



WEA Community Health Education in Stoke-on-Trent (CHEST) Project: Women's Boot Camp, Cobridge

Mental Well-being Impact Assessment (MWIA)

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The Impact of the WEA's Community Health Education in Stoke-on-Trent (CHEST) project Women's Boot Camp, Cobridge on Mental Well-being

1. INTRODUCTION

Adult community learning (ACL) is learning with people in their communities “somewhat removed from more formal educational provision” (Coare and Johnston, 2003, p. Xi). It often involves outreach to less advantaged people and encompasses “a social purpose regarding the promotion of equalities, social justice and a critical democracy” (Coare and Johnston, 2003)” (Lewis, 2012a, p. 522). Groups towards whom ACL is targeted include the long-term unemployed, those living in poverty or with a disability, and ethnic minority groups. The Workers' Educational Association (WEA) is the largest third sector provider of ACL in the UK with a long history of providing adult community-based education dating back to 1903.

This report describes a MWIA of a WEA women's health course in Cobridge, Stoke-on-Trent, England. The course combines keep fit classes with structured adult education in 'health literacy'. Classes cover areas such as healthy eating, the benefits of physical activity, food labels, salt, sugars and fats, benefits of exercise, understanding bones and muscles, understanding gym equipment, community campaigning, keeping mobile, FAST stroke recognition, measuring health improvements, maintaining wellbeing, and condition management. The course is one of 55 10 week programmes run each year as a culturally competent health education and physical activity project delivered by the WEA's Community Education in Stoke-on-Trent (CHEST) team, which has been developed in response to significant health inequalities in the local area. It is targeted towards women from the Pakistani and Bangladeshi communities around Cobridge because these communities are identified as being particularly affected by health, social and economic inequalities.

Why was this MWIA undertaken?

Both health outcomes and learning outcomes are used to provide evidence of the impact of the CHEST project on individuals and communities (Hurst and Vincent, 2011, p. 5). This MWIA was conducted because mental health is important within the planned health outcomes of the project, particularly given the association between physical activity and mental health (BHF National Centre for Physical Activity and Health, 2013a; Physical Activity Guidelines Advisory Committee, 2008) and between mental health and physical health (Friedli, 2009; Marmot et al, 2010). In addition, the planned outcomes of the CHEST project surrounding confidence in accessing public health service provision and voluntary community activity relate to mental well-being, and the MWIA was aimed at helping achieve a planned outcome relating to awareness of culturally competent service delivery among voluntary, community and statutory organisations. The MWIA adds to an evidence base which includes an external evaluation of the CHEST programme and programme case studies relating to mental health collected by the WEA. It also adds to other research into the impact on mental

health and wellbeing of the WEA's provision more widely (Attwell et al, 2013; Lewis, 2012a and b).

The women's health course was selected for assessment because inequalities of socio-economic status, ethnicity and gender have been shown to impact mental health (Rogers and Pilgrim, 2003) and particular public mental health concerns have been highlighted for British women of South Asian origin living in areas of high deprivation (e.g. Burman et al, 2002, SEU, 2004). In England, a recent household survey showed rates of reported anxiety and depression are significantly higher among women than men, that South Asian women in England experience higher levels of mental health issues than other women and South Asian men, and that mental health is significantly impacted by income level (McManus et al, 2007).

Women's mental health is significantly impacted by socially-determined gender power inequalities (see Patiniotis and White, 2011) and the cultural context of their lives (Burr and Chapman, 2007; Stoppard, 2000). The social issues which disproportionately impact women's mental health include caring responsibilities (National Mental Health Development Unit, 2010; see also RCGP, 2013), domestic violence (HM Government, 2010) and social exclusion (SEU, 2004). The women for whom social exclusion is a particular concern include some minority ethnic women, women who are disabled and older women (ibid). Bangladeshi and Pakistani women are among the least economically and educationally advantaged women in the UK (Ward and Spacey, 2008) and have the lowest levels of learning participation (Aldridge et al, 2008).

The CHEST Project

CHEST is a health education programme which "blend[s] health improvement outcomes with life skills, increased confidence and more active citizenship" (WEA, 2011, p. 4). Its overall aim is to improve the health and well-being of disadvantaged adults residing within Stoke-on-Trent through educational programmes. Other aims are to improve beneficiaries' health and fitness levels and understanding of health information and to reduce social isolation within and between deprived communities (WEA, 2011).

The project was developed in 2007 in response to a needs analysis which showed pronounced health inequalities in Stoke-on-Trent and poor health indicators in comparison to other West Midlands areas (Hurst and Vincent, 2011; see further under 'population profile', pp. 15-20). It is modelled on a project in Dudley called Tandrusti. As described in an evaluation of the project conducted in 2011:

The CHEST project worked in partnership with NHS Stoke-on-Trent to develop a small pilot project which led to the Big Lottery bid for the CHEST project across the city. This funding enabled the WEA and the PCT to grow the work and reach new communities as well as the initial BME groups. Three years on, CHEST courses have run in most areas of the city and the project provides an important referral route for health services, while the groups themselves have become valuable peer-support networks. (Hurst and Vincent, 2011, pp. 5-6)

Funding for the project has been received from the Big Lottery Fund Reaching Communities, NHS Stoke-on-Trent Primary Care Trust and WEA West Midlands Region. In 2011 it was awarded Big Lottery continuation funding to run until 2017.

The context for the project includes evidence that physical inactivity is a causal factor in coronary heart disease, breast and colon cancer, and type 2 diabetes and can have a significant positive influence on mental health (BHF National Centre for Physical Activity and Health, 2013a and b). Fitting with a range of cross-departmental Government plans and initiatives, it aims to help meet local need and to address health inequalities through:

- supporting healthier and fitter communities;
- reducing social isolation caused by health inequalities;
- developing stronger social ties within and between health deprived communities;
- encouraging volunteering and involvement in social action;
- promoting greater self-reliance. (WEA, 2011, p. 8)

The CHEST project delivers courses across 18 locations currently and has been in over 30 venues since the start of the project. It is currently delivered by a management /administrative team, four tutors and additional support workers (both salaried and sessional), with additional support from volunteers. Combining keep fit with learning in health literacy, it covers topics such as:

healthy eating – food labels – salt, sugars and fats - benefits of exercise – understanding bones and muscles – understanding gym equipment - community campaigning – keeping mobile – FAST stroke recognition and – measuring health improvements – maintaining wellbeing – condition management – using NHS Choices and the internet – communicating in English. (Hurst and Vincent, 2011, p. 11)

The project therefore addresses health literacy in a variety of ways, and this includes through “contextualized literacy, ICT and numeracy courses” (WEA, 2011, p. 7). Progression is built into both the physical and health literacy aspects of the courses (Hurst and Vincent, 2011).

Apart from community centres, health centres and schools, the numerous local partners include Age UK, Staffordshire University, VAST, Saltbox, WRVS and the Beth Johnson Foundation, which runs Ageing Well projects (ibid). Third sector partnerships have been important in the face of the closure of the Racial Equality Council in Stoke-on-Trent and partnerships more generally have “helped provide progression options, choice for learners and peer support for project staff and volunteers” (ibid, p. 15).

The outcomes tree for the second phase of the project is shown below:

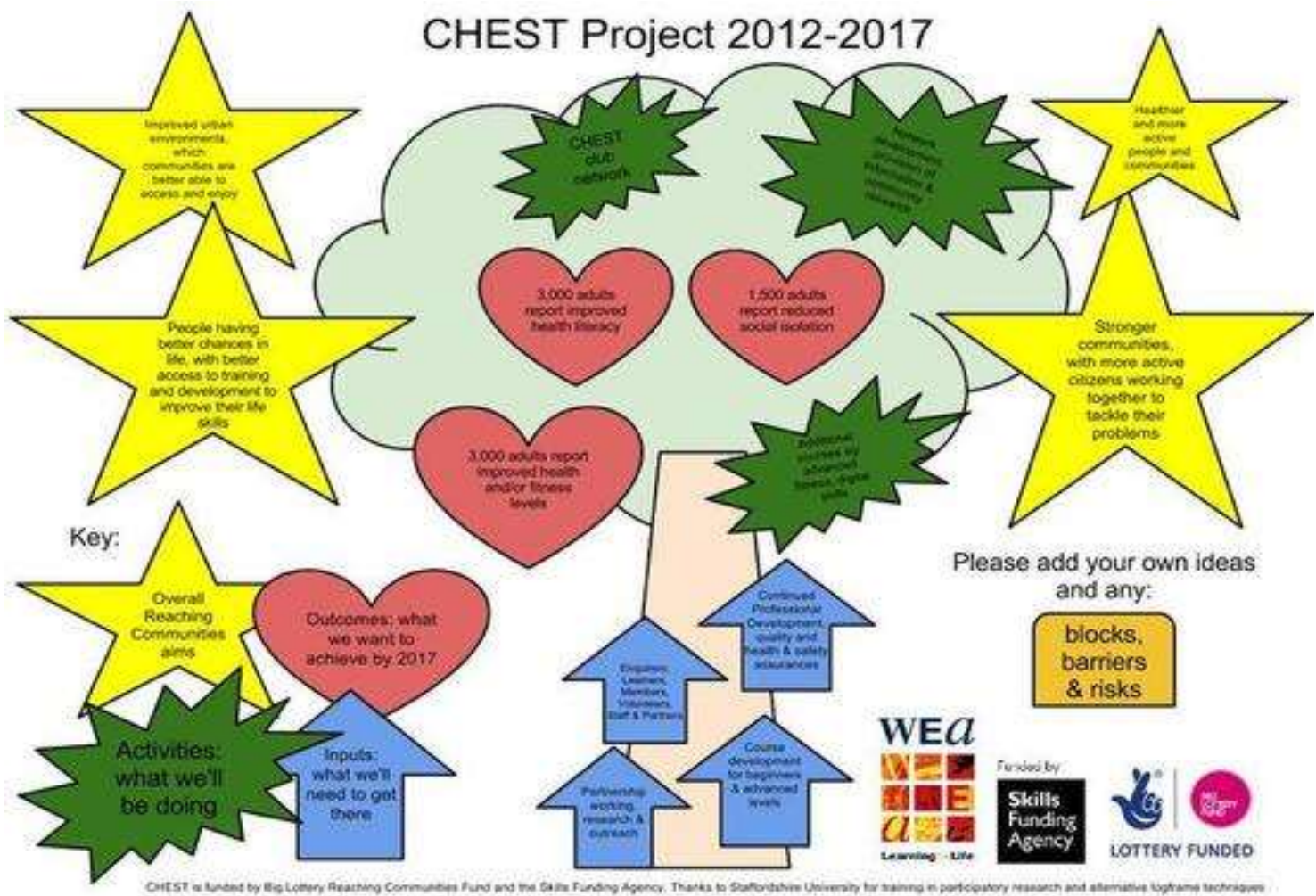


Figure 1. CHEST Project Outcomes Tree. From: WEA CHEST project web site:
<http://www.westmidlands.wea.org.uk/stokehealth>

The Women's Boot Camp, Cobridge

This course grew out of a project called Exercise in the Community, which was set up in 2007, to "try out ways of promoting physical activity and health living among members of Black and Minority Ethnic (BME) communities in Stoke-on-Trent" (WEA West Midlands Region, 2011, p. 2). It was supported by the Neighbourhood Renewal Fund to help meet local targets surrounding health improvement and targeted particular areas including Cobridge. Most participants were female and activities have been particularly popular with older people (ibid).

The women's health course is called Women's Boot Camp, Cobridge. The participants are mainly from the Pakistani and Bangladeshi communities around the Cobridge area, although there are also four white British people in the group. The WEA started a health education and

fitness course over 6 years ago in Cobridge which was match project funded with Stoke NHS. The WEA and the local PCT wanted to engage with the BME community to promote health messages and to reduce health inequalities. For several years, courses ran in partnership with an older person's lunch club and was mixed, but since the lunch club finished it has become a women's-only group. Increased attendance by the women and ongoing requests for a second class at higher intensity has led to the development of twice-weekly 'Boot camp'-style courses.

Aims of the MWIA

- To identify how the Cobridge Women's Boot Camp potentially impacts on the mental health and well-being of adult learners.
- To identify ways in which the project might maximise its positive impacts and minimise its negative impacts
- To develop indicators of mental well-being that can be used to measure, evaluate and improve the mental well being of women attending WEA targeted health courses.

2 WHAT DO WE MEAN BY MENTAL HEALTH AND WELL-BEING?

There are many definitions of well-being and mental well-being. The one that is often used, and which fits the theoretical base of MWIA is:

Mental wellbeing "...is a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society." (Foresight Mental Capital and Wellbeing Project, 2008, p. 10).

Put simply our mental well-being is about how we think and feel (as psychological and emotional dimensions) and our social functioning (relations with others and society) (Friedli, 2009; NICE, 2008). From a capabilities perspective, a social theory which underpins MWIA concerned with how social inequalities impact opportunities and choices (Sen, 1999, 2010), mental health may be understood in terms of what we are able to do, be and achieve and how we feel (Lewis, 2012a and b). Related to this conception, a useful way of understanding mental well-being is to view it as encompassing "subjective wellbeing (how we feel about ourselves and our lives), social wellbeing (relationships and connections) and coherence (sense of meaning or purpose)" (Friedli, 2011a: 13).

3. FRAMEWORK AND METHODOLOGY

The Mental Well-being Impact Assessment (MWIA)

MWIA is an innovative and effective process to ensure that forms of social provisioning improve people's mental well-being as much as possible. MWIA uses a combination of methods, processes and tools to assess the potential for a policy, service, programme or

project to impact on the mental well-being of a population. It enables evidence-based recommendations to be identified to strengthen the positive and mitigate against the negative impacts. It also includes a process to develop indicators to measure improvement. It focuses on population groups who may experience health inequalities and social injustice with a particular emphasis on those most at risk of poorer mental well-being. It also makes the link with social determinants – the causal factors underpinning inequalities in mental health status between social groups.

The DOH 'Making it Happen Guidance' for mental health promotion (2001) identified key areas that promote and protect mental well-being:

- Enhancing Control
- Increasing Resilience and Community Assets
- Facilitating Participation and Promoting Inclusion

The MWIA is based on these key areas and helps participants identify things about a policy, programme or service that impact on feelings of control, resilience, participation and inclusion and therefore their mental health and well-being. In this way the toolkit enables a link to be made between policies, programmes or service and mental well-being that can be measured.

“How people feel is not an elusive or abstract concept, but a significant public health indicator, as significant as rates of smoking, obesity and physical activity” (Making it Happen, Department of Health 2001).

In order to make an assessment of impact on mental well-being three sources of data are collected and triangulated to ensure confidence in the impacts and recommendations identified. The three sources of data are:

- Population data – A profile of the community/ies that are impacted on by the form of social provisioning being assessed.
- Literature Review - published evidence on the impact of similar interventions/policies on mental well-being.
- Stakeholder perspectives – qualitative data that give insights into the experience and perspectives of those involved and impacted on.

The MWIA methodology was taken from the *MWIA: A Toolkit for Well-Being* published by the National MWIA Collaborative, NMHDU in 2011. It is available to download at: www.hiagateway.org.uk.

The stage-wise approach for this MWIA was as follows:

- The project team was formed during a MWIA training session, at which the proposal to conduct a MWIA on the WEA women's health course in Cobridge was put forward.
- Project team member, Janet Henson held initial feasibility discussions with the CHEST project manager and the course tutor, and organised the fieldwork in liaison with these parties and with an NHS healthy eating trainer, who provided lunch during the fieldwork day. Local stakeholders, including GPs and members of third sector partner organisations were invited, along with the adult learners.
- The project team undertook a desktop MWIA Screening. The initial exercise was led by Alexandra Wood and the report of screening was written up by Lydia Lewis and Alexandra Wood.
- A population profile was drawn up. Lydia Lewis provided data on the Bangladeshi and Pakistani communities in England and Wales and social inequalities and mental health, and Alexandra Wood and Lydia Lewis contributed data on the population of Stoke-on-Trent. Material on the profile of the women attending the WEA course was provided by Janet Henson and Clare White.
- Background information about the course, a profile of its participants (adult learners), the original Big Lottery bid and an existing evaluation of the course was provided by Janet Henson.
- A desktop review of published literature identifying the mental well-being impacts of adult community learning and the benefits of women-only spaces was carried out by Lydia Lewis with input from Lyn Marie Chapman and Janet Henson.
- A stakeholder workshop using the MWIA methodology was conducted with 16 women attending the Cobridge women's health course and two third sector stakeholders from Brighter Futures Mental health (a housing charity) and the Beth Johnson Foundation on 5th March 2013. It was organised by Janet Henson. All the women adult learner workshop participants were from the Pakistani and Bangladeshi communities. Two of the adult learner participants were over the age of 65 with the rest of younger age groupings (including young women in their 20's and 30's). The workshop was conducted in English, Urdu, Bengali and Hindi, with two adult learners and a volunteer acting as interpreters.
- A debriefing session between members of the project team discussed main significant findings and reflected on the workshop.
- Lyn Marie Chapman collated responses from the workshop participant evaluation forms.
- The evidence was collated to formulate the assessment.
- Lydia Lewis led the compiling of the report, wrote the additional sections and drew up the recommendations. The indicators of mental well-being were formulated by Lydia Lewis, Clare White and Janet Henson. The report template, including some generic text, was provided by Lyn Snowdon and Anthea Cooke.

