Department for Education

Community learning mental health research project

Phase two evaluation report: Annexes

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Contents

Annex 1: Administration of learner survey

In phase two, learners completed a survey at up to five points:

- Their initial IAG session (to assess eligibility);
- The first week of their course
- The third week of their course
- The final (5th or 6th) week of their course
- At any top-up sessions they attended.

This survey was designed by DfE and hosted online using the SmartSurvey[1] platform. Learners completed the survey using tablet devices, which DfE supplied to learning providers for this purpose. Learners completed the survey with assistance from learning provider staff, but were encouraged to complete it as a self-assessment as much as possible.

The survey questionnaire is presented in Annexe 2. The survey was routed so that not all questions were asked at all points. For example, demographic and equalities information was collected at the IAG session, social mobility questions were asked during the third week of courses, and progression questions were asked in the final week of courses and at top-up sessions.

The online survey went live in February 2017. Some learning providers began running phase two courses before this point, and these learning providers collected a more limited range of information from learners using paper questionnaires. Fewer than one in four (18%) of survey responses were collected in this way.

Some learners required additional support to complete the survey, and this was recorded. During phase two 0.4% of responses were completed using an easy read format; 0.3% were completed using a written translation; and 0.2% were completed using an interpreter. Smaller numbers of responses were completed with the aid of a support worker or sign language interpreter, or with a combination of the above.

[1] http://smartsurvey.co.uk

Annex 2 Learner survey questionnaire

1. Select the correct questionnaire from the list below:

- ☐ Thinking: Initial Guidance Meeting (1st self-assessment and equalities questions)
- ☐ Getting: Course week 1 (2nd self-assessment)
- ☐ Getting: Course week 3 (3rd self-assessment, social mobility and for final week courses progression questions)
- ☐ Getting-Keeping: Course week 5/6 (4th self-assessment and progression questions matching survey)
- ☐ Keeping-Thinking: Every refresher session (self-assessment and progression questions)

Staff guide

Before you start:
If it's in blue, it's for you, i.e. notes and questions in blue text are intended for you, as staff. They contain guidance and information to help you and are questions where you gather information through your guidance conversation with a potential research volunteer. Text in black in guidelines is for you to say to or ask the person. We encourage you to ask people any questions written in black text if they want to and are able to complete them for themselves.

Make sure:

- You have a populated and blank copies of the Discovering Potential wheels
- You have information about available courses and organisations you may need to signpost people to
- You have hard copies of the research information sheet and consent form
- You have alternate formats of the mood and wellbeing scales (PHQ-9, GAD-7 and SWEMWBS)
- Your IT equipment and Wi-Fi work - so that you can record the person's informed consent and ensure that their data will be securely stored online as soon as you finish their guidance conversation
- Someone is available to offer mental health first aid/additional support if needed

- You know your organisation's safeguarding and data protection policy and procedures
- You are familiar with the order and security of this survey and when and how to capture the person's informed consent
- You have a link to the 1-verse Thank you For the Data film (it may be useful to show, for example in a waiting area, during a short break, and to help you explain why their data is so important to us) https://youtu.be/fUqv0vpyg58

Using the 'Thinking' stage of Discovering Potential, it is your job to:

Make sure everyone who is eligible has equal opportunity to take part in and benefit from this research - we really want diverse research volunteers who reflect our local communities Assess the person for accessibility, communication, language and/or literacy needs, so you can make adjustments in this guidance session so they:

- Understand what is involved in the research
- Opt-out if they want
- Complete the screening questionnaires (e.g. do you need translated PHQ-9/GAD-7/SWEMWBS?)
- Give their informed consent to being involved

Assess the person for signs of distress and respond appropriately Introduce the research in the Thinking stage, as one option available to the person - have a conversation around the person's initial thoughts about learning and being involved in research and what being involved in the research would mean for them i.e.

- They need to meet the nationally set criteria for this research to be eligible
- We will ask them to self-assess their mood and wellbeing 2 or 3 times more on the same (tick-box) scales as the ones they fill in this time
- We need their informed consent/permission to collect this information from them and use it for the research
- We need them to really try to complete their course (i.e. not to leave the course before it ends or if they do to come back and finish it a refresh session)

2. Your (staff) name:

3. Today's date: DD/MM/YYYY

Helping people opt-out or give their informed consent

You must obtain oral consent from the person for them to see if they are eligible to volunteer to this research project:

- Give you minimal contact details
- Answer the 'screening' questions to see if they are eligible (these are PHQ9 and GAD7 and depending on their score, what support if any they are getting with their mental health)

Informed consent is in 2 stages, i.e.

- Informed oral consent to answering the initial (PHQ-9 and GAD-7) screening scales and recording their responses and contact details
- Informed written consent from people who are eligible, giving us permission to collect their data and to analyse, and link it to other information held by government

Check the person is able to give informed consent
Do not encourage someone to volunteer against their best interests. You must ensure people do not keep taking part in research. It's why people involved in phase 1 can only join refresher sessions in phase 2.

You MUST assess the person so that you are confident their health or social circumstances are not making them vulnerable to pressure from others to volunteer, and that they have the mental and/or emotional ability to give their informed consent at this time.

Exclusions
Explain the exclusion criteria early. Warn the person some information may be sensitive. This lets people opt-out before you ask them any questions or they share difficult personal information they may afterwards regret telling you.

You must obtain informed oral consent before the person answers the screening scales (PHQ-9 and GAD-7).

If they say 'no':

- Thank them for their interest
- Offer to look at mainstream courses they can do
- Do not complete this survey any further

4. Getting the person's informed oral consent before they fill in the (PHQ-9 and GAD-7) scales to see if they are eligible

Say: "Thank you for your interest in volunteering to help with this research project. It's trying to find out if: “Community learning courses help people manage better problems they are experiencing, like not sleeping, stress, finding it hard to go out, worrying, feeling anxious, sad or low?”

The research is not suitable if you: Are younger than 19 when the course you want to take starts Have serious /severe and enduring mental health problems Have a serious problem with (non-prescribed) drugs and/or alcohol and are still using Can't or don't want to give your informed consent to us collecting information from you during the research Are you happy for me to proceed/do you still want to volunteer to be involved in this research?"

If the person says 'Yes' they are happy to continue, select 'Yes' below. If they say 'No' they are NOT happy to continue, i.e they have decided to opt out now, select 'No'. Finish the survey, and continue with a general guidance session. *

- ☐ Yes, I want to volunteer
- ☐ No, thank you. I'd like to stop now. I don't think this research is for me

Guidance conversation

5. How are you having this conversation? NB: Keep telephone guidance to a minimum but it can be important for some people and projects where distance and public transport or bad weather are a problem. *

- ☐ 1:1 face to face meeting
- ☐ 1:1 telephone conversation

About you

The person's name, date of birth and postcode provide the link across all the research data they give us.

6. Person's name? *

First name:

Surname or family name:

7. Person's date of birth *

DD/MM/YYYY

8. Person's Postcode: NB. if the person is homeless enter ZZ99ZZ as their postcode (this is for the ILR) *

Have your personal details changed?

9. Has learner’s name or gender identity and/or any personal contact details changed? Say: " Since the last time you completed the mood scales, have you changed you name, or gender identity, or email, telephone number/s, address, postcode, or emergency contact details?" *

☐ No

☐ Yes

10. Change of personal details If these have changed please update below as applicable

New name

New email

New phone number

New address

New emergency contact

New gender identity

Other

Attendance

10. Attendance register (weeks 1, 3, 5/6 and refresher sessions)

Check you know which format PHQ-9, GAD-7 mood self-assessment scales learner uses?

11. Attendance: Why is the person not present?

Note: This question is not asked

Language support

12. Is English learner's first/preferred spoken language? *

- ☐ Yes
- ☐ No
- ☐ Not explored
- ☐ Don't want to answer

If 'no' please provide details of their preferred language:

NOTE: Avoid you asking these questions about accessibility. If learner can complete them pass them the keyboard/ tablet.

Accessibility support

13. Do you consider yourself to be d/Deaf or disabled or neurodiverse or to have physical or mental health problems? *

- ☐ Yes
- ☐ No
- ☐ Don't want to answer

14. Please select all that apply (A-Z order) *

- ☐ Blind/partially sighted
- ☐ Deaf
- ☐ Deafened
- ☐ Facial disfigurement

☐ Hard of hearing

☐ Head injury

☐ Learning difficulties (includes learning disability)

☐ Long-term illness | medical condition

☐ Manual dexterity difficulties

☐ Mental health problems

☐ Mobility difficulties

☐ Neurodiverse (e.g. people who are often labeled (A-Z order) with Attention Deficit Hyperactivity Disorder, (ADHD) Autistic Spectrum, Dyscalculia, Dyslexia, Dyspraxia,Tourette Syndrome and others)

☐ Progressive medical condition

☐ Speech difficulty

☐ Don't want to answer

☐ Other (please describe):

15. What help in learning (if any) do you need from us, with any of the following? (A-Z order) *

Communication (hearing, seeing, speaking)

Language (community language including sign language/s)

Movement (writing, using a keyboard, sitting/standing)

Physical accessibility (getting to and from classes and in and out of buildings/rooms)

Reading/writing

Don't want to answer

Other

If other (please describe)

What's involved in being a research volunteer?
Say:

"Thank you. Now I'd like to ask you to fill in 2 short tick-box questionnaires. They are:

So you can see what we mean by the scales, what they ask and how long it takes to fill them in.

To see if you are eligible to be part of the research - don't worry if you aren't.
We'll simply look at which other courses you can join."

You need to gauge how much of the following (in black text) it is useful to tell the person (mostly at this stage they will be anxious to know if they are eligible so if they are happy to complete the scales you can always come back to this information at a later time):

"You might have seen the scales before (in a magazine, on the NHS website on TV or at your GP surgery). They are called: PHQ-9 and GAD-7. GPs sometimes ask people to complete them and they use the answers people give to work out what might be wrong and which, if any, treatment to recommend. We do not use the scales in this way. We do NOT diagnose you or offer you treatment. This research involves joining a community learning course to see if it makes a difference to your mood and wellbeing.

The scales are quick and easy to complete. If you have not seen them before some questions might feel a bit sensitive or personal. We don't mean to pry or upset you. We used them last year and most people found them helpful. This first time you fill in the scales it is to see if you meet the criteria for this research. After that, you use the scales as part of your course so that you can see how your learning is going. It's your answers that we record for the research.

16. Informed oral consent

Check with the person whether they have any questions first and (if they have not already done so) they want to see the research information sheet or if they want to

get on and complete the mood (PHQ-9 and GAD-7) scales first and go through the information sheet with you when they know if they meet the criteria for the research.

Obtain the person's oral consent to the screening questions. Informed oral consent is where you as the researcher and the volunteer have a conversation where you give information/answer their questions so that if they say they give their consent they feel they understand what you are asking them to do and why. If the person says 'Yes', you do NOT need to get them to sign the paper consent form at this stage, but it is good practice to make a note of their decision below. If they/you want you can make and upload a quick audio recording in which they say they are happy to fill in the scales.

If the person says 'no' the survey will finish: Thank them for their interest Offer to continue your guidance conversation Do not complete this questionnaire any further

Ask: "Are you happy to do the scales now - to see if you meet the criteria for the research project and if you'd be happy to do the same thing 3 or 4 times during your course? Are you happy for me to record your answers?" *

☐ Yes

☐ No

17. If you want, where it says 'Choose File' below you can upload an audio file of learner's informed oral consent to filing in the screening questionnaire/s.

Accessible versions of the questionnaires

18. How will learner complete the mood and wellbeing PHQ-9, GAD-7 and SWEMWBS questions?

☐ Standard written format in English

☐ NHS easy read/learning disability version

☐ NHS written translation (into community language)

☐ via a community language interpreter

☐ BSL video translation

☐ via a communication support worker/registered sign language interpreter

☐ combination of above

19. In which community language?

About learning on your course and after

20. About Learning Below are some statements about learning. Please choose the ones that best describe your experience of each over the last 2 weeks

	None of the time	Rarely	Some of the time	Often	All of the time
I feel ready and able to learn new things	☐	☐	☐	☐	☐
I feel confident to ask for help if I get stuck	☐	☐	☐	☐	☐
I share what I've learned with others	☐	☐	☐	☐	☐
I know what I want to learn next	☐	☐	☐	☐	☐
I can talk about what I'm good at	☐	☐	☐	☐	☐

21. Does this include a score for each statement? *

☐ Yes

☐ No

22. If 'No' you MUST explain which statements were not scored and why not.

	Qu 1	Qu 2	Qu 3	Qu 4	Qu 5
Select	☐	☐	☐	☐	☐

23. learner's About Learning score is *

1st mood scale (PHQ-9)

Please self-assess yourself on the mood scale below. There are no right or wrong answers, it is about how you've been feeling over the last 2 weeks.

NOTE: This is a self-assessment tool. Avoid you orally asking the questions. If learner can complete it let them.

24. 1st mood scale (PHQ9) Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself- or	☐	☐	☐	☐

	Not at all	Several days	More than half the days	Nearly every day
that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading a newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking slowly that other people could have noticed? or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Answers to questions 8 / 9 on PHQ-9
When someone completes the 1st mood scale (PHQ-9) you need to check if their responses to PHQ-9 include being "bothered by...

8. Moving or speaking slowly that other people could have noticed? or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?"

and/or

9. Thoughts that you would be better off dead or of hurting yourself in some way?"

If they choose any response to these questions other than 'not at all', it does not mean they can't volunteer and it does not have to trigger safeguarding (unless your local policy says it does). But it does mean you MUST explore their answers with them to assess their risk of harm.

Ask learner if:

- They still feel like that now or if was earlier in the 2 weeks period?
- If they are planning/have a plan to hurt/kill themselves?
- Need immediate help from you to keep safe?
- Have anyone else helping them with their mental health?
- Think they should see someone, like their GP?
- Want you to put them in touch with a service that might be able to help?

You need to make a judgement and act as appropriate to what the person describes and explains the experiences behind their responses, e.g.

- If they feel that way now
- If they have a plan to harm or kill themselves
- How distressed they are
- If they need mental health first aid
- Your safeguarding policy
- If they want you to signpost/refer them to another service

25. Does learner's total score include a score for every statement on the PHQ-9 scale?

☐ Yes

☐ No

26. If 'No' you MUST explain which statements were not scored and why not.

	Qu 1	Qu 2	Qu 3	Qu 4	Qu 5	Qu 6	Qu 7	Qu 8	Qu 9
Select	☐	☐	☐	☐	☐	☐	☐	☐	☐

27. learner's PHQ-9 score is

If they missed any answers you should not change this numerical score but when you work out if learner is eligible, if their score is at the upper end of eligible then you may have to think about what their score would potentially be/ask them again if they are willing to answer the question.

Be honest with them about why you are asking. This is a partnership in which someone is hoping to get help and we want to offer help but we can only offer them the opportunity to join the research if it is safe for us to do so (i.e. if they meet the criteria we have been approved for by the research panel). *

28. Is learner PHQ-9 score too high to be eligible, i.e. is it 20 or more?

☐ Yes

☐ No

2nd mood scale (GAD-7)

Please self-assess yourself on the mood scale below. There are no right or wrong answers, it is about how you've been feeling over the last 2 weeks.

NOTE: This is a self-assessment tool. Avoid you asking the questions. If learner can complete it let them.

29. 2nd mood scale (GAD-7) Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐

	Not at all	Several days	More than half the days	Nearly every day
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

30. Does this include a score for every statement? *

☐ Yes

☐ No

31. If 'No' you MUST explain which statements were not scored and why not.

	Qu 1	Qu 2	Qu 3	Qu 4	Qu 5	Qu 6	Qu 7
Select	☐	☐	☐	☐	☐	☐	☐

32. learner's GAD-7 score is *

33. Is learner’s GAD-7 score too high to be eligible, i.e. is it 16 or more?

☐ Yes

☐ No

34. Eligibility check: Is learner eligible because: Their PHQ-9 score is 5-19 and their GAD-7 score is less than 16? OR Their GAD-7 score is 5-15 and their PHQ-9 score is less than 20? *

☐ Yes

☐ No

33. Thinking: Are their mood scores too low - except for Group C?

If the PHQ-9 and GAD-7 scores are BOTH 0 - 4, learner is only eligible if your project is in Group C

35. Which research group (A, B or C) are you part of? *

☐ Group A - Mental health focused courses for people concerned to improve/manage symptoms/problems with their mental health

☐ Group B - General ACL courses for people who are concerned to improve/manage symptoms/problems with their mental health

☐ Group C - General ACL courses for some people in the group who have symptoms/problems with their mental health that they want to improve/manage and some people who don't have mental health symptoms/problems

If you are in group A or B the next screen will ask you what information, advice or guidance you have provided, e.g. signposting to your usual provision or another service

Mood scores too high for the research?

What to do if learner is not eligible to join the research because one of their screening scores is too high

You should explain this carefully and sensitively and invite learner to tell you if they are getting any help for their mental health and wellbeing in case they need support at this time.

Depending on their response:

If learner is getting help ask who is giving them support and if that support is enough for how they are feeling at present? Or, does learner need to make an appointment to see the person/organisation/s that support them?

If learner is not getting help:

- Suggest they see their GP
- Ask if they want information about local services that can provide support
- Ask if they want you to help them make contact
- Remember it is their choice. You cannot make learner seek help. They may have been living with symptoms for a long time before seeking any kind of help

Note: Some people who have severe and enduring mental health problems may be in recovery, and it may not be unusual for their PHQ-9 and/or GAD-7 scores to be higher than the range we have defined for this research. For this group of people, they may not want or need to access their mental health support because of a high score and may simply want to get into learning and for you to explore with them which of your mainstream courses they can access.

Is anyone helping you with your mental health?

36. Is anyone helping you look after your mental health and wellbeing?

If learner is NOT eligible because one or more of their (PHQ-9 or GAD-7) scores is too high and they refuse to answer this question, you MUST Respect their decision NOT pressurise them Ask if they want you to tell them where they can get some help or to refer them for support Offer to find them a mainstream course instead Support them to make their own decisions Signpost as appropriate to what this person wants for themselves Provide mental health first aid if required and/or refer learner to safeguarding if you believe them to be at serious risk of harm. *

☐ Yes

☐ No

☐ Don't want to answer

Submit the data you have collected from learner.

DO NOT add their details to the ILR. The SFA has confirmed that this is not required (unless of course they choose one of your mainstream courses in which case complete your usual enrolment and ILR documentation).

37. Who or what is helping you? (A-Z order) *

☐ A local voluntary mental health charity or organisation

☐ Alcohol/drugs service /worker

☐ Family member or friend or neighbour or work colleague

☐ NHS mental health services (e.g. counselling/IAPT/Recovery College/Mental Health Trust)

☐ Private therapist/doctor

☐ See family doctor/GP/someone at GP surgery or health clinic

☐ Social worker

☐ Take tablets (e.g. sleeping tablets, anti-depressants)

☐ Don't want to answer

☐ Other (please describe):

38. Is anyone helping you look after your mental health and wellbeing? (A-Z order) Select all that apply *

☐ Not explored

☐ A local voluntary mental health charity or organisation

☐ Alcohol/drug service/worker

☐ Family member or friend or neighbour or work colleague

☐ NHS mental health services (e.g. counselling/IAPT/recovery college/mental health trust)

☐ None

☐ Private therapist/doctor

☐ See family doctor/GP/someone at GP surgery or health clinic

☐ Social worker

☐ Take tablets, e.g. sleeping tablets, anti-depressants

☐ Don't want to answer

☐ Other

Wellbeing scale (SWEMWBS)

Please complete the following questions.

NOTE: This is a self-assessment tool. Avoid asking the questions. If learner can complete it let them.

39. Wellbeing scale Below are some statements about feelings and thoughts. Please choose the ones that best describe your experience of each over the last 2 weeks

	None of the time	Rarely	Some of the time	Often	All of the time
1. I've been feeling optimistic about the future	☐	☐	☐	☐	☐
2. I've been feeling useful	☐	☐	☐	☐	☐
3. I've been feeling relaxed	☐	☐	☐	☐	☐
4. I've been dealing with problems well	☐	☐	☐	☐	☐
5. I've been thinking clearly	☐	☐	☐	☐	☐
6. I've been feeling close to other people	☐	☐	☐	☐	☐
7. I've been able to make up my own mind about things	☐	☐	☐	☐	☐

40. Does this include a score for every statement? *

☐ Yes

☐ No

41. If 'No' you MUST explain which statements were not scored and why not?

	Qu 1	Qu 2	Qu 3	Qu 4	Qu 5	Qu 6	Qu 7
Select	☐	☐	☐	☐	☐	☐	☐

42. Wellbeing (SWEMWBS) score?

NOTE: This is a self-assessment tool. Avoid you orally asking the questions. If learner can complete it let them.

