The North West Further Education Project:
The Mental Health & Well-being of Learners aged 14-19

Final Report

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Executive Summary

Introduction

In 2007 a North West Child and Adolescent Mental Health Service (CAMHS) Lead approached the North West Learning and Skills Council (NW LSC). She was concerned about the rising numbers of young people in the North West who were experiencing both diagnosed and undiagnosed mental health difficulties.

The NW LSC 14-19 Director and Learning and Quality Director were also concerned about high college drop out rates at age 17. These Directors were able to provide funding for research into the area of mental health. As a result the project described in this report was developed through the NIACE¹, LSC² and Inclusion Institute Partnership Project. This partnership exists to improve learning services for people with mental health difficulties in post-compulsory learning and skills. This project centres on a survey for young people developed by the Partnership Programme in the North West and SHEU³.

The aims of the project were to explore real levels of emotional and psychological distress, and to look at the mental health and well-being needs, of young people aged 14-19 engaged in further education in the North West; and also the extent to which learning providers are able to support these needs.

The study was governed by these objectives:

- To identify the levels of emotional and psychological distress among young people engaged in learning in Further Education establishments.
- To involve young people in developing effective support strategies.
- To identify current and emerging areas of innovative practice.

The study explored and painted a picture of both the emotional and psychological well-being of young people in the North West, and the role of learning providers in responding to this. It acknowledges that there is ‘interest and goodwill’ in the FE system (Warwick et al, 2006) but suggests it is now the time for this ‘interest and goodwill’ to become ‘purpose and action’.

Policy context

A number of policies and laws have come into being over the past few years, several of which underpin the need for greater support for young people’s mental health and well-being as well as the importance of learning and skills to a person’s emotional, psychological and physical well-being.

These include the high profile government strategy Every Child Matters (Chief Secretary to the Treasury, 2003), and Public Service Agreements to raise the

¹ National Institute of Adult Continuing Education
² Learning and Skills Council
³ See www.sheu.org.uk for more information about this organisation
educational achievement, and to improve the health and well-being, of children and young people (HM Treasury 2007).

The Social Exclusion Unit Report Mental Health and Social Exclusion (Office of the Deputy Prime Minister, 2004) highlighted the challenges for the learning and skills sector and subsequent activity has been seen in the LSC to address mental health needs: the LSC published a strategy for Improving Services for People with Mental Health Difficulties (LSC, 2006b) which was subsequently refreshed and revised in 2009 with LSC Mental Health Strategy – The Way Forward (LSC 2009). This strategy emphasises the importance of a whole organisation approach and partnership working, and aims to ensure systems are in place that can be carried through the Machinery of Government changes.

The mental well-being of young people

The mental well-being of the nation’s children and young people has come increasingly into the spotlight in recent years. Various studies, such as Warwick et al, 2006, Aylward, 2003 and Mind, 2009, have highlighted the extent of psychological and emotional problems experienced by young people. Examples include the findings that ten % of five to 16 year olds have a diagnosed mental health disorder (National Statistics, 2004) and ten % of 16 to 25 year olds have had thoughts that life is not worth living (The Prince’s Trust, 2009).

Subsequently the mental health and well-being of young people has an increasingly high profile resulting in the need for more support and greater awareness among front line staff, especially those in the further education system. This need is reinforced by recent policy developments meaning more learners with mental health difficulties are likely to be entering the further education (FE) system. The aim for increased collaboration between learning and skills providers, and health providers is also highlighted along with a move towards the ‘Healthy FE’ concept.

Methodology

This study comprised three stages:
- Part 1 - an online survey for young people (learners);
- Part 2 – an email survey for Further Education providers across General Further Education, Work-based Learning and Sixth Form Colleges;
- Part 3 – three interviews and field visits to develop case studies of innovative or interesting practice, or learners’ stories (see appendix 2).

Findings: Young People’s Survey

1329 young people engaged in learning responded to the survey. The majority were 16 or 17 years old. 52 % were male and 48 % female. These percentages match the estimates for the population for 2008 from the Office of National Statistics (National Statistics, 2009). 72 % were white. The majority were also enrolled with learning providers in the Greater Manchester and Greater Merseyside areas.

When asked about what keeps them healthy, respondents appeared to think about physical health (57 %) but also seemed to see a link between meaningful
relationships and health (30%). Respondents reported that the main factors that they think keep them healthy were fitness and exercise (57%), diet (35%), friends and relationships (30%), hygiene (23%) and not smoking (23%).

The vast majority reported that they did not worry about diet. Forty % of respondents to this survey said they never worried about how much they ate, and a further 40 % said that they watched what they ate but never really dieted. More females reported dieting behaviour than males.

When asked about drinking habits, 27 % reported drinking regularly (at least once a week). Although the age profile of this study was slightly different, this compares favourably to the finding that approximately 50 % of 16-17 year olds in the UK drink at least once a week (Institute of Alcohol Studies, 2007). 19 % of the sample use illicit or non-prescription drugs weekly or more often, while 50 % had used them once or twice. Cannabis was the most frequently used drug with 39 % of respondents having used it at some point. Males reported greater levels of cannabis use than females. There are known links between the use of cannabis and mental health problems.

Respondents were asked whether they had ever experienced psychological or emotional problems (not necessarily diagnosed mental health difficulties). 18 % had in the term current to the survey and 39 % had in the past. More females than males reported such problems. In addition, 31 % had thought life is not worth living, 18 % had thought about taking their own life, 14 % had received counselling or other such help and 7 % had attempted suicide.

Respondents reported they had experienced difficulties with changing friends and settling into college suggesting the transition from school to college can be particularly difficult. Respondents also reported difficulties with changes at home and 21 % said family problems had affected their work this academic year.

The majority of respondents have a close confiding relationship with someone but 11 % reported they did not. However, for comparison, The YouGov Youth Index (Prince's Trust, 2009) found that 40 % of the UK's 16-25 year olds did not have anyone to talk to about their problems. More males than females reported not having a close confiding relationship (16 % of males as opposed to 6 % of females).

When asked about their use and knowledge of various services, Connexions/careers service and Student Services seem be amongst those with the highest profiles and be the most frequently used. The general and more specialised services offered by providers e.g. counselling and study support are also quite well known, but less frequently used. This implies that although the young people know they are there, they may be reluctant to use them, possibly due to stigma.

However, when asked what learning providers could do to support the mental health and well-being of young people, most common responses suggested learning providers should offer counselling, listen to, communicate with and try to understand learners, offer one-to-one support with a named person, and/or have staff attend lessons on a regular basis to inform students of support available. Being able to talk
to someone who has experienced mental health difficulties themselves was also a fairly frequently occurring response.

**Findings: Learning Providers’ Survey**

Fourteen respondents completed and returned a questionnaire. There was a good response from Work-based Learning providers (seven); four respondents were from General Further Education Colleges, while two were from Sixth Form Colleges and one described their organisation as ‘other: Higher Education Institution with Further Education provision’. This differs from the range of establishments who administered the young people’s survey; the majority were General FE Colleges.

Respondents reported how many learners within their organisations had mental health difficulties that the staff were already aware of. The average percentage across the 13 providers who responded to this was 0.9% which contrasts with the findings from the young people’s survey that showed 18% had experienced emotional or psychological problems in the current term. The percentage was smaller for providers that were small and Work-based Learning providers. All 14 respondents believed the figures recorded by Individual Learner Records (ILR’s) were not representative of the real levels of mental health difficulties experienced by this age group, but that in reality more learners actually experience mental health difficulties.

Across all respondents various mental health specific Information, Advice and Guidance and support services (including counselling services) are in place to support young people and well as staff in designated job roles to provide such support. They also offered more generic services and activities to promote well-being including enrichment programmes, induction programmes, etc.

Providers that were small and Work-based Learning providers appeared to, generally, have far fewer services in place than other providers (only one reported having a counselling service). However they expressed a desire in further developing the services they did have in place.

Respondents had contact with and signposted learners towards a range of external services including Early Intervention in Psychosis (EIP) services and Child and Adolescent Mental Health Services (CAMHS). Again there were fewer examples of such contacts in small and Work-based Learning providers.

Respondents to the provider survey reported various barriers and frustrations associated with supporting the mental well-being of young people including difficulties linking with external services, a reluctance on the part of learners to disclose mental health difficulties (especially within small and Work-based Learning providers), a gap in external mental health services for 16-17 year olds, stigma and a lack of resources.

Over half of respondents had used Additional Learning Support Funds to support learners with mental health difficulties in general ways (such as to ensure smaller group sizes and greater mental health awareness) or in more specific ways (to fund counselling services).
Three respondents engaged in specific activity to support the mental health needs of Black and Minority Ethnic learners, largely centred on having Black and Minority Ethnic support staff in place.

Most providers had mechanisms for learner involvement in place such as learner forums and councils but only one had something specifically for learners experiencing mental health difficulties.

When asked to suggest advice for other learning providers to enable them to effectively support the mental health needs of young people, many respondents referred to the need for contacts within external services, designated mental health and well-being support services, individualised well-being support for learners, a whole organisation approach, and the provision of a counselling service.

**Conclusion**

The study highlighted some concerning findings. Over half the sample of young people reported having experienced emotional or psychological difficulties, a prevalence that is much higher than figures from ILR’s suggest. Worryingly 31% had thought life was not worth living. Only 14% had received counselling or other such help and only 39% of these had found this intervention to be helpful. This reinforces the suggestion that young people are not seeking support, or could be offered more appropriate support when they do.

The main issues that appeared to be causing worry for the sample were related to transitional aspects: changing friends and settling into their courses; however the majority of respondents reported that their college work had not suffered as a result.

Although issues relating to physical health (such as exercise and diet) were common, findings also highlighted the perceived importance of family and friends to emotional and overall well-being and happiness. Friends and family was the group respondents turned to most when they wanted to discuss their problems. Only 11% thought they did not have anyone to talk to about their problems. While this is of course concerning, other studies have suggested higher percentages experience this isolation (The Prince’s Trust, 2009).

Regular alcohol use appeared to be only half that of the national average (Institute of Alcohol Studies, 2007), and regular use of the most commonly used drug, cannabis, was only 8%, while nationally 17.9% of 16-24 year olds were found to use this drug on a regular basis (Hoare and Flattley, 2008).

Respondents seemed familiar with the types of service and support available in their place of learning, but the specialised services were used less frequently than the more generic. This could be down to level of need for these specialised services, or due to stigmas attached to using them, for example in the case of the counselling services. Stigma could also account for the low levels of declaration reported by the respondents to the learning provider survey.

Findings from the provider survey showed learning providers did have a range of services and activities in place to provide support, encourage disclosure and
promote mental well-being among learners. In particular, the importance and benefit of having a counselling service was mentioned repeatedly by many respondents. Having mentoring systems in place also appeared to feature fairly prominently in respondents’ answers. Additional Learning Support funds are used to establish provision specifically for learners with mental health needs.

Many small and Work-based Learning providers appeared to have far less in place than other providers and appeared to be less far along the journey towards holistic support for mental health, although they are taking steps towards this.

Contact and partnership work with external services was a key theme running through many providers’ responses. It was seen as both a positive enabler for better support for young people, and also a source of frustration and a barrier. Often partnership arrangements were ad hoc rather than through some form of partnership agreement. Partnership working was less well developed for small Work-based Learning providers.

Another common theme running through the advice from providers was to develop a whole organisation approach to mental health support and promotion, recognising that maintenance of mental well-being was everybody’s responsibility.

Overall, there appeared to be something of a mismatch between the reported mental health difficulties of the young respondents and the knowledge providers had of the extent of such difficulties. Providers were, however, aware of this mismatch. That mental health support needs are only captured at enrolment for official statistics via the Individual Learning Record raises questions as to whether this is the most appropriate way of collecting and holding such data.

While providers appeared to take their supportive role and the need for mental health support seriously, often this was impeded by a lack of resources or problematic partnership working with health services. The findings from this study reinforce those from other studies that recommend that investment is needed to facilitate more and better partnership working between learning and health providers.

**Recommendations**

This report culminates in a series of recommendations aimed at learning providers and health providers, as well as a checklist of ‘good and promising practice’ which can be found in the Appendices. As these recommendations will drive this agenda forward and, it is hoped, will act as the launch pad for subsequent activity it was felt that these summarised recommendations should be also be viewed in full on pages 45-49.

1. **Strategy and Policy**

Commitment must be sought at management and strategic levels in order to embed the importance of the agenda into policy and practice and drive it forward. Where possible personnel and time resources should be dedicated to mental health and steps should be taken towards a ‘Healthy FE’ approach.
2. **Whole Organisation Approach**

It is the responsibility of everyone involved with an organisation, all members of staff and learners, to contribute towards an inclusive learning environment. Awareness for all on how to maintain mental health, as well as awareness of mental health difficulties is essential. It is important to realise that what may be put in place to improve the experience of all learners and staff with mental health difficulties will improve the experience of *all* learners and staff. Involvement in Healthy FE, Mindful Employer and You’re Welcome is recommended and further details of these can be found in the Recommendations section of the full report.