4 POPULATION PROFILE

Public mental health aims to promote and protect the mental health of the whole population, while recognising that (as is the case for physical health) levels of vulnerability to poor mental health will vary among different population groups. That is, social factors, including social class, gender, age and ethnicity are associated with mental health status, so that social inequalities are associated with mental health inequalities (Friedli, 2009; Marmot et al, 2010).

A profile of the community that the WEA Cobridge Women's Boot Camp is targeting is provided below. The section begins with an outline of the Bangladeshi and Pakistani communities in England and Wales and then discusses features of the research evidence on social inequalities and mental health that are of relevance to this MWIA. The section then provides a social, health and mental health profile for Stoke-on-Trent and the area around Cobridge more specifically. It finishes with a profile of learners on the CHEST programme and the Women's Boot Camp, Cobridge.

The Bangladeshi and Pakistani communities in England and Wales

There are around 447,000 Bangladeshis (0.8% of the population) and 1.1 million Pakistanis (2% of the population) living in England and Wales (ONS, 2011a). The majority of these populations are Muslim. "Both Pakistani and Bangladeshi groups have a younger demographic profile and also larger families compared with the rest of the population" (Tackey et al, 2006). The Bangladeshi community has a median age of 24, and the Pakistani Community 25, compared to 39 for the population of England and Wales as a whole (ONS, 2011a).

Bangladeshis and Pakistanis are the ethnic groups in Britain with the highest proportion of low income households – at around 60% for Pakistanis and 70% for Bangladeshis (DWP, 2010). 55% of Pakistanis and 65% of Bangladeshis (compared to 20% for white British) are defined as being in 'income poverty' (Kenway and Palmer, 2007a). This is due to a range of factors, including low pay, family composition and family work status (ibid). A "high proportion of working-age Bangladeshis and Pakistanis, particularly women, are not in paid work" (Kenway and Palmer, 2007b, p. 1) and high percentages of women look after a home or family full-time (HEA, 1999).

Contextual factors affecting labour market disadvantage include migration and settlement patterns and the fact that "a relatively small proportion of working-age Pakistanis, but especially Bangladeshis, were born in Britain" (Tackey et al, 2006). In terms of education levels for those aged 16 and over migrating to Britain, Pakistanis and Bangladeshis have among the lowest levels (ibid), and life chances for Bangladeshis are also affected by their relatively recent migration to Britain and under-achievement at school (Mac an Ghaill and Haywood, 2005). Labour market discrimination may also be a contributing factor (ibid).

Many women from Bangladeshi and Pakistani communities in Britain “positively choose to give primacy to family life”, although there are cultural and religious influences on attitudes to women working within these communities (Tackey et al, 2006). In a study of young Bangladeshi people’s experiences of transition to adulthood, Mac an Ghaill and Haywood (2005) identify gender stereotyping as resulting in limiting life course opportunities. Research does, however, suggest a recent “fundamental shift in attitudes towards Pakistani and Bangladeshi women working outside the home” among young women, as a means of becoming more independent (Tackey et al, 2006). Childcare and other caring responsibilities have been identified as the “most significant household barriers” to their engagement in paid work (ibid).

Some research suggests that Bangladeshi communities in Britain tend to be relatively insular (e.g. Rasinger, 2007) although generational differences need to be noted. In their study of young Bangladeshi people in Newcastle, Mac an Ghaill and Haywood (2005) report:

For an older generation, this community is much more insular and segregated in terms of their work, housing and leisure. Many of the young people reported that their parents worked within close proximity to their family, friends and neighbours, thus providing a picture of community self-sufficiency. However, the young people in this study represented themselves as less segregated.

The languages spoken by members of the Bangladeshi community in Britain include Bengali (written), Sylheti (spoken) and English and by the Pakistani community, Urdu (written), Punjabi (spoken) and English. There are generational and gender differences in English language use. For example, the National Centre for Languages (2006, p. 9) reports that “many older Pakistani women conduct their lives entirely within the community and have little need to speak English”. The Fourth National Survey of Ethnic Minorities (Modood et al, 1997) found that “only four per cent of Bangladeshi and 28 per cent of Pakistani women aged 45-64 years spoke English fluently or well” (Tackey et al, 2006). Survey research by the HEA (1999, p. 32) in England found that:

While nearly all Indian men and more than nine in ten Pakistani and Bangladesh men could speak English, only three-quarters of Pakistani women and less than three fifths of Bangladeshi women could speak English. For all three ethnic groups, and both men and women, the percentage able to read English was rather lower, but in each ethnic group, the percentage of men able to read English was higher than the corresponding percentage for women.

Health data suggests high levels of diabetes among Pakistani and especially Bangladeshi people (ibid). There are also reports of worse levels of general health among Bangladeshi men and women compared to other Black and minority ethnic groups, “including particularly high levels of stomach ulcer; heart disease and headache/migraine” (ibid p. 36). Women within BME groups more generally have been found to report higher rates of high blood pressure than men (ibid).

Among minority ethnic groups, Bangladeshi and Pakistani groups have been found to have lower levels of ‘health literacy’ related to lowering the risk of serious illness and lower levels

of engagement in 'health promoting behaviours' (ibid). As the table below shows, women from the Pakistani and Bangladeshi communities have been shown to have low levels of engagement in leisure sports:

	African-Caribbean %	Indian %	Pakistani %	Bangladeshi %
Males				
Sedentary (group 1)	32	38	47	50
Medium (group 2)	30	29	24	25
Regular active (group 3)	38	33	29	26
Females				
Sedentary (group)	31	47	50	53
Medium (group 2)	44	36	26	29
Regular active (group 3)	25	17	14	18

Source: Health Education Authority, 1999, p. 92.

Ethnic inequalities in health and health experience can be explained to a significant extent by ethnic inequalities in socio-economic status. However, there is also a need to consider other factors, including inequalities in access to health services, which are well established in the research literature (ibid; see also Modood et al, 1997). Language barriers may impede communication with health professionals; research has shown that "a significant number of South Asians (particularly Bangladeshi women) and Chinese people find it difficult to communicate with their GP" (HEA, 1999, p. 37). In addition, "there may be cultural differences in the expression of symptoms, making the use of western diagnostic approaches inappropriate for some groups, especially as far as mental illness is concerned" (ibid, p. 5).

Social inequalities and mental health

Social inequalities, encompassing intersecting dimensions of social class (or socio-economic status), gender and race and ethnicity, among others, are associated with mental health inequalities and produce other health inequalities (Marmot et al, 2010; see also Friedli, 2009). There is also a relationship between educational outcomes and both physical and mental health (Marmot et al, 2010). Research shows that "those living in poor areas are more likely to suffer from depression, stress and poor mental health" (Hurst et al, 2012a, p. 12, citing Stafford and Marmot, 2003 and Lorant et al, 2003).

Community surveys consistently show higher rates of 'depression' in women compared to their male counterparts and an association between socio-economic status and mental health status. For example, in a study by McManus et al (2007) in England, rates of reported anxiety and depression ('common mental disorders' or CMDs) were significantly higher among women than men, and lower levels of income were associated with higher levels of CMD. Furthermore, "the largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45-64, among whom the rate rose by about a fifth" (ibid, p. 12). The highest rate overall for women was among 45-54 year olds.

Gender inequalities in mental health need to be understood in relation to gender power relations (e.g. Patiniotis and White, 2011). Women's mental health is largely a product of the socio-political positions that they occupy and the cultural contexts of their lives. Cultural expectations of womanhood, workloads which often combine paid work with main responsibility for the home and caring for others (working a 'double shift'), social isolation due to caring responsibilities, and economic hardship are important causal factors in women's 'depression' (see, for example, Burr and Chapman, 2004; Lewis, 2000; Stoppard, 1998, 1999, 2000). Social relations are a key determinant of women's depression (Kazi et al, 2006; Pilgrim et al, 2006), and sexual and domestic violence are significant gender equality and mental health issues for women (Kelly, 2011; National Mental Health Development Unit, 2010). Women are more likely to be on the receiving end of domestic violence than men (HM Government, 2010; McKie, 2006), while risk of violence also varies across localities according to economic deprivation as well as levels of inequality and ethnicity (Friedli, 2009, citing Krantz 2002 and Krueger et al 2004). For these reasons organisations must provide women-only services and spaces because it meets the specific needs of women. Additionally, all public authorities have a duty to 'advance equality of opportunity', in recognising the different needs of men and women

The following findings from the household survey of psychiatric morbidity in England cited above (McManus et al, 2007) are of additional relevance to this MWIA:

- "After age-standardisation, there was little variation between white, black and South Asian men in the rates of any CMD. However, in women all CMDs (except phobias) were more prevalent in the South Asian group. The number of South Asian women in the sample was small, so while the differences were pronounced they were only significant for CMD as a whole, generalised anxiety disorder and panic disorder." (ibid, p. 25)
- "Rates of having at least one CMD were higher for white, black and South Asian women than for white, black and South Asian men respectively. The greatest difference was among South Asian adults where the age-standardised rate among women (34.3% of South Asian women) was three times that of men (10.3% of South Asian men)." (ibid, p. 31)
- "After age-standardisation, South Asian women appeared to be more likely than other women to have experienced a trauma (43.9%, compared with 31.4% of both white and black women). Despite this apparent increased trauma rate among South Asian women, the rate of screening positive for current PTSD did not vary in women by ethnicity." (ibid, p. 59)

Further data on ethnic variation in rates of CMD in England, and intersections of age and gender, are provided by the EMPIRIC (Ethnic Psychiatric Morbidity Rates In the Community) Study (Weich et al, 2004). These authors report "higher rates of CMD among Indian and Pakistani women aged 55-74 years, compared to White women of similar age" (p. 1543). They also report that the "prevalence of CMD among Bangladeshi women was lower than among White women, although this was restricted to those not interviewed in English" (ibid).

This low prevalence of CMD among Bangladeshi women was seen to contrast with high levels of socio-economic deprivation among this group.

In order to explore the possibility of under-estimation by the survey instrument in the EMPIRIC study of the prevalence of CMD among South Asian groups, scores on the somatic symptoms section were compared across ethnic groups. These analyses found “some evidence that Bangladeshi men, and Indian and Pakistani women may have a tendency to express psychological distress by means of somatic symptoms” (McManus et al, 2007, p. 35, citing Weich and McManus, 2002).

While rates of suicide are higher among men than women in England, South Asian women are “indicated nationally as having high suicide rates” (Burman et al, 2002: 645; Husain et al, 2011; SEU, 2004). In addition, levels of reported suicidal thoughts and attempts are higher among women than men (McManus et al, 2007), although evidence in this area for women of South Asian origin more specifically appears mixed and is of questionable validity due to reliance on self-report (Burman et al, 2002). McManus et al (2007) found that for both women and men in England, reported levels of suicidal thoughts, attempts and self harm are lower among South Asian adults than among White and Black adults. Yet other research evidence shows “increased risk of suicide and attempted suicide among British South Asian women” (Husain et al, 2011, citing Bhui et al, 2007), with older women of South Asian origin identified as being at particular risk (McKenzie et al, 2008). UK studies by Husain et al (2006) and McKenzie et al (2008) also suggest that “rates of self harm in British South Asian women are higher compared to the white population” (Husain et al, 2011). The fact that local Asian women’s organisations have mobilised around suicide and self harm (Burman et al, 2002) further indicates that this is a significant issue for this population group.

About Stoke on Trent

249,008 people live in Stoke-on-Trent (SoT) (ONS, 2011b). Within the city, 86% of the population are of a White British ethnic background, whilst “people from a South Asian background (Indian, Pakistani or Bangladeshi) make up the largest ethnic minority group [at] 5.5%” (Iqbal, 2012, p. 8).

SoT “was ranked the 16th most deprived local authority (out of 326) in England (based on the 2010 Indices of Deprivation)” (Iqbal, 2012., p. 8; Department for Communities and Local Government, 2011). It is “nationally one of the most deprived local authority districts in England” (NHS Stoke-on-Trent and City of Stoke-on-Trent, 2011 p. 105) in terms of employment, income, education and skills, health and disability and crime and disorder, and also has higher levels of living environment deprivation compared to regional and national levels (ibid) .

Within the city there are 160 lower layer Super Output Areas (SOAs) (small geographical areas of relatively even size, around 1500 people), and of these 50 (31%) are within the 10% most deprived in England (Department for Communities and Local Government, 2011) – a population of 74,728 (Iqbal, 2011). 97 SOAs (60.6%) are “ranked among the top 25% most

deprived” (Iqbal, 2012, p. 8). This means that “the *majority* of the population in Stoke-on-Trent are likely to be living in areas of the city considered to be among the *most deprived* in the whole of the country” (ibid). About 14,400 children live in poverty in SoT (English Public Health Observatories, 2012). Levels of unemployment are higher in SoT compared to the England average and in 2010 23% of people of working age were claiming a key benefit compared with 15% for England as a whole (ONS 2011b).

Social capital and community cohesion

Social isolation is related to social inequalities, including social class, ethnicity and disability, being “more common among low socio-economic groupings, Black and Minority Ethnic (BAME) communities and people with learning or physical disabilities” (WEA, 2011, p. 8), and is a significant issue affecting mental health (SEU, 2004) and linked to health inequalities (Marmot et al, 2010). It can lead to “low levels of confidence and self-esteem, low levels of participation in lifelong learning opportunities, worklessness, poor mental health and physical inactivity (NIACE, 2010)” (WEA, 2011, p. 8).

SoT’s Joint Strategic Needs Assessment for 2010-15 (NHS Stoke-on-Trent and City of Stoke-on-Trent, 2011) reports the city scoring poorly on community cohesion and social networks; community participation and involvement and social inclusion and belonging. The report (pp. 60-61) states that:

Less than 10% (9.4%) of people in Stoke-on-Trent were involved in ‘civic participation’ – being involved in groups which make decisions that affect their local area. ... This is in the worst 5% of local authorities in the country. ... Just under 55% of people in Stoke-on-Trent feel as if they belong to their immediate neighbourhood. This compares with 59% in the West Midlands, and nationally, and is in the worst 25% of local authorities in the country. Just over 70% say that they are satisfied with their area as a place to live. This compares with 78% in the West Midlands, and nearly 80% nationally and is in the worst 10% of local authorities in the country.

Further information is provided by a survey carried out for the *My Health Matters* Project which aimed to increase physical activity and health eating among residents in the SoT area of Burslem South, Weston and Meir North and Bentilee and Townsend (Hurst et al, 2012a and b). This postal survey of local residents (which returned a 12% and 14% response rate at baseline and follow-up respectively, with respondents numbering 343 and 375) found that while a large proportion of residents lived close to green space, this was often poorly maintained. In relation to social capital, the survey found that:

most respondents enjoyed living in their area with individuals, on average, living in their neighbourhood for over 20 years. However, across all three areas, there was low perception of trust of others and perceptions of problems with teenagers and vandalism. One-third of respondents, did, however, take part in groups or organisations (e.g. church groups, social clubs). (Hurst et al, 2012a, p. 4).

As part of the same project, a community consultation in these wards revealed the following in relation to community cohesion and isolation:

- Lack of knowledge of existing activities and services ('nothing going on in the area')
 - Feelings of abandonment, being let down and a lack of trust, especially in regeneration areas.
 - Lack of cohesion between long-standing residents and short term rental tenants.
 - Some existing groups can be too protective and possessive of facilities.
- (Hurst et al, 2012a, p. 6)

Health Information

SoT has “some of the highest morbidity and mortality rates in the UK” (Hurst et al, 2012b, p. 2). On health and disability, it was shown in 2007 to be “the most deprived local authority in the West Midlands (out of 34)” with 109 SOAs in Stoke-on-Trent falling within the 20% most deprived in England (NHS Stoke-on-Trent and City of Stoke-on-Trent, 2011 pp. 115, 117).

The health of people in the SoT area is “generally worse than the England average” and “life expectancy for both men and women is lower than the England average” (English Public Health Observatories, 2012, p. 1). Men in the city experience a life expectancy of 75.4 years which is 2.9 years less than the average male life expectancy for England as a whole. Women in the city have a life expectancy of 79.9 years, which is 2.4 years less than the female life expectancy for England as a whole (ONS, 2011b). Early death rates from heart disease, stroke and cancer are higher than the England average (English Public Health Observatories, 2011). Furthermore: “Life expectancy is 8.2 years lower for men and 4.7 years lower for women in the most deprived areas of SoT than in the least deprived areas” (English Public Health Observatories, 2012, p.1). The infant mortality rate is 6.2 per 1000 live births compared to an England average of 4.4 (ONS 2011b).

Estimated levels for adult ‘healthy eating’, physical activity, obesity and smoking are also worse than the England average, as is the rate of diabetes (English Public Health Observatories, 2011), which is a particular risk in the BME community. Almost a quarter of all adults in SoT are thought to be obese (Iqbal, 2011). In addition, poor consumption of fruit and vegetables has been found to be higher in SoT than the West Midlands regional average (South Stoke PCT, 2006). Obesity is associated with a range of health conditions including CHD, stroke and diabetes and may also affect life chances through impacting mental health and increase the risk of social isolation (National Institute of Clinical Excellence, 2007, cited in WEA, 2011).