43. Below are some statements about learning. Please choose the ones that best describe your experience of each over the last 2 weeks

	None of the time	Rarely	Some of the time	Often	All of the time
I feel ready and able to learn new things	☐	☐	☐	☐	☐
I feel confident to ask for help if I get stuck	☐	☐	☐	☐	☐
I share what I've learned with others	☐	☐	☐	☐	☐
I know what I want to learn next	☐	☐	☐	☐	☐
I can talk about what I'm good at	☐	☐	☐	☐	☐

44. Does this include a score for every statement? *

☐ Yes

☐ No

45. If 'No' you MUST explain which statements were not scored and why not.

	Qu 1	Qu 2	Qu 3	Qu 4	Qu 5
Select	☐	☐	☐	☐	☐

46. About Learning score?

Permission/signing up as a learner

Say:

"Thank you for answering those questions.
How did you find completing the scales? Is that something you would be happy to repeat:

- At the start of your first class?
- And twice more during your course?
- And if you come to a refresh session?

Are you still happy to be involved in this research project?

Do you have any questions you want to ask me about the research?

If I go through the research information sheet and consent form with you now, are you happy to sign the research consent form?"

Project information sheet and obtaining the person's written consent

If you have not done so already, give learner copies of:

- the research information sheet, and
- the research consent form to complete

You may have already given learner a copy of the research information sheet and you should have covered much of its content by this point. If you have not done so yet, you MUST give them a hard copy of the information sheet and offer to read aloud any sections you have not yet covered or (assuming that you are confident of their literacy) invite them to read it before they complete and sign their consent form.

NB: You need to be able to answer any questions learner has about how locally you will secure and store their information (i.e. the same as for other learners).

47. Confirm that you have a hard copy signed written consent form for learner?

Note, what happens next for each of the possible responses you can select below. If you select: 'Yes', - you will be asked to upload it on the next screen 'No because this guidance session is by telephone', - use the additional notes section at the end of the survey to alert your project manager/lead that the course tutor will need to get learner to sign the consent form at the start of the first class. The tutor MUST upload a photo of the consent when learner completes the learning, mood and wellbeing scores in week 1. It they fail to do this, learner cannot be included in the research. 'No consent refused' - if you select this option the survey will finish and you will not be able to add any further information. *

☐ Yes

☐ No because telephone guidance

☐ No consent refused

48. Take and upload 2 photos (one of each side) of learner's signed consent form. Return the hard copy to your Project Lead (who will need to store it for 3 years). NOTE: If you can't take or upload photos of the signed consent you MUST contact your Project Lead as soon as possible. They will have to take the photos and upload them to learner's data. If their signed consent is not linked to this survey response by either you or your project lead learner cannot be included in the research because the external evaluators will not be able to use this data.

Eligible for SFA funding?

Please provide details about residential status.

Do you need to check the person's eligibility to access Skills Funding Agency funded community learning, i.e. by checking their residential status? If so, check the following:

49. What is your country of birth?

50. Have you been resident in the UK or other EU country for at least 3 years?

☐ Yes

☐ No

51. What is your current (immigration) status in this country? (A-Z order)

- ☐ Asylum seeker (for 6 months)
- ☐ Exceptional/indefinite leave to enter/remain
- ☐ Family visa
- ☐ Granted refugee status or a family member of a person granted refuge status
- ☐ Granted humanitarian protection or a family member of a person granted humanitarian protection
- ☐ Student visa
- ☐ Visitors/working visa
- ☐ Don't want to answer
- ☐ Other

If 'other' please describe:

Do you need to check learner's immigration status or their family members' status?

A116. If the person has any of the statuses listed below, they are eligible to receive funding and are exempt from the three-year residency requirement rule. You must have seen the learner's immigration permission in these circumstances.

A116.1. Refugee Status.
A116.2. Discretionary Leave to Enter or Remain
A116.3. Exceptional Leave to Enter or Remain.
A116.4. Indefinite Leave to Enter or Remain.
A116.5. Humanitarian protection.
A116.6. Leave Outside the Rules.
A116.7. The husband, wife, civil partner and child of any of the above in this paragraph. (A116.1 – A116.6).
A117. The learner's immigration permission in the UK may say that they have a 'No recourse to public funds' condition, but public funds does not include education or education funding, so it does not affect someone's eligibility for learning and if they

meet the criteria above, for the research.

Asylum seekers are eligible to receive funding if it is 6 months or more since they applied for asylum. For full guidance see the SfA Common and Performance Management funding rules 2016-2017.

Use the 'Getting' stage in Discovering Potential to guide a conversation with learner about any barriers to them taking up learning, e.g. things they need to consider (like getting to the course venue or fitting it around school hours or regular commitments they have to others during the week) to help them decide:

Which course to take?

When?

Where?

What else would help learner succeed in learning and get the change they want?

Your roles and responsibilities

In this section we look at the person's personal roles (e.g. daughter, parent, partner, son, student, worker, volunteer), and responsibilities (looking after someone, working, etc.)

52. Does learner look after anyone? (A-Z order) *

☐ Not explored

☐ No caring responsibilities

☐ Primary carer for a child/children/sibling (under 18)

☐ Primary carer for a disabled child/children/sibling (under 18)

☐ Primary carer for my disabled adult (aged 18 or older)

☐ Primary carer for an older person (65 or older)

☐ Don't want to answer

Other:

53. Does learner work or volunteer? (Paid or unpaid) (A-Z order) *

☐ Not explored

☐ Apprenticeship

☐ Employment training scheme (government programme)

☐ Full time education

☐ Full-time employed working for an employer or employers (30 hours or more /week)

☐ Full-time self-employed (with or without employees)

☐ Long-term sick or disabled

☐ Looking after home

☐ Looking after someone

☐ Part-time employed working for an employer or employers (less than 30 hours/week)

☐ Part-time self-employed (with or without employees)

☐ Retired from paid work altogether

☐ Taking part in another part-time course as well as this one

☐ Temporarily sick or disabled

☐ Unemployed and looking for work

☐ Volunteer

☐ Zero hours contract

☐ Don't want to answer

☐ Other

Circumstances – income and welfare benefits

54. Does learner's income include any welfare benefits?

☐ Not explored

☐ Yes

☐ No

☐ Doesn't want to answer

55. Which benefit/s? (A-Z order)

☐ Carer's Allowance

☐ Child Tax Credit

☐ Employment and Support Allowance

☐ Housing Benefit or Council Tax Credit

☐ Incapacity Benefit

☐ Income Support

☐ Jobseekers Allowance (JSA)

☐ Pension Credit

☐ Personal Independence Payment (PIP)

☐ Severe Disablement Allowance

☐ Universal Credit

☐ Working Tax Credit

☐ Doesn't want to answer

☐ Other (please describe):

Which (if any) qualifications do you have?

56. Which is the highest qualification learner holds? *

☐ No qualifications

☐ Qualifications obtained outside the UK

☐ Qualifications below level 1

☐ Level 1 e.g. GCSEs/O levels (grades D-G), or less than 5 grades A-C)

☐ Level 2 e.g. 5 or more GCSEs/O levels (grades A-C)

☐ Level 3 e.g. 2 A levels, BTEC, OND

☐ Level 4 e.g. BTEC, HNC, QCF level 4, PGCE

☐ Level 5 e.g. Degree, HND, QCF level 5

☐ Undergraduate degree (e.g., BA, BSc)

☐ Master’s degree (e.g., MA, MSc)

☐ Doctorate degree (e.g., PhD)

☐ Professional qualifications (e.g. teaching, nursing, accountancy)

☐ Other (please describe)

☐ Don't want to answer

57. Which of the following forms of identification has learner supplied so you to check/obtain their Unique Learner Number (ULN) from the SFA? (A-Z order) *

☐ Bank Credit/Debit Card

☐ Driving Licence

☐ ID card or other form of national ID

☐ ISD/BRP/ARC

☐ National Insurance Card

☐ Passport

☐ None - to bring in at/before first class

☐ Other

If 'other' please describe:

Equalities questions | the ILR

NOTE: Data relating to a person's racial or ethnic origin; their religious beliefs; or beliefs of a similar nature; physical or mental health; sexual life; the commission of any offence, or criminal records are classified in law as sensitive data. When you collect sensitive personal data you MUST always get the person's explicit consent, i.e. learner's consent must be absolutely clear.

The ILR usually only ask learners for a narrow range of equalities information. In this research we ask learners to provide more information than you may be used to asking. There are 3 reasons for this:

- In research we need to know if something works and if it does who does it work for and in which circumstances.
- Researchers MUST take all reasonable steps to make sure that people across all of the protected groups who are eligible to participate in a project

have equal access to take part and the opportunity to benefit from the research. Decisions at all stages, especially for recruitment, MUST be free from discrimination.

- The people who are most likely to experience mental health problems in our society are those who experience prejudice and discrimination because of protected grounds. This makes it important to ensure our sample includes large enough numbers of people across all protected grounds and to be able to analyse the data we collect by different protected grounds. Otherwise, we will not be able to generalise any findings across protected groups.

As the person representing this research to potential research volunteers, it is your role to trust explain why we need to ask for sensitive data, how we will store it and what we do with it.

The order and way in which the following equalities questions are presented and worded may be unfamiliar to you. It is deliberate and based on best practice so that people can 'see' their identities in the responses. Sharing the rationale for questions and descriptors (without making the process too long) has a positive effect on people with protected grounds trust to answer these questions fully and not simply tick 'Don't want to answer' all the way through. We have included some of the rationale but you can help by sharing the rationale for any questions the person does not recognise/understand and by explaining how the organisation where they will be learning:

Welcomes and protects people of difference

Uses equalities information to ensure everything treats people fairly

Makes sure everyone can succeed in learning

Equalities questions

"Please help us check that all different groups of people benefit from this research by answering the questions that follow.

• We are asking these questions to make sure this research is fair and open to different groups of people.

• We know that people who begin to develop symptoms of mental health problems have often experienced prejudice and discrimination because of other aspects of their identities and worry about the stigma (which is slowly getting less) that can be associated with having mental health problems.

• Different people will find some of the questions 'matter more to them' based on how we see ourselves and the experiences we've had because of who we are.

• You may feel that some of the information in the next set of questions is sensitive.

• We promise we do not mean to upset or offend anyone.

• We hope that you will want to answer these questions but you don't have to (there's always a ‘don't want to answer’ option)"

NOTE: Avoid you orally asking these sensitive questions. If learner can complete them let them do it.

58. What is your age? *

- ☐ 14-18
- ☐ 19-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-39
- ☐ 40-44
- ☐ 45-49
- ☐ 50-54
- ☐ 55-59
- ☐ 60-64
- ☐ 65-69
- ☐ 70-74
- ☐ 75-79
- ☐ 80+

☐ Don't want to answer

59. How do you describe your nationality? (A-Z order) *

☐ British

☐ English

☐ European

☐ Irish

☐ Northern Irish

☐ Scottish

☐ Welsh

☐ Don't want to answer

☐ Other (please describe)

If you chose 'other' please describe:

Describing our diverse heritage
As the world changes so does our sense of ourselves and how we describe our diverse ethnic heritage as humans. Heritage and identity are political and personal. In 2014, following years of lobbying, Cornish was officially recognised as a distinct ethnic group. It is expected that the next group that will be given similar recognition are people from South America.

People in positions of privilege and power tend to see themselves as some kind of 'default' group against whom everyone else is compared and can fail to recognise how personal equalities monitoring questions matter to people who are outside of that dominant group. In the UK and Europe, in 2016, evidence of the sensitivity of this is all around us. It makes those who feel outside of the 'default' group - experience equalities monitoring as highly personal. If among the questions and response options people cannot identify with /find a way to see themselves they

often experience such monitoring as othering and sometimes that those of us asking the questions are being at best thoughtless and at worst deliberately hurtful.

Research volunteers cannot be expected to share such personal information with us unless you and your organisation demonstrate to them that you/your organisation can be trusted with it. The explanations you give for particular questions and the language you use can be critical.

Language changes all the time, including how we describe our diverse ethnic heritage as humans. No-one today would dream of describing Native American people or people from East and South-East Asian countries such as China or Japan by skin colour. We all know that it would be deeply offensive and disrespectful.

Heritage describes people as humans – 'colour' does not. The majority of population groups are described in terms of their heritage, but two are still described by ‘skin colour’: “black” and “white”, i.e. people of direct African descent and those of European descent. For many people this terminology is out of date and overdue for change because it calls up the racism of the Atlantic Slave Trade and it fails to treat all populations with equal dignity and respect. People of African descent remain hugely over-represented in secondary mental health services in the UK making this highly sensitive.

Staff and students from across Europe often tell us how 'othering' they find ethnicity monitoring in the UK and no, the 'Other ethnic group' category does not help. In some ways it makes it worse. For example, the pan-ethnicity 'Arab' grouping appears as a single ethnicity in the 'Other ethnic group', yet as it includes Western Asia, parts of North Africa, the Horn of Africa and East Africa, and 'lumps together' the world's second largest and incredibly diverse and divided ethnic group.

However, because this research project needs to compare our findings with other research we have had to use much of the official language and grouping (below). We have hopefully made it less othering for people by listing them in A-Z order.

60. What is your ethnic identity? (A-Z order) *

- ☐ Arab/North African
- ☐ Asian/Asian British: Bangladeshi
- ☐ Asian/Asian British: Chinese

☐ Asian/Asian British: Indian

☐ Asian/Asian British: Pakistani

☐ Any other Asian background (please describe)

☐ Black/African/Caribbean/Black British: African

☐ Black/African/Caribbean/Black British: Caribbean

☐ Any other Black/African/Caribbean background (please describe)

☐ Mixed/multiple ethnic background: Asian and White (European)

☐ Mixed/multiple ethnic background: Black African and White (European)

☐ Mixed/multiple ethnic background: Black Caribbean and White (European)

☐ Mixed/multiple ethnic background: Any other mixed background (please describe)

☐ White: Cornish

☐ White: English

☐ White: Irish

☐ White: Northern Irish

☐ White: Scottish

☐ White: Welsh

☐ White: Gypsy, Roma, Irish Traveller

☐ Any other White background (please describe)

☐ Any other ethnic background (please describe)

☐ Don't want to answer

Any other please describe

61. Please describe your gender identity (A-Z order). Choose all that apply.

NOTE: Because this questionnaire is not anonymous, we cannot follow the trans-inclusive gender identity question below with the question we usually ask about whether the person's gender identity is different to the sex they were assumed to be at birth. Currently under the law, monitoring information about transgender people must not be linkable to their name. Outing somebody as having the protected characteristic of gender reassignment without their permission, even accidentally, could lead to either civil court proceedings for unlawful harassment and discrimination under the Equality Act 2010 or even to criminal charges under section 22 of the Gender Recognition Act 2004. *

☐ Female (including male-to-female trans women)

☐ Intersex

☐ Male (including female-to-male trans men)

☐ Non-binary

☐ Other (as your identity)

☐ X

☐ Don't want to answer

☐ Any other (please describe):

62. The government has agreed that the Skills Funding Agency will introduce inclusive gender identity monitoring by 2018. Until then, they are only able to monitor gender using the binary 'female' or 'male'. For our funding we have to record one or the other. Which one are you willing for us record? Female or male? *

☐ Female

☐ Male

63. What is your sexual orientation? (A-Z order) *

☐ Bisexual

☐ Gay man

☐ Gay woman

☐ Heterosexual/straight

☐ Undecided

☐ Don't want to answer

☐ Other (please specify):

64. Which beliefs (if any) or none do you hold? (A-Z order) Choose all that apply. *

☐ Agnostic

☐ Atheist

☐ Humanist

☐ No beliefs

☐ Non-religious philosophy | belief-based lifestyle choices

☐ Religious beliefs

☐ Don't want to answer

65. What is your religion? (A-Z order) Choose all that apply. *

☐ Buddhist

☐ Christian

☐ Hindu

☐ Jain

☐ Jewish

☐ Muslim

☐ Pagan

☐ Quaker

☐ Rastafarian

☐ Sikh

☐ Any other religion (please describe)

The ILR Course Code is 340 for every course that is part of the research. You do NOT need to record other community learning aims for learners who are involved in this research.

Once you have completed the fields on the next page you will be able to email it to learner so they have all the details they need about their course.

66. What's the name of my course? It is essential for the research volunteer and the research, that you accurately record the formal title of the course here.

67. What's my course code?

68. Who is the tutor?

69. Which day of the week is my course on?

70. What's the start date for my course?: DD/MM/YYYY

71. What time does my course start? HH/MM

72. What date does my course finish?: DD/MM/YYYY

73. What's the address and postcode where the course will take place?

74. How will I get there?

☐ Independently

☐ Other

If 'other':

What (if anything) do I need to take with me to the first session?

75. learner's email address

Progression

This section can be used in conjunction with the Keeping section of the Discovering Potential Wheel.

Using the Keeping stage of Discovering Potential, have a conversation to see if learner has identified any further support needs or challenges they face that could get in the way of their learning.

You can capture notes later.

General Administration

76. Personal Details: Please note you must record below either an address or 'homeless no address' in address line 1. The details on this page are only required for your local MiS and the ILR. They are not required for the research. The reason some fields are optional is in case some learners do not have the relevant information. *

Address line 1:

Address line 2:

Address line 3:

Address line 4:

77. Telephone number/s

Mobile phone number (if available)

Landline number (if available)

78. Is there someone you'd like us to contact in case of an emergency? (You don't have to)

☐ Yes

☐ No

79. What's their name and contact number?

Name

Telephone number

What advice or information did you offer the person?

Please summarise below the information and/or advice you offered learner and any outcome/s

80. What information and/or advice did you offer learner?

Advice

Information

None

Other

If 'other' please describe:

81. Did you signpost/refer learner to an alternative course or service?

☐ Yes

☐ No

82. Where did you signpost learner to? (A-Z order) *

☐ A different learning provider

☐ Another one of our courses (not part of the research)

☐ Appointment for another 1:1 guidance session

☐ Direct referral to debt/benefits advice service

☐ Direct referral to drug or alcohol service

☐ Direct referral to employment advice service

☐ Direct referral to mental health service (IAPT, recovery college)

☐ Encouraged to contact a different service

☐ Encouraged to see their GP

☐ Other

Please describe:

83. As a result of your meeting with learner today, did you give them mental health first aid or refer them to safeguarding?

- ☐ No, neither
- ☐ Yes, mental health first aid
- ☐ Yes, safeguarding referral
- ☐ Yes, mental health first aid and safeguarding referral

Social mobility

84. Did any of your parent/s or guardian/s complete a university degree course or equivalent (e.g., BA, BSc or higher)?

- ☐ I don't know
- ☐ No
- ☐ Yes
- ☐ Don't want to answer

85. Which type of school did you mainly go to between the ages of 11 and 16? (A-Z order) *

- ☐ Attended school outside the UK
- ☐ Didn't go to school
- ☐ Home school
- ☐ I don’t know
- ☐ Independent or fee-paying school
- ☐ Non-selective state-run or state-funded school

☐ Selective (on academic, faith or other ground) state-run or state-funded school

☐ Don't want to answer

86. At any point during your school life, did your household receive income support? *

☐ I don't know

☐ No

☐ Yes

☐ Don't want to answer

87. At any point during your school life, did you receive free school meals? *

☐ I don't know

☐ No

☐ Yes

☐ Don't want to answer

88. Does your course take place over 3 or 4 weeks? If so, we need to know whether this is your final week in order to capture progression data. Is this the final week of the course?