3. **Learner Involvement**

Involving learners in planning of services to support their needs is vital. Involve learners in terms of their expert opinions and in terms of peer support. Consult with them about their real needs in order to provide individualised and appropriate support.

4. **Partnership Work**

Actively seek contacts and develop creative ways of working with external organisations for the benefit of learners and service users. Learn from each other as professionals. Ensure strategic commitment and develop partnership agreements which are reviewed on a regular basis. Use the partnerships to add value by managing transitions for learners and reaching out to employers. Seek out and learn from aspects of good practice used by other organisations.

5. **Proactive Approach**

Taking a proactive approach to the above themes will encourage success. Be proactive in making contact with external organisations – don’t wait until their service is needed. Publicise and promote mental health and wellbeing and embed it into both curricular and extra-curricular activities. Frequently inform *all* learners of the support that is available to them.
The North West Further Education Project: The Mental Health & Well-being of Learners aged 14-19

Introduction

In 2007 a North West Child and Adolescent Mental Health Service (CAMHS) Lead approached the North West Learning and Skills Council (NW LSC). She was concerned about the rising numbers of young people in the North West who were experiencing both diagnosed and undiagnosed mental health difficulties.

The NW LSC 14-19 Director and Learning and Quality Director were also concerned about high college drop out rates at age 17. These Directors were able to provide funding for research into the area of mental health. As a result the project described in this report was developed through the NIACE\(^4\), LSC\(^5\) and Inclusion Institute Partnership Project. This partnership exists to improve learning services for people with mental health difficulties in post-compulsory learning and skills. This project centres on a survey for young people developed by the Partnership Programme in the North West and SHEU\(^6\).

The aims of the project were to explore real levels of emotional and psychological distress, and to look at the mental health and well-being needs, of young people aged 14-19 engaged in further education in the North West; and also the extent to which learning providers are able to support these needs.

We refer to ‘real levels of emotional and psychological distress’ as many young people may experience emotional distress but may not have received a diagnosis and do not use conventional names to label their distress. Many may not have disclosed to health services and thus the real levels of emotional distress in young people may be higher than those suggested by official statistics.

We also use the term ‘mental health difficulties’ in this report to refer to a variety of experiences that may or may not be diagnosed conditions, including emotional distress, anxiety, panic attacks, phobias, depression, schizophrenia, personality disorders, etc. When we refer to ‘young people’ we mean learners aged 14-19. When we refer to Further Education (FE) providers we mean General Further Education Colleges, Work-based Learning Provides and Sixth Form Colleges.

The study was governed by these objectives:

- To identify the levels of emotional and psychological distress among young people engaged in learning in Further Education establishments.
- To involve young people in developing effective support strategies.
- To identify current and emerging areas of innovative practice.

It was decided that the age range covered by the study would be 14-19. This was to take account of any 14-15 year old learners receiving some of their education in FE establishments through the 14-19 curriculum; however it is important to note that this

\(^4\) National Institute of Adult Continuing Education  
\(^5\) Learning and Skills Council  
\(^6\) See [www.sheu.org.uk](http://www.sheu.org.uk) for more information about this organisation
project does not cover the emotional well-being of school pupils, just 14 and 15 year olds who happen to receive some of their education at a college of Further Education.

This report outlines the context of the project, and describes its main findings. It goes on to make recommendations for the support of learners with mental health needs within FE based on learner and provider views, and uses case studies to illustrate good and promising practice, the characteristics of which are also outlined.

Please note that this research was carried out before the full scale of the current recession was made public, therefore the ‘credit crunch’ has not been taken into account in the discussion around findings.

Policy Context

The NIACE/LSC/Inclusion Institute Partnership Programme works to improve learning services to people with mental health difficulties in post-compulsory learning.

This report acknowledges the need for greater support for younger people involved in post-compulsory learning, and indeed the need for more investment of resources by health services into the prevention of mental ill health in young people, and adequate support for those experiencing it. This report also recognises the need for effective partnership working between health, social care and education services.

These needs have been supported by many policies over the last five years, relating to young people, and also to mental health and learning, with the necessary cross-over areas:

**Disability Discrimination Act**
The aim of the *Disability Discrimination Act* (DDA) 1995 (Office of Public Sector Information, 1995) is to end discrimination towards people with disabilities, including mental health difficulties. In 2005, the Act was extended to include rights in education, employment, and access to goods facilities and services (Office of Public Sector Information, 2005). Recent extensions also include rights for those experiencing *undiagnosed* mental health difficulties.

**Every Child Matters**
The government strategy *Every Child Matters* (Chief Secretary to the Treasury, 2003) set out 5 key outcomes for children and young people: being healthy; staying safe; enjoying and achieving; making a positive contribution and economic well-being. This is a high profile government priority that needs to underpin all public services for young people.

**National Service Framework for Children, Young People and Maternity Services**
The *National Service Framework (NSF) for children, young people and maternity services* (Department of Health, 2004) is the ten year programme whose aims and objectives intend to effect what was proposed in *Every Child Matters*. It aims to do
this by setting standards for health and social services to improve the health and well-being of children and young people.

**The Children’s Plan**

*The Children’s Plan* (Department of Children, Families and Schools, 2007) also aims to implement what was recommended by *Every Child Matters*. It resulted in *The Children Bill* and also commissioned the external review of Child and Adolescent Mental Health Services (CAMHS) in 2008.

**Public Service Agreements (PSAs)**

Moving forward a few years along the policy timeline sees the Government setting out Public Service Agreements defining the Government’s priority outcomes for the spending period applicable from 2008-11. PSAs exist to drive forward public service delivery and improve outcomes. The following PSAs are linked to the NSF (HM Treasury, 2007):

*PSA 10: Raise the educational achievement of all children and young people.*
*PSA 12: Improve the health and well-being of children and young people.*

**Social Exclusion Unit (SEU) Report**

In 2004 the Social Exclusion Unit Report *Mental Health and Social Exclusion* was published by the Office of the Deputy Prime Minister. This report aimed to tackle the stigma and discrimination surrounding mental health difficulties, and to promote and support the inclusion of people experiencing such difficulties; including inclusion in mainstream services, and challenging low expectations attached to this group (Office of the Deputy Prime Minister, 2004).

This report spurred activity within the learning and skills sector.

Mental Health was subsequently in the Grant letter to the Learning and Skills Council (LSC) for 2005/2006 (DIES, 2005), and in the Annual Statement of Priorities (LSC, 2005) for that year, and proposals were developed to improve services for people with mental health difficulties.

In 2005 in *Through Inclusion to Excellence*, LSC made recommendations for provision for Learners with Learning Difficulties or Disabilities (LLDD) in order for people with disabilities to contribute actively to their communities through skills acquisition and progression towards employment (Learning and Skills Council 2005).

**Youth Matters: Next Steps**

*Youth Matters: Next Steps* (Department for Education and Skills, 2006) suggested that young people needed to have quality information, advice and guidance about issues that concerned them, and that this should be available to them when and where they wanted to receive it. This included support on health and well-being issues.

**Learning for Living & Work**

In 2006 LSC launched *Learning for Living & Work* – the national Learners with Learning Difficulties or Disabilities (LLDD) strategy that includes Mental Health. This
strategy seeks to see England as an exemplar in planning and provision for LLDD by 2015 (Learning and Skills Council, 2006a).

**LSC Mental Health Strategy – The Way Forward**

This is a 2009 refresh of the 2006 strategy, Improving Services to People with Mental Health Difficulties (Learning and Skills Council, 2006b), and aims to ensure that robust systems are in place to provide inclusive learning environments for learners with mental health difficulties, which can be carried through Machinery of Government changes to the Young People’s Learning Agency (YPLA) and the Skills Funding Agency (SFA).

The refreshed strategy puts forward the vision that:

> ‘...people with mental health difficulties should, by accessing learning and skills provision, be able to lead active and fulfilling lives as part of their communities and in employment, in a way that sustains mental well-being.’

(Learning and Skills Council, 2009, p.3)

It places an emphasis on a whole organisation approach, and on moving away from discrete, and towards mainstream, provision. It stipulates that Local Authorities should work with Connexions and health services to ensure that young people are assessed, leading to more appropriate provision.

**Children and young people in mind: The final report of the National CAMHS Review (2008)**

This Government commissioned review of Child and Adolescent Mental Health Services lays out recommendations to improve and close gaps in the current systems for young people from birth to age 19 (CAMHS Independent Review Expert Group, 2008). The review is in support of the National Healthy Colleges Framework and recognises that if staff in FE are to be successful in the promotion of mental well-being and appropriate early intervention, they need access to the same support and specialist advice that has previously been available to schools.

**Healthy Colleges**

The proposal of a National Healthy Colleges Framework, based on the success of the National Healthy Schools Framework (NHSF) funded by DH\(^8\) with support from DIUS\(^9\) and DCFS\(^10\), is just getting underway with the formation of a national steering group. The intention is to see young people in the FE system continue to make healthy choices regarding their lifestyle as they approach adulthood through improved access to health related information, advice and guidance at college.

To summarise, these are governmental policies and initiatives which underpin the importance of learning and skills to emotional, psychological, and indeed physical, well-being; and the importance of a young person’s choice and access to appropriate provision that enables them to learn in a way that promotes their health and well-

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\(^7\) Child and Adolescent Mental Health Services  
\(^8\) Department of Health  
\(^9\) Department for Innovation, Universities and Skills  
\(^10\) Department for Children, Families and Schools
being, while providing assistance when extra is needed, which are notions that this report focuses on.

The Mental Well-being of Young People

The mental well-being of the nation’s children and young people has come increasingly into the spotlight in recent years. In 2004 it was reported that emotional problems amongst young people had increased by 70% over the previous five years (Warwick et al., 2006, p.10). Ten% of five to 16 year olds have a diagnosed mental health disorder (National Statistics, 2004) and ten% of 16 to 25 year olds have had thoughts that life is not worth living (The Prince’s Trust, 2009). There are also differences across gender and race with more young females experiencing mental health difficulties than males (Aylward, 2003) and over representation in mental health services of young people from Black and Minority Ethnic (BME) backgrounds (MIND, 2009).

We are realising that today’s children with mental health needs will become tomorrow’s adults with mental health needs, and more research and work is being put into working with children, families and schools to address emerging issues early on, and where possible to prevent the causes of issues. The fact remains, however, that some young people will reach college age without receiving support for mental health difficulties, or without wanting to or knowing how to disclose that they need support.

It is also known that the adolescent years, with all of the associated transitions and risky behaviours, are difficult times during which mental health issues can begin to manifest. This is why frontline professionals working around young people during these phases must be aware of the issues, and have the confidence and resourcefulness to address them and recognise when to signpost to more specialised services; or have the capacity to accommodate young people accessing learning while under hospital care.

Learners with mental health needs can often have ‘spiky profiles’ when it comes to their attendance at college, caused by time taken off during periods of illness, and may experience anxiety or poor concentration during learning. Young people with mental health needs may also face the added age related issues of wanting to fit in with their peer group, feeling isolated from friends and lacking independence (Aylward, 2003).

The policy drivers described in the Policy Context section of this report have laid the foundations for an argument that more learners with mental health needs are likely to be entering the Further Education system, and with the introduction of the ‘healthy FE’ concept, more learners may be declaring mental health needs in the wake of better Information, Advice and Guidance (IAG), support and referral mechanisms

North West Snapshot

The North West region of the United Kingdom is made up of five areas: Cheshire, Greater Merseyside, Greater Manchester, Lancashire and Cumbria. It has 46 local authorities and a population of 6.7 million, 60% of which live in the areas of Greater
Manchester and Greater Merseyside. In the 2001 Census there were approximately 436505 15-19 year olds, with a similar figure for five to nine year olds (National Statistics, 2009).

The main centres of Liverpool and Manchester are experiencing economic growth and regeneration; however the region still has poor performance in social indicators like health inequalities, life expectancy and low demand housing (Government Offices for the English Regions, 2009). Outside London, the North West shows the highest incidence of severe mental health problems (North West Regional Employment Team, 2008).

Methodology

There were three stages to this project:

- Part 1 - an online survey for young people (learners);
- Part 2 – an email survey for Further Education providers across General Further Education, Work-based Learning and Sixth Form Colleges;
- Part 3 – three interviews and field visits to develop case studies of innovative or interesting practice, or learners’ stories (see appendix 2).

