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Circle Dancing For Dementia

Case Study of a Community-Driven Development Initiative in Little-Lever, Bolton with the Aim of Scale Up

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CONTENTS

EXECUTIVE SUMMARY

In this report the circle dancing project in little-Lever, founded by Bolton Community Partnership, aimed at improving the health and well-being of the local community with a focus on people with dementia, is reviewed as an Asset-based Community-driven Initiative.

Following an overview of the background, principles and practices of ABCD, CDFD in Little-Lever is examined regarding major elements of ABCD approach in the light of current literature and outcomes from current research. This involves criticizing the traditional needs-based approach, exploring the theory of 'Salutogenesis', introducing ABCD as an approach, strategy and model, describing the concept of assets in public health, discussing lessons learned from CDFD project in Little-Lever and recommending a framework to scale up a similar project in Halliwell UCAN Centre.

For this report data was collected through desk-based study, observations as well as structured and unstructured interviews. The findings from this research shows that the circle dancing project in Little Lever underwent the guidelines for the ABCD approach. The benefits derived from the circle dancing programme indicates that the model possesses the potential for the promotion of health and wellbeing in communities.

The findings of this project shows that the circle dancing program can have positive benefits on physical fitness, cognition, and quality of life of people with dementia.
The feasibility and scalability of the circle dancing for dementia project was evaluated. The results revealed that the project can be scaled up in Halliwell UCAN Centre but the characteristics of the target community should be considered during the scaling up.

The results in general indicates that circle dancing project as a health promotion intervention for people with dementia can be successfully implemented utilizing the ABCD principles but recommends that efforts should geared towards identifying and expanding the network of assets towards the improvement of the project.

SECTION 1: INTRODUCTION

This report is written for the Bolton Community Development Programme [BCDP] to fulfil the requirements for Research and Professional Practice Module in the School of Environment and Life Sciences, University of Salford.

It consists of four sections: The introduction, the Methodology, the Findings & Discussions and the conclusion and recommendations.

Background

Increased concerns of policy makers and funders in terms of allocating scarce resources more effectively and efficiently, directed efforts toward addressing the sustainability of health related interventions and promotion programmes (Shediac-Rizkallah & Bone, 1998). Furthermore, gradual and constant cuts to public health service delivery due to unsteady economic conditions, have brought a new momentum about discovering more sustainable and pragmatic procedures to reach the expected outcomes of health policies (Morgan A, 2010). However, shortcomings of public health spending are affecting services that provide long term health and well-being such as community centres and adult social care and also can impact services in various ways like deflection, delay, deterrence, denial, selection and dilution. This reduction or closure has the potential to seriously compromise the health and well-being of most vulnerable communities.

Alongside the cuts of local governments and health services budget, demographic changes such as an aging population mean that more people are going to be in need of help and support which can be triggered by widening the gap in health inequalities (Foot & Hopkins, 2010). At that point individuals who are relatively deprived have successively worse health outcomes than those who are more advantaged. This fact known as social gradient in health accentuates that Social position

which is determined by factors such as age, gender, ethnicity or geography should be considered as one of the major sources of health inequality (Marmot & Bell, 2012).

Health inequalities are differences between people or groups' health status or in the distribution of health determinants due to social, political, biological or geographical factors. Some of these inequalities such as ethnicity or age may be fixed and ethically or ideologically unavoidable because they are attributed to biological variation and free choice, whereas others rooted in external environment and conditions mainly outside the control of individuals are avoidable due to the fact that they are most commonly associated with socio-economic inequalities or discrimination and can lead to health inequities.

Increasing the health inequality gap especially in those aspects with a large preventable component shows that the current pattern of service delivery is largely failing to address this issue and underlines the need to rethink how and what services are delivered.

Needs Based Approach

Needs-based approaches have traditionally been used by the helping professions in response to desperate situation of troubled communities. This perspective is generally understood as a deficit model which focuses on the community's deficiencies, problems and needs (Kretzmann, 1995).

The major disadvantages of this approach can be listed as follows:

- Firmly stablished in government and non-governmental service delivery which is very unlikely to change.
- Fostering leadership that weakens the community.
- Community members put trust in what their leaders are stating and consider themselves as deficient and incapable.
- Community leaders exaggerate the severity of problems to attract institutional resources.

- People start acting like clients or consumers of services with no motivation for collaboration in service delivery.
- Weakens neighbour to neighbour links due to reliance on dealing with associations outside the community rather than partnership with the groups within the community.
- Creates dependency on outside resources and solutions.

Despite the fact that some needs-based health interventions have achieved outstanding outcomes in addressing the health related issues, they commonly fail to adopt actions to address the social setting and condition in which individuals grow, live and age, all of which considerably affect health and well-being. Therefore, interventions based on the needs or issues of community are not achieving impartial and viable outcomes considering limitations, the demands of an aging population, and increasing diversity within the community, transforming impacts of disease and rising public and patients' expectation. Consequently, emphasis shifts toward redressing the balance between meeting needs and fostering the talents and capabilities of people and communities to work differently to tackle persistent inequalities.

Asset Based Approach

Appraising, nourishing and nurturing the strengths of individuals and the gifts and assets of a community, facilitates new strategies to improving health and responding to poor health.

Ottawa charter as an international agreement for health promotion launched five major action areas as follow ("Ottawa Charter for Health Promotion," 1986) :

- Building healthy public policy.
- Creative supporting environments.
- Reinforcing community action.
- Evolving personal skills and abilities.

- Reorienting public health services toward prevention rather than treatment and promotion of health.

According to this charter, the fundamental strategies necessary to promote the health of populations are as follow (Saan & Wise, 2011):

- Advocate: health and well-being of population influenced are affected by social, cultural and environmental factors. Therefore, health promotion interventions should be designed and implemented in a way that makes these parameters favourable through advocacy for health.
- Enable: equity is one of the main objectives of health promotion programs. Health equity must be reached by reducing inequalities in health status and providing equal and accessible facilities and opportunities for all members of community to empower them to control the determinants that influence their well-being and reach their highest health potential.
- Mediate: health promotion success will depend on coordinated action and collaborative cooperation by all related sectors and stockholders including governmental, non-governmental and voluntary organizations, industry, media, social groups and people from all walks of life.

The key message of this agreement is that promotion of public health requires promotion in participation at local levels by empowering individuals and local communities and emphasizing their positive attributes. As a result of these new ways of thinking and working, public health services are built around people and communities regarding their needs, expectations, capabilities and skills to boost their self-governance abilities and resilience.