As Iqbal (2011, p. 23) points out: “One of the main reasons why people become obese is due to a lack of physical activity and exercise”. Approximately 90% of the population in SoT do not engage in the levels of physical activity recommended to benefit health (ibid) and levels of inactivity are worse than the regional average (South Stoke PCT, 2006). Indeed, the city has “one of the lowest rates of physical activity in the UK” (City of Stoke-on-Trent and Sport England, 2009, p. 3) and sport participation rates well below the national average (Sport England, 2013). In 2011, Stoke-on-Trent was placed 350th out of 354 Local Authorities in England for adult participation in sport and active recreation (Hurst and Vincent, 2011). Consultation for the SoT City Health Development Plan 2005/08 indicated that participation

levels in physical activity amongst women, older people and people in particular disadvantaged areas are lower than the city average.

Iqbal (2011, p. 23) points out that: “The recent rise in prevalence of obesity in the UK is known to be associated with the wider determinants of health, including education, employment and access to transport “. It is related to social class and age, being more prevalent among those from low socio-economic groupings and older adults, and there are also variations between ethnic groups (DH, 2004).

Linked to poor educational attainment, SoT has identified poor levels of health literacy (WEA, 2011). The current JSNA (NHS Stoke-on-Trent and City of Stoke-on-Trent, 2011) highlighted that “a higher proportion of adults from settled and new migrant BAME communities and disabled adults have lower level/no formal qualifications compared with the average for the West Midlands region” and linked these circumstances to “less healthy choices, riskier behaviours, poorer physical and mental health, more hospitalisations and high health care costs” (WEA, 2011, p. 7).

A number of areas within SoT are “among the top 5% most deprived areas in the whole of England. These include areas within the wards of Bentilee and Ubberrley, Abbey Hulton and Townsend (both located in the east of the city), Burslem Central, Moorcroft, Etruria and Hanley (in the west and north) and Meir North (in the south east)” (Iqbal, 2012, p. 8). A community consultation carried out for the *My Health Matters* project identified the following health-related issues for residents in Burslem South, Weston and Meir North and Bentilee and Townsend:

- “Lack of knowledge relating how to cook fresh fruit and vegetables.
 - Poor levels of health in each study area.
 - Health not being a priority and local residents not seeking health advice until a health problem arises (reactive, not preventive).
 - Some residents not registered with health services, e.g. GPs, dentists.”
- (Hurst et al, 2012a, pp. 5 and 6)

The ward in which the MWIA was conducted and the course is located is called Moorcroft. This is highlighted as one of the three “most unhealthy wards” in the city in SoT’s Public Health Annual Report 2012 (Iqbal, 2012, p. 24). It is the ward with the highest mortality rate (ibid). The number of people who claim their health is ‘bad’ or ‘very bad’ in the SOA where this research was conducted (SoT009E) is almost twice the England average at 10.2 % compared 5.4% (ONS, 2011b). Education attainment is low, and only 12.5% of people living in this SOA have a degree level qualification or higher, while 42% have no formal qualifications (ibid). The SOA has very high levels of health and education deprivation (ibid).

Mental health Information

SoT’s Community Mental Health Profile for 2013 (North East Public Health Observatory, 2013) reports high levels of depression among adults in the area, at 16% compared to 12% for the England average, meaning it falls within the 25% worst areas for depression in the

country (with the England worst at 20%). There is also a significantly higher rate of dementia in SoT compared to the England average.

Mental health and wellbeing is highlighted by the city's current Joint Strategic Needs Assessment (NHS Stoke-on-Trent and City of Stoke-on-Trent, 2011) as a particularly important issue. This is because of the high levels of deprivation. The following factors are listed as significant: low income, poor education, poor housing, unemployment and family breakdown. It is noted that these affect mental health and resilience - "someone's ability to respond to all the negative factors that are risks to mental health and still retain good mental wellbeing" (ibid, p. 213). The Community Mental Health Profile for SoT 2013 (North East Public Health Observatory, 2013) additionally highlights a high level of violent crime as a significant social determinant and low levels of physical activity (9% compared to an 11% average) and high level of adults living with a limiting long-term illness (23% compared to a 17% average) as risk factors. The JSNA notes that the city's profile means that the current economic downturn and public spending cuts will inevitably disproportionately affect the mental health of people in SoT compared to other localities.

Other data of significance for mental health from the JSNA include:

- "An increase in the number of domestic crimes reported to police between 2008-09 and 2009-10 from 1,424 to 1,729." (p. 136)
- "Stoke-on-Trent remains above the regional and national average for the percentage of population of all people providing unpaid care." (And the majority of carers are female, at 58%.) (NHS Stoke-on-Trent and City of Stoke-on-Trent, 2011, p.53)

Using data from the Adult Psychiatric Morbidity Survey 2007, the JSNA provides the following picture of estimated common mental health problems for SoT in 2010:

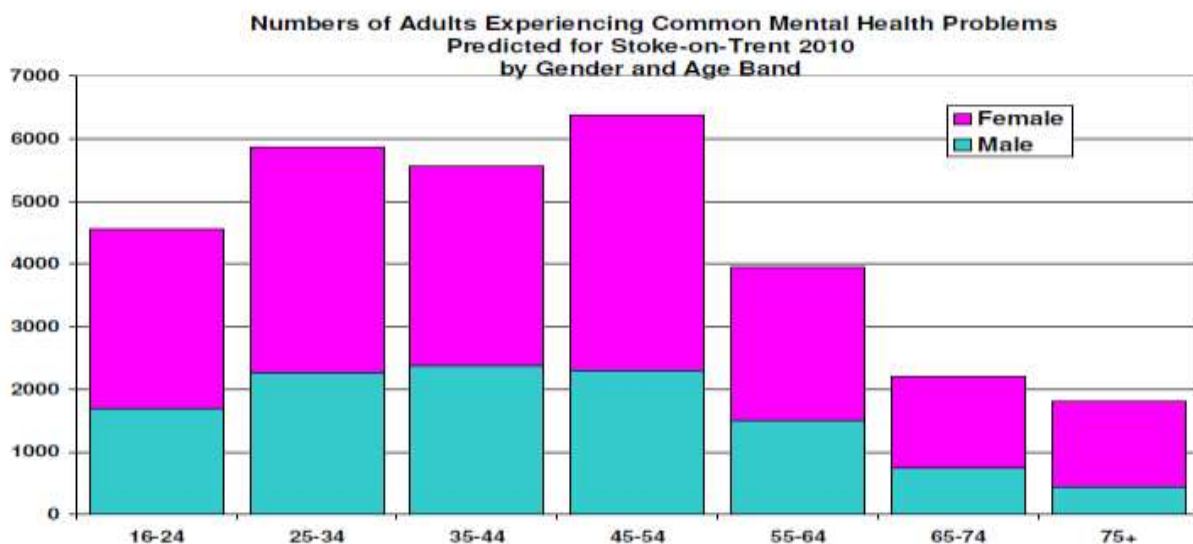


Figure 2. From: NHS Stoke-on-Trent and City of Stoke-on-Trent (2011), JSNA 2010-2015, p. 216

In 2010-11 4343 females and 3569 males accessed NHS specialist mental health services in Stoke-on-Trent (ONS, 2011b). The rates for hospital admissions for mental health are significantly higher in SoT compared to the England average (North East Public Health Observatory, 2013). Hospital stays for self harm and alcohol-related harm are also higher than average (with the number for the former at 596 in 2012, and a local value of 255 compared to 212 for the England average) (English Public Health Observatories, 2012).

Responses to SoT's health challenges

As the above profile indicates, there are considerable challenges facing the Local Authority in SoT with regard to maintaining and improving the population's health (Iqbal, 2011). City-wide strategic plans have been developed to increase physical activity and improve life expectancy, and there have been a range of initiatives in the city towards these aims. For example, in 2008, the Stoke Primary Care Trust *Floor Target Action Plan for Physical Activity* set a target of 30% of the adult population to undertake at least 30 minutes physical activity of at least moderate intensity on three or more days per week by 2012, and the city's *Sport and Physical Activity Strategy 2009-2016* proposes a 1% increase in participation each year. Stoke-on-Trent is one of the 14 designated Healthy Cities in the UK and is a designated member of the WHO European Healthy City Network. A Healthy City is "committed to the process of trying to achieve better physical and social environments which support and promote better health and quality of life for its residents" (WHO European Healthy Cities Networks, 2011). Following publication of the Government's mental health strategy, *No Health Without Mental Health, A Joint Mental Health and Wellbeing Strategy for Stoke-on-Trent* was drawn up in 2012.

WEA profile of learners on the CHEST programme and the Women's Boot Camp, Cobridge

In the three teaching years 2008/9 to 2010/11, the CHEST programme recorded the following enrolment data:

- 1,868 enrolments, with an 86% retention rate;
- 85% female and 15% male enrolments;
- 58% of learners were aged over 55, 38% 25-54 years, and only 4% aged 24 and under;
- 26% declared a physical disability and 12% a learning disability;
- 28% (of 98% of enrollees who declared their ethnicity) were from an ethnic minority, and these learners had a 77% retention rate;
- 76% (of 80% of enrollees who declared their qualifications) had qualifications below level 2 at the start of their CHEST course.

(Hurst and Vincent, 2011)

In comparison, the Women's Boot Camp groups have smaller numbers:

- 25 enrolments
- 100% female
- 12% over 55, 88% 25-55 years old;

- 15% declared a physical disability, 0% a learning disability;
- Of the learners who declared their ethnicity, 100% are from ethnic minorities (but this is due to incomplete form-filling as the group does have non-BME learners). The backgrounds of the group includes Asian or Asian British – Pakistani, Bangladeshi, Indian; Mixed - White and Asian. These learners had a 77% success rate in the last academic year.

5. FINDINGS FROM SCREENING

The first stage of the MWIA process was to screen the Women's Boot Camp in order to ascertain an initial assessment of the population group who are the target of the project, and its likely impact on them. Further to this, the purpose was to identify the likely impact of the course on the wider determinants of health and three mental well-being protective factors. The screening enables an informed decision to be made as to whether the project or service provision would benefit from having a more in-depth assessment such as a workshop with stakeholders.

An initial screening was undertaken on 29th January 2013. Contributing to the MWIA screening were Alexandra Wood, Janet Henson, Lyn Marie Chapman and Lydia Lewis. The MWIA screening toolkit was used to promote discussion of the initial assessment of impacts.

The full findings from the screening can be found in Appendix One. A summary is presented here.

Population groups

The course is likely to have a positive impact on all the population groups identified. It facilitates 'empowerment' and capability development for the women through developing social capital and knowledge, skills, assertiveness and awareness of health issues. In turn, it is likely to have wider benefits for participants' families and friends through improving the women's well-being and through the knowledge and skills gained. The knowledge gained is likely to benefit their families through changes to diet, health literacy and 'modelling' for children. However, on the negative side, it may also place a further burden of responsibility for family health on the women (it was noted that there isn't an equivalent group for men to attend). The women may feel guilty if they are not achieving healthy eating / lifestyles for themselves and their families. The course is likely to have a positive impact on inequalities of race/ethnicity in relation to well-being as the majority of the women are on course are from BME backgrounds.

Wider determinants of health

The course is likely to have a positive impact on: physical environment (access to green space); good quality food; leisure opportunities; tackling inequalities (through generating social capital which can help address associated issues); local democracy (through bringing the women together and as the course covers community campaigning); access to education and public services; and challenging discrimination. In relation to this last point, the course

helps challenge discrimination in access to health education and education more broadly (as progression is built in). It also enables the building of social capital and social support among the women which is likely to be empowering for them and to enable them to challenge sexism and racism. In addition, the course is designed to promote community cohesion and, although targeted for the South Asian community, includes a mixture of ages and ethnic backgrounds. There are likely to be indirect benefits in terms of economic security (e.g. through skills development and volunteering opportunities) and access to quality housing (e.g. through information-sharing and enhancing skills in dealing with housing agencies).

Protective factor: enhancing control

The impacts are likely to be all positive or indirectly positive for this factor, at both individual and community/organisation levels. In relation to collective organisation and action, the course brings women from two different minority ethnic groups together in a public space and builds social capital; encourages volunteering/self organisation; and community campaigning is included in the course curriculum. However, in relation to 'resources to make healthy choices', although the course provides knowledge and skills in this area so the impact on this component is likely to be positive, the issue above regarding family responsibility and possible guilt if not 'making health choices' negatively impacting well-being needs to be noted. There is also one component for which there are both positive and negative possibilities for impact: opportunity to influence local decisions. The impact here is likely to be positive in that participants are encouraged to develop their own activities and to volunteer and campaigning is included in the curriculum, but a negative is that the course itself is not really 'student-led' and is still 'put on' for the community without members leading or providing sessions.

Protective factor: Increasing resilience and community assets

The impacts here are likely to be positive or indirectly positive for all the individual and community/organisation level components. At the latter level, the course builds social networks, relationships and emotional support and enables women who are full-time carers and housewives to access public spaces. The women also 'have fun' attending the courses. The impact on the local economy is both positive and indirect. For example, the tutor is paid to run the course; it helps provide funding for the community centre that hosts it; participants gain skills and are encouraged to progress with their education; volunteers are involved with the course and participants are encouraged to volunteer locally.

Protective factor: facilitating participation and promoting inclusion

The likely effects on the two individual level component 'having a valued role' and 'sense of belong' are positive. There is also likely to be a positive effect in terms of 'feeling involved' in community life although it was queried whether the women have enough say in course content and how it is run. At the community/organisation level, the course brings women from different South Asian communities together, provides practical support, e.g. through information-sharing, provides ways to get involved (e.g. through taking part in the course and volunteering) and is an accessible and affordable form of provision, as it is local, during school hours and currently free to attend. In addition, it is culturally acceptable to the targeted

communities as it is a women-only course, and because of its content and venue. In terms of cost, the course is currently free but could be chargeable in the future (so impact is both positive and negative). The effect on conflict resolution in the private and public spheres is currently unknown. In terms of community cohesion, the course helps women who are full-time carers and housewives to access public spaces. It brings together women from the Pakistani and Bangladeshi communities in the locality. There are some white British women on the course and the tutor is White British so although targeted for women from the South Asian communities, it may also be helping to enhance community cohesion between these groups.

Positive Impacts

Population groups/factors: early years, older children, adolescence, later life, gender; race/ethnicity; socio-economic position; physical health; disability.

Wider determinants of health: physical environment; good quality food; leisure opportunities; tackling inequalities; local democracy; ease of access to high quality public services; access to education; challenging discrimination.

Enhancing control: a sense of control; belief in own capabilities and self-determination; knowledge, skills and resources to make healthy choices; self-help provision; opportunities to influence decisions; opportunities for expressing views and being heard; workplace job control (work-life balance, with 'workplace' encompassing domestic sphere); resources for financial control and capability; maintaining independence; collective organisation and action.

Increasing resilience and community assets: emotional well-being; ability to understand, think clearly and function socially; having beliefs and values; learning and development; healthy lifestyle; trust and safety; social networks and relationships; emotional support; shared public spaces; arts and creativity.

Promoting participation and inclusion: having a valued role; sense of belonging; feeling involved; activities that bring people together; practical support; ways to get involved; accessible and acceptable services or goods; cost of participating; cohesive communities.

Indirect impacts:

Wider determinants: access to quality housing; economic security.

Enhancing control: collective organisation and action; resources for financial control and capability.

Increasing resilience and community assets: sustainable local economy.

Promoting participation and inclusion: none (though conflict resolution is a possibility).

Negative impacts

Population groups/factors: women (see discussion above regarding enhanced burden of family responsibility/ possibility of guilt if not 'making healthy choices' for family and self negatively impacting well-being).

Wider determinants: none.

Enhancing control: opportunities to influence decisions.

Increasing resilience and community assets: none.

Promoting participation and inclusion: feeling involved (it was queried whether learners have enough say in what is included in the course, how it is run etc.); cost of participating (course is currently free but may be chargeable in the future).

Actions identified

Proceed with MWIA.

6 FINDINGS FROM STAKEHOLDERS

A key element of the MWIA process is to collect 'evidence' from the 'stakeholders' of the provisioning being assessed and this takes the form of a participative workshop. The purpose of the workshop was to work with those with an involvement and interest in the Women's Boot Camp to identify from their perspective the impacts that the project is having on their mental well-being. It was also to identify actions to maximise positive impacts and minimise potential negative impacts on mental well-being.

Details of the participants in the workshop and how they were invited to take part are provided on p. 9.

What does mental well-being mean to the stakeholders in the project?