☐ Yes

☐ No

89. How likely is it that you would recommend the course you have just completed to a friend or colleague? *

	0	1	2	3	4	5	6	7	8	9	10	
Not at all likely	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Extremely likely

Keeping-Thinking: Progression

Use the Keeping and Thinking stages of Discovering Potential to explore with learner:

What they thought of the course they have just completed (friends/colleagues test)

What (if anything) in their life has changed since starting their course

What they need to do to keep any positive changes they have made through learning

What's next for them

Say:

"Using the wheel, think back to when you first volunteered to this research project and to the change/s you wanted to get in your life and the skills you wanted to develop or brush up on"

90. Have some things stayed the same? *

☐ Yes

☐ No

☐ Not sure

☐ Don't want to answer

91. What's stayed the same?

- ☐ My ability to cope with stress?
- ☐ My communication /use of numbers/language/IT skills?
- ☐ My employability/work and/or volunteering?
- ☐ My general health and wellbeing?
- ☐ My learning?
- ☐ My living circumstances (e.g. income/debt/housing/support)?
- ☐ My mental health?
- ☐ My personal skills?
- ☐ My relationships with other people family/friends/neighbours/work colleagues?
- ☐ Other

92. Has anything got worse? *

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Don't want to answer

93. What's got worse?

- ☐ My ability to cope with stress?

☐ My communication /use of numbers/language/IT skills?

☐ My employability/work and/or volunteering?

☐ My general health and wellbeing?

☐ My learning?

☐ My living circumstances (e.g. income/debt/housing/support)?

☐ My mental health?

☐ My personal skills?

☐ My relationships with other people family/friends/neighbours/work colleagues?

☐ Other

94. Has anything changed for the better? *

☐ Yes

☐ No

☐ Not sure

☐ Don't want to answer

95. Using the sliders show how much have the following changed for you for the better? 0 = no change 100 = most change Please note: If you are using a tablet or smartphone, turn it to landscape (longest edge along the top and bottom and shortest edge along the sides) so you can move the sliders.

Personal skills?

Looking after my general health and wellbeing?

My mental health

Taking responsibility?

Progress in learning?

Progress in my communication /skills in using numbers/language/IT?

Taking a positive approach to things?

My income/debt/housing circumstances/?

At home/with family/friends/neighbours?

Having people and things to do in my life?

Progress in my employability/at work /in volunteering?

Handling knockbacks?

Other

96. Where has the biggest single change been for you? Note: It's OK if it is something NOT listed above

What changed the most?

What has the benefit been for
you/your life?

What were the small steps to getting
this change?

Step

Step

Step

What helped you get this change?

How will you keep this change?

97. What's next for you (if anything)? (A-Z order) *

☐ Application for Access to Work

☐ Carer's assessment

☐ Change in welfare benefits (less benefit)

☐ Change in welfare benefit (more benefit)

☐ Getting more support with my mental health

☐ Getting signed off by GP/mental health services

☐ Going back to work after being off sick

☐ Going on holiday

☐ More learning

☐ Not sure yet

☐ Taking a break

☐ Volunteering

☐ Work

☐ Work trial

☐ Don't want to answer

☐ Other (please describe):

98. Which kind/s of learning? (A-Z order)

	I'm thinking about this	I've already enrolled for this
Any other kind of learning	☐	☐
Apprenticeship	☐	☐
Employability course	☐	☐
English course	☐	☐
ESOL course	☐	☐
Higher education	☐	☐
IT course	☐	☐
Maths course	☐	☐
More informal, non-accredited (community) learning	☐	☐
Self-organised/directed learning	☐	☐
Traineeship	☐	☐
Other formal learning (leading to a qualification)	☐	☐

If you've enrolled on a course what's the name of it?

Good luck in your next learning adventure

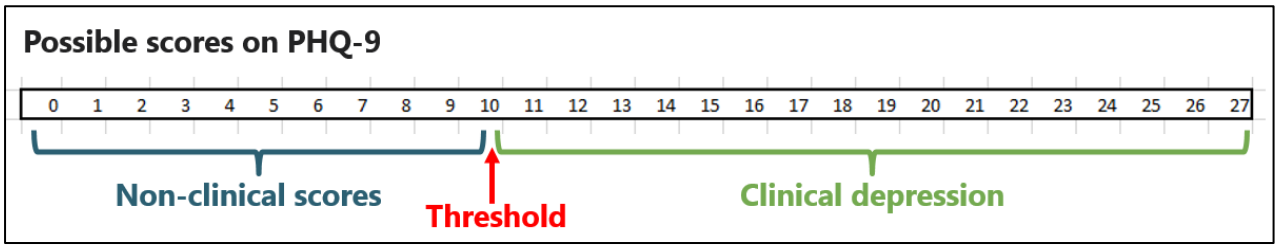
99. Additional Notes:

100. Optionally upload up to 10 documents, images, audio or video files, as examples, evidence, etc. that learner and you think valuable/important.

Annex 3: Information on interpretation of MHSA scores

The evaluation captured measures of mental health outcomes using the PHQ-9 and GAD-7 screening tools. These are self-assessment multiple-choice questionnaires which measure symptoms of depression and anxiety respectively. These measures have been extensively validated[2] and are widely used in the NHS[3] and internationally. Completion of the questionnaires produces a numerical score; the higher the score, the greater the severity of reported symptoms. In clinical settings, these tools are used to screen patients and determine the threshold at which it is appropriate to initiate treatment, known as "caseness". This is generally considered to be a score of 10 or more on PHQ-9, and/or a score of 8 or more on GAD-7,[4] although this may vary between different health services. The diagram below shows the caseness threshold for the PHQ-9 scale.

Figure 1: Caseness threshold for PHQ-9 scale



In order to measure changes in learners' mental health outcomes, the evaluation team calculated the change in mental health self-assessment scores between the first and the most recent valid PHQ-9 and GAD-7 scores recorded by an individual learner. This is referred to as "distance travelled".

Changes in scores over time need to be sufficiently large to be interpreted as improvement or deterioration. Research has been carried out into the minimum change in scores which can be interpreted as a genuine sign of recovery[5].

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[2] See e.g. Gilbody S, Richards D, Barkham M. Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ–9 and CORE–OM. *The British Journal of General Practice*. 2007;57(541):650-652.
Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical care*, *46*(3), 266-274.

[3] https://www.nice.org.uk/guidance/cg123/chapter/1-Guidance#step-1-identification-and-assessment

[4] Gyani, A., Shafran, R., Layard, R. and Clark, D.M., 2013. Enhancing recovery rates: lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*(9), pp.597-606

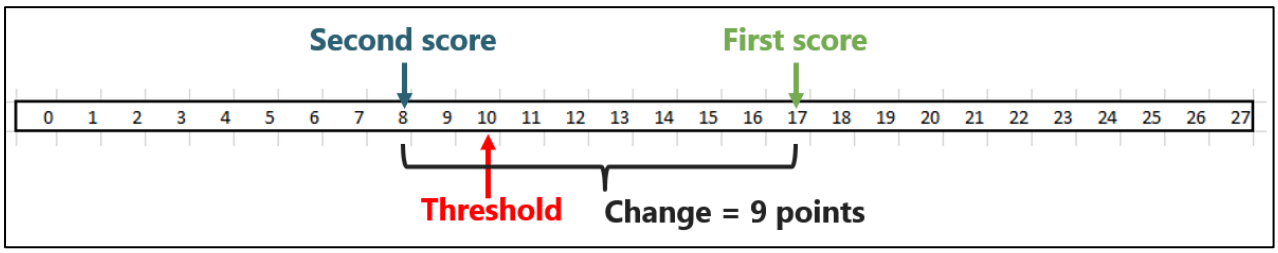
[5] See e.g. Kroenke K., Spitzer R.L., Williams J.B.W. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine. 2001;16(9):606–613.; Kroenke K., Spitzer R.L., Williams J., Monahan P.O., Löwe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Annals of Internal Medicine. 2007;146(5):317.; Jacobson N.S., Truax P. Clinical significance: a statistical approach to Defining meaningful change in psychotherapy research. Psychology. 1991;59(1):12–19.

Statistically reliable change at the individual-level is defined as a change on the PHQ-9 scale of six points or greater, and on the GAD-7 scale of 4 points or greater[6].

The evaluation also reported on a "reliable recovery" measure. Research into the Improving Access to Psychological Therapies (IAPT) programme[7] has used such a measure in order to define statistically reliable change which represents recovery[8]. This is defined as a decrease in scores which is large enough to be statistically reliable (as defined above), and where the later score is sufficiently low to be below the clinical cut-off point for treatment (the caseness thresholds described above).

In order to allow broad comparisons to be drawn with the IAPT programme, the evaluation also used this measure, although the evaluation reported results for recovery from depression separately to recovery from anxiety[9]. The diagram below shows an example of a pair of scores on PHQ-9 that would demonstrate reliable recovery.

Figure 2: Example of reliable recovery on PHQ-9



[6] Changes of less than either of these figures are considered to be within the measurement error of the tools. This does not relate to statistical significance and is not affected by the size of the sample.

[7] The NHS IAPT programme began in 2008 and provides evidence-based treatments for people with anxiety and depression, and over 900,000 people access the service each year. IAPT interventions such as cognitive-behavioural therapy are recommended by NICE as one of the initial treatments of choice for people with mild to moderate depression: https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#step-2-recognised-depression-persistent-subthreshold-depressive-symptoms-or-mild-to-moderate;

[8] Gyani, A., Shafran, R., Layard, R. and Clark, D.M., 2013. Enhancing recovery rates: lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*(9), pp.597-606

[9] The IAPT programme uses various scales to diagnose mental health needs and then collects follow-ups using whichever scale is appropriate based on the diagnosis, reporting recovery on these scales. In contrast, the CLMH research project collects data on depression, anxiety and wellbeing throughout, and we have therefore reported depression and anxiety separately.

Annex 4: Technical detail of analysis of data from survey

Processing and analysis of survey data

As outlined in the main report, the main source of data for this evaluation was learner-level data collected by individual learning providers from learners. Data was collected using a survey designed and implemented by DfE.

The evaluation team at Ipsos MORI received and processed the data for analysis. Some of the key steps in processing this data are outlined below.

- **Matching learner responses over time:** No unique numeric identifier existed for individual learners. Matching responses completed for different surveys by the same learner was therefore conducted using full name, date of birth and a project identifier number. Matching was much more successful than during phase one. However, it is possible some learners were unable to be matched (e.g. due to inputting errors when names and dates of birth were provided), and therefore their distance travelled data is not included in the analysis upon which this report is based. Where duplicate learner records were identified, the evaluation team made efforts to remove these errors as far as possible; however, it is possible that some may remain.
- **Matching in ILR data:** Where demographic data was not collected for learners (learners commencing phase two courses before the SmartSurvey system was made available to research sites), the evaluation team have attempted to complete this using ILR data. This was matched to the data using the same details outlined above. This reduced, but did not completely remove, missing data for demographic questions.
- **Calculating total scores for standardised scales:** PHQ-9, GAD-7 and the short-Warwick-Edinburgh Mental Wellbeing Scale are all validated scales. Standard rules apply to the processing of data collected using these scales, to arrive at the total score for an individual learner (for example disregarding data if an individual has missing data for too many items on a scale). These rules have been applied here.
- **Coding of free-text responses to progression questions:** Free-text responses to the progression questions were coded by Ipsos MORI's coding team, and the output reviewed and signed-off by the evaluation team.

Beyond the steps outline above, substantial data cleaning and editing has not been undertaken on this dataset.

Statistical analysis of mental health outcomes

This section outlines the statistical approach undertaken to analyse the most relevant predictors of reliable recovery from mild to moderate depression and anxiety (examined separately) for CLMH participants.

To assess the impact of the CLMH project, the analysis was originally designed to allow a comparison between two groups: those who attended the courses and a group of similar individuals who did not participate.

However, the process of obtaining the data for a suitable matching comparison group proved challenging (see section 1.4 of main report). In the absence of such a comparison group, the evaluation team instead applied a logistic regression approach to the survey data.

A logistic regression model is applied when the dependent variable is binary, i.e. has only two possible outcomes. In this context, we chose “reliable recovery”, measured both on the PHQ9 and the GAD7 scale, as defined in Annexe 4, as the dependent variable, and tested a number of potentially relevant predictors.

The final regression specification includes:

- delivery approach/group (A, B or C);
- gender;
- additional support received for mental health;
- highest level of qualification attained;
- current working or volunteering activities; and
- whether the respondents received income support at some point during their school life.

We selected these variables after having tried different combinations of predictors. Some of these predictors were discarded as their effects were not statistically significant.

Other variables explored but not included were:

- whether the respondent had caring responsibilities;
- whether their parents had attended university;
- the type of school they attended; and
- whether the respondent was eligible for free school meals.

This last variable in particular was very correlated with income support received at school, so in order to avoid multicollinearity[10] only the latter was chosen for the final model[11].

Table 1 shows the regression results for both Model 1 (PHQ9 scale) and Model 2 (GAD7). All the variables are categorical and each one has a "reference category", which is used as a comparison term for interpretation purposes. For example, respondents in group B display a lower chance of a reliable recovery compared to group A, while people in group C are slightly more likely to attain recovery than group A.

When a coefficient is less than zero, this shows that the chance of recovery is lower, conversely when the coefficient is above zero this means that the chances are higher. However, not all the variables can be considered statistically significant. In fact, only those with a star indicate a true effect on the dependent variable. The level of statistical significance considered is 95%. A legend can be found at the bottom of the table. The other variables can be interpreted as follows:

- women were 1.65 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 (0.55 times and 0.58 times respectively) to recover from depression or anxiety compared with learners in full-time employment;
- learners who had a university qualification were twice (2.02 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 (0.66 times as) likely to recover from depression than learners whose families had received income support; and
- learners who reported receiving additional support for their mental health from their GP were around half (0.53 times) as likely to recover from depression or anxiety than those who were not receiving this additional support. This was

[10] Multicollinearity is a frequent issue in regression analysis. It happens when the explanatory variables are too correlated with each other, leading to unreliable regression coefficients.
[11] Also testing one varibale at the time, income support was proving significant, while free meals did not show any significant effect.

also true of learners who reported taking tablets for their mental health (0.52 times as likely to recover) compared with those who were not.[12]

The number of significant predictors is significantly smaller for recovery from anxiety (group, gender, educational attainment and income support are no longer significant). All the other variables display effects in line with what was observed for recovery from depression: the likelihood of a reliable recovery from anxiety is, in this analysis, affected only by other support received for mental health and by employment status.

Table 1: Logistic regression results

	Model 1	**Model 2**
Dependent Variable	**phq9**	**gad7**
	reliable recovery	**reliable recovery**
main		
	Ref. category	Ref. category
group A	(.)	(.)
	0.652**	0.813
group B	(-2.79)	(-1.42)
	0.945	1.201
group C	(-0.41)	(1.38)
gender female	1.577**	1.083
	(3.04)	(0.57)
gender male	Ref. category	Ref. category
	(.)	(.)
local charity	0.704	1.009
	(-0.83)	(0.03)
alcohol or drugs service	1.064	0.304
	(0.06)	(-1.02)
friends and family	1.224	1.124

[12] 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.

	Model 1	Model 2
Dependent Variable	**phq9**	**gad7**
	(0.89)	(0.55)
NHS	0.700	0.834
	(-1.19)	(-0.64)
private therapist	0.915	0.386*
	(-0.20)	(-2.00)
GP	0.525***	0.669*
	(-3.43)	(-2.31)
social worker	0.736	0.532
	(-0.57)	(-1.24)
tablets	0.549***	0.496***
	(-3.61)	(-4.37)
other	1.259	1.093
	(0.88)	(0.36)
No support	Ref. category	Ref. category
	(.)	(.)
No qualifications	Ref. category	Ref. category
	(.)	(.)
Qualifications outside the UK	1.231	0.711
	(0.44)	(-0.86)
At or below level 1	1.468	1.165
	(1.68)	(0.72)
Level 2	1.543	1.115
	(1.93)	(0.52)
Levels 3, 4 or 5	1.343	1.286
	(1.39)	(1.27)
University	1.710*	1.378
	(2.33)	(1.51)
Studying or training	1.275	1.093

	Model 1	Model 2
Dependent Variable	**phq9**	**gad7**
	(0.53)	(0.21)
Full time employed	Ref. category	Ref. category
	(.)	(.)
Part time employed	0.776	0.842
	(-1.03)	(-0.73)
Sick or disabled	0.504**	0.537**
	(-2.99)	(-2.75)
Unemployed	0.504**	0.584*
	(-2.77)	(-2.24)
Caring or volunteering	0.770	0.666
	(-1.17)	(-1.87)
Retired	0.933	0.836
	(-0.24)	(-0.67)
Income support yes	Ref. category	Ref. category
	(.)	(.)
Income support no	0.697**	0.866
	(-2.61)	(-1.08)
N	1279	1349
Exponentiated coefficients; t statistics in parentheses		
="* p<0.05	** p<0.01	*** p<0.001"

Annex 5: Notes on interpreting data

Interpreting quantitative findings

Phase two of the CLMH research project set out to collect quantitative data for as many of the learners taking part as possible. This was intended to provide data that allows conclusions to be drawn about the experiences of, and outcomes for, learners participating in the project, and not to form a sample from which findings can be generalised for the population in general.

While caveats associated with sampling tolerances do not apply in full here, it is possible that there were a very small number of learners for whom the evaluation team do not have data, and some learners have been disregarded as their survey responses could not be matched with each other.

In the absence of suitable population profile of learners against which to assess the profile of individuals for whom we have data, the data have not been weighted.

Therefore, quantitative findings should be viewed as representing the experiences of the majority of learners participating in phase two of the CLMH project.

Interpreting qualitative findings

Qualitative research approaches are used to shed light on why people demonstrate outcomes, or have particular experiences, rather than how many people have those experiences. These approaches are used to explore the nuances and diversity of experiences, the factors which shape or underlie them, and the situations in which experiences can change. The results are intended to be illustrative and explanatory, rather than statistically reliable.

It is not always possible in qualitative research to provide a precise or useful indication of the prevalence of a certain outcome or experience, due to the relatively small number of participants generally involved (as compared with the much larger volume of learners for whom we have survey data).

Sometimes, ideas can be mentioned a number of times in a discussion, and yet hide the true drivers of experience; or a minority view can, in analysis, turn out to express and important emergent view or trend. The value of qualitative work is to identify the issues which bear future investigation. In reporting the qualitative findings we focus on exploring the breadth of experiences, and identifying the main themes, rather than the number of people who have expressed that thought.

It is sometimes useful to note which ideas were discussed most by participants, so we also favour phrases such as ‘a few’ or ‘some’ to reflect views which we mentioned infrequently and ‘many’ or ‘most’ when views are more frequently expressed. Any proportions used in qualitative reporting should always be considered indicative, rather than exact.

Verbatim comments have been included in this report to illustrate and highlight key points. Where verbatim quotes are used, they have been anonymised and attributed by the delivery group (A, B, C) only.

Annex 6: Data tables

Table 2: Participation

Groups	A	B	C	Total
Total number of individuals	3,286	2,936	3,829	**10,051**
IAG	3,168	2,795	3,699	**9,662**
Week 1	2,373	1,872	2,846	**7,091**
Week 3	2,027	1,506	2,369	**5,902**
Final week	1,882	1,513	2,480	**5,875**
Took part in a course (completed at least one of above three surveys)	2,513	2,056	3,134	**7,703**
Completion rate	75%	74%	79%	**76%**
Top ups	551	453	492	**1,496**
Top ups excluding learners from phase one	456	359	460	**1,275**
Top up participation rate	18%	17%	15%	**17%**

Source: Ipsos MORI analysis of DfE survey data

Table 3: Mental health needs

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Learners in target group at IAG	2885	2498	2363	**7746**	91%	89%	64%	**80%**	75%	74%	78%	**75%**
Learners in target group - week 1 starts	2294	1797	1796	**5887**	97%	96%	63%	**83%**	88%	87%	88%	**88%**
Learners with clinically significant symptoms (on either PHQ-9 or GAD-7) and in target group at IAG	2114	1554	1456	**5124**	67%	56%	39%	**53%**	74%	73%	77%	**75%**
Learners receiving other support at IAG	1728	1126	1283	**4137**	75%	64%	61%	**67%**	73%	71%	80%	**75%**

Source: Ipsos MORI analysis of DfE survey data

Table 4: Sex

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Men	843	503	877	**2223**	29%	20%	24%	**24%**	76%	74%	80%	**77%**
Women	2083	2074	2772	**6929**	71%	80%	76%	**76%**	75%	74%	79%	**77%**

Source: Ipsos MORI analysis of DfE survey data and ILR. Base: all learners with gender recorded.

