiety and/or depression: slightly more than half (52%) no longer had clinically significant symptoms at the end of their course.

Despite positive outcomes for a significant minority of learners, two-thirds (66%) of all learners in the target group reported no significant change in their symptoms of depression over the course of their participation, and just over half had no significant change in their symptoms of anxiety (52%). However, it is possible that in some cases taking part may have stabilised learners' mental health when it would otherwise have got worse; 10% of learners reported worsening symptoms of either depression or anxiety.

While the research project and evaluation was not designed to compare the effectiveness of the CLMH approach to that of the NHS IAPT service, broad comparisons provide context to what is achievable for mental health interventions. Both the recovery rate and deterioration rate observed for the CLMH research project were broadly in line with that of the IAPT service (49% and 6% respectively).

Qualitative research suggests that the courses had positive effects on mental health by giving learners an opportunity to focus on something other than day-to-day life, to make time for themselves to do something enjoyable, and to have something to look forward to. However, these positive effects were by their nature largely limited to the time period during which learners were taking part; many learners were saddened when their course ended, with some identifying this as a setback.

Those learners who identified a longer-term positive impact from participation often attributed this to having developed a new skill or interest which they could continue to pursue. Many learners reported that learning a new skill had increased their confidence, and that they were motivated to continue learning. This suggests that creating appropriate progression opportunities for learners following the end of their course is important in sustaining any positive effects from it.

Which delivery approach (A, B, C) was the most effective?

Of the three groups, group A had the largest proportion of learners from the target group who showed a significant improvement in their symptoms, for both depression and anxiety. Group A learners were also more likely to report improvement in their overall mental health and in other aspects of their life such as taking a positive approach to things, making progress in learning, and handling knockbacks. Group A learners also showed the greatest improvement in average wellbeing. When differences between the composition of the three groups are taken into account, learners in group B were less likely to show reliable recovery from depression than learners in groups A and C.

These findings collectively indicate that group A had the most positive outcomes, followed by group C, with outcomes for group B being the least positive. This indicates that courses which are explicitly focused on managing mental health symptoms are more effective than general adult learning courses; it also indicates that general adult learning courses are more effective at improving mental health outcomes when delivered to a mixed group of learners rather than only to learners with mental health problems.

Qualitative research, and survey data on what learners considered to be the biggest impact of the course for them, identifies differences between the three groups in terms of what helped to achieve positive outcomes. For group A learners, the greatest benefits of the courses appeared to be in learners' outlook: taking a more positive, optimistic attitude and becoming less stressed or anxious. Learners in groups B and C, on the other hand, were more likely to identify improvements in their skills, learning and confidence. Group C learners were most likely to say that their skills had improved and to say that they would go on to further learning. However, the mixed nature of participants in group C was identified by some learners as contributing to a more competitive or daunting environment – perhaps because learners were more likely to be primarily motivated by the opportunity to improve their skills and knowledge of the course subject, rather than to improve their wellbeing.

Is the approach more effective for particular groups of people?

Analysis suggests that learners were more likely to report signs of recovery if they were not receiving other kinds of support for their mental health, such as medical treatment, at the time they signed up for the course. The initial severity of mental health symptoms was similar for learners who were and were not receiving additional support, but it may

be that learners who were receiving medical treatment for their mental health are more likely to have long-standing mental health problems, which may be less likely to be fully addressed through short-term interventions of the kind offered through the CLMH research project (for example they might require multiple sources of support over a longer period of time).

As is typical for adult and community learning, the project attracted a high proportion of women, particularly in phase two; female learners were also more likely than male learners to report recovery from depression during their participation, and more likely to say that they would go on to further learning. This apparent difference in outcomes may be due to the predominantly female environment in which the courses took place; the majority of project staff were also female.

The project attracted a larger proportion of people who were unemployed or unable to work than the IAPT service; however, it also appeared to be somewhat less effective for people in these circumstances and for people who had lower levels of qualifications.

What can the evaluation tell us about completion in this kind of provision?

