learning and mental health

A GUIDE TO SUPPORTING ADULT LEARNERS WITH MENTAL HEALTH DIFFICULTIES
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Glyn Owen  October 2006
How to use this pack

Who is this pack for?
This training pack has been designed for anyone working in an organisation that provides learning opportunities. It looks at the prevalence of people experiencing mental health difficulties and the impact this may have on the learning population. It also invites you to look at your own organisation and see how it can support both learners and staff with mental health difficulties.

The open learning pack comprises a manual and CD ROM. To get the full benefit from the pack, it is important to work through the activities. You can print off copies of forms and flow charts used in the pack from the CD ROM. The pack can be used in a number of ways:

General interest raising
- Myth buster sheet can be circulated to all staff
- What do you know about mental health? A quiz that can be used in team meetings, at training events or circulated electronically as an email attachment
- Frequently Asked Questions are the responses of an ‘expert’ focus group to questions posed by tutors

Awareness raising
- The pack has been designed in three sections.
- Section A is for all staff and looks at the prevalence of mental health difficulties in the general population and the role of the media and language in promoting stigma around mental health issues.

Supporting tutors
- Section B is designed for tutors. It looks at the reasons why learners are a particularly vulnerable group, the role of the tutor in offering support and invites tutors to assess how well their own course supports learners with mental health difficulties.

Developing the DES Action Plan
- Section C is designed for senior managers and those working in learner support services. It looks at the legal obligations of public authority learning providers towards learners with mental health difficulties and will help project groups to develop their action plan for the Disability Equality Scheme.

Staff Training
- There is an Agenda, Session Plan, Handouts and PowerPoint presentation so that you can deliver a half day mental health awareness session with little additional preparation.
How to use this section

This section of the pack is for ALL staff working in a learning environment. This includes library staff, security staff, learning support tutors; in fact anyone who comes into contact with learners. It will give you an overview of the prevalence of mental health difficulties in the general population and explain why all of us should be aware of the barriers that learners face when entering our learning environments. You will read about the way that language and the media shape our views on mental health and find out why people experiencing mental health difficulties find it so difficult to talk about them.

You can use this section for your own information or try out some of the exercises with your colleagues.

But before you start…try the Quiz.
### What do you know about mental health?

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 1 | What proportion of people experience mental health difficulties at any one time according to the Office for National Statistics? (Source: Office for National Statistics 2000) | a) 1 in 10  
   b) 1 in 4  
   c) 1 in 6                                                                                                                          |
| 2 | In a survey of almost 8,000 families selected at random in Great Britain, what percentage of young people 5-16 years old, had a clinically diagnosed mental health disorder? (Mental health of children and young people in Great Britain 2004) | a) 5%  
   b) 8%  
   c) 10%                                                                                                                                  |
| 3 | In a Mental Health Foundation survey carried out in 2000 with 528 respondents, what percentage didn’t tell their families that they had mental health problems? (Source: Mental Health Foundation) | a) 10%  
   b) 22%  
   c) 42%                                                                                                                                   |
| 4 | What ratio of GP consultations are concerned with mental health issues? (Mental Health: Britain’s Biggest Social Problem? Richard Layard 2004) | a) 1:10  
   b) 1:3  
   c) 1:2                                                                                                                                  |
| 5 | What is the most common symptom of mental distress? (Source: Office for National Statistics 2000)                                                                                                        | a) anger  
   b) fatigue  
   c) crying  
   d) violence                                                                                                                                 |
| 6 | What percentage of people with mental health difficulties said that they had experienced discrimination in the workplace? (Source: The Mental Health Foundation, ‘Pull Yourself Together’) | a) 7%  
   b) 17%  
   c) 27%  
   d) 47%                                                                                                                                  |
### Section A

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 7 | Which of the following is NOT a symptom of developing a mental health problem? | a) loss of appetite  
   b) increase in time spent alone  
   c) sleeping a lot  
   d) loss of intelligence  

(Source: Change your mindset, Mindout)  

There is no evidence that mental health difficulties impair intellect, however, concentration and memory may be affected during the period of difficulty.  

| 8 | What is the number of people in England on Incapacity Benefit that report their primary condition to be mental ill health? | a) 100,020  
   b) 454,200  
   c) 865,900  

(Summary of Intelligence on Mental Health: Dacorum 2005)  

| 9 | The Disability Equality Scheme (DES) relates to which of the following? | a) Staff attitudes  
   b) Teaching materials  
   c) Access to education  
   d) Employment of tutors  
   e) Ancillary and contracted staff working on providers premises  

| 10 | One of the definitions of discrimination under the DDA is failure to make a reasonable adjustment when a disabled person is placed at a substantial disadvantage in comparison to a non disabled person. ‘Reasonable means… | a) What a member of the public thinks  
   b) What your governing body thinks based on the evidence  
   c) What a judge in a court of law thinks is reasonable  

| 11 | In a survey of newspapers in 2005, what percentage of articles relating to mental health focused on violence? | a) 10%  
   b) 27%  
   c) 40%  

(Mind over matter, SHIFT- 2006)  

Answers to the Quiz can be found in the Resources section of the pack.
What is mental health?

Everyone has mental health in the same way that everyone has physical health. Sometimes it’s good and sometimes it’s not. Most people’s mental health fluctuates, from day to day or hour to hour. Changes in mood, confidence, and emotions are part of everyone’s life. We all need to look after our mental health and be aware of external and internal factors that affect it. It is not always obvious when people, even close friends, are experiencing mental health difficulties.

A survey carried out by The Mental Health Foundation ‘Is Anybody There’ (1) examined the relationship between friendship and mental health problems. They found:

- 1 in 4 people only realised that their friend had a mental health problem when he or she was admitted to hospital.
- Many people with mental health problems felt that they could only tell a few or no friends about their mental health problem. 1 in 3 found very little understanding from some of their friends.
- People reported friendships ending as a result of a friend’s mental health problems. 1 in 10 people reported losing all or most of their friends after telling them about their mental health problems.

If you were experiencing mental health difficulties, who would you tell? Your employer? Your partner? Your children?

Spend a few minutes writing down the benefits and risks of telling people.

<table>
<thead>
<tr>
<th>People you might tell</th>
<th>Benefits of telling them</th>
<th>Risks of telling them</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Having friends and people to talk to can be an important way of coping with problems and the difficulties that we encounter every day.
RETHINK, a charity that supports people with severe mental illness recommends:

There are plenty of ways to maintain your mental health or to help you feel better:

- Keep in touch with family and friends – arrange to meet up.
- Make time to do things you really enjoy.
- Look after your mind and body, eat well and exercise – it really helps your state of mind.
- Take time to relax – don’t push yourself too hard with work or exams.
- Talk to people you trust about worries or problems.
- If you feel you can’t cope, talk to your GP or get in touch with a support group.

RETHINK is an organisation that supports people with ‘severe’ mental difficulties, yet the activities they recommend seem so ordinary. Look at the list again. What do you do to keep your mind healthy?

Think about the ‘feel good’ activities that you participate in on a weekly/daily basis. Do you punctuate your days with ‘treats’? e.g. I’ll have a biscuit/glass of wine when I finish this report/lesson plan/essay.

List the treats that you give yourself.

<table>
<thead>
<tr>
<th>Treat</th>
<th>When do you have it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piece of chocolate cake</td>
<td>When I’ve put the kids to bed.</td>
</tr>
</tbody>
</table>

The list is a good indicator of the way that you pace your life and maintain your own state of mental health. Think about the way the ‘treat’ acts as a reward. How it affects your mood and motivates you.

We are all on a continuum of mental health. Our moods change in response to a wide range of internal and external triggers. Unpaid bills, failing a driving test, finding a bargain in the sales, falling in love, hormonal flows, running out of paper for the printer… there are thousands of things that can affect our moods.
Try rating your mood. How do you feel on a scale of 1 -10 right now.

<table>
<thead>
<tr>
<th>Awful</th>
<th>OK</th>
<th>Fantastic!</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Most of us hover between 4 and 7 for most of the time. During a bad period we may stay at 4 for a couple of days, but eventually move towards 5 and maybe higher, quite quickly. Mental health difficulties affect our moods, change our patterns of response and reduce our resilience to knocks. We may find ourselves staying around 4 or below for long periods, so long in fact, that we forget how to feel pleasure and find ourselves unable to find joy in any of the things that used to make us happy. Alternatively, we may swing from one extreme to another, joyous and desperate in speedy waves, unable to control our moods or our thoughts.

You can read more about the way that people experience mental health difficulties in NIACE’s publication, One in Four, a compilation of words, pictures and poems created by learners experiencing mental health difficulties. Here is an example. It’s a poem from One in Four, written by Beryl Izzard and reproduced by kind permission of NIACE.

Time is of the Essence (2)

You sit there all powerful, Mr Consultant
Behind your threateningly large desk;
Suited and booted as if for an event
And I creep in, flustered and out of breath
Spreading confusion with my anxiety.
You give me no greeting, don’t introduce yourself
And hardly looking, tersely ask what’s my problem then
If I’d been well would have said
Have you got half an hour?
But feeling very ill, I burst into tears
Of anguish and weeping misery
I cannot say what’s wrong.
I feel so dreadful I need help, is what I want to say.
All you ask is how I’m sleeping,
And looking at your classy watch (It’s latish Friday afternoon)
Write a prescription, just for sleeping pills
And glancing at your watch again and not at me
You stand as if to go.
So I am left lamenting,
Waiting in a strange place, for an expensive taxi
To take me home, to be alone with my unhappiness.

Beryl Izzard

NIACE owns the copyright to One in Four and the contributors to their respective works but you can get a copy of the complete book by contacting Sue Parkins at NIACE, 21 De Montfort Street, Leicester LE1 7GE Telephone 0116 2044247, email susan.parkins@niace.org.uk
Definitions of mental health

How would you define mental health? Spend a couple of minutes writing out your own definition, and then read on.

Mental health is ______________________________________________________________
_______________________________________________________________________________

For many people, the term ‘mental health’ immediately sets up negative thoughts and their definitions reflect that. How did you define mental health? Did you describe problems, difficulties, inability to function? Read the definition below.

“Mental health is the emotional resilience which enables us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others’ dignity and worth.”

(HAD, formally H.E.A.)

Mental health is like physical health. We all have it. It’s about resilience and bouncing back. We all need to look after our own mental health and be aware of the things we do that may affect others’ mental and emotional wellbeing.

How common are mental health difficulties?

Look at some of the statistics that have been published concerning mental health difficulties and the impact they can have: (3)

- Stress related conditions are now the commonest reported cause of sickness absence. 895,900 adults on Incapacity Benefit in England report their primary condition to be mental ill-health.
- 1 in 3 GP consultations concern mental health issues.
- Suicide is the leading cause of death amongst young men. Road accidents kill 2,300 people every year in England, about 4,500 people kill themselves, more than 12 a day. (1)
- 1 in 6 adults at any one time has a mental health problem, around 9 million people.
One of life’s little secrets

You may be forgiven for asking why, if mental health difficulties are so common, don’t more people talk about them? A survey carried out by the Mental Health Foundation in 2000 asked mental health service users about the stigma and discrimination they had experienced in everyday life and how this affected their views on who they could tell about their mental health difficulties. (4)

- 42% of people experiencing mental health problems said that they couldn’t tell members of their family.
- 22% said that they couldn’t tell their partners.
- 74% didn’t mention it on application forms.
- 19% felt that they couldn’t tell their GP.

So why do people feel that they can’t talk about mental health problems?

The report goes on to ask about the nature of the discrimination that respondents have experienced. Over half said that they had experienced discrimination within their families and from friends. Discrimination took many forms. Some respondents found that after talking about their problems to family and friends, subsequent feelings and responses were incorrectly and frustratingly attributed to their ‘condition’. “Well you would say that...”. Others were told ‘snap out of it’. One respondent described what happened when he disclosed his condition on a job application and why he wouldn’t do so again. “I would not apply for a job outside my current employer. The last time I did I was subjected to 2 medical and GP reports...”. Others felt that their ability to carry out a job was underestimated. “A lot of employers seem to look down on the illness, as if it affects my ability to be smart and work just as hard as anyone”.

Normal everyday life

When reading the statistics, it may seem clear that mental health difficulties are part and parcel of everyday life, yet for many people they are still a taboo subject. In the recent past, people diagnosed as mentally ill were kept away from mainstream society, locked up in asylums or criminalized. The diagnosis of mental health was, and still is, problematic.
It is not difficult to find examples of political dissidents, unmarried mothers and homosexuals who were incarcerated following a mental health diagnosis, the behaviour itself viewed as evidence of madness. Homosexuality was an official mental illness until 1965 and suicide was a criminal offence until 1961.

Throughout history, different models of mental health have been built around popular ideas and beliefs. These included the influence of witchcraft, and evil spirits! The stigma attached to those experiencing mental health difficulties remains in our language today. The terms “nutter”, “loonies” “psychos” and “maniacs” are unwelcome descriptions that most people would prefer to avoid. It is not surprising that many people experiencing difficulties decide to keep quiet.

“We should never underestimate the wonderful gift of signing an enrolment form and enabling someone to become a student. Many people have spent the majority of their adult life as a patient or a client”.
Phil Hopkins, Stepping Out Programme Manager 2004(5)

Fear of disclosure
Keeping quiet about mental health problems can have a knock on effect for learners and tutors. It delays the possibility of help and support, perpetuates the idea that mental health difficulties are shameful and often results in a poor quality of life for the person experiencing the difficulties.

Setting out the ground rules
The important thing for tutors to remember is that the classroom and all learning environments should be safe and inclusive. Phillip Hopkins, a tutor at an FE college in Leeds, liked to set out the ground rules at the start of all his courses. He believed that it gave a clear message to all of his learners about acceptable behaviour and mutual respect. It also meant that he could have fun with his learners, and that they could relax knowing that he was on their side! (5)
The problem with Mental Health is there’s lots of stigma and misinformation around. When we encounter mental health difficulties ourselves, it’s not something we like to broadcast. It’s about working in an inclusive way. People with mental health difficulties don’t come to college to be singled out; they come because they want to be the same as any other learner. All the tutors who work with me are good subject specialists. Students come because we have a good pottery specialist not because we are mental health workers.

Tutors need to be good listeners, able to reflect on their own skills and take into account personal experience, be flexible, react to needs of individuals, be resourceful, able to think on their feet, change direction in the middle of a class if the conversation has gone in a different route to the way expected, and develop a programme of learning that will suit the individual.

It’s important for tutors to establish the ground rules in the classroom whether learners have mental health difficulties or not. The tutor can come up with a group- learning contract e.g. are we going to turn mobile phones off?

Tutors must take a lead when it comes to tolerance. Some people may miss sessions because of their illness. One of the hardest things for people who have time off with poor mental health is to come back.

As tutors and managers working with this particular student group, we shouldn’t underestimate the important job that we do. I’ve had many students come up to me at the end of a course or part way though and say how wonderful it is to be a student in a college and what it means to them. We should never underestimate the wonderful gift of signing an enrolment form and enabling someone to become a student. Many people have spent the majority of their adult life as a patient or a client.

Interview with Phil Hopkins, Manager of the Stepping Out Programme, Park Lane College, Leeds 2004. (S)
Section A

Language the media and stigma

Mental health word game

Go through the word game and circle any words you think are commonly used to describe people with mental health difficulties. Go on…..don’t hold back. There are at least 17 words in the game. (answers on the bottom of page 23.)

How did you find the game?

Boring, childish, predictable……..well that’s stereotyping for you!

Or

Did you find it difficult, offensive, and confrontational?

Don’t be part of the problem
Phil Hopkins, formerly manager of the Stepping Out Programme at Park Lane College in Leeds, believed that learners who came onto his courses should be encouraged to deal with language in an open way. (5)

Learners were encouraged to look at some of the most offensive terms associated with mental health and discuss them in the context of their own lives.

"It's no use pretending the words don't exist."

He used flash cards to prompt discussion about the range of offensive terms that people had to deal with and the same method for encouraging learners to develop skills and knowledge to counteract the prejudice they may have experienced.

Our basic needs being met
Including food, finance, housing, security, affection, freedom from hazards and exploitation.

Our feelings, thoughts, beliefs about ourselves and others.
Including our feelings of worth, power, control, safety, inclusion, acceptance, being understood, supported and fulfilled.

Mental well-being is about........
"How I deal with my world"
"How I deal with other people"
"Where I live and what my life is like"

Our emotional skills
Including being able to cope with change, manage relationships, handle stress, communicate, and learn.

FEAR
40% of the public associate mental health problems with violence. In fact, they are much more at risk from young men under the influence of alcohol.
Why do words matter?
We have become aware of the impact and entrenched thinking that is conveyed through the use of racist terms. Most people find racist terms unacceptable because:

- They reduce people to a ‘type’.
- They speak ‘about’ not on behalf of.
- They speak about, they exclude.
- Words define ‘them’ and ‘us’.
- Words reflect the interests, perspective and fears of the people who use them, not the people they describe.
- Words carry a history of ideas with them.
- They stop people looking for other factors; the racist term becomes an explanation in itself.
- Selected traits from some members of the ‘target group’ are distorted and applied to the whole group.

Some of the language used in relation to people with mental health difficulties is just as damaging.

<table>
<thead>
<tr>
<th>The words psycho, nutter, whacko, freak, basket case, loony, crazy etc., used as a description.</th>
<th>The terms are clearly offensive and offer no insight into the condition of the person described. Such terms are condemned by mental health professionals. They exist outside of any medical or psychological definition.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim of (could be) depression, schizophrenia, mental illness etc.</td>
<td>The term ‘victim’ presents the individual as hopeless and unable to help themselves and works against modern ideas around recovery. It’s an unhelpful term and a better description is ‘a person who experiences ……’</td>
</tr>
<tr>
<td>Mental illness</td>
<td>This term tends to be used to cover everything from severe and long term symptoms to short lived, one-off episodes of mental health difficulties. It can detract from social factors that may have contributed to the individual taking the action they did. Watch out for this term being used as a ‘reason’ when it is really an incidental or contributory factor.</td>
</tr>
<tr>
<td>Committed suicide</td>
<td>The word ‘committed’ is from the days when suicide was criminalized or, as it still is in many parts of the world, a sin.</td>
</tr>
<tr>
<td>Successful suicide</td>
<td>A strange choice of description for an act that ends in death.</td>
</tr>
<tr>
<td>A depressive, a psychotic</td>
<td>These terms serve to define the person by a medical diagnosis. The terms can be very undermining and be used to negate the views, feelings and actions of the individual e.g., ‘well you would say that wouldn’t you?’</td>
</tr>
</tbody>
</table>
The mass media and mental health

“The trouble is that TV and cinema have become overwhelming socializing forces. By the time children are seven, most will have spent the equivalent of three school years in front of a television set.”

“In the case of mental illness, many stereotypes would probably be illegal if used on ethnic or religious minorities, and the general effect is corrosive.”

Robin McKie the Science Editor of The Observer

Not just television

The mass media isn’t just television; it includes newspapers, radio and magazines. The media is a major force in both representing the interests of the public and also representing information to specific audiences. It is an international opinion maker, though in reality owned by a handful of conglomerates. Did you know that “The Sun”, “The Times” and the “News of the World” are all owned by the same company, FOX that also owns TV channels, publishing houses and international news groups? News articles are exchanged across the world as a commodity. TV soaps and films carry their implicit values and messages across cultures. So, if people experiencing mental health difficulties don’t want to talk about them, the media is happy to fill the gap, but only if the story will sell.

And now for some good news.

Bonkers wacko nutter knifeman psycho
There have been dramatic changes in the mental locked up emotionally unstable way that the press now reports mental overdosing a depressive bitter knife health compared to 10 years ago. wielding fled freed to attack schizo Common mental health difficulties are given terrified committed suicide slashed ‘star’ treatment, however, prejudiced attitudes about through freed to attack cannibal free to severe mental health illness remain deeply ingrained in kill. our society.
Almost 10 years ago Glasgow University study looked at the content of 562 newspaper items written in a one month period that had representations of mental health. 62% of the stories focused on violence. They concluded that most media attention is drawn to stories that connect mental illness to crime or violence.