Table 5: Ethnic Groups

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Asian	252	428	270	**950**	9%	17%	8%	**11%**	79%	77%	86%	**80%**
Black	117	115	66	**298**	4%	5%	2%	**3%**	70%	75%	77%	**73%**
Mixed and other	169	107	115	**391**	6%	4%	3%	**4%**	70%	73%	77%	**73%**
White	2255	1857	3116	**7228**	81%	74%	87%	**82%**	76%	74%	79%	**77%**

Source: Ipsos MORI analysis of DfE survey data and ILR. Base: all learners with ethnicity recorded.

Table 6: What is your age?

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Under 20	33	19	32	**84**	1%	1%	1%	**1%**	61%	58%	64%	**62%**
20-29	489	403	502	**1394**	15%	14%	13%	**14%**	72%	68%	78%	**73%**
30-39	617	614	638	**1869**	19%	21%	17%	**19%**	72%	73%	76%	**74%**
40-49	781	627	706	**2114**	24%	22%	19%	**21%**	77%	72%	82%	**77%**
50-59	756	622	902	**2280**	23%	21%	24%	**23%**	77%	74%	80%	**77%**
60-69	388	411	655	**1454**	12%	14%	17%	**15%**	79%	80%	80%	**79%**
70-79	128	162	283	**573**	4%	6%	7%	**6%**	79%	79%	80%	**80%**
80+	47	50	86	**183**	1%	2%	2%	**2%**	74%	85%	88%	**84%**

Source: Ipsos MORI analysis of DfE survey data and ILR. Base: all learners with age recorded.

Table 7: What is your ethnic identity?

Groups	A	B	C	Total
Arab/North African	28	19	23	**70**
Asian/Asian British: Bangladeshi	30	42	17	**89**
Asian/Asian British: Chinese	18	20	23	**61**
Asian/Asian British: Indian	64	230	107	**401**
Asian/Asian British: Pakistani	94	44	76	**214**
Any other Asian background (please describe)	46	92	47	**185**
Black/African/Caribbean/Black British: African	45	49	23	**117**
Black/African/Caribbean/Black British: Caribbean	57	49	38	**144**
Any other Black / African / Caribbean background	15	17	5	**37**
Mixed/multiple ethnic background: Any other mixed background (please describe)	22	13	20	**55**
Mixed/multiple ethnic background: Asian and White (European)	23	12	13	**48**
Mixed/multiple ethnic background: Black African and White (European)	12	*	5	**21**
Mixed/multiple ethnic background: Black Caribbean and White (European)	18	15	17	**50**
White Cornish	*	*	59	**64**
White English	1687	1298	2198	**5183**
White English / Welsh / Scottish / Northern Irish / British *(data from ILR so not possible to break down further)*	354	382	565	**1301**
White Gypsy Roma Irish Traveller	*	*	*	**7**
White Irish	45	20	62	**127**
White Northern Irish	5	5	5	**15**
White Scottish	21	12	36	**69**
White Welsh	12	10	30	**52**
Any other White background	125	127	158	**410**
Other	66	44	37	**147**
Don't want to answer	123	64	56	**243**
Not recorded	370	365	206	**941**

Source: Ipsos MORI analysis of DfE survey data and ILR. Base: all learners with ethnic group recorded. Numbers lower than 5 are replaced with * to avoid identifying learners.

Table 8: Do you work or volunteer (paid or unpaid)?

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Not explored	157	248	156	**561**								
Apprenticeship	*		*	**5**	0%	0%	0%	**0%**			75%	**75%**
Employment training scheme (govt. programme)	8	7	*	**18**	0%	0%	0%	**0%**	88%	100%	100%	**93%**
Full-time education	21	12	26	**59**	1%	1%	1%	**1%**	67%	78%	73%	**72%**
Full-time employed, 30 hours or more per week	179	168	342	**689**	8%	9%	12%	**10%**	73%	81%	84%	**80%**
Full-time self-employed	46	20	64	**130**	2%	1%	2%	**2%**	65%	88%	80%	**77%**
Long-term sick or disabled	321	211	341	**873**	15%	12%	12%	**13%**	65%	68%	81%	**72%**
Looking after home	178	173	160	**511**	8%	10%	6%	**8%**	75%	71%	83%	**77%**
Looking after someone	81	101	76	**258**	4%	6%	3%	**4%**	52%	72%	84%	**70%**
Part-time employed (less than 30 hours per week)	184	183	360	**727**	8%	10%	13%	**11%**	75%	75%	85%	**80%**
Part-time self-employed	71	22	79	**172**	3%	1%	3%	**3%**	73%	65%	77%	**73%**
Retired	183	214	435	**832**	8%	12%	16%	**12%**	74%	83%	82%	**81%**
Taking part in another part-time course	17	13	16	**46**	1%	1%	1%	**1%**	69%	91%	100%	**86%**
Temporarily sick or disabled	138	79	111	**328**	6%	4%	4%	**5%**	77%	75%	73%	**75%**
Unemployed and looking for work	483	296	313	**1092**	22%	17%	11%	**16%**	80%	67%	79%	**77%**
Volunteer	212	172	332	**716**	10%	10%	12%	**11%**	82%	76%	82%	**81%**
Other	81	96	77	**254**	4%	5%	3%	**4%**				
Don't want to answer	64	62	27	**153**								

Source: Ipsos MORI analysis of DfE survey data. Learners could only select one option. Numbers lower than 5 are replaced with * to avoid identifying learners.

Table 9: Do you look after anyone?

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Not explored	175	346	127	**648**								
No caring responsibilities	1448	1060	1919	**4427**	65%	62%	70%	**66%**	74%	74%	81%	**77%**
Primary carer for a child/children/sibling under 18	523	459	569	**1551**	24%	27%	21%	**23%**	75%	73%	83%	**77%**
Primary carer for a disabled child/children/sibling under 18	24	33	46	**103**	1%	2%	2%	**2%**	81%	75%	87%	**82%**
Primary carer for a disabled adult	92	69	120	**281**	4%	4%	4%	**4%**	76%	71%	84%	**79%**
Primary carer for an older person (65 or older)	49	41	63	**153**	2%	2%	2%	**2%**	83%	74%	88%	**83%**
Other	79	37	38	**154**								
Don't want to answer	40	37	51	**128**								

Source: Ipsos MORI analysis of DfE survey data

Table 10: Does your income include any welfare benefits?

					Percentages (yes and no)			
Group	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Yes	1,426	1,066	1,401	**3,893**	67%	60%	51%	**59%**
No	713	709	1,335	**2,757**	33%	40%	49%	**41%**
Don't want to answer	135	103	60	**298**				
Not explored	149	195	132	**476**				

Source: Ipsos MORI analysis of DfE survey data

Table 11: Which benefits?

Group	A	B	C	Total
Carer's Allowance	83	65	94	**242**
Child Tax Credit	235	181	230	**646**
DLA	43	39	78	**160**
ESA	523	392	511	**1,426**
Housing Benefit/ Council Tax Credit	346	313	448	**1,107**
Incapacity Benefit	22	29	38	**89**
Income Support	124	110	104	**338**
JSA	276	152	190	**618**
Pension Credit	54	62	85	**201**
PIP	247	159	284	**690**
Severe Disablement Allowance	32	23	39	**94**
Universal Credit	126	81	72	**279**
Working Tax Credit	74	42	96	**212**
Other benefit	44	26	39	**109**

Source: Ipsos MORI analysis of DfE survey data. Figures are for the 3,893 learners answering yes to question "Does your income include any welfare benefits?"

Table 12: What is your sexual orientation?

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Bisexual	64	35	40	**139**	3%	2%	2%	**2%**	68%	79%	81%	**74%**
Gay man	23	11	27	**61**	1%	1%	1%	**1%**	82%	100%	91%	**88%**
Gay woman	10	6	25	**41**	1%	0%	1%	**1%**	50%	100%	73%	**71%**
Heterosexual/straight	1856	1440	2492	**5788**	95%	96%	96%	**95%**	76%	73%	81%	**77%**
Undecided	11	13	14	**38**	1%	1%	1%	**1%**	70%	75%	80%	**75%**
Don't want to answer	423	571	327	**1321**								

Source: Ipsos MORI analysis of DfE survey data

Table 13: Which is the highest qualification you hold?

					Percentages				Completion Rate			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
No qualifications	344	368	368	**1080**	15%	19%	13%	**15%**	73%	71%	81%	**75%**
Qualifications obtained outside the UK	49	103	62	**214**	2%	5%	2%	**3%**	79%	72%	88%	**79%**
Qualifications below level 1	102	94	88	**284**	4%	5%	3%	**4%**	70%	67%	87%	**74%**
Level 1	345	241	324	**910**	15%	13%	12%	**13%**	74%	82%	90%	**81%**
Level 2	432	323	441	**1196**	19%	17%	16%	**17%**	77%	76%	79%	**77%**
Level 3	342	276	456	**1074**	15%	14%	16%	**15%**	72%	74%	78%	**75%**
Level 4	122	103	196	**421**	5%	5%	7%	**6%**	74%	73%	81%	**77%**
Level 5	141	127	250	**518**	6%	7%	9%	**7%**	76%	72%	83%	**79%**
Undergraduate degree	226	146	309	**681**	10%	8%	11%	**10%**	74%	79%	82%	**78%**
Master's degree	110	88	134	**332**	5%	5%	5%	**5%**	66%	74%	79%	**73%**
Doctorate degree	10		16	**26**	0%	0%	1%	**0%**	78%		93%	**87%**
Professional qualifications	55	39	161	**255**	2%	2%	6%	**4%**	85%	76%	83%	**82%**
Don't want to answer	151	174	128	**453**								

Source: Ipsos MORI analysis of DfE survey data

Table 14: Did any of your parent/s or guardian/s complete a university degree course or equivalent (e.g., BA, BSc or higher)?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
No	1037	714	1433	**3184**	76%	77%	78%	**77%**
Yes	335	214	399	**948**	24%	23%	22%	**23%**
I don't know	238	203	289	**730**				
Don't want to answer	112	97	112	**321**				

Source: Ipsos MORI analysis of DfE survey data

Table 15: Which type of school did you mainly go to between the ages of 11 and 16?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Attended school outside the UK	197	200	183	**580**	13%	19%	9%	**12%**
Didn't go to school	17	9	11	**37**	1%	1%	1%	**1%**
Home school	15	7	10	**32**	1%	1%	0%	**1%**
Independent/fee-paying school	105	50	148	**303**	7%	5%	7%	**6%**
Non-selective state-run or state-funded school	991	647	1344	**2982**	63%	61%	65%	**63%**
Selective state-run or state-funded school	247	148	373	**768**	16%	14%	18%	**16%**
I don't know	36	61	57	**154**				

Source: Ipsos MORI analysis of DfE survey data

Table 16: At any point during your school life, did your household receive income support?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
No	904	701	1414	**3019**	73%	80%	82%	**79%**
Yes	326	175	312	**813**	27%	20%	18%	**21%**
I don't know	361	254	402	**1017**				
Don't want to answer	131	98	105	**334**				

Source: Ipsos MORI analysis of DfE survey data

Table 17: At any point during your school life, did you receive free school meals?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
No	889	704	1376	**2969**	63%	72%	73%	**69%**
Yes	526	278	501	**1305**	37%	28%	27%	**31%**
I don't know	179	150	255	**584**				
Don't want to answer	128	96	101	**325**				

Source: Ipsos MORI analysis of DfE survey data

Table 18: Do you consider yourself to be d/Deaf or disabled or neurodiverse or to have physical or mental health problems? *

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Yes	1687	1508	1587	**4782**	60%	61%	49%	**56%**
No	1112	960	1629	**3701**	40%	39%	51%	**44%**
Total yes and no	2799	2468	3216	**8483**				
Prefer not to say	100	40	57	**198**				
Not explored	112	122	127	**362**				

Source: Ipsos MORI analysis of DfE survey data

Table 19: Disability - detailed

	A	B	C	Total
Blind/partially sighted	55	38	61	**154**
d/Deaf	27	36	49	**112**
Deafened	16	22	44	**82**
Facial disfigurement	*	*	8	**14**
Hard of hearing	70	63	109	**242**
Head injury	16	11	44	**71**
Learning difficulties/disability	147	149	148	**444**
Long term illness or medical condition	360	326	335	**1021**
Manual dexterity difficulties	44	39	51	**134**
Mental health problems	1185	1079	818	**3082**
Mobility difficulties	248	228	323	**799**
Neurodiverse	153	154	165	**472**
Progressive medical condition	57	50	65	**172**
Speech difficulty	28	18	30	**76**
Don't want to answer	20	20	21	**61**

Source: Ipsos MORI analysis of DfE survey data. Numbers lower than 5 are replaced with * to avoid identifying learners.

Table 20: Which beliefs (if any) or none do you hold?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Agnostic	77	48	132	**257**	3%	2%	4%	**3%**
Atheist	81	58	135	**274**	3%	3%	4%	**3%**
Humanist	41	33	70	**144**	2%	1%	2%	**2%**
No beliefs	610	362	716	**1688**	23%	16%	24%	**21%**
Non-religious philosophy	179	84	232	**495**	7%	4%	8%	**6%**
Religious beliefs	917	746	1154	**2817**	35%	33%	38%	**36%**
Don't want to answer	559	770	540	**1869**	21%	34%	18%	**24%**

Source: Ipsos MORI analysis of DfE survey data

Table 21: What is your religion?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Buddhist	21	9	24	**54**	1%	0%	1%	**1%**
Jewish	8	35	13	**56**	0%	2%	0%	**1%**
Christian	668	442	909	**2019**	25%	20%	30%	**26%**
Jain	*	5	*	**8**	0%	0%	0%	**0%**
Sikh	16	47	21	**84**	1%	2%	1%	**1%**
Muslim	121	104	89	**314**	5%	5%	3%	**4%**
Pagan	9	5	10	**24**	0%	0%	0%	**0%**
Quaker	*	*	*	**10**	0%	0%	0%	**0%**
Rastafarian	*	*	*	**3**	0%	0%	0%	**0%**
Hindu	10	78	45	**133**	0%	3%	1%	**2%**
Any other religion	73	30	59	**162**	3%	1%	2%	**2%**
All asked	2632	2261	3010	**7903**				

Source: Ipsos MORI analysis of DfE survey data

Table 22: Is anyone helping you look after your mental health and wellbeing?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Yes	1829	1166	1363	**4358**	76%	65%	63%	**69%**
No	563	626	803	**1992**	24%	35%	37%	**31%**
Don't want to answer	6	5	6	**17**				

Source: Ipsos MORI analysis of DfE survey data

Table 23: Types of support received for mental health

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Alcohol or drugs service	82	42	47	**171**	3%	2%	2%	**2%**
Family member or friend or neighbour or work colleague	539	396	531	**1466**	21%	18%	22%	**21%**
GP	954	615	736	**2305**	37%	28%	31%	**32%**
A local voluntary mental health charity or organisation	352	201	265	**818**	14%	9%	11%	**11%**
NHS mental health services	500	389	397	**1286**	20%	18%	17%	**18%**
Private therapist	80	47	71	**198**	3%	2%	3%	**3%**
Social worker	90	73	51	**214**	4%	3%	2%	**3%**
Tablets	696	457	555	**1708**	27%	21%	23%	**24%**
Other	157	81	112	**350**	6%	4%	5%	**5%**

Source: Ipsos MORI analysis of DfE survey data

Table 24: Changes in symptoms of depression (PHQ-9)

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Improvement	682	482	479	**1643**	33%	28%	27%	**29%**
No change	1320	1163	1218	**3701**	63%	68%	69%	**66%**
Deterioration	84	65	77	**226**	4%	4%	4%	**4%**
Total	2086	1710	1774	**5570**				

Source: Ipsos MORI analysis of DfE survey data

Table 25: Changes in symptoms of anxiety (GAD-7)

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Improvement	873	653	663	**2189**	42%	38%	37%	**39%**
No change	1051	926	941	**2918**	50%	54%	53%	**52%**
Deterioration	161	131	168	**460**	8%	8%	9%	**8%**
Total	2085	1710	1772	**5567**				

Source: Ipsos MORI analysis of DfE survey data

Table 26: Proportion of learners demonstrating reliable recovery

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
PHQ-9 reliable recovery	540	337	334	**1211**	43%	40%	39%	**41%**
Base: PHQ-9	1246	846	846	**2938**				
GAD-7 reliable recovery	608	416	436	**1460**	47%	45%	48%	**47%**
Base: GAD-7	1298	929	905	**3132**				
Base: both PHQ-9 and GAD-7	918	640	603	**2161**				
Reliable recovery on either	511	333	332	**1176**	56%	52%	55%	**54%**
Reliable recovery on both	312	190	179	**681**	34%	30%	30%	**32%**

Source: Ipsos MORI analysis of DfE survey data. Base: learners in target group with clinically significant symptoms at the start of participation, and distance-travelled measure.

Table 27: Proportion of learners demonstrating recovery

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Below caseness on both PHQ-9 and GAD-7 at end of course	791	537	568	**1896**	52%	51%	53%	**52%**
Base	1518	1046	1069	**3633**				

Source: Ipsos MORI analysis of DfE survey data. Base: learners in target group who were above caseness on at least one scale at IAG, and have distance travelled measure

Table 28: Wellbeing: learners in target group

Group	A	B	C	Total
Average wellbeing at IAG	19.42	20.31	20.26	**19.96**
Average wellbeing at end of course	22.11	22.56	22.47	**22.36**
Change	2.69	2.25	2.21	**2.4**
Base	2085	1709	1774	**5568**

Source: Ipsos MORI analysis of DfE survey data. Base: learners in target group with distance travelled measure.

Table 29: Wellbeing: learners in group C with and without symptoms of mental health problems

	Average wellbeing in survey 1 (IAG)	Average wellbeing in survey 4 (end of course)	Change in wellbeing	Average wellbeing at top-up
Group C learners without symptoms of mental health problems (n = 897)	25.50	27.36	+1.86	26.96 (n = 119)
Group C learners in target group (n = 1513)	20.22	22.48	+2.26	22.01 (n = 278)

Source: Ipsos MORI analysis of DfE survey data. Base: learners with distance travelled measure.

Table 30: What's changed for the better?

Group	A	A%	B	B%	C	C%	Total	Total %
Other improvement	290	**18%**	129	**11%**	209	**11%**	628	**13%**
My income/debt/housing circumstances	528	**33%**	295	**24%**	492	**25%**	1315	**27%**
Progress in employability/at work/in volunteering	790	**50%**	430	**35%**	878	**44%**	2098	**44%**
At home or with family/friends/neighbours	918	**58%**	530	**43%**	991	**50%**	2439	**51%**
Handling knockbacks	1035	**65%**	577	**47%**	1153	**58%**	2765	**58%**
Progress in skills (communication/numbers/language/IT)	1013	**64%**	638	**52%**	1160	**58%**	2811	**59%**
Taking responsibility	1154	**73%**	689	**56%**	1237	**62%**	3080	**64%**
Having people and things to do in my life	1113	**70%**	706	**58%**	1413	**71%**	3232	**67%**
Personal skills	1214	**76%**	827	**68%**	1446	**73%**	3487	**73%**
My mental health	1309	**82%**	865	**71%**	1470	**74%**	3644	**76%**
Looking after my general health and wellbeing	1330	**84%**	877	**72%**	1501	**76%**	3708	**77%**
Taking a positive approach to things	1324	**83%**	894	**73%**	1593	**80%**	3811	**79%**
Progress in learning	1271	**80%**	913	**75%**	1677	**84%**	3861	**80%**

Source: Ipsos MORI analysis of DfE survey data

Table 31: Where has the biggest single change been for you?

Group	A	A%	B	B%	C	C%	Total	Total %
New skills, progress in learning	61	**5%**	56	**7%**	225	**12%**	342	**9%**
Confidence, self-esteem	151	**11%**	151	**19%**	391	**22%**	693	**17%**
Making friends, meeting new people	81	**6%**	22	**3%**	81	**4%**	184	**5%**
Positivity, optimistic thinking	112	**8%**	49	**6%**	120	**7%**	281	**7%**
More relaxed, less stressed and anxious	137	**10%**	31	**4%**	57	**3%**	225	**6%**

Source: Ipsos MORI coding of free text survey responses. Top five responses shown.