Overall, more than three-quarters (76%) of learners starting a course went on to complete it. While exploring completion and non-completion was not a primary aim of the evaluation, the evidence collected does allow some exploration of the factors contributing to non-completion.

The evidence would suggest that reasons for non-completion were largely practical. Learners who were retired or volunteering were most likely to finish their course (81%) while learners who described their main occupation as caring or who were long-term sick or disabled had the lowest completion rates (70% and 72% respectively). This is supported by the qualitative research, which indicated that some learners were unable to finish their course, or attend all sessions, due to health-related commitments (e.g. hospital appointments) or caring responsibilities.

In some cases, the final session was also delayed by one week and learners had already made other plans. However, it is worth noting that in a very few cases, learners explained that they stopped attending their course because they did not think they were benefitting from it and did not enjoy the course content. This is to be expected with any kind of intervention where participants have self-selected and there are no consequences for withdrawal.

7.2 Lessons learned

This evaluation has generated a number of lessons relating to both:

- the opportunity for using short, non-formal, part-time adult and community learning courses to support self-management, and recovery from, mild to moderate mental health problems
- how to conduct robust evaluations of interventions in an adult learning setting.

In this section, we consider what the possible implications of these findings are for both policy makers and commissioners at a national and local level.

We also include suggestions that may help support robust evaluations of future pilots in an adult learning setting.

Lessons for policy makers and commissioners

The absence of a comparison group means that we cannot confidently assess how effective the CLMH offer piloted is compared to doing nothing. However, quantitative analysis of mental health outcomes, and of qualitative follow-up interviews with learners, would support a conclusion that the offer tested can lead to positive changes in mental health and wellbeing, or associated outcomes. Rates of recovery for learners participating in this project are broadly equivalent to those for NHS IAPT services.

In particular, the findings suggest that the type of courses delivered as part of the CLMH research project may help people in a number of ways, such as improved confidence, making friends, and a range of other outcomes (see 4.6). The qualitative research identified evidence that participation was, for some learners, crucial to improvements in mental health and wellbeing, and wider improvements in their life (for example progression to further learning, or volunteering). However, the evidence also shows that most people will not experience significant improvement in or recovery from their mental health problem. This suggests that the offer has a place in helping people to manage and/or live with their mental health problem, rather than as a sole strategy for addressing mild-to-moderate mental health problems.

These findings provide the following lessons for policy makers and commissioners.

- As a result of participation in the research project, some adult learning providers involved in the CLMH Research Project wish to continue their offer in future funding years, while others may wish to begin offering mental health and wellbeing-focussed courses. If the model is likely to form part of adult and community learning delivery going forward, Ofsted inspectors and staff in any other organisations responsible for quality assuring adult and community learning provision should be provided with the findings of the research project, and the

evaluation, and other resources produced as part of the project. This will help to ensure that future delivery benefits from the experience of the research project, and that where services are inspected, a fair assessment of the offer is possible.

- The Department for Education should consider, if learning providers are likely to continue providing (or start providing) the offer tested as part of the CLMH research project, whether there is justification for a national focus on ensuring the adult education workforce has the necessary skills and capability to deliver this effectively (please see lessons learned for adult learning providers for more information).
- The Department for Education, individual research sites, and the evaluation team produced and collated a large volume of resources as part of the research project. As well as this report, and associated evaluation dissemination materials (infographic, animation and slide pack of key findings, a number of delivery-focussed resources were also produced. Examples of these resources are best practice guidelines on involving volunteers in community learning in the CLMH context, a recruitment video for the project aimed at men, recorded webinars on how senior leaders in Further Education can support learners with mental health problems, and a slide presentation on lessons learned about working with BAME learners in the CLMH research project. The Department for Education should make the best resources, some of which are currently available via the MHFE website[80] available to support adult learning providers who were not involved in the project to incorporate elements of the offer into their delivery, if they see fit. This will ensure that providers can learn from the good practice examples developed during the research project.
- Commissioners and policy makers outside of the adult learning sector (e.g. health, employment and welfare) should be made aware of the research project, its findings and the availability of local support for people with mental health problems, with a view to enabling:
    - joint commissioning where feasible; and,
    - joined-up awareness raising to ensure that people who need support understand the different options available to them. For example, health practitioners and JCP advisers could signpost people to learning provision.