It’s not surprising that newspaper articles focus on violence. According to the Shift Report, ‘Mind over matter’, the criminal justice system (the police and courts) were the most common source of news stories about mental health. The same report goes on to point out that journalists struggled to see mental health as a topic to be covered in its own right. Only if the story was about conflict, the unusual or sensational was it newsworthy.

“We make a judgement about what the audience will be interested in. there is no sexiness in mental health unless someone has committed a terrible crime.”

Changes in reporting have been directly affected by a large number of anti stigma groups and campaigns that have lobbied the government and newspaper editors. The National Union of Journalists now acknowledge the part they play in forming public opinion and see themselves as part of the government’s five years plan to reduce stigma and discrimination experienced by people with mental health difficulties.

According to Shift’s report, the main changes in reporting relate to the media coverage of the more common mental health difficulties, such as post-natal depression, anxiety attacks and eating disorders. Readers relate to stars and celebrities such as Gail Porter, Robbie Williams and Sadie Frost and their difficulties. The sympathetic nature of reporting and the celebrity focus invites readers to put themselves in the celebrities shoes or at least see another perspective.

“It’s a bit like being stabbed in the leg and having a five inch gouge in it and saying that shouldn’t hurt ‘cos you’ve got this great pool and this great view.”

(From an interview with Robbie Williams talking about his recurring depression and the unsympathetic responses he experienced. 2003)

The Shift report suggests that the reporting of severe mental health difficulties is still problematic. Homicides and crimes were still the most common stories in March 2005 and made up 27% of all mental health coverage. The report looked at the tone of articles about mental health and found a clear focus on risk of violence. People with mental health problems were only quoted in six percent of all pieces. (6)
In the foreword to the Shift report written by Jonathan Freedland, Guardian columnist, Freedland compares the reporting of mental health with that of historic reporting of black people.

“There was a time when the press reported on black Britons not as people, but as a challenge, or even a threat, to the ‘rest of us’. Often the only time a black face appeared in a newspaper was to illustrate a story on a crime..........Slowly, the media changed its ways. Gradually it began to report on the lives of black people in their own right – not solely for their impact on white folk. The tired racist associations--of black men with violence--first receded and then became off-limits.” (6)

In a similar way to racism, people with mental health difficulties experience prejudice through language. In newspaper articles it is often difficult to separate fact from opinion. Here is an exercise to try with colleagues or learners. Invite them to collect and read newspaper articles relating to mental health and see if they can identify any of the following approaches used by the journalists and editors.

<table>
<thead>
<tr>
<th>They reduce people to a <code>type</code></th>
<th>The subject of the article is no longer seen as an individual with a life history, family, etc. Derogatory words sensationalise and would not be tolerated if used, for example, in a racist context.</th>
</tr>
</thead>
<tbody>
<tr>
<td>They speak <code>about</code> not on behalf of</td>
<td>When reading the article work out who the writer is speaking to? If you had a mental health difficulty, how would the article make you feel?</td>
</tr>
<tr>
<td>Words reflect the interests, perspective and fears of the people who use them, not the people they describe.</td>
<td>Is there a sub text to the article? Why has the writer selected this particular information, those particular words? Can you build up a picture of the writer from the words he or she has used? Can you separate the facts from the opinions of the author?</td>
</tr>
<tr>
<td>Words have a history</td>
<td>Words used to describe mental health often have histories and connotations linked to popular culture. E.g. psycho is linked to an Alfred Hitchcock film about a murderer who owned a motel. Psycho is not a medical term or a description of a medical condition.</td>
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<tr>
<td>They stop people looking for other factors, the term becomes an explanation in itself</td>
<td>Are social or political factors described in the article, or is everything put down to the mental health ‘condition’ of the individual?</td>
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Impact of media coverage

Frequently reported effects of discrimination include long-term emotional problems such as low self-esteem, social isolation and exclusion, depression and anxiety. In a Mind survey carried out in 2000, 22% of the respondents said that media coverage of mental health issues had made them feel more isolated and withdrawn. 8% said that it made them feel suicidal. (4)

Here is another exercise to try with colleagues or learners. Collect magazine and press articles that relate to mental health from a variety of newspapers over a one month period. Work in small teams to look at the articles and decide whether the editor was right to publish (the article was informative and gets a Green light), was wrong to publish (sensational and biased, Red light) or can’t decide (Amber). Put your articles on three piles and discuss the ‘Amber’ pile with the whole group. See whether your findings support the Shift report.

<table>
<thead>
<tr>
<th>Article</th>
<th>Sensational or informative</th>
<th>Subject treated as a public threat or health matter</th>
<th>Common mental health difficulty or severe</th>
<th>Red, Green or Amber light</th>
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Over the past 15 years, the media has responded to many mental health pressure groups and gone a long way to raise awareness among its own members about the impact of poor reporting of mental health.

Mental health awards

The mental health awards are an annual event sponsored by the Disability Rights Commission and BAFTA. The event is attended by journalists, broadcasters, producers and mental health workers.
Winners are judged on their ability to create an informative programme. Members of the public are invited to nominate Soaps, Print, Television and Radio News and Drama for awards.

“Have you seen or heard a programme or read an article this year which you felt increased people’s understanding of mental health? We are looking for programmes or articles that have challenged stereotypes; provided information or given a voice to people with direct experience of mental distress.”

Invitations for nominations for the Mental Health awards 2006.

It is clear that factual, informed reporting and portrayal of mental health in the media has a significant influence on the way that the public views people who are experiencing mental health difficulties. Television drama has a key role to play in developing realistic and informed storylines about mental health. Eastenders and Emmerdale have been commended for their sensitive treatment and realistic storylines around key characters who are experiencing the effects of depression and schizophrenia and their role in informing the viewing public.

Challenging the media locally

Pauline Bispham was appointed Media Officer for Positive Mental Health in 2003. She is based in Leeds North West Primary Care Trust and organises media training for service users and carers, campaigns and collaborative work with the local press and she established an action group, ‘Media Minders’.

One of her first tasks was to analyse the coverage of mental health in the local press in 2002 (Yorkshire Evening Post and Yorkshire Post). She found that the most frequent themes relating to mental health were crimes/violence committed by a person with a mental health problem (38 articles). This mirrored the picture nationally. Only 6% of articles included the views of service users or carers:

The aims of the Media Minders project

- Less stigmatising language used in relation to mental health in the local print by Dec 2004.
- More positive coverage of mental health issues in 2004 than in the baseline survey.
- Greater representation of the views of service users and carers in the press by Dec 2004.

Pauline has been successful so far with her project. In 2003, positive stories on mental health replaced stories about crime and violence by 21:14 and the views of carers and service users rose from 14 in 2002 to 40 in 2004. (7)
In her booklet, ‘Have your say’, Pauline describes the role of the ‘Media Minders’.

“We are a group of service users and mental health workers who look at how mental health issues are presented in the local and national media. We aim to help to reduce discrimination by challenging negative stereotyped images and by praising positive and honest reporting.”

The booklet describes how to complain about negative and poorly written articles. It provides templates for letters of complaint, a summary of mental health statistics and a list of media organisation contacts. This is an excellent booklet and promotes action to challenge stereotyping and bad reporting of a wide range of mental health issues.

The ideas also provide an excellent way to raise awareness around mental health issues and engage students who are learning to improve their letter writing skills or provide a project for media students who are deconstructing popular myths in the press and on TV. Pauline makes an important observation about the way that the ‘media’ is evolving from a linear delivery medium to a more interactive one. The Internet, blogging and podcasting have all enabled people to actively engage and communicate with each other in public forums and challenge the conventional ‘push’ information systems where the public was dependent on assorted professionals to interpret and present events for them.

“In the last few years there has been a rapid increase in the number and range of media outlets and greater fragmentation of media usage. There is also talk of people becoming their own editors, selecting information from a variety of sources rather than reading a newspaper in a linear manner. It costs very little to set up a website and a much more bottom-up approach to generating news and information is becoming apparent.”

Taken from ‘Basic Media Skills’ Pauline Bispham 2006 (8)

If you would like further information about Leeds Media Minders, contact Pauline Bispham, media officer for POSITIVE Mental Health, Leeds Northwest Primary Care Trust on 0113 395 7354 email Pauline.bispham@leedsnorthwest-pct.nhs.uk

Word Game answers (Page 15)

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Understanding mental health statistics

We are all now familiar with the 1:4, 1:3 or 1:6 figures presented to illustrate the high prevalence of mental health difficulties in the general population, however, the term ‘Mental Health Difficulties’ encompasses a wide range of conditions. Richard Layard in his report Mental Health: Britain’s Biggest Social Problem, describes the consequences for Britain’s economy and the human misery of ignoring mental health. (9) His report is informed by a household survey carried out in 2000 by the Office of National Statistics (ONS). The findings of the survey were based on 90 minute interviews with 9,000 adults aged 16-74 who were living in private households. Mental health difficulties, if present, were diagnosed using a standard medical classification. The survey suggested that one in six adults or 16% of adults of working age have a mental illness and half of those are seriously ill.

- (Other) mixed depressive and anxiety difficulties 8.8%
- Generalised anxiety 4.4%
- Depressive episodes 2.6%
- Phobias 1.8%
- Obsessive Compulsive Disorders 1.1%
- Panic attacks .7%
- Psychosis (mainly schizophrenia) .5%
Statistics quoted in this pack

It's wise to be cautious when reading statistics. Some figures that aim to show how common a particular problem is in the general population will be based on the number of people treated by healthcare professionals. This figure would not reflect those who use other services or no services at all.

The statistics quoted in this pack have come from a wide range of studies and surveys; however, the methods used to collect responses, the sample size and analytical approaches will all influence the findings. This pack does not attempt to provide a comprehensive review of the research on people's experiences of mental health difficulties but it does highlight trends and examples.

It is not possible, therefore, to compare statistics from say the Office for National Statistics Household Surveys to the findings of a local University survey on a like-for-like basis. Both, however, will have relevant things to say within the context of their own study.

Why do the figures contradict themselves?

It is not unusual to find widely differing figures quoted when reading about the prevalence of different mental health conditions. For example, some reports predict 1:4 people will experience mental health difficulties, others 1:6. One reason for this discrepancy is that the figures do not always measure the same thing. Here are some terms and definitions provided by MIND:

- **Prevalence:** this measures the number of people with a particular diagnosis at a given time.
- **Lifetime prevalence:** measures the number of people who have experienced a particular mental health problem at any time in their lives.
- **Incidence:** is a measure of the new cases of a particular mental health problem that appears at any given time.

What does this mean for the tutor?

The statistics illustrate both the high prevalence of people with mental health difficulties but also the range of difficulties and mainstream support that people are able to access. As a tutor in a mainstream organisation it is difficult to anticipate the proportion of learners that you could reasonably expect to experience mental health difficulties. Although 1 in 6 of us may have difficulties at any one time we do not access education and other services in equal proportions. Social deprivation, stigma and attitudes present barriers for many. It is difficult to be accurate about the percentage of learners with mental health difficulties because many do not disclose and when they do, they are counted under a global term of ‘learners with disabilities’.
Social factors

Mental health difficulties do not occur in a vacuum. There are significant differences in incidence between women and men and the diagnosis of mental health difficulties between people from different ethnic backgrounds. Social factors such as low income and lack of social stability, general lack of cultural awareness in the population and in health care professionals, all appear to increase the chances of developing mental health difficulties, particularly in children.

Children and young people

Recent reports have shown that 15% of pre-school children will have mild and 7 percent will have severe mental health difficulties, though the percentages will not be the same across the entire population. (10) When prevalence is cross referenced with other factors such as income, qualifications of parents and children from single parent families, significant differences appear.

In 2004, 7,977 families, selected from the Child Benefit records held by the Dept. for Work and Pensions, participated in interviews with researchers looking at the prevalence of mental health difficulties in children and the impact this had on their lives. (11) One in ten children and young people (5-16yrs) were found to have a clinically diagnosed mental disorder. Boys were more likely to have a disorder than girls, though the difference narrowed as they approached their teens. The prevalence of mental disorders was greater among children in lone parent families (twice as high), where parents had no educational qualifications (17% compared to 4% where they had a degree level qualification) and in families where neither parent worked (20% compared to 8% where both parents worked).

The findings of the survey support the Social Model of disability, showing links between social factors and prevalence of mental health difficulties starting in childhood and impacting on adult life.

Black and minority ethnic groups

Many studies have looked at the treatment of black and minority ethnic groups within the health service. A study published in the British Journal of Psychiatry compared admission rates and unmet needs by ethnicity of patients admitted to high security psychiatric hospitals. (12) 1255 in-patients were interviewed. The survey found that black patients were over-represented by 8.2 times compared to their white counterparts. Trends in diagnosing black patients with severe mental health difficulties rather than the more common and less severe personality disorders or learning difficulties were found. Rates of admission into hospital were 3 or more times higher for black and mixed race people than white people. (13) If you are from a black or Caribbean group you are twice as likely as a white person to be referred to mental health services by the police or courts.

The report `Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England` found that: (14)

“Cultural and racial stereotyping is a common experience in the context of assessment and decisions concerning treatment. This may well influence the types of services and diagnosis individual from minority ethnic backgrounds seek and receive.”
The report found that people from ethnic minority backgrounds are more likely to be misdiagnosed by GP’s and to be prescribed drugs and ECT rather than talking treatments. Re-admission rates are higher, hospital in-patients younger and outcomes appeared worse than for their white counterparts.

The same report found that many people from ethnic minority backgrounds encountered barriers when seeking help from healthcare professionals. Barriers included language difficulties, differences between the doctor and patient’s interpretation of symptoms, lack of knowledge by the patient on the range of statutory services available and cultural barriers relating to assessment. Chinese groups tended to present to GP’s only after long delays so were in a more advanced state when presenting. South Asian patients were found to be less likely to have mental health problems recognised by their GP’s or conversely, were over diagnosed with mental health difficulties.

“There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well, or better than, the majority white community.”(14)

A culmination of social factors including low income, poor access to education and health services, language and cultural difficulties and the double discrimination associated with stigma around race and mental health, means that ethnic minority groups are particularly vulnerable. There is a clear need for more cultural awareness training for GP’s and the mental health services in general. ‘Inside Outside’ presents a framework for improving mental health services for people from ethnic minority backgrounds. It supports the unequivocal statement in the Mental Health Service Framework that users can expect services to be non-discriminatory and outlines what this could mean in practical terms for service providers.

The Woodwork course for Chinese speakers at Roundhay Road Day Centre commenced in December last year and I am very pleased to report that it is now in full swing. Three women initially enrolled, but the word then spread and we now have a committed class of seven. The only difficulty is trying to get the women to stop for a cup of “char”.

I have been particularly moved by the way in which some women have talked about the way in which they struggle to come to terms with feelings about China no longer being their homeland, alongside similar feelings of isolation about living in this country. This is especially true of Chinese women who traditionally stay at home while their husbands go out to work. Most of the women in the class speak little English. With these facts taken into account, it is hardly surprising to learn that so many Chinese women, who have relocated here, develop mental health problems. I believe that the Stepping Out programme is playing a small but significant part towards helping these women learn new skills, improve their confidence, integrate into the wider community and improve their language skills.

Gary Crowder, Stepping Out Programme Tutor, Park Lane College, Leeds. (2004)
Your legal obligations

If you work in a College, University or Adult Community Learning organisation you are required by law to ensure that people with mental health difficulties are not discriminated against. Discrimination can take many forms and the Act and accompanying Guidelines attempt to encourage organisations and the individuals they employ to review their current practices, structures and systems.

Legislation under the Disability Discrimination Act (1995) and Special Educational Needs and Disability Act (2001)

In September 2002, part 4 of the Disability Discrimination Act (DDA) came into force. This brought education under the Act, giving all staff (teaching and non-teaching) duties in relation to disabled learners.

The act defines Disability as:

“A physical or mental impairment which has a substantial and a long term adverse effect on a person’s ability to carry out day-to-day activities.”

Until recently, to qualify under this definition, the mental impairment would have lasted, or be expected to last, at least 12 months and to be clinically well recognised. The requirement for the mental impairment to be, “clinically well recognised” is being removed through amendments to the Act in 2006.

To qualify under the Act the impairment must have a substantial and long term adverse effect on the individual’s ability to carry out normal day to day activities. If the effects of the impairments come and go, but are likely to keep on returning, they are treated as if the impairments were continuing. People who have had impairment within the definition are protected from discrimination even if they have since recovered. (15)

There are some conditions that are excluded from coverage by the Act, even though they may fall into the area of mental health difficulties.

Exceptions not covered by the Act:

- Dependency on alcohol, nicotine or other substances.
- Tendency to set fires.
- Tendency to steal.
- Tendency to physical or sexual abuse of other persons.
- Exhibitionism.
- Voyeurism.

Such behaviour would be dealt with under the organisations’ existing policies e.g. Health and Safety, Acceptable Behaviour, etc.
Defining disability discrimination

The Act states that unlawful discrimination occurs:

“....when a disabled person is treated less favourably than someone else and the treatment is for a reason relating to the person's disability and that reason does not apply to another person and that treatment cannot be justified.”

Learners with disabilities were given new rights to ensure that they were not overtly discriminated against. Discrimination can be defined by the Act as 'less favourable treatment' for reasons related to their disability or by the organisation failing to make 'reasonable adjustments'. The guidance also states that it may be necessary to treat some learners more favourably than others to ensure equal access to learning.

To come under the Act, the disability/impairment would affect the person in one or more of the following areas:

<table>
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<tr>
<th>mobility</th>
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<th>memory</th>
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<tr>
<td>dexterity</td>
<td>hearing</td>
<td>concentration</td>
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<tr>
<td>motor co-ordination</td>
<td>sight</td>
<td>learn or understanding (dyslexia is included)</td>
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The DDA Part 4 gives FE Colleges and ACL providers anticipatory duties in respect of disabled learners rather than reactive ones. That means that learning providers must anticipate potential barriers that individuals may face and take reasonable action to reduce them. The duties apply not just to teaching and learning but to anyone delivering a service to learners e.g. canteen staff, security staff, cleaning staff, examination officers.

The Act encompasses all aspects of the learning experience and environment. For example, it might require the organisation to make reasonable adjustments in all or any of the following:

- admissions procedures
- examination procedures and timings
- staff training in inclusive teaching and assessment methods
- expectations around attendance
- necessity for group work and clarity over core and optional aspects of courses
- provision of additional learning support, including one-to-one support and mentoring
- help with travel to the learning venue
If learning providers are serious about attracting learners with mental health difficulties, they will also need to look at their outreach activities, promotional literature and events and links with external community groups.

**What is a `reasonable adjustment'?**

Skill (National Bureau for Students with Disabilities) has produced an information sheet on the DDA. Skill offers guidance to learning providers with regard to `reasonable adjustments'.

> “When determining whether or not an adjustment is `reasonable’, the education provider can take account of factors such as the maintenance of academic standards, cost and resources and the practicality and effectiveness of the adjustment. However, institutions will have to think through the implications before refusing to make an adjustment.”

You can obtain a copy at [www.skill.org.uk/info/infosheets/dda.doc](http://www.skill.org.uk/info/infosheets/dda.doc) (16)

**Collaboration with external mental health support services**

In 1999 the government published the National Service Framework (NSF) for Mental Health. In the NSF for Mental Health there are seven standards one of which recommends: `Health promotion and awareness of mental health issues in schools, colleges and workplaces’. (17)

The NSF through setting targets and standards was encouraging collaborative work between agencies. Education providers were encouraged to network with specialist mental health services to tackle stigma and prejudice and make steps towards the inclusion agenda. It had become clear that there was little communication between the various sector specialists who supported people with mental health difficulties.