Table 32: What's next for you?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Application for Access to Work	112	41	66	**219**	6%	3%	3%	**4%**
Carer's assessment	35	13	36	**84**	2%	1%	1%	**1%**
Change in welfare benefit (more benefit)	36	12	26	**74**	2%	1%	1%	**1%**
Change in welfare benefits (less benefit)	34	21	25	**80**	2%	1%	1%	**1%**
Getting more support with my mental health	306	150	197	**653**	15%	10%	8%	**11%**
Getting signed off by GP/mental health services	44	20	34	**98**	2%	1%	1%	**2%**
Going back to work after being off sick	78	33	71	**182**	4%	2%	3%	**3%**
Going on holiday	338	195	453	**986**	17%	12%	19%	**17%**
More learning	944	811	1368	**3123**	48%	52%	57%	**52%**
Taking a break	145	95	151	**391**	7%	6%	6%	**7%**
Volunteering in other learning	249	114	223	**586**	13%	7%	9%	**10%**
Volunteering somewhere else	351	149	315	**815**	18%	10%	13%	**14%**
Volunteering to this mental health research project	146	48	79	**273**	7%	3%	3%	**5%**
Work	325	134	306	**765**	16%	9%	13%	**13%**
Work trial	72	32	44	**148**	4%	2%	2%	**2%**
Not sure yet	411	372	484	**1267**	21%	24%	20%	**21%**
Don't want to answer	94	104	100	**298**	5%	7%	4%	**5%**

Source: Ipsos MORI analysis of DfE survey data

Table 33: What kinds of learning?

					Percentages			
Groups	**A**	**B**	**C**	**Total**	**A**	**B**	**C**	**Total**
Apprenticeship	56	21	38	**115**	**3%**	1%	2%	**2%**
Employability course	146	53	62	**261**	**7%**	3%	3%	**4%**
English course	108	70	67	**245**	**5%**	4%	3%	**4%**
ESOL course	68	13	42	**123**	**3%**	1%	2%	**2%**
Higher education	113	74	84	**271**	**6%**	5%	3%	**5%**
IT course	168	102	115	**385**	**8%**	7%	5%	**6%**
Maths course	92	84	69	**245**	**5%**	5%	3%	**4%**
More non-formal, non-accredited (community) learning	411	379	841	**1631**	**21%**	24%	35%	**27%**
Self-organised/directed learning	188	146	177	**511**	**10%**	9%	7%	**9%**
Traineeship	47	18	28	**93**	**2%**	1%	1%	**2%**
Other formal learning (leading to a qualification)	198	154	174	**526**	**10%**	10%	7%	**9%**
Any other kind of learning	443	350	650	**1443**	**22%**	22%	27%	**24%**

Source: Ipsos MORI analysis of DfE survey data

Annex 7: Information on sampling and recruitment for qualitative follow-up

In January 2018, DfE approved additional qualitative data collection for the evaluation. This consisted of follow-up interviews with CLMH learners to ask about their experience of taking the course, any difference they felt the course had made for them, and their perceived reasons for this.

The evaluation team chose six research sites in which to carry out these interviews. These research sites were chosen to represent a spread across the three groups (two sites from each group). Within each group, one site was chosen where there had been a comparatively high proportion of learners reporting improvement in their symptoms of mental health problems, and one site was chosen where there had been a comparatively low proportion of learners reporting improvement (based on initial descriptive analysis of the data collected). The need to achieve a good spread in terms of geographical location was also considered in the research site sample.

To minimise burden on learners, participation in interviews was opt-in. With the assistance of staff from learning providers, the evaluation team sent letters to learners from the six research sites and invited them to contact the evaluation team by phone, email or text if they wished to take part. Reminders were not sent to learners not responding to the initial letter.

The evaluation team only contacted those learners who had taken part in courses in the summer term 2017. This meant that the interviews would take place around eight or nine months after the end of their course. The evaluation team did not write to learners who had taken courses prior to this, as it was felt that too much time would have elapsed since the course and learners would find it difficult to remember the course in detail.

The evaluation team also did not contact any participants who:

- had not been in the target group for the project (did not have symptoms of mild to moderate mental health problems at IAG); or
- appeared to have taken a course in phase one as well as in phase two; or
- did not have photo evidence that they had completed a consent form to take part in the research.

Around 70 individuals contacted the evaluation team to arrange an interview, and interviews took place with 58 of these individuals. The mode (and location, if relevant) of interviews was chosen by the learner, based on what they would feel most comfortable with. Slightly fewer than half the interviews (24) took place face-to-

face, typically in learners' homes or in locations such as cafes. The remainder were carried out over the phone.

Interviews were around 45 minutes long, and began with completion of the mental health self-assessments (PHQ-9 and GAD-7), followed by a semi-structured discussion using the discussion guide presented in Annex 9. The evaluation team gave learners £30 to thank them for their time and contribution.

Due to the opt-in nature of the interviews, the evaluation team was unable to control the demographic or other characteristics of the sample once the initial invitation letter had been sent. Of the 58 learners interviewed:

- 13 had not finished their course;
- 20 were from group A, 12 were from group B, and 26 were from group C;
- 36 were from higher-performing sites, and 22 were from lower-performing sites;
- 50 were female and 8 were male;
- 49 were white, 3 were Asian, one was Black, and two were from other ethnic groups (the remaining 3 learners did not have their ethnic identity recorded);
- Around half of the sample were aged between 50 and 69. The age profile of learners taking part is shown in the table below (one learner did not have their age recorded).

Table 34: Age profile of learners taking part

Age band	Number of interviews
Under 20	0
20-29	3
30-39	13
40-49	7
50-59	13
60-69	14
70-79	4
80+	3

Annex 8: Participant information sheet for qualitative follow-up

Understanding your views about the Community Learning Mental Wellbeing Research Project

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What is this research study about?

The research study will help government and adult learning providers find out more about how to support people to improve their mental wellbeing through community learning.

We want to ask you about your personal experience of the community learning course you took last year, and your mental wellbeing.

We are speaking with research volunteers about their experience of taking part in the community learning courses. Afterwards, we will write a report based on what people tell us. We will give the report to the Department for Education and they will publish it later in 2018.

Who is doing the research?

We are researchers from Ipsos MORI, which is an independent research company. This means we are not connected to the government or to your course provider.

What is involved in taking part?

We will ask you some questions about yourself, your experience of the course and any changes you noticed in your life during or after the course. This will be a conversation, so you can answer in your own words.

We will also ask you to fill out the same tick box mood scale questionnaires as on your course. In total, the conversation and filling in the mood scales will not last more than 45 minutes.

Before the conversation, we will look at the surveys you completed whilst you were on your course, so that we have some basic information about you and your course.

If you choose to take part, we will give you £30 as a thank you for your time. If you meet us we will give you £30 at the end of the interview. If you speak with us on the phone, we will send the £30 to you after the interview as a cheque, by first class post, or if you prefer as a bank transfer.

Do I have to take part?

No. It is your choice. You do not have to say 'yes'. If you decide to take part, you can choose not to answer a question, or you can stop the interview completely.

You can change your mind about us speaking with you up until 19th March 2018, as that is the latest date we will be interviewing people. If you change your mind after we speak with you, please call the number below to let us know if you no longer wish to take part. We will delete your information and we will not contact you again.

Your choice to take part will not affect any benefits or services you currently receive or expect to in the future.

Who will know I have taken part?

Your participation is confidential. We will not share your name or personal details with anyone outside of our small research team. Nothing you say will go back to the Department of Education or

your course provider in a way that could make it possible for anyone to identify you personally.

There is one exception to this: if you say something that means you or someone else is at risk of serious harm, we may have to tell someone, such as a mental health professional. If this happens, we will talk to you about it first.

What happens to my information?

We will write a report at the end of the research about what people tell us. We might use short quotes, but we will not give any names or say who has said what.

With your permission, we will tape record the conversation. This will help us write the report. We will store the recording and notes securely, in accordance with the Data Protection Act. Only our researchers will see what you tell us. We will destroy the recording and notes after the end of the project in June 2018.

Can I get help to take part?

If you would like a friend, family member or carer to attend the interview with you, then please let the researcher know before your interview. They would not have to contribute to the interview in any way.

Please let the researcher know if you need any accessibility assistance, for example if you are hard of hearing.

Where can I get more information?

If you would like to find out more information about the research, or if you have any questions, please contact:

You can find out more information about Ipsos MORI on our website http://www.ipsos-mori.com/

You can find out more information about Department for Education on their website https://www.gov.uk/government/organisations/department-for-education

Annex 9: Discussion guide for qualitative follow-up

CLMH Phase 2 Evaluation

Learner interview discussion guide

Research objective

The evaluation of Phase 2 aims to generate evidence on the effectiveness of learning to help people develop strategies for managing mild to moderate mental health problems. These interviews will gather in-depth data on a range of issues, including: learner/research volunteer experience before, during and after course delivery; sustainability of outcomes; use of other services; and next steps for learners.

This guide is designed for use with **research volunteers (adult learners age 19+)**; it aims to understand their experiences/views in relation to the courses, considering what works (or did not), why and in what circumstances. **Understanding why and how the courses may or may not have made a difference for learners is a key focus for the interviews, as is understanding how courses could be improved, and how they could reach more learners from a wider range of backgrounds and circumstances.**

Please note the following points when using this guide:

- ***Before interview*****:** *Please be aware of any accessibility requirements for the participant. This information should be collected at the time of setting up the interview and will also be available in SmartSurvey records.*

- The guide outlines key areas of topic coverage and includes prompts and probes for interviewers/discussion. The discussion will be learner led and the guide will be used responsively by the interview i.e. the exact questions on the guide may not be asked as presented here.

- Interviewers/discussion leaders will form questions in suitable, accessible language (depending on the needs of the respondent) and will use follow-up questions as appropriate.

- Probe lists are for use as prompts and not intended to be covered in full or any particular order.

- The order of the discussion will also be adapted according to each respondent. The guide is intended to be an aide memoire to researchers.

- Although this guide uses the term 'learner' here, please refer to the interviewee as a 'research volunteer' as this was the language used during the course / survey data collection.

Introduction / Collect Informed Consent	
5 min	• Thank the participant for taking the time to meet / speak with us today. • Share the information sheet with the participant and walk through each of the key points, as below. • **Introduce self, Ipsos MORI**: Ipsos MORI is a research organisation that works independently from the government. We gather a range of opinions from a range of people: all opinions are worth listening to. We want the people we speak with to feel comfortable: it is your choice to speak to us and you can change your mind. • **Explain the research aims**: We are undertaking research to better understand their experience of taking the community learning course and if it made a difference for them (or not), including whether it affected their mental health and wellbeing. We will also ask them to complete the same mood scale questionnaires they did during the course. • **Length**: In total, we expect the conversation to last around 45 minutes and it will not take longer. Please ask the respondent if that is okay or how long they will be able to give for the interview. Please also reassure the participant that the interview can be stopped at any time. • **Explain confidentiality clearly**: Everything you say will be anonymous, meaning we won't use your name or any other details that would allow someone to identify you [explain exceptions as per disclosure policy]. The only people who will know are a few members of the research team; nothing you say will go back to DfE or your learning provider in a way that could identify you personally. • **Get permission to digitally record**: we will use this to make sure our notes are correct and we may use quotes so we capture your views in your own words. If we use quotes, we will not use your name or any other identifying details. If they do not wish to be recorded, please take detailed notes including any key quotes, where possible. • Ask if they are still happy to take part and ensure the **consent form** is completed. • ***IF TELEPHONE:*** Confirm details for sending 'thank you' payment, including time frame when this will be received. Ensure they have researcher contact details so they can call/email if they do not receive payment. • Any questions before we begin?
MHSAs (PHQ-9 and GAD-7)	
10 minutes	***Section aim:*** *To collect data at a follow-up point to explore whether positive changes have sustained following course completion.* **INTERVIEWERS:** Please hand participants the MHSAs to complete on paper and check they are OK to read and complete them. If participants need assistance completing the scales please provide this (e.g. reading the questions out to them).

	Please ensure you are familiar with the disclosure policy for this project before undertaking discussions with learners, and follow the guidance in this policy if needed following completion of the MHSAs. Samaritans Freephone number: **116 123**
Background and joining CLMH course	
5 minutes	***Section aim:*** *In this section we aim to gain brief details on the learners' backgrounds and gain understanding of their route into learning, including how they first heard about the CLMH course and reasons for joining the course.* **Could you tell me a bit about yourself, and what you do day-to-day?** Probe: nothing, work/volunteering, training, family (any caring responsibilities), hobbies; consider any mental health or wellbeing issues they face, how they have been feeling and how this influences day-to-day life. **What are you most pleased or proud of about signing up for the research project?** Probe: what was it about the research that interested them or made them want to get involved. **What made you decide to sign up for this community learning course?** Probe: what was it about the course that was appealing (community learning focus / mental health focus); did you choose this course over any other options/services; was the decision related to improving your mental health and wellbeing. What were your expectations for the course. - Did/do you use other services in combination with community learning (to manage mild MH symptoms)? What do you like or dislike about this mix? **Do you recall the first meeting where you completed the survey to see if you were eligible to take part in the research project and course? This may have been face-to-face or over the telephone.** (*Note to interviewer: This was also called an 'initial advice and guidance session' or IAG which the interviewee may understand better).* Probe: What do you remember about this meeting? How did you find this meeting (e.g. confusing, helpful, too much/little information)?
Experience during the course	
10-12 minutes	***Section aim:*** *In this section we aim to explore the facilitators and barriers to getting what they wanted from the course and benefits they experienced during the course e.g. peer support, managing MH symptoms, taking their mind off symptoms, something to do with my hands* **Overall, how did you find your experience on the course and research project?** Probe: positives/negatives; likes/dislikes; get a sense whether they were able to attend some/most/all sessions. - Were you aware if your learning provider worked with other organisations to help deliver the course? If so, what did you think about this?

	Was the course and research project like what you expected it to be? Probe: In what ways was it similar or different than expectations? Was this a good or bad thing? **<u>Progression (during):</u> During those 5-6 weeks while you were taking part in the course, what changes (if any) did you notice in:** - Your learning and your personal skills? - Your relationships with other people (friends, family, neighbours, colleagues)? - Your living circumstances? - Your volunteering/caring/work? - Your health and the way you looked after your own health and wellbeing? - How you were feeling (taking a positive approach, confidence, feeling hopeful about the future, ability to cope with stress/knockbacks) **For the positive changes that you mention (if any), what helped you achieve these?** Probe: - The things they learned about on the course - Experience of learning, learning offer - Delivery style, non-formal nature - Peer support/meeting new people/social capital (bonds, links) - Location, accessibility, timing; employer flexibility, access to childcare - Free - Involvement in research project (incl. surveys, guidance session, top-up/refreshers) - Social prescription/mandated/feared sanctions - Previous experience with learning provider/another course - Just wanted something/anything to help - Other aspect of the course ***[If not already mentioned]* Could you tell me about the other research volunteers on your course?** Probe: - How much interaction did you have with other research volunteers? Was this the right amount of interaction, too much, too little? - Did you talk about mental health and wellbeing with the other research volunteers? If so, were their experiences similar or different to yours? How did you feel about this? **If you didn't get what you wanted out of the experience, were there any aspects about the course or other circumstances that could have helped you achieve what you wanted?** Probe: - Changes to the course content - Changes to learning offer (or 'learning not for me') - Changes to delivery style, didn't like non-formal nature - Not able to do the course they wanted/courses being cancelled - Issues with involvement in research project (incl. surveys, guidance session, top-up/refreshers) - Didn't meet expectations/their need - Changes in situation e.g. employment, health

	- Location, accessibility, timing; employer flexibility, access to childcare - The course moved too slowly/quickly - Peer support/social capital (bonds, links) - Social prescription/mandated/feared sanctions - Other circumstances **Did you speak to anyone at your learning provider about the course not meeting your needs?** Did they offer any support at that point? **If you didn't get what you wanted from the experience, did you find something else that worked/helped? If so, what?** **The delivery of the course might change over time and we are interested in your views on how this might look:** - Thinking of the three parts of the course - the guidance session, the course itself and the top-up sessions - if the course removed <u>one</u> element of the offer what would you recommend removing and why? If <u>two</u> elements of the offer were removed, what would you recommend and why? - If you could add <u>one</u> thing to improve the offer, what would that be? - If the course had to introduce a fee, how much do you think it would be reasonable to charge? Why do you say that? - Some people think that it would be better for course like the one you did to be run by the National Health Service, while other people think it's better that they are run by adult learning providers, like your course was. What do you think? What makes you say that?
Experience since their course finished (the keeping part of the wheel)	
10-12 minutes	***<u>Section aim:</u>*** *In this section we aim to explore whether any positive changes observed during the course period have been sustained following completion of the course; and to seek evidence of progression- including to or within, or maintaining employment, training or further learning.* *Note to interviewer: For these questions, please refer back to the learner's responses to the previous section and phrase the question appropriately.* **<u>Progression (after):</u> Since the course ended, have any of the changes you mentioned (*in previous section*) stayed the same? Has anything else in your life changed (i.e. get better or worse)? Probe:** - Your learning and your personal skills? - Your relationships with other people (friends, family, neighbours, colleagues)? - Your (living) circumstances? - Your volunteering/caring/work? - Your health and the way you look after your health and wellbeing? - How you are feeling (taking a positive approach, confidence, feeling hopeful about the future, ability to cope with stress/knockbacks)

	To what extent do you think these changes were because of your experience on the course or with the research project (incl. surveys, guidance session, top-up/refreshers)? Where things have changed for the better, what helped most? Probe: peer support, learning experience, skills learned, etc. *<u>If mentioned managing mental health and wellbeing</u>:* - What about the course, the overall learning experience or research project helped you to better manage your mental health and wellbeing (cope with anxiety/stress; handle knockbacks)? - Any examples of strategies? **Do you think any of the changes you've experienced were because of other support services you were accessing? Where things have changed for the better, what was it about these other services helped?** Probe: has use of other services changed since the taking the course (e.g. fewer/more GP visits/less/more/different medication) and why (e.g. NHS waiting times)? **Is anyone helping you look after your mental health and wellbeing?** Probe: Is this new (or all along) and/or ongoing? **What would help you <u>keep up</u> these positive changes?** Probe: focusing on me more; self-management techniques; trying new things; more learning; family, friends, other support networks; socialising; other services **If you had to pick one area, what would you say changed the most for you?** Probe if not discussed already: How has this benefitted you/your life? What helped you get this change? What steps did you take to get this change? How will you keep this change? **Are you interested in taking part in further learning courses? Have you looked into this or done this since finishing this one?** Probe: what type of course; similarly focussed or different from previous course and why (focussed on community learning or mental health more overtly; different kinds of provision; higher level course) **What's next for you (if anything)? Probe:** - More learning - Looking for work/going back to work/progression at work/volunteering - Getting more/less support with mental health
Wrap up	
2 – 3 minutes	***<u>Section aim:</u>*** *To thank the learner for their help during the CLMH course (filling in surveys), understand their thoughts on being part of a research study, and for the interview today.* Would you recommend another course like this to a friend or colleague? Why or why not? We also wanted to understand what it meant to you to be involved in the course knowing that your course was part of a research study.

	- Did being part of the research study encourage you to take part? - And do you think it helped encourage you to complete your course? - Did you have any concerns about being part of a research study? Is there anything else you wanted to add that would be useful for us to know? Do you have any questions for me? **End interview with a light/fun question**, for example, based on a hobby or event they mentioned earlier: e.g. Is there anything coming up that you're looking forward to? **Express appreciation** from Ipsos MORI/DfE/learning providers/tutors for their help throughout the research project and emphasise the value of their contribution. Thank for their time today and close.

Annex 10: Literature review

Summary

This literature review was undertaken by the Centre for Mental Health, who were part of the evaluation team for the Community Learning Mental Health research project (CLMH) funded by the Department for Education. This pilot, which ran from April 2015 to August 2017, 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. The purpose of this literature review is to explore what is currently known about the relationship between adult community education and mental health, and therefore set the findings of the CLMH research project in context of the wider body of evidence.

This review was initially conducted in March 2017, and has been updated in March 2018 to include additional evidence made available since the first review.

This review outlines the evidence-base on adult community learning and its impact on mental health and wellbeing. It will present findings from existing research and examine the quality of the evidence. The review will explore what makes adult community learning accessible and, where possible, investigate how it compares to other interventions.

There is robust evidence that:

- That learning is positive for wellbeing, based on the conclusions reached by a separate review conducted by the What Works Centre for Wellbeing (2017).