Community is a social unit of any size connected by durable relations that shares common values, belief, resources, preferences, needs and risks and usually situated in a given geographical area. Community in contrast with locality points out to a geographical area and is often used to talk about the population of a geographically defined location spotlighted the social aspects of living in a specific locality, mainly the shared values, goals and actions of a group. Moreover, communities may consist of a group of people come together for a particular basis regardless of their location (Payne, 1999)

The Asset Based Community Development framework facilitates the procedure of obtaining a community's goals by bringing their individual and collective assets into focus and mobilizing people through their assets rather than their needs (Fisher, Geenen, Jurcevic, McClintock, & Davis, 2009). Recently, The ABCD approach to public health improvement in the United Kingdom is considering nationally to motivate community-driven progresses based on development of existing gifts and talents within the community to improve the determinants of health (Baker, 2014).

In this perspective "a health asset is any factor or resource which enhances the ability of individuals, groups and communities to preserve, prolong and sustain their health and decline health inequalities and can operate individually or within the family or community as supportive and fostering factors to mitigate life's stresses"(Morgan A, 2010).

The major advantages of this approach can be listed as follows:

- Novel policy for community development especially in neighbourhood scale.
- Organizing people in community to derive development process.
- Identifying and mobilizing existing but unrecognized assets.
- Focusing on social assets, social capital and individuals talents.
- Stronger and liable framework of administration at the local level.

- Encourage active citizenship in the sense of citizen to citizen ties
- Build powerful communities based on capacities of local people and their associations
- Shifting communities from being consumer of services to designers, partners and producers of programmes.
- Appreciate and utilize resources that would otherwise have been ignored ,undiscovered or dismissed
- Mobilising informal networks can activate formal institutional resources and leverage additional support and entitlement

In the process of implementing ABCD, it will be very important to make a differentiation between the needs that can be met by met inside the community by individuals social network, those can be met through partnership between service providers and communities, and those should be delivered by actual service providers. Moreover, it should be mentioned that implementing an asset based approach which is community-led, long-term, open-ended with less certain, unpredictable outcomes, would be supportive when considered as one element in a multi-faceted approach.

Salutogenesis, the Basis for ABCD

The theory of salutogenesis as developed by Antonovsky (1993), concentrates on the resources and capacities of people which positively impact their health. Salutogenic model as opposed to traditional medical model described the relationship between health and disease as a continuous variable called the "health-ease versus dis-ease continuum" where An ability called a ‘sense of coherence’ enable people to understand their situation, have reasons to improve their health and have power and resources to cope with challenges.(Lindström & Eriksson, 2005)

The key elements in the Salutogenic development are, firstly, the orientation towards problem solving and, secondly, the capacity to use the resources available.(Lindström & Eriksson, 2005)

How ABCD is Facilitated

The ABCD process has principles for accomplishing a remarkable level of community-driven advancement and characterized by a series of practices that have been used to organize and encourage community members around a common vision or plan. While there is no certain pattern, this procedure could typically include(Mathie & Cunningham, 2003):

- **Collecting stories about community successes:** Conducting informal discussions and interviews can provide an opportunity for citizens to reveal their experiences from past attempts. This discussion has a dual effect; not only does it uncover unrealized gifts and talents, but it also helps them to build confidence to their personal abilities. Through celebration of achievements and realization of what they have to contribute, they would be motivated to play a part in the sustainable community development process.
- **Asset mapping:** Every community has an enormous reservoir of assets and gifts that can be utilized to strengthen the community and address the issues(Kretzmann & McKnight, 1996). The process of asset mapping prepares and inventories information about the strengths, abilities and resources of a population. Following the accumulation of information, uncovered strengths and resources are illustrated in a map which enables community developers to think and plan to utilize these assets to address community issues and improve health by promoting community involvement, ownership, and empowerment. According to McKnight and Kretzmann (2012), key steps of asset mapping based on the accessibility of the assets for local people are as below:
    - *Discovering primary building blocks*: make a capacity inventory from assets and capacities located inside the community, mainly under neighbourhood governance including individual, associational and organizational assets such as skills and

experiences of community members, gifts of labelled people, citizens associations, cultural organizations, faith based organizations, etc.

- *Discovering secondary building blocks*: community actors need to conduct inventory as well as constructive strategies to enhance regenerative uses of assets and capacities physically located within the neighbourhood but predominantly managed and directed from outside of community such as private and non-profit organizations, universities and other education institutions, social service providers, schools, police, libraries, parks, etc.
- *Discovering Potential Building Blocks*: Resources originating outside the community and ruled by Outsiders including major public assets such as public information and public expenditure.

- **Forming a core steering group:** during the process of collecting the stories and asset mapping, some individuals may be characterized by their distinguished sense of commitment and leadership skills. Organizing a group of these people based on their personal interest can lead to utilizing their network of connections in the process of exploring community assets as a cooperation interaction.
- **Building relationship:** due to uncovering of local assets, a rich reservoir of resources will be available. Building the linkage among local people, institutions and organizations is the key to effectively organize these assets in order to address the issues of local concern collaboratively. Building relationships across the community will help implement the goals and vision of the community developments programs because the community becomes self-supporting and more self-standing when locals, institutions, and community groups are associated in confronting and tackling local issues or concerns.

- **Convening a board Representative Group to Build a Community Vision and Plan:** undiscovered assets are coordinated around an activity of their concern. This task should be tangible, prompt and attainable by existing assets within the community. It should also bring people from all walks of life together and strengthen them by appreciating and utilizing their skills and abilities. The identified power of community in associational level will be demonstrated by a representative group and institutions leaving decision-making to those who have been distinguished as leaders in the community with key connections to associational networks.
- **Mobilising Assets for Community Development:** the procedure proceeds as a continuous mobilization of community assets for development and expanding the relationships between assets to share the information. Associations are encouraged to participate by engaging in their interests, finding shared conviction and ensuring that they are contributing on their own terms. Eventually, an "association of associations" emerges.
- **Leveraging Activities, Investments and Resources from Outside the Community to Support Asset-Based, Locally Defined Development:** External resources are not tapped until local resources have been utilized. This puts the community in a position of strength in dealing with outside institutions.