For health care professionals, education could represent an important contribution to their client’s recovery. It offers access to resources, re-integration into community activities, structure, goals and a route to employment for some. For educationalists, an understanding of the practical and social support needs of their learners could improve retention and success rates.
Pete Vickers from Joseph Priestly College notes that Colleges have a wide agenda but they need to be honest about the level of support they can give: (18)

“Colleges need to recognise the difficulties associated with the support and development of community partnerships. We have a development worker in the community, working to help learners who have lost confidence in their learning.

Colleges have many priorities and with this group there needs to be an honest acceptance of the values and achievements for sure, but also shortcomings. This creates then a platform for dovetailed arrangements with other agencies.”

Tricia Clark, Learning Support tutor at Bradford College, talks about the value of working with external support services: (19)

At Bradford College we recognise that students with mental health issues may already have or may benefit from the involvement of other professionals or agencies. At the initial assessment and throughout their programme of support I will establish with students whether liaison between myself and other professionals may be necessary, appropriate or beneficial in meeting the wider needs of the student to ensure they have the best possible chance of being maintained on course and achieving their learning outcomes. A consistent and ‘joined up’ approach is very important, especially where a student may have a number of professionals involved in different aspects of their support. With the consent of students, I often liaise directly with Community Psychiatric Nurses, Key Workers, Social Workers, and Cognitive Behaviour Therapists, etc. Although students must always refer themselves, I will often recommend or support students in contacting such agencies and also GPs, the College’s Counselling Service or community counselling services and various community/voluntary services. Thereafter the student’s involvement with such agencies/professionals remains confidential and I have no knowledge of this unless the students themselves disclose information. This holistic approach to student support has proved to be very effective in many cases. For example, I have liaised with Cognitive Behaviour Therapists on a number of occasions to support students with Obsessive Compulsive Disorder, and also those experiencing severe anxiety or panic attacks as a result of some phobia, to ensure that the approaches and strategies being used in college to support the student have been consistent with the desensitisation programmes being implemented by the CBT. These CBTs have come to regard the work being done in the college as complementing and reinforcing the work they do and, with the students’ consent, have been more willing to liaise. This two-pronged collaborative approach has proved very effective in supporting these students in overcoming significant and often entrenched difficulties.

Tricia Clark 2006
Many education providers still seem to have a low expectation of learners with mental health difficulties. (20) The Social Exclusion Unit’s document ‘Action on Mental Health’ states in its key facts that:

- People with low levels of educational achievement are likely to have less income and be overall less healthy.
- Among people with common mental health problems, just under one in three have no qualifications.

It goes on to say that:

‘Potential learners can be constrained by low expectations, with some college and health and social care workers assuming that they cannot or do not want to access mainstream education, and that they will not want to undertake accredited courses. For many people, taking part in mainstream learning at the local college will promote better health outcomes. However, particularly at the outset, it may be necessary to provide additional support…’

Action on mental health: Factsheet 7 (20)
References for Section A

1. `Is Anybody There? A survey of friendship and mental health, April 2001. Publications Department at The Mental Health Foundation, Tel 020 7803 1101 or email books@mhf.org.uk  http://www.mentalhealth.org.uk/

2. `One on Four' 2006. NIACE Publications. You can get a copy of One in Four by contacting Sue Parkins at NIACE, 21 De Montfort Street, Leicester LE1 7GE Tel. 0116 2044247, email susan.parkins@niace.org.uk


5. Interviews with Phil Hopkins in 2004. Former Stepping Out Programme manager at Park Lane College Leeds


8. ´Basic Media Skills’ 2006. Pauline Bispham, Leeds North West Primary Care Trust


10. The Mental Health Foundation  www.mentalhealth.org.uk


16. Skill info sheet. You can obtain a copy at www.skill.org.uk/info/infosheets/dda.doc


18. Article by Pete Vickers, ACE Project Coordinator at Joseph Priestly College on Leeds. 2004

19. Article by Tricia Clark, Learning Support Tutor, Bradford College. 2006

Section B

Why worry about learners’ mental health?

How to use this section
This section of the pack is designed for tutors. It looks at some of the reasons why learners are a particularly vulnerable group and the role of tutor as support. It provides descriptions of some of the mental health difficulties your learners might experience and invites you to assess how supportive and welcoming your own course is.
The best time of your life

Being a student is the best time of your life......really? There is a stereotypical view of learners who are all young free and single. They are not constrained by family and work and only have to think about themselves. In reality, many learners are also carers; they have young children, or elderly parents. They may have given up work to return to study or may have been unemployed for long periods or have been made redundant and pushed back into learning in a way that was never in their life plan.

For full-time students, debt is on the increase and the Department for Education and Skills estimates that a learner starting a higher education course in 2006/7 will owe £15,000 by the time they complete their course, though Barclays bank estimates it to be almost double that amount. It is less clear how much debt learners attending Further Education (FE) will have over the period of their studies. Some will live at home with parents but the FE population includes significant numbers of adult learners. Many learners work part time to pay their way. They may have borrowed from family and friends as well as taking out a student loan.

Learners can be a particularly vulnerable group, old or young. The pressure of exams, pressure to succeed and get good grades, change of circumstances, lower or no income can all contribute to a worsening of mental health. It’s not surprising that those providing learning support find their time and budgets stretched.

Here are some significant statistics concerning incidences and onset of mental ill-health in young people: (1)

- Between 5%-10% of young people will have anxiety problems that are bad enough to affect their ability to live a normal life.
- 2%-3% of adolescents will experience symptoms of depression for long enough to be clinically diagnosed.
- 10% of young people will deliberately self harm, though many more may consider it.
- 1% of young people have Obsessive Compulsive Disorders.
- 1% of the population will develop Schizophrenia. The most likely age of onset is 15-35.

A study carried out in 2000 ‘Tomorrow’s Minds’ highlighted the plight of young people who develop mental health difficulties and felt unable to tell anyone about it.

The majority of young people believed that having a mental health problem would lead to discrimination and over half wouldn’t want anyone to know they had a mental health problem.
It is clear that young adults are a group at high risk of experiencing mental health difficulties. NIACE in its Briefing Sheet, ‘The Learning Needs of Young Adults with Mental Health Difficulties’ outlines the important role that the Learning and Skills sector plays in enabling young adults to progress. It begins, ‘Studies have shown that young adults are one of the groups most at risk of having a mental health difficulty which will contribute to severe disadvantage and exclusion from society.’

The Briefing Sheet describes the life events that converge on young adults, the transition from childhood to adulthood, the many competing expectations about the future, and pressure from families and peers. This combined with low self-esteem and lack of emotional stability, can contribute to the onset of mental health difficulties. The Sheet goes on to outline the results of research to identify good practice in terms of meeting the needs of the target group. These include support that focuses on low self-confidence and negative self perceptions experienced by many learners with mental health difficulties and the benefit of access to a range of services.

The Sheet suggests that policy makers must be aware of the high level of skill necessary in tutors if they are to develop meaningful support for this group. It also highlights the need for learning providers to recognise the interrupted learning patterns that people with mental health difficulties experience and the off-putting hurdle that accreditation can present for many. The Briefing Sheets can be found on http://www.niace.org.uk/information select ‘Briefing Sheets’ and then Young Adults MHD. (2)

Many potential learners are trapped in a vicious circle of low self-esteem linked to past experiences of failure in learning. This mitigates against a return to learn despite the benefits that learning can offer i.e. structure and stability, confidence and self-esteem, support networks. For the young, mental health difficulties are frequently redefined as ‘emotional or behavioural difficulties’ resulting in dismissive responses from adults e.g. ‘you’re too young to be depressed’.

Where do learners go for support?

Lancaster University carried out a survey of Higher Education learners who sought support during mental health difficulties and found that over half turned to their personal tutor compared to only 7% who used counselling services.

This pack will not equip you to counsel or diagnose learners with mental health difficulties, it should, however, help you to identify and support those learners. Support may include sign posting them to a person or service or it may be just to listen and talk to them.

One of a team

Read through the interviews with three specialist mental health support providers. There are many consistencies in their advice to mainstream tutors about the kind of support that learners of all ages might benefit from.
Lesley White is manager of a Day Service in Sheffield

“People are referred to the day service by the community mental health team. We help people to understand their mental health issues and accept them. We help them to develop coping strategies to manage their mental health difficulties themselves and then go back into the community. The biggest problems people face when trying to return to learn is lack of understanding by tutors. We don’t just say, you’ve got your coping strategies, now off you go! Many people feel anxiety, they feel they can’t keep up and tutors won’t understand where they are coming from. Some people need one-to-one support at times and lots of reassurance. Our project is called Stepping Stone. It’s a partnership with Sheffield Adult Learning Forum. Half of the work is about education, and the rest is return to study and return to work. It’s a 10 week course. We’ve developed workbooks so people can work at their own pace. Our team works alongside college tutors. They may travel with learners to college, help them find bus routes and stay involved. We have managed to drastically reduce drop-out rates by keeping involved and offering re-assurance.”

- Hand holding during periods of transition is vital.
- Learners may need lots of reassurance to stay on course.
- Collaborative work between education providers and mental health workers is very effective at improving retention.

John Pattinson is Communities and Primary Care Development Lead for Care Services Improvement Partnership (CSIP) Regional Development Centre for North East, Yorkshire and Humber

“People need to be able to earn a decent salary to achieve at least the same as they get when receiving benefits. That is not necessarily minimum wage. One of difficulties people who want to return to work face is that they don’t necessarily have a qualification, and they don’t want to do a long course either. People who have experienced long term mental health difficulties can find that the nature of the illness tends to strip away elements of their personality; this can impact on their motivation and self confidence. During the process of transition between education and employment, many people need support. It’s essential that learning providers take a sensitive approach to this particular group. It’s the same type of awareness that tutors would need for people with mobility difficulties for example; sensitivity and a desire to address the practicalities.

We have seen a very small increase in Direct Payments in North East, Yorkshire & Humber. The concept of Direct Payments is that the social services authority would give you an amount of money, say £1,000. You might say ‘I would like to spend £500 on learning to become a potter and £500 on someone giving me support to go to a pottery class’. People spend the money on what helps to keep them on their journey of recovery. The concept is important, because the message is about individual choice. The individual is a consumer. If someone wants a support worker to sit with them then potentially that’s what they can use their budget for.”
People experiencing long term mental health difficulties can lose a lot of confidence.

People need support during transition from one phase of their life to another.

Direct Support payments can be used to pay for a wide range of support at the learner’s discretion.

Additional sources of information

www.neyh.csip.org.uk (NIMHE information for the Y&H and North East regions

www.socialinclusion.org.uk (National Social Inclusion Team website)

www.ndt.org.uk (National Development Team website with emphasis on social inclusion and related tools)

Andrew Cambridge, manager at Future Prospects in York. Andrew manages a North Yorkshire Wide project that supports people with mental health difficulties to get into work or learning.

“The project is about skills for work. We run skills development workshops for going onto a training course or for a workplace. People may go on to do qualifications and other types of learning. In York, our project is very established. We work through Community Mental Health teams and GP surgeries. We get huge referrals through health professionals. We don’t just deal with learning. We look at what the individual wants. We would go to the college with them and work around building confidence and getting individuals prepared to take next steps.

We are dealing with health agendas but not in a health environment. All our training is in workshops outside of health care premises. We are reaching out to those people who want to do something but don’t have the confidence. That’s where you need the learning experience to be a good one. We find that we get good retention rates when we provide close mentoring whilst the learner is attending a learning programme. We can ensure they know about learner support and steer them through the processes.

We work with people with all forms of mental health issues. The condition is irrelevant. What we should be thinking about are the issues that affect their learning. It’s simply about adapting to a social environment. But we’ve got to get the learners into the classroom in the first place! Any tutor should have some advice on what to do but only around learning. You’ve got to have faith in the rest of the system. Your focus is on supporting learning.

Don’t worry about the DDA. If you are looking at good support, you will comply with DDA. DDA is about minimum standards. Often all the learner wants is just to have a word with someone, nothing more.”(5)

- Advocates and befrienders can steer learners through complex systems.

- Confidence is key to returning to learn. Work with other specialists. They can offer different kinds of support. Think of yourself as one of a team with your own specialist contribution to make.

- Tutors should focus on the learning support need, not the mental health condition of the learner.

- Work with other specialists. They can offer different kinds of support. Think of yourself as one of a team with your own specialist contribution to make.
How do you know if your learner has a mental health difficulty?
Everyone has bad days, but not everyone experiences mental health difficulties. When people have experienced difficulty over a period of time they can lose confidence, be unable to get a good night’s sleep and find it difficult to concentrate.

Read through these case studies and try the exercise

You may want to do this alone or with colleagues. Work through the scenarios on the following pages. List the ‘symptoms’ and decide whether you would do anything about them.

Scenario 1
Ravi is 18 and a Business Studies student. He is one year into his course and has a good attendance record. His work is usually good to average. In recent weeks you have noticed that he is missing sessions, has failed to hand in any work in and seems distracted. He often arrives late for classes and leaves in the middle of them without explaining.

You have asked him about outstanding coursework but he tells you that he has done it but forgotten to bring it in. He seems very agitated when you talk to him, he blushes and seems to be desperate to leave the room.

Scenario 2
Selma is a mature student who is studying to gain a place at University. She has always been an unconfident student but lately seems exceptionally quiet in class and appears to be losing a lot of weight. You have asked her why she seems reluctant to join in discussions and she tells you that she is feeling depressed and is thinking of leaving the course. She recently stopped seeing her boyfriend and feels very lonely. She also burst into tears then left before you could say anything more.

Scenario 3
Carl is an unpopular member of the class. He is 10 years older than most learners and seems to tell lies. Of late he seems to be sullen and has missed a few classes. On some occasions he has turned up late smelling of alcohol. Some learners have complained to you that Carl has made abusive remarks to them and that he is often rude and leaves the group without explanation.
When you have completed the exercise, ask colleagues about the actions they would take in similar circumstances. Look to see if there are any differences between your responses and theirs?

What are the aspects of behaviour that concern you?

<table>
<thead>
<tr>
<th>What are the aspects of behaviour that concern you?</th>
<th>Would you do anything?</th>
</tr>
</thead>
</table>

Feedback

You may have listed symptoms such as missing lessons; late work, appears distracted; abusive, weight loss; not joining in discussions; breath smelling of alcohol. Is there anything remarkable about the list? It’s probably remarkable because the ‘symptoms’ are so common place. There can be few of us who haven’t had off days, missed the odd class, handed work in late or given an abusive response etc. What tutors are likely to be concerned about is a marked and on-going change in the individual’s typical behaviour.

There are many reasons why learners behave as they do. The important thing for the tutor to remember is to not diagnose the difficulty but to work with the learner to help him or her to remain on the course and complete their studies.

Ravi may be pre-occupied with problems at home about money, relationships etc. or, he may be worried about a court appearance or an appointment with a doctor. He may be experiencing panic attacks or be developing a form of social phobia or any mixture of these and many more problems. You may have considered that Selma may be developing an eating disorder and that Carl has an addiction to alcohol. Before jumping to conclusions, go to http://www.mentalhealth.org.uk and select ‘Problems Treatments’. OR try www.bbc.co.uk/health/mental/ and select ‘disorders’.

What should you do?

In all cases, you may have decided to talk to the learner, their friends or ignore the situation. Here are some things to consider before deciding what to do:

“First seek to understand, then to be understood is the hardest principle to master…..we typically seek first to be understood. Most people do not listen with the intent to understand, they listen with the intent to reply.”

Stephen R. Covey
If you have noticed that the learner is behaving in a different way, you should mention it. E.g. I have noticed that you......shows that you are aware and concerned. Stick to factual non-judgemental words. Don’t refer to gossip, it indicates that you are talking about them to someone else and this is not a good basis for confidentiality.

It is important to acknowledge and recognise personal and professional limits when offering support. Don’t raise false expectation in the learner. Not all tutors may feel that they are able to offer direct support to learners, but they should know how to refer people to a source of help.

Don’t try to take responsibility for solving other people’s problems. At the same time, acknowledge that you do have a responsibility not to ignore problems. Listen, reflect and refer when appropriate. Some people just want to talk. Make your own limits clear to the learner.

Don’t feel you have to come up with a total solution. In most cases you won’t be able to but you may be able to do practical things to help the learner remain on course. This may include a more flexible timetable, negotiated deadlines and acting as advocate with exam boards. Don’t underestimate the massive impact that small changes can make.

Don’t ignore requests for help or obvious signs of distress. It is important not to make the learner feel embarrassed about asking for help. It’s a myth that people who talk about killing themselves never do it. The majority of people who kill themselves have mentioned it to someone within 2 months of taking their own lives.

If you decide to talk to the learner, make sure that you have adequate time. A quick word between sessions in the corridor will not do. Set a time, turn up on time, and agree how long the meeting will last at the start. If you agree to do something....DO IT as a priority.

If you feel a situation is life threatening you must raise the matter with a specialist. It is vital to know who you can tell and what they will do as a result.

If you need to tell someone else about the situation, discuss it with the learner. You could offer to go with her/him to speak to a third party, or make an appointment while they are with you. If the learner does not want to see anyone else you will need to decide how critical you think the support is, and how equipped you are to give it. You could discuss the situation with colleagues if you kept the identity of the learner anonymous.
### Your Safety

It is extremely rare for anyone with a mental health difficulty to pose a threat to someone else. If a learner is in crisis, turning up for lessons may not be high on their agenda. Even if a crisis occurs, they are far more likely to harm themselves than others. If you are concerned about one-to-one support with a learner, make sure that other staff know where you are. Find out what the staff safety protocols are in your organisation.

If a learner is rude, abusive or violent, then they must be dealt with by your normal college procedures. A condition of return may be that the learner agrees to involve a mental health specialist in conjunction with your own learning support tutors.

Often people link safety concerns with mental health when really they are general security concerns, e.g. staff working alone at night or in remote venues. They are in reality more at risk of young men drinking alcohol than learners with mental health difficulties.

### If the Learner Becomes Distressed

Stay calm. Let the learner know that you are taking the situation seriously and listen to what is being said. Acknowledge their state and tell them that you recognise that they are very upset.

Summarise their main issues and ask what you can do to help. Be clear about what you can and cannot offer and what help is available.

DON’T walk away or be dismissive and let them know that you will not leave them alone.

If there are other learners around, calmly ask them to leave but to notify named staff and let them know where you are and what’s happening.

Be yourself. Don’t stare or panic.

Don’t join them in their mood, e.g. frustration, panic. You can comment on the way they present e.g. You are clearly very angry.

When the learner calms down, ask them who should be contacted or if they have an advanced planning sheet. (People in Recovery may carry an advanced plan of whom to contact and what to do in case of a crisis).

Learners who do behave violently or appear to be a danger to others must be treated in the same way as any other learners. Get the help of security or other staff. Talk to your learner support staff about next steps. They may have contact numbers and a crisis plan in place.
**Asking the right questions**

Trying to persuade a learner to talk about difficulties that are hindering their learning is always difficult, but this is exacerbated by the stigma surrounding mental health. Future Prospects is an organisation working out of a high street learning information shop in York. Andrew Cambridge manages a project that supports people with mental health difficulties back into learning. Although the project targets young adults with mental health difficulties, there is no mention of mental health on the promotional literature. Andrew suggests that by asking the same questions to all learners you create opportunities for people to discuss a wide range of support needs that focus on learning and not mental health.

- Do you think that you might want some additional support to do your course? This is entirely optional.
- Do you have a health problem that you think we should know about? If so, could you give me some brief details?
- Have you received any support with your learning in the past? What support did you get? Was it helpful?
- Would you like to meet an advisor to talk about your situation in relation to learning?
- Is there any other information that you think might be useful for us to know to support you with your course?