There is low-moderate quality evidence that:

- Participating in informal and non-formal adult education leads to improved mental health or wellbeing. Harding and colleagues (2014) found that non-formal learning and wellbeing-focused learning improved wellbeing amongst adults and older adults. Three cohort studies found that participation in adult education was associated with improved wellbeing (Jenkins and Mostafa, 2012; Duckworth and Cara, 2012; Dolan, Fujiwara, and Metcalfe, 2012). These studies found that participation in non-formal learning led to better outcomes than formal learning.
- Participation in mental health focused learning improves the mental health and wellbeing of individuals with identified anxiety and depression. Outcomes

provided evidence of reductions in anxiety and depression levels to below clinical thresholds.

There is low quality evidence that:

- Participating in adult learning with a broad focus on wellbeing improves participant mental health and wellbeing.

There is exploratory evidence that:

- Explains how adult community learning improves wellbeing, namely through increased confidence, self-esteem and self-efficacy.
- Participating in adult community learning also positively affects wellbeing through creating structure in the day and providing a supportive space.
- Participation is accessible for individuals because the environment is not stigmatising. The experience does not position the learners as “problems” but enables them to reshape their identities. Additionally, the relationship built with the teachers and between peers is key to the accessibility of learning.

Implications for policy

There is promising evidence that participating in non-formal adult education contributes to improved mental health and wellbeing. Specifically, non-formal forms of education (for example, participating in music groups, gym or sports clubs) appear to contribute to improved wellbeing amongst adults and older adults. The evidence in this review indicates that adult community learning initiatives are accessible to groups who have often been marginalised from mainstream educational and mental health services (e.g. BME communities, individuals with disabilities). There is also promising evidence that mental health and wellbeing focused learning (for example, learning that looks at coping strategies, experiences of mental health) contributes to improved mental health amongst individuals who have an identified mental health need. The evidence suggests that there is value in implementing community-based learning initiatives to support the improvement of mental health and wellbeing across different communities. From this evidence, it is not possible to say whether community learning initiatives are more beneficial than traditional mental health services. It was apparent from qualitative research that there were factors which led to community based learning being perceived as more accessible to some participants.

Implications for practice

The evidence suggests that participating in learning has positive outcomes for mental health and wellbeing, both for people who have an identified mental health need and amongst adults more generally. Several studies have discussed what makes adult community learning accessible and helpful, providing important lessons for organisations or individuals delivering similar projects.

- Good relationships between teachers and other learners are very important in making the learning accessible.
- Teachers need to be supportive, positive and non-judgemental to help people to feel comfortable in the courses. This can help learners to reshape their identities, for example, changing from seeing themselves as “ill” and “bad” at learning to seeing themselves as having strengths and something to offer.
- The learning environment can be an important supportive space, which provides the opportunity for peers to help one another and build support networks.
- The research discussed how it is important to think about how mental health topics are taught and to do so in ways that empower the individual. For women learning about domestic violence and mental health, it was helpful and empowering to consider the gender and political context which the women lived in.
- It is key to consider how learners can access the courses and seek to provide transport if necessary.
- It is also important to consider whether including examination as part of courses is helpful as this was raised as something that could cause anxiety and stress. The evidence indicates that informal types of learning, which do not involve examination, had a more positive impact on wellbeing.

Introduction

This literature review was undertaken by the Centre for Mental Health, who were part of the evaluation team for the Community Learning Mental Health research project (CLMH) funded by the Department for Education. This pilot, which ran from April 2015 to August 2017, 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. Individuals with mild to moderate anxiety and/or depression took part in short, part-time courses, delivered in community settings. Courses topics were either related to mental health or to general interests such as crafts or exercise. Measures relating to wellbeing and self-assessed symptoms of mental health problems are completed by learners at intervals before, during and after their participation to understand how these may change over time. The purpose of this literature review is to set these findings in context by presenting what is currently known about the relationship between adult community education and mental health.

There is an increasing volume of evidence that engagement in adult community education is positively associated with improvements in mental health and wellbeing. Previously, research has demonstrated a relationship between adult learning and general health (e.g. Feinstein, 2004). However, it is important to note at the outset that the evidence-base included in this review has been of varying quality. Several qualitative studies have concluded that adult education impacts wellbeing, but although these studies provide insight, they have not employed the methodology required to infer that improvements in wellbeing were caused by participation in education. There has been some quantitative investigation, but this has largely been through cohort studies and pre-and post-designs. The evaluation of the CLMH research project includes a quasi-experimental aspect, but it was not possible to incorporate a counterfactual analysis, and to date there has been little other quasi-experimental research in this area. This lack of rigorous investigation means that the findings in this review need to be treated with some caution.

Adult community learning has been described as falling into three categories:

- **Formal education:** acquiring values, skills and knowledge via structured, graded, specialised courses, usually qualification-bearing.
- **Informal education:** acquiring values, skills and knowledge via channels such as the internet, TV, personal experience and/or the support of friends, colleagues, or family members at home, work or play
- **Non-formal education:** acquiring values, skills, knowledge via structured, organised educational activity, usually not qualification-bearing.

Field (2009) discusses how adult education has the potential to impact wellbeing directly, through increasing confidence, sense of self and self-efficacy, and building support networks. It also has the potential to impact wellbeing indirectly, through leading to further learning opportunities, employability and earnings (Field, 2009). Lewis (2014) discussed how adult community learning builds individuals' capabilities to be identified (by themselves and others) as someone who has "knowledge". Learning environments have been discussed as providing space for individuals to participate in their community, belong and develop a support group (Westwood, 2003, Mental Health Foundation, 2011). Prins and colleagues (2009) discussed how adult community learning provided spaces for individuals to self-develop, which was described as reshaping their identities as "educated" individuals and developing communicative and social skills. Research has pointed to the supportive space that adult community education provides (Lewis, 2014), fostering support networks.

There is also some research exploring whether learning that focuses on wellbeing and mental health has a positive impact on mental health. In mental health services, psychoeducation (i.e. learning about mental health symptoms, coping strategies and triggers) has been shown to improve mental health and self-care. For example, a 2011 systematic review and meta-analysis of psychoeducation-based interventions demonstrated that learning about symptoms and developing coping strategies had a positive effect on the mental health of people with a diagnosis of Schizophrenia (Xia et al, 2011). Outside of traditional mental health services, Recovery Colleges have highlighted the impact of working within an educational paradigm, where people are positioned as experts in their lives and care is developed collaboratively (Centre for Mental Health, 2012). There is a growing but small body of research, which looks at the impact of community learning programmes that specifically focus on mental health and wellbeing. For example, research by the Mental Health Foundation (2011) found that mental health-focused education promoted self-care and improved the mental health of people with anxiety and depression.

Methodology

This review specifically focuses on adult community education and included studies that met the following inclusion criteria.

Types of studies

Studies were included that explored the relationship between adult community education and mental health or wellbeing outcomes. This meant that qualitative, quantitative and mixed-methods study designs were included in this review. Both impact and process evaluations were included. Longitudinal cohort designs, which explored the relationship between naturally occurring participation in adult education

and mental health/wellbeing were also included. Grey literature[13] and Government documents were included.

Types of participants

The review included any study where individuals were adults (18+) who were participating in adult community education. This included both general population learners and those who had an identified mental health need.

Types of outcome measures

Studies needed to have reported outcomes relating to mental health or wellbeing in order to be included. This included both standardised measures of mental health or wellbeing, e.g. the Warwick-Edinburgh Mental Wellbeing Scale, as well as qualitative explorations of wellbeing from the participant's perspectives. Cost-effectiveness studies needed to report the outputs from cost, cost-utility, cost-effectiveness, cost-benefit or cost-consequence analyses to be included.

Types of interventions

The focus of the review was adult community learning, defined as encompassing a broad range of non-formal learning (e.g. music, art, gym classes, gardening) undertaken to pursue an interest, acquire a new skill or become healthier.

Studies were also included if the focus of the learning was related to mental health or wellbeing. To be included, the learning needed to take place in an educational or community setting rather than a health/mental health one, and be delivered by educators/teachers/tutors rather than mental health professionals or individuals with mental health backgrounds. Psychoeducation interventions in mental health settings were therefore excluded.

Comparison group

Comparisons groups of any type were included, regardless of whether they were randomised. The review searched for studies which compared adult community learning with traditional mental health services.

Assessment of quality

The quality of each study is assessed using guidelines from Cochrane reviews (2011) and the Critical Appraisals Skills Programme (CASP) (2013), which outline criteria for assessing the robustness of a study. The quality of each study is

[13] Grey literature is defined as research produced by government, academics, business and industry which is either unpublished or published outside of traditional commercial or academic channels.

described narratively throughout the findings and presented in table two. The following areas were considered:

- Study design
- Comparison group
- Participant recruitment
- Sample size and characteristics
- Detail of interventions
- Outcomes measures
- Method of data analysis
- Peer reviewed

Each study that included quantitative elements was given a NESTA score, which is a five-point scale that demarks the quality and robustness of a study (see figure one) (2013). The scores for each individual study are presented in table two.

Figure 1: Nesta Standards of Evidence

Level	Our expectation	How the evidence can be generated
At Level 1	You can give an account of impact. By this we mean providing a logical reason, or set of reasons, for why your intervention could have an impact and why that would be an improvement on the current situation.	You should be able to do this yourself, and draw upon existing data and research from other sources.
At Level 2	You are gathering data that shows some change amongst those receiving or using your intervention.	At this stage, data can begin to show effect but it will not evidence direct causality. You could consider such methods as: pre and post-survey evaluation; cohort/panel study, regular interval surveying.
At Level 3	You can demonstrate that your intervention is causing the impact, by showing less impact amongst those who don't receive the product/service.	We will consider robust methods using a control group (or another well justified method) that begin to isolate the impact of the product/service. Random selection of participants strengthens your evidence at this Level, you need to have a sufficiently large sample at hand (scale is important in this case).
At Level 4	You are able to explain why and how your intervention is having the impact you have observed and evidenced so far. An independent evaluation validates the impact. In addition, the intervention can deliver impact at a reasonable cost, suggesting that it could be replicated and purchased in multiple locations.	At this stage, we are looking for a robust independent evaluation that investigates and validates the nature of the impact. This might include endorsement via commercial standards, industry Kitemarks etc. You will need documented standardisation of delivery and processes. You will need data on costs of production and acceptable price points for your (potential) customers.
At Level 5	You can show that your intervention could be operated up by someone else, somewhere else and scaled up, whilst continuing to have positive and direct impact on the outcome, and whilst remaining a financially viable proposition.	We expect to see use of methods like multiple replication evaluations; future scenario analysis; fidelity evaluation.

Source: Nesta (2013)

Search methods for identification of reviews

Databases such as PsychINFO, PubMed, Web of Science and Eric were searched as well as a number of Adult Learning Journals using the following search terms and variations:

"Adult Education" or "Adult Learning" or "Community Learning" or "Community Education".

Grey literature and government documents were searched. Adult learning and mental health organisations were contacted in Australia and New Zealand because

preliminary research highlighted their research interest in this area. Reference lists of all relevant reviews were also searched.

Results of the searches

Twenty studies were included in this review. Table 1 presents the characteristics of the included studies. Studies were included regardless of their quality but the review critiques their robustness. Table 2 presents the quality assessment of each study and NESTA score.

In addition to those studies identified through the search detailed above, additional studies were suggested for inclusion in the review by other experts in the field following a panel discussion held in December 2017.

Table 1 Characteristics of included studies

Study	Date	Location	Participants	Intervention	Method	Outcomes	Conclusion
What Works Centre for Wellbeing	2017	Global	NA	Adult learning	Review of existing evidence	Various mental health and wellbeing measures	There is strong evidence that adult learning programmes have a positive impact on mental health.
Prins, E., Willson Toso, B. & Schaft, K.	2009	Pennsylvania, USA	30 professionals, 41 female literacy participants from White, Black, Latina, Asian and Eastern European ethnic background. Age 18-44. Majority came from low socio-economic backgrounds.	Community-based literacy programs.	Qualitative analysis using semi-structured interviews and focus groups.	Psychological and emotional wellbeing was explored through interviews.	Adult education and family literacy programs play a key role in providing women living in poverty with social support and improving their psychological wellbeing.
Perkins, R. & Williamon, A.	2014	UK	98 (F=74, M = 22) music learning and comparison group participants. Mean age: 67.87.	Community-based music lessons	Quantitative questionnaires measures completed with intervention and comparison group pre- and post-course.	Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) and Health-Promoting Lifestyle Profile II (HPLPII).	Promising evidence that community music lessons improve wellbeing and warrants further investigation
Jenkins, A. & Mostafa, T.	2012	UK	Adults aged 50-69 who responded to the English Longitudinal Study of Ageing (ELSA).	Formal (e.g. accredited) and non-formal learning (e.g. music/gym classes) learning.	Cross-sectional analysis of the ELSA cohort study.	CASP-19 (measure of wellbeing for older adults).	Non-formal learning was associated with better wellbeing.

Study	Date	Location	Participants	Intervention	Method	Outcomes	Conclusion
Duckworth, K. & Cara, O.	2012	UK	8,316 adults aged 50 who responded to the National Child Development Study	Accredited learning, work related training and leisure and activity learning.	Cross-sectional analysis of the NCDS cohort study.	Life satisfaction, Malaise Inventory, Self-efficacy.	Leisure and activity based learning was associated with better wellbeing.
Dolan, P., Fujiwara, D. & Metcalfe, R.	2012	UK	Adults who responded to the British Household Panel Survey (BHPS).	Formal and non-formal learning.	Cross-sectional analysis of the BHPS cohort study.	Mental health was measured using the General Health Questionnaire, self-worth, satisfaction with social life, satisfaction with health, satisfaction with use of leisure time, self-reported drugs and alcohol misuse.	Adult learning has an impact on health and wellbeing.
Chevalier, A., & Feinstein, L.	2006	UK	6,666 adults aged 42 who responded to the National Child Development Study (NCDS) which collected data on a cohort of individuals born in 1958 at ages 7,11,16,23,33 and 42.	Formal and non-formal learning.	Cost-effectiveness analysis of NCDS cohort study.	Mental health was measured using the Malaise Inventory	Education reduces the risk of poor mental health.
Narushima, M	2008	Canada	15 students engaged in learning through Toronto District Student Board and 4 teachers.	Non-formal learning	Qualitative analysis of interviews, participant observation and	Mental health and wellbeing were explored through interviews.	The results indicated that participation improved wellbeing through increased

Study	Date	Location	Participants	Intervention	Method	Outcomes	Conclusion
					relevant study materials.		social support, purpose and achievement.
Westwood, J.	2003	UK	12 service users of mental health services enrolled in college.	College	Qualitative analysis using semi-structured interviews.	Mental health and wellbeing were explored through interviews.	The results indicated that attending college improved confidence, self-esteem, socialisation and motivation.
Lewis, L.	2012-14	UK	36 (21 women and 15 men) adult learners aged 18-71.	Adult community learning (ACL) with focuses on mental health, psychology, spirituality, politics and social science elements.	Qualitative analysis using focus groups.	Mental health and wellbeing were explored through focus groups.	ACL improved mental wellbeing through providing recognition, generating resources and enhancing agency freedom.
Lewis, L.	2016	UK	Adults engaged in creative learning groups in the West Midlands and London.	Community learning with a wellbeing focus.	Qualitative analysis using semi-structured interviews	Mental health and wellbeing were explored through interviews.	Engagement in community learning improved wellbeing through sharing experiences and support.
NIACE	2014	UK	Adults who are engaged in the 97 Community Learning Innovation Fund projects. Participants included individuals with poor	Community learning with a wellbeing focus.	Mixed methods with different evaluations being employed across site. One-third of sites used a pre and post design.	Improved mental health and wellbeing were reported but it is not clear how they were assessed.	41 projects identified key outcomes in relation to mental health, primarily improved mental wellbeing, reduced

Study	Date	Location	Participants	Intervention	Method	Outcomes	Conclusion
			physical and mental health, poor housing, an offending history, substance misuse and poverty.				anxiety, reduced stress and greater involvement in positive activities.
Lipman et al	2005 and 2010	Canada	116 mothers were randomly assigned to community based learning and control. Eight mothers took part in interviews.	Community learning with a wellbeing focus.	Mixed methods. Quantitative pre- and post- and qualitative interviews.	Centre for Epidemiologic Studies Depression Scale, Rosenberg Self-Esteem Scale, Social Provisions Scale and the Parenting Scale.	The study found evidence of short-term improvement in mood and self-esteem in the intervention group,but not at longer term follow up.
Callanan, M., Ming Mik, T. & Edovald, T. (2015)	2015	UK	194 adults (68% male) who were job seeker claimants who engaged in the Group Work Sessions.	Group work sessions which focused on wellbeing and employability.	Mixed methods. Quantitative pre and post and qualitative interviews.	World Health Organisation Wellbeing Index (WHO-5), General Self-Efficacy Scale (GSE), Job Satisfaction Survey (JSS) and Patient Health Questionnaire (PHQ-9).	There is promising evidence that work sessions which focus on psychological wellbeing improve mental health and wellbeing needs.
Harding, C., Clay, D., Mortimer, E., Ghezelayagh, S., & Bloch, A.	2014	UK	Adults engaged in community learning programmes. 23% had a mental or physical health problem.	Community learning with a wellbeing focus.	Quantitative analysis post and follow up participation in the course using the Office for National Statistics (ONS)	Mental wellbeing was measured through the ONS measure of subjective wellbeing.	Higher scores of wellbeing than compared with the general population.

Study	Date	Location	Participants	Intervention	Method	Outcomes	Conclusion
					measure of subjective wellbeing. ONS scores compared with the general population.		
Adult Learning Australia	2016	Australia	Adults with mental health problems engaged in community learning initiatives.	Community learning with a focus on mental health care.	12 case studies of initiatives across Australia.	Mental wellbeing were explored through case studies.	Engagement in adult learning programmes improved mental wellbeing.
Mental Health Foundation	2011	UK	Adults with mental health problems engaged in Learn 2b.	Learn2b - a community based learning project which focuses on mental health and wellbeing care.	Quantitative analysis pre and post intervention.	Mental health was measured using the Hospital Anxiety and Depression Scale and the Recovery Evaluation Form.	Engagement in Learn2be was associated with improved mental health after the intervention.
Weiss	2006	US	Adults with depression and lower literacy engaged in a community health centre.	Literacy lessons in a community health centre.	Quantitative pre and post measures	Mental health was measured using PHQ-9 and REALM	Engagement in the literacy classes led to larger levels of reduced depression, compared with control.