As an introductory exercise, workshop participants were asked to form three groups and then to think of things they associate with mental well-being. These were written on post-it notes and stuck on flip chart paper. Participants were then asked to group the post-it notes into themes. The facilitator for each group fed back ideas to the whole group. Findings are presented below:

Group 1

Feelings: decreased levels of stress and depression more positive feels really good energetic feel good after exercise not angry; positive mood exercise makes me feel better happy not shouting at the kids	Support: share concerns with other (problems) talk about nutrition and physical activity 'can ask anything' made friends
Energy: more energy active after exercise I have more energy to clean the windows, cook nice food for my family	Personal development: learn how to ride a bike here I would like to go swimming

Group 2

Security: Security, good finances feeling safe	Leisure time and relaxation: holidays relaxation time for holidays, to go to Westport lake reading	Physical surroundings: Parks, open spaces and green spaces and trees Sunshine
Family, relationships and pets: dog and cat family relationships	Physical exercise: swimming, exercise walking	General: health

Group 3

Physical appearance: appearance e.g. weight loss	Thoughts and feelings: stress free healthy mind	Routines and sleeping: having a daily routine sleeping well
Social: social life meeting people friends	Health literacy, choices and behaviours: making the right choices for children health literacy e.g. reading food labels, awareness of what one's eating healthy eating; balanced diet healthy choices and lifestyle	Bodily feelings: less pain and aching

Findings from stakeholders: The Potential Impact of the Women's Boot Camp on participation and Inclusion

As discussed earlier, the MWIA toolkit provides a three factor framework for identifying and assessing protective factors for mental well-being, adapted from *Making it Happen* (Department of Health, 2001) and incorporates the social determinants that affect mental well-being into four factors that evidence suggests promote and protect mental well-being:

- *Enhancing control*
- *Increasing resilience and community assets*
- *Facilitating participation and promoting inclusion.*

As it was considered to be of most relevance to the course and its objectives, and due to limited time availability, this workshop focused on the MWIA factor 'participation and inclusion'. Participants were introduced to the factor and asked to think about the Women's Boot Camp in relation to it. Specifically, they were asked to rate how important the course was to the adult learners in this regard and the potential impact that the service could have on this factor.

Facilitating participation and promoting social inclusion – a summary of the evidence from the MWIA Toolkit (2011)

Facilitating participation

Participation is the extent to which people are involved and engaged in activities outside their immediate household, and includes cultural and leisure activities, as well as volunteering, membership of clubs and groups, as well as participation in local decision-making, collective action, voting and other forms of civic engagement. Some aspects of participation may overlap with social support/social networks; however network rich individuals and communities do not necessarily participate in civic affairs. The percentage of people who feel they can influence decisions in their locality is an indicator for the cross-sector outcome "to build cohesive, empowered and active communities".

For individuals, social participation and social support are associated with reduced risk of common mental health problems and better self reported health. Measures of social integration are highly correlated with risk of coronary heart disease. Voting abstention, possibly an indicator of low social capital, has negative lifetime health effects, over and above low socio-economic position.

Social isolation is an important risk factor for both deteriorating mental health and suicide. Similarly for recovery, social participation increases the likelihood, while low contact with friends and low social support decreases the likelihood of a recovery by up to 25%. Many cross-sectional studies show a correlation between well-being, social ties and pro-social behaviour e.g. participation, civic engagement, volunteering. One longitudinal study found that well-being (positive affect) predicted participation in volunteering but volunteering also increased positive affect.

Participation in education and employment both have strong positive effects on mental well-being. Having a secondary qualification reduces the risk of adult depression by 5 to 7 percentage points; an effect that remains after work and family characteristics are controlled for. Other studies have found that women with low literacy skills were five times more likely than those with average or good literacy skills to be depressed. Research drawn from an analysis of BHPS data suggests a significant relationship between literacy and social engagement, which in turn may impact on mental well-being. Community participation is higher among men and women with higher literacy skills, while non-readers and those with poor basic skills are:

- less likely to vote or have an interest in politics
- less likely to participate in their local community
- less likely to belong to a membership organisation.

“To be literate is to gain a voice and to participate meaningfully and assertively in decisions that affect one's life”.

Where we have comparisons, the effects of initial schooling on health are generally greater than the effects of subsequent adult learning. However, adult learning remains an important influence in positive outcomes in health and well-being amongst adults. There is some (limited) evidence that the health benefits of adult learning may be greater for those with less education than for others. Quantitative analyses of data from the 1958 National Child Development Study (NCDS) provide evidence for an association between participation in learning and self efficacy, particularly for adults who had low levels of achievement at school.

There is very robust evidence that participation in employment, notably good quality employment, is good for mental health and, even more unequivocally, that unemployment is bad for mental health (Waddell and Burton, 2007).

Promoting social inclusion

“...a lack or denial of access to the kinds of social relations, social customs and activities in which the great majority of people in British society engage. In current usage, social exclusion is often regarded as a 'process' rather than a 'state' and this helps in being constructively precise in deciding its relationship to poverty.” (Gordon et al, 2000)

Social inclusion is the extent to which people are able to access opportunities, for example employment, education, leisure, credit. It is often measured in terms of factors that exclude certain groups, e.g. poverty, disability, physical ill-health, unemployment, old age, poor mental health. People experiencing mental health problems are among the most socially excluded on a wide range of indicators. For individuals, feeling useful, feeling close to other people and feeling interested in other people are key attributes that contribute to positive mental well-being. Social exclusion on any grounds is both a cause and consequence of mental health problems. Like participation, social inclusion plays a significant role both in preventing mental health problems and improving outcomes.

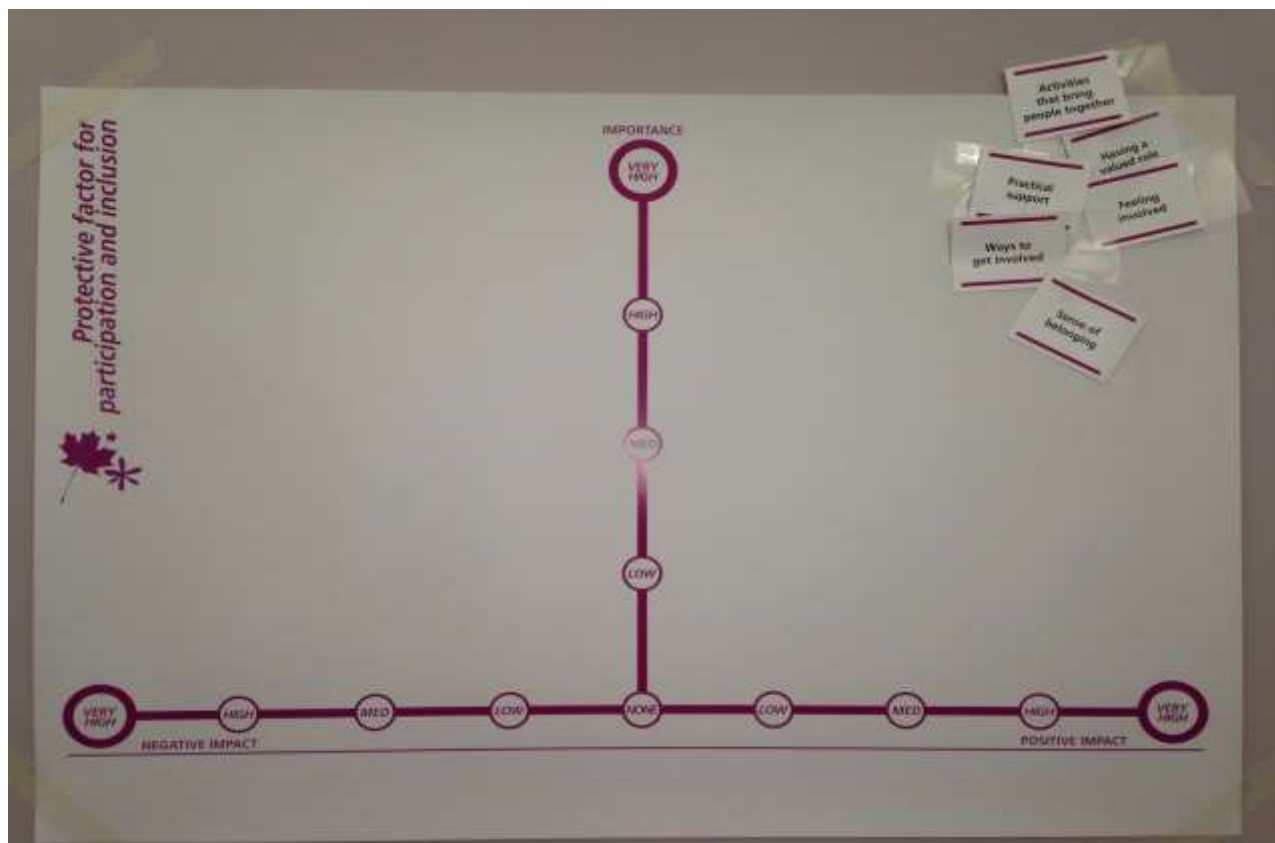
Factors influencing social inclusion include anti-discrimination legislation and policies designed to reduce inequalities. There is a strong correlation between socio-economic deprivation and levels of social integration. One study demonstrated a strong correlation between socio-economic disadvantage and social integration, using the following measures:

- availability of a confidant partnership
- close ties
- social participation

Facilitating participation and promoting social inclusion – workshop findings

Participants were invited to come up and select an element from the chart. Taking one at a time, a discussion was then facilitated around each element regarding a.) participants' understandings of it, and b.) whether they felt the Women's Boot Camp had had a positive or negative impact on this element for its participants, and the degree of importance of that impact. The results are presented in Figure 3.

Figure 3 Prioritisation Grid – Participation and inclusion



Top priorities

Having discussed the above elements, and rated their importance and the impact of the course upon them, participants were invited to work through their top three priorities. The purpose of this was to identify in more detail the potential impacts of the course and any recommendations that emerged. The results are presented in Figure 4.

Figure 4: Participation and inclusion: top 3 priorities table.

Protective factor: Participation and inclusion				
Top 3 priorities	Impact of your proposal on this protective factor			Actions identified
	(+) Positive	(-) Negative	(?) Unclear	
① Accessible classes and services Timing of group	Tues morning Timing Location is good Blood pressure checks. Helps us understand what GP does	Thurs afternoon - Timing		Additional class - for more varied activities - walking - swimming - crafts - something with
② Practical Support	Feel more comfortable Being able to follow	Written instructions and note taking Providing help/interpreting takes time and interferes with taking part.		Written class notes/instructions available in advance in various languages
③ Cost of participating	Free classes or very low cost ie. £1 a class Local class ♀ only			

Findings from the group discussion

Initial comments at the start of the workshop were that the enrolment process had helped induction into the course. The value of “having people there”, registering, weighing etc. was expressed. Participants also said that “explaining up front what was coming” was helpful. In addition, the point was made that the adult learner group was “not easily led”; they “need to be pushed”. This encouragement was seen as important for ensuring the adult learners made best use of the time. The workshop then moved to selecting elements (sticky notes) from the chart. Notably, ‘*conflict resolution*’ was last to be selected, perhaps due to a combination of perceived relevance and the sensitive nature of this issue. The following comments were made in relation to each element:

Having a valued role:

This was discussed as important to participants in terms of roles within the family, this class, and the community and “valuing the roles of one another”. One older participant commented

(through translation): “it’s more important than you could imagine – feeling part of this”. One translator summarised discussion from one small group thus: “They enjoy it and want to see more of it”. It was noted that, reflecting demand, weekly sessions had increased to twice weekly. It was also noted that it can be a problem if translators aren’t available to help, and this can also mean they don’t take part in exercise, but they feel valued doing it.

Accessibility:

The timing of the course sessions was a key point of discussion here. Some of the younger participants commented that the afternoon session didn’t suit them and that mornings suit them better. There was also reference to someone who wasn’t attending because her daughter is at school (and she needs to collect her in the afternoons). Participants stated that the sessions need to be in school time, so the Tuesday class is ok, but the Thursday one is not suitable. In terms of the location of the classes, the general view was that it’s important that they are local.

Cost of participating:

This element was discussed as significant in relation to social isolation and inclusion; for example, one participant commented: “the majority of Asian ladies don’t get out of the house”. The fact that the class is free was considered important, and some participants said they probably wouldn’t come if they had to pay. The rising cost of living was noted here.

Feeling involved:

The feeling among the women was that the class was helping them to feel involved in community life in their locality. For instance, one related the view that, “coming to the class and participating, knowing that you’re coming to do something makes you feel involved”, and another that “if you have something to say, people will listen to you and you feel involved”. The fact that the tutor would listen to opinions was also seen as important. In addition, a sense of community obligation was expressed: “You feel like if you don’t come, you should make the effort to come so the facility isn’t closed down”; “if you don’t come, you feel like you haven’t done your bit”.

Another point of discussion on the theme of involvement was the benefits of incentives for helping with attendance, such as points as a reward for punctuality or a present or gift at the end of the day. The fact that if you were late, the door was closed seemed to be seen as a good incentive for timely arrival. The child friendly nature of the class was also seen as beneficial as one participant’s child regularly took part in the class with the women and it was noted that, in contrast, gyms wouldn’t accept a child.

In terms of ways to enhance feelings of involvement, one suggestion was ladies-only swimming. The women commented that local pools had been closed down and mixed swimming was seen as undesirable. Currently, there was only one person in the group who paid for another fitness activity (swimming). In order to encourage swimming, women-only sessions were viewed as very important. Sessions at a pool at Holden Lane were seen as a possibility while taking children along, and although it requires an entry fee, a cost of £3 or £4

was seen as acceptable. However, this pool is the other side of the city and is likely to close soon. Participants said they “could go together” by car, and the more people involved, the less the transport cost, as this could be shared.

Bringing people together:

There was evidence of the development of social capital through the classes, particularly bonding capital through bringing together women from the target communities. The course was also evidently bringing together women of different generations from within these communities. However, the fact that the White British women did not attend the workshop may have indicated that the course was being less successful at generating ‘bridging capital’ between ethnic groups. One participant expressed the view that “coming down here is very important” and others in the group agreed. Highlighting the value for women of women-only spaces, another commented that “because Asian ladies can’t get out much, this is a space for us”.

The women were asked if they knew one another before coming to the classes, and they responded that some did, and some of the adult learners were members of the same families, but this was not the case for everyone. The women also commented that they “do more together now”, such as texting one another about an event going on. They also said that if someone new moved to the area, they would tell them about the class. It was suggested that publicity for the class could be improved through posters in the grocery shop, GP surgeries, and in the community centre itself.

In addition, the women recounted that they motivate one another to attend, for example if someone is complaining that they don’t feel well. One commented: “We are all like family, we help each other”. Participants also discussed how they like to go for walks with their children and with friends’ children. Leading walks was highlighted as a potential area for the development of volunteering. In terms of the length of the classes, the women expressed the view that they are all busy so they don’t need a longer class; two hours is enough.

Practical support:

Translation was a key point of discussion here. It was noted that if translators are not in attendance, the participants wouldn’t get practical support to overcome the language barrier. Currently, they help one another with this. If the translators are there, they also explain other events from posters, flyers etc. to the women who can’t read English. Most of the women do understand the class but sometimes are not sure if they are listening to the right thing. They sometimes get confused with instructions, but can follow others. A Bengali interpreter for the classes might be useful. At present, the interpreter’s role has been picked up by some participants as they saw a need for this. It is done as a matter of good will, due to the need to fill that gap.

Ways to get involved:

Points of discussion here were as follows:

- Individual vs. team exercise: Some participants felt that individual exercises can sometimes be a bit boring, and that team games can be more enjoyable and a better way of 'getting involved'. Football in groups and riding a bike were identified as desirable activities.
- Volunteering: This was discussed in term of formalising what some participants are already doing and enabling people to take the lead themselves. However, liability was identified as a barrier as "people worry they are taking all the risk". In response, it was noted that the WEA can insure the group and that training would support people. It was felt that it may be a good idea for the interpreters to be recognised as volunteers. Seven people said they felt they would like to get more involved in a volunteering capacity (something which was later noted by WEA staff running the project as a real progression for this group). One participant commented: "If I can help my community, I will". Leading walks, involvement in more classes, organising swimming and reading and writing support were identified as potential areas for volunteering development.
- Getting involved in other activities: There was discussion of a woodwork class at the centre which some participants had enjoyed (e.g. one woman had made a plant pot). They had heard about this class because they were already coming to the Centre. There was therefore indication that the Women's Boot Camp was acting a catalyst for further participation in adult learning and community life.

Sense of belonging:

There was also indication that the Women's Boot Camp was enhancing this element of the social participation and inclusion factor. For example, one participant stated: "It does make you feel that you belong somewhere". The setting and size of the group was considered important in this respect, as the women felt that "going to a gym or a big group, you wouldn't feel as confident". This comment, along with the other findings reported above, additionally indicated that these features of the group, as well as its women-only nature and the social support it generated, were important for developing a sense of agency among the women.

The table below gives more detail (from the discussion) about the top three priorities identified by workshop participants and outlines the subsequent actions and responses from the provider (the WEA).

Top priorities	Impacts of the Women's Boot Camp on Participation and inclusion		Comments and Actions
	(+) Positive Impact	(-) Negative Impact	
<u>Accessibility</u>	Location is good (local). Has the class helped participants access health services? No – they were already fine with this. But does help them to discuss health issues with GP and other practitioners a bit more. Taking B.P. in class – that helps as appointments with GP can be a hassle; with class don't have to make an appointment. Having BP taken here can be reassuring. Women only is good.	Some ladies no problem with Thursday, but no problem if changed the time. Just people with children for whom is difficult.	Walking group and if possible extra class. Day: Mon, Tues or Friday ok. Friday morning ok. Mornings best for majority of group. 9.30 onwards. More varied activities e.g. walking, swimming, crafts. Children can come swimming. Good for bonding between parent and child. Actions taken: The class has been changed to a Thursday morning. Janet gave out 6 volunteers forms to the groups so we could start a walking group and training. None were returned, asking over several weeks. The swimming has not been arranged yet as the local council can't find time at the local pool for a ladies only session. Since the workshop, the Cobridge Community Centre has closed due to funding problems and we have moved both classes to the TA Centre, which is accessible to these learners but has less wider community activity.

