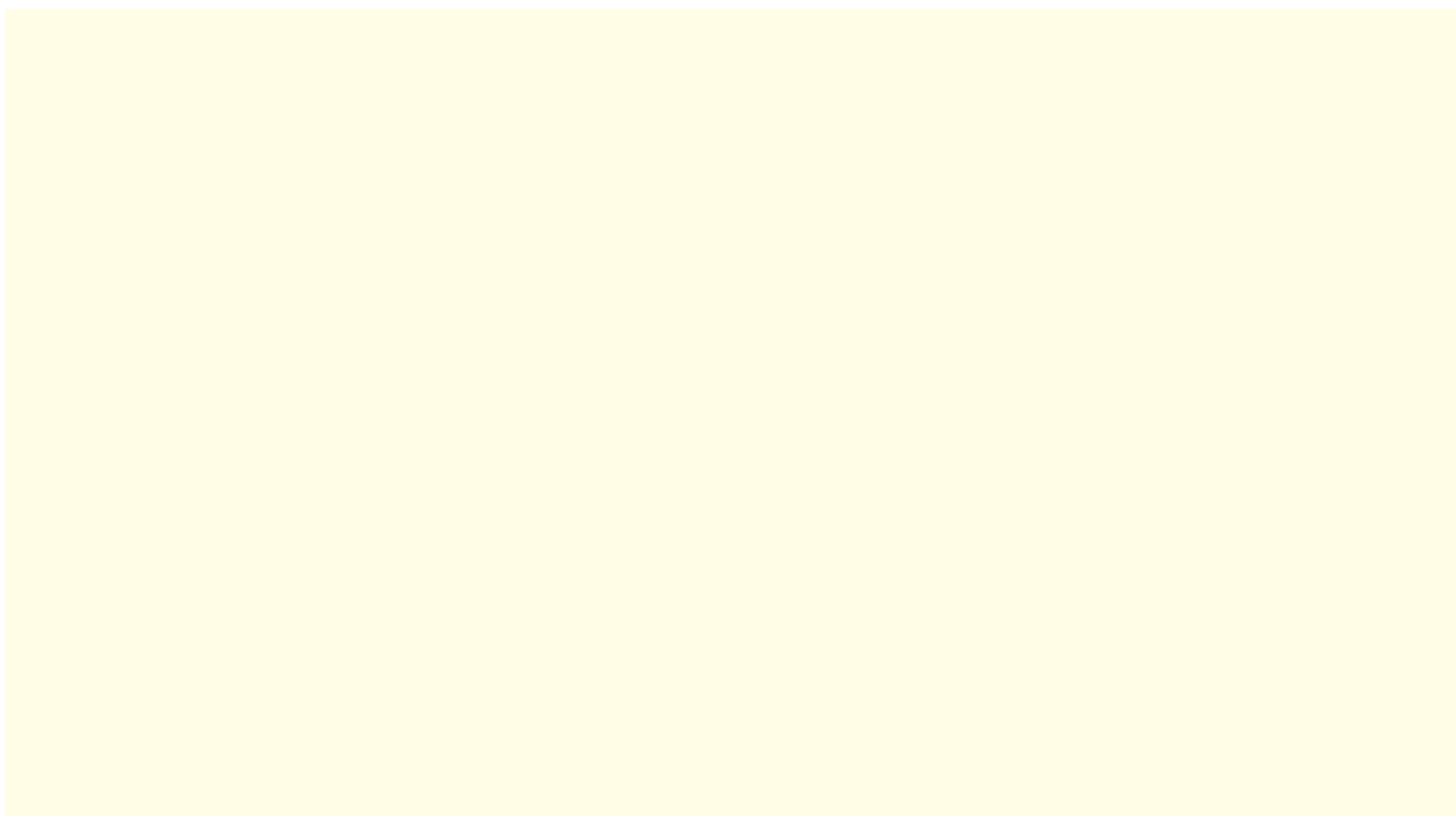


Guidance for colleges and  
other post-16 education  
providers on implementing the  
Disability Discrimination Act



# Supporting learners with mental health difficulties

Kathryn James



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This guide is about how to support the implementation of the Disability Discrimination Act (DDA) and how to develop more inclusive provision in further education (FE), adult education (AE) and work-based learning (WBL) for learners who are experiencing mental health difficulties.

It is aimed at tutors and teaching staff in further and adult education and work-based learning who are not 'specialist' mental health support staff. It can be used by:

- individual tutors and teaching staff, particularly those on general courses, who want to reflect on and improve the support that they give to their learners who may be experiencing mental health difficulties
- managers and team leaders who want to support their team members to be better able to meet the needs of learners with mental health difficulties
- senior managers who ultimately have responsibility for the implementation of the DDA and for the overall quality of the learner experience
- 'specialist' mental health staff and tutors who want to work with and support their colleagues across the whole organisation to be better able to meet the needs of learners with mental health difficulties
- frontline staff, such as enrolment staff, advice and guidance staff and receptionists, at least in part.