Table 2 Assessment of quality of included studies

Name	Study design	Comparison group	Sample recruitment	Sample size	Intervention stated	Outcomes measured	Data analysis	Peer reviewed	NESTA score
Prins et al (2009)	Qualitative	NO	Projects were sampled through stratified random sampling. Learners who accessed the projects were then asked to participate.	51 learners; 30 personnel.	YES – comprehensive detail given.	Qualitatively explored wellbeing	Content analysis	YES	N/A
Perkins and Williamon (2014)	Mixed methods	YES – matched music learners from high socioeconomic group with non-music learners from high socioeconomic group.	Convenience sampling, recruited through charities, advertisements and word of mouth.	Study one: 98 learners. Study two: 21 learners.	YES – comprehensive detail given.	Standardised measures of wellbeing and health promoting behaviours.	Study one: ANOVA. Study two: Interpretative Phenomenological Analysis.	YES	3
Jenkins and Mostafa (2012)	Quantitative.	NO	Analysed data from the English Longitudinal Study of Ageing.	Approx. 3000 respondents.	YES – briefly defined.	Standardised measures of mental health and wellbeing.	Cross-sectional regression analysis.	NO	2

Name	Study design	Comparison group	Sample recruitment	Sample size	Intervention stated	Outcomes measured	Data analysis	Peer reviewed	NESTA score
Duckworth and Cara (2012)	Quantitative	NO	Analysed data from the 1958 National Child Development study	8,316 respondents.	YES – briefly defined.	Standardised measures of mental health and wellbeing.	Cross-sectional regression analysis.	NO	2
Dolan, P., Fujiwara, D. & Metcalfe, R.	Quantitative	NO	Data analysed from the British Household Panel Survey (BHPS)	35,133 and 36,300 observations for mental health and wellbeing measures	YES – briefly defined.	Standardised measures of mental health and wellbeing.	Cross-sectional regression analysis.	NO	2
Chevalier, A., & Feinstein, L.	Quantitative	NO	Data analysed from the 1958 National Child Development Survey	11,419	YES – briefly defined.	Standardised measures of mental health and wellbeing	Regression and cost-effectiveness analysis.	NO	2
Narushima, M. (2008)	Qualitative	NO	Convenience sampling through the Toronto District Student Board.	15 students and 4 teachers	YES	Explored perceived impact on wellbeing.	Multiple case study analysis	YES	NA
Westwood, J. (2003)	Qualitative	NO	Convenience sampling through the Education Link Teams.	12	YES – comprehensive detail given.	Explored perceived impact on wellbeing.	Framework analysis.	YES	NA

Name	Study design	Comparison group	Sample recruitment	Sample size	Intervention stated	Outcomes measured	Data analysis	Peer reviewed	NESTA score
Lewis, L. (2012/14)	Qualitative	NO	Convenience sampling	36	YES – comprehensive detail given.	Explored perceived impact on wellbeing.	Thematic analysis	YES	NA
Lewis, L. (2016)	Qualitative	NO	Convenience sampling		YES – comprehensive detail given,	Explored perceived impact on wellbeing.	Thematic analysis	YES	NA
NIACE (2014)	Mixed methods	NO	Sampling through the 97 projects.	97 projects with 10,829 participants.	YES – briefly defined.	Does not state how mental health was measured.	Does not state how the data was analysed.	NO	1
Callanan, M., Ming Mik, T. & Edovald, T. (2015)	Mixed methods	NO	Convenience sampling	194	YES – comprehensive detail given.	Standardised measures of mental health.	Pre and post statistical analysis	NO	2
Lipman (2005;2010)	Mixed methods	YES	Random assignment	116 single mothers	Yes – comprehensive detail given.	Standardised measures of mental health.	Pre- and post-statistical analysis	YES	3
Harding et al (2014)	Mixed methods	YES – compares wellbeing scores with general population.	Recruited through learners participating in community	1,951	YES – briefly defined.	Standardised measures of mental health and wellbeing.	Scores assessed against general population.	NO	3

Name	Study design	Comparison group	Sample recruitment	Sample size	Intervention stated	Outcomes measured	Data analysis	Peer reviewed	NESTA score
			learning initiative.						
Mental Health Foundation (2011)	Mixed methods	NO	Sampled through Learn 2b attendees.	256	YES – comprehensive detail.	Standardised measures of mental health and wellbeing.	Pre- and post-test analysis.	NO	2
Weiss et al (2006)	Quantitative	YES	Random assignment	70	YES – comprehensive detail.	Standardised measures of mental health.	Pre- and post-test analysis.	YES	3
Adult Learning Australia (2016)	Qualitative	NO	Sampled through projects.	12 project case studies. Not clear how many learners.	YES – comprehensive detail.	Explored perceived impact on wellbeing.	Case study.	NO	NA

The studies included were grouped into three categories, below, and this review is structured around these:

1. Studies which examine the impact of general informal learning on the wellbeing of adults in general (i.e. they may or may not have mental health problems).

2. Studies which examine the impact of learning which has a broad wellbeing focus on the mental health and wellbeing of adults, some of whom have identified mental health needs.

3. Studies which examine the impact of adult learning focused on mental health for people with identified mental health needs.

Six studies were included that related to the impact of general non-formal learning on wellbeing. Eight studies were included that related to the impact of either mental health or wellbeing-focused learning. There were six mixed-methods, five quantitative and six qualitative designs. Four studies employed some form of comparison group, and two of these used a form of random assignment. No studies were found that compared the impact of adult community learning with traditional mental health services.

Findings

Adult and community learning and wellbeing outcomes for all adults

A What Works Centre for Wellbeing[14] review in 2017 collated 25 studies examining the impact of learning on wellbeing. Their review focussed on examining the evidence in four areas of learning: literacy and numeracy; learning for older adults; learning that aims to empower marginalised people, and community-based learning. We summarise the key findings from these four areas below:

- **Literacy and numeracy.** Four studies reported that literacy and numeracy has positive effect on learner wellbeing. Formal outcomes such as recognition of skills and competencies as well as increased confidence, self-esteem and self-fulfilment have all been observed as outcomes.
- **Learning for older adults.** Eight studies included in the review found that adult learning leads to significant positive outcomes for older adults. In particular, the

[14] The What Works Centre for Wellbeing is part of the What Works Centre network, and is an independent institution focussing on bringing together evidence about the relative impacts of wellbeing policies and projects. Further information can be found online: https://whatworkswellbeing.org/

social experience associated with learning was found to be important for older adults.

- **Learning with a focus of including marginalised groups**. This type of learning has also led to improved wellbeing outcomes. Ten studies were included and demonstrated the impact of learning on increasing formal outcomes, such as educational qualifications as well as developing self-esteem, self-worth, confidence and reducing depression and stress.
- **Learning that engages individuals in their community.** The review considered the impact on both individual learners and the community. The seven studies included in this strand found that learning has a positive impact on wellbeing through facilitating social contact, as well as increasing a sense of purpose and confidence.

The **What Works Centre for Wellbeing (2017)** assessed the quality of the studies in their review. The evidence came from a mixture of qualitative and quantitative studies of varying quality. They found that there was **robust evidence** that learning is positive for wellbeing and **promising to strong evidence** that outcomes are affected by what and how individuals learn, with a preference for unstructured learning amongst older men. There was **initial evidence** that the learning environment is key to learning.

Further qualitative studies have explored the experiences of adult learners, including why they found the courses accessible and the perceived impact on their wellbeing. **Prins and colleagues (2009)** found that adult community education provided a supportive space for women living in poverty and social isolation. They concluded that this space positively impacted their psychological wellbeing. Their study took place at two sites in Pennsylvania, USA and the researchers held interviews and focus groups with 51 female learners who were from marginalised groups living in poverty. The women lived in three different types of areas: urban, rural and micropolitan (i.e. small town) and most lived well below the US poverty level. The women identified as White, Black, Latino and Asian ethnic groups and their age ranged between 18 and 44 years old. In total 51 learners (50 female and one male) took part in the study. In addition, 30 staff (e.g. educators, directors, case managers) were interviewed. This study found that for women with limited social support and social ties, the family literacy programs provided social spaces which enabled the women to leave their houses, enjoy social contact, develop support systems and supportive relationships. The programmes also enabled women to self-develop. Their involvement in the adult learning programmes was seen as a time and space for themselves to recreate their identities as educated and to develop their social and communicative skills. This was perceived to impact their psychological wellbeing through giving new meaning, purpose and sense of self. The

learners discussed what helped them to access and persist with the course and identified the importance of the supportive relationships both with peers and with the teachers as key.

The study used a qualitative design to explore learners' experiences of the education programmes. This was useful in gaining insight into how this intervention might work, for example, in providing an informal supportive space. The participants of this study were women in poverty experiencing social isolation, the majority from BME communities. Females living in poverty from BME communities have often faced exclusion from educational and mental health services and so this study provides an important insight into what made this programme accessible to a marginalised group. The exploratory design aided understanding of what made this programme accessible and provides important lessons for other interventions seeking to meet the needs of this group. The study provides adequate detail on the sample recruitment methodology and characteristics to gauge applicability to other groups. Through recruiting individuals engaged in adult community learning programmes, it gained a large sample for qualitative research (51 learners). There is a risk that because the learners were individuals already engaged in learning, they are individuals who are more likely to benefit from learning. The study also details the method used for analysis, and its analysis includes contradictory cases (i.e. both negative and positive findings). However, given the qualitative design, the study does not set out to investigate improvements in mental health and wellbeing in a measurable way (i.e. with standardised questionnaires). Although the design allows for exploratory investigation of participants' experiences, it cannot make causal inferences about the impact of adult community learning on mental health and wellbeing.

Perkins and Williamon (2014) found that participating in music lessons led to improved wellbeing outcomes, particularly regarding some health promoting behaviours amongst older adults. Their study comprised 98 learners (74 female, 22 male, 2 no response) with a mean age of 67.87. The intervention group were categorised into higher socioeconomic and lower socioeconomic status (SES). The study employed a comparison group, which included only participants identified as higher SES. Intervention participants were enrolled in a 10-week music programme, which was either one-to-one or in small groups and involved learner-led tuition. The comparison group were recruited through the University of the Third Age and were enrolled in a 10-week shared learning programme, which focused on a non-music topic (e.g. history). The researchers measured wellbeing and health promoting behaviours using the standardised tools Short Warwick Edinburgh Mental Wellbeing Scale and Health Promoting Lifestyle Profile II. Perkins and Williamon (2014) found that all three groups

(music learners from higher SES, music learners from lower SES and comparison group from higher SES) showed an improvement in wellbeing and health promoting behaviours between pre-and post-participation. The rate of improvement was steepest for music learners from higher SES across certain health promoting behaviours (physical activity and spiritual growth). The higher SES appeared to benefit significantly more than lower SES music learners and comparison group members with equivalent SES. Through further qualitative analysis Perkins and Williamon (2014) sought to understand the experiences of learners and gain insight into how learning music in later life might affect wellbeing. Participants discussed how they perceived the music lessons helped them to engage in increased social interaction, and increased their sense of fulfilment, achievement and self-satisfaction.

Few studies in this area have employed a control group and in doing so Perkins and Williamon (2014) aimed to investigate whether music learning was more beneficial than another type of learning. However, the study would have required a bigger sample to be confident about the findings (there were only approximately 30 participants in each group). Additionally, the comparison group was only matched with the higher SES participants. Future studies would need a bigger sample which, ideally, would randomise participants to groups, or match them across key characteristics. A strength of this study was that the programme was designed as an evaluation and participants were therefore recruited to the research before the programme began. This meant that data was collected pre-intervention so that the study could track changes over time. The design could be improved with longer term follow up. The study used objective measures to assess mental health and wellbeing, making it possible to understand the level of change. Like many of these studies, individuals self-selected to participate in a learning programme. Although participants did not have previous music learning experience (and therefore may not know or have experienced any benefits previously), the fact that they choose to participate suggests that they saw potential benefit in taking part.

Four studies used longitudinal cohort datasets to examine the relationship between adult education and mental health and wellbeing. **Jenkins and Mostafa (2012)** found that participating in non-formal learning (e.g. music lessons, gym classes, gardening) was positively associated with improved wellbeing. Their study used the English Longitudinal Study of Ageing (ELSA), analysing survey data for approximately 3000 adults collected at four points in time over six years. At wave four, 23% of females and 28% of males had participated in non-formal learning, while 19% of females and 18% of males had taken part in formal learning. The researchers conducted cross-sectional regression analysis, which investigated whether there was a relationship between

learning and wellbeing. This study examined the relationship between adult community learning and wellbeing in the most recent wave of data collection, and whether there had been a change in wellbeing scores between wave three and four (a two-year gap). The researchers looked at both formal learning, defined as obtaining qualifications or participating in training courses, and non-formal learning, such as participating in music, arts, sports and exercise. They found that 44% of adults aged 50-69 were participating in learning, 31% of those in non-formal learning and 19% in formal learning. Participation in learning was greater for those with higher levels of educational attainment and for those who were retired or employed. Participation in formal learning decreased between the ages of 50-69 and 65-69 whereas non-formal learning remained almost the same.

Wellbeing was measured using the CASP-19, a subjective measure for wellbeing developed for older adults, covering control, autonomy, self-realisation and pleasure. Jenkins and Mostafa (2012) found that participating in non-formal learning positively predicted good wellbeing. Those who undertook non-formal learning had statistically significant higher levels of wellbeing, compared with similar individuals not taking part in non-formal learning[15]. Although both music/arts and gym/exercise based learning was associated with higher CASP-19 scores, the relationship was only significant for gym/exercise based learning. Participation in formal learning was not associated with higher wellbeing. Jenkins and Mostafa (2012) also assessed change in wellbeing scores between wave three and four (approximately two-year gap) and found that non-formal learning positively predicted wellbeing.

A strength of the analysis conducted by Jenkins and Mostafa (2012) analysis is that they controlled for other factors (i.e. marital status, work status, wealth quintile) that are known to affect wellbeing. This increases confidence that high wellbeing scores may be due to participation in adult education. They also used a standardised measure to assess wellbeing, which has been used across the time-points. However, it remains difficult to attribute change to adult education because there are likely to be other life events over this period which may have affected wellbeing. Regression indicates whether one variable (adult education) predicts another (wellbeing) but does not infer causation. Additionally, there is no control over and limited information available on the type of learning programme that respondents engaged in and the study is not reporting on a particular intervention. Respondents may have taken part in a variety of learning

[15] Individuals were compared in terms of age, gender, highest qualification, work status, marital status, self-reported health and wealth quintile.

programmes, with different lengths, structure and focus. With little information on the type of learning undertaken, the potential to assess what worked is limited.

Duckworth and Cara (2012) found that participation in leisure and interest-related learning at age 42-56 is positively associated with good mental health, life satisfaction and self-efficacy at age 46-50. Their study also examined the impact of learning on wellbeing, looking specifically at three types of learning: accredited courses (i.e. that lead to either vocational or academic qualifications), work-related training (which did not lead to qualifications) and leisure and interest activities. They used the two most recent datasets from the 1958 National Child Development study, looking at participation in learning at age 42-46 and analysing the relationship with wellbeing measures at age 46-50. Mental health and wellbeing were measured using the Malaise Inventory (a measure of mental health and depression) and self-efficacy and life satisfaction scales. At age 46, 24% of females and 19% of males had participated in leisure-related learning, 29% of females and 37% of males had participated in work-related training and 26% of females and 18% of males had participated in accredited learning. Consistent with Jenkins and Mostafa's study (2012), they found that people with higher levels of education were more likely to participate in adult learning. Duckworth and Cara (2012) found that participation in non-accredited learning was associated with higher wellbeing than accredited learning. Leisure-related learning positively predicted later life satisfaction and reduced depression. Once controlling for other factors (e.g. childhood factors, family background, socioeconomic position), the relationship remained significant for females but not males. Once other factors (e.g. socioeconomic position, educational qualifications) were included, there was no significant relationship between gaining qualifications and life satisfaction and reduced depression. The study suggested that participation in accredited learning was negatively related to some aspects of wellbeing. Authors discussed that accredited learning for this age group tended to be post job loss, which may have contributed to observed reductions in self-efficacy.

The longitudinal design of this study enabled an assessment of whether participation at one time-point relates to improved wellbeing at the next time-point. This design does risk high attrition across the time-points, which could have resulted in a less representative sample, but analysis of attrition bias revealed that this was not a problem. Controlling for a comprehensive set of potential confounding variables increased the likelihood that the observed higher levels of wellbeing were caused by participation in adult education. There were a wide range of measures, including the standardised Malaise Inventory, making it possible to assess their validity in showing a change. The time lapse between participation in education and measured wellbeing was a long period and would have varied between respondents. It is possible that other

variables will have affected wellbeing between these time-points. Like Jenkins and Mostafa's study (2012), there is little known about the type, date and length of the learning interventions, making it difficult to establish a causal relationship. Although this study demonstrated a significant relationship between leisure-related learning and wellbeing for females, an experimental design is needed to establish a causal relationship.

Dolan, Fujiwara, and Metcalfe (2012) found that adult learning was positively related to mental health and wellbeing outcomes, and that this relationship was stronger than for the other outcomes explored (e.g. family relationship outcomes). Their study investigated the impact of adult formal and non-formal learning on wellbeing, examining data from the British Household Panel Survey (BHPS) which interviews 10,000 adults each year since 1991. It has included questions on adult education since 1997 and asks about up to three courses respondents have participated in the previous year. The study divides learning types into formal and non-formal learning. Sample size varied dependent on the outcome, but there were between 35,133 and 36,300 observations for mental health and wellbeing measures. Mental health and wellbeing was measured using the General Health Questionnaire, questions on satisfaction with life and self-reported drug and alcohol use. Across a range of outcomes, adult learning demonstrated the greatest impact on health and wellbeing. Participation in learning was linked with higher self-reported life satisfaction, happiness, self-worth, satisfaction with social life and with use of one's leisure time. Participation in adult learning was linked with higher levels of self-confidence, more than twice the impact of being employed. It was also associated with lower levels of self-reported depression. These effects were larger for men aged 40 and above.

This design had a big sample size, strengthening the robustness of the findings. It also used a standardised measure to assess mental health and wellbeing outcomes. Like the previous study, there is no indication of how much time had lapsed since participating in education. Although data is collected each year, reducing the gap between a course and the next measurement of wellbeing, authors commented that respondents did not complete the survey every year. This design is again helpful in establishing whether there is a positive relationship between adult education and wellbeing but cannot infer causality.

Chavalier and Fernstien (2006) conducted a cost-effectiveness analysis of the effect of education on mental health, using data from the British National Child Development Study. Their study looks at the impact that increasing educational attainment could have on the incidence of depression. The study looks at prevalence of depression at the latest data collection (aged 42) across 6,666 respondents. The researchers found that

a secondary school education reduced the risk of poor mental health and of becoming depressed, findings which were constant throughout life. The effects were stronger for women and those engaged in low to mid-levels of education. For women, each additional qualification reduced the risk of becoming depressed. Using the Malaise Inventory, the study found that participation in education improved mental health more generally. They calculated that for women with no qualifications, risk of depression at the age of 42 was reduced by 15%, if this group gained a qualification. This group represents 17% of the individuals with depression aged 42. From these findings, they estimated the benefits of improving educational attainment on mental health. Their economic analysis concluded that a policy which supported women to increase their education levels from no to basic qualifications would reduce the total cost of depression for this population by £230 million per year or £4.9 billion over their life course.

The longitudinal design of this study allowed for assessment of the relationship between education and mental health over half a lifespan. The design made it possible to investigate how improving someone's education levels may improve their mental health. This study looks at the benefit of education in childhood and as an individual is growing up, which is not the focus of this review. However, its analysis discusses the mental health benefits of improving education levels, which provide important implications for education policy in adulthood. As with all of the longitudinal designs, it is not possible to conclude that changes in depression are attributable to education.

Narushima (2008) explored the experience of older learners engaging in non-vocational learning in relation to their health and wellbeing. The research examined five different classes in the Toronto District School Board (calligraphy, sewing, Chinese poetry, folkdance and fitness). Interviews took place with 15 senior students (10 female, five male) whose age ranged between 64 and 83, and four informants. Participants discussed how participating in the classes helped to keep them motivated and healthy, and it was seen as a reason to get out of bed. Participants saw themselves develop and achieve, which gave them a sense of pride about themselves. The classroom became a social support network, where participants made new friends who checked in with one another outside of classes. The classes provided an opportunity to "stay social". Participants discussed meeting people from different backgrounds and developing a greater sense of social connectedness through attending the classes. A challenge highlighted by participants was the costs of participating in education and the need for older adult education to be affordable. For most participants, engagement was over a long-term period (rather than a short-term course) and became an integral part of daily life.

Narushima (2008) provides further evidence of the wellbeing benefits for older adults in participating in classes, particularly in providing social support and a sense of belonging and achievement. The study also highlights what it was about these classes which was perceived to impact wellbeing. However, as a small scale qualitative study it was unable to infer a causal relationship between participation in learning and improved wellbeing. A larger study with measures of mental health and wellbeing is needed to assess the effectiveness of this intervention.

Learning with a broad wellbeing focus for adults some of whom have mental health problems

The second group of studies examined mental health outcomes associated with learning with content that broadly included wellbeing (e.g. personal/community wellbeing) and where at least some of the participants were identified as having poor mental health.

Westwood (2003) found that learners who were mental health service users perceived their participation in education to improve their mental health and wellbeing. Learners described a variety of benefits in relation to their mental wellbeing, including increased confidence, knowledge and skills, a sense of achievement and belonging and improved self-esteem. The researchers qualitatively explored the experiences of adult learners who were mental health service users in the UK enrolled in college. The study recruited 12 participants who were mental health service users (seven females, five males); participants had a mean age of 40 years and were all White British and White Irish. Participants were enrolled in individualised learning at a college following a healthcare referral. The courses took place at a further education college, independent college and a mental health day care centre. The classes (comprising 6-8 students) covered a variety of subjects, such as craft, catering, complementary therapies, information technology, basic skills and languages.