Scaling Up of Health Interventions:

Scaling up of health interventions has become a central subject matter in public health agendas because of reasons such as globalization, renewed interest in primary health care and emergence of well-funded health partnership which aim to significantly increase access to specific range of interventions.(Marais et al., 2012). Strong appeals to scale up emerge from a common sense that

the advantages gained from new innovations and interventions in health services should have broader, greater and more rapid impacts on improving health and well-being.

World Health Organization (2009) defined scaling up as deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis. Based on this definition, every practice including a set of interventions and necessary processes to build sustainable implementation capacities which are new and have not been used in a specific location could be considered as innovation . These interventions should be supported by locally generated evidences of practical effectiveness and feasibility acquired from pilot or experimental projects. Moreover, scaling up is a guided process in contrast with spontaneous diffusion of interventions with the focus on institutional capacity building and sustainability.

Moreover, scalability as 'the ability of a health intervention shown to be efficacious on a small scale and/or under controlled conditions to be expanded under real world conditions to reach a greater proportion of the eligible population, while retaining effectiveness' should be considered in the process of scaling up(A. J. Milat, King, Bauman, & Redman, 2013).

Main factors which can influence scale up process are grouped in to six categories: underestimating the resources required for scale-up; political and policy naivety; lack of attention to issues of sustainability and scale-up during early efforts to test or implement innovation uptake; an over-emphasis on either the vertical or horizontal spread of innovations; inattention to spatial elements of scaling-up; and inattention to the demand side of scale-up(Edwards, 2010).

A proposed framework for successful scale up of health interventions is categorized as follow(Yamey, 2011):

- Attributes of the Tool or Service Being Scaled Up

    - Simplicity
    - Scientifically robust technical policies.
- Attributes of the Implementers
    - Strong leadership and governance.
    - Engaging local implementers and other stakeholders.
    - Using both state and non-state actors as implementers.
- The Chosen Delivery Strategy
    - Applying diffusion and social network theories.
    - Cascade and phased approaches to scale-up.
    - Tailoring scale-up to the local situation, and decentralizing delivery.
    - Adopting an integrated approach to scale-up.
- Attributes of the Adopting Community
    - An engaged, activated community.
- Socio-Political Context
    - Political will and national policies.
    - Country ownership
- Research Context
    - Incorporating research into implementation (learning and doing)

Bolton Community Development Program

Bolton Community Development Programme [BCDP], was established in 2015 to be the spur for communities to improve themselves using their assets. This programme, governed by a steering group --ABCD Partnership; a non-governmental organisation--

consists of a multidisciplinary team from diverse interest fields: health, business, research, civil service, academics, politics, policy, journalism, faith and legal back ground working together to improve policy environment for advancing community development in Bolton.

BCDP aims to provide critical data for developing policies and programmes for scaling up best practices relating to community development and also providing support needed to engage with communities and their aspiration with the focus on utilizing the asset based community–led development approach (ABCD). The significant objective of BCDP based on the aims above is to conduct research projects and utilize the results to build public health awareness and advocate for policy changes about critical community development issues in Bolton ("Bolton community development programme," 2015).

Dementia

Dementia as a critical public health issue and a major cause for disability and dependency among older people, occurs when the society experiences super-aging. It is an umbrella term to describe defects to the memory, language, and thinking of mostly aged people with hidden cases of brain disorder which affects their cognitive abilities("World Alzheimer Report 2015," 2015) .

Community-based interventions go a long way in giving opportunities for the assets in different communities to be effectively utilized(Mathie & Cunningham, 2003) . Great in its emergence has been the efficacy of community-based and community-wide, multi-strategic approaches to preventing major public health issues, of which Dementia is part (Fisher et al., 2009). Recently due to high prevalence and huge burdens of dementia, new concepts like “dementia-friendly community”, “dementia-supportive community”, “dementia-capable community” and “dementia-

positive community" are incorporated into public health policy to facilitate the process of normalization of dementia in communities (Lin & Lewis, 2015).

There are 850,000 people living with dementia in the United Kingdom, of whom two-thirds live in the community. Dementia currently costs the UK £26 billion per year, including £11 billion of unpaid support provided by 670,000 family members and friends. Government policy emphasizes the need for high quality, evidence-based interventions(Wenborn et al., 2016).

Resource-oriented Treatment Approach

The history of medicine has been dominated by a traditional deficit focus approach where diseases are distinguished by deficits and treatments are designed to remove or mitigate the presumed deficits. Application of this approach in form of pharmacological or psychotherapeutic treatments has a series of potential challenges; reinforce a negative image of patients, reduce their sense of control and shifting them to be passive recipients of care services(Priebe, Omer, Giacco, & Slade, 2014).

Against this background, a number of novel models of therapeutic interventions from a salutogenic perspective, concentrate on utilizing inner potentials and positive personal and social resources of patients to ameliorate health and well-being. However this approach generally known as resource-oriented treatment eventually may indirectly mitigate the consequences of a defined illness, primary target is patients' resources rather than deficits(Prufer, Joos, & Miksch, 2013).

Dance movement therapy (DMT) as a resource-oriented treatment approach for elderly suffering from dementia shows a preventive effect against dementia and a salutary effect in improving cognitive functioning. DMT associated with development of self-awareness and awareness of others, reducing aphasia and agnosia, improved mood and concentration, better communication

and may help to improve general well-being and increase the quality of life by maintaining the capacities and performances of daily activities of dementia patients(Bräuninger, 2014).

Circle Dancing for Dementia

With a growing number of elderly being identified with dementia there is a call to explore practical and engaging interventions to ameliorate their quality of life, assist emotional expression, stimulate cognition and try to prevent or manage the mental and behavioural consequences that often go along with dementia as it progresses(Hamill, Smith, & Roehricht, 2012).

One current method of rehabilitation and treatment/therapy for dementia is DMT and appears to protect against the onset of dementia(Van de Winckel, Feys, De Weerdt, & Dom, 2004). Moreover, DMT stabilizes cognitive functions and memory recall, improves body image and psychosocial functioning, increases stress management and self-awareness (Hamill et al., 2012), preserves the dignity of the elderly, respects their individual needs and improves their social participation (Bräuninger, 2014).