Online survey for young people

The study began with the formulation of a questionnaire to seek information from the learners. SHEU created the questionnaire, which took the form of an online survey, designed so that tutors in the participating colleges could administer it and have access to the raw scores for their establishment only. If any serious issues were flagged up, the exact response could only be narrowed down to year and subject group, so awareness raising activity could be targeted at the whole group. Providers were advised to remind learners of support available within the organisation when administering the survey.

The survey had questions around educational activity, general health and well-being, mental health and well-being, and personal information such as age, gender and ethnicity. All responses were anonymous. The survey was set up to direct young people to a variety of health and mental well-being websites on its completion. These websites were recommended by a North West CAMHS Lead. The survey was piloted with 100 young people in two organisations, and changes made based on feedback. These changes were shared with research colleagues to ensure quality.

Using LSC regional databases, and members of the North West Provider Network (Work-based Learning Providers), invitation emails were sent out to Principals of Further Education and Sixth Form Colleges and the Chief Executives or Directors of Work-based Learning Providers. The emails gave a deadline for response, after which the online questionnaire pack was sent out to the participating establishments by SHEU. The email made the recommendation that to avoid collecting skewed data; the survey should be administered across the whole student population, not just learners who had already declared a mental health difficulty to the college. The deadline for the completion of the online survey was extended twice, with a final date set for 7 November 2008 after several providers explained that they were being asked to conduct a large number of surveys with the learners.
After the completion of the survey raw scores from this survey were generated by SHEU and sent to NIACE. NIACE only had access to the scores when combined so answers from individual providers could not be identified.

**Survey for learning providers**

The second phase of the study comprised of a survey to capture the support offered, and gaps in provision experienced, by learning providers. The provider survey was devised by NIACE and aimed to gather information that would build upon the information provided by the Young Persons’ online questionnaire. The questions covered support offered, activities around mental health, and partnership working arrangements. Again, the survey was piloted with two organisations and quality assured by research colleagues.

The provider survey was sent to the contacts at the organisations who had participated in the Young Persons’ questionnaire, the remaining organisations on the LSC database, and to the North West Provider Network. The colleges received the survey via the NIACE Additional Learning Support Manager Network. The survey was sent out by email with responses returned directly to NIACE. A deadline was set for 16 January 2009. The data were analysed manually.

**Interviews and field visits**

Following the analysis of data provided by learning providers, three responses were selected for further contact interviews and field visits based on their description of interesting or innovative models of support. One Sixth Form Centre within a General FE College, one Work-based Learning Provider and one Sixth Form College were interviewed. The providers were also asked to invite learners to be interviewed to talk about their experiences and ideas for methods of support.

The interviews were devised to draw out more information on interesting points raised in the provider survey, learner interviews being focused on their experiences of support with the provider. The interviews were informal and only semi-structured. The information from these has been written up into case studies which can be viewed in Appendix 2. These are intended to illustrate aspects of good and promising practice, and areas for development.

The findings of this research will now be presented.
Young Person’s Survey: Summary of main findings and discussion

Respondents’ general details

Responses to this survey came from 1329 learners across 11 learning providers in General Further Education, Work-based Learning, and Sixth Form Colleges. Although all responses were anonymous in terms of respondent and provider name, the data shows that the majority of learners took part in this survey were with providers based in Greater Manchester and Greater Merseyside.

Age

The survey was aimed at learners aged 14 to 19 involved in Further Education. The lower limit was extended to include learners under the age of 16 who were following an alternative school curriculum. Only a very small percentage of respondents made up the lower end of the age range. Similarly, a small percentage of learners above the upper age limit of 19 have responded to the survey. The ages of these respondents ranged from 20 to 25. Chart 1 shows that the majority of respondents were aged between 16 and 18.

![Chart 1: Age of respondents (n=1329)](chart)

Gender

The total sample group was almost equally distributed between the sexes: 52 % male and 48 % female. This is the same UK population gender split for this age group estimated by the Office for National Statistics (National Statistics, 2009).

Ethnicity

The majority of respondents selected White as their ethnic background (72 %), with 7 % Asian or Asian British. Black including Black British, Chinese, Mixed and Other all fell between 1 % and 3 %, and 10 % did not respond.
Due to the predominantly white ethnic representation of the sample, further questions related to culture were not analysed. It cannot be said whether the low numbers of BME learners taking part in the survey is due to low numbers in attendance with the learning providers who took part, or whether it is due to most responses coming from providers in areas with very small BME communities. These are not issues that can be discussed further by this particular report.

**Year and type of course**

The majority of respondents were in the first year of their college study (64 %), with 32 % in the second year and 3 % in the third year.

Most were also taking AS/A2 Level courses (34 %), with 29 % on BTEC courses and 12 % taking NVQs. The remaining 25 % was split between qualifications including HNDs, GCSEs, Basic Skills and Pre-foundation level courses.

**General Health**

**Health & Well-being**

Respondents were presented with a range of factors and asked them to select the three main things that they think keep them healthy.

Respondents identified each of the following factors as one of the three most important things that keep them healthy.

- Fitness/exercise: 57 %
- Diet: 35 %
- Friends/relationships: 30 %
- Hygiene: 23 %
- Not smoking: 23 %

The range of factors that were seen as less effective (i.e. fewer than 10 % identified them as one of the three important things that they think keeps them healthy) comprised medication/alternative medicine, warmth, having a busy life, fresh air/sunshine, vitamins/supplements, not drinking in excess, work, absence of stress, security (e.g. happy home life/religion) and having lots/adequate sleep. Further findings on general health and well-being can be viewed in Appendix 3.

**Diet**

Respondents were asked to select a statement that applied to them with regard to their dieting habits (see Chart 2).
Responses from males and females differed in this area, as seen in Charts 2a and 2b in Appendix 4 along with further findings relating to diet. More females reported dieting behaviour than males.

These findings suggest that overall the young people thought about physical health when asked about what keeps them healthy with fitness/exercise and diet being the top two choices. However the fact that 30 % chose friends/relationships suggests that they see the link between these meaningful relationships and their health, possibly making the link with happiness and contentment.

The responses to the diet questions do not raise any major concerns with only 3 % saying they were always on a diet. The highest ranking statement, “I never worry about how much I eat” could draw different conclusions. It could suggest that the young people have a carefree attitude to how much they eat, or it could suggest that they have a careless attitude, the effects of which would depend on the type of food eaten. On the whole, the findings suggest that diet is not a cause of worry for this sample group.

**Use of Drugs and Alcohol**

**Alcohol**

Respondents were asked to describe their drinking habits. 27 % drink alcohol regularly (see Chart 3).
Other key findings relating to alcohol were:

- Respondents were asked on how many days during the last week they had drunk alcohol. 39% had not drunk any alcohol and 39% had drunk alcohol on 1 or 2 days. 2% had drunk alcohol on all seven days.
- The most common drinks respondents reported drinking were pints of beer or lager, spirits, and cans/bottles of pre-mixed drinks/alcopops.
- 14% had thought at some point they should cut down on their drinking and 12% reported other people thought they should cut down on their drinking.
- 2% had had a drink first thing in the morning, within the last week, to steady their nerves.
- 8% thought the amount they drink was harmful to their health and 4% thought it was harmful to their studies.

When it is considered that half of the UK’s 16-17 year olds drink alcohol at least once a week (Institute of Alcohol Studies, 2007), it is encouraging that only just over a quarter of this sample group selected this frequency. The survey did not ask about whether the respondents had become drunk as a result of the amount of alcohol consumed on these occasions.
Drugs

Respondents were asked to describe their experience of taking drugs. They were asked to describe the frequency of their use, if any, of the following illicit or non-prescription drugs:

- cannabis
- speed/amphetamine
- cocaine powder
- crack
- acid/LSD
- magic mushrooms
- ecstasy
- aerosol/glue/solvents
- poppers
- heroin
- body-building steroids
- sedatives or tranquillisers e.g. Valium (not prescribed)
- anti-depressants e.g. Prozac (not prescribed)

The percentages stated here represent the frequency of respondents' overall drug use, and refer to all of the drugs on the list. Therefore, the percentages do not add up to 100 %: they instead show how many reported the frequency of drug use for any of the above drugs.

19 % said they used one or more of these drugs “...weekly or more”.
50 % said they had used one or more of these drugs “...once or twice”.
41 % said they had used one or more of these drugs “...in the past but not now”.
See Appendix 5 for more responses linked to drug use.

Chart 4 illustrates the frequency of use for cannabis, the most commonly used drug within the sample group, showing that at least 39 % have used it at some point. We can only say that those who fall into the “Never Used” category have never used cannabis; we cannot say that they do not have experience of any other drug.
This finding is consistent with The British Crime Survey for 2007/08 which stated that cannabis was the most common drug, with 17.9% of 16-24 year olds using in the year of the report (Hoare and Flatley, 2008). In January 2009, cannabis was reclassified from a Class C to Class B drug due to the more potent strains, such as skunk, being easily available. There are known links between use of cannabis and mental health problems, including short term psychological effects such as paranoia and panic attacks, and longer term effects: it is thought there are links to cannabis use and relapses of mental health conditions.

**Mental Health & Well-being**

**Emotional or psychological problems**

Respondents were asked ‘have you ever experienced emotional or psychological problems (for example depression, anxiety, worry or stress that interfered with your life)?’ 57% of respondents had experienced emotional or psychological problems either that term or in the past (see Chart 5).
Responses from males and females differed in this area, as seen in Charts 6 and 7. More females reported emotional or psychological problems.

Of all respondents, the 57% of respondents who reported experiencing emotional or psychological problems were asked for more details. The findings below have been related to the whole sample (1329 people):

- 31% had had thoughts that life is not worth living.
- 18% had thought about taking their own life.
- 14% had harmed themselves at some point.
- 14% had received counselling or other help for depression or other emotional problems. This comprised 181 people. Of these, 39% thought it had been effective.
- 7% had attempted suicide.
- 6% had taken medication for a mental health problem such as depression, anxiety, psychosis, etc.
When analysing these figures, the method of capturing the information on the online survey was looked at again. The online survey would only allow a respondent to choose one answer to the overall question as to whether respondents had experienced emotional or psychological problems. Therefore, someone could not answer ‘yes’ to this term and ‘yes’ to in the past, so the percentages that are presented are straightforward. Of the respondents, 18% had experienced what they considered to be an emotional or psychological problem which had interfered with their life in the current term. The question is of course open to interpretation as each individual’s experience will be different. What one young person considers an ‘emotional or psychological’ problem may not be considered as such by another. The key part of the question is “…that interfered with your life.” The World Health Organisation 2001 defined mental health as:

‘...a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.’
(Cited in World Health Organisation, 2004, p. 10)

Everyone has mental health needs, but occasionally these can become problems that require the support of other people or services (CAMHS Independent Review Expert Group, 2008).

The experiences of emotional and psychological distress that interfered with the lives of these young people do not mean that these are all diagnosed and clinical mental health difficulties, but it could mean that these periods of distress may turn into bigger problems if support is not accessed.

The question does not ask when the 39% who had experienced these problems in the past had experienced them. The continuum of mental health and the Recovery Model must be considered here (James, 2006). People can and do recover from mental health difficulties so the fact that a person has experienced emotional or psychological problems in the past does not mean that they are still experiencing them, or will continue to experience them. Statistics have shown that 50% of people with mental health difficulties are no longer affected after 18 months, 25% of people with Schizophrenia will make a good recovery and 20% of people with Bi-polar conditions will only have one episode of illness (Office of the Deputy Prime Minister, 2004). This means that the figure for experiences in the current term is the more important one.

The figures for females are also slightly higher than for males. This could show that more females than males have experienced these problems; it could show that more females than males are willing to accept their experience of mental health; or it could be related to females experiencing different pressures from society. The Mental Health Foundation found that 6% of males and 16% of females aged 16 to 19 experienced mental health difficulties (cited in Aylward, 2003), and Charts 6 and 7 show that the percentages for this sample are slightly higher at 15% and 22% respectively.
Attitudes to self and others

Respondents were also asked questions about their attitudes towards themselves and others around them. They were given a number of statements and were asked to choose a response to indicate the extent to which they agreed with the statement. The most notable findings are described here (percentages relate to the whole sample):

44% agreed with the statement “I am easy to like” with only 3% disagreeing.
48% agreed with the statement “I feel relaxed and well in my day to day life”. 11% disagreed with this.
54% agreed that they were “...interested in the people around me and their lives”, and 46% strongly agreed with the statement “I am glad I am who I am”.

These findings are more encouraging and show that within the respondent sample there are fairly high levels of positive attitudes towards themselves and other people.