In Section 1 the guide provides an overview of the DDA and an overview of other policy initiatives in mental health that support equality and inclusion for people experiencing mental health difficulties. It also considers the central concepts of the medical and the social model of disability and their implications for the development of inclusive learning. Section 2 provides basic information on mental health and mental health services. Section 3 looks at supporting learning, understanding how a person's mental health affects their learning and what policies and procedures are in place to support achievement. Section 4 is about your own mental health and how to ensure that you maintain positive mental health at work. Finally, Section 5 provides details of further reading and support.

When writing good practice guides on supporting learners with mental health difficulties it is impossible to cover every aspect of support, or every eventuality. How people experience mental health difficulties and how mental health difficulties affect the way a person learns will vary from one person to the next. You cannot make any assumptions. Equally, learning situations vary greatly so that what works well in one setting may not be quite so appropriate in another. This guide will give you some information, some general guidelines and some exercises, but it will be up to you to think about what may work for you in your particular teaching situation. It can also be used as a trigger for discussion between you and your colleagues about how your team can support the needs of learners with mental health difficulties. This guide is not able to give you all the 'answers'; it will give you ideas and suggestions.

Much of what constitutes support for learners with mental health difficulties is actually good teaching and learning, so you will probably know most of the ‘answers’ already; this guide will just put it into a context of supporting learners with mental health difficulties. As you will read in Section 2, what supports people experiencing mental health difficulties in their recovery journey<sup>1</sup> is feeling valued and accepted in everyday situations, regaining skills and confidence, feeling in control and able to cope, having a sense of learning and growing and a sense of hope and optimism. Participation in learning supports all of that, especially when people can take part and achieve alongside ‘everyday people in everyday situations’. Good teaching and learning that take place in inclusive organisations support that most of all.

## Background

During 2003–04 a consortium, led by LSDA and including Skill and NIACE, managed 20 action research projects, each involving 4–5 sites from the further education, adult education and work-based learning sectors. These projects examined different aspects of DDA implementation. This report is based on Project 16, which specifically focused on developing inclusive provision for learners experiencing mental health difficulties. The project sites looked at how they might be better able to implement the DDA in their own institutions by becoming more inclusive of learners with mental health needs. The project sites varied from large FE colleges to smaller adult and community provision. Some project sites had a history of working with learners with mental health difficulties, while for others this was a new area of work. Despite these differences, the emerging findings from the action research were remarkably similar.

<sup>1</sup> Recovery is not just about being ‘free’ of symptoms: it is the journey or process that enables you to have the life you want. It is discussed more fully in Section 2.

The project reports from all five sites found that there were barriers in their own institutions that prevented learners with mental health difficulties from accessing learning and progressing.<sup>2</sup> Learners are often able to access provision set up specifically for people with mental health difficulties, but moving on to 'mainstream' opportunities or going directly to 'mainstream' opportunities in the first place was much more problematic. It appeared that adopting a whole-organisation approach to meeting the needs of learners with mental health needs is a major challenge to most learning providers. Of course, adopting a whole-organisation approach to supporting learners with mental health needs is the responsibility of everyone, from senior managers to teaching staff and non-teaching staff, but one of the most strongly articulated needs for support comes from teaching staff. In all subject areas, many teaching staff said that they felt unskilled, unsupported or unaware of how to support learners with mental health needs. This guide aims to meet some of those needs.

<sup>2</sup> Project reports can be viewed on the LSN website at [www.lsneducation.org.uk/DDA](http://www.lsneducation.org.uk/DDA)

In this section we look at the legislative and policy context shaping this area of work and informing how we support learners experiencing mental health difficulties to access and achieve in learning. First, we look at the Disability Discrimination Act and what that means for providers. Second, we look at the changing agenda within mental health services and how the modernisation of mental health services will affect the learning and skills sector. Finally, we consider the medical model versus the social model of disability and how this and the ideas central to a model for independent living can underpin the development of inclusive learning opportunities in education.

## The Disability Discrimination Act

The Disability Discrimination Act was first introduced in 1995. Initially it only covered disabled people's rights in employment (Part 2). This was subsequently revised to cover goods and services (Part 3) and in 2002 was amended again to cover education (Part 4). DDA Part 4 granted new legal rights to education for people with disabilities and learning difficulties. The Disability Discrimination Act uses a wide definition of disability to include physical or sensory impairment, dyslexia, medical conditions and learning difficulties, as well as mental health difficulties. Under Part 4 of the DDA, education providers will have responsibility:

- not to treat disabled learners less favourably for a reason relating to their disability
- to provide reasonable adjustments for disabled learners.