The ‘Circle Dancing for Dementia’ as a DMT model, came into existence in the 1970’s from traditional folk dance and has been a common approach to relieving consequences of dementia. CDFD was aimed at making people with dementia in respective communities feel connected to music they had been used to from their youth and earlier years. This was supposed to help them feel and stay involved with peers as music is connected to different kinds of celebrations and allows for social and cultural exploration. It involves holding hands and other repetitively simple movements that provoke comments, thoughts and expressions and features of being in a group, touch, holding, gentle rocking, promotes re-attachment, sound, stimulation, enjoyment and reminiscence help retain connections with others and the sense of personhood ("What is Circle Dancing?," 2014). Participants appeared to benefit emotionally, socially and cognitively as a result

of a dance movement group therapy and points to the scope for such interventions in community settings(Hamill et al., 2012).

Minority Ethnic Communities and Dementia

Nearly 25,000 people from Black, Asian and Minority Ethnic (BAME) communities are currently suffering from dementia in the UK and this figure will rise to 50,000 by 2026 and 172,000 by 2051 in accordance with the ageing BAME population living in the UK(dementia, 2013). In 2001 approximately 532,000 people from BAME groups were aged 65 years and over and anticipated to increase to approximately 3.8 million by 2051 (Lievesley, 2010). Thus, notable population of BAME communities will be aged 65 years and over when compared to White British people.

BAME communities are also relatively influenced by substandard education, illiteracy and deprivation. Furthermore, various cultural perceptions about dementia, language barriers, and lack of local knowledge, unfamiliarity with systems and services and lack of concern within services to the needs of different communities such as gender, diet and habits can lead to poor or late access to supportive services for people with dementia and their families.

Therefore, in the light of cultural competence concept, dementia related interventions should be designed on the basis of Understanding and functioning effectively within the complex context of caste, religious customs, language differences, culture, inter-racial historical tensions and political events (Hare, 2014).

SECTION 2: METHODOLOGY

Overview

The methods adopted in achieving the set aims and objectives of this research is presented in this chapter.

The aims of this research include:

- Reviewing and evaluating the effects of an ABCD based intervention on PWDs.
- Developing a framework to scale up ABCD projects to enhance the health and well-being of the community.

In order to achieve these aims, the following objectives were looked at:

- Ascertaining if the ongoing CDFD project in Little-Lever underwent the ABCD principles/guidelines.
- Identifying and characterizing the benefits of this community-driven intervention on PWDs as reported by the project providers and confirmed by the observation report of the research team.
- Determining the feasibility and procedure of scaling up CDFD in Halliwell UCAN centre

The purpose of the research is aimed at making a case study of the current circle dancing project in Little Lever, Bolton with the intent of scaling it up to Halliwell UCAN Centre.

Data Collection

For the purpose of review and evaluation of CDFD in Little-Lever, data was collected through desk-based study, observations and interviews, structured and unstructured. Our choice of methods, purely qualitative, was to avoid crossing our boundaries and heading into the

medical/clinical boundary to prevent stating unattainable objectives. The data collection tools and their suitability for this evaluation are described in details below:

- *Desk-based Study*: In a bid to always review related existing literature and compare it with the ongoing research, this tool hardly ever outlives its usefulness until recommendations for the study have been made. As the name implies, it involves getting a wide range of existing information around and about what research one is involved in. This tool is effective as it is pretty fast and cost effective and most pieces of foundational information could be retrieved, which would serve as the basics for this research (Steinmann, Häusler, Klettner, Schmidt & Lin, 2013). For this research, however, the desk-based study was used to find out in details the principles of ABCD, what circle dancing was all about, why it was for dementia and a whole lot of other information. It was also used to get the diverse cultural and religious backgrounds existent in Halliwell.
- *Observation Report*: This data collection tool is used in cases where participants of the research are unable to speak for themselves. Haley and Anere, (2009) were of the opinion that this tool requires more than just vision, it involves using all our senses, and getting involved with the group, if we can. The researchers were involved with the group of PWDs and participated in their sessions after having themselves introduced. This was done to eliminate any kind of strains in relationship and have them behave as they would in our absence.
- *Unstructured Interview*: This involved informal discussions with the program instructors as well as project coordinators on various specifics about and around this project in order to obtain sensitive information, considering the nature of PWDs. This method of data collection according to Gill, Stewart, Treasure and Chadwick (2008), allows the

interviewee spontaneity without intervention and re-directions from the interviewer. The interviewees, through this method reveal things that the interviewer might never have thought of as well as details that are historically extinct.

- *Structured Interview*: Also known as face-to-face interview, this method of data collection involved a direct and official session with the project coordinators, using questionnaires, with a view to obtain in details some specifics of the project. The researchers also had the permission of the interviewees to have their voices recorded, hence enabling the research team listen to the recordings, all over again. The structure of the questionnaires required the interviewees to state the history, benefits, challenges and recommendations, to mention but a few. Structured interview as a time-saving and fast method of data collection allows researchers to acquire an abundance of information (Robson & McCartan, 2016).
- *Attendance Log*: The essence of this tool was solely for monitoring the participation and commitment level among the participants in order to evaluate the acceptability and sustainability of the CDFD project.

Figure 1 provides an outline of the aims, objectives and methods of the study to address the objectives of the study.