<u>Practical support:</u> <u>Interpreting</u>	Participants can follow practical exercises; if they don't understand, they just follow.	People interpreting, may interfere with own exercise. While explaining, have to work both ways – do exercises yourself and explain to others. Language barrier means understanding written instructions in English and note-taking is difficult for some, as is filling in forms. Miss a lot of information.	It would be useful to have written information/class notes available in advance in various languages. In terms of filling out forms, it might be useful to have something prepared in advance of the class. If volunteers had the information and forms in advance, that might help. Response: The tutor explains the week before what they will be doing and gives them time to research homework. All written materials are explained with time given for the group to help each other understand. We normally do not provide translated printed materials because of the many different languages which often learners speak but do not read, and because of legal issues surrounding translating health documentation. A support worker or other staff member attends courses at the beginning and end of the course, and on request, to help learners complete forms.
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<u>Cost</u>	Fact there are no travel costs (because class is local) is helpful. Important that it's free of charge – encourages people to come.		This seen as a priority. Asked if would pay. Response that would pay £1 per session; everyone here could come if the charge was £1. But may not have spare change. If asked for £20 up front, people may drop out. One person pays for swimming. Response: Current courses will remain free of charge through the Big Lottery funding until 2017. Further courses would need subsidies from other funders.
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Summary

Understandings of well-being

The understanding of well-being arising from the responses of workshop participants was broad, encompassing and extending the definitions given on p. 8. It covered subjective well-being ('feelings' e.g. 'feeling good after exercise'); social well-being (social contact, relationships and support e.g. 'making friends and sharing concerns'; 'family, relationships and pets'); and psychological well-being (e.g. 'stress free'; 'healthy mind'; routines and sleeping). Other factors mentioned included security (feeling safe and financially secure); energy; physical exercise; bodily feelings (less pain and aching); physical appearance; health literacy, choices and behaviours; leisure time and relaxation; physical surroundings (e.g. green spaces, trees and sunshine) and personal development (aspirations to gain new skills). This latter factor resonates with the understanding of well-being provided by the Foresight Group in terms of developing one's potential and speaks to the relationship between capabilities and subjective well-being (Lewis, 2012a and b, following Sen, 1999, 2010).

Participation and inclusion – psycho-social factors

The workshop provided evidence that the course was affording the women a sense of being valued and a sense of belonging, which were highlighted as important with various comments. The women commented that in order to foster a sense of belonging, it was important that the group was local and small. In addition, the women discussed ways in which the course was helping them feel involved in community life and listened to. There was evidence of social capital generation through the classes, especially bonding capital. The women discussed mutual support in terms of helping one another and how the course was enabling information-sharing and networking. Some participants also said it was helping with interacting with health professionals. The component 'conflict resolution' was the last to be picked from the chart and was not discussed in the group due to lack of time/inclination.

Overall, the women commented that the course was very important to their lives. They discussed the importance of 'getting out' and of having their own space in this way, thereby indicating the value of the course being women-only. There was evidence that the distinctive features of the group and the social support it generated was helping develop the women's agency. The fact that the features of the course enabled the women to feel confident attending was expressed, along with the fact of members of the group needing 'to be pushed'. There was suggestion that the course was encouraging the women to go on walks together but only limited evidence that the course was acting as a catalyst for joining other adult learning classes. However, at the end of the workshop, 7 members volunteered for leadership roles.

Participation and inclusion – practical features

Accessibility issues were discussed in relation to timing due to child care responsibilities and the importance of the class being local and free. The length of the class (2 hours) was seen as about right. In terms of practical support, a key point was translation support as currently this is provided informally in the group. Members who translate in the class also sometimes do so outside formal class time e.g. events posters and flyers in the community centre.

Suggestions

Women-only swimming
More publicity in local shops and venues
Leading walks – potential area for development of volunteering
Team games and bike-riding.
Craft activities.
Course materials in various languages and more translation support.

Top priorities

The stakeholders identified three top priorities that were both of high importance and had a high impact: accessibility, practical support for interpreting and cost. A focus on these for the Women's Boot Camp will help promote participation and inclusion for, and consequently the mental well-being of, women within the Pakistani and Bangladeshi communities around Cobridge.

An evaluation of the workshop can be found in Appendix Two.

7 REVIEWING THE LITERATURE EVIDENCE BASE

The MWIA toolkit assessment criteria for the protective factors (discussed in section 6) are based on a review of the published literature that research suggests are helpful in promoting and protecting mental well-being. In order to build on this evidence base a short additional literature review was undertaken to identify what published research studies there may be suggesting that the WEA Women's Boot Camp, Cobridge may have an impact on mental well-being. This is intended to provide further evidence to substantiate or challenge the findings from the MWIA workshop.

A brief scoping literature review drew on the following sources:

- material on the wider benefits of ACL, including evidence specifically on community health education programmes and community sport and wellbeing, collated for a previous study conducted by one of the co-authors;
- additional citation searching of this literature for further evidence relating to BME groups and learning;
- grey literature relating to women only spaces, women's mental health services, and engaging BME communities in activities for well-being provided by one of the authors;
- academic literature on women and depression and service responses to South Asian women who self harm known to one of the authors;
- grey literature on physical activity and health known to the CHEST programme organiser;
- research evidence compiled for the original CHEST programme funding bid and a follow-up bid;
- previous evaluations of the CHEST programme and related programmes.

The well-being benefits of adult community learning (ACL)

Successive governments have regarded ACL as helping to meet both a social justice and equity agenda and an economic employment and skills agenda (Ball, 2008), although the latter of these has often been prioritised (Coare and Johnston, 2003). The current coalition government has framed these functions in terms of 'social inclusion' (BIS, 2010, 2011), while 'social exclusion' was an important focus of the previous New Labour Government (e.g. SEU [Social Exclusion Unit], 2004).

The social and personal benefits of ACL are well documented. Social benefits include ACL being associated with participation in other community activities (Calaghan et al, 2001). It is therefore often viewed as a way of enhancing social capital and 'civic renewal'. For example, Nanton (2009) describes women's use of social capital in ACL contexts "to advance women's empowerment and the development of their communities" (Nanton and Alfred, 2009, p. 1). Citing Moser (1996), she discusses how "in situations of poverty, vulnerable communities marshal specific resources for survival during economic adversity, including household relations and social capital among other tangible and intangible assets of communities" (Nanton, 2009, p. 15).

The personal benefits of ACL include positive effects on mental health and general well-being (Birch et al, 2003; Calaghan et al, 2001; Dutton, 2007; Feinstein et al, 2008). It can help develop self esteem and confidence for adult learners (ibid; Aldridge and Lavender, 2000; Calaghan et al, 2001; Dutton, 2007); help people to deal with stress and increase their resilience to challenges they face (Hammond 2002; Attwell et al, 2013); and so can be an important factor in improving poor mental health (James, 2005). Indeed, as Dutton (2007: 13) point out, benefits for participants include "providing a sense of purpose, reduced isolation, more friendships, better coping mechanisms and a sense of hope in being able to deal with any problems". These benefits may be enhanced for those experiencing health problems or with disabilities (Dench and Regan, 2000). Engagement with ACL can also provide a way back into more formal education through encouraging progression and help individuals access further training and employment opportunities (Birch et al, 2003; Calaghan et al, 2001). Indeed for some it has been described as facilitating "transformational changes in individuals' lives" (ibid).

A recent WEA study of the impact of their provision, involving telephone interviews with 522 students, found that:

87 percent noted the course had kept their mind and body active which rose to 94 percent in those with a long-term physical or mental illness. ... 69 percent of respondents said the course made them feel better about themselves generally and this increased for those with children under eighteen (75 percent) and for those with a long-term physical or mental illness (73 percent). (Attwell et al, 2013, p. 8)

Another qualitative study conducted for the WEA by one of the co-authors (Lewis, 2012a and b) found ACL that is targeted for mental health impacts beneficially upon the mental health of those who take part through three main processes: providing recognition (feeling oneself to

be a worthy and valued person, a phenomenon produced through mutual support and a humanistic learning environment); generating resources (or 'capitals', including social and emotional capital, which was often mentioned as most important); and enhancing agency freedom. This freedom was recounted in relation to five themes: "taking part in social life; speaking out; standing up to violence and abuse; collective action and participation in political life; and generating educational and vocational capabilities" (Lewis, 2012b, p. 3). Lewis (2012b) notes:

These processes appeared to vary for differing social groups and so to be having an impact on tackling mental health inequalities. Most notably, breaking isolation and generating social support was found to be a particularly significant benefit for older participants, while agency freedom in terms of speaking out on and standing up to violence and abuse was of particular importance for the mental health of women participants, many of whom had experiences in this area. (p. 3)

An important finding was the way in which the targeted provision in the area of 'self help'/'personal development' was found to be creating "supportive spaces in which people were able to break silences on key issues in the context of mental health which are surrounded by stigma and shame: domestic violence, problems with alcohol use and suicide attempts" (ibid). The study links these findings to other research which shows how these social issues can be effectively tackled through community programmes which break isolation and build social support, thereby promoting community resilience (Wilding, 2011; see also Mguni and Bacon, 2010).

The study also identified ways in which the targeted ACL may have been working to diminish or inhibit, as well as promote, the adult learners' freedoms. One issue here was the potential perpetuation of stigmatizing 'mental illness' identities through the targeted nature of the programmes, although, through enabling the development of social solidarity, the programmes also helped participants challenge these identities. Another issue related to the nature of the provision and the social capital it generates "risking inhibiting progression to other mainstream educational opportunities, particularly for women" (Lewis, 2012b, p. 533), although the over-riding finding was that the programmes were enabling educational and vocational progression through developing participants' capacities for engagement in learning.

The participation of women from UK Pakistani and Bangladeshi communities in learning

Recent data shows men and women in the UK to be equally likely to take part in learning (Aldridge and Hughes, 2012), although women take up opportunities for ACL more specifically in greater numbers than men (Jones, 2010). Socio-economic class is an important predictor of participation in learning. For example in the 2012 NIACE Adult Participation in Learning survey, those in the highest classes were significantly more likely to report having taken part in learning in the previous 3 years (Aldridge and Hughes, 2012).

Aldridge and Tuckett (2011) report higher levels of learning participation among minority ethnic adults in the UK compared to white respondents. However, there are differences between different ethnic groups. Data from the Labour Force Survey on participation in learning shows lowest rates among Pakistani and Bangladeshi groups, especially women (at 42% for Pakistani women and 34% for Bangladeshi women, compared to a 71% national average) (Aldridge et al, 2008). This survey has also found these ethnic groups to have the highest percentages of respondents with no qualifications (Aldridge et al, 2006). In a review of adult learning participation conducted for the Equality and Human Rights Commission, Jones (2010, pp. 25-6) reports:

It is the position of Bangladeshi and Pakistani adults, and women from those communities above all which constitutes the most persistent and extreme form of inequality of all the minority ethnic groups. The gender dimensions of this are particularly striking. "Women learners with a Bangladeshi background over 35 years of age participate at less than half the national rate" (Aldridge et al., 2008: 5) ... Participation by Bangladeshi and Pakistani adults has patterns which are particularly concerning because despite the fall in the numbers of Bangladeshi adults with no qualifications between 2004 and 2006, "the proportion of Bangladeshi learners taking taught classes dropped from 66% to 57% over the same period" (Aldridge et al., 2008: 5).

Reasons for low rates of participation

The low rates of adult learning participation among women from the Bangladeshi and Pakistani communities in the UK have been seen to be associated with motherhood and full-time child care (Dale et al., 2000, 2006). However, Li et al (2008) note heightening educational aspirations among these women and Ward and Spacey (2008) a shift towards more liberal attitudes regarding women's roles within these communities in recent times. Dutton (2007, p. 13), suggests the reasons for variations in learning participation by ethnic group are unclear, postulating that: "The differences may relate to the cultural importance given to adult learning, the cultural appropriateness of the learning opportunities available, the environment such as the venue, and background/ethnic origin of the tutor delivering the learning (White 2002, McNulty 2003, Aldridge and White 2005)".

Important and insightful data on hindrances and facilitators to learning for the most disadvantaged Bangladeshi, Pakistani and Somali women in the UK are provided by Ward and Spacey (2008). They interviewed 100 women, including 62 not presently taking part in organized education and women with few skills in English, due to this being associated with societal exclusion. The authors identify the following barriers to engagement:

- **"personal and cultural** – the women's own, husband's, family's and community attitudes and expectations of women's place and role;
- **practical** – gender oppression – restrictions and violence from families, especially husbands, poor health, old age, caring responsibilities, lack of time;
- **psychological** – lack of confidence, feeling too old or too sick to learn;
- **institutional** – lack of information and advice; classes not at the right level, located in inaccessible locations at unsuitable times, fees, lack of affordable childcare." (p. 2)

Confidence was cited as a major deterrent when combined with lack of English. In practical and institutional terms, the authors note:

Provision far from home is a barrier for women who are not able to travel independently, as is the need to juggle classes with other responsibilities such as collecting children from school. Potential costs deter some women and lack of information means that others never discover a class. Some respondents reported a scarcity of women only provision, something that excludes women not allowed to learn in mixed environments. (p. 3)

Implications for ACL

In drawing out implications for learning provision, Ward and Spacey (2008) argue for a range of strategies to ensure all, and especially the most marginalized women from the Bangladeshi, Pakistani and Somali communities, are reached. They recommend the following:

- Community outreach approaches based on word of mouth.
- Creative consideration of access issues: Appropriate provision in easily accessible venues that are considered safe by the community; social activities, taster sessions and events; provision of childcare; ensuring affordability; providing women only spaces; content that is flexible to learners' needs as well as interesting and relevant; teachers with cultural awareness and understanding and experience of working in communities.
- Individually tailored learning and support.
- The complementing of structured learning with good learner-teacher relationships, peer support and mentoring, role models and social activity (which can be used for practicing English and are a valuable means of forging friendships, and important for breaking isolation and generating solidarity and support, particularly if the women are facing home or community disapproval of their participation).
- The need to encourage women to aim higher through offering vocational information and advice, encouragement and bridges to progress.

In relation to this last point NIACE's (2012) Manifesto for Women's Learning, *Every Woman's Right to Learn*, adds that adult learning should allow women to "learn something for themselves" and to "pursue their hopes, dreams and desires" (and not just be oriented towards employment). It also stresses the importance of opportunities being made available at different life stages.

In terms of community cohesion, the study of adult learning participation among women from the UK Bangladeshi, Pakistani and Somali communities by Ward and Spacey (2008, p. 5) found:

There are relatively high levels of involvement in communal leisure activities, informal support networks, or voluntary organizations for their own ethnic groups. In contrast, there is a noticeable lack of activity outside, and only a small minority of women volunteer or intend to volunteer in the future. Women engaged in learning reported

more use of amenities but in general not greater involvement in mixed community activity. English is one of a number of reasons for this, but lack of interest or inclination, a lack of time or opportunity or no information or encouragement from community organizations were also cited.

The authors state the urgent need for learning programmes with the “specific aim of fostering cohesion either in discrete groups or in mixed community based groups” (ibid).

While noting the challenge of engaging women, Woodward (2013) provides interesting examples of how such cohesion among women can be fostered through informal community education aimed at women’s empowerment. Taking a community development approach, she describes a successful course in Birmingham aimed at getting women interested in politics, and how participants reported that the course had also helped their assertiveness in dealing with issues in the domestic sphere. Keys to success included introducing politics through an organized trip to a place of interest to participants (London on International Women’s Day) and involving a South Asian female councilor. She also describes engaging a diversity of women residents from the Handsworth area of Birmingham (which has a recent history of racial conflict) in walking tours concerned with the socio-political history of the locality from the time of the industrial revolution.

The benefits of women-only services

The benefits of women-only services are widely known within the women’s and ACL sectors. In making the case for women only services, the Women’s Resource Centre (WRC) (2011) points out that these services:

- Provide opportunities for women to share experiences, come to shared understandings and develop a sense of solidarity – factors which are crucial for women’s mental health (see also Williams, 2005);
- May enable women to contribute to society in other ways eg. through volunteering for the VCS and have important indirect benefits e.g. for the women’s families;
- Provide economic benefits e.g. through enhancing women’s employment prospects, preventing re-victimisation and staving off health problems.

Similarly, Patiniotis and White (2011) reporting on experiences facilitating a mental health service user group, highlight the difficulties of discussing gender inequalities issues relating to mental health in a mixed group. The WRC (2011) argues powerfully that without women-only services, many women would be left without support:

There was evidence that many service users would not access support if it was not women-only. Therefore, many women in need of vital support services would not receive them. The possible consequences could include deterioration in health, missed employment and educational opportunities, ongoing violence etc. (p. 17)

Working towards Women’s Well-being (National Mental Health Development Unit, 2010), a progress report on the extent of progress with women’s mental health policy and services since the publication of the Women’s Mental Health Strategy in 2002 and accompanying implementation guide in 2003, reported continuing variability and patchiness in gender-

specific service provision and concerns about the sustainability of women's day services, most of which are still provided by the third sector. In addition, it reports significant gaps in personalised services, particularly for women from BME communities (among other groups), although the Delivering Race Equality (DRE) programme had led to the development of some community projects for these women. Significantly for this MWIA, the report notes that: "Voluntary sector community groups continue to play a central role in provision for BME women, but cannot be expected to fill this gap without secure funding" (p. 7).