**What about you?**

If you feel worried or disturbed by information given by the learner, seek help yourself. Don’t bottle things up. Discuss with colleagues and a line manager the possibility of setting up a ‘buddy’ group to support each other.

**Making notes**

You will need to decide on the formality of the interview/meeting with your learner. You may decide to make notes of the meeting as an aide memoir or because your organisation requires it. Think carefully about the terms you use. Stick to the facts. Don’t use diagnostic terms or jargon. Remember, the learner can request to see what you have written. Make a note of any actions you agree to take and put a time frame against them. If you agree to do something, do it! You may want to put a reminder in your calendar and update your notes after taking action. Consider asking the learner to sign the notes if they have agreed to certain actions. For example, you may agree that if a situation deteriorates, you have the learner’s permission to contact a parent or partner.
Tutors are expected to take reasonable steps to ensure that learners are not placed at a substantial disadvantage when taking exams. Tutors may contact external Examination Boards for permission to make any adjustments that they feel are reasonable on behalf of the student, for example, allowing extra time. If the Examination Board refuses to allow the adjustments then the tutor would be expected to appeal on behalf of the student. If such an appeal failed then the tutor can do no more. (6)

Diane Heywood, Possitive Assets Co-ordinator for Humber Mental Health Teaching NHS Trust, offers some words of caution to tutors who try to interpret the signs of mental illness in learners: (7)

“People are all different. For example, two people with schizophrenia don’t present the same way, they don’t have the same needs, they don’t have the same background. It’s about the person and what they want. Check your own value base and own knowledge and assumptions. People think schizophrenia is lifelong, you have it forever. Someone diagnosed 5 years ago may never have a repeat of the symptoms again.”

What makes you feel valued?

- Being listened to?
- Being told when you have done something well?
- Others being honest with you?
- Others being fair with you?
- Others being happy to spend time with you?
- Others being interested in you?

When I interviewed learners with mental health difficulties there was a recurring theme. They wanted tutors to listen to them and to respect their views. Although the list, ‘What makes you feel valued’ may sound obvious, it’s worth taking some time to explore what it really means to ‘be interested’, ‘spend time’, ‘be fair’, be honest’ and ‘to listen’.

How do you know when someone has really listened to you? Try to remember a time when you sought advice from someone. How did you decide who to ask? What did you find useful and less useful about the advice you received?
Section B

Individual learning plans and tutorials

Tutorials should, in theory, provide an ideal opportunity for tutors to discuss a wide range of issues with learners and discuss suitable adjustments to individual learning programmes. The learner may not, however, see the tutorial as an opportunity to talk about personal issues related to mental health without a clear signal from the tutor that’s it ’OK’.

Decision-making

There is a useful set of workbooks written by Dr Chris Williams on practical matters such as Problem Solving and Being Assertive. They are part of a larger self-help workbook called ’Overcoming Depression’. You and your learners may find the workbooks useful. You can view and download the packs form the Leeds University website. (8) Try out the problem solving pack yourself to see how it works!

Some typical barriers that learners with mental health difficulties face

This is an exercise that you could do with colleagues when considering the kind of adjustments learners may benefit from.

<table>
<thead>
<tr>
<th>Perceived practical barriers</th>
<th>What would help the learner?</th>
<th>What could you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long formal lectures without a break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor concentration due to anxiety or the effects of medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing sessions due to medical appointments and ’bad’ periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having to sit in a room with other people for long periods</td>
<td></td>
<td></td>
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<tr>
<td>Getting out of the house for 9.00am starts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems focusing on the task in hand and organising work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t want to join in class discussions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terrified of exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End-to-end exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feel awful at break times with no-one to talk to</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Consider the practical suggestions that you and your colleagues make in the light of your own organisation’s policies, for example, flexibility of attendance and the provision of additional tutorials. Would such responses pose any problems for you or your employer? There are some more considerations on the following pages.
Other considerations for tutors

What is your code of confidentiality?

Does your organisation have one? If it doesn’t what parameters does your own personal code of confidentiality have? If you expect learners to confide in you, they need to believe that you will treat the information with respect. What does ‘with respect’ mean to you?

- Who would you pass information to?
- When would you pass information on to a third party?
- How would you pass information on?

Disclosing information

Information about learners with mental health problems should only be obtained and shared for the purpose of providing care or protection for the learner or others. Think in terms of ‘need to know’. If you intend writing down information about learners, check that you only make a note of factual information that is relevant and useful for the reader. Do not use diagnostic labels or jargon.

Consent

The learner should always be asked to consent before information about them is shared. They should know why the information is being shared, who will receive it and why they need to know. You may want to think about the ways that learners can give written consent for information about them to be shared. This may be on enrolment or at other key points. If you ask all learners, as a standard request, to agree to information about them being shared, you will need evidence that individuals have understood the consequences of the form of consent they are giving and that such understanding is current.

Make sure that the people receiving the information understand the terms on which it is given and the confidential nature of it. For learners in recovery, they may have already planned who should be contacted in a crisis. Sharing this plan can help you to give the right kind of support.

External agencies

You cannot pass on information about a learner to an external agency without the learner’s consent. This may also apply to relatives and friends of the learner. Be aware of papers containing confidential information lying around on desks. Do not leave confidential information displayed on computer screens. When the screen ‘times out’, the data will still remain for the next user to see. Find out what the protocols are in your organisation for contacting external agencies.

Exceptions to the code

There are a few circumstances where the need to obtain the learner’s consent may be waived. If their condition has deteriorated to the point where they are a danger to themselves or others, or if they have committed a criminal act then third parties will require information to help them support the learner.
Data Protection Act

Under the 1998 Data Protection Act, all data relating to a person’s physical or mental health is regarded as sensitive personal data:

- The Act covers personal data in both electronic and manual forms.
- Personal data should not be kept longer than is necessary.
- Appropriate security measures must be taken against unlawful or unauthorised processing of personal data.

Data subject rights

The Act gives rights to individuals in respect of data held about them. These include the rights to:

- Request copies of all personal data held that relates to them.
- To prevent processing likely to cause distress.
- To take action for compensation if they suffer damage or distress by any contravention of the Act.
- To take action to rectify, block, erase or destroy inaccurate data.

If you are recording information about learners, think carefully about your use of language and any assumptions you make. Always consider that the learner may ask to read what you have written.

To find out more about the Data Protection Act go to http://www.informationcommissioner.gov.uk

Find out how your own organisation protects the data it collects. Remember, the subject has the right to read any comments that you have made on their file and to seek redress if they feel the comments are untrue or have caused them harm.
Walking in the learner’s shoes

Depression, stress and anxiety are the most common types of mental illness. Learners may experience low self-esteem, low confidence levels, and fatigue but they still have the same intellectual capabilities as the rest of their peers.

Gary has suffered depression for many years. Some days he goes to a mental health day centre in Mirfield to catch up with friends, he is also a member of a self-help group and attends Dewsbury College as a student. Gary is studying Intermediate guitar and working towards a CLAIT exam.

I get a lot out of the courses, I’m a creative person and it’s very productive to play the guitar. The CLAIT course is very loose, very flexible. You are given a booklet to work through at your own pace. It’s very much a matter of working at your own pace and in your own time. There’s no competition between students.

I did a similar course on an evening. It attracted different types of people, I found it very intimidating. There were people there with very advanced computer skills, even though it was advertised as a basic computer course. I felt left behind. I felt my skills were so inadequate on the course. Others were whizzing through. They came straight from the office and worked with computers all day. They just wanted a certificate.

Because my self-esteem was low, I didn’t want a fuss so tried to work it out for myself. I did tell the tutor that I suffered from depression but it didn’t help in the way they treated me as a student.

On the course I am doing now, it’s very flexible, and I can come and go as I want. It’s a relaxed environment. I don’t feel under any pressure. There are only 5 assignments so you can work at an incredibly slow pace and still get a certificate. The tutor is very supportive.

Should a learner tell the tutor they have a mental health difficulty? I think it depends on the individual. Some people are afraid of the consequences of disclosing. They may be stigmatised. I would recommend doing it right from the start but that’s just my opinion. Some people are just not confident enough or articulate enough.

The only advice I can offer tutors is to have a general understanding and empathy, not putting too much pressure on people, allowing them to work at their own pace, leaving them to their own devices but being there to offer support when required.

Gary, a student at Dewsbury College and service user at Mirfield Day Centre (2004)
Pauline, Ivan and Mel go to a mental health day centre in Shipley. All are following courses at the Day Centre and enjoy the support provided by Shipley College tutors, however, they have had mixed experiences of adult education in the past.

**Pauline**

I did a computer course, a CLAIT exam; I had a nervous breakdown and decided I needed to do something. I did talk to my tutor about mental health difficulties. I wasn’t treated any differently to anyone else.

I think she could have spent a bit more time with me. When I came to do the exam, the first time I did it I made a mistake. I couldn’t correct it. She said I had plenty of time and could do it again. I told her I couldn’t and I looked terrible, I was shaking, but she said I could do it but she didn’t understand at all.

**Ivan**

I’m doing a course here. I’m trying to get my CLAIT. If I ever will!

I feel I can talk to the tutors here, I feel I’m in a safe place.

All staff treat you with respect for a start. They know how to talk to you. Nobody is condescending or patronising.

The college tutors I have are very good. They take a small group from the project. But I couldn’t go in the main building and do any certificates with all these young kids. They have no respect.

**Mel**

One of the first things to go is concentration. You notice that first before you realise you are ill. You can’t concentrate on anything, even your favourite soap. The first time I came here I felt exhausted and I was only here 2 hours.
### Mental health problems

There is widespread misunderstanding and prejudice about mental health, despite the fact that about one in five of the population experiences some form of mental ill health at some stage in their lives. This prejudice in itself will have an impact on learning basic skills. Depression, stress and anxiety are the most common types of mental illness. Learners may lack confidence and have low self-esteem. Learners may have the same full range of intellectual abilities as the population as a whole.

### Impact on learning

Learners with mental ill health may experience greater anxieties about learning basic skills than other learners. Some may take medication that affects their concentration, memory and their ability to participate. Short-term memory may be especially affected.

For many people their mental health may be variable, with good and bad days. This may affect their attendance, punctuality and behaviour. Some learners may be unable to engage in the learning process until relevant emotional issues are resolved. Progress will be variable, and regression can be common.

Success can mean that some learners may be reluctant to 'move on'. Assessment, particularly when it is formal (such as written tests), can be stressful and cause the person to perform below standard.

### Approaches to consider:

- Establish a good relationship and give plenty of encouragement. Deal sensitively with personal information and focus on what is needed to help the learner to learn.
- Enable learners to have immediate successes in learning.

Some learners may experience changes in behaviour that may create an uncomfortable situation in the learning environment. It is better to allow learners to withdraw, if they wish to, rather than feel obliged to 'manage' the behaviour, which could lead to confrontation. This behaviour is more likely to be caused by external circumstances rather than the current learning situation.

- Allow sufficient time for learners to settle down and demonstrate their skills to the full.
- Plan flexible programmes of learning to respond to variations in capacity to learn, attendance, etc.

For these learners, it will be particularly crucial to design learning sessions that include a variety of activities. When designing learning programmes and learning support, consideration should be given to maximising access to 'catch-up' activities when sessions are missed. (This applies equally to all learners with attendance difficulties.)

- Provide practice, reassurance and possibly extra time for formal assessments, and consider providing alternative assessment approaches when appropriate.

Discussion of personal issues can occur in basic skills classes, and teachers may begin inappropriately to take on the role of other professionals, such as counsellors. Teachers need to be clear about the extent of their role and know when and how to refer on.

Encourage a supportive environment and activities that can accommodate individuals when they find social interaction problematic.

DFES
Pete Vickers, from Joseph Priestly College in Leeds has written up a learner’s experience that illustrates how a number of small events can result in an individual giving up the idea of becoming a learner. (10)

The course I wanted didn’t run. Only four of us turned up. I was passed from pillar to post, each time I met someone new. That is what I found the hardest. I lasted until October and left college. Nobody rang me to see where I was. That was the start of five years in the wilderness.

This is what one learner had to say about her experiences of using a discrete mental health education service.

I have enjoyed the Stepping Out Programme’s Confidence Building course tremendously. Having suffered from low self-esteem, it put me under no pressure at all, and I feel that I have gone from strength to strength. I’m constantly amazed now at my own self-awareness and my ability to see things in others and pass on my knowledge. It has given me the motivation to keep learning. The teaching staff are very friendly and enthusiastic. Their caring and empathy helps you to get the most out of their courses, so anyone thinking of embarking on such a course, please do. It has changed my entire outlook on life and made it much brighter!

Linda Allinson, Stepping Out student at the Vale Day Centre.

Stepping Out Programme

The Stepping Out programme is part of the Faculty of Adult and Community Education provision run out of Park Lane College in Leeds. It is the only such programme dedicated to providing a discrete provision of courses and widening participation for adults with mental health difficulties, in Leeds and West Yorkshire.

The student group is made up of adults with diverse mental health difficulties. This can range from an individual who has no previous clinical diagnosis or contact with the mental health services, who feels that the programme is a way of making the first step back into education; to someone with a serious mental illness, such as schizophrenia or bipolar disorder.

The programme currently provides over 50 part-time courses citywide, at 12 different venues. There are 500 enrolments on the programme.

Phil Hopkins, Park Lane College, Leeds (11)
The Social model of mental health recognises the social barriers such as stigma, bullying, fear that learners face in accessing education. Read what Karen Lockey, Manager of the Cellar Project in Shipley, says about the reasons why she believes her learners enjoy attending a dedicated mental health service.

The Cellar Project's main aim is to help people move out from specialist services into mainstream services. We have clients from 16-65 who have experienced mental health problems. We do a lot of IT courses, beginners to more advanced, as well as ceramics, horticulture, stress management, catering, woodwork, desktop publishing and first aid at work.

People are referred to the project by health care professionals. Our aim is to start people off gently, and lead them onto mainstream education and employment, but we continue to support them. Mental health isn't choosy who it hits. We have a wide range of learners; they may be bank managers, college lecturers and people who have never worked.

The main problems people face when learning as adults are large buildings, large classes and perceived unsafe environments. People who have no experience of mental health difficulties don't realise the problems of socialising. We go along to help people to enrol on external courses, help them to look at the workload and their support needs.

Tutors can help by befriending people so that they feel comfortable around the tutor and comfortable asking for help. They must have good interpersonal skills. They need to set clear boundaries of what their role is. They can't be all things. They need to know when to refer on rather than take it all on themselves.

We have links to the local colleges and some of the tutors are very experienced at working with people with mental health difficulties. They receive no specialist training from us. Some tutors naturally seem to adapt but some don't, and it becomes apparent very quickly. They say 'this client group is not for me'.

Our learners need constant confidence building. If a person gets positive feedback, and continuous assessment rather than waiting to the end of the course to see how they have done, it helps.

The special thing here is that everyone who attends knows that other people have mental health problems of one sort or another, and the staff know how difficult it's been for them to get here. It's about mutual respect. Tutors working here have to have a wide range of skills. A class of 8 people may have 2 people with masters degrees and the rest with no qualifications. It can be a problem for some tutors, but not for learners. It's down to the tutor's personality.

Outside of specialist organisations, there is often fear about mental health, fear of people reaching a crisis or violence. In the 14 years I have been here I can honestly say that I can count any such incidence on one hand.

Karen Lockey Manager, The Cellar Project, Shipley (12)
What does an inclusive programme look like?

Northern College is based in a grade 1 listed building in a rural setting close to Barnsley in South Yorkshire. It runs a wide variety of courses from 2 day personal development programmes offered on a residential or day basis, to full Diploma courses. The college’s programmes are designed for adult learners and it has a particular remit to encourage disadvantaged groups to return to learn. As a result of proactive work with many disability groups, the college has a disability disclosure rate of 29.5% across its entire student population and a 97% retention rate of students in receipt of Learner Support. John Rowley, Additional Support Coordinator at Northern College was asked to describe what he thought were the key features that encouraged learners to disclose details about their disabilities. (13)

“Since I started here 4 years ago, we have had a Disability Forum and we take advice from it on everything. Detail is important. The Forum is made up of learners. They made the rules of the Forum and wrote their own Terms of Reference. We meet 3 times a year and discuss any issues they want to raise that relate to disability. I take advice from the Forum on everything. Right down to how my room is arranged for interviews, even where we sit, the choice of chairs and arrangement of the seating. It’s all down to advice from the Forum.

It’s very important to accept that every person is different. We have more than 10 support workers at Northern College. It’s important for Support Workers to be experienced at working with disabled people. They need to build up a relationship with learners because it’s not just about note taking. Confidentiality is important. Learners pass information to them and they need to then act on it. For example, we’ve had learners who experienced anxiety attacks. Sometimes, the Support Worker acts like a shield, learners say ‘just be there for me’. Once their confidence is built up, some will come to me and say ‘I don’t need anybody now, I’m fine’ that’s really good.

Some people don’t like walking through crowds. We can arrange with the tutors for them to arrive 5 minutes after the class has gone in, and leave 5 minutes later. It’s just practical support. Tutors in the main, don’t really need to make any adjustments. We have a quiet room so learners can get away from the crowd if they need to, and a Counselling service.

Cont...
Part of my role is to go out with the course tutor and design a course around the needs of different groups. We have groups that come in and run their own courses. For example, ‘Mind’ brings its own support workers in. They use our facilities but deliver their own courses. Once people come here they start to feel more confident and many learners start off as a member of a special supported group e.g. MIND, but then come back on their own to our other courses.

Last year I did 160 assessments but not everyone with a disability wants an assessment. Even when they have been assessed, they can refuse additional help, because they don’t want to be different and therefore don’t want to accept additional resource, like computers, that other students don’t get! If any learners want to build additional skills, they can through our Pathways courses.

I go out and work directly with disadvantaged groups, promoting learning and the college facilities. Staff training is important. ALL staff and most importantly, contracted workers. Don’t forget catering staff and other auxiliary workers. We are making it a requirement that all staff should receive Disability Equality training as a compulsory part of any contract. The biggest complaint we get about staff through the Forum is that auxiliary staff can be patronizing...they talk to the disability, not the person.

We are now getting ready for December 4th with our Disability Equality Scheme. We’re looking at all staff, not just the work I do. I will have input on all staff training, at induction, with contracted auxiliary workers and on Training the Trainer courses. The feedback I get is that we are already doing well but you can always do better.”

Interview with John Rowley, Additional Support Coordinator, Northern College. 2006
Key points from the interview

- You must be backed from the top. Right down to the detail such as requiring handouts in a particular font and a particular size.
- You need allies in the Senior Management Team – people who can make things happen.
- You must have a Disability Forum or similar where learners can have their views heard and appropriate action taken. Members should run the group, set the agenda and set the pace. They should also receive feedback on progress of actions taken.
- Be assertive in your demands. See things from the point of view of the learner and push that point.
- Walk around your organisation as a learner. In Northern College there are notices in EVERY classroom to inform learners about the support available and the confidential nature of it.
- Travel is important. If you are asking people to turn up for assessments, remember this is over and above the course requirements and may involve additional time and cost to get there.

How does your own course measure up?

Walk in the shoes of an average learner starting a learning programme in your organisation. Be specific. Think about one individual and one course. Make notes on the next page about the experiences a learner would have at each of the stages. Underline any experiences that learners may find particularly stressful.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Who will they meet?</th>
<th>What will they see/do?</th>
<th>What do staff need to be aware of?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Advice and Guidance</td>
<td></td>
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<tr>
<td>Pre-enrolment</td>
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<td>Enrolment</td>
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<tr>
<td>Induction</td>
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<td>First session</td>
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<tr>
<td>Additional support</td>
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<tr>
<td>Homework/assignments</td>
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<tr>
<td>Feedback</td>
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<tr>
<td>Assessment</td>
<td></td>
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<td></td>
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<tr>
<td>Exams/tests</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>If difficulties arise</td>
<td></td>
<td></td>
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<tr>
<td>Progression arrangements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On completion of their course</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Before and during enrolment

☐ Does the course literature mention support for people with mental health difficulties so that those considering enrolling are aware of the kind of support that they can expect to receive?