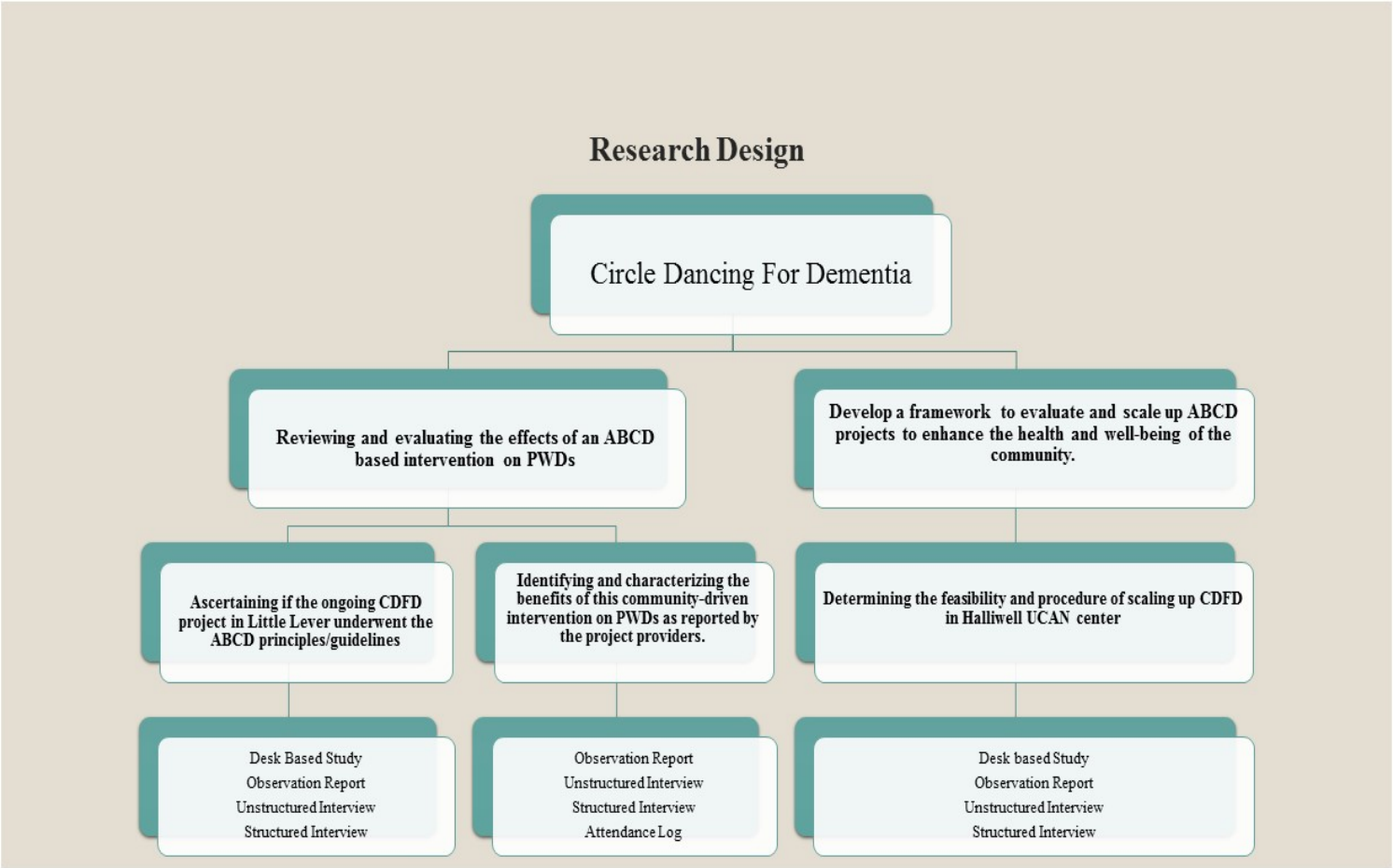

Figure 1: Research Design

Chronology of Circle Dancing In Little-Lever

The circle dance for the participants is organized by Precious Gems at the Christ Church in Little Lever. The dance is held fortnightly on the 1st and 3rd Tuesday of the month between 1:30pm and 3:00pm. Usually, the participants are served with light refreshments of biscuits and coffee before the commencement of the main circle dancing activity. The Instructors also ensure that each participant signs the attendance register. It is also expected that the dementia patients come with a financial contribution whenever they come. To an extent, it is assumed that this action tests their memory abilities and overall commitment to the program.

The circle dancers are in physical contact with each other and a hand to hand connection is made. The participants follow the leader around the dance floor while holding the hand of the dancers beside them. This action indicates a clear sense of group coherence. The dance can be gentle or energetic depending on the rhythm of the music playing. The song choices are a mix of traditional British folk music and popular music. Regardless of the fact that memory loss is often associated with dementia, it was observed that the participants remembered the lyrics of each song on every session. This lends support to the hypothesis that music therapy serves as a way of stimulating long-forgotten memories back to mind of the people with dementia and thus suggests there is an improvement in the general well-being of the patients. Sometimes, the participants are handed some musical instruments at intervals during the dancing period. A twiddle muff, a double thickness hand muff with bits and bobs attached inside and out is passed around during the process. It is designed to provide a stimulation activity for restless hands for the patients suffering from dementia.

The researchers observed that the circle dancing is an enjoyable way for people with dementia to experience the physical benefits of exercise. Further observations show that participants seemed

more alert and more responsive during the circle dancing activity. The observations also noted that the program was fun and amusing for the participants involved as well as helping participants bond and interact amongst each other. An example to illustrate the associated interaction was that a ball was usually passed around and everyone introduced themselves by saying their name. In spite of the fact that some of the participants have been diagnosed with dementia, no one needed any prompting before passing the ball on and introducing themselves.

From close introspection, the participants derive a lot of benefits from the whole program which include enjoyment which may be recalled, movement and mobility; essential and required exercise; emotional and inner well-being as well as reminiscence. It also provides the opportunity for a shared activity between mixed physical ability users in both seated and standing dances during the session.

Demographical Characterization of Research Sites

Little-Lever:

Little Lever & Darcy Lever has a total resident population of 13,000 people and covers an area of 481 hectares where population structure roughly follows the Bolton and national figures.

Little Lever & Darcy Lever contains significantly smaller numbers of people of Black or Minority Ethnic (BAME) origin than Bolton and England. Around 5% of the population are from a non-White BAME group, compared to 18.01% in Bolton and 14.05% in England. The largest BAME group within Little Lever & Darcy Lever is people of Indian origin, who constitute less than 1% of the total population· There are also small numbers of people of Pakistani and mixed ethnic origin, but no other minority ethnic group constitutes more than 1% of the total population of Little Lever & Darcy Lever.

Around 74% of people in Little Lever & Darcy Lever stated their religion was Christianity, compared to 62.07% in Bolton and 59.04% in England & Wales. Little Lever & Darcy Lever as a whole also demonstrated relatively high levels of religiosity, with only 9% of the population stating they had no religion, compared to 15% in England & Wales.

Halliwell:

Halliwell has a total resident population of around 14,000 people and covers an area of 277 hectares. Halliwell contains significantly larger numbers of people of Black or Minority Ethnic (BAME) origin than both Bolton and England. Almost one third of the population are from a non-White BAME group, compared to 18.1% in Bolton and 14.5% in England. The largest BAME groups within Halliwell are people of Indian and Pakistani origin, who make up around 12% of the total population each. This can be compared to 2% in England for people of Indian origin, and around 1.5% Pakistani. There are also larger proportions of Other Asian, Black or Black British, Chinese and people of Mixed Ethnic origin in Halliwell compared to Bolton as a whole. Around 43% of people in Halliwell stated their religion was Christianity, compared to 62.07% in Bolton and 59.04% in England & Wales. 27.09% of the population in Halliwell stated their religious identity as Muslim, compared to 11.07% in Bolton as a whole, and 5% in England & Wales. Further to this around 5% of the population stated they were Hindu, compared to 2.02% in Bolton and 1.05% nationally. Halliwell as a whole demonstrated relatively high levels of religiosity with around 9% of the population stating they had 'no religion' compared to 15% nationally.