  This may help reduce demand for NHS mental health services (such as IAPT) and provide a more acceptable form of support for people who do not want a medical

[80] Some of these resources are available on the Mental Health In Further Education website: https://mhfe.org.uk/content/box-sets
and accompanying YouTube channel: https://www.youtube.com/user/mhfewhatsnew/videos

intervention or are less likely to access medical treatment for mental health problems.

Lessons for adult learning providers

As discussed above, it is likely that the model piloted in this project will continue to be offered, in some form, by some learning providers. Other adult learning providers, who were not involved in the research project, may also want to consider including courses based on the model as part of their ongoing adult and community learning offer. The following suggestions are aimed at those planning to either begin, or continue, to offer (for providers who participated in this research project) adult and community learning courses as a mental health and wellbeing intervention.

- The findings of our evaluation of courses delivered during phase two suggests that courses that are explicitly focused on mental health and wellbeing may be more effective in improving mental health outcomes than general adult learning courses. Learning providers should therefore consider how to design courses which can help people identify, share and manage symptoms they are experiencing, and build resilience. As with group A CLMH courses, these courses could use subjects like art, dance or technology to help people develop self-management strategies, but subject-related outcomes should be secondary to self-management outcomes.
- Some learning providers plan to use mental health self-assessment scales to assess the mental health and wellbeing of current or future adult learners. These tools can be useful in assessing eligibility for courses, or as a tool for monitoring progress during learning. All staff administering these assessments must be properly trained.
- As part of the CLMH research project, staff have been trained, and gained significant experience of delivering adult and community learning for people with symptoms of mild-to-moderate mental health problems. Learning providers considering continuing the offer should focus on retaining the staff with the necessary experience to deliver this approach effectively.
- Staff delivering courses, and especially those dealing with initial assessments, must be well-informed about alternative, more appropriate sources of mental health support for learners who may have more severe and enduring forms of mental health problem. Additional safeguarding procedures should be put in place if necessary.
- Learning providers should make sure that adequate support is in place for staff delivering courses focussed on managing mild-to-moderate mental health problems, or general adult and community learning courses aimed at learners with

mental health problems. The experience of this research pilot shows that some staff may require additional support for their own mental health.

- Research shows that men are less likely than women to seek help for mental health problems[81]. Analysis of the profile of learners participating in the CLMH research project shows that a majority of learners were female, increasing in phase two. Providers should, when designing and advertising their offer, include courses tailored to be more appealing to men.
- The short, non-formal, nature of the course was well-received by learners. However, some learners were left unsure about what was next for them once their course finished. Some felt that a source of support was being withdrawn, which could potentially compromise the progress an individual learner had made. A greater emphasis should be placed on supporting learners with the transition following the end of a course, e.g. by signposting learners to other support for mental health problems, or supporting them in making decisions and identifying opportunities for progressing to further learning, self-directed learning, volunteering or other appropriate self-development opportunities.
- The qualitative research shows that the free nature of the course was an important factor for some learners, especially those from more economically disadvantaged backgrounds who may have struggled to justify spending money on taking part in a course otherwise. When seeking to deliver adult and community learning courses to support people with mild-to-moderate mental health problems, providers should try, where funding levels allow, to offer courses at a subsidised rate (if not free), for the reasons outlined above. Consideration should be given to whether links to social prescribing initiatives would help the offer to reach those who may benefit from it but may not seek out learning opportunities proactively.

Lessons for future pilots

Some aspects of the design and implementation of the CLMH research project affected the ability of the evaluation to draw robust conclusions about the effectiveness of the intervention.