The results indicated that adults attending college felt more confident and had improved self-esteem, socialisation and motivation following their participation. Westwood (2003) described the benefits experienced by learners, such as gaining knowledge and skills, a sense of achievement, developing self-identity, increasing confidence, self-esteem, self-belief and feeling a sense of belonging. For some participants, their experiences of poor mental health had reduced their confidence and they found that participation in college increased it. Westwood (2003) highlighted how participants' self-perception changed from seeing themselves as failures to individuals with worth and skills. For participants who had experienced social isolation through their mental illness, the space to meet and make friends was of huge significance. College also provided a structure to

the day, which participants perceived to improve their wellbeing. Learners felt that the learning experience had reduced their symptoms of depression, anxiety and psychosis. The study also examined some of the drawbacks for adults accessing education, discussing how for those doing examinations this caused heightened anxiety. Getting to college was also cited as a key barrier and participants suggested having better transport support. There was also some worry amongst participants about how they felt they would be perceived by college tutors because they had been referred through mental health services.

The qualitative design of this study provides an insight into what it was about the college course that made it accessible to mental health service users. It also aided understanding regarding what it is about the college course that might impact wellbeing, for example through providing structure to the day and developing a sense of belonging. In addition, it examined the learners' experiences of barriers to learning, which provides useful insight for practitioners seeking to deliver a service. However, the small number of participants may limit the study's generalisability. As with Prins and colleagues' (2009) research discussed earlier, this design does not establish causal relationships between participation in learning and improved wellbeing. Rather it is an exploratory design, which aids understanding of what it is about this intervention that is perceived to make it more accessible and to improve wellbeing.

Lewis (2012) conducted research into adults' experiences of literacy, numeracy and personal development courses and their perceived impact on wellbeing. Her research included five discussion groups with 36 students in total and a group discussion with three tutors (Lewis, 2012). The research identified three themes in how the learning experience affected wellbeing, as detailed below.

- Students described how the learning provided a space for them to feel personally and socially recognised as someone of worth who was able to achieve. The tutor was described as important in creating an informal, non-pressurised and social atmosphere, based on care and equality. Achievement and progression was seen to be validated with certificates.

- Students also described how the learning experience increased social, emotional, cultural and spiritual resources. It was perceived to impact their sense of identity, learning to hold a valued view of themselves. In addition, students developed skills and competencies which enabled economic participation.

- Students also highlighted how the learning groups created a sense of agency, through leaving the house and meeting new people, engaging in collective action

and local community activities and in developing educational and vocational capabilities. This could help to overcome previously negative experiences of formal education.

Lewis (2014), in a later study, discussed adults' experiences of community learning, the perceived impact it had on their wellbeing, and what made community learning distinct from mental health services. This study highlighted the importance supportive space, learners' relationship with their peers and with the teacher, the education content, and how the learning enabled them to reshape their identities. Lewis (2014) conducted focus groups in England with learners engaged through the Workers' Educational Association (WEA). Some of the courses had a specific mental health theme and others encompassed broader spiritual, psychological, political and social science elements. The study explored participant's distinctions between their experiences as mental health service users and adult community learning (ACL) participants. The study identified two broad themes which illustrated why participants found ACL more accessible than traditional services.

First of all, in mental health services learners reported that they were positioned as people with "*illnesses*". In contrast, the "*whole person approach*" in ACL they thought led to them being seen and treated as people (Lewis, 2014:364). The supportive and non-formal nature of the learning environment meant that participants, the majority of whom had poor experiences of education, could move away from a "*negative learner*" identity (2014:362). Lewis (2014) described how ACL allowed participants to reshape their identities and develop a sense of self-belief.

Secondly, the education situated mental distress in a wider context and in doing so empowered rather than problematised individuals. For example, experiences of domestic violence were explored through a gendered, socio-political lens, seeking to counter the self-blame experienced by women subject to domestic violence.

Lewis (2012; 2014) provides a detailed insight into what factors were perceived to make ACL accessible and beneficial. It presents a comprehensive and evidenced narrative of what the learners gained through accessing ACL and why that was not possible in their previous mental health and educational experiences. It also provided an insight into why ACL was perceived to improve mental health. Lewis (2014) outlines the methodology, although does not provide much detail on the analytic method used to arrive at the themes. The study does provide comprehensive detail on the socio-demographic characteristics of participants, which helps to gauge how transferable findings are to other similar groups. However, although the sample size is fairly large for a qualitative study (36 learners), the small number of participants does create problems in

generalising these findings to a wider population. As with all the qualitative studies included in this review, the study provides key insights into learners' experiences but cannot be used to infer causation.

A more recent study by **Lewis et al (2016)** found that participating in creative adult community learning promoted health and wellbeing. This study involved five creative community learning groups in the West Midlands (a woman's jewellery group, a beginners painting and drawing course, a creative writing circle, a confidence through creativity group and a reablement art course). It also included two London-based mental health participatory arts organisations, an art studio and a poetry group. Methods included participant observation as well as interviews and focus groups with adult learners (n=50) and practitioners and volunteers (n=16). In addition, interviews were conducted with project organisers and managers (n=10).

Community-based creative arts adult education and art therapy initiatives were seen as creating opportunities for mutuality, specifically participatory practice, sharing experiences and building social support (Lewis et al, 2016). Being part of a creative group was seen as supporting wellbeing through improving self-esteem, creating a self-care practice and different identity of oneself. The spaces promoted supportive friendships and shared experiences, increasing a sense of connectedness. Learning was shared and coproduced between different members and practitioners, which challenge traditional hierarchical roles associated with mental health settings. Learners were given the opportunity to become actively involved and to take leadership roles, seen to promote wellbeing.

Lewis et al (2016) provided a comprehensive and robust analysis of the processes underpinning creative learning groups. This provides useful insight into what it is about these spaces, which are perceived to affect wellbeing and mental health. Lewis (2016) provides comprehensive detail on the socio-demographic characteristics of participants, which helps to gauge how transferable findings are to other similar groups.

NIACE (2014) presents evaluation findings from 97 projects funded by the Community Learning Innovation Fund in 2012-13, concluding that 41 projects identified mental health outcomes. The learning focused on these themes: learning for families, learning for communities, learning for digital inclusion and learning for social and economic wellbeing. Almost half of the projects identified social and economic wellbeing as the primary focus of the learning. The projects specifically targeted marginalised communities, reaching a higher proportion of men, learners with disabilities and learners from BME groups than previously. Participants were identified as facing multiple

challenges, including having poor physical and mental health, poor housing, an offending history, substance misuse and poverty.

The projects and types of learning varied considerably (e.g. gardening projects, museum visits) and although projects were asked to evaluate their impact, methods used were different across sites. The evaluation standards varied and only one third of sites were deemed to have a robust methodology in place. A third of the projects additionally carried out a standardised pre- and post-intervention design to assess change over time. Forty-one projects identified key outcomes in relation to mental health, primarily improved mental wellbeing, reduced anxiety, reduced stress and greater involvement in positive activities. Just under one-fifth of sites reported improved family relationships. 60% of learners participating in additional evidence collection reported positive overall perception of their mental health at the beginning of their involvement with the CLiF learning; this was the lowest proportion of positive responses for any of the outcomes measured (e.g. physical health). After learning, positive perceptions of mental health had risen to 80% of respondents. The responses of over one-quarter of learners indicated an improvement in their overall views of their mental health.

NIACE (2014) present findings from a large-scale study with a big sample size, which makes it more likely to be representative of the wider population. This study also discussed how it engaged participants who have traditionally been excluded from these types of services and programmes (e.g. learners with disabilities, learners from BME communities). The study includes participants with identified mental health needs but does not detail how many learners had these needs or whether change is tracked for this group. This limits what can be said about whether adult learning is associated with improved mental health amongst those identified as having mental health difficulties. Further, it is not apparent how mental health has been assessed and the degree of improvement being observed. It is not clear if any standardised measures were used. The community learning projects were extremely varied in terms of length, focus and set up, making it hard to assess what it is that works. Additionally, no comparison group has been employed, which limits the study's ability to conclude that adult learning is of greater benefit than other types of interventions.

Harding et al. (2014) found that participants of community learning initiatives had higher subjective wellbeing after completing their course than the general population. They evaluated the impact of community learning initiatives funded by the Department of Business, Innovation and Skills. The learning focused on four broad headings: Personal and Community Development Learning; Family English, Maths and Language Learning; Wider Family Learning; and Neighbourhood Learning in Deprived

Communities. Three-quarters (76%) of participants were women, and participants were more likely to be older; 21% were 60-69 years old, whereas this age group makes up 13% of the overall population. Participants were also more likely to be from BME communities; 19% of participants were from BME groups compared with 11% nationally. Participants were also more likely to be retired and to have qualifications. 45% were on an annual salary of less than £20,000. Twenty-three percent of participants had a long standing mental or physical health problem. Data was collected within seven months and again between 18-24 months after participating in the course. At 18-24 months after participating in the course, 49% of participants reported improved confidence, which they associated with their involvement in the course. The study included ONS questions on subjective wellbeing, which revealed that following participation in their course, course participants had higher scores than the general population for life satisfaction, feeling worthwhile and feeling happy yesterday. Subjective wellbeing scores remained consistent between seven months and 18-24 months after participation in the course.

A strength of this design is that using the ONS subjective wellbeing measure creates a way of comparing intervention participants with the general population. This is because a wider group also complete this measure. This enables assessment of whether a learning intervention is associated with improved outcomes compared to the general population. Little is known about the comparability between groups and a randomised design would be needed to improve this. Additionally, it is not known whether the wider population are in receipt of any other interventions which might have a positive or negative effect on their wellbeing. Following up participants at 24 months provides evidence of sustained outcomes. However, a limitation of this study is that despite the longer term follow up, there was no pre-intervention measure, which makes it difficult to assess the change before and after participation, and means it is not possible to gauge whether the intervention sample had better wellbeing than the general population before they began the course.

Callanan, Ming Mok and Edovald (2015) evaluated the Group Work intervention pilot. They found that participation in one week's course was associated with improved mental health and wellbeing outcomes, particularly for individuals with mild psychological needs. Their study investigated the benefits for Jobseeker's Allowance (JSA) claimants who had been referred to six group sessions. Of 461 claimants that were referred to Group Work, 236 (51%) attended the first session of the intervention. Of those, 194 (40%) completed the week-long course. Of the participants, 68% were male. Mental health was measured using the WHO-5 wellbeing index, the General Self-Efficacy Scale, the Job Search Self Efficacy Index, Generalised Anxiety Disorder 7 Item

Scale (GAD-7) and the Patient Health Questionnaire (PHQ-9). Measures were taken before and after the course and qualitative interviews with claimants and staff were also held. The course consisted of five sessions, which covered discovering job skills, dealing with obstacles to employment, finding job openings, resumes, contacts and interviews, completing an interview and planning for setbacks. There was an improvement across all mental health measures between pre-and post-intervention. Wellbeing scores improved to above the cut-off for low wellbeing and a decrease was observed in depression and anxiety scores. These improvements were bigger for individuals with mild psychological needs compared with individuals with more severe needs. The study concluded that the course was more suitable for individuals with mild psychological needs.

A strength of this study was the higher number of men who participated. Previous studies have commented on challenges of engaging men and further investigation could explore what made the course more accessible to this group. The fact that only 40% of claimants went on to participate in the course means that there was a large group who did not take part and little is known about why. It is possible that individuals who did take part were individuals who were more likely to benefit from it. This study used standardised measures to assess mental health and wellbeing, which were used before and after the study. This allows for assessment of change over the course of the intervention. This was a feasibility pilot and had no form of comparison group. To attribute the change to involvement in the course would require a comparison group of individuals not receiving an intervention.

Lipman and colleagues (2005;2010) found short-term improvement in self-esteem and mood amongst lone mothers engaged in a community-based learning programme. They conducted a randomised controlled trial (2005) with 116 single mothers with children aged 3-9 years, most of whom reported financial and mental health problems. The conducted a further in-depth qualitative study (2010) with eight of the mothers from the first study to explore their perceptions on the impact of the programme. In their first study, 116 mothers were randomly assigned to the intervention group or control group. The intervention group consisted of a 10-week programme of group sessions (1.5 hours per week), which took place either in the morning or evening. The sessions included learning on both child-related (e.g. child development, behaviour, school involvement) and maternal topics (e.g. social isolation, coping, stress). The control group were given a standard list of community resources and were assigned to a waiting list. Mothers were reminded of the sessions with weekly phone reminders and received bus tickets or taxi fares to assist with transportation. They also had food whilst at the session.

Lipman and colleagues (2005) assessed the impact of the programme on mother's mood, self-esteem, social support and parenting. Outcomes were measured using the Centre for Epidemiologic Studies Depression Scale, the Rosenberg Self-Esteem Scale, the Social Provisions Scale and the Parenting Scale (Lipman et al, 2005). Outcomes were measured at baseline, immediately after the intervention, at three and six months after the intervention. Mothers in the intervention group reported significantly improved mood and self-esteem compared to the intervention group. There was no difference relating to parenting and social support between the two groups. There was no difference between the two groups in the longer term follow up. Lipman et al (2005) reported that a time-limited, focused, group-based programme in isolation may have little potential to make lasting changes, as these women faced chronic and multiple disadvantages. In the follow-up study (2010) participants described how before the programme they experienced feelings of isolation, stigma for being a single mother, a sense of failure, and facing challenges in managing finances and budgeting for their family. Women also discussed how the programme enabled them to share experiences and access support from women in similar situations. They described developing increased confidence and strength through participation in the programme as well as improved parenting in feeling calmer, more relaxed and being able to better communicate with their child. They discussed feeling more hopeful through accessing the programme. Lipman et al (2010) suggested that the qualitative study may have been able to pick up on some of the more nuanced and less tangible effects of the programme, which were beyond the scope of the standardised self-reported outcomes tools used.

A strength of this research is that Lipman et al (2005) conducted a randomised controlled trial, which enabled comparison between an intervention and control group. Their mixed method approach to the evaluation utilised the strength of different methods, providing a comprehensive picture of experience and impact. A limitation of this research is the element of selection bias introduced through the self-selection of participants. This means that findings may not be generalisable to all single mothers. This study was conducted in "real life", rather than trial conditions and women from both groups could access other forms of support whilst attending the programme. This may have meant that other sources of support were having an impact on mothers. In addition, there was a small number of women (eight out of 58) who did not attend at least half of the intervention sessions, which may reduce the improvement seen across the group.

Learning with a mental health focus for people with an identified mental health need

Research by the **Mental Health Foundation (2011)** found that participating in mental health and wellbeing-focused learning improved the mental health of people with anxiety and depression. They conducted a three-year evaluation of Learn 2b, a community-based adult learning course for people with moderate depression and anxiety. The course focused on wellbeing (CBT, stress management, confidence building), creative expression (e.g. art, music, poetry) and healthy living (e.g. food, yoga). All courses were taught by adult learning tutors and each course was on average two hours per week for four to nine weeks.

There were 256 people who participated in the evaluation: 180 were female and 89% of those who responded identified as White British. 47% had attended mental health services in the past and 44% were currently receiving support for their mental health from health services or local mental health groups. Of the 256 in total, 161 of those were attending the wellbeing course. Outcomes were measured over four-time points (before the first session, at the end of the course, 6 months after the course and 12 months after the course) using the Hospital Anxiety and Depression Scale (HADs) and Recovery Evaluation Form (REF). The mental wellbeing of adult learners improved after people had completed a Learn 2b course and the effect was statistically significant across wellbeing, depression and anxiety outcomes. The outcomes observed were maintained 12 months after the course. Anxiety significantly reduced from moderate to mild levels and depression reduced from mild depression to sub-clinical levels.

Mental Health Foundation (2011) provide comprehensive information on who participated in the evaluation and how they were recruited (i.e. through the Learn 2b programme). They presented information on the mental health needs of the sample, which helped to interpret the level of change after the intervention (e.g. anxiety symptoms reduced from clinical to sub-clinical thresholds). The pre, post and follow up design allowed for an assessment of change up to 12 months after the intervention. Further, the mixed-methods design allowed change to be assessed and the impact of intervention investigated, while also exploring participants' experiences and gaining understanding about what was perceived to work. The use of a standardised measure increased confidence that the study was assessing change in both anxiety and depression. This was a non-randomised study with no comparison group and to increase confidence in findings would require employing some form of comparator (ideally randomised).

Weiss et al's (2006) study found that attending literacy classes reduced depression amongst individuals with depression and limited literacy, using a randomised control trial approach. The study involved randomly assigning 70 adults at a community health centre to intervention and control groups. Their study took place in the US and was based at a centre serving primarily disadvantaged service users. The intervention was standard treatment for depression (e.g. medication and / or counselling) as well as participating in tailored literacy classes. Participants' literacy levels were assessed and then the teacher and learner developed a learning plan. Learning was facilitated through computer-assisted instruction, traditional text-based instruction and/or self-paced learning modules (Weiss et al, 2006). Students could attend as many sessions as they liked, and could choose to work individually, in small groups, or with one-to-one tutors. The program also offered employment support. The control group had standard depression treatment (i.e. medication and/or counselling) (Weiss et al, 2006).

Depression was measured using PHQ-9 at baseline and then three follow-up studies, finishing one year after the study. Literacy levels were measured using REALM, a standardised assessment including word recognition. Mean PHQ-9 scores were similar in both groups at baseline and both groups experienced a significant reduction in PHQ-9 scores over time. The decrease in scores was significant larger in the intervention group, which saw the biggest reductions by the final follow-up (Weiss et al, 2006). These findings indicated that participation in literacy classes alongside standard depression treatment had a greater effect on depression scores than standard treatment alone.

Through use of a randomised design, this study could robustly compare the impact of literacy leaning against standard treatment. The standard treatment in the intervention and control were recorded and well matched (similar levels in both groups were receiving medication and/or counselling). A widely used and standardised scale of depression was used to measure outcomes, and identified measurable reduction in levels of depression and assessed this against other clinical interventions. However, the sample size was very small once participants were split into control and intervention groups, raising the possibility that the change was due to chance (Weiss et al, 2006). The study did not include any qualitative research and was therefore unable to explore or comment on the processes contributing to the observed changes.

Adult Learning Australia (ALA) (2016) reported on 12 case studies, which demonstrated that adult learning was perceived by learners to positively impact social inclusion and mental health. They presented 12 case studies of organisations in Australia who provide adult and community education with the aim of improving mental health and wellbeing. Some of the organisations provide education specifically to

individuals with mental health difficulties. They reported that engagement in adult and community education is perceived by learners to positively impact social inclusion and reduce symptoms of mental health conditions ranging from depression to schizophrenia. One example, Bouncing Back, an organisation which works with women with postnatal depression, providing learning which includes psychoeducation and stress management, had promising outcomes on treating postnatal depression. Engagement in adult learning was seen to support individuals with mental health problems into pathways to skills development, employment and mainstream education.

The 12 case studies present by ALA (2016) provide insight into specific learning projects in Australia which are showing promise in supporting people with mental health needs. At the moment there is no rigorous investigation of these services and an evaluation needs to take place to improve confidence in the findings.

Conclusion

The studies included in this review indicate that there is promising evidence that non-formal adult education positively impacts mental health and wellbeing. The evidence demonstrated that wellbeing improved for adults in general as well as those with identified mental health needs. There is initial evidence that mental health-focused learning (i.e. that focuses on coping skills, mental health experiences) also contributes to improved wellbeing. Of important note, is that people who are often excluded from mainstream services (e.g. BME communities, learners with disabilities) were found to be accessing the adult community learning explored here in greater numbers. This would suggest that there is something about adult community learning which made it accessible to traditionally marginalised groups. Qualitative research provided insight into what made these projects more accessible, highlighting the informal and supportive nature of the courses. In addition, individuals felt like they were seen and treated differently, which enabled them to view themselves more positively.

There are, however, significant limitations to the evidence, which weaken confidence in the findings. Firstly, people who engage in learning courses choose to do so and may therefore already perceive them to be of benefit. The evidence does not investigate individuals who chose not to participate or did not complete the course. These studies are therefore subject to selection bias because individuals chose to take part, possibly because they anticipated potential benefits of participation. Secondly, the included studies used self-reported measures of mental health, which means that there may have been reporting bias. This could be reduced by the use of other indicators and observation sources to provide support to the findings, such as participants' use of

mental health services. Thirdly, as has been discussed throughout the review, tit has not been possible to identify any studies which employ an experimental or quasi-experimental design. The two studies that do use comparison groups are limited. The first one compares intervention participants with the general population, with no analysis of how comparable the groups are. The second has an extremely small sample size in each condition, making it difficult to generalise findings. However, despite the limitations, this review has found promising evidence of adult education positively impacting mental health and wellbeing. The CLMH research project is intended to contribute to a strengthening of the evidence in this area.

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