Table 1 shows the demographical characteristics of research sites retrieved from UK national census website.

Figure 2 illustrates the geographical position of research sites within Bolton Bureau (Bolton Council, 2016).

Figure 2: Map of Bolton Wards (Source: Bolton Council, 2016)

parameter	Halliwell	Little lever	Bolton	UK
Population	13929	12799	276786	53012456
Males	7129	6266	136660	26069148
Females	6800	6533	140126	26943308
Households	6302	5521	116371	22063368
Very good health	39.9	44.3	45.4	47.2
Good health	32.9	34.4	33.9	34.2
Day to day activities limited	13.4	10.4	10	8.3
Christian	42.7	73.9	62.7	59.4
Muslim	27.9	1.7	11.7	5
Hindu	4.6	0.7	2.2	1.5
Asian	31.6	2.5	12.8	5.6
Black	4.2	0.5	1.6	3.4
White	60	95.4	81.9	85.5
Age 65 and over	13	17.2	15.3	16.4
Age 45-64	20.9	28	25.2	25.4

*Table 1.*Demographical Characteristics of Research Sites
Note: Data from UK National Census, 2011.

SECTION 3: FINDINGS AND DISCUSSION

Data Analysis

Desk-based study and observational reports were done, structured and unstructured interviews were conducted by the researchers with the backing of voice recordings. The results and findings would be discussed in this section.

OBJECTIVE 1: ASCERTAINING IF THE ONGOING CDFD PROJECT IN LITTLE LEVER UNDERWENT THE ABCD PRINCIPLES/GUIDELINES

The origin of Circle Dancing for Dementia was borne out of the passion of individuals who had people closely related to them, taken away by dementia. This spurred them into the line of thought: 'How do we involve PWDs in activities that would help slow down the progressive pace of dementia, from early to late stages?' This is the motivation behind CDFD in Little-Lever.

For the sake of this section, the guidelines for ABCD as stipulated by Mathie and Cunningham (2003) was linked to the programme background to satisfy the first objective of this study.

Collecting Stories about Community Successes

Having previously conducted a successful on-going ABCD project --Knit and Natter-- that was geared towards getting elderly people around things they enjoy doing, hence ensuring they are active and have a community; the Precious Gem team were confident enough to embark on this CDFD project. The positive responses from elderly people versus the need to get PWDs active and going, around things they enjoy meant that this guideline was undertaken.

Asset Mapping

This guideline is in three stages, Discovery of: Primary, Secondary and potential building blocks.

- ***Primary Building Blocks***: The process of identifying the primary building blocks in Little-Lever was well guided by the already existent knit and natter project. Due to the structural connection between the Kearsley Methodist Church and Christ Church in Little-Lever, the latter was offered the opportunity to house this project seeing that it was of organisational and personal interest. The Patron of Little-Lever sent the word out to the congregation and was able to spot volunteers who were interested in being part of the programme. These identified assets in the community became part of the Precious Gem Team, thereby helping in the implementation of CDFD as an ABCD initiative.
- ***Secondary Building Blocks***: Following the already identified assets, efforts were made by the Precious Gem Team to reach out to the secondary building blocks within the community. These building blocks: The Local Health Services, schools, libraries, care homes and other community centres helped in the extra publicity of the CDFD project.
- ***Potential Building Blocks***: For the purpose of mobilising the assets obtained during the first and second steps, the Precious Gem team approached the potential building blocks such as: Big Lottery, University of Salford, Dementia Pathfinders, Bolton F.M and Bolton CVS. Utilising these assets provided the project with funding, training and publicity.

Forming a Core Steering Group

With the aim of developing the project, a group of people who were interested and possessed the necessary skills for carrying out the project, such as: Church Patron, Identified volunteers alongside the Precious Gem representatives formed the steering group.

Building Relationship

Simultaneously, the Precious Gem Team attempted to build a relationship between the mapped assets, as previously mentioned, in order to bring them around the issue of dementia in the community and utilise their capabilities for the purpose of addressing this issue within the Little Lever Community. As a result of this network of connections, benefits such as funding, logistics, training, advertisement and support were achieved.

Convening a Representative Group to Build a Community Vision and Plan

The case study of this project shows that the core steering group also acted as the representative group, charged with making decisions as regards the day to day running and management of the CDFD project.

Mobilising Assets for Community Development

The process of identification of the assets within the community on the basis of their potential capabilities in supporting PWDs, empowered the Precious Gem Team to build an association of people centred on the CDFD project in Christ Church. The members of this association now become a people who participate based on their shared interests, common convictions and personal terms.

Leveraging Activities, Investments and Resources from Outside the Community to Support Asset-Based, Locally Defined Development

The Dementia Pathfinders, University of Salford and Big Lottery are resource donors who exist outside the community of Little Lever, Bolton.

In a more general way, the project underwent all the principles/guidelines of ABCD as stipulated by (Mathie and Cunningham, 2003). However, considering the fact that all communities are different as well as the limitations and the networks of the Precious Gem team, all the principles were not exactly followed to the letter.

OBJECTIVE 2: IDENTIFYING AND CHARACTERIZING THE BENEFITS OF THIS COMMUNITY-DRIVEN INTERVENTION ON PWDS AS REPORTED BY THE PROJECT PROVIDERS AND CONFIRMED BY THE OBSERVATION REPORT OF THE RESEARCH TEAM.