The new duties under the DDA Part 4 apply not just to teaching staff but to any service provided specifically for learners, including library services, information and learning resources, and to all aspects of the premises. Therefore all staff, including estates and facilities staff, reception, administrative and support staff, learning support staff, library and resource centre staff, marketing and recruitment staff, advice and guidance staff, senior managers, human resource management staff, and governors as well as teaching staff, have a duty to ensure that Part 4 of the DDA is implemented.

In December 2006 the Disability Discrimination Act 1995 will be amended to place a duty on all public bodies to promote disability equality actively. The Disability Equality Duty (DED) means that disability equality will have to be built in at the beginning of the process rather than as an adjustment at the end. In essence, this means that the duty placed on providers will shift in emphasis from relying on disabled people to complain about discrimination to the public sector becoming a proactive agent of change.

There are four particular aspects of the DDA that we will consider with regard to learners with mental health difficulties.

### **Anticipating support needs**

Providers are required to be 'anticipatory' and not just reactive in meeting the needs of learners with disabilities. In short, it is not sufficient to wait until a learner asks for a particular type of support before it is put in place. Providers now need to make sure that support is put in place and that support available is made known and explicit so that learners are not discouraged from applying because they are unaware of how they may be supported to access and achieve in learning. This could mean making sure that types of support available are made known to learners through any marketing materials, on application or enrolment forms, on course information or during induction. Some disabilities are 'hidden', such as mental health difficulties, and it is therefore important to consider the approach that is taken when communicating, verbally or in writing, to all learners. People with mental health difficulties often find it hard to disclose their mental health needs, so it is crucial that staff are aware that just because a potential learner or current learner has not 'disclosed' a mental health need, or does not 'look' disabled, this does not mean that they do not have mental health difficulties. As one college involved in Project 16 wrote:

*As there is a great deal of stigma attached to mental health difficulties, students worry or find it difficult to disclose them, thereby making it hard for the college to address their needs. It is vital therefore that college staff use every opportunity to promote positive mental health and to break down the stigma surrounding mental illness. The college should encourage students to disclose mental health needs by making clear the organisation's commitment to mental health and the support which specialist staff, tutors and support staff can offer students.*

When providers fail to do this, learners may be discriminated against in all manner of ways. Another college involved in Project 16 wrote:

*Administrative staff responsible for enrolling students on courses were believed to lack familiarity with the needs of students with mental health problems, learning difficulties and disabilities. In one case, an employee of an agency providing education and training for individuals with learning difficulties and/or disabilities described how enrolment staff had addressed her rather than communicating directly with the individual she was supporting. Enrolment staff were also felt to lack knowledge regarding the benefits which trigger free entitlement to courses. These problems were reported not to occur if learners enrolled on one of the college sites where there were staff that had specific experience and awareness of the needs of learners with mental health problems.*

Therefore, when anticipating what support learners with mental health difficulties may need it is important to promote positive mental health and to make statements that show that you value and support learners who may experience mental health difficulties, while at the same time it is important to break down the barriers to learning that people with mental health difficulties may experience. In the next section we will look at possible barriers to learning for people with mental health difficulties, but you may want to think about the barriers your learners may specifically face and then decide what action you and your team need to take.

## Encouraging disclosure

Providers are expected to take reasonable steps to encourage learners to disclose a disability. When learners are able to disclose mental health needs it enables the learning provider to discuss with the learner how their disability might affect their learning, and how best the learning provider can meet those needs. Many people experiencing mental health needs do not disclose their difficulties because they are fearful or have experience of discrimination and harassment when they have been open about their mental health. Many people experiencing mental health difficulties would have no reason to believe that a learning provider would be any different from any other organisation where they might have experienced prejudice. Institutions therefore have to take overt and reasonable action to ensure that potential applicants, applicants and learners feel able to disclose their mental health needs and that if they do so, any information they pass over will be treated with respect and in confidence. Taking reasonable steps to encourage disclosure may involve:

- making written statements on marketing and publicity materials, such as prospectuses
- providing opportunities on application forms
- making frontline staff, particularly enrolment staff, aware of this and training them in dealing sensitively with any disclosure issues
- ensuring that there is a confidential and private environment in which a person can talk freely.

Further guidance on disclosure is available in *Do you have a disability – yes or no? (or is there a better way of asking?)*.<sup>3</sup>

<sup>3</sup> Rose C (2005). *Do you have a disability – yes or no? (or is there a better way of asking?)*. Learning and Skills Development Agency.