☐ Does the course literature mention learner confidentiality?

☐ Does your course literature make it clear for learners what they have to do to complete the course and what is optional? Does it describe flexible options (if any) e.g. drop-in workshops, extended programmes?

☐ Does course information tell learners about assessment methods, and where different exam boards can be used to offer different forms of assessment methods?

☐ Does your literature make it clear what the 'return to study' procedures are and that learners with mental health difficulties will be supported if they need to take time away from study?

☐ Is it clear in course information what the procedure is for accessing support services?

☐ Does literature explain what will happen once learners have disclosed on the enrolment form that they have a mental health or other difficulty?

☐ Learners will not always disclose personal information on cue. If a learner does choose to disclose information then the member of staff must decide on an appropriate course of action and support. This may include offering the learner the opportunity to discuss their difficulty with them (if they felt confident) or a specialist within their own or a partner organisation.

☐ Do you know how and where to direct learners to support?

☐ Are you aware of the implications of the Data Protection Act and for written information kept about learners? Did you realise that learners can ask to read any information kept that concerns them?

☐ On enrolment do you give learners more than one opportunity and way to disclose their support needs?
In the classroom or workshop

- For many years flexibility in learning programmes has been valued by adult learners. The ability to accommodate disruptions, extend learning periods, spread courses over several terms or sometimes years all contribute to making it possible for some learners who have chaotic or disrupted lifestyles to continue learning.

- What proportion of the courses you offer, have a 'flexible option'?

- Are learners asked about their preferred learning method?

- In the classroom do you challenge all negative comments about mental health in the classroom in the way that you would challenge racist comments?

- Do you offer return to learn and study skills support?

- Do you give your learners the opportunity to talk to you in an area where they cannot be overheard?

Taking exams and tests

Exams can be one of the most stressful times for any learner. Tutors can do a lot to help learners to reduce their stress levels.

Tutors can negotiate:

- Extra time for exams if they have problems with concentration, memory or anxiety, or if they need to take breaks to exercise or rest.

- Extensions for assignments if they are ill or change medication.

- Sitting exams in a different venue that might be quieter, smaller and less stressful, or sitting the exam in a private room if necessary.

- Building in a rest period between exams.
Supervising the learners overnight to enable them to move an exam into the next day.

- Altering the format of the exam, for example, dividing a three hour paper into three one hour papers or replacing some examinations with assignments.

- Have a support worker to stay with the learner through the exam.

Are you aware of the adaptations that your exam boards would accept and how to request them and the evidence they might require?

Read Amy’s views on what tutors need to know to support her effectively

I’ve just completed a Creative Therapy Degree. It was a 3 year course but took me 4 years to complete. Initially I didn’t know anything about additional support, I didn’t access it in my first year and I became very unwell. I had to leave the course in the first year and then wait and re-join.

To get additional support you had to complete a form. The form said ‘Do you consider yourself to have a disability?’ And I don’t. I suppose it is in some ways but personally no, I don’t, I’m not disabled. It was really difficult getting everything in place every year. The initial assessment had been really messy in getting the information to the individual tutors. Some tutors couldn’t remember reading it or didn’t open their emails. Sometimes I needed extra time or extensions. It was the same with library; they never had it in place. I don’t like having to stand there in public and say, ‘look I need these books, I couldn’t bring them back because…’

This year I had a support session every week, sometimes I didn’t really need it but it’s good to have that regular check-in. Time to think and consider. I found using mind maps really helpful. But she (learner support) was really helpful on college procedures, mitigating circumstances, extensions and standing up for my rights.

I don’t think tutors need to know my diagnosis, I don’t find having my diagnosis is helpful. 40% of psychiatrists don’t agree about diagnosis, and that figure came from the Royal College of Psychiatrists! I have had so many different diagnoses, and this is just the most recent.

Things that would help me are extra tutorials if I missed a lesson or don’t understand some things. Tutors understanding about the need for extensions and also not stereotyping. Sometimes mental health fluctuates. I can be hands up all the time and other times just washed out. You know, as long as they are aware. It’s up to me to take responsibility for my own mental health.

Amy, student in West Yorkshire College
Reading the signs

If we believe the statistics, then one in four of us will experience mental health difficulties in the course of our lifetime. Some of us may have experienced difficulties in the past or be going through difficulties right now.

Imagine any situation where a group of adults converge, it may be a football match, a cinema, market place. According to published statistics, 1 in 6 of the people there will be experiencing mental health difficulties. Of course it’s not that simple.

Mental health difficulties cover a wide spectrum. Not everyone will seek, need or receive hospital treatment or even go to their GP. Social class, life experiences and inherited factors all contribute to our sense of ourselves in the world, the interpretation we put on things that happen to us and our abilities to respond.

Try this exercise with colleagues. It was kindly provided by Lesley White, Day Services Manager for Sheffield Care Trust. (14) Go through the actions and decide which ones could indicate a mental health difficulty. Does the exercise tell you anything about the nature of mental illness?

Someone who:

<table>
<thead>
<tr>
<th>Actions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a Talks to herself out loud sometimes</td>
<td>✓</td>
</tr>
<tr>
<td>b Hears voices and holds angry conversations with them</td>
<td></td>
</tr>
<tr>
<td>c Says the neighbours are trying to kill him and playing loud music to annoy him</td>
<td></td>
</tr>
<tr>
<td>d Sits in the garden all day crying and shouting following a bereavement</td>
<td></td>
</tr>
<tr>
<td>e Says that nothing is worthwhile and she wants to die</td>
<td></td>
</tr>
<tr>
<td>f Suddenly gives away all his savings to <code>save the world from hunger</code></td>
<td></td>
</tr>
<tr>
<td>g Won’t catch a bus with a number 3 on it</td>
<td></td>
</tr>
<tr>
<td>h Is fearful of leaving the house, has lost his job and can’t visit his children</td>
<td></td>
</tr>
</tbody>
</table>
Which actions are signs of mental health difficulties?

Did you decide that mental health difficulties were just an extension of everyday obsessions and eccentricities that we all exhibit, or something completely different?

You probably came to the conclusion that they all could be symptoms of mental health difficulties but it depends on the duration and impact it has on the individual experiencing it. Many of us talk to ourselves, crying after bereavement is not unusual in our culture, but defining it as a mental health difficulty depends how long the grief lasts and how much it adversely affects the life of the grieving person.

‘Signs’ alone are not an adequate basis on which to form a judgement about mental health. The context, endurance, the impact on the individual, social norms and expectations all come into play. It is not possible to present a simple list of mental health difficulties, their accompanying symptoms and on that basis be able to support learners with those symptoms.

We all experience changes in mood that affect our resilience and ability to function at an optimum level in the world. One of the difficulties with diagnosing mental health is that there is often no simple test. Doctors diagnose by assessing symptoms, talking to the ‘patient’ about their experiences and history and observing their behaviours over periods of time. They seek to find patterns of behaviour in order to categorise the ‘illness’ and decide how to ‘treat’ it. This is of course, a medical view of mental health but it does not operate outside of the wider social values. For example, homosexuality was considered an official mental illness in England until 1965. What is considered ‘odd’ behaviour in one period can become acceptable in another.

A more modern view of mental health difficulties focuses on the way that the ‘difficulty’ prevents or inhibits the individual from leading a full and satisfying life and also how stigma and ignorance acts as a barrier to participation for some members of society. It is a ‘well-being’ model carrying with it a belief that society as a whole benefits from healthy happy individuals. Among people with common mental health problems, one in three has no qualifications. It has been recognised by educationalists for many years that participation in learning improves self confidence, earning power and self-esteem. People who are in work are healthier and they and their children seem to be less prone to mental health difficulties. (15)

For people working in education, it is important to identify barriers that prevent individuals with mental health difficulties from participating in learning, and working with them to remove the barriers. It also requires that we listen closely to learners and recognise that they may experience barriers that others don’t. This does not make the barriers any less real.
What support do learners want?

In preparing this pack, I spoke to many learners with mental health difficulties. They were all in agreement about the kind of support they would like from educators. In all cases, it added up to no more than good learning support. They wanted people to listen and respect their views. Flexibility of provision was important and responsive honest staff the most valued resource. They did NOT want tutors and people working in education to diagnose them, to label them, to play doctor and advise them on treatments. In most cases they felt that tutors did not need to know their diagnosis. They, the learners, were the ‘experts’ on their own condition, the tutors were the experts on learning. Good learning support was what they would like from people working in education.

The Recovery Model

People experiencing long term mental health problems, and who have sought support and enrol on learning programmes, are likely to be in recovery. Recovery is not the same thing as cure. It is the conscious and positive management of one’s own circumstances. There are several models of recovery but in the main they include the following: hope, healing, empowerment and connection. Recovery is about re-engaging with society and managing oneself in order to do that. It is also an acceptance of one’s own mental health condition as one important aspect of the whole person. (16)

Some people will accept that they will always need medication to manage their symptoms. Others find a battery of tactics and strategies that minimise the frequency and severity of their symptoms. Finding out what makes them happy, learning to recognise triggers that cause distress, recognising the signs of the onset of crisis and making plans for what to do about it, are all part of recovery. At the centre of recovery is self-esteem and ownership. A learner who is in recovery will decide who needs to know about his or her condition and what practical help is needed.

Wellness Tools

An example of a Wellness Tool has been developed by Sue Barrow and Tracey Jobes in conjunction with Nimhe(17). It is in the form of a small booklet that would fit easily into a pocket or bag. Read through the Wellness Tool. The booklet has been reproduced here by kind permission of Sue Barrow. It will give you a good idea about the recovery approach. You’ll see that the user of the tool acknowledges that their condition may decline and their wishes are outlined should such a situation arise.
Section B

Wellness Recovery Action Planning

**Step 1 Wellness Tools**

“In short your wellness tools are a list of day to day things that make you feel good.”

A few examples may include the following...
- Going to the gym
- A cup of tea
- Hot bath
- Listening to music
- Being alone in a quiet place

Now write down what makes you feel good on the opposite page.

**Step 2 Triggers**

“Triggers are a list of actions or situations that will remind you of an unhappy or hurtful situation, feeling or experience within your life.”

A few examples may include the following...
- The smell of something
- Locked doors
- The sight of something
- A certain place
- The sound of something

Triggers can be anything!!!

**Step 3 Early Warning Signs of distress**

“This should be a list of warning signs that will tell you that your health is beginning to decline.”

Questions to ask yourself could include...
- Am I still doing all on your list of wellness tools?
- If not why?
- Are you doing them at the same time?

It’s important to recognize your early warning signs!

**Step 4 Decline**

“At this stage your wellness tools are failing. No matter what you try you feel worse every day.”

A list of signs that you are declining could typically include...
- Staying in bed all day
- Not eating
- Not moving
- Feeling down

**Step 5 Crisis Planning**

“Unlike the first 4 steps of WRAP which can be completed alone, should you wish, step 5, crisis planning, to the nature of what it involves, will need you to consult, involve and get the agreement of other people.

The crisis plan is a list of instructions, i.e. dos and don’ts, what should be implemented on your behalf should you not be able to do so yourself.”

Examples of crisis planning could include...
- Someone will pick up the children
- They should be out of the house
- The dog should be out of the house
- The dog should not be seen by a vet doctor
- Please do not force me to test...
A similar approach could be taken in an education setting by learners who are confident in the support they will be offered by tutors or specialist staff working in learning organisations. It should never be underestimated how much trust is required to share the details of such a plan with a tutor or support worker.

Hope

A key factor in recovery is hope. At a basic level, the individual must believe that recovery is possible. Hope is about small steps, recognising achievement, looking forward, setting priorities and goals. Such hope can be squashed if the learning institution itself does not support the learner and provide real opportunities. (17)

“Potential learners can be constrained by low expectations, with some college and health and social care workers assuming that they cannot or do not want to access mainstream education, and that they will not want to undertake accredited courses. For many people, taking part in mainstream learning at the local college will promote better health outcomes. However, particularly at the outset, it may be necessary to provide additional support, especially if the student is moving away from home to study and having to form new support networks.’

Action on mental health: A guide to promoting social inclusion.

Tricia Clark works provides learning support at Bradford College. She uses a wide range of strategies to support learners who come to her. She describes her work as ‘coaching skills’ and compares it to the kind of support that professionals and sports people seek to enhance their performance. (18)

<table>
<thead>
<tr>
<th>Tricia</th>
<th>My job entails assessing the additional learning needs of people who declare some kind of need. The first thing I do with the student is to discuss how their difficulties might in the future impact on their learning. The next thing to look at is what practical support they might need and whom and on what basis we might share the information so their needs can be met.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glyn</td>
<td>Is it counselling?</td>
</tr>
<tr>
<td>Tricia</td>
<td>It’s definitely not counselling and nor is it a form of therapy. I do have quite a bit of counselling training in one way or another. I use some of those skills for example active listening. Active listening is a very important skill in counselling and in what I do. It’s not just what they say but how they say it. How they present when they say it. Some of the most important work that I do, students tell me afterwards, is when I ask them ‘Is that what you really think’. Because their body language, facial expression, the tear in their eye tells me something else. I don’t ignore that. What I do, hopefully before it happens, is create a relationship with students sufficient to be able then to say to them, ‘what was that about’.</td>
</tr>
<tr>
<td>Glyn</td>
<td>What do you call what you do, if it isn’t counselling and not therapy?</td>
</tr>
</tbody>
</table>
Tricia

I call it Coaching. I liken it to a personal trainer when going to the gym. It's accepted these days that 'normal' people can have a personal trainer. Someone who encourages them to go to the gym, to engage in the work, extend their performance, to use strategies. ‘If you want to do this, maybe this programme would help’. It's a bit like personal training for the mind. Now I've got quite a number of students who recognise and value the fact that even at those times when they would not say that they are having difficulties they still value the support in developing their positive mental well-being.

Glyn

What does a session look like?

Tricia

Varies according to the needs of the student. Often students will say for example, I want to work on confidence or their negative self talk, because they impact on their learning. One of the strategies I use is to ask people to think about language; how they talk to themselves. We look at language and how we can change it. We look at where it comes from and how you could make small changes. Seemingly small changes can have a big impact. We use what we call the Change Strategy. When people catch themselves in negative self talk they are able to tell themselves to stop. Stop. Why am I thinking that? We look at choice quite a lot. People can feel that things are the way they are, it's always been this way and there's nothing I can do about it. This can be quite a revelation. It's very powerful for people to look at where they have a choice and what their choices are, what choices they are making and why they make them. Students often say to me that one of the most important things they get is their sense of power back. They may not have choices about things that occur to them, but they do have choices about how they respond.

So choice strategy. I use something called the GROW model. It's a way of looking at goal and target setting. And that's really important to people with regard to their learning. It may be that we look at learning goals but this is not always the case. We may look at other things to do with housing, or confidence building or whatever is impacting on them. I don't get into the deep psychology, the history, the story behind it. I don't go there, that's not my job. I look at this situation and at how this is impacting on them and their learning, attendance, performance and ask them what they want to do about that.

GROW, G is for goals and target setting, R is for the reality of the situation, where are the issues that you need to consider, O is options that you have available to you. From those options the student will be encouraged to identify the next step. The W is for will. A strategy I use a lot with students is to look at the difference between Wants and Commitment. Students often say I want this, I want that. We look at the reality of the situation. If that's what you want to achieve, then what are your options. Then, from those options, the student will be encouraged to identify the next step and decide what they will do.

Glyn

I spoke to one of your students and she talked about coming off medication within a month of starting to see you. Is that something you encourage learners to do in general?
| **Tricia** | No, never. I don’t encourage people to do anything specific. It’s very much led by them. Some students have reached the decision to withdraw from medication and sometimes I’m not aware of it until they tell me afterwards. What happens is that they will start to recognise an improvement in their own well-being and they see alternative strategies that work for them. And maybe those things will work for them instead of medication. It’s important for a lot of people to consider whether or not they will be able to be free of medication at some time. Some of them have been on medication for a long time and don’t know if they will ever be able to be free of it. If the issue of medication comes up, I always stress to students that they MUST involve the appropriate mental health professional or GP, whether reducing amounts or coming off it altogether because I can’t advise them on that. |
| **Glyn** | In terms of the skills you use, is there anything the average tutor can use? |
| **Tricia** | I think the time and the ability to be able to sit down with somebody on a one-to-one basis and explore the issues and decide which strategy to use and then actually work through this does take time. My average tutorial is an hour or an hour and half, often once a week. We might just use one strategy in a whole session. I use the analogy of a tool kit. The idea is not that the student should become dependent on me, but that they should take these strategies as tools to add them to their own toolkit. I don’t see any reason why course tutors couldn’t use the tools if they have time. It’s the time and the training to do it. |
| **Glyn** | Anything else you would like to say about the way that you work with learners that may be useful to tutors. |
| **Tricia** | 2 fundamental things. The whole process is student led. When students first come in I ask them where are they at that moment, about current events, and what they would like to work on. I don’t have a pre-set agenda. |
| **Glyn** | Do students know what they want to work on? |
| **Tricia** | It does take time for them to be able to do that. I might make suggestions in the early stages. I would listen very carefully to what they say and pick up an issue, but in time they do it themselves. Because it’s student led, it doesn’t fit with a lot of things like tutorial observation for example, where often people are required to prepare in advance with targets and agendas. It doesn’t work like that. Although I work with mental health difficulties, what I do applies to a whole host of learners. They are very general issues, relationship difficulties, concerns about work, studying, financial difficulties. We all have those issues. So, what I’m doing is responding to somebody and the issues that they bring. I am not consciously dealing with somebody with Bipolar Disorder or Schizophrenia. I might know that that’s their diagnosis but I’m not dealing with their Bipolar Disorder. And sometimes I’m not dealing with issues, sometimes I’m working with someone’s well-being. I’m giving them the tools to stay well. |
Now read what one of Tricia’s learners has to say about the support she received.