The benefits of the community driven intervention on people with dementia that have been identified will be characterized and discussed. These benefits will be examined by exploring the impact of the circle dancing program on the people with dementia from the perspective of the project providers. Interviews were performed with the staff members and volunteers of Precious Gems in Little Lever. All interviews were conducted individually. Although it was not always possible to conduct interviews in a private setting, they were conducted with the maximum amount of privacy available. All interviews were conducted face-to-face by the researchers. Interview guides were followed closely but the open-ended questions allowed for elaboration and clarification as needed during the interview. These interviewees were selected for follow-up interviews based on need for clarification and also on availability of the interviewee. Interviewees were given no external incentives to volunteer for this study. Researchers expressed appreciation and gratitude for each person‘s involvement. Some conversations were recorded and the interview was played back to allow for transcription. Based exclusively on the reports from the project providers, six major benefits can be pinpointed or identified:

- **Increased Physicality** - Interviewees reported that participants displayed improved physical performance capabilities over the course of the program. There were several interview questions that addressed the dance program‘s impact on the physicality of participants. Components of physicality may include strength, endurance, range of motion, balance, standing tolerance, or other signs of physical health. In response to these questions, all interviewees reported noticeable improvements in the physical involvement of residents in the circle dancing program. All interviewees mentioned the circle dancing as an enjoyable way for people with dementia to experience the physical benefits of exercise. These descriptions are consistent with previous research findings (Alpert et al., 2009; Eyigor et al., 2007).
- **Sense of flow**- In all of the interviews, project providers made numerous references to the fact that participants seemed more alert and more responsive during the circle dancing program. This increase in alertness and responsiveness that people with dementia displayed during the dance program‘s activities may provide additional evidence that they were experiencing a sense of flow, or absolute engagement, in the activities of the dance session.
- **Fun and Excitement**- Interviewees described the circle dancing program as being an enjoyable experience for everyone involved. ―Fun was one of the most commonly used descriptors throughout every interview performed during this study. All interviewees repeatedly mentioned that the program was fun and amusing for everyone involved. All interviewees believed that the dance program was an excellent way for people with dementia to have fun, and stated that a majority of participants seemed to sincerely enjoy their time in the dance sessions, thus promoting improved quality of life. These reports

closely echo previous researchers' assertions that pleasurable activity can have significant positive effects on quality of life in people with dementia (Eyigor et al; 2007)

- **Bonding**- The circle dancing program appeared to promote relationship-building among participants. All interviewees discussed the relationship-building that seemed to occur during the program. These relationships could be amongst the dementia patients themselves or between instructors and volunteers.
- **Reminiscence-** The projects providers also suggested that the choice of songs which is mix of unforgettable traditional British folk and popular music hits goes to a large extent to soothe, stimulate and bring to mind long-forgotten memories of the people with dementia. This form of music therapy helps the people with dementia recollect past experiences or events and thus serves as a way of reminiscence.
- **Best effort by participants/Participant centeredness -** The project providers also suggested that the circle dancing activity boosted the confidence and self-esteem of dementia patients thus providing an avenue for every one of them to participate to the best of their individual abilities.

The results of this study lend support to the hypothesis that the circle dancing program can have positive effects on physical fitness, cognition, and quality of life in the elderly. In addition to the circle dancing for dementia program's effects on balance and functional performance of activities of daily living, previous research has also found that circle dancing may have a positive impact on people with dementia's overall health-status (Cohen, et al.; 2006)

OBJECTIVE 3: DETERMINING THE FEASIBILITY AND PROCEDURE OF SCALING UP CDFD IN HALIWELL UCAN CENTER

The process of conducting a health intervention from a pilot project into a pragmatic real-world performance commonly requires a change of scale or 'scaling up'. The appropriateness of interventions for scaling up, however, is mainly presumed to be based on its efficacy, cost-effectiveness, acceptability by target audiences and feasibility(Andrew John Milat, King, Bauman, & Redman, 2012). Considering the information on circle dancing for dementia in little-lever which was collected through selective formal and informal interviews with collaborators and confirmed by observations of research team, in addition to expectations, potential resources and demographical characterization of Halliwell ward and Halliwell UCAN centre, it revealed that a range of amendments that potentially could work in the target community should be undertaken in order to devise a tailored intervention.

Regarding the intention of BCDP and willingness of Halliwell UCAN centre to implement a supportive program based on the principles of ABCD approach conducive to people with dementia who are living in Halliwell neighbourhood, and applying the lessons and experiences from conducted CDFD in Little-Lever, key considerations can be listed as follows:

- **Attributes of the Implementers**: Scaling up generally requires a highly committed group of individuals to push it along and involves a partnership of organizations working on service delivery, financing and management. reviewing the BCDP vision strategy which includes objectives such as utilizing ABCD principles to build stronger communities, encouraging collaborative networks and helping citizens to meet local needs by utilizing local assets, alongside with a comprehensive collection of local, associational and institutional assets within the BCPD in the form of steering group which governs the partnership, disclosed that BCDP possesses the essential structural and managerial

prerequisites for scaling up the project. Moreover, Halliwell urban care and neighbourhood centre (UCAN) as a communal focal point charged with the task of providing tailored services and social activities to meet the needs of neighbourhood community, seems to be an optimal centre to scaling up the supportive program for people with dementia. It emerged in the interviews and supported by our observation that effective management and motivated personnel at the local level are prepared within the Halliwell UCAN centre as essential capacity to implementing the intervention. Halliwell UCAN centre is a good reflection of the Halliwell community considering that the staff are from differing backgrounds, age groups, ethnicity and religion, hence, are armed with various personal and professional skills and languages.

- **Attributes of the Tool or Service Being Scaled Up**: circle dancing for dementia as the service which is planned to be scaled up, carries the general requirements for scalability. Circle dancing is a simple, replicable and transferable intervention with straightforward principals and practice that can be delivered safely without complicated expensive procedures. Our findings from Little-Lever indicate that CDFD is an agreed project with no dissenting opinion among the stockholders which could be the precondition of success. Nevertheless, differences between the condition under which the trial was directed and the scale-up setting should be regarded.
- **The Chosen scale-up approach**: As Gilson and Schneider say, “there is no simple recipe for managing scaling-up processes”(Gilson & Schneider, 2010) but empirical researches based on the experiences and lessons from similar attempts will help to pinpoint which strategy is best appropriate to address a particular health issue within a particular community and setting. Contemplating the various strategies were pointed out in section

one, and considering the characterization and demography of Halliwell ward, it could conceivably be suggested that tailoring scale up to the local situation on the basis of ABCD approach is the most likely feasible model to scaling up a supportive intervention for people with dementia in Halliwell UCAN centre. This argue may be explained by the fact that successful pilot have not automatically scaled up, whatever their merits, they may require adaptation to succeed in different context. While it is useful to draw lessons from successful experiments, scale-up is a context-specific and needs better understanding of local context.