Difficult and worrying experiences

Respondents were presented with a range of experiences relating to transitional and life events, and were asked which they had experienced difficulties with this year. Chart 8 illustrates the responses.
The largest percentage ‘changing friends’ (20%) followed by ‘settling into this college (15%) suggests that respondents found the transition from school or other activity into college particularly difficult. This also emphasises the need for extra support to be provided at these times of transition; particularly for more vulnerable or ‘at risk’ groups such as young people with additional learning needs, care leavers or young carers.

The transition from school to college is well known as being a difficult point for young people, not least because it generally coincides with adolescence. Not only will young people have the difficulties associated with the transition from childhood to the responsibilities of adulthood (Aylward, 2003), but they will also be doing it at a time of educational transition. A time when they are maybe leaving behind old school friends and embarking upon programmes of learning and skills development which may have a major impact on their future career or vocational choices.

The third highest percentage ‘changes at home’ (13%) is strengthened as an issue by a further question on family worries. 21% of the sample said that family problems had affected their work this academic year. The most frequently occurring family problems were

- Parents not getting on with the young person
- Parents not getting on with each other
- Parents not supporting the young person in other ways
- Death of a family member

A further set of factors, such as study problems and money, were then presented for respondents to consider how often they worried about them. Findings are illustrated by Table 4 in Appendix 6. The majority of respondents did not feel these worries affected their college work.

**Relationships**

**Confiding relationships**

The majority of respondents thought they had a close confiding relationship with someone (i.e. someone they can talk to about concerns, anxieties, feelings or other things), either at college, home or elsewhere. However, 11% responded they did not have a close confiding relationship with anybody. More males than females reported not having a close confiding relationship: 16% of males as opposed to 6% of females.

Thirty % of the respondents to this survey said they had this type of relationship with someone at college, but the question did not ask them to specify who this person was; it could be a tutor or it could be a peer. This is an interesting finding, given the difficulties indicated in changing friends and settling into college. However, this finding also highlights the need for awareness at college from a whole-organisation perspective – awareness needs to be raised with management, teaching and non-teaching staff, and the whole student body, not just those with a mental health support need.
Where respondents turned when experiencing problems

Respondents were presented with a list of factors that could cause problems in day to day life; and were asked to indicate who they would turn to if the problems were making them feel down or depressed. Respondents could select more than one option for each problem. The findings are presented in Table 2.

Table 2: Where respondents turned when experiencing problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>% Parent or Family</th>
<th>% Lecturer, tutor, mentor</th>
<th>% Friend</th>
<th>% Youth Worker</th>
<th>% Employer or colleague at work</th>
<th>% Counsellor or agency</th>
<th>% Doctor</th>
<th>% Other Adult</th>
<th>% Careers Service</th>
<th>% Keep it to yourself</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work problems</td>
<td>35</td>
<td>10</td>
<td>14</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Exams, tests or coursework</td>
<td>23</td>
<td>36</td>
<td>15</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Money problems</td>
<td>56</td>
<td>1</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Unemployment</td>
<td>39</td>
<td>1</td>
<td>11</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Health</td>
<td>34</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Problems with friends</td>
<td>27</td>
<td>1</td>
<td>39</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Family problems</td>
<td>29</td>
<td>1</td>
<td>34</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>The way you look</td>
<td>20</td>
<td>0</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Relationships</td>
<td>17</td>
<td>0</td>
<td>47</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>16</td>
<td>1</td>
<td>19</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Sexuality (heterosexuality, homosexuality, bisexuality)</td>
<td>22</td>
<td>1</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>Smoking</td>
<td>21</td>
<td>1</td>
<td>32</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Drinking</td>
<td>23</td>
<td>1</td>
<td>32</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Drugs</td>
<td>20</td>
<td>1</td>
<td>31</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>21</td>
</tr>
</tbody>
</table>

Again family and friends are turned to the most when problems arise, but worryingly the percentages for problems being internalised tend to be the third highest. This suggests that college staff will not necessarily be the first to be approached with a problem, but could again highlight the need for information on college support services to be made available to all learners, and perhaps families too.

Support at College

Knowledge and use of services

Respondents were asked about their use and knowledge of various services (see Table 3).
### Table 3: Respondent’s reported use of services

<table>
<thead>
<tr>
<th>Service</th>
<th>% Respondents who have used this service</th>
<th>% Respondents who know what it is and how to get access but haven’t used it</th>
<th>% Respondents know what it is but don’t know where/how to get access</th>
<th>% Respondents have heard of it but don’t know much about it</th>
<th>% Respondents have never heard of this service</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Careers service or Connexions</td>
<td>38</td>
<td>25</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Student services e.g. Registry/EMA/SAM</td>
<td>37</td>
<td>21</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Personal tutors</td>
<td>22</td>
<td>29</td>
<td>6</td>
<td>12</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Study support</td>
<td>12</td>
<td>33</td>
<td>7</td>
<td>16</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Counselling service</td>
<td>8</td>
<td>27</td>
<td>9</td>
<td>22</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>College nurse/Health care service</td>
<td>6</td>
<td>26</td>
<td>11</td>
<td>21</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Learning/Study support e.g. dyslexia</td>
<td>6</td>
<td>30</td>
<td>7</td>
<td>19</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Special needs tutor</td>
<td>4</td>
<td>30</td>
<td>7</td>
<td>20</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Student Union/Association and its officers, e.g. Equality and Diversity Officer</td>
<td>3</td>
<td>23</td>
<td>7</td>
<td>23</td>
<td>22</td>
<td>22</td>
</tr>
</tbody>
</table>

Connexions/careers service and Student Services seem be amongst those with the highest profiles and be the most frequently used. This could be due to the administrative element of Student Services, particularly around Education Maintenance Allowance (EMA) payments. Most students may also be familiar with the Connexions service in particular having had involvement with a Connexions Advisor in secondary school. They would not have the same advisor, but would at least be familiar with the nature of the service. The general and more specialised services offered by providers e.g. counselling and study support are also quite well known, but less frequently used. It needs to be highlighted that just under a quarter of the sample did not respond to each of these options. This could be due to some providers not being large enough to offer all of these services, so some options would not be applicable to learners from those providers.

**What could the college do?**

Respondents were asked what their college could do that would be effective in improving any aspects of students’ **health** information. Respondents selected the following:

- Flyers and leaflets = 43%
- Talks and videos = 34%
- College website = 33%
- Discussions and workshops = 31%
• Posters and notices = 31%
• Tutorials = 29%
• Email = 25%
• Posters and stickers in toilets = 22%
• College nurse = 21%
• Trained students (peer education) = 16%
• Events in lunchtime = 15%

The Learner Voice

Finally respondents were given the opportunity to contribute their own ideas by being asked ‘What else could learning providers do to support the mental health and well-being of young people?’

Here are the most frequently occurring response themes:

• Offer counselling
• Listen to and communicate more with learners
• Try to understand
• Offer one to ones with a named person
• Offer regular visits to lessons by suitable staff to provide information on the services available
• Nothing - the support provided is good

Other responses included:

‘Provide firsthand experience with someone who has been through similar problems. When being spoken to by a learning provider, I feel cross examined. I think it would be better if the approach was more relaxed and less formal.’

‘Just to talk to someone who has been there and been through that situation and on how they changed their life around.’

‘Do not judge a student if they turn to you for support; often learning providers are the closest thing some students will get to a parent. Help in any way you can.’

‘Talk about it more than once, more than just one visit a year, regular visits and reminders of where to get help…’

It is not only encouraging that several learners considered that their learning provider was already putting good support in place, but also that the learners had so many ideas and opinions on what would be effective.
Provider Survey: Summary of main findings and discussion

Overview of respondents

Fourteen respondents completed and returned a questionnaire. There was a good response from Work-based Learning providers (seven); four respondents were from General Further Education Colleges, while two were from Sixth Form Colleges and one described their organisation as ‘other: Higher Education Institution with Further Education provision’

Job titles of respondents varied. Some job titles indicated the respondent specialised in mental health and/or well-being, while others appeared less specialist or indicated a managerial role

Number of learners who had declared a mental health difficulty

Respondents were asked approximately how many individual learners aged 14-19 were enrolled at their organisations, and how many of these had declared a mental health difficulty. There were some inconsistencies among how this data was provided.\(^\text{11}\)

If we assume the responses given reflect the number of learners that providers were aware had mental health difficulties (as opposed to the number of learners who had formally disclosed) the findings are:

- Within data from all providers, the average (mean) percentage of learners with known mental health difficulties was 0.9 % (n=13 providers). The range of percentages was from 0 % to 2.5 %. The mode (the value that occurred most frequently) was 0 % (five providers).

These percentages contrast starkly with the percentages from the young persons’ survey where 18 % said they had experienced difficulties of this nature. Thinking back to the continuum of mental health, questions can be raised about where someone might be on that continuum before they feel able to declare their difficulties - so at what point were these figures captured: at enrolment or further into the term?

However, there were interesting differences in the data given by providers that were small (400 learners or fewer) Work-based Learning providers and the data provided by large (800 learners or more) other providers (sixth form colleges, further education and higher education). These differences may be attributable to the type of provider, the size of provider, both of these factors, or how much encouragement and support is given for disclosure.

- Within small and Work-based Learning, the average (mean) percentage of learners with known mental health difficulties was 0.6 % (n=7 providers). The

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\(^{11}\) One only provided the number of learners who had requested support, but stated that more may have declared but not requested support. One was uncertain and thus their response has been removed from this section. One provided a number that combined both those who had declared and others they were aware of.
range of percentages was from 0 % to 2.5 %. The mode (the value that occurred most frequently) was 0 % (five providers).

- Within large and other (non Work-based Learning) providers the average (mean) percentage of learners with known mental health difficulties was 1.3 (n=6 providers). The range of percentages was from 0.8 % to 1.5 %.

The data above show an interesting finding about small and Work-based Learning providers. While the data from these providers suggested the percentages of learners who are known to have mental health difficulties were low (5 of the 7 respondents from small and Work-based Learning providers said that they were not aware of any learners in this age range with mental health difficulties, or at least none had declared this) the provider which had the greatest percentage of learners with mental health difficulties was also a small Work-based Learning provider, with 2.5 % of their 400 learners having declared a mental health difficulty.

All 14 respondents felt these official numbers were not representative of the real levels of mental health difficulties experienced by this age group, but that in reality more learners actually experience mental health difficulties. This suggests that this is a common issue which may warrant more work to bring it to the forefront.

**Use of Internal and External Services**

**Internal service provision**

Respondents were asked about their own provision for supporting mental well-being, their links with external organisations and services. They were also asked which of these were most successful, particularly in encouraging learners to disclose their mental health support needs.

Many referred to various services and activities they provide, including general services such as learner services, Information, Advice and Guidance (IAG) services, inductions and tutorials.

Some also specified they provide counselling services and chaplaincy services. There was an implication that having such services would encourage learners to disclose and provide a place/service in which to do this:

‘Learner Services provide information on support at all stages: enquiry, application and enrolment.’

(General Further Education College)

‘Within each of our training centres there is a designated IAG section which learners are made aware of.’

(Work-based Learning Provider)

Eight respondents reported that their organisations have a counselling service. Only one of these was a Work-based Learning provider. One respondent reported that there was a waiting list for this service. One was able to describe what appeared to be a fairly extensive counselling service, including trainees in Cognitive Behavioural Therapy (CBT), while another referred to the need for such a service:
‘We have a Mental Health and Well-being Adviser and a Counselling, Health and Well-being Adviser who is also able to undertake mental health risk assessments. We have 2 part-time counsellors, one each at each of our campuses with Further Education provision. We also have other counsellors including trainee CBT specialists.’

(Higher Education Institution with Further Education provision)

‘We need a qualified counsellor to direct learners’ issues to, particularly when they disclose specific sensitive and confidential information to a tutor.’

(Work-based Learning Provider)

Respondents identified a large number of specific job roles and staff members in response to this question including learning mentors, mental health specialists, health promotion advisors, college nurses, outreach workers and learner support workers, learning performance officers, key workers and outreach workers.

‘All students have a senior tutor who they see each week for tutorial and throughout the year for 1-1 discussions on progress. Students are encouraged to discuss any issues with their senior tutor and this would include disclosure of any mental health difficulties, with or without a formal diagnosis.’

(Sixth Form College)

They also referred to more generic activities which were used as opportunities to promote well-being. Some respondents mentioned various curricular and extracurricular activities such as ‘well-being activities’, a ‘rolling programme that covers drug and alcohol misuse’, ‘enrichment programmes’ and ‘PE programmes’, induction programmes, Freshers’ Fairs and regular assemblies. It should be noted here, that although these were internal events, the respondents often stated that they had brought external agencies in to aid delivery.