<table>
<thead>
<tr>
<th>Rachael</th>
<th>I’d suffered with depression for three and half years before going to college. I put this down on the application form when I joined.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glyn</td>
<td>Were you happy to do that?</td>
</tr>
<tr>
<td>Rachael</td>
<td>By that point, yes. When I first started with depression I didn’t like telling anybody, but by that stage it was, ‘look, this is me’. Tricia contacted me because of the application form. I don’t think I’d have sought out help myself….well I didn’t know it was there. When I first came to college I realised I had dyslexia and Tricia picked it up. I look back at school and realise I should have got support there.</td>
</tr>
<tr>
<td>Glyn</td>
<td>What effect did the support have?</td>
</tr>
<tr>
<td>Rachael</td>
<td>It was fantastic, changed my life. It showed me a new approach to doing things. I’d done the cognitive behaviour therapy before, I was on stacks of medication, I’d done counselling but nothing had worked. I’d been through everything. I started college in September, I saw Tricia in October and by mid November I came off the tablets. I’d attempted to come off before and I’d taken them for 3 yrs. But always went back on.</td>
</tr>
<tr>
<td>Glyn</td>
<td>What made you feel confident to do that?</td>
</tr>
<tr>
<td>Rachael</td>
<td>I just knew basic strategies that Tricia taught me would work. I could see how effective they were instantly. Tricia used to say they were simple but not easy.</td>
</tr>
<tr>
<td>Glyn</td>
<td>Can you give me an example?</td>
</tr>
<tr>
<td>Rachael</td>
<td>Evidence baskets. I had a tendency always to look on the negative side. Tricia made me talk about the words I used. We imagined weighing scales. Negative words in one side and positives in another. She made me examine statements, visualising things.</td>
</tr>
<tr>
<td>Glyn</td>
<td>How often did you see Tricia?</td>
</tr>
<tr>
<td>Rachael</td>
<td>Often, once a week. It was important,…the main reason I came to college in the first year. I couldn’t bare the thought of not having that support. If she’d not been there I’d have left. When I came off my tablets, I leant on Tricia quite a lot at that time. I struggled with college and was going to give up. We then used the ‘Wants and Commitment’ strategy.</td>
</tr>
<tr>
<td>Glyn</td>
<td>What’s that?</td>
</tr>
<tr>
<td>Rachael</td>
<td>Wants are not real…I want to win lottery but I don’t buy a ticket.</td>
</tr>
<tr>
<td>Glyn</td>
<td>Have you taken skills with you?</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Rachael</td>
<td>My whole life is completely different. It's now just part of life, a new way of thinking. My husband saw the transformation and he became really interested. It taught him a few things about himself.</td>
</tr>
<tr>
<td>Glyn</td>
<td>Could an average tutor use these skills in a classroom or are they very specialist skills?</td>
</tr>
<tr>
<td>Rachael</td>
<td>Average tutors could use some of them. It's just about everyday life for a person. It's such a big problem. I know so many people with mental health issues. This should be part of schooling; teaching how to manage our own emotions. It's something you never get taught about. You're taught how to help other people but never taught about yourself. One of the problems with general tutors is they struggle to see people as individuals and find out what they need. My class teachers didn’t make allowances for me and this helped me, but some could have been more sensitive. I once had a little bit of a breakdown and the tutor didn’t know what to do and just pushed it away. She didn’t know how to cope with it. One of my tutors said to another student 'she won’t get anywhere'. I’m currently studying midwifery at Bradford University.</td>
</tr>
</tbody>
</table>

There are many categories of mental health difficulties. One of the most frequent types is depression. It is estimated that 1 in 4 people in the UK will experience depression at some point in their lives. Social background, poverty and employment are all factors that are reflected in the statistics of people experiencing mental health difficulties. The World Health Organisation (WHO) suggests that 1 in 7 children will experience mild forms of mental health difficulties and 1 in 14 severe mental health problems. Children from the lowest social classes are more likely to experience difficulties than those from more affluent backgrounds.

**What kind of difficulties are we most likely to see in adult education?**

There are many different ways of viewing mental health difficulties. The dominant view in England is the medical model that is a diagnosis based on symptoms. Here are a few of the most common diagnoses. (1)

**Mood Disorders** - such as depression characterised by low moods, loss of pleasure and interest, poor sleep, feelings of worthlessness and guilt, poor concentration. 2%-3% of young adults will be clinically diagnosed as having depression. Diagnosis is dependent on the presence of specific symptoms, e.g. loss of interest or pleasure, feeling sad or empty, over a given period of time. Depression can lead to suicide. Therapy can be useful and in more severe cases, a combination of therapies and medication.

**Bipolar Disorder** - this tends to affect men earlier in life than women. It’s thought that early treatment in childhood could halve the rate of cases in adults. The learner’s mood will change from depression to inflated self-esteem. Talking therapies along with medication can be very effective.
Self monitoring is an effective way for people with bipolar disorder to predict episodes of mania or depression.

Anxiety Disorder - this can include generalised anxiety disorder, features include excessive anxiety, restlessness, easily tired, irritability, poor sleep. It may include panic attacks - pounding heart, shortness of breath, sweating fear of going crazy or dying. Between 5%- 10% of young people will have anxiety problems that will affect their ability to live a ‘normal’ life. Therapeutic support includes listening and understanding, and helping people to find ways of coping with their feelings.

Obsessive-compulsive disorder - ideas or urges that seem to force themselves into your mind, fear that self or others may come to harm. To attempt to ‘neutralise’ the fear people may perform rituals such as repeatedly washing hands, counting repeating phrases, touching, arranging items, checking and re-checking doors and windows, etc. It’s thought that 1% of young people have OCD. Some people get better on their own, but treatments are available.

Deliberate self-harm - can be the way that people find release from the pressure of experiences that have left them feeling guilty, bad or ashamed. This behaviour clearly put young people at risk and can continue into adulthood if not treated. More than 10% of young people self-harm. This can be through drugs and alcohol as well as the more obvious cutting, and burning of skin. The intention may be to create scarring, but such dangerous practices can lead to death. Therapeutic support can be helpful to contain or reduce risk. In some areas, managed self harm is being piloted. In the same way that needle exchanges hope to ensure that drug users practice their drug use safely.

Psychosis - tends to occur in episodes and can last a few hours, days or weeks at a time. The severity, symptoms and distress caused by the condition vary enormously from one person to another. The symptoms of psychosis are the development of distorted thoughts and beliefs, for example, people may believe that others are ‘out to get them’, to harm their property or to kill them. The individual may hear voices as clearly as if a person was standing next to them, but the voices are imaginary ‘auditory hallucination’. The most common form of psychosis is Schizophrenia. It affects 1% of the population and the most common time for it to start is between 15 – 35 years. Schizophrenia is a disabling illness and young people require specialist psychiatric support that may include anti-psychotic medication that alleviates the most distressing symptoms.

Eating disorders - anorexia nervosa and bulimia. These are much more than ‘slimming disorders’. People with eating disorders may maintain normal body weight and their condition may be undetected for years. Anorexia often starts in the teens and is thought to be linked to low self-esteem and physical or emotional abuse. The need to control their weight dominates all emotions and thoughts. Bulimia includes excessive eating then purging using laxatives and vomiting. Bulimia is estimated to affect between 1-2 % of women aged 15-40. Anorexia affects between 1-5 women in every 100,000. The onset is usually age 16-17 yrs. Long term damage can include irregular heartbeat, damaged kidneys and eroded teeth. Symptoms that affect learning can be low moods.
Does ‘knowing’ who has mental health difficulties and what they have help you as a tutor?

Although the list of mental health ‘diagnosis’ seems long and varied, the barriers to learning presented by the different types of difficulties are remarkably similar. Fatigue, lack of confidence, coping with the effects of medication, may need to take time off for medical appointments, etc.

What would you need to know if a learner comes into your organisation with a broken leg?

- You might ask if they need help getting upstairs (if appropriate!).
- They may need to sit by the door to get in and out of classrooms more easily.
- They may need help with travel to and from the building.
- You may need contact details to notify family/ partners/ friends if they run into difficulties.
- They may need to leave the classroom at short notice without a fuss (cramp).

What else might they tell you?

- They may be taking pain killers that affect their concentration.
- They may have to go to hospital appointments and miss classes.
- They may feel embarrassed and prefer to study at home until the pot comes off.

The information above will help you to enable the learner to continue with their studies. It may help tutors, reception staff or security to better support the learner. In the main it is practical information. The support is dependent on the learner disclosing and requesting. It is also dependent on the organisation’s willingness to meet the requests.

Mental health difficulties are a little different. Firstly they are not as obvious (in the main) as a broken leg. So it is down to the learner to raise the subject of support. Secondly, it is socially acceptable to ask people with broken legs how they did it and if it hurts. This is not the case in our culture with mental health or indeed with other physical disabilities e.g. someone using a walking stick.

The key difference between support for learners with mental health and support for learners with physical disabilities is that the learner or their advocate must request it. The tutor can, however, help by making sure that there are lots of opportunities for the learner to request support.

Once support has been requested, it can be treated as any other learner support. Because of the stigma attached to mental health difficulties, learner confidentiality is particularly important. Who needs to know and how will be very much dependent on each organisation’s protocols and policies.
What do you really need to know?

Always ask yourself - ‘How will knowing about a learner’s mental health difficulty help me to support them better? Would I treat them differently to other learners? Do I need to treat them differently? If so, how?’

In most cases the answer is that it wouldn’t help. Consistent good teaching and support is all that most learners need. Plus the invitation to discuss their own particular support needs in a practical, non judgmental and non-patronising way.

The modern view of mental health and well-being includes:

- A sense of well being and contentment.
- A zest for living.
- Resiliency – being able to deal with life’s stresses and bounce back from adversity.
- Self realisation.
- Flexibility – the ability to change and grow.
- A sense of balance in one’s life.
- The ability to care for oneself.
- Self confidence and good self-esteem.

Some people recovering, or just starting with mental health difficulties may not be as resilient as their peers or have quite the same ability to ‘bounce back’. It’s often the simple expressions, e.g. a welcome smile, being prepared to listen, that makes the difference between a learner starting a course and leaving before they get to the reception desk. When I asked learners with mental health difficulties what mattered to them, the most frequent reply was, ‘being treated with respect and being listened to.’

Learners who are in the early stages of developing mental health difficulties may not realise it. Your role could be vital in ensuring that they seek support and an early diagnosis. Research shows that mental health difficulties in adults could be halved if symptoms were picked up early. It also means that the individual avoids prolonged and unnecessary distress.

Some tutors try humour to help learners who they believe are experiencing mental health difficulties. Whilst it is important for tutors to be themselves, humour can also be very unwelcome when used in the wrong place or when the learner is the butt of the joke. On the other hand, over sensitive tutors can make the learner feel like an outsider.
There’s nothing ‘funny’ about feeling stressed, depressed or ‘different’. Read about John’s experience below.

**John’s story**

John enrolled on two courses at his local FE College. He hoped to get into University to study Media. He decided early on in the courses to tell his tutors that he had an obsessive compulsive disorder. He didn’t believe that his disorder would affect his studies but he was aware that he lacked confidence.

John described one of his tutors as his “guardian angel”. She was supportive and enthusiastic. She told John that she believed that everyone deserved an education and that she was certain he would be successful. John was successful and gained an A grade in her subject.

John was not so fortunate in his second tutor. He thought that the tutor found it difficult to look at him, was uneasy around him and would avoid eye contact. His fears were confirmed when she welcomed him to his second lesson with the words “it’s OK, we take psychos here’. John left the course after a few weeks and dropped his ambition to go to University. He is very philosophical about his experiences though annoyed about the insensitivity of one of his tutors.

When asked what kind of support he would like, he said “to be treated with respect, like everyone else. Sometimes I need things to be repeated or explained twice. I lack confidence, so it really helps if tutors are supportive and let me know when I’ve done something well.”

**Mirfield Day Centre service user**

**Self help and information**

If you would like to find out more about different mental health conditions and their symptoms the Mental Health Foundation website is excellent. www.mentalhealth.org.uk and select ‘Problems and Treatments’

There are many mental health support sites on the Internet. To get a feel for them and see how they work try some of the websites on the following pages and make a note of those that you think may be useful for your learners and colleagues. You may want to point your learners or colleagues to these sites, but check them out first to make sure that they are appropriate to the learner’s needs, reading ability and interest. Your organization may already keep a directory of mental health support services, or you may have your own in-house counselling and/or learner support provision. It is important to find out what the correct protocol is before pointing learners to external agencies. Some learners may already be receiving confidential support from in-house services.
### Some support organisations

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Telephone</th>
<th>Website/Info</th>
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</thead>
<tbody>
<tr>
<td>Careline</td>
<td>020 8514 1177</td>
<td>Confidential telephone helpline. It offers support in many languages, including Hebrew, Gujarati, Punjabi and Urdu.</td>
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<tr>
<td>Eating Disorders Association</td>
<td>01603 619090</td>
<td><a href="http://www.edauk.com">www.edauk.com</a></td>
</tr>
<tr>
<td>MIND</td>
<td>020 8519 2122</td>
<td><a href="http://www.mind.org.uk">www.mind.org.uk</a></td>
</tr>
<tr>
<td>National Phobics Society</td>
<td>0870 7700 456</td>
<td><a href="http://www.phobics-society.org.uk">www.phobics-society.org.uk</a></td>
</tr>
<tr>
<td>SKILL (National Bureau for Students with Disabilities)</td>
<td>020 7450 0620</td>
<td><a href="http://www.skill.org.uk">www.skill.org.uk</a></td>
</tr>
<tr>
<td>The Mental Health Foundation</td>
<td>020 7535 7400</td>
<td><a href="http://www.mentalhealth.org.uk">www.mentalhealth.org.uk</a></td>
</tr>
<tr>
<td>The Samaritans</td>
<td>020 8394 8300</td>
<td><a href="http://www.samaritans.org.uk">www.samaritans.org.uk</a></td>
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</tbody>
</table>
Section B

Websites that offer advice to individuals. A copy of the table can be found on the CD ROM accompanying this pack.

<table>
<thead>
<tr>
<th>Website</th>
<th>What does it offer?</th>
<th>Who might be interested?</th>
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</thead>
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<tr>
<td><a href="http://www.support4learning.org.uk/health/stress.cfm">http://www.support4learning.org.uk/health/stress.cfm</a></td>
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<tr>
<td><a href="http://www.at-ease.nsf.org.uk/what_is.html">http://www.at-ease.nsf.org.uk/what_is.html</a></td>
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<tr>
<td><a href="http://www.leeds.ac.uk/ahead4health/index.htm">http://www.leeds.ac.uk/ahead4health/index.htm</a></td>
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<tr>
<td><a href="http://www.bbc.co.uk/health/mental/emotional_index.shtml">http://www.bbc.co.uk/health/mental/emotional_index.shtml</a></td>
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<td></td>
</tr>
<tr>
<td><a href="http://www.mentalhealth.org.uk/">http://www.mentalhealth.org.uk/</a></td>
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</table>
Who supports the supporters?

Staff who become involved in supporting learners with mental health difficulties, may themselves need support. It’s a stereotype to assume that all learners with mental health difficulties will pose a problem for tutors. The vast majority of learners will manage their own difficulties and tutors, family and friends may never know about them. If learners do decide to disclose their difficulties to tutors it will, in the main, be practical support that they are seeking, e.g. flexibility of attendance, additional tutorials or permission to bring digital recorders into lessons. There may, however, be times when tutors and support staff may feel out of their depth, confused about their role and unsure what to do with information that has been given by the learner. Informal support of any learners can take its toll and be quite draining on individuals who have no experience, training or expectations in this area. Particularly if they do not know where to refer learners for support or feel that the learner is dependent on them.

Any employee working in a learning environment may become the first point of contact for learners with mental health difficulties. The onus is on the organisation to adequately prepare and support its employees for the roles they may take on when working with their clients, the learners.

How can organisations support their staff?

- Develop support networks.
- Develop and promote clear protocols for dealing with issues that may arise.
- Develop policies that reflect values and beliefs held by the organisation.
- Design inclusive staff training programmes that take account of everyone’s contribution to the support of learners.
- Provide information about learner confidentiality at induction and in Continuing Professional Development.

Phil Hopkins ran the Stepping Out programme, part of the Faculty of Adult and Community Education provision run out of Park Lane College in Leeds. It is a programme dedicated to providing a discrete provision of courses and widening participation for adults with mental health difficulties. (11)

The student group is made up of adults with diverse mental health difficulties. This can range from an individual who has no previous clinical diagnosis or contact with the mental health services, who feels that the programme is a way of making the first step back into education, to someone with a serious mental illness, such as schizophrenia or bipolar disorder.

Phil described in an interview the kind of skills tutors need to support learners with mental health difficulties and the kinds of support system that he and his team have developed to support themselves.
What is the range of mental health difficulties that you come across?

We never really measure people’s mental health. We have people who may have no history of working with the mental health services, they may have seen their GP, they contact me because they are just lacking in confidence and they want to get back into education. The programme is a good way to ease them back into learning.

We also have people with more serious difficulties like schizophrenia and bipolar disorder and very serious mental illness. Do you have formal training for trainers working on your programme?

“We don’t have formal training. I spend a lot of time with new tutors offering them support, and also giving them some reading information and material; fairly simple stuff because I don’t want to frighten new tutors and they may only be teaching for a few hours for me.

Do your tutors find the work stressful?

They are very busy, and often tutors are teaching out of the back of their car, travelling to community venues and mental health day centres or hospitals; it’s easy to forget about ourselves and our own mental health.

Because I have a large team of tutors, 15 different subject specialists, it’s hard to support everyone and taking into consideration my own mental health limits, it would be unreasonable for me to support 15 tutors throughout the year. We devised a buddy scheme. The team was divided into groups of 3 or 4. They meet once a month and also keep in telephone contact with each other to talk about work situations that come up. These are very casual, informal meetings and could be a few members of staff sitting in a tutor’s car in the car park of a day centre. They find a space for themselves where they can be uninterrupted. They can discuss any concerns they may have and speak freely, knowing that what they say will not go beyond the group.

What kind of things do they discuss?

It may be a tutor that is having particular difficulties and they may find a better way to work with individuals. When working with people with mental health difficulties, tutors can gather a lot of bad stuff. Students will disclose information about themselves that can be distressing. You can take it home with you and carry around in your head. The buddy system is one way to manage this.

The buddy system is similar to the way that a team of counsellors might work. They have something called supervision. A place where they can talk independently of their colleagues, to a trained individual, a ‘supervisor’. They can ‘off load’ some of the work related issues that may be bothering them and also celebrate the good stuff that they do. The focus is on work not personal life issues.

It’s about supporting one another really. It’s important that all teams working with people who have mental health problems should have an opportunity to talk about any concerns they have. It doesn’t require any special skills to set this up. We don’t in FE have time to discuss the way that teaching experience affects us personally. In social services or the health world they do.

Phil Hopkins, Stepping Out Project Manager, Park Lane College, Leeds (2004)
Mentoring/buddying - a system of staff mentoring could be set up to work across the organisation to facilitate and promote good practice in supporting learners experiencing a range of difficulties.

A less formal and local ‘buddying’ system could be set up by departments. Its purpose would be to provide a regular forum for staff to discuss issues of concern about the nature of support for individual learners. Such a process would need to operate within clear protocols of confidentiality.

Debriefing - debriefing should be managed by experienced counsellors. It would provide a debriefing service for staff who want to discuss their experiences of supporting learners. Fears that an incident could have been prevented or that action taken was inappropriate are symptomatic of the concerns staff have about their own adequacy in dealing with situations. Debriefing is important to enable staff to express their fears and address them.

Do you know?

- How many of your colleagues are or have been involved in supporting learners with mental health difficulties?
- What the ranges of difficulties they experience are?
- Where tutors go for information and support?
- Whether tutors feel they have the skills and knowledge to take on this role?
- Whether tutors believe this is a part of their role?

One way to start to raise awareness of mental health difficulties in your organisation is to carry out a survey of your colleagues. This could be a questionnaire given out at staff meetings or a sample of face-to-face interviews. The University of Hull carried out a survey of its staff and found that over one third of the academic staff had experience of supervising learners with mental health difficulties and over a quarter felt that they did not have the knowledge, skills and experience needed to deal with them.

2. The Learning Needs of Young Adults with Mental Health Difficulties. NIACE Briefing Sheet. 2002 The Briefing Sheets can be found on http://www.niace.org.uk/information select ‘Briefing Sheets’ and then ‘Young Adults MHD’ (2)

3. Interview with Lesley White, Day Service Manager, Sheffield Care Trust, 2006

4. Interview with John Pattinson, Care Services Improvement Partnership (C SIP) Regional Development Centre for North East, Yorkshire & Humber

5. Interview with Andrew Cambridge, Manager, Future Prospects, York 2006


7. Interview with Diane Heywood Positive Assets Coordinator, Humber Mental Health Teaching NHS Trust. 2006


9. The DFES has published on its website some guidelines for approaches to consider when supporting learners with mental health difficulties. Source: www.dfes.gov.uk/curriculum_literacy/access/mhealth


11. Interview with Phil Hopkins, former Stepping Out Project Manager, Park Lane College, Leeds. 2004

12. Interview with Karen Lockey, Manager, Cellar Project, Shipley. 2004

13. Interview with John Rowley, Additional Support Coordinator, Northern College 2006

14. Resources and exercises informed by materials kindly provided by Leslie White, Day Service Manager, Sheffield Care Trust


17. Wellness Tool reproduced by kind permission of its creator Sue Barrow.

18. Interview with Tricia Clark, Learning Support Tutor and Life Coach, Bradford College 2006
Developing more inclusive services

How to use this section
This section of the pack is for managers and those responsible for learner support services. It looks at the economic cost of mental health difficulties and some of the factors to consider when developing your Disability Equality Scheme. It also offers templates for those wanting to develop inclusive policies.
The cost of mental health difficulties

It has been estimated that almost 900,000 people on Incapacity benefit claim their primary condition to be mental ill health. 1 in 3 visits to the GP are related to mental health difficulties and work related stress affects about 1 in 5 workers. Output lost from time off due to depression is around £4 billion per year. If GP time, costs of mental health trusts, drugs and social services are added to the lost work output of those experiencing mental health difficulties, we would arrive at a grand total of £25 billion per year - over 2% of GDP. It is not surprising that the government has turned its attention to mental health, learning and work. (1)

Welfare Reform Bill - The Bill aims to end the ‘legacy of benefit dependency and deprivation’ and seeks to achieve 80% employment rate for people of working age. In order to do this, the government will have to reduce the number of people on benefit by 1 million and particularly target older workers and lone parents (300,000 lone parents into work). A significant number of those in receipt of benefit will have mental health difficulties. The reform claims to focus on what people can do rather than what they can’t.