Burman et al (2002) highlight the inadequate service provision in Britain for women of South Asian background who have attempted suicide or self-harm. They argue that "these omissions have resulted in the distress of South Asian women going unrecognized in the name of respect for cultural diversity, thereby sanctioning policies and practices that further the oppression of South Asia women" (p. 641). In a report entitled, *Creating Inclusive Learning Communities: Promoting access to learning and skills for people from black and minority ethnic communities who experience mental health difficulties*, Dutton (2007) similarly highlights the "need for more support services to meet women's needs" and argues that "healthcare employees need training on specific women's cultural issues" (p. 10).

There is also evidence of the benefits for women of women-only provision for fitness and swimming. For example, women may be more likely to experience 'social physique anxiety' and to shorten their workouts in mixed sex gym facilities (Kruisselbrink et al, 2004). The fact that middle-aged women who don't exercise have been found to express greater fears about body image than those who do (Whaley, 2003) also indicates the need for appropriate provision for women within community leisure facilities to ensure they are likely to feel comfortable and are encouraged to use the facilities.

Community health education and improvement programmes

Evidence suggests that the relationship between being over-weight and education is mediated by a range of factors which include food literacy, self esteem and cost (Vandenbroeck et al. 2007). Learning about the benefits of health eating and increasing opportunities for physical exercise may therefore be effective ways of helping people to manage their weight (ibid; WEA, 2011). In addition, evidence suggests that there is an association between physical activity and mental well-being. For example, the Physical Activity Guidelines Advisory Committee, (2008, cited in BHF National Centre for Physical Activity and Health, 2013a, p. 7) report that: "On average, active adults have a 30% lower chance of feeling distressed or a 30% higher chance of enhanced wellbeing than inactive adults. Physically active adults have a 20-30% lower risk of depression, distress and dementia". Moreover, exercise has been found to causally benefit mental well-being through a range of mechanisms: effecting brain chemistry and hormones; lifting mood and blocking negative thoughts; and enhancing cognitive functioning (Naz, 2011, citing Beydoun and Wang, 2010). Group exercising can also enhance well-being through providing opportunities for increased social contact and the generating of social capital in local communities (ibid; BHF National Centre for Physical Activity and Health, 2013a). For those experiencing mental health difficulties, community sports activities have been found to be an effective, non-

stigmatising way of building social support and enabling the broaching of the difficult personal and social issues for groups unlikely to access traditional health services (e.g. Spandler et al, 2012).

There is a body of research evidence on community health education and health promotion for BME groups. This includes programmes for managing specific conditions such as diabetes (e.g. Wang and Chan, 2005). The literature often refers to health literacy (e.g. Marks, 2009) and peer education models are often used (e.g. Fabiano, 1994). Reported outcomes include improvement in health knowledge and 'behaviours' and social support, while health-related quality of life is also sometimes used as an outcome measure (e.g. Rana et al, 2009). For example, Shaknar et al (2007) in a study of a nutrition education intervention for urban African American women, found that "for some residents of low-resource communities, small group interventions are popular, effective vehicles for nutrition education". Similarly, Sun et al (1999) in a study of a community-based nutrition education programme targeting Chinese-American college students report improved dietary behaviour and social support. However, there is often a disparity between health knowledge (e.g. of good dietary practice) and health behaviours (Murphy et al, 1996; Naz, 2008a).

Moreover, a key issue for community-based health education and improvement programmes is the degree to which they are oriented towards socio-political action compared to individualistic and behaviourally-related approaches (Whitehead, 2004). A related point is the need to ensure that approaches do not "reinforce prevailing oppressive positions of women and structural heterosexism/homophobia" (Burman and Chantler, 2003, p. 307), for example through the assumption of women's responsibility for family health. Current thinking favours 'systems based approaches' which move beyond a behavioural scientific perspective to consider the change that is needed at social and cultural, environmental and policy levels (Hurst et al, 2012a; see Vandenbroeck et al. 2007). While the value of participatory approaches that aim towards community 'empowerment' is often heralded (e.g. Fabiano, 1994, Israel et al, 1994; Wallerstein and Bernstein, 1994), such models may not be applied in practice (Whitehead, 2004), with many programmes adopting individualist paradigms grounded in information (Fabiano, 1994).

Much evidence suggests the benefits of a community development approach to health improvement. This approach aims to address the social determinants of health such as social isolation and educational disadvantage (Hurst et al, 2012a). They often include an assets-based approach which "values the capacity, skills, knowledge, connections and potential within a community" (ibid, pp. 1-2). Within such an approach desired outcomes and understandings of health are defined by community members and there is a need for effective participatory decision-making so communities can set their own agendas for change (Marmot et al, 2010). Reporting on a community-led intervention called *My Health Matters*, Hurst et al (2012a, p. 12) argue for "a community-led collaborative approach to combating inequalities in health" as "many of the complex determinants of health lie beyond the control of the individual and even of clinical and public health institutions alone".

These authors argue that a community-led approach in which health priorities and interventions are defined by local communities can help to influence health-related behaviour and address some of the wider determinants of health, for example through building social capital. This can be achieved, they suggest, through a community capacity-building and 'empowerment' approach which focuses on helping individuals to identify and share their assets, such as skills, knowledge and experience. However, such an approach to health improvement also needs to engage with the structural, including economic, constraints on people's lives and the ways in which these impact on psycho-social factors (Friedli, 2009, 2011b). As Foot and Hopkins (2012, p. 6) point out: "Work to improve health-enhancing assets has not only to focus on psychosocial assets but also on the social, economic and environmental factors that influence inequalities in health and wellbeing."

Barriers to engagement

The WEA's research evidence in this area includes a report on the *Community Research for Better Health* Project, a three year (2010-13) action research project supported by the University of Leicester's Institute for Lifelong Learning and also funded by the Big Lottery Fund. The project involved Community Researchers investigating barriers to physical activity and healthy living for "Black, Asian and Minority Ethnic (BAME) people living in health deprived communities and working with them to identify ways forward to overcome these barriers". It worked "directly with over 100 adults within the inner city areas of Sandwell, Stoke-on-Trent and Birmingham, particularly the 'hard to reach'" (see: <http://www.westmidlands.wea.org.uk/crbh-health-project>). Many of the barriers to participation in physical activity identified by the project did not differ significantly to those for non BAME communities. However, cultural barriers included "the lack of gender-segregated physical activity programmes for men and women, lack of culturally competent choices, language barriers, lack of role models and lack of information" (Naz, 2011, p. 7). The research also identified "a need for physical activity provision to be culturally competent and made more appropriate to women and men from ethnic minorities, and for it to be low cost and to provide childcare" (ibid).

Another example of a community health education programme is *Fit as a Fiddle*, a programme for BME older people run by Age UK and funded by the Big Lottery Fund as part of the Well-being Programme which aims to engage faith and BME communities in activities for well-being (see www.fitasafiddle.org.uk). Age UK provides programme case studies in which participants report health and social benefits from taking part in classes, information and advice on healthy eating and healthy cooking sessions. However, they also outline barriers to engagement:

- Religious concerns about dress, segregation and prayer times;
- Previous bad experiences of service provision;
- Family advice that being active is not culturally appropriate for older people, particularly women, or they can only do certain things;
- Lack of confidence;
- Access/location may be problematic for some BME older people who find it difficult to use public transport;

- Sport and recreation policy is often not culturally inclusive to the needs of BME older people;
 - Cost of activities may put off people on low incomes;
 - Lack of culturally appropriate facilities/settings.
- (Age UK, 2012, p. 11)

An important implication of these identified barriers is the need for organisations to “work with BME older people to help overcome the intrinsic barriers that result from fear, uncertainty and lack of prior involvement in education”, a function which they argue can usefully be fulfilled by volunteers acting to provide support for older people (ibid, p. 12). In addition, as, for those with strong religious allegiance, the issues of appropriateness of clothing and single-sex provision may be problematic, it is “important that consideration is given to the provision of single sex activity and that older people are allowed to wear traditional dress or other clothing they feel comfortable with” (ibid, p. 13).

These findings are supported by the findings from a consultation for the *Next Steps in Health: City Health Development Plan for Stoke 2005-8* (Stoke City Council, 2005, pp. 40-42), which found the following barriers to participation in physical activity: “lack of time (48%), not being able to afford activities (28%), lack of knowledge about what is available (24%), facilities being too far away (21%), lack of transport (18%) and that there is no local group or club (10%)”. It also reported a perception of local provision as being adequate or poor.

Focus group research conducted by the WEA in 2011 with members of local BAME organisations (e.g. Gurdwaras and Mosques), disabled people's groups (e.g. Shelton Day Care Centre, Deaf Links) and working men's groups (e.g. trade unions and Football Club Community Programmes) found that participants were “concerned about leading sedentary lifestyles, becoming increasingly isolated in their community and keen to take part in regular exercise” (WEA, 2011, p. 8). The research also highlighted barriers to participation in physical activity including “a lack of local, affordable, informal, culturally competent group health education and exercise programmes” (ibid).

A community consultation for the *My Health Matters* project discussed earlier identified the following barriers to using physical activity facilities among residents in some of the most deprived wards around Stoke-on-Trent:

- Existing facilities not appealing or sufficiently inclusive to residents.
 - Existing facilities too expensive or inaccessible due to opening times or a lack of transport to get to them.
 - Community facilities – under-resourced and under-used.
- (Hurst et al, 2012a, p. 5)

The CHEST programme is designed to address many of the above-identified barriers to participation in physical activity (WEA, 2011). For example, the WEA West Midlands Region's (2011, p. 23) continuation funding application states that:

While an objective of the project is to advance opportunities for interaction between communities, culturally competent provision and specialist groups are important to

overcome the barriers that might result in non-participation and build up confidence. Publicity and teaching and learning materials will be produced in different languages and formats if appropriate. In addition, we will encourage beneficiaries to identify their own learning goals and become peer-to-peer mentors or community health champions.

The project also aims to enhance social cohesion and thereby address inequalities in access to services:

By delivering an innovative educational project that brings together excluded people from different social and cultural backgrounds to share expectations and experiences around health improvement, the project will promote a shared sense of belonging. This, in turn, will help promote inclusion and the integration of vulnerable groups, by building up their ability to navigate services and negotiate on an equal level to other citizens. (ibid)

Evaluations of WEA health education programmes

Tandrusti

An evaluation of Tandrusti, the Dudley-based programme on which the CHEST project is based, mapped the health journeys of 50 BME and non BME individuals in Dudley. The evaluation found that the programme was providing important mental well-being benefits for participants:

Whilst many people reported that they were attracted to Tandrusti as a physical activity programme, they greatly valued the emotional and social support gained from sharing experiences with others. In short attending programmes helped improve their mental health and well-being. (Naz et al, 2008b, p. 5)

Naz (2008a; slide 17) summarises the main findings in relation to mental health as follows:

- “Physical and mental illness can be intertwined; [it’s] easier to talk about physical symptoms;
- [As] poor mental health [may involve] social and emotional dysfunction, it is often seen as unfavourable for it to be shared outside the family;
- Mental health services need to understand the intricacies of cultural norms and their impact on attitudes and behaviour.”

The evaluation of Tandrusti concludes that it indicates the success of the project in promoting healthy lifestyles among BME communities, and the benefits of multi-agency working. It also highlights the need for on-going consultation with minority ethnic community groups about health messages and for longer-term funding to ensure sustainable outcomes.

My Health Matters

A related project called *My Health Matters* was designed “to help build partnerships with statutory healthcare providers and the local voluntary and community sector to help meet the challenge of increasing physical activity levels and healthy eating in targeted areas in Stoke-on-Trent” (Hurst et al, 2012a, p. 1). The project adopted a community-based participatory approach, developing and evaluating a community-led intervention to help address health inequalities over a three year period (2009-12). Intervention activities were in the following

areas: physical activity; healthy eating; health promotion; education and awareness; well-being; and environment-related and gardening activities.

Over its lifetime the project engaged over 11,000 individuals in the targeted areas. Results from a community survey conducted as part of the project showed statistically significant changes post-intervention in areas including self-report physical activity, neighbourhood perceptions of crime and social capital, and positive trends in relation to perceived health status and a mental component score. Telephone interviews for a sub-sample (n=181) of people who engaged with *My Health Matters* (n=1,678) showed statistically significant changes from baseline to follow up for physical activity levels and daily fruit and vegetable intake.

Focus groups for the same project found that: “people often ‘don’t know what’s available on their door step’ and frequently, it is ‘word of mouth’ that is most effective in promoting projects” (ibid, p. 12). The project also reported that “the biggest challenge in engaging communities was overcoming apathy, especially in increasingly cynical, over-consulted areas without evidence of subsequent action” (p. 14). Identified key learning points included:

- “Deliver ‘quick wins’ to demonstrate that action can be achieved. This aids the development of rapport and trust.
- The importance of supporting empowerment and ownership of programmes within communities.
- Realising the power of individuals within communities to influence peers and the importance of ‘gate keepers’ in engaging communities.
- It is important to use an asset-based approach, focusing on the positives in communities, including the value of skills, experience and local knowledge of individuals.” (p. 13-14)

Internal evaluation data on the CHEST programme

The WEA has collected a range of evaluation evidence from beneficiaries. This includes learner evaluation forms, learner testimonials, discussions with tutors and other project staff, focus groups and participation in the West Midlands Learner Feedback Survey (WEA, 2011). Drawing on this evidence, the organization reports:

We consistently receive positive feedback from learners about the impact of the project on their lives. They value the health and social benefits, including the chance to become friends with people of different cultures or backgrounds, very highly and they have provided a wide range of examples of how improved health literacy has benefited them, their families and the wider community.

Outcomes data from the CHEST project in 2011 found:

Over 75% of learners showed at least one health improvement while on courses, such as weight loss, lowered blood pressure or waist circumference. In addition, we had reports of improvements in areas like depression, back pain, mobility and overall confidence. The project also improved learners’ ability to navigate health services and food information and articulate their views to decision-makers within health and social care. (WEA, 2011, p. 20; see also <http://www.westmidlands.wea.org.uk/chest-year-1-summary>)

Ofsted have graded the WEA's health, fitness and personal development provision as 'outstanding', with highlighted key strengths including "ability to attract and engage 'hard to reach' adults from disadvantaged communities" (WEA, 2011, p. 21). The *Exercise in the Community Project* in Stoke-on-Trent (which targeted members of minority ethnic communities in particular areas including Cobridge), more specifically, was found to be successful in encouraging exercise and giving people "more confidence to make use of local health services and to begin changing their lifestyle" (WEA West Midlands Region, 2011, p. 2). The WEA's health improvement summary reports:

- 95% of beneficiaries were women; 5% were men;
- Of the 121 people who completed a programme of study 77% achieved health improvements (reduced weight, body mass index, waist circumference and blood pressure).

The report also states success in terms of social cohesion "as people from different ethnic/cultural backgrounds have come together to share expectations and experiences of health education and to take action to improve their health" (ibid, p. 3). The following enablers to success are identified:

- "Enthusiastic involvement from local voluntary, community and statutory organizations;
- Community gym programmes and activities at local venues that are familiar to participants and where they feel 'safe';
- The possibility of support with cost of childcare facilities and transport to access exercise in the community;
- Structured and bespoke health education programmes that are free of charge;
- Availability of regular health checks
- Culturally competent programmes such as single sex gym sessions and flexibility in course delivery (e.g. to fit around religious festivals and extended overseas leave);
- Supportive learning environment facilitated by friendly tutors;
- The opportunity to 'have a voice' in shaping programmes;
- Referrals to Beth Johnston Foundation mid-life project for additional support in health checks and developing healthy living action plans." (WEA West Midlands Region, 2011. P. 3).

The WEA also report testimonials from observers, which attest to the 'reach' of the exercise in the community project and its impact on individuals "physically, socially and mentally" (ibid, p. 7).

External evaluation of the CHEST project

An external evaluation in 2011 (Hurst and Vincent, 2011) reported on the health and learning outcomes of the CHEST programme as a whole, using recorded learner health outcomes data and participatory appraisal methods (4 workshops with learners; N=65). They report that:

Learners had consistently high levels of achievement in both learning and health outcomes. Approximately, 77% of learners showed at least one health improvement whilst taking part in a CHEST course, such as weight loss, lowered blood pressure or waist circumference. This is not only demonstrated through objective measures of health status but also the perceptions of learners in relation to their own health status. (p. 54)

Qualitative data from the workshops show participants reporting that involvement in the CHEST programme had resulted in them living healthier lifestyles, having improved levels of fitness, and having improved awareness of health issues. Improvements in mental well-being were noted; for example one participant reported benefits in terms of “meeting people [and] keeping fit in mind and body”, and another that it “makes you more alive”. Others reported a “feeling of well being and [feeling] relaxed”, “feel[ing] uplifted”, that you “take away a fresh mind” and “it clears your mind” (p. 47). A sense of achievement from the course was also identified as important for mental health improvement. In addition, more awareness of mental health issues was reported, for example participants commented that the project had made them think about “mental fitness; staying at home is not an option” and “positive attitude, motivation, age and keeping well” (pp. 46-7).