When asked which of these services were most successful in supporting the mental health needs of learners and encouraging disclosure, many referred to various services (both internal services and links with external services) including group tutorials on mental health awareness, a ‘books on prescription scheme’, IAG services, a card detailing external services, learner services office, close links with external services, anger management sessions and study skills sessions. Three providers suggested that counselling services and therapeutic support were particularly successful, and half said that the counselling service was used most frequently. It was noticeable that, with the exception of one or two providers, Work-based Learning providers offered little in the way of response to this question.

‘Learning Mentors deliver group tutorials on the theme of mental health awareness. These are effective in triggering individual requests for 1-to-1 support.’

(General Further Education College)

‘The ‘Books on Prescription’ scheme is used across the borough with our College library and support services part of their strategic group. This scheme
allows GPs to “prescribe” self help materials which are accessible via the College library.’

(General Further Education College)

One provider referred to awareness raising events and the use of drama and media:

‘We take part in mental health awareness week and Hedstrong\textsuperscript{12} events in partnership with the NHS and Primary Care Trust (PCT). These events are usually run in the town centre and classes of students are taken along to visit by their tutors... The film 'Dragon Fly Dreams' has been used repeatedly over three or four years to raise students’ understanding of mental health issues. The local Drug and Alcohol Team have performed a play, ‘The Door’, to large numbers of students in 2006 and this was really well received.’

(General Further Education College)

Other responses highlighted the importance of offering personalised support and having a supportive body of staff and a supportive culture:

‘Designated support adapted to individual need.’

(General Further Education College)

‘We have a strong sense of community at the college and students support each other. We have (had) several bereavements and other incidents at the college (e.g. the earthquake in Pakistan affected many of our students) and one of the ways we respond is by gathering as a community to support each other, emotionally and practically…’

(Sixth Form College)

‘[We] explain why disclosure can help us to support them within their training programme.’

(Work-based Learning Provider)

They also specified how they use publicity to raise awareness, such as via websites and prospectuses, moodles, leaflets and via events and campaigns (e.g. displays at World Mental Health Day).

Some referred to awareness raising events and promotion of issues using leaflets, although one referred to the time limitations relating to this:

‘Mental health campaigns are run throughout the year and students can access leaflets on mental health awareness links to relevant organisations etc.’

(Higher Education Institution with Further Education provision)

‘College has discussed possibility of Mental Health Awareness Day, but difficulty in implementing this because of demands on everyone’s time.’

(Sixth Form College)

\textsuperscript{12} Hedstrong07 was a series of cultural events which took place to celebrate World Mental Health Day
With the exception of one or two respondents, the difference in the amount of services between Work-based Learning providers and other providers was particularly noticeable. Work-based Learning providers, on the whole, appeared to have far fewer services in place. It is worth noting that this finding, and others within this section that show differences between Work-based Learning and other providers, may be attributable to the type/sector of provider or to size of providers: all Work-based learning providers who responded had 500 or fewer learners aged 14-19.

There is a general sense that mental health awareness and support is something that could be further developed within Work-based Learning, but there is a lot of good work taking place. The responses from this provider survey seem to support this notion; however, it could be argued that some Work-based Learning providers are too small, or do not have enough learners to be able to provide this level and variety of support and activity themselves. Also due to the nature of Work-based Learning with learners being out on placement, there may not be as many chances to build relationships as college based learners and staff might have. But, are there fewer learners with mental health difficulties in Work-based Learning because of the lack of appropriate support, and are there fewer services because there is less need? This is interesting in light of the DDA which requires that providers should anticipate the provision of reasonable adjustments, including support.

External services

Respondents were asked which external services they signpost learners to. Respondents listed a wide range of services. Responses that were mentioned more frequently included Connexions, Early Intervention in Psychosis (EIP) Services, Child & Adolescent Mental Health Services (CAMHS), Community Mental Health teams (CMHTs), GPs, various locally based young people’s mental health organisations, counselling and drug and alcohol organisations in the voluntary and community sector, and information and assistance services and websites such as CALM\(^\text{13}\) and Kooth.\(^\text{14}\)

Many respondents referred to their partnership working and links with external services, and how they try to maximise these to encourage learners to declare:

‘We acknowledge World Mental Health Day…by… inviting in members outside agencies such as CALM, Child and Adolescent Mental Health Services (CAMHS), the Young Women’s Christian Association (YWCA), MIND etc who publicise their service and the support that they can offer.’

(General Further Education College)

‘Learners are also issued with an IAG support card giving details of support agencies including services to support mental health issues.’

(Work-based Learning Provider)

\(^\text{13}\) Campaign Against Living Miserably: Information Service For Men www.thecalmzone.net

\(^\text{14}\) Kooth offers free online advice for young people aged 11-25 in several, but not all, areas of the North West www.kooth.com
Many respondents referred to contact they have with external services regarding individual learners:

‘Early Intervention [in Psychosis] Services (EIP) have proved to be very helpful when advice is needed regarding a young person. If the situation is serious enough the Crisis Team can be involved.’

(General Further Education College)

‘We are often invited to participate in early intervention meetings for individuals.’

(Work-based Learning Provider)

Many referred to the fact that systems are in place to refer learners onto, and receive referrals from, external services:

‘We have referral pathways to the above services.’

(Higher Education Institution with Further Education provision)

Some referred to the partnership work they undertake around the transitions process, both from school and from hospital, the general contact they have with external services at meetings, and the training opportunities they seek to gain through partnership work:

‘Young people leaving secondary education who have been supported in schools because of mental health issues can be identified to us via Connexions “S140” forms… We have close contact with some schools’ Learning Mentors/inclusion officers who will pass on names of young people who have support needs due to mental health problems.’

(General Further Education College)

‘I have worked with a local psychiatric hospital around the transition of a patient back into the community: attending college would be part of a package.’

(Sixth Form College)

Once again, even the Work-based Learning providers who said they did work in partnership with external services appeared to have far fewer systems and examples of partnership work than other providers.

**Barriers and frustrations**

Respondents were asked what barriers or frustrations they have come across in supporting the mental health needs of young people.
A common response was that which highlighted problems regarding links with other, external services. These responses highlighted a lack of information sharing and poor communication across agencies, difficulties engaging with health services, difficulty regarding contact with social services, and the lack of awareness among other services of learning providers’ inputs. Providers suggested the following were key barriers or frustrations:

‘Getting local NHS providers on board- this is complicated by the fact that we cross several PCTs.’

(Higher Education Institution with Further Education provision)

‘(Being) not sure what other input they (learners) are having and not wanting to interfere with other therapy that may be ongoing. I don’t feel that education is seen as part of the team of professionals who may be working with an individual.’

(Sixth Form College)

‘Poor inter-agency communication.’

(Work-based Learning Provider)

It is well documented there are links between learning and mental well-being, and that learning can aid the recovery process, with a study on the subject showing that 89% of participants found that learning had a positive effect on their emotional and physical health (Aldridge and Lavender, 1999).

The feeling that health providers need to have heightened awareness around this link may be a valid one, but is not solely the responsibility of health providers to attend to this. Learning providers must take some responsibility for this too by, where possible, being proactive in raising awareness of the benefits of education with health providers, and both must encourage this as a reciprocal process.

Another key barrier or frustration was seen to be reluctance on the part of learners to disclose. This was particularly prominent in responses from Work-based Learning providers:

‘The disclosure, most young people generally are reluctant to voice if they are having mental health issues.’

(Work-based Learning Provider)

‘Our apprentices are made up mainly of young men who I feel may find it difficult to bring up the topic of mental health with their assessors/peers even though they may wish to talk about it.’

(Work-based Learning Provider)

‘An apparent reluctance to discuss mental health issues.’

(Work-based Learning Provider)

As discussed earlier on in this section, this may be in part due to the providers needing to increase their promotional activity about the support they can offer or
signpost to. A case study interview with a Work-based Learning provider revealed another possible reason for the reluctance to disclose:

> ‘They may think disclosure jeopardises their chances or future opportunities in certain occupational areas.’
> (Work-based Learning Provider)

So for example, a learner wishing to undertake Work-based Learning in childcare may be scared a mental health difficulty may prevent them from doing so. This highlights the need for Work-based Learning providers to work with the employers who provide their placements around challenging the stigma associated with mental health difficulties; and for the learners to be reassured by this. This could also point towards more DDA awareness training.

Other barriers and frustrations included a **gap in mental health provision** for 16-17 year olds, **stigma** and lacking sufficient **resources**:

> ‘THE GAP IN PROVISION FOR 16 AND 17 YEAR OLDS!!!! Many of our students needing help are too old for C.A.M.H.S. and too young for adult services.’
> (General Further Education Services)

> ‘Reducing the stigma of mental health amongst the wider student and staff population.’
> (Higher Education Institution with Further Education provision)

> ‘Availability of time to co-ordinate awareness campaigns; Absence of a designated person with designated time to lead mental health awareness issues.’
> (Sixth Form College)

These all point to the benefits of increased partnership working, pooled resources and sharing approaches to tackling stigma between learning and health sectors.

Less common responses referred to not having a tool or process to recognise mental health needs and offer support and accepting there is a cut off point: that they are a learning, not health, provider. This could indicate a need for better CPD training for staff on how to manage boundaries and assess risk.

**Additional Learning Support Funds**

Respondents were asked whether they use the **Additional Learning Support funds** to support learners with mental health difficulties. Eight said they did, five did not (one of whom said ‘this is not a criteria’) and one did not know.

Of the eight who did use these funds, some suggested the funds were used for fairly general things such as ‘small group sizes’ and ‘wider mental health awareness. There were some suggestions the funds were used to provide more specialised services such as ‘counselling’ and ‘funding pastoral support workers’:
'As appropriate, there may be one or more of the following: additional sessions with personal tutors, a learning support assistant in the classroom, some additional 1:1 to support assignment work, and counselling.'

(Higher Education Institution with Further Education provision)

'Counselling; To provide 1-1 sessions to help students manage their difficulties or discuss any issues they may be facing, particularly in college; To provide support around subject and academic input if students are missing lessons, or not understanding work, e.g. due to lack of concentration.'

(Sixth Form College)

'Funding any transport costs to access external help/ support.'

(Work-based Learning Provider)

**Black and Minority Ethnic learners**

Respondents were asked whether they use any particular approaches to ensure that BME learners with mental health difficulties are supported. Ten did not. Four said they did. Of these one told us ‘all Learners have the same support as other learners.’ However, the other three were able to offer more specific information:

‘Just in the process of planning a well-being group that will be supported by an Asian Male Counsellor.’

(General Further Education Provider)

‘The counsellor has consulted with… (a) designated Asian worker… about issues relating to Black and Minority Ethnic students…’

(Sixth Form College)

‘We have an Equality and Diversity manager who delivers regular training and input to staff members related to these groups.’

(Work-based Learning Provider)

The involvement of workers from the same cultural background seems to be a step in the right direction in terms of providing support for learners from BME backgrounds. There is evidence that in order for provision for these learners to be attractive and successful it needs to be targeted, relevant and culturally sensitive (Lau and Sturdy, 2008).

**Involving learners**

Respondents were asked if their organisation has models or arrangements in place to ensure learners can be involved in organisational development. Ten said they did, two were from organisations in the process of developing these and two did not.

Respondents reported involvement activities from the organisation including learner councils, meetings and forums, links with student unions, having student advocates or representatives for meetings and committees, focus groups, questionnaire and surveys, and feedback systems including IT based systems for messages and
feedback cards. One specified they have a ‘Student Mental Health Forum’ while another reported:

‘We consult with the University’s Student Union on policy and strategies in relation to student mental health.’

(Higher Education Institution with Further Education provision)

Respondents were asked about any measures they take to specifically include learners with mental health difficulties in these models or arrangements. All but one respondent either did not answer or suggested that access was open to all but not targeted specifically. However, the provider with the ‘Mental Health Student Forum’ reported:

‘[The] Mental Health Forum is not open to all students, and members are offered anonymity if wished.’

(General Further Education College)

Future plans

Respondents were asked if they had any future plans or ideas for ensuring that they support the mental health needs of young people more effectively. While two said no and two did not know, ten did have plans. Of these, some referred in vague terms to ongoing evaluation, monitoring and reviewing procedures. Others referred in vague terms to putting support structures in place, ensuring learners have equal access to provision and to update services in response to learners’ needs. However, others were able to be more specific: Some referred to developing better links with external services, increasing publicity and campaigning, setting up specific groups, improving the transitions process or devising policies:

‘Visits from local (CALM) group to target young people and raise awareness.’

(General Further Education Group)

‘Organise a Mental Health Awareness Day / Campaign.’

(Sixth Form College)

‘We need to continue to push for more information on each young person, from either the school or connexions service - at the earliest opportunity. We still do not get often vital information in good time to be able to give more immediate support – pro-active contact activities form part of our Quality Improvement Plan.’