A raft of initiatives has been launched to re-focus benefits and associated mental health services. There will be mandatory work focused interviews and various incentives to return to work, including improved support for job seekers and encouragement to employers to offer more flexible working arrangements. People coming off benefits will be eager to ensure they do not move to a lower standard of living. For many, earning more than a minimum wage will mean that they need qualifications and an obvious next step would be to seek, or be directed to training.

Mental Health and Social Exclusion Report - This report was published in 2004 and represents a significant step change in the government’s policy and practices around mental health. The report focuses on the removal of barriers to learning, employment, services and community participation for those experiencing mental health difficulties, and was produced in consultation with service users and service providers. (2)

The National Social Inclusion Programme is responsible for implementing the recommendations set out in the Mental Health and Social Exclusion Report. It has established a cross governmental team with national and regional partnerships. The key outcomes for the programme that are of interest to education providers are:

- Changes to Incapacity Benefits - making them more supportive and encouraging people with mental health difficulties to return to work.
- The LSC’s prioritisation of adult learners with mental health difficulties.
- The setting up by NIACE of nine regional learning and social care networks of mental health service providers.
An increase in access to Direct Payments for people with mental health difficulties to enable them to pay for the right kind of support to reintegrate into the community, learning and the workforce.

Shift - a national anti stigma and discrimination programme focusing on media reporting of mental health.

**Action on mental health** - published by the Social Exclusion Unit - is a comprehensive guide to promoting social inclusion. It presents a holistic approach to supporting individuals with mental health difficulties and is divided into 12 very readable Factsheets that focus on a wide range of services including: Health and Social Care, Employment, Welfare Benefits, Housing, Ethnicity, Families and Carers, Criminal Justice System, Financial Service and Education and Training.

The Education and Training Factsheet - comprises guidance on supporting individuals with mental health difficulties, case studies, advice on staff training and ways to fund additional support.

You can get a copy of the Factsheets from [http://www.socialexclusionunit.gov.uk/](http://www.socialexclusionunit.gov.uk/)
The Disability Equality Duty (DED) - What is the Duty?

All public organisations have a duty to ensure equality of access to services for everyone. We all share the same hopes and aspirations for our families and ourselves. The Disability Equality Duty for the public sector aims to ensure that people with disabilities are treated fairly. The duty covers all functions and activities, not just employment and service delivery, but budget setting, procurement, regulatory functions and setting the framework within which the organisation will deliver services.

The duty requires public authorities, when carrying out their functions, to:

- have due regard to the need to promote equality of opportunity between disabled people and other people.
- eliminate discrimination that is unlawful under the DDA.
- eliminate attitudes towards disability-related harassment.
- promote positive attitudes towards disabled people.
- encourage participation by disabled people in public life.
- meet disabled people’s needs, even if this requires more favourable treatment.

Evidence gathering

The DED focuses on the practical aspects of access and this involves evidence gathering, not as an end in itself but as a means of engaging people with disabilities, which includes mental health difficulties. It requires providers to measure current provision, plan and take action to address inequalities and measure the effectiveness of actions taken.

Nationally, there is no single data source on disability. Prevalence data is collected through various household surveys. Often the data is not disaggregated by ethnicity, age group, impairment, etc. Questions around mental health in the surveys tend to use terms such as ‘ill’ or ‘disability’. These terms come from a medical model of mental health, and can be confusing for those responding and analysing the responses. People may consider themselves to be ill but not disabled and vice versa.

In order to measure and challenge access issues faced by people experiencing mental health difficulties, providers must recognise ‘barriers’. The Social Model of disability suggests that access and inclusion problems are in the main created by public attitudes to mental health, lack of understanding and blinkered social structures. If such barriers are to be dismantled then a thorough understanding of their construction and the purposes they serve is essential.

Alongside the Duty is the requirement for all public authorities to develop a Disability Equality Scheme (DES). This represents practical implementation of the Duty.
The Disability Equality Scheme (DES)

The scheme applies to all major public authorities. It is in essence a vision statement and assessment of current practice in relation to disability equality and an action plan for improvements. The Scheme must be published by the 4th December 2006. It can be contained in other documents but it is essential that disabled people know where to find it. In the months leading up to December 2006, providers must carry out a self assessment of current practices and gather evidence to draw up their completed DES. The DES must be reviewed annually and rewritten/revised every third year. It is vital to understand that the DES applies to learners, potential learners and employees with mental health difficulties, equally.

There are essential elements that the scheme must cover:

- A statement of how disabled people have been involved in developing the scheme, both staff and learners.
- The action plan (steps to be taken by the authority).
- How performance information on disability equality will be gathered.
- How the impact of the activities will be assessed.
- Details of how the authority will use the information gathered in continuous improvements in employment and service provision.

The Disability Rights Commission (DRC) has the power to take legal action if authorities fail to deliver against their DES.

The Guidance put out by DRC suggests that the DES should demonstrate commitment at the very highest level and the introduction should be signed by the Chief Executive or equivalent. They recommend that a senior member of staff should take overall responsibility for developing the scheme and its implementation and that a disabilities ‘expert’ may be helpful in drawing up the Scheme.

How do you know what you don’t know?

Evidence gathering is an essential component of the DES. Take a few minutes to consider ways that you currently involve learners in continuous improvement of your services. Complete the grid on the next page.
## Section C

### Current involvement of learners

<table>
<thead>
<tr>
<th>Collecting evidence</th>
<th>Do you do this?</th>
<th>Who designs the method and content?</th>
<th>What happens to the data?</th>
<th>Are learners with mental health difficulties identified as a sub group?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveys and questionnaires</td>
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<td>Interviews</td>
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<td>Enrolment data reviews</td>
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<td>Mystery shoppers</td>
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<td>Other</td>
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Each method will have its own strengths and weaknesses. Quantitative data will provide quick statistics, e.g. the percentage of people who disclose mental health difficulties on application, but it will not tell you about the experience of disclosing. Focus groups are more likely to tell you about the quality of the experience. Similarly, data collected on retention rates will not tell you anything about the retention rates of those with mental health difficulties compared to those without, unless you are able to link disclosure data to retention data and compare different sub sets.

Getting to the heart of the problem

From whose point of view do you currently collect information? Who creates the surveys or forms? Where does the information go? Who has access to it?

If you want to collect meaningful information:

- ask those with disabilities what barriers they experience (staff and learners).
- involve the target groups and representatives in designing surveys and questionnaires.
- involve the target group in analysing responses if you want to get to the heart of the barrier and prioritise actions to remove it.
- provide feedback on progress to participants in a form that is useful and relevant so that they can 'see the point' of participating.

It is only by consultation and involvement with the target groups that you will start to build up a picture of the barriers people face. It will also help you to know where to put your efforts and not extend less effective data collection that gives general feedback across all learner groups.

Target setting

Target setting is central to the DES and as the guidance states:

“To establish successful outcomes for disabled people it will be important to know what success will look like.”

Involvement is different to consultation. It requires active participation by representatives of the group in influencing and challenging the organisation’s decision making processes. Mental health difficulties are very individual and it will be more important for the service provider to show that they are capable of meeting the needs of an individual learner than providing general equal opportunities to a group. This requires policies and protocols to ensure that the individual is at their heart.
Identifying indicators of success can be difficult. For example, statistics showing a reduction in the use of specialist learner support services could indicate a) there are fewer learners/employees with difficulties b) services are invisible to many learners/employees i.e. they don’t know that they exist c) the whole organisation has become more inclusive so there is less need for special support. To find out the true reason why demand is lower, the organisation would need to do some qualitative research involving the target groups, both those who use special services and those who don’t.

**Disclosure**

Disclosure rates in many organisations can be very low. The DRC recommends that participants should understand the terms by which they contribute information and that this will increase confidence in the data collection processes and improve disclosure rates.

What participants should know before providing personal information.

**Voluntary**
- Participation is voluntary.

**Confidential**
- Personal information about participants will not be passed on or disclosed to others without their consent. In some cases it is important to be able to cross-reference data, e.g. enrolment and retention data. Where this occurs, any further documents produced must take care to conceal the names of participants and retain anonymity.

**Transparency**
- It should be clear to participants why data is being collected, how the data will be used, and when and how participants will receive feedback on progress.

**Positive**
- Participants should be informed that the data is being collected to enable the organisation to achieve equality of access to its services and what will happen to them as a result of providing the data.

**Accessible**
- Participants must be able to make sense of the questions and be able to access help to complete the survey/questionnaire/interview if needed.

**Involvement of disabled people**
- It should be clear that a representative group of disabled people have been involved in the creation of the survey and will be involved in the analysis and actions resulting from it.

**Data protection**
- Participants should know that the information they have provided will not be traceable to them. Anonymous data, that is data that is not traceable to individuals, is unlikely to be covered by the Data Protection Act. Where it is possible to trace individuals through data provided, the individuals concerned must be made aware and have the right to decline to provide information.

**Trained staff**
- Participants should benefit from trained staff administering the information gathering process. Staff should understand the purpose of the data collection and be sensitive to issues of disclosure and confidentiality.
Section C

Making sense of the data

Analysis of the information/data you collect will be an essential part of the Disability Equality Scheme. It may compare:

- before and after data on specific outputs such as participation, disclosure, attendance.
- progress in removing identified barriers.
- before and after attitudinal surveys.
- performance indicators between different learner groups.
- your own organisation's performance against that of others.
- the inclusion of service users in your development processes.

It is important to be able to differentiate between responses from learners/employees with different mental health difficulties. It is also useful to be able to analyse data by department or type of course and to explore the reasons why some parts of the organisation appear to be more inclusive than others.

Monitoring employment

The DES produced by public authorities must include arrangements for recruitment and the retention and development of disabled employees. These arrangements may include reviews of applicant numbers, types and grades of jobs being undertaken by disabled people, training attended, career progression, full time/part-time mix, reports on harassment and disciplinary action and analysis of exit interviews.

The DRC recommends that employers regularly resurvey staff on disability as impairments can develop at any stage in a working career. All learning providers collect data and may feel that they already have much of the information they need to hand. A first step in developing the DES will be to evaluate current data sources and clarify exactly what they tell you. For example, data kept on learners who request adjustments only tell you that! It will not tell you how many learners would benefit from adjustments, and so may not be a reliable indicator of actual need.

The Mental Health Trust approach

When thinking about service user involvement, it is worth looking at some of the ways that the Mental Health Service providers employ service Users. Diane Heywood is the Positive Assets Coordinator at Humber Mental Health Teaching NHS Trust. One part of her role is to develop service user involvement to inform continuous improvement in the Trust's services. (6)
It's not just about consultation. Service Users are involved in lots of areas in the Trust; research, job interviews and training. One of the pitfalls to avoid is using the same people all the time. In every area of your workplace there will be one group who are very vocal, and what happens is that you keep going to that group because it’s easy. You must keep asking ‘are they representative of the whole group, or just themselves?’

Another factor to consider is ‘are you going to pay people?’ If so, will it affect their benefits? For example we use service users on job interview panels. So if you’ve got other people on that panel being paid and if you expect the service user to know what they are doing and to turn up and do a good job you need to pay them like everyone else on the panel.

Participants go on Recruitment and Selection training and we pay for them to be trained. We’ve had service users, interview for senior posts such as Directors and we try to get a service user on every mental health Trust interview. People in the Trust take them very seriously. We find the service users are often the most experienced people on the panel. If you take an average manager, they may interview 3 times a year tops, whereas the trained service users are interviewing all the time.

Service users take part in all sorts of training about mental health. They talk about their own experiences. They also do research. We pay user researches, because if we want people to be open, they are more likely to talk to other service users.

Also they’re involved in monitoring services. MOSOS (Monitoring Our Services Ourselves) is a group of volunteers that monitor how well the Trust is doing against standards and advise on actions where they spot a weakness.

What I’d really like is to involve service users in appraisal. If you apply this to a college, you could ask the student to say 3 good things about their lecturer and one thing they would like them to develop.

Diane Heywood, Positive Assets Coordinator 2006
Section C

Embedding the Disability Equality Duty in relation to mental health

Work through the list of ‘ways of working’ that support the DES and tick those that you think your organisation does well and those you feel it does less well or not at all. Each point could be ‘unpacked’ to explore what it really means within the context of your work and what evidence you have to show that you do it well. You can add some of your own ‘ways of working’ or work with a group of colleagues to consider the list.

<table>
<thead>
<tr>
<th>Some good ways of working</th>
<th>Well</th>
<th>Less well</th>
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<tr>
<td><img src="image" alt="Lightbulb" /> Working with external and internal specialists to develop in-house training and review support services.</td>
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<td>Ensure that ALL staff are involved in awareness training and training around mental health, including Security staff, Catering staff, and Reception and Library staff.</td>
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<td>Review staff workloads regularly and in a systematic way, anticipating mental health support needs.</td>
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<tr>
<td>Have an effective system that gives learners many opportunities to disclose. Feedback on disclosure rates to staff.</td>
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<tr>
<td>Provide clear protocols for staff to support learners in a wide variety of situations. Ensure that this includes Security, Catering, Library and other support staff.</td>
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<tr>
<td>Engage learners with mental health difficulties in the ongoing development of your policies, procedures and programme development.</td>
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<td>Work across the organisation to share good practice.</td>
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<td>Feedback progress on learner support developments to all learners and staff in a meaningful and relevant way.</td>
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<tr>
<td>Devise effective monitoring systems for your support policies and involve learners with mental health difficulties in monitoring the support services you offer.</td>
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<td>Participate in campaigns to raise awareness of mental health.</td>
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<td>Participate in cross sector regional networks such as the ones managed by the LSC’s and NIACE.</td>
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<tr>
<td>Support your staff through mentoring or buddying systems.</td>
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- 91 -
As you implement your DES, you will be working with the strengths and weaknesses of your organisation. For example, the effectiveness of staff training in mental health issues will probably mirror the effectiveness of staff training in other areas. This may be a good opportunity to review staff training effectiveness overall and look at some of the current ways that you measure the impact of training on your organisation.

**Developing or revising a student mental health policy: why bother?**

The process you work through with staff and external support agencies when developing your DES will, of itself, raise awareness and interest in the subject. Think of the process as staff training.

A central consideration of any DES project group may be the updating or creation of a Mental Health Policy. Policies enable the organisations to establish meaningful protocols and processes through which learners can access support. They standardise the nature of support across an organisation for both staff and learners.

**Where to start**

First you need to decide whether your organisation believes that it should develop a separate policy, protocols and procedures specifically for those experiencing mental health difficulties! Some providers feel that the act of producing a ‘separate’ policy reinforces the idea that mental health is ‘different’. Tricia Clark, Learning Support Tutor at Bradford College describes how her College’s policy was developed. (7)

Bradford College decided against developing a separate policy for learners with mental health difficulties but reviewed its existing policies to make sure they were inclusive. On the next page is an example of Bradford College’s ‘Student Return to Study Procedure’ presented as a flow chart. You can see how the procedure would apply to any student with attendance problems.

You can view the set of Bradford College protocols and procedures on the CD ROM accompanying this pack. The flowcharts and protocols may be copied and amended for your own purposes on condition that Bradford College is referenced as the source and named within your new document.

N.b. The Bradford College protocols were developed several years ago. In the light of the Disability Equality Scheme, think about ways that you could increase the involvement and representation of learners and employees with mental health difficulties in the consultative process of developing policies.
Following some specific incidents involving students thought to have mental health difficulties and concerns that staff were not sure how to respond to these, the College’s Senior Managers requested a working party be set up to develop policies, protocols and procedures for dealing with students with mental health issues. A working party was set up that consisted of the Heads of Student Services, Department of Learning Support, Counselling Service, College Health Centre, Admissions Department, and a course tutor. This was ‘led’ by myself, Learning Support Tutor for students with mental health issues.

From the outset the working party decided it was inappropriate to develop separate policies and procedures specifically for those with mental health issues. We set out instead to produce protocols and guidelines for staff which focused on specific situations rather than singling out particular groups of students, which we felt would be prejudicial even if well-intentioned. Past experience has shown that it is not just those with diagnosed mental health issues who may present themselves in such situations.

The Head of the Department of Learning Support regularly fed back progress to the College Directorate. College staff were given the opportunity to comment on the draft protocols before they were passed through the appropriate channels and finally incorporated into the Management Information Handbook and the Personal Tutor’s Handbook, both of which are available to all staff in hard copy and on the College’s Intranet.

When devising the protocols, full account was taken of existing policies, such as those relating to disability, data protection and confidentiality, and particularly health and safety. Account was also taken of existing disciplinary and emergency procedures and reporting mechanisms. The work was further informed by AMOSSHE and DRC guidelines on good practice and policies/protocols readily available from other similar institutions via a national mental health network, of which I am a member.

We were concerned that the protocols, procedures and guidelines should be in a readily accessible format, rather than long-winded documents. A flow chart format was used for the two main protocols: ‘Protocol for Responding to Personal Emergencies’ and ‘Protocol for Responding to Distressed/Troubled Individuals’. A ‘Return to Study Procedure’ was also devised in a flow chart format. Further guidance was given for responding to an individual where there is a possibility of a substance overdose, for dealing with distressed or troubled individuals and for evaluation following an incident/situation. This guidance is given in the form of succinct bullet points and/or questions which serve as prompts. The protocols outline step-by-step actions to be taken, including clear indications of issues to consider, who else to involve and how and when to report and to whom. Staff consultation on drafts of the protocols and the appendices indicated that the format was indeed user-friendly, the content sound and that they served the intended purpose.

Tricia Clark, Bradford College. 2004
Student Return to Study Procedure

Absence Trigger Mechanisms
- Frequent Episodic
- Absence

Documented Interview with Course Tutor (to include the following questions)
- Is there a problem that is affecting student health or attendance?*
- Is there a particular problem at College that is affecting student health or attendance?
- Is there anything the College can do to help improve student attendance?
- What else might be done to improve the situation?

*Student to provide medical evidence of fitness to return where required (Fmed3-GP sick note) or complete a Personal Sickness Certificate in accordance with 4.2.3 of Student Handbook

Consult if appropriate:
- Student Services
- Counselling Service
- Dept. of Learning Support
- Health Service

No further action required

Action Plan and Review in accordance with Tutorial System

Ongoing monitoring of student by Personal Tutor

Is the student managing course work and responding appropriately to College environment?