- **Attributes of the Adopting Community:** statistics from the last UK national census revealed that Halliwell ward in Bolton embodies diverse communities of ethnicities and religions.
    - Ethnicity: Halliwell contains significantly larger numbers of people of Black or Asian Minority Ethnic (BAME) origin where more than 35% of the population are from a BAME group, compared to 3% in Little-Lever. The largest BAME groups within Halliwell are people of Indian and Pakistani origin. There are also larger proportions of Other Asian, Black or Black British, Chinese and people of Mixed Ethnic origin in Halliwell compared to Little-Lever.
    - Religion or belief: Around 43% of people in Halliwell stated their religion was Christianity, compared to 74% in Little-Lever.moreover, 27.09% of the population in Halliwell stated their religious identity as Muslim, compared to 1.7% in Little-Lever. Further to this around 5% of the Halliwell population stated they were Hindu, compared to 0.7% in Little-Lever. Both Halliwell and Little-Lever demonstrated relatively high levels of religiosity compared to UK as a whole.

UK national dementia strategy emphasizes the higher probability of dementia among BAME communities due to higher prevalence of dementia risk factors such as high blood pressure, diabetes, stroke and heart failure. On top of that, knowledge and understanding about dementia in BAME communities is very low which in turn acts as a barrier to access services and receive the support they need(dementia, 2013).

Key factors in designing and promoting a feasible and pragmatic initiative programme for supporting people with dementia in ethnically diverse communities are as follow:

- Raise awareness: conducting the principles of ABCD, a public information campaign that aims to raise awareness of dementia among BAME community should be founded where potential assets of target community and faith groups within the community are incorporated in the design of the campaign. Considering the role of young people to changing community attitudes, a target campaign should be focused on schools and youth clubs. Specific BAME printed or broadcasting media would be utilized to build trust in target community. Informative materials should be culturally relevant and in the language of target population.
- Identifying the needs and assets of local community: Growing numbers of people with dementia and increasing number of older people from BAME groups accentuated that local areas need culturally sensitive dementia services to understand the needs of their local community in order to provide the efficient support. At the same time, local assets within the communities that could be utilized to support people with dementia from ethnic minorities should be recognized based on the ABCD asset mapping models. This would include BAME community groups as well as dementia-specific programs, social

care and voluntary sectors. Considering ABCD approach, next step is making links between them, to enable the sharing of knowledge, expertise and facilities.

- Designing a cultural relevant intervention: Culture, ethnicity and religion are closely associated together and a potentially successful intervention should take account of the fact that the needs of people from ethnic groups may be different and they may require specifically-tailored programmes. Therefore, every intervention must earn credibility in the ethnic community either by support of community leaders and faith agents or by involving them in the leading of the intervention in order to increase a sense of adherence within the target community. An appropriate programme should scrutinize community perspectives on the care of the elderly, stigma surrounding dementia in different cultures, myths and misconceptions about dementia and diversity within the ethnic groups.

  A board representative group founded on the ABCD strategy including people from all walks of life is indispensable to build a community vision and plan toward the issue of dementia as an activity of concern.

- Socio-Political Context: assessing the primary issues of socio-political associates of BCDP steering group such as Bolton council, local councillors and local authority representatives revealed that applying an intervention to mitigate the burden of dementia for the patients, their families and carers and the community as a whole, is one of the agreed priorities and targets of local administrators. Further attempts to meet this priority will be facilitated by this insight among the local leaders and policy-makers.
- Research Context: It goes without saying that integrating research (learning) into application (doing) would lead to accomplishment and achievement of goals in real-world

projects. Employing the potentials and capabilities of the academic sector inside the BCDP to design, implement and evaluate the projects based on the latest academic findings and literatures as it was done through knit and natter project and also through current research, is a reliable practice to bridging the gap between decision-making and application by means of science.

SECTION 4: CONCLUSION AND RECOMMENDATIONS

Conclusion

- **Ascertaining if the ongoing CDFD project in Little Lever underwent the ABCD principles/guidelines**

Information for this objective was collected using desk based study, observation report and interviews (structured and unstructured). Taken together, the findings indicate from a general viewpoint that the Precious Gem team went through the principles of ABCD approach during the implementation process of CDFD in Little Lever.

There were a few differences, however, between the classic model of ABCD described in the literature review and the pragmatic application of this model in Little Lever. This can be justified by the differing community characterizations and limitations, as well as the capacity of Precious Gem as the implementer.

- **Identifying and characterizing the benefits of this community-driven intervention on PWDs as reported by the project providers and confirmed by the observation report of the research team.**

The data for this objective was collated using observation report, interviews (structured and unstructured) with the dance instructors and the attendance log. A range of benefits from physical to mental to social benefits were discovered during the dance sessions.

- **Determining the feasibility and procedure of scaling up CDFD in Halliwell UCAN centre**

Desk based study, Observation report and interviews (structured and unstructured), were used to gather the information for this objective. From the findings, CDFD is a scalable project in Halliwell UCAN centre, but the characteristics of the target community should be considered in the scaling up process.

Recommendations

- Complimentary and specific asset mapping geared towards identification and expansion of the network of assets (individuals and institutions) who can be utilized to further improve the CDFD project is recommended
- Shifting to an evidence-based programme which would involve data collection and archiving of documents recommended for procedural implementation, hence ensuring applicability --of the documents-- for further monitoring and evaluation of programme.
- For the purpose of project management, evaluation process is recommended to be designed for circle dancing project in little-Lever: to identify the strengths, weaknesses and future challenges.
- Continuous On-Job staff training and development recommended to be undertaken to provide the staff with better understanding of The ABCD concept, as well as up-to-date methods of working with people suffering from dementia.
- In light of the lessons and experiences from the previous projects, ABCD is recommended as an appropriate and applicable approach towards scaling up in the Halliwell UCAN centre, however, considerations should be made, on the basis of the classic models of ABCD, with respect to the characteristics of the target community.

Limitations

The research has reached its aims but there were some unavoidable limitations. First because of a time limit, this research was conducted only on a few sessions of circle dancing for dementia in Little-Lever. Therefore to generalize the findings with the aim of scaling up, the study should have involved more sessions. Moreover, lack of documented evidence or lack of accessibility to those documents about the process of establishing circle dancing for dementia in Little-Lever should be mentioned as a probable limit to ensure the findings. Furthermore, self-reported data received from interviews is limited by the fact that it rarely can be independently verified.

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