The social benefits of taking part were identified as important by the majority of learners. This included ‘bonding’ social capital -“being with friends” and “being in a group”, as well as ‘bridging’ social capital in terms of “mixing with different people and different cultures” (p. 45). Support from tutors was valued, as was ease of access in terms of location and low cost. Consequently, the evaluation reports that: “The CHEST project promotes and encourages a sense of community and supports individuals who wish to get involved in the project and also wider local issues” (p. 52). This was noted as particularly important to older people and others who would otherwise have limited opportunities for social engagement, and in the face of evidence regarding social capital having a protective effect on health (Bolin et al, 2003).

Wider benefits of the learning were identified in terms of health literacy for the rest of the family: e.g. “I tell my family what I have learned” (p. 48). In addition, there were benefits relating to the planned outcome of increasing confidence in accessing public health service provision, as learners suggested they could use the information gleaned and skills developed, stating, for example, “I can tell my doctor when there is something wrong with me” (p. 49). There was indication too that involvement in the programme had encouraged other activities such as gardening, dancing, walking and running.

Qualitative case studies included in the evaluation provide additional data of relevance to mental well-being. For example, one describes how engagement in the CHEST programme had helped overcome social isolation and despondency for an older woman learner (‘Sarah’), who went on to volunteer for the programme, completing health checks and leading walks, and to join a running club.

In conclusion, the evaluation found that: “The project has made a positive impact on the mental, physical and social well being of learners and volunteers” (p. 52). Learner involvement in shaping the provision was described as key to ensuring it meets needs of the local community. The fact that there is a high level of enrolments, that retention is good, that individuals have been recruited from minority groups and that in terms of next steps, learners requested ‘more of the same’ was also taken to suggest the provision is meeting local needs and is a valuable asset for local residents. This was reinforced by the fact that “clusters of learner recruitment were identified in areas of high deprivation” (p. 54). Partnership working

and encouraging learner progression to further activities and to healthy lifestyle achievement and maintenance were also identified as a key success factors. Too much form-filling was a highlighted negative aspect of the courses and learners suggested the need for more promotion of the courses, for example through local media and display of notices.

Given the profile of the learner group, including low levels of educational attainment, which is linked to health outcomes (Marmot et al, 2010) and the health inequalities data for Stoke-on-Trent, the report authors surmise: “There is still a need for this work as the added-value of community health education to physical activity provision contributes to reducing health inequalities in Stoke-on-Trent” (p. 53). Programmes such as this contribute towards the Floor Target Action Plan for Physical Activity (FTAP) for Stoke-on-Trent, which was aimed at addressing health inequalities. The evaluation concludes that “taking a culturally competent education approach to physical activity can be a successful way of promoting a healthy lifestyle among groups living in deprived neighbourhoods within Stoke-on-Trent” (p. 58).

Summary - key points for this MWIA

- **There is a body of evidence on the wider benefits of ACL** including its function in developing social capital, especially for less advantaged groups, and positive effects on mental health and well-being. ACL can also promote well-being through enabling progression into other educational, volunteering and employment opportunities.
- **Women from the Bangladeshi and Pakistani communities in are among the most under-represented groups in adult learning in the UK.** They are also among the groups most likely to have no formal qualifications and report low rates of involvement in mixed community activity. Reasons for their low rates of adult participation in learning include cultural expectations, practical issues such as having caring responsibilities and cost, and lack of suitable provision (e.g. women only) or information about provision. Implications for learning provision for these groups include the need for creative consideration of access issues and to complement structured learning with efforts to generate solidarity and mutual support. They also include the need to develop good learner-teacher relationships, the value of mentoring and role models, and for learning programmes which aim to foster community cohesion.
- Informal community education programmes aimed at **women’s empowerment** can stimulate an interest in politics among a diversity of women and help develop women’s assertiveness in dealing with issues in the domestic sphere.
- **Women-only services and spaces offer a range of benefits for women** including access to support (which may otherwise not be accessed), and the opportunity to share experiences and develop a sense of solidarity. There is also a need for women-only provision for fitness and swimming. There remain significant gaps in appropriate mental health service provision for BME women.
- **Exercise has been found to promote mental well-being** through a range of mechanisms, including lifting mood and increasing opportunities for social contact.
- There is a **body of research evidence on the benefits of community health education and health promotion/improvement programmes for BME groups** with reported outcomes including improvement in health knowledge and ‘behaviours’ and in

social support. However, there is often a disparity between health knowledge and behaviours.

- **Additional aims of community health education programmes** may include building up confidence and social capital, enabling people's ability to navigate services and to negotiate on equal terms with other citizens, and increasing opportunities for interaction between communities (WEA West Midlands Region, 2011).
- A key issue for community-based health education and improvement programmes is the degree to which they are **oriented towards community empowerment and socio-political action compared to individualistic and behaviourally-related approaches**.
- Much evidence suggests the benefits of a **community development approach to health improvement** which aims to address the social determinants of health. They often use an assets-based approach. Such an approach needs to focus not only on psycho-social assets but also the economic and environmental factors that influence inequalities in health.
- Many of the **barriers to engagement for BAME adults** in physical activity do not differ significantly to those for non BAME communities, although there are also cultural barriers (e.g. language barriers, lack of gender-segregated provision, lack of information, cultural acceptability of older people, especially women being physically active, lack of confidence) which indicate the need for community health education and improvement programmes to be 'culturally competent'. This provision can also benefit from being low cost, local and providing child care. The background/ethnic origin of the tutor may also be significant e.g. from the point of view of language.
- It may be seen as unfavourable within some BAME communities to **discuss issues of mental health outside the family** and this is also something which service provision needs to take into account.
- **An evaluation of WEA health education programme, Tandrusti** found participants reported mental well-being benefits e.g. from emotional and social support.
- **An evaluation of a related project called My Health Matters** founds significant changes from baseline to follow-up for factors including social capital and physical activity. The project also reported that apathy was the biggest challenge to engaging communities. Learning points included supporting empowerment and ownership of programmes within communities, the power of peer influence and the value of an asset-based approach.
- **Internal evaluation data on the CHEST programme** shows positive feedback from learners on health and social benefits and wider family and community benefits. This includes reported improvement in depression and confidence and ability to navigate health services and food information. Success in terms of social cohesion is also reported. Identified enablers to success include partner involvement, local provision, free of charge provision, culturally competent programmes and the "opportunity to 'have a voice' in shaping programmes".
- **External evaluation of the CHEST project** showed improved health status for 77% of learners and reported healthier lifestyles, awareness of health issues (including mental health) and mental well-being among participants. Social benefits in terms of

both bonding and bridging social capital were also reported. Wider benefits included impact of health literacy on the rest of the family, enhanced confidence in accessing public health service provision and encouragement of others activities. The programme was seen to be meeting local needs and learner involvement in shaping the provision was seen as key in this respect. Learners suggested the need for more publicity for the courses.

8 CONCLUSIONS: APPRAISING THE EVIDENCE

Evidence demonstrating that the population groups targeted by the Women's Boot camp are those most in need comes from:

- Data on health inequalities in Stoke-on-Trent and the Co-bridge area more specifically, and which shows poor scores for measures relating to social capital and community cohesion in SoT;
- Research on income and labour market disadvantage and educational inequalities affecting the Bangladeshi and Pakistani communities in England and Wales;
- Data on ethnic inequalities in health and health literacy;
- Evidence on gender inequalities in mental health, and on mental health inequalities affecting women from the target communities;
- Evidence showing low levels of physical activity among these communities, particularly women; and
- Data which shows that women from the aforementioned communities are among the most under-represented in adult learning and limited English language usage among many older women members.

In terms of assessing impact, there are clear synergies between the literature review and the workshop findings. Points to note are as follows:

- Concurring with the evidence on reasons for the under-representation of women from the UK Pakistani and Bangladeshi communities in adult learning, which include cultural expectations and the priority placed on caring responsibilities, women in the workshop reported that **“getting out of the house” was an issue for women within the communities.**
- Reference was also made to having **“space for ourselves”, resonating with literature on the importance of women-only spaces** for providing support for women, and of these for allowing some BAME women to access services at all. Single-sex provision is often discussed in the literature on community health education as an important aspect of ‘culturally competent’ provision.
- Resonating with other research evidence on community education programmes, the course was found to be having an impact in terms of **enhancing ‘confidence’ to take part in community activities.** Setting and group size were important factors here. In a wider sense, and again according with other research on community learning, the

workshop suggested the course was helping to develop the women's agency freedom, the capability to pursue one's own valued goals (Sen, 2010). Linking to the finding of the external evaluation of the CHEST project regarding courses encouraging other activities, the Women's Boot camp was found to be encouraging and supporting the women to go on walks together. However, in contrast to the published literature on the wider benefits of ACL, there was only limited evidence of the course acting as a catalyst for joining other adult learning classes. As opportunities for progression are important for well-being, and there was demand among workshop participants for other organised physical activities as well as courses in other areas, this could be an area for development. Suggestions included: women-only swimming; team games and bike-riding; and craft activities.

- Concurring with published literature, **childcare responsibilities** were highlighted as an issue affecting the women's participation in adult education. In this workshop, the action suggested by participants was to change the timing of one of the classes to fit within school time. The literature suggests providing childcare to increase up-take of ACL courses for BAME (as well as non BAME) women, but this possibility and whether it would increase up-take was not discussed in this workshop.
- Other **practical features of the course** which were highlighted in this workshop as well as in other research and evaluation on similar provision included the importance of the provision being accessible in terms of cost and locality, and it being culturally acceptable in terms of being women-only and the setting. While the literature suggests that the background/ethnic origin of the tutor delivering the learning can be a barrier to engagement, this issue was not specifically discussed in this workshop, except with regard to the associated language barrier. **Language issues were an area of particular discussion and translation support indicated as a priority.** Participants also indicated that it would be useful to have the course materials in various languages.
- Resonating with the research evidence, the importance of a good **learner-tutor relationship** was indicated by the workshop; participants stated that it's important that the tutor listens to you.
- Linking to the external and internal evaluations of the CHEST project and widely reported benefits of physical exercise, the **well-being benefits of the course** for participants included a subjective dimension (e.g. 'feeling good after exercise') and a social one (e.g. 'making friends and sharing concerns'). In accordance with the literature evidence base too, including the evaluation of Tandrusti, the workshop revealed that the 'social side' of the course meant it was very important to their lives. Its impacts in terms of **breaking isolation and generating solidarity and emotional support** align with the recommendations of research such as Ward and Spacey (2008). Furthermore, resonating with a study of mental health ACL by the lead author, there was evidence that the course was helping participants feel listened to and

valued, thereby 'providing recognition' (making people's experiences visible, positively shaping personal and social identities, and appreciating common humanity).

- Further to the research evidence outlined, the workshop indicated a positive impact on '**sense of belonging**'. The women in the workshop also reported that the course was helping generate their sense of **feeling involved in community life**. Indeed, 'activities which bring people together' was the component which was rated as of most importance in the initial charting exercise for the inclusion and participation factor.
- Resonating with an often-cited impact of ACL in relation to health, well-being and resilience, and women's strategies for coping with adversity, the way in which the course was enabling the **development of social capital** and the importance of this 'asset' for the women's well-being was evident from the workshop findings. As well as helping with mutual support and solidarity, there was evidence that the course was enabling information-sharing and translation support (e.g. of advertised local events) and extending networking among participants outside of formal class time.
- Concurring with the external evaluation which found an impact of enhanced health literacy from attending CHEST courses on the rest of the family, as well as other literature on the 'wider benefits of learning', there was evidence of **wider family benefits** from the Women's Boot Camp (e.g. enabling 'healthy choices' for the rest of the family).
- Research on the participation of women from the Pakistani and Bangladeshi communities in adult learning points to the need for learning programmes for women from these communities which also aim to **foster community cohesion**. This is one aim of the CHEST programme as a whole, although the Women's Boot Camp is specifically targeted for South Asian women. Success in terms of 'social cohesion' is reported in the internal evaluation of the CHEST programme, while the external evaluation of chest programme similarly reported the generation of both bonding and bridging social capital. In this impact assessment, there was evidence of the course promoting interaction between women from the local Pakistani and Bangladeshi communities, and the fact that there were also some White British women in the group additionally indicated that the course was facilitating some 'bridging' between women from the South Asian and White British communities. However, the fact that the White British women did not attend the workshop made it difficult to assess the success of the course in this latter regard (although this in itself was not a positive indicator).
- One aim of the CHEST programme is to help members of BAME groups to "negotiate on an equal level to other citizens" and in the screening exercise the effect of the course on 'conflict resolution' was highlighted as unknown. The literature review included evidence from internal and external evaluation data that the CHEST programme has helped participants' ability to navigate services, and evidence that ACL programmes can help women's assertiveness in the private sphere which may

translate into helping with conflict resolution. In this assessment, there was similarly **evidence that the course was helping with discussion of health problems with practitioners**. However, the fact that the '**conflict resolution**' component was last to be chosen in the workshop suggested either that this was an issue of sensitivity or that the women did not see it as immediately relevant to their participation in the course. Unfortunately there was not time / inclination for discussion of the component so the MWIA did not reveal any further data on this matter. This could be an area for future exploration, perhaps in relation to the issue of 'empowerment' more generally.

- The literature suggests the importance of community health education and improvement programmes being shaped by communities and participants, and so in the screening exercise for this MWIA, the issue of whether the course needed to be more learner-led was raised. The participants in the Women's Boot Camp reported that the course was enhancing their sense of 'feeling involved' and, like the other components, this was rated as being of 'very high' importance. However, **the issue of how to build upon the course's success in order to encourage more 'empowerment' and 'ownership' of the course and its related activities in alignment with an assets-based approach was identified in this MWIA**. Resonating with the literature evidence base on barriers to participation in adult learning among the target communities, one of the first comments at the workshop was the need for the women 'to be pushed', and although there was initial enthusiasm for volunteering for leadership roles among participants (with leading walks as a potential area for development of volunteering), this did not subsequently materialise into action despite being followed up by the course organiser. The issue for this course of how to shift further towards a community empowerment approach and further develop the assets of the group and their wider communities therefore remains. This is a particular concern given the currently limited funding period.
- Chiming with the external evaluation of the CHEST programme, participants suggested the need for **more publicity** of the Women's Boot Camp in local shops and community and health service venues.

An appraisal table is provided in Appendix Three.

9 DEVELOPING INDICATORS OF WELL-BEING

"What gets counted, counts." Therefore being able to measure progress and impact of the Women's Boot Camp on the determinants of mental well-being identified by the stakeholders through the MWIA is an important step. Building on the initial ideas from stakeholders about "how you know" that certain impacts have happened 16 indicators have been developed.

Factor	Components	Data collection	Frequency
Wider determinants of mental well-being	- Access to education - Local democracy - (Economic) security	Monitor educational backgrounds of enrolees (enrolment form) Track progression (learner evaluation form- LEF). Additionally: ICECAP-A measure (achievement and progression item) Evaluate outcomes on community campaigning aspect of curriculum (learning plan/diary; LEF; tutor self assessment). ICECAP-A measure (settled & secure item).	Termly or as appropriate during the term for learning plan/diary.
Increasing control	- A sense of control - Opportunities to influence decisions - Opportunities for expressing views and being heard - Collective organisation and action	Ask the women to rate/reflect on this – e.g. as part of learning plan/diary or using Rogers et al (1997) Empowerment Scale. (Note also that ICECAP-A measure includes related items). Additionally: include item in group discussion/workshop. LEF; tutor self assessment. (Direct impact through providing opportunities to influence aspects of course and take part in community campaigning.) LEF; tutor record of examples (self assessment). (Direct impact through tutor and volunteers soliciting views of course attendees at regular intervals; active listening to views built into course.) LEF & tutor self assessment (both of formal learning objectives relating to campaigning & informal developments among learners). Additionally: measure inclination to engage in collective action – Empowerment Scale.	As appropriate during the term or at beginning & end of term; yearly (for group discussion/workshop) Termly “ Termly; beginning and end of term for Empowerment Scale
Resilience	- Emotional well-being - Social networks and relationships - Shared public spaces	LEF; social impact and wellbeing surveys, Additionally: ICECAP-A measure (love, friendship and support; enjoyment & pleasure); group discussion/workshop. LEF. Additionally: ICECAP- A measure (love, friendship and support); short social inclusion scale; grp discussion/ workshop. Monitor local provision (e.g. community centre closure)	Termly/yearly (for grp discussion/workshop) “ On-going
Participation and inclusion	- Feeling involved - Activities which bring people together - Having a valued role - Practical support - Accessible and acceptable services or goods - Cost of participating	Learning plan/diary; LEF (to ask about group activities which develop from the class, progression and volunteering). Additionally: short social inclusion scale; group discussion/stakeholder workshop. LEF. Additionally: group discussion/ stakeholder workshop. Monitor funding situation.	Termly or as appropriate/ yearly for grp discussion / workshop. “ On-going

See Appendix Four for further information about measures.