The biggest challenges across both phases of the project were:

[81] See e.g. https://www.mentalhealth.org.uk/news/survey-people-lived-experience-mental-health-problems-reveals-men-less-likely-seek-medical

- Difficulties in identifying a suitable comparison group either before delivery had commenced, or even during the research project.
- Timescales, for set-up of the evaluation and for the research sites to prepare for delivery, did not allow sufficient time for data collection tools to be designed and implemented before delivery commenced.
- Research sites found data collection to be challenging, which reduced the amount of data available to the evaluation team, and hindered the analysis. This was a particular issue during Phase One.

The evaluation team and DfE identified these issues during phase one, and as a result made changes to the specification for phase two. Some of the changes helped significantly to overcome some of the issues faced.

We make a series of suggestions below to aid policymakers and researchers running similar pilots in the future, especially those working in an adult and community learning setting. Some of these suggestions were adopted in phase two of the CLMH research project, and significantly improved the quality of data available.

- Funders (e.g. DfE) and researchers designing research projects to test the efficacy of new interventions should ensure that evaluation is considered from the outset. If an external evaluation is being commissioned, the evaluators should be in place before research sites are selected. [82]
- The invitation to apply for funding should emphasise the nature of the project from the procurement stage onwards, ensuring that applicants:
    - are aware that they will be participating in a research project; and,
    - understand what will be expected from them accordingly.

  Specifications for the research project, and the responsibilities of participating learning providers (for delivery and evaluation), should be clearly set out.
- Funders and researchers should consider how tightly to specify the model/s of course delivery, depending on the nature of the research question. If a comparison between different delivery models is required, it is vital that the number of differences between these models is limited so that successful attributes can be more easily identified. This was done in phase two of the CLMH project by introducing a tighter specification (e.g. standardising the length of courses and prohibiting outsourcing of course delivery) and introducing a means of assuring fidelity (peer-assessment of delivery by providers).

[82] It is accepted that this is ideal solution is not always possible given the context within which government policy is made.

- Research sites should be made fully aware of the potential benefits of the research for the wider sector, for their own organisation and for their learners. This will increase providers' readiness to comply with the requirements of the research, and to share this message with participants.
- Funders should have at their disposal a method to sanction learning providers that do not comply with key elements of delivery as agreed in contracts. Any possible sanctions should be made clear to providers at the outset of a project. Providers must also ensure they can enforce compliance with the delivery specification by any subcontractors.
- Assessment of outcomes should, where possible, be based on use of data that is already collected. Where new data collection is required, researchers should consider how data collection activities introduced as part of the evaluation can be aligned with or make use of existing data collection undertaken by providers (e.g. ILR reporting), to minimise duplication and burden on providers, and more importantly, learners.
- The About Learning tool, used to measure learning self-efficacy, was developed by the DfE team for use in this project as no suitable tool existed for this purpose. It would be helpful for researchers to undertake a process of testing and validating this scale in order to create a validated learning self-efficacy measurement tool for future research.
- Funders should consider the inclusion of a smaller-scale scoping and piloting stage if exploratory work is required to inform the development of the final specification. This would allow a much more prescriptive specification for larger scale piloting that would be more suitable for robust evaluation.
- Funders and researchers should ensure that:
    - the requirements of the evaluation are kept as straightforward as possible; and,
    - that every learning provider taking part ensures that all staff involved with the project have a sufficient level of IT literacy.
- Researchers should explain the evaluation requirements in a clear and accessible way. Researchers should frequently repeat this information to learning providers and ensure that it is available online at all times for providers to access. The evaluation team provided one-to-one support to individual projects throughout Phase Two, which proved helpful in clarifying the evaluation requirements
- In line with the practice implemented during the Phase One extension, and throughout Phase Two, researchers should regularly monitor the quality and volume of data received from research sites to identify any issues and follow-up with research sites about these promptly.

Department for Education

Reference: DFE-RR612

ISBN: 978-1-78105-946-3

This research was commissioned under the 2010 to 2015 Conservative and Liberal Democrat coalition government. As a result the content may not reflect current Government policy. The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

Any enquiries regarding this publication should be sent to us at: www.education.gov.uk/contactus

This document is available for download at www.gov.uk/government/publications