(Work-based Learning Provider)

Advice for learning providers

Respondents were asked to contribute to good practice guidance by suggesting three pieces of advice they would give to other learning providers to enable them to effectively support the mental health needs of young people. The full range of responses can be seen in Appendix 7. Many respondents referred to the need for links with external services, designated mental health and well-being support services, individualised well-being support for learners, a whole organisation
approach, and the provision of a counselling service. This is a selection of the responses:

- Provide a well-publicised and accessible support network for all students. Then, if something does develop, or a learner has particular needs, they don’t feel out of the ordinary in accessing support.
- Developing an understanding of the responsibilities of other agencies and the work they do will help to provide a cohesive structure of support for learners in this age group.
- Promoting good mental health is everybody’s responsibility.
- Hold campaigns which emphasise the importance of well-being for staff and students.
- Get to know your student. Find out what they will find difficult (eating in public, being in a busy area of the college etc). If the student gives consent brief the teaching team and warn them of any unusual behaviour. For example a student with psychosis laughing out loud at a tutor in a lesson when they are responding to voices in their head.
- CAFT^{15}.
- Try to include a ‘wraparound’ type of support i.e. involve the parents/ family/ employer if appropriate.

These responses show what providers have found works well, and support the notion that providers all have the answers within themselves.

**Conclusion**

This project aimed to investigate the levels of emotional and psychological distress in North West learners aged 14 to 19 engaged in Further Education. Due to the distribution of the sample group, findings only describe the experiences of this sample group, and can not be attributed to the general population. Most respondents were aged 16 or 17, but we can not draw conclusions about the mental well-being of this age group in comparison to other age groups as the other age groups were not represented in similar proportions. Nor can conclusions be drawn about the experiences of learners from BME backgrounds as their representation in the sample group was very small, making them conspicuous by their absence in the sample group. This raises the question about why this was the case, but is a question that would warrant more investigation.

Most responses came from learners enrolled with providers based in Greater Manchester and Greater Merseyside, both areas with Local Authorities that feature highly in the Economic Deprivation Index 2008 (Mclennan et al, 2009). The Social Inclusion Unit Report links mental health problems to deprivation:

> ‘Anyone can be affected by mental health problems, but people from deprived backgrounds are at significantly greater risk.’ (Office of the Deputy Prime Minister, 2004, p.11)

\(^{15}\) Common Assessment Framework Training
Findings show over half of the sample group had experienced distress that had interfered with their lives, which is quite a concern, and just under one fifth (18 %) were experiencing problems at that specific time. For comparison, the figures for how many adults in the UK are experiencing mental distress at a specific time is thought to be one in six (The Office for National Statistics Psychiatric Morbidity report (2001) cited in Metal Health Foundation (2006)), so the prevalence is slightly higher for this sample group of North West young people. It is important to remember that differences between findings from this report and other data sets may be due to difference in methodology or question phrasing. The incidence of distress was higher in females than in males, but this could be due in part to gender differences in attitudes towards mental health.

The recent findings from The Prince’s Trust (2009) said that 10 % of all British 16-25 year olds felt that life was not worth living. When asked this question 31 % of the sample of respondents for this report had had these thoughts. Due to the difference in the range of ages, a direct comparison cannot be drawn, but the percentage is still worrying. The nature of the question suggests the respondents were experiencing problematic levels of depression or other difficulties, yet only 14 % of the sample had received counselling or other help, and only 39 % of these found the intervention to be successful. This reinforces the suggestion that young people are not seeking support, or may not be offered the most appropriate support when they do.

Findings also show that the main issues that appeared to be causing difficulties and worry for the sample group were related to transitional aspects: changing friends and settling into the learning provider; however the majority of respondents reported that their college work had not suffered as a result. This link to psychological and emotional distress and transitional life events is consistent with previous research on young people and mental health (Aylward, 2003).

Changes at home were the third highest cause of worry, suggesting that there is a perception of the importance of family within the sample. Prince’s Trust YouGov Index (2009) and the OfSTED TellUs Survey (cited in the Guardian, 2009) both indicate that relationships with family and friends were key to emotional and overall well-being and happiness. This is echoed by the findings in the North West, as although the majority of the sample linked physical aspects of health to their overall health and well-being, a significant proportion made the connection between well-being and relationships with social and familial networks too. Some reported that where their relationship with their family was suffering, this also had an adverse effect on other areas of their life, such as college.

Regular alcohol use appeared to be only half that of the national average (Institute of Alcohol Studies, 2007), and regular use of the most commonly used drug, cannabis, was only 8 %; however although the known links between cannabis use and effects on mental health are recognised, conclusions cannot be drawn about cannabis being a catalyst for psychological distress in this sample. Respondents may have also answered these questions on drugs and alcohol use with caution.

On a positive note, The YouGov Index found that 40 % of young people don’t have anyone to talk to about their problems (The Prince’s Trust, 2009), whereas only 11 % of the respondents to this survey felt like this. This is in turn supported by the Ofsted
Tellus survey which found that young people in several areas of the North West report having stronger relationships than young people in the rest of the country (cited in the Guardian, 2009).

The findings also show that family and friends are turned to the most when this sample group wants to discuss their problems. This finding may state the case for learning providers to make all members of the learner cohort, and possibly families or cohabitants aware, of the support available and how to signpost to this support. Respondents overall did seem familiar with the types of service and support available in their place of learning, but the specialised services were used less frequently than the more generic. This could be down to level of need for these specialised services, or due to stigmas attached to using them, for example in the case of the counselling services.

When giving their opinions on what learning providers could do to improve the well-being of learners, leaflets and flyers were selected as being the most popular choice for disseminating information. Other common themes in open responses were to have regular reminders about what support is available, and having opportunities to talk to others who could share similar experiences.

Findings from the provider survey gave insight into what they were doing to provide support, encourage disclosure and promote mental well-being in environments where the true level of psychological and emotional distress of learners was thought to be higher than official records indicate.

Findings show that respondents did appear to have a variety of services and activities in place to support the mental health and well-being needs of young people. In particular, the importance and benefit of having a counselling service was mentioned repeatedly by many respondents. Having mentoring systems in place also appeared to feature fairly prominently in respondents’ answers. Additional Learning Support funds are used to establish provision specific for learners with mental health needs.

Partnership work and links with external agencies was a key theme running through responses. This seemed an important thing to have in place and respondents provided many examples of successful partnership work. However, many also cited a lack of partnership working and difficulties in this area as a key barrier or frustration, and while there was some evidence of campaigning and awareness raising activity, this did not appear to be extensive.

In terms of partnership working, there was a sense from the responses that approaches to this were ad hoc, with no real patterns to how the work was taking place with links being made with external services informally and through proactive activity by certain individuals, rather than through some form of partnership agreement.

Partnership working appeared to be less well developed for Work-based Learning providers. Many Work-based Learning providers appeared to have far less in place than other providers and appeared to be less far along the journey towards holistic support for mental health. Work-based Learning providers also cited that reluctance
on the part of learners to disclose was a key barrier or frustration. This could be due to the factors described earlier in this report, or could be due to learners not wanting to disclose for fear of jeopardising their chances of following particular vocational paths.

Many respondents had mechanisms in place for learner involvement, but there was very little in place in terms of involvement activities specifically for learners with mental health difficulties, or activities to specifically engage learners with mental health difficulties in generic involvement activities.

Little was in place to specifically support Black and Minority Ethnic learners with mental health difficulties, although there were a small number of specific activities that were in place. Descriptions of these showed that considerations were being made to the culturally specific differentiation of supporting activity, for example, the involvement of external workers of the same ethnic background.

When asked to share their advice for good practice with other providers, several respondents suggested allocating a specific job role, or allocation of time to activities concerning mental health and well-being. A lack of these resources was also raised as a frustration by some respondents. This concept of dedicated resources to carry the agenda and create the links is supported by other research reports.

In Lau and Sturdy’s report on EIP services in London (2008), results showed that high proportions of the EIP service caseload were supported to be in education if the EIP teams had developed relationships with learning providers. The report also went on to recommend that PCT commissioners should channel resources to invest in a dedicated post in each EIP team to liaise across education and employment services.

Warwick et al (2006) came to a similar conclusion on successful contributory factors in terms of educational staff:

‘Having staff in place with particular mental health responsibilities – to include… liaising with external agencies and developing college-wide activities to promote mental health.’

(Warwick et al, 2006, p. 27)

Another common theme running through the advice was to develop a whole organisation approach to mental health support and promotion, recognising that maintenance of mental well-being was everybody’s responsibility. So where there may be one person driving forward the agenda, it is the responsibility of the whole organisation to achieve results through policy and practice, also recognising that improving services for learners, and staff, with mental health difficulties, will improve services for all learners and staff creating a fully inclusive environment.

In conclusion, many of the young people involved in this research were experiencing some form of psychological and emotional distress at the time of the study, or had done in the past; but learning providers are aware that more young people may be in need of support than those whose have disclosed this need. Much is being done to encourage this disclosure, and learners can disclose their support needs at any point
during their college career. However, it is only at enrollment that mental health support needs can be captured for official statistics through the completion of the Individual Learner Record (ILR), which cannot be updated at a later stage. This begs the question: is this the most appropriate way of collecting and holding data on learners? When most other means of data collection in the FE system, for example tracking systems and progress reports, are open to regular review, and this is seen as good practice, then why is this not the case for the ILR?

Providers recognise the need and importance of working with partner organisations, including secondary ‘feeder’ schools, health services and voluntary sector services; and it is certainly clear that more needs to be done on both the parts of education providers and health providers to gain an understanding of each other’s work and to build enabling relationships, as reported by the Headspace Back on Track Project (Ringland, 2008).

Finally providers have a range of support and awareness raising activities available, but some recognise that they could do more, or create more solid frameworks for support that would allow necessary flexibility within them.

The Thomas Coram Research Institute report in 2006 concluded that there was, ‘…interest and goodwill among those working in the FE sector to develop further their provision to support and promote… mental health…’ (Warwick et al, 2006, p 27), but also found that providers wanted further guidance on how to support and promote the mental health and well-being of learners. This same sentiment is reflected in this report from 2008/09.

Perhaps, with the weight of the 2009 refresh of the LSC Mental Health Strategy and recommendations from the 2008 review of CAMHS, it is now the time for this ‘interest and goodwill’ to become ‘purpose and action’.

This report will now set out recommendations for learning providers to take steps towards galvanising their activities around mental health and well-being, and also presents characteristics of ‘good and promising practice’ guidance drawn from the ideas and experience imparted by the learners and learning providers themselves.
Recommendations

These recommendations are aimed at learning providers and health providers, and have been consolidated from the responses to the young people’s and providers’ surveys and interviews, while paying reference to some of the policy context. Information gathered through interviews with learners and providers is further represented by the case studies in Appendix 2.

Common themes and characteristics emerge, and these have also been set out in a checklist of ‘good and promising practice’ in Appendix 1. This checklist will allow providers to see ‘at a glance’ which areas of practice are consistent with their current ways of working, and which they may want to develop.

1. Strategy and Policy

Learning providers who had support from senior management to drive forward the mental health agenda indicated that this was invaluable to the work. Embedding mental health awareness, promotion and support into policy at a strategic level within an organisation, or embedding the importance of multidisciplinary partnership working across education and health systems can only be achieved with backing at high levels. This concept is at the heart of the refreshed LSC Mental Health Strategy, which endeavours to ensure that effective partnership working takes place post Machinery of Government changes.

1.1 Strategic partners in Learning & Skills and Health need to work together to formulate models of working to achieve Headline Action 5 of the LSC Mental Health Strategy (Learning and Skills Council, 2009). This could in part be accomplished by the establishment of a peer mentoring system for learning providers and health providers who have good relationships to buddy others that are interested in developing these relationships. The findings of the report on the Headspace Back on Track Project on supported education can be looked at for examples (Ringland, 2008). This project saw collaboration between an Early Intervention in Psychosis (EIP) Service and a Further Education College resulting in the re-engagement of young people on the EIP caseload with college.

1.2 Mental Health should be covered by an organisation’s policy documents, for example Equality & Diversity or Health & Well-being. Mental health should be incorporated into any Single Equality Schemes that are in development.

1.3 Where organisations feel they have an ad hoc approach to mental health promotion/support processes/partnership work, attempts should be made to create a more structured but obviously flexible system. This could maybe be achieved by the formation of a steering group, or again by peer mentoring. The Anticipatory Quality Checklist (Elmes, 2007) produced by the NIACE/LSC/Inclusion Institute Partnership Programme North West Network could be employed as a starting point to help an organisation create

16 The Headline Action states: “In 2009-10, the LSC will roll out models of collaborative working between our providers and early intervention in psychosis (EIP) services and child and adolescent mental health services (CAMHS)” (Learning and Skills Council, 2009, p.26)
anticipatory reasonable adjustments in line with the DDA. The Anticipatory Checklist can be downloaded from the NIACE/LSC/Inclusion Institute Partnership Programme website at www.niace.org.uk/mentalhealth. South London Learning Partnership have also produced two useful resources, which are also useful for Work-based Learning providers: College & Learning Providers’ Toolkit for Supporting Staff and Learners with Mental Health Issues (Spencer-Perkins, 2008); and Employers’ Toolkit for Supporting Staff and Learners with Mental Health Issues (Spencer-Perkins, 2008).