Yes

No

Review meeting with:
- Student
- Student Representative (optional)
- Personal Tutor
- 1 Senior Departmental manager

5 day notification and outline of purpose of meeting to be given by Personal tutor
Written summary of meeting to be given to student

Referral to Dept of Learning Support

Voluntary deferment or withdrawal from course

Disciplinary Procedure
The project team

Whether you are developing a new policy or re-visiting an existing one, a good way to start is to set up a project team. The team should represent the whole organisation and include admin staff, students, support services, teaching staff and senior managers. The team will need a named ‘leader’ who will be responsible for taking the initiative through to completion. Here are few considerations,

- Don’t just invite the usual suspects.
- Look for diversity of contribution including learners and external specialists.
- Think about development opportunities for people.
- The team should look like a diagonal slice through your organisation.
- See the project as an AWARENESS RAISING process for those involved, and their colleagues. Involvement is part of the training.

If you expect all staff to implement the policy, then representatives from all staff roles should be involved in its development and ownership.

Expertise

It is essential to involve mental health experts and learners when drawing up or amending your policy. You may wish to invite them to join your project group in the early stages, or to attend specific meetings. There are many benefits to this approach. Your project will be informed by up-to-date thinking in the field of mental health, you will be able to find out what other training organisations are doing and your organisation will develop links to support agencies that may be crucial in enabling you to design systems to effectively support staff and learners in the longer term.

Further sources of information

A suite of materials has been designed to provide practical advice, tools and examples for adult learning providers.

Core document: The journey towards disability equality
Booklet 1: How to actively involve disabled people
Booklet 2: How to gather and use information to improve disability equality
Booklet 3: How to carry out disability equality impact assessments
Booklet 4: How to take a whole-organisation approach to disability equality
Booklet 5: How to meet the employment duties
Booklet 6: How is the disability duty different to the race equality duty?

These documents can be accessed from the Learning and Skills Network website www.LSNeducation.org.uk/pubs/ then search by core document title or author.
References for Section C


   http://www.socialexclusionunit.gov.uk/


5. The DRC has produced Guidance on Involving Disabled People in work undertaken towards meeting the Disability Equality Duty. It can be downloaded from http://www.ecu.ac.uk/guidance/disability/guidance.htm

6. Interview with Diane Heywood, Positive Assets Coordinator, Humberside Mental Health Teaching Trust NHS. 2006

Frequently asked questions

An on-line focus group of mental health experts came together between the 17th and 20th July to respond to questions put by tutors working in Adult Education in Yorkshire and the Humber region. The questions came from an on-line survey of tutors carried out in June 2006 and also included ‘frequently asked questions’ raised in mental health workshops that had taken place in the region over the past year.

The on-line focus group

Liz Johnson  Acting Head of Patient Experience, Social Inclusion and Diversity, Sheffield Care Trust
Pauline Bispham  Media Officer for POSITIVE Mental Health, Leeds North West Primary Care Trust
Andrew Cambridge  Manager, Future Prospects
Tricia Clarke  Learning Support Tutor, Bradford College
Vicky Utting  NIACE Regional Project Officer – Mental Health for East Midlands
Diane Heywood  Positive Assets Co-ordinator, Humber Mental Health Teaching Trust

The following pages contain a summary of the responses from the on-line focus group. A full copy of the on-line discussion is on the CD ROM accompanying this pack.
**Day 1 - Summaries and key points**

1. What are the common mental health difficulties that tutors in mainstream organisations are likely to see in their learners?
2. Based on your own experiences of learners with these difficulties, what are the common barriers/difficulties they will face in staying on their learning programmes?

Learners with quite an extensive range of difficulties are now common in mainstream education - anxiety problems and panic attacks, depression, bipolar disorder (otherwise known as manic depression), obsessive compulsive disorder, post traumatic stress disorder and schizophrenia are all common difficulties that learners in mainstream education experience. The most common barriers are lack of awareness, knowledge and understanding by those around them and fear and prejudicial assumptions, particularly with regard to conditions like schizophrenia. Many are still frightened by this label and make unfair, unfounded or misguided assumptions about individuals who have this diagnosis. Other factors which impact on learners staying on programmes are a lack of 'user-friendliness' or flexibility in application and admission procedures, within programme structures and scheduling, methods of delivering, exam systems & scheduling etc and also lack of appropriate support.

- Each person is unique and they will have developed their own coping strategies for their own difficulty. It's important that students have opportunities to regularly review with tutors the support they require.
- Always challenge negative comments about mental health. In any student group there may be people with mental health difficulties, and if they see you 'go along' with the attitudes they are unlikely to open up.
- Anxiety/depression, this is often related to their own feelings of self worth, and embarking on a new course of study can often trigger very negative feelings relating to their early experiences of education.
- It may also trigger feelings of guilt to women returners who have been used to giving to other members of the family, and not putting themselves first.
- Very low self-esteem, which can often have an effect on their learning, making them feel that they are incapable of learning.
- Learners may feel their problems are insurmountable. They must know who they can talk to. It was the one-to-one support offered to the students that was always cited in the Evaluation reports as the most valuable support. Tutors should always assume that they may have a range of learners with a range of barriers and should be championing equality and diversity throughout their delivery. Incidentally my colleagues who work with other 'unseen' disabilities like dyslexia, medical conditions, etc, advocate exactly the same principle and practice, e.g. don't ask learners to read out loud, do provide regular food and rest breaks, etc, regardless of what you actually know about individual students. Good practice is good practice - for all!
It is important that any tutor can see past any diagnosis and consider the individual barriers that any health issue could create.

Be aware of the barriers that learners face if they have to take time off during a course and then return.

Diagnosis does not give us insight into the predictability of their outcomes. There are people with schizophrenia who need little support and people with depression who need much more. Their own learning history may have more to do with success in learning than their mental health condition.

Organisational systems need to be in place to support both the tutor and the learner.

We also need to make sure that there is zero tolerance for discrimination. It is all well and good putting in the structures but just in the same way that, for example, we automatically challenge racist language, we need to ensure an accepting culture within the tutor and wider student population, and we must challenge whatever comes up that needs challenging (direct or indirect discrimination).

Adult (especially return to learn mature) learners find barriers to accessing learning. A mental health difficulty can amplify any of these barriers in addition to ones created by the mental health problem, e.g. side effects and stigma.

Day Two

1. How do I recognise `signs' that indicate a student may have mental health difficulties and is not just being awkward?"

2. If a tutor thinks that a learner is experiencing mental health difficulties (this may be because of behaviour that has changed or they have become disruptive to others) how should the tutor broach the topic with the learner?

Pauline Bispham

“I will reply from the perspective of being a student myself and experiencing mental health problems. I think the work load and pressure on my M.Sc was intense plus I was travelling 35 miles each way from Edinburgh to Stirling. I know that my severe depression came on very quickly and it would have been hard for tutors to 'read the signs'. One day I was experiencing sleeplessness but struggling into Uni, the next day I could not function. My tutors and co-students were really surprised when I rang in to say I was going to have to take time out and wasn’t sure if I would be back that year or not.”
I guess I didn’t put anything on any application forms about health problems as it was 9 years since my previous spell of depression and I felt it wasn’t ‘relevant’. So I didn’t ‘disclose’. I don’t want to generalise from my experience just to emphasise how hard it must be for tutors to ‘spot’ problems in some cases. What helped was that my tutor obviously had had someone in her family with mental health problems and just said take as much time as you need to get yourself right then come back.”

Many tutors express concerns about personal safety and learners with mental health difficulties. The Mental Health Alliance provides some useful statistics to put this in perspective. Learners with mental health difficulties are more likely to harm themselves than anyone else.

- Homicides by people with mental health problems are rare: of 873 homicides in 2002, less than 5% were attributable to mental illness.
- Violence has not increased as a result of care in the community: the frequency of such homicides has remained the same since the 1950s, whilst the total number of homicides continues to rise.
- Prejudice about mental illness remains a major social problem. The most recent surveys commissioned by the DH show rising levels of hostile attitudes among the public.
- Most homicides by people with mental disorders are among those not in contact with services. Over 1 in 4 with schizophrenia, and over half of offenders with personality disorder had never had contact with services.

Day 3

1. What is the first point of contact for building up support networks between learning providers and Primary Care Teams? Are there specific education liaison people working in Primary Care teams?

2. Can you suggest effective ways of working to raise awareness about mental health in colleges and other adult learning organisations?

A whole organisation/college approach is the only way.

Pauline Bispham:

“In 2002 I attended Park Lane College Horsforth campus as an evening student taking Spanish. I was not working in mental health at the time. I saw posters and post cards from the ‘MIND OUT’ campaign, displayed along the corridor. They stayed there all year. I felt it sent out powerful signals that this college took mental health seriously.”
The profile of mental health can be raised by curriculum activities. (Pauline has produced a book called ‘Basic Media Skills (2006)’. The book is a good way of opening discussions with learners about society's attitudes to mental health and for tutors to look at their own attitudes and assumptions.)

Mental health topics can be incorporated into many curriculum areas. Media studies is an obvious example, but any programme that includes communication skills can look at making complaints to the media via letter or phone calls. Numeracy courses could develop surveys about learners' views on mental health or monitor mental health reporting in the press and on television.

Organisations can run awareness campaigns and involve the Student Union, learners and health care specialists. Get mental health on everyone's agenda.

Raising awareness amongst learners could be achieved by incorporating material into student inductions, personal group tutorial programmes, etc, and also by incorporating it into the curriculum of courses such as Citizenship, Health & Social Care, etc. I'm sure more use could be made of Student Unions too.

Pauline cited Liz Sayce who writes on social exclusion, stigma and discrimination in terms of mental health, has identified what she thinks 'works':

- Public attitudes tend to change when people meet mental health users/survivors.
- People tend to take their peers more seriously than officialdom e.g. video on mental health made by students and distributed with lesson plans to all local schools for 15-16 yr olds.
- Enhancing positive attitudes may be as helpful as reversing negative ones.
- Good to profile how people with mental health problems are contributing not taking.
- Crime and mental health are key issues - there is a need for accurate statistics and an emphasis on the fact that service users/survivors are responsible for only a tiny fraction of violent crime (I noticed that violence/unpredictability was an undertone of one of the questions earlier in the week and Liz Johnson quite rightly challenged it).

From Psychiatric Patient to Citizen' by Liz Sayce. 1998 Basingstoke:Macmillan

Other ideas from the group:

There is an increasing emphasis nationally on prevention and mental well being so the amount of available literature and resources is increasing. As well as staff inductions perhaps it is useful to include this in the student induction programme.
One of the most effective ways of making contact with the appropriate support people is through the NIACE/NIMHE Network. There is a lot of information on the Primary Care Trust websites; these can be accessed through the NHS website www.nhs.uk. Once you find your local Primary Care Trust website they will provide links to any specialist posts. Organisations such as Sheffield Care Trust which is a health and social care trust, is responsible for both health and social care and, therefore, has good links to local authorities. In other areas, functions may be less integrated so it would depend on the local area. The following posts/roles may have a particular interest in linking up with education:

- Occupational Therapists working in mental health.
- Community mental health services.
- Services provided through the voluntary sector - housing, advice, employment, etc.
- Recovery/Rehabilitation services.
- Support Time and Recovery Workers (STR).
- Some organisations have specialist services related to employment and or vocational issues.

The key issue is that tutors have access to advice and a referral network. This type of contact could easily be organised on a college wide or departmental basis. It’s important that tutors concentrate on what they are good at. That is assisting learners on their journey.

Having a mental health champion could be useful. Positive images are always useful to remind everybody that the negative stereotypes and poor information they see through the media are inaccurate, ignorant and out of date.

Organisations need to consider who is best placed to link to external specialists. Any referral must involve negotiations with the learner. Tricia Clarke describes how she works with external specialists:

“In my experience, who might make such contact, when and how, is best negotiated with the learner as early on as possible. I usually ask learners, if possible when they are relatively well and coping, to consider this in the context of a bigger conversation about what they would want to happen if they became unwell. It is my experience that learners are quite willing to have support staff liaise with partners, parents/carers, care/heath workers etc but reluctant to have course tutors involved in this way. Also, in our context, tutors would consider this beyond their remit and would not expect to do this.”
Don’t just raise awareness amongst staff. The attitudes and reactions of peers are just as important. Look on the major mental health websites such as MIND. Send off for their materials and join their campaigns.

Art and creative writing projects can be used to promote positive images of mental well being.

Ideally mental health awareness should be included in all teaching qualifications.

Many healthcare professionals have teaching and awareness raising as part of their job roles. Linking in with them will be useful.

Work with a named person within college - a mental health support worker or a development worker. Tutors need support and to be careful not to overstretch workloads and boundaries.
Myth buster

Only a small minority of people experience mental health difficulties

895,900 adults on Incapacity Benefit in England report their primary condition to be mental ill-health:

- 1 in 3 GP consultations concern mental health issues.
- 1 in 6 adults in England has a mental health difficulty at any one time.
- 1 in 4 of us will experience mental health difficulties in the course of our lifetime.

The CBI has estimated that output lost from time off due to depression anxiety and stress is around £4 billion a year. The total cost of mental health difficulties is £25 billion per year. This represents 2% of the gross GDP - that's everything that we in England spend and invest each year!

Children don’t experience mental health difficulties, they’re just naughty

In a study of 10,496 households carried out in 2004, one in ten children aged 5-16 years was found to have a clinically diagnosed mental health disorder. Social factors appeared to affect the incidence of mental health difficulties:

- 16% in lone parent families compared to 8% in two parent families.
- 17% in families where the parent had no educational qualification compared to 4% in those who had a degree level qualification.
- 20% in families where neither parent worked compared to 8% where both worked.

Those who talk about suicide don’t do it

In one survey, over 70% of those who killed themselves discussed it with someone in the 2 months prior to their deaths. Around 4,500 people kill themselves each year in England. That’s nearly twice as many as those who die as a result of road traffic accidents. Until 1961, suicide was a criminal act in England; hence the term ‘committed suicide’. For people aged 15-24, suicide is the third most recorded cause of death.

Differences between ethnic groups can be seen in suicide statistics. One study found that the suicide rate of young women between 16-24 yrs, who were of Asian origin, was 3 times that of their white counterparts.
People with mental health difficulties are likely to be violent

You are 4 times more likely to be attacked by someone who regularly abuses alcohol than someone with a severe mental health difficulty. The media tends to report on mental health matters only when it can draw a link between mental health and criminal activity.

In 2005, a survey of national newspapers found that 27% of stories in the press linked mental health difficulties to murder or criminal activity. Mental health was reported as a matter of public safety rather than a health concern.

Not surprisingly, journalists sourced their stories from the Police and Courts so the vast majority of stories they reported related to criminal activity. Only 6% of the stories consulted health care professionals, carers or the person reported on for comment:

- People with mental health difficulties are far more likely to injure themselves than injure others.
- People with mental health difficulties are six times more likely to be victims of homicide than the general population.
- Less than 5% of people who kill a stranger have symptoms of mental illness.

Care in the community has increased the violence we see on the streets

There has been no increase in stranger homicides in the last 30 years since Care in the Community was introduced. Home Office figures show a decrease in attacks by people with mental health difficulties, though homicide figures overall have increased.

Once you’ve had a mental health difficulty you can’t work or study

Employment and education are key factors in many people’s recovery from mental health difficulties. Goal setting, re-engaging with social groups, access to resources and meaningful activity can be as crucial to recovery as clinical care and medication. Many people that you know socially, work with or teach, will be managing their own mental health difficulties and will need little, if any, special support from employers or colleagues. A general well-being awareness and good supportive learning and employment practices are all that most people need from colleagues, tutors and employers.
## Quiz Answers: What do you know about mental health?

1. What proportion of people experience significant mental health difficulties at any one time, according to the Office for National Statistics?
   
   **According to the Office for National Statistics, 1 in 6 people experience significant mental health difficulties at any one time.**
   
   *(Source: Office for National Statistics 2000 (ONS))*

2. In interviews with almost 8,000 families in Great Britain (sourced from general Child Benefit records held by the Dept. for Work and Pensions), what percentage of young people aged 5-16, were found to have a clinically diagnosed mental disorder?
   
   **5%**
   
   **8%**
   
   **10%**

   *(Mental health of children and young people in Great Britain. 2004)*

3. In a Mental Health Foundation survey carried out in 2000 with 528 respondents, what percentage of respondents said that they couldn’t tell their families that they had mental health problems?
   
   **42%**

   *(Source: Pull Yourself Together: Mental Health Foundation 2000)*

   The survey also found that 74% felt that they couldn’t disclose their difficulties on application forms and 19% couldn’t tell their GPs.

4. What ratio of GP consultations are concerned with mental health issues?
   
   **1:10**
   
   **1:3**
   
   **1:2**

   *(Mental Health: Britains Biggest Social Problem? Richard Layard. 2004)*

5. What is the most common symptom of mental distress?
   
   **anger**
   
   **fatigue**
   
   **crying**
   
   **violence**

   *(Source: Office for National Statistics (ONS))*
|   | What percentage of people with mental health difficulties said that they have experienced discrimination in the workplace? | 7%  
|   | 17%  
|   | 27%  
|   | 47%  
| (Source: The Mental Health Foundation, Pull Yourself Together 2000) |
| 7 | Which of the following is NOT a symptom of developing a mental health problem? | loss of appetite  
|   | increase in time spent alone  
|   | sleeping a lot  
|   | **loss of intelligence**  
| (Source: Change your mindset, Mindout) |
| 8 | What number of people on Incapacity Benefit in England report their primary condition to be mental ill health? | 100,020  
|   | 454,200  
|   | 865,900  
| (Summary of Intelligence on Mental Health: Dacorum 2005) |
| 9 | The Disability Equality Scheme (DES) relates to which of the following? | All are covered by the DES |
| 10 | One of the definitions of discrimination under the DDA is failure to make a reasonable adjustment when a disabled person is placed at a substantial disadvantage in comparison to a non disabled person. *Reasonable means... | What a member of the public thinks  
|   | What your governing body thinks based on the evidence  
|   | **What a judge in a court of law thinks is reasonable**  
|   | The DDA, Part 4, imposes a legal obligation on education providers so ultimately a Judge would decide, but only after taking account of all the other aspects. The governing body is the responsible body under the Act |
| 11 | In a survey of newspapers in 2005, what percentage of articles relating to mental health focused on violence? | 10%  
|   | 27%  
|   | 40%  
| (Mind over matter. SHIFT - 2006) |
Half day training session on learning and mental health

This section contains everything you will need to run a half day mental health awareness session. It includes a PowerPoint presentation, Agenda, Session Plan and Handouts.

Aims:

- To raise awareness of the prevalence of mental health difficulties in the general population and learner population in particular.
- To encourage participants to review their own services for inclusivity.
- To encourage discussion about existing protocols and policies operated by the organisation.
- To encourage participants to consider ways to involve service users in the continuous improvement of services.

An Agenda for the half day training session can be found on the next page. The PowerPoint presentation, Session Plan and Handouts are on the CD ROM accompanying this pack.
Learning and mental health

Half Day Programme

Registration and welcome

Introduction to facilitators and each other and an outline of the day's activities

Session one: Why mental health?
Pairs Quiz to discover some of the statistics about the prevalence of mental health difficulties in the UK population.

Session two: How is it for you?
This session looks at the legal obligations and financial consequences of not addressing the need to support learners with mental health difficulties. It includes case studies that bridge the gap between theoretical practice and real life situations.

Refreshment break

Session three: Culture, language and stigma
A personal reflection exercise, then a game looking at examples of media coverage of mental health and the impact of stigma and stereotyping that we all are complicit in.

Session four: Your organisation's obligations
This session invites participants to review their own working practices in a systematic way. It comprises small group exercises and results in an action plan and discussion of next steps for the organisation.

Optional session: Hands-on search of websites
Participants need Internet access and will work through a series of Mental Health support websites and rate them for their usefulness to tutors and learners.

The session is a balance of facilitator input, small group work, pair work and whole group work. It invites you to reflect on your own ideas and assumptions about mental health and how this affects your working practices. You will identify and explore some of the barriers that people experiencing mental health difficulties face and consider your own and your employer's legal obligations.
Be kind to yourself.