10 RECOMMENDATIONS

- Explore further ways of promoting increased involvement in and 'ownership' of the course and related group activities among members of the target communities.
- Seek ways of developing further ACL activities of interest to the target communities in local, culturally acceptable venues, and continue to encourage course participants to progress to other educational, volunteering and vocational opportunities, where appropriate, offering information and advice.
- Broaden the range of physical activities included within the Women's Boot Camp, in accordance with participant feedback. Continue to seek opportunities for women-only swimming in local venues.
- Explore ways to resolve the language issues for course participants identified in this MWIA e.g. employ a support tutor or volunteer(s) from the target communities, develop (further) course materials in various languages.
- Consider ways of enhancing the social activities / opportunities for social interaction and informal support built into the course.
- Consider ways in which the course or related activities/courses may be developed to further foster community cohesion between BAME and non BAME women in the locality.
- Publicise the Women's Boot Camp more widely e.g. in local shops and community and health service venues and through further use of community outreach approaches based on word of mouth.
- Evaluate further the impact of the course on the women's lives in relation to issues of 'empowerment'.
- Consider administering the additional well-being measures / methods of data collection identified in this report.

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APPENDIX ONE

MENTAL WELL-BEING IMPACT ASSESSMENT: SCREENING REPORT

Report by: Lydia Lewis and Alexandra Wood

Screening Meeting Date: 29th January 2013

Present: Alex Wood, Lydia Lewis, Janet Henson, Lyn Marie Chapman.

1. Initial questions

Why do you want to look at the impact of the Women's Boot Camp on the mental well-being of participants?

The provider (the WEA) is interested to learn more about the impact of this course on participants' mental well-being, as this is not directly measured in course outcomes. The WEA needs to evidence the well-being impact of its provision for the purposes of funding and development of its provision and is also keen to improve its existing provision where possible to maximise the well-being benefits it is able to offer.

Is there an opportunity to influence or change the ways in which the Women's Boot Camp is delivered or managed?

Yes there are opportunities, although these are dependent on resources (including availability of local venues for the course and funding). Changes to associated service provision (e.g. local leisure facilities) are dependent on co-operation from the Local Authority/other local agencies.

2 Population groups/factors. Table 1 presents an assessment of impact on mental well-being for different population groups and factors – these are clustered into groups that the evidence suggests are more vulnerable to poorer mental well-being and factors that affect well-being.

Table 1: MWIA Screening of

Population group/factor	Likely impact e.g. Positive (+ve) or Negative (-ve)
Early Years	Positive impact – main focus on women many of whom have children, so impact is on parents and families.
Adolescence	Positive impact - same as above
Later life	Positive impact – older adults attend the course and the educational impact of the course is likely to be long-lasting for the other adults.
Gender	Positive impact – on women as this is an opportunity to facilitate capability development and 'empowerment' through developing social capital and knowledge, skills, assertiveness and awareness of health

	issues. Improving the women's well-being is likely to have a positive impact on their families and friends. The knowledge gained is also likely to benefit their families through changes to diet, health literacy and 'modelling' for children. However, on the negative side, it may also place a further burden of responsibility for family health on the women (note there isn't an equivalent group for men to attend). The women may feel guilty if they are not achieving healthy eating or lifestyles. This needs to be considered in what messages are given and support available. For example: using promotional messages about produce being cheaper or making healthy eating easy may be more attractive.
Race and ethnicity	Positive impact – the majority of the women are on course are from BME backgrounds; they translate the course for one other.
Socio-economic position (SEP)	Positive impact – reduce inequalities through increasing knowledge, and increasing volunteering opportunities
Physical health	Positive impact
Disability	Positive impact – should help prevent long-term, potentially debilitating conditions such as diabetes and help keep older adults mobile.
Sexuality and transgender	No impact - Should be no different
Other population groups	Positive impact on older children as per family health above.
Others in settings	n/a

3. **Wider determinants** Table 2 presents the assessment of the impact of the Women's Boot Camp on the wider determinants of health

Table 2: Wider determinants of health

WIDER DETERMINANTS (often at a socio-economic/environmental level)	Likely impact? Positive, negative or is it an indirect impact?
Access to quality Housing e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate	Indirect – e.g. through information-sharing in the group and increasing confidence in dealing with housing agencies.
Physical Environment e.g. access to green space, trees, natural woodland, open space, safe play space, quality of built environment	Positive - community centre is surrounded by green space, nearly all learners walk to the centre, course encourages confidence in using green public spaces and encourages volunteers to lead walks.
Economic security e.g. access to secure employment (paid and unpaid), access to	Indirect - learners are encouraged to volunteer as part of the programme; educational

an adequate income, good working conditions, meaningful work and volunteering opportunities Good quality food e.g. affordable, accessible Leisure opportunities e.g. participate in arts, creativity, sport, culture Tackling inequalities e.g. addressing relative deprivation and poverty Transport access and options e.g. providing choice, affordability and accessibility Local democracy e.g. devolved power, voting, community panels Ease of access to high quality public services e.g. housing support, health and social care Access to Education e.g. schooling, training, adult literacy, hobbies Challenging discrimination e.g. racism, sexism, ageism, homophobia and discrimination related to disability, mental illness or faith Other?	progression is built in and the course is designed to provide a way back into education for groups at risk of educational exclusion. Positive – women learn about nutrition and affordable and accessible healthy options . Positive – the course includes physical activity and learners use their friendship through the group to engage in further activities. Positive – course generates social capital which helps tackle associated problems. none Positive – through building social capital among the women and as the course covers community campaigning. Positive – health literacy and enhanced confidence facilitates interactions with health professionals. Positive – the course comprises adult education provision and progression is built in. Positive – the targeted provision is important in challenging discrimination in access to health education and education more broadly. The course also enables the building of social capital and social support among the women which is likely to be empowering for them and to enable them to challenge sexism and racism. In addition, the course is designed to promote community cohesion and, although targeted for the South Asian community, includes a mixture of ages and ethnic backgrounds.
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4. Protective factors

The MWIA toolkit suggests a four-factor framework for identifying and assessing protective factors for mental well-being, adapted from Making it Happen (Department of Health 2001) and incorporates the social determinants that affect mental well-being into four factors that evidence suggests promote and protect mental well-being:

- *Enhancing control*
- *Increasing resilience and community assets*
- *Facilitating participation*
- *Promoting inclusion.*

These four factors (the latter two are put into the same box), are made up of a set of 'components' which the evidence base states are important contributory elements that contribute to each factor. For example, for the protective factor 'Enhancing Control', a component is 'maintaining independence' e.g. support to live at home when severely disabled or elderly. The screening exercise requests assessment of the potential positive or negative impact that the service or provisioning is likely to be having on these factors and components. Tables 3-5 show the prioritised findings identified through the Screening activity.

Tables 3-5: Protective factors

Enhancing Control	Likely impact? Positive, negative or is it an indirect impact?	Comments or recommendations
Individual level		
A sense of control e.g. setting and pursuit of goals and ability to shape own circumstances	Positive	Social capital, support and development of skills and knowledge likely to enhance women's sense of control and agency (ability to act and to choose). Knowledge and information about health issues likely to enhance sense of control over choices affecting health e.g. healthy options and cooking; how to improve health and weight control through physical exercise.
Belief in own capabilities and self determination e.g. sense of purpose and meaning	Positive	See above. Physical activity also likely to enhance motivation and friendships through the group to enhance sense of meaning and purpose. Volunteers are involved with the course, motivated by a

Knowledge, skills and resources to make healthy choices e.g. understanding what makes us healthy and being able to make choices	Positive	desire to help their communities. Course content covers these issues. (But see discussion above in relation to gender and enhanced burden of family responsibility/possible guilt negatively impacting well-being if not 'making healthy choices'.)
Maintaining independence e.g. support to live at home, care for self and family	Positive	Learning to adopt a healthy lifestyle and physical activity on the course helps to maintain independence
Community/organisation level		
Self-help provision e.g. information advocacy, groups, advice, support	Positive	Social capital generation helps develop sharing of knowledge and information and mutual support.
Opportunities to influence decisions e.g. at home, at work or in the community	Positive/Negative	See above regarding local democracy and challenging gender inequality. Positive also in that participants are encouraged to develop their own activities and to volunteer and campaigning is included in the curriculum. Negative in that the course is not really 'student-led' and is still 'put on' for the community without members leading or providing sessions.
Opportunities for expressing views and being heard e.g. tenants groups, public meetings	Positive	Views encouraged from all participants to enable people to learn from each other.
Workplace job control e.g. participation in decision making, work-life balance	Positive	Work-life balance: course enables women to have time away from domestic responsibilities and provides additional social and physical activity for women who are in part-time employment.

Collective organisation and action e.g. social enterprise, community-led action, local involvement, trades unions	Positive/Indirect	Course brings women from two different minority ethnic groups together in a public space and builds social capital; encourages volunteering/self organisation; community campaigning is included in the course curriculum. Social capital and confidence-building is likely to enhance likelihood of other group activities.
Resources for financial control and capability e.g. adequate income, access to credit union, welfare rights, debt management	Positive/indirect	Information-sharing likely to enhance access to welfare entitlements and course builds confidence in dealing with agencies. Knowledge of nutrition and healthy eating helps with food budgeting.
Other?		

Table 4

Increasing resilience and community assets	Likely impact? Positive, negative or is it an indirect impact?	Comments or recommendations
Individual level		
Emotional well-being e.g. self esteem, self worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun	Positive	Improves social life/networks and learners report enjoying the course
Ability to understand, think clearly and function socially e.g. problem solving, decision making, relationships with others, communication skills	Positive	Course includes health literacy and women also need to follow exercise routines; course is in English so may help with language skills; some participants translate for others.
Having beliefs and values e.g. spirituality, religious beliefs, cultural identity	Positive	Targeted course may afford recognition to cultural identities; bringing women together may help sense of group identity.
Learning and development	Positive	Adult learning course;

e.g. formal and informal education and hobbies Healthy lifestyle e.g. taking steps towards this by healthy eating, regular physical activity and sensible drinking	Positive	progression is built in. This is the focus of the course.
Community /Organisation level		
Trust and safety e.g. belief in reliability of others and services, feeling safe where you live or work	Positive	Locally- based course; access for under-represented groups to WEA provision – builds their knowledge of and trust in the organisation; learners have to rely on one another for translation.
Social networks and relationships e.g. contact with others through family, groups, friendships, neighbours, shared interests, work	Positive	Friendships have been built or got stronger through this course.
Emotional support e.g. confiding relationships, provision of counselling support	Positive	Course helps build friendships and social support among the women.
Shared public spaces e.g. community centre, library, faith settings, café, parks, playgrounds, places to stop and chat	Positive	The course helps women who are full-time carers and housewives to access public spaces. Funding the courses to take place at the local community centre helps keep the centre going (although since this MWIA was completed the centre has been earmarked for closure)..
Sustainable local economy e.g. local skills and businesses being used to benefit local people, buying locally, using Time Banks	Positive/Indirect	Positive – Tutor is paid to run the course; course helps provide funding for the community centre that hosts the course. Indirect - participants gain skills and are encouraged to progress with their education; volunteers

Arts and creativity e.g. expression, fun, laughter and play Other?		are involved with the course and the women are encouraged to volunteer locally.
	Positive	Learners have fun attending courses

Table 5

Facilitating participation and promoting inclusion	Likely impact? Positive, negative or is it an indirect impact?	Comments or recommendations
Individual level		
Having a valued role e.g. volunteer, governor, carer	Positive	Volunteers are involved with the course and some of the women translate for others. The women support one another.
Sense of belonging e.g. connectedness to community, neighbourhood, family group, work team	Positive	Takes place in local community centre so likely to help build sense of community belonging; targeted course likely to help build sense of connectedness among women from similar ethnic and cultural backgrounds.
Feeling involved e.g. in the family, community, at work	Positive/negative	Community-based course. But query whether learners have enough say in what is included in the course, how it is run etc.
Community /Organisation level		
Activities that bring people together e.g. connecting with others through groups, clubs, events, shared interests	Positive	See above – course brings women from different South Asian communities together around shared needs. Some local white British women also participate.
Practical support e.g. childcare, employment, on discharge from services	Positive	Development of social capital provides the opportunity for practical help e.g. with translation outside of the formal curriculum and through information-sharing. Child takes part in the course.
Ways to get involved e.g. volunteering, Time	Positive	Women volunteer formally and informally for the course.

Banks, advocacy		Volunteering opportunities need to be further explored.
Accessible and acceptable services or goods e.g. easily understood, affordable, user friendly, non-stigmatising, non-humiliating	Positive	Local, during school hours and currently free to attend. Women-only course, and its content and venue are culturally acceptable to the targeted communities.
Cost of participating e.g. affordable, accessible	Positive / negative	Courses are currently free; they could be chargeable in the future.
Conflict resolution e.g. mediation, restorative justice	Unknown	Assertiveness-building through the course may help participants when dealing with (potential) conflicts in the public and private spheres but this is largely unknown. There is also the possibility that their course attendance may cause domestic conflicts.
Cohesive communities e.g. mutual respect, bringing communities together	Positive	The course helps women who are full-time carers and housewives to access public spaces. It brings together women from the Pakistani and Bangladeshi communities in the locality. There are some white British women on the course and the tutor is White British so although targeted for women from the South Asian communities, it may also be helping to enhance community cohesion between these groups.

5 Scale of impact and population

There are two more aspects to consider:

A) Scale of the impact on mental well-being

If known (or suspected) at this stage, what is the duration of the likely mental health and well-being impacts of your proposal? (This could be more than one period of time.)

Brief [] Weeks [x] Months [x] Years [x]

(The course has been running since 2007 and is on-going.)

B) Scale of the population whose mental well-being is impacted

What is the scale of the whole population that your project impacts upon?

A small part of the population [x]
 A majority of the population []
 The entire population []

6 Having completed the screening assessment process the following sections will help determine what to do next.

Favouring further appraisal	Question	Not favouring further appraisal
<i>Don't know</i>	Does your proposal affect in a negative way any of your population groups in Table 1?	
<i>Don't know</i>	Does your proposal affect in a negative way any of the wider determinants and protective factors in Tables 2- 5	
Yes	For some of the wider determinants and protective factors of mental well-being, are some of the impacts of your proposal unknown?	
Yes	Are the impacts likely to be over a long period of time (one year or more)	
Yes	Is there an opportunity to influence the delivery of the proposal you are screening?	

If there are two or more answers of yes or 'don't know' then it is advisable that there is likely to be value in undergoing further MWIA investigation.

Outcome: Undertake MWIA, and as the workshop will need to be conducted through translation, will prioritise protective factor 'participation and inclusion' for this as this seems most relevant and has some possible negative impacts and one unknown. Workshop will also include 'sense of control' if there is time as this also has some possible negative impacts that can be explored.

Next Steps: Arrange MWIA workshop to take place on 5th March; begin literature review; draw up initial population profile.

APPENDIX TWO

Evaluation of the Stakeholder MWIA workshop

Participants were invited to complete an evaluation form. The results suggest the workshop was successful in:

- Increasing participants' understanding of mental wellbeing
- Providing an environment in which participants felt comfortable in discussing mental well-being with others, and a workshop which participants found to be useful and interesting.
- Addressing issues of relevant to the adult learners.
- Providing a valued learning experience for the third sector participants.
- Demonstrating the value of MWIA for third sector services.

Comments from third sector participants included:

- using this tool would add value to Brighter Futures services
- It was very helpful to learn how to use impact assessment in group work and the value of the feedback

MWIA Workshop 05.03.13 Summary of Participant Evaluation					
Question	Response				Left Blank
How confident are you in discussing mental well-being with others?	Not at all 1	Not very much	A fair amount 4	A great deal 7	
How relevant was today's workshop to you and your role?	Very relevant 9	Fairly relevant 1	Slightly relevant	Not relevant	
Did the workshop increase your understanding of mental wellbeing?	YES 10		NO		
How confident are you now in discussing mental well-being with others?	Not at all	Not very much	A fair amount 6	A great deal 3	1

Was the workshop:	Useful YES 9 NO Blank 1	Understandable YES 8 NO Blank 2	Interesting YES 9 NO Blank 1	Enjoyable YES 8 NO Blank 2	
How do you think the MWIA will contribute to your local project?	Helping to run the project 1 Better Understanding Brighter Futures has customer consultation in every service using this tool would add value to BF services (MH Worker). It was good				
Would you recommend this workshop to others?	Yes 10		No		
Other comments	It was very helpful to learn how to use impact assessment in group work and the value of the feedback (MH service Worker).				

APPENDIX THREE

Factor: Participation & Inclusion. Assessment table.

Components	Community Profile	Published research	Stakeholders (workshop)	Degree of synergy between the source of evidence?
Accessible goods & services	Women Parents BME	Women-only Local Culturally acceptable Child care provision More publicity needed	Timing of sessions – childcare Women only Local Women only swimming sessions closed down More classes and publicity	High; possible enhanced take-up with child care provision not discussed
Cost of participation	High unemployment and levels of deprivation Fee remission Low socio-economic profile of target communities	Cost important to access and take-up Fitness/health related activities not prioritised	Free or low cost provision important	High
Practical support	BME Women Parents Older people Low income	Social capital/building communities Volunteering can help generate support Benefits of developing 'health literacy' Need for help with language barrier	Priority placed on translation support Like a family Feeling valued (by WEA) Make friends Health checks Tutor gives us a push	High

APPENDIX FOUR

Measurements

WEA instruments and methods used to gather data from students include:

- Enrolment forms that capture key learner data;
- PAR-Qs;
- Health assessment forms;
- Individual learning plans / course evaluation forms;
- One-off surveys and assessment materials (e.g. quizzes)
- Capturing data in course discussions and events that bring learners together.