1.4 Having a specific member of staff with time to take work forward would ensure dedication to this agenda. This approach would be beneficial for all organisations across learning and health, but may require input of financial resource at strategic level along with the drawing up of partnership agreements.

1.5 Adopt a Healthy FE approach. The Department of Health is currently developing a National Healthy FE Framework\textsuperscript{17} and this is supported in the National CAMHS review which acknowledges that staff in FE need, ‘the same access to support, training and specialist advice as school staff’ (CAMHS Independent Review Expert Group, 2008, p.42). Working towards the new You’re Welcome Quality Criteria\textsuperscript{18} developed by the Department of Health will also go some way to supporting a Healthy FE approach. These criteria are aimed at making health services more ‘young person friendly’ and can be applied to learning providers that offer health advice and services, including work with CAMHS. Working towards the Mindful Employer Charter\textsuperscript{19} will move an organisation towards this approach from the point of view of its staff. Mindful Employer aims to create workplaces that are sensitive and supportive to the needs of people with mental health difficulties. NIACE has also produced a training course and pack called ‘Working Well: Staff well-being in the Post-16 sector’\textsuperscript{20} which aims to promote and protect mental health and well-being for staff in the Post-16 sector and draws on the themes of Healthy FE and Mindful Employer.

2. Whole Organisation Approach

There are strong indications that learning providers acknowledge and understand the importance of taking a ‘whole organisation approach’, again something which is advocated by the LSC Mental Health Strategy.

2.1 Whole organisation means \textit{whole organisation}. It is the responsibility of everyone involved with an organisation, all members of staff and learners, to play their part in creating an inclusive learning environment. The message needs to come from the top-down and from the bottom-up.

\textsuperscript{17} www.healthyschools.gov.uk
\textsuperscript{18} http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586
\textsuperscript{19} www.mindfulemployer.net
\textsuperscript{20} http://www.niace.org.uk/mentalhealth/docs/working-well.pdf
2.2 Nurture an inclusive culture: open door, enabling and informing e.g. explaining why disclosure can aid support can often encourage disclosure. NIACE has produced a leaflet called Should I Say? (NIACE, 2009). This aims to help learners decide whether or not to disclose their mental health difficulty when going into learning. It is available for free download at www.niace.org.uk/mentalhealth/downloads.htm. There is also an easy read version available at the same web address.

2.3 As mentioned in the Strategy and Policy section, the Healthy FE Framework, Mindful Employer and You’re Welcome will help to achieve a whole organisation approach as the needs of learners and staff are taken into consideration.

2.4 Raise awareness with all learners, not just those who are experiencing or are at risk of mental health difficulties. Indications are that involving families and friends of learners with needs would be beneficial. Word of mouth recommendation from other learners is a powerful tool in promoting support provision. Promote mental health and well-being to the whole student body, and families or cohabitant where possible, and provide information on steps to be taken if someone is worried about a friend or family member.

3. Learner Involvement

Involving learners in planning of services to support their needs is vital for learner-centred provision.

3.1 Through consultation with learners, establish their real needs and provide personalised, individual and flexible support with various forms on offer based on the real needs of the learners. Use Additional Learning Support funds where possible, and be creative in the way in which curriculums are diversified and other reasonable adjustments made. Counselling is a popular choice of providers and of learners according to the results of both surveys. Explore ways of differentiating traditional forms of support like counselling for learners from BME communities if appropriate.

3.2 Involve learners in the information collection process – explaining why information is collected and why disclosure could support them to achieve their goals. Again, the Should I Say? leaflets (NIACE, 2009) can be used.

3.3 Involve learners in terms of their expert opinion on forums and informing wider organisational thinking, but also in support mechanisms for learners experiencing difficulties: peer support, or bringing in ‘experts by experience’. The LSC Mental Health Strategy (2009) p.11, offers an example of how learner involvement can add value.

3.4 Get input and advice on learner involvement from the following references, details of which can be found in the ‘references’ section of this report:
4. Partnership Work

Partnership work between internal departments and also external organisations across health, social care and voluntary and community sectors is vital to achieving holistic and appropriate support for learners. It is a term that is used with abandon, but for it to be truly effective it is something that requires investment of resources, planning and review.

4.1 Build and maintain links, relationships and contacts within health services or community services e.g. visiting GP practice meetings, CMHT/CAMHS/EIP service meetings and voluntary and community sector providers to talk about what learning provision is on offer, and to raise the profile of education professionals as part of the multi-disciplinary team. Encourage reciprocal information or training sessions where health professionals can be made aware of learning services and of the benefits of learning to mental health; and education professionals receive information and advice on working with young people in times of psychological and emotional distress.

4.2 Through these partnerships, manage transitions – from school and hospital into FE, and from FE onto Higher Education or employment. Arrange reciprocal visits for secondary school pupils who may benefit from knowing a face in the FE provider support team; ensure that education is in the support plan of anyone coming into learning from a hospital environment; and liaise with Supported Employment providers when learners who have employment as a progression goal need more intensive support to achieve this.

4.3 Work with employers, in the case of Work-based Learning placement providers. For example having an awareness of DDA responsibilities and being able to suggest reasonable adjustments for the placement, or just raising the employer’s awareness of mental health could make all the difference to the learners’ experience on work placement.

4.4 Get involved with the NIACE/LSC/Inclusion Institute Partnership Programme. Join the regional networks such as the NIACE Mental Health and Learning network and its Virtual Learning Networks (VLN), and where possible, involve a buddy from another sector. More information on these cross-sector network meetings and VLN’s or ‘moodles’ can be found at the Partnership Programme website: [www.niace.org.uk/mentalhealth](http://www.niace.org.uk/mentalhealth).
5. Proactive Approach

Evidence from the survey suggests that where individuals or organisations have been proactive in their approaches to the above themes, higher degrees of success have been achieved. The use of the Anticipatory Checklist mentioned above is a good example of using a proactive approach.

5.1 Learning providers and health teams need to be more proactive in informing each other of their services. As suggested above, this could be done through visiting meetings.

5.2 Publicity and promotion is key. Use promotional materials such as those provided in the NIACE One in Four campaign pack, or by the Time to Change campaign\(^{21}\) to normalise mental health and challenge stigma.

5.3 Include mental health in both curricular and extra-curricular activities, e.g. incorporating mental health into the more generic activities e.g. Freshers' Fair, induction, general assemblies, having a 'mental health awareness week' or recognising World Mental Health Day.

5.4 Give learners more frequent reminders of how, when and where to access support – directed at all learners. This could be by tutor group visits, leaflets, intranet, text, email, toilet stickers, and college TV/advert system (if available).

\(^{21}\) [www.time-to-change.org.uk](http://www.time-to-change.org.uk)
References


Aylward, N. (2003) *Looking Forward to Thursdays: Effective Learning for Young Adults with Mental Health Difficulties* Leicester: NIACE


Learning and Skills Council (2005) *Through Inclusion to Excellence* Coventry: Learning and Skills Council


Learning and Skills Council (2006a) *Learning for Living and Work* Coventry: Learning and Skills Council

Learning and Skills Council (2006b) *Improving Services for People with Mental Health Difficulties* Coventry: Learning and Skills Council


Learning and Skills Council (2009) *LSC Mental Health Strategy - The Way Forward* Coventry: Learning and Skills Council


Appendix 1: Checklist of good and promising practice

These are suggestions for characteristics of good and promising practice in promoting awareness of mental health, and providing support to learners with mental health needs.

The list is not exhaustive, but has been compiled to incorporate the common themes emerging from the experiences of learners and learning providers who took part in the NIACE/LSC/Inclusion Institute surveys and interviews.

The checklist format provides an opportunity for organisations to identify current and new ways of working, and is a starting point for achieving some of the recommendations set out in this report.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Red</th>
<th>Amber</th>
<th>Green</th>
<th>By When</th>
<th>Who</th>
<th>Evidence /Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy and Policy</strong></td>
<td></td>
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<tr>
<td>• Mental health is mentioned in organisational policies, particularly a Single Equality Scheme</td>
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<td></td>
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<tr>
<td>• The support of senior management is sought and obtained</td>
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<tr>
<td>• Work is carried out through a formal, yet flexible system, process or model</td>
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<tr>
<td>• The Anticipatory Checklist, or the College &amp; Learning Providers’ and Employers’ toolkits are used</td>
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<tr>
<td>• A dedicated role or time resource exists to drive work on mental health and for liaison between the organisation and external partners</td>
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<tr>
<td><strong>Whole Organisation Approach</strong></td>
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<tr>
<td>• All staff and learners are aware of their responsibility in promoting and maintaining positive mental health and well-being</td>
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<tr>
<td>• An inclusive, nurturing and ‘open door’ culture is evident</td>
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<tr>
<td>• The needs of learners and staff alike are considered through involvement with:</td>
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<tr>
<td>- National Healthy FE Framework</td>
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<tr>
<td>- You’re Welcome Quality Criteria</td>
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<tr>
<td>- Mindful Employer</td>
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<tr>
<td>• Information on support available goes beyond those in need of support or at risk, to all learners and where</td>
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</tbody>
</table>
possible, families or ‘significant others’.

- Guidance exists for those who are worried about the well-being of a peer.

**Learner Involvement**

- Learner involvement takes a variety of different forms and is accessible to all, including learners from BME communities
- Learners are consulted about changes in policy and practice regarding mental health
- Learner involvement is central to the planning of personalised support

**Partnership Work**

- Cross-sector links are built and maintained, with partnership agreements in place.
- Opportunities are sought for reciprocal training provision between organisations
- Transitions in and out of provision are managed through links with feeder schools, hospitals and employment services
- The organisation is represented at local networks which share good practice

**Proactive Approach**

- Information on learning provision is provided to teams in health, social care and voluntary sectors through attending team meetings and supplying promotional literature
- Mental health is promoted throughout a variety of curricular and non-curricular and enrichment activities using promotional materials with positive imagery
- All learners regularly receive a variety of information about what support is available around mental health.
Appendix 2: Case studies

Case Study A: The Sixth Form College

Provider A is a Sixth Form College with approximately 1800 learners. They have a very multi-ethnic cohort of learners and a strong pastoral culture supported by its senior management.

Provider A has a tutorial system involving eight Senior Tutors and 80 Tutors which operates from a ‘whole-life’ approach, assisting learners with difficulties in their home and college lives. The Study Skills Team provides an important part of this work. The Lead Tutor of the Study Skills Team finds that many learners who are referred for this service open up during these 15 minute one-on-one sessions, talking about underlying problems which are often preventing them from achieving their potential at college. This tutor had encouraged the appointment of a counsellor, and eventually a second counsellor. Both work part time, but do not have a static structure and have been able to increase hours to accommodate the level of demand. One counsellor works one day a week, and the other works three days.

This counsellor has a social work and Child and Adolescent Mental Health Services (CAMHS) background. She has made links with local Early Intervention in Psychosis services and also attends a group of counsellors from other local providers through which good practice and other developments can be shared.

Further links have been forged with an Asian worker from a local young persons’ mental health service. Through this relationship the counsellor has been able to explore and share ideas on why this group of learners is under-represented in counselling services, and on how to make it more accessible.

Provider A also has a strong relationship with its Educational Psychologist. Although he essentially assesses learning differences, he will often pick up cases where a counselling referral may be necessary, for example in the case of an African asylum seeker who was identified as suffering from trauma.

The Pathways Department supplies provision for learners with Special Educational Needs, including learners with mental health difficulties, and this department has liaised closely with a local psychiatric hospital to assist with patients’ transitions back into learning.

The culture of the college means that tutors are very supportive and will make referrals to study skills and the counselling service, and these two departments work in harmony with each other.

Despite the range of support mechanisms on offer at Provider A, they recognise that they need to galvanise their systems into a more formal structure and have created a steering group to look at ways of doing this, including the development of a mental health policy. The intention to improve their service is there, and they are now seeking a way to bring it all together.
Case Study B: The Work-based Learning Provider

Provider B is a Work-based Learning Provider with approximately 100 learners. They run programmes in childcare, horticulture and business administration. They also have an E2E and pre-E2E programme.

Provider B has strong links with several local organisations who can offer assistance and awareness sessions to learners on a variety of issues including mental health, substance misuse, sexual health and anger management. They have paid for learners to have counselling and this is something that the local Connexions service has also provided funding towards.

Provider B has fostered strong links with the local Community Health Champions, one of whom attends the provider on a monthly basis to deliver talks on aspects of health. This Health Champion is also a trained counsellor and has been instrumental in assisting the provider to administer appropriate support to learners when needed.

Learner Voice is very important to Provider B, and they are striving to develop this area. Each day is started with a half hour ‘Get it Off Your Chest’ session which allows learners to air their views and raise issues. Points raised are always followed up demonstrating that the learners’ views are valued.

Provider B is planning future staff development that will improve support for learners with mental health difficulties, including Common Assessment Framework Training which will facilitate the sharing of information where learners are already involved with health or social services.

Learner B: Learner B has been with the Provider on E2E for 16 weeks. She feels that a lot of the learners on the course lack motivation and do not see how E2E can help them. She says “To get on in life, you need life skills.” Learner B has been supported by her tutor on E2E. She has been enjoying gaining experience in contacting employers for work placements. She is not sure where she wants this course to lead as “she can’t see the horizon yet”. Learner B does not think that she would discuss any problems she had with an employer while on placement, but would just “keep them to herself”; she also feels that other learners would not discuss their problems with each other, again preferring to keep their problems to themselves.

Case Study C: The General Further Education College: Sixth Form Centre

Provider C is a large General Further Education College. The provision described in this case study relates to learners in the Sixth Form Centre.

This Provider has good links with the local Primary Care Trust (PCT) and the college has been able to get involved with local town centre events to promote well-being. Group tutorials on different themes are also delivered within the college by the Mentors. These can be chosen by learners on enrolment and can also be requested by tutors. Between September 2007 and July 2008, eight mental health awareness sessions and 15 self esteem sessions were delivered. Provider C also invites
external organisations such as CALM and Mind in several times a year to participate in information fairs, and acknowledges World Mental Health Day with an event.

The Sixth Form Centre Manager has, over the last decade, developed ways of recording information that are aimed at drawing out the support needs of learners. The most recent incarnation of this is an electronic tracking system that personal tutorials can be based around. Learners have access to the system and can view and enter information. The system is centred on two simple questionnaires: ‘Right Choice’ and ‘How’s it Going?’ ‘Right Choice’ helps to identify problems early on, soon after enrolment; whereas ‘How’s it going?’ can be completed at any time. This measures and scores student vulnerability, flagging up when it would be a good idea for a learner to seek support from a tutor or mentor. Learners are tracked at the start, middle, and end of their time at college, and a status bar on the tracking screen will turn red if their circumstances have changed allowing tutors to discuss matters with the learner. All learners receive an explanation of how and why this system collects information when they start. This system is available to the Work-based Learning and Adult Education departments to use with their learners.

The provider feels that this system has been successful in helping learners and tutors identify support needs, and also track progress.

**Learner C**

Learner C is in the final year of a two year Level 3 course at the college. The course is experiencing problems due to staffing, and although Learner C is frustrated by this she does not feel college is causing her any problems. She has accessed support from a mentor for problems she has experienced outside of college.

When her problems became too much, she became depressed and did not feel like getting out of bed. Her mother wanted her to seek help, but then a friend suggested she contact a mentor who she had found supportive. The mentor helped Learner C see that coming to college and being with other people was beneficial.

Support started with weekly appointments that would last as long as Learner C needed them to. Now she just sends a text to the mentor when she needs an appointment, and does not need to see the mentor that often now.

Support from the college has also extended to the mentor arranging a gym membership for Learner C. Some of her problems stemmed from an eating disorder, and both learner and mentor felt the membership could counter some of the problems.

Learner C has now recommended the mentor service to a young man on her course. He has since sought help for the problems he is experiencing.

Learner C says the support at college helped by,

‘…just being able to speak to someone who is not a family or friend. Family or friends just say “Oh, you’ll be alright”, or they might judge. (My mentor) does not judge and everything is confidential.’
Appendix 3: Findings from young people: further findings on general health and well-being

Table 1: Respondent’s reports of things they think keep them healthy

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage of respondents identified this as one of the three most important things that they think keeps them healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness/exercise</td>
<td>57</td>
</tr>
<tr>
<td>Diet</td>
<td>35</td>
</tr>
<tr>
<td>Friends/relationships</td>
<td>30</td>
</tr>
<tr>
<td>Hygiene</td>
<td>23</td>
</tr>
<tr>
<td>Not smoking</td>
<td>23</td>
</tr>
<tr>
<td>Leisure/social activities</td>
<td>13</td>
</tr>
<tr>
<td>Sex</td>
<td>13</td>
</tr>
<tr>
<td>Positive mental attitude</td>
<td>13</td>
</tr>
<tr>
<td>Lots/adequate sleep</td>
<td>9</td>
</tr>
<tr>
<td>Security e.g. happy home life/religion</td>
<td>9</td>
</tr>
<tr>
<td>Absence of stress</td>
<td>9</td>
</tr>
<tr>
<td>Work</td>
<td>7</td>
</tr>
<tr>
<td>Not drinking in excess</td>
<td>7</td>
</tr>
<tr>
<td>Vitamins/supplements</td>
<td>6</td>
</tr>
<tr>
<td>Fresh air/sunshine</td>
<td>6</td>
</tr>
<tr>
<td>Busy life</td>
<td>6</td>
</tr>
<tr>
<td>Warmth</td>
<td>2</td>
</tr>
<tr>
<td>Medication/alternative medication</td>
<td>1</td>
</tr>
</tbody>
</table>

There were some differences between males and females. Males appeared to favour above females:

- fitness and exercise - 63 % of male respondents identified this as one of the three most important things that they think keeps them healthy, as opposed to 50 % of female respondents;

- sex - 19 % of male respondents identified this as one of the three most important things that they think keeps them healthy, as opposed to 7 % of female respondents;

- leisure and social activities - 15 % of male respondents identified this as one of the three most important things that they think keeps them healthy, as opposed to 8 % of female respondents.

Females appeared to favour above males:

- diet - 40 % of female respondents identified this as one of the three most important things that they think keeps them healthy, as opposed to 30 % of male respondents;

- friendships/relationships - 34 % of female respondents identified this as one of the three most important things that they think keeps them healthy, as opposed to 25 % of male respondent
Appendix 4: Findings from young people: further findings on dieting

Of all respondents, the 19% who told us ‘I try and lose weight a couple of times a year’ or ‘I am always on a diet’, were asked further questions about what methods they have used to control their weight or appearance. The findings below have been related to the whole sample (1329 people):

- 10% of respondents had missed certain meals during the day to control their appearance often or several times.
- 3% of respondents had hidden food or pretended to family and friends they had eaten when they had not often or several times.
- 2% of respondents had made themselves sick after eating often or several times.
Appendix 5: Findings from young people: further findings on drug use

Respondents provided the following findings with regard to how often they did or had used drugs:

- “Used weekly or more”
  19% said they used one or more of the drugs on a regular basis, with use of cannabis having the highest percentage within this 19%. The use of cannabis by males at this frequency was more than double the use by females (11% and 4% respectively).

- “Used once or twice”
  50% said that they had this level of experience with one or more of the drugs. Again use of cannabis was the most common at 14%, followed by poppers (11%). Speed and ecstasy were less common with 4% and 5% trying these, and the rest only showed nominal figures at 1% or 2%. The gender difference for this frequency shows that female use of cannabis, poppers and ecstasy were equal or slightly higher than male use.

- “Used in the past but not now”
  41% chose this frequency to describe their experience with one or more of the drugs, with cannabis being the most common at 13%. Female responses were higher for cannabis, poppers and speed; male for cocaine, magic mushrooms and ecstasy.

The last two statements about drug use possibly show which drugs males and females are more likely to experiment with, only using once or twice, or using and then stopping.

Other findings relating to use of drugs:
- Of those respondents who had some experience with drugs, 56% had used the drugs before starting at their college, and 24% had obtained their experience since starting at college. These percentages were split almost equally across the genders.
- 11% thought their use of drugs prevented them from studying; 77% did not; and 12% did not know.
- 29% thought their use of drugs affected their health; 58% did not; and 13% did not know.
Appendix 6: Findings from young people: further findings about factors that worry young people

Table 4: Respondents’ answer to ‘How often have you worried about the things listed below in the last month?’

<table>
<thead>
<tr>
<th>Factor</th>
<th>% Never</th>
<th>% Rarely</th>
<th>% Sometimes</th>
<th>% Often</th>
<th>% Most Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study, work-load problems</td>
<td>17</td>
<td>19</td>
<td>27</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Money problems</td>
<td>19</td>
<td>18</td>
<td>23</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Physical health</td>
<td>29</td>
<td>25</td>
<td>22</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Emotional health</td>
<td>34</td>
<td>22</td>
<td>20</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Problems with friends</td>
<td>32</td>
<td>26</td>
<td>21</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Problems with lecturers and teachers</td>
<td>50</td>
<td>25</td>
<td>11</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Boyfriend/girlfriend problems</td>
<td>37</td>
<td>20</td>
<td>17</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Sex</td>
<td>56</td>
<td>20</td>
<td>9</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Family problems</td>
<td>34</td>
<td>22</td>
<td>20</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>The way you look</td>
<td>26</td>
<td>20</td>
<td>20</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>What people think of you</td>
<td>29</td>
<td>21</td>
<td>22</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>67</td>
<td>13</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Gambling e.g. lottery tickets</td>
<td>76</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Smoking</td>
<td>65</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Drinking alcohol</td>
<td>62</td>
<td>14</td>
<td>10</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Drugs</td>
<td>74</td>
<td>8</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>66</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

On the whole, females reported that these things caused them worry more than males did. Female worry about ‘The way you look’ and ‘What people think of you’ being almost double to that of males. The factors that caused more worry in males than in females were ‘Gambling e.g. lottery tickets’ and ‘Drugs’.

Again, respondents were asked to consider any effect on their college work. They were asked “In the last month have you worried so much about any of the issues listed that it has affected your studies?” (see Chart 9).
Appendix 7: Findings from providers: advice on supporting the mental health of young people

Providers were asked to give 3 pieces of advice to other learning providers to enable them to effectively support the mental health needs of young people. The full range of responses is presented here:

- Provide the facility for learners to speak in confidence about any issues they may be facing.
- Include mental health awareness as part of equal opportunities session in induction.
- Provide a well-publicised and accessible support network for all students. Then, if something does develop, or a learner has particular needs, they don’t feel out of the ordinary in accessing support.
- Support the learner community at times of stress, for example, a bereavement or incident which affects the learning community. As well as providing help at that time, it demonstrates how we can support each other during stressful times and demonstrates that some reactions are normal and understandable.
- Develop links with external agencies and know when to pass things on. Developing an understanding of the responsibilities of other agencies and the work they do will help to provide a cohesive structure of support for learners in this age group.
- Provide a calm, safe area where young people feel welcome and accepted.
- Promoting good mental health is everybody’s responsibility.
- Hold campaigns which emphasise the importance of well-being for staff and students.
- Offer a wide variety of support methods i.e. counselling 1-to-1, on-line counselling and Books on Prescription.
- Be approachable.
- Include facilities available and procedures in induction.
- Develop facilities for identifying potential problems.
- Seek help.
- Talk to someone.
- Take advice.
- Attempt to give more one to one time early on after enrolment to gain learner confidence and establish potential issues.
- Obtain feedback from all personnel involved with the individual to build up a pattern of behavioural trends/issues.
- Ensure IAG is integral to the learning programme and learners know how to source advice in a private and confidential manner.
- Get to know your student. Find out what they will find difficult (eating in public, being in a busy area of the college etc). If the student gives consent brief the teaching team and warn them of any unusual behaviour. For example a psychosis student laughing out loud at a tutor in a lesson when they are responding to voices in their head.
- Develop relationships with local Mental Health teams and support orgs.
- Offer flexible support with a range of approaches.
- Have named contacts.
- Identify a designated person to take the lead and ensure that they have time within their role to carry out this responsibility.
• Offer a counselling service.
• Have support sessions for staff to raise awareness and support them in their understanding of the students’ mental health needs.
• Establish links.
• Networking across provision.
• CAFT.
• Make access easy to a wide range of counselling/therapy modalities
• Get local NHS services on board.
• Have a clear policy/strategy relating to student mental health needs and protocols for supporting them. Ensure staff are aware of protocols.
• Young person needs to train/ work within an environment they respect and trust.
• Designated and trained persons on hand to provide guidance/support outside of the classroom.
• Try to include a ‘wraparound’ type of support i.e. involve the parents/ family/ employer if appropriate.
• They would need a designated contact to direct learner enquiries to, such as a counsellor.
• Effective communications with external agencies i.e. Social Services etc.