However, learners do not always fit neatly into our schedules and processes and may not disclose at the start of a year or course or by using the application or enrolment procedures. This may be particularly true of learners with mental health needs who may have more anxieties about disclosing their needs; it may be some weeks into a course before a learner feels 'safe' to disclose mental health needs. A tutor or member of the support staff, rather than enrolment or advice and guidance staff, may be the first person that they tell about their mental health difficulties. All staff therefore need to be aware of the procedures for handling disclosure. Would you or members of your team know what to do in this situation? Are you aware of the procedures in your organisation for handling disclosure? In Section 3 we will look in more depth at some of the questions and concerns that might arrive when a learner discloses mental health needs.

On the other hand, a learner has the right not to disclose mental health needs, or any other disability, and it is important to respect that right. Some learners with mental health needs may get along perfectly well in a learning situation that supports their achievement and gives them ample opportunities to discuss their progress, get feedback and raise concerns about their learning if any arise. Good teaching and learning is the best kind of support for any learner, and particularly for learners with mental health difficulties. Some tutors and staff may raise concerns about 'situations' or 'crises' for which they may feel unprepared if they do not know that a learner has a mental health difficulty. 'Situations' and 'crises' are less frequent than one might think, and may arise because of something unconnected to the learning and unpreventable no matter how much was disclosed about the person's mental health or regardless of how much support is put in place. Fear of 'situations' and 'crises' does not give us an automatic right to know about a person's state of mental health. Rather, we need to concentrate our efforts on creating learning environments that promote positive mental health for all learners, by valuing all learners and promoting the achievement of all learners. We are then more likely to create environments where learners will feel comfortable and safe to disclose mental health needs.

## Sharing information

Under the DDA, once one member of an organisation knows about a learner's disability, and providing the learner is happy for this information to be shared, the whole organisation is deemed to know. This means that it is not the responsibility of the individual learner to go to every relevant member of staff to let them know of their disability. However, it does not mean that the whole organisation needs to know. What it does mean is that staff need to be aware of the procedures within the organisation for passing on relevant information regarding a learner's disability. Under the Data Protection Act, medical information, and information about a person's disability, is classified as 'sensitive'. So under the Act, information cannot be passed on without the learner's explicit and informed consent. The DDA reinforces the requirements of the Data Protection Act, and reaffirms learners' rights to confidentiality about their disability. Therefore, when a learner discloses a disability, including mental health difficulties, apart from discussing what this means to the learner in terms of any learning needs, it is also necessary to discuss with the learner who will need to know. It is necessary under the Act to gain consent before any information is passed on to any other member of staff. Again, further guidance on passing on information can be gained from *Do you have a disability – yes or no? (or is there a better way of asking?)* and from *Disclosure, passing on of information and confidentiality*.<sup>4</sup>

## Making reasonable adjustments

Under the DDA, institutions are expected to make reasonable adjustments to meet the needs of learners with disabilities. This is a requirement for all staff: for teaching staff it may mean adapting teaching delivery, changes to teaching materials, providing extra support, and changes to assignment and assessment procedures.

<sup>4</sup> Rose C (2005). *Do you have a disability – yes or no? (or is there a better way of asking?)*. Learning and Skills Development Agency, and *Disclosure, confidentiality and passing on information. Guidance for Post-16 providers on implementing the Disability Discrimination Act Part 4*. (Oct 2003) Learning and Skills Council.

Learners with mental health difficulties will vary greatly in their experience of mental health difficulties, whether medication has any side-effects or not, their previous experiences of learning, and in the skills and experience they bring to the learning environment. It is important not to make any assumptions about what reasonable adjustments may need to be made. People may have developed very effective strategies for coping with any symptoms of their mental health difficulties or any side-effects of medication, and it will be worth discussing with the learner how these strategies may be adapted in the learning situation. Together you may be able to come up with some simple but effective 'reasonable adjustments' that enable the learner to access learning. Everyday strategies such as the learner always sitting with their back to the wall, or sitting near the door, being able to take short comfort breaks at regular intervals, being able to take a drink into the classroom or knowing there is a named person they can go to should difficulties arise, are the kinds of strategies that have proved to be very effective for many learners.

More of these strategies will be covered in Section 4, but it is worth noting that many reasonable adjustments can be simple arrangements that enable the learner to relax, feel comfortable and so able to concentrate on their learning. It can also be useful to share ideas with colleagues who may have had similar experiences or who may help you to think 'out of the box' about a situation.<sup>5</sup> One college involved in the LSDA action research on providing support wrote:

*We learned not to second-guess what might work; not to restrict our thinking; not to forget the individual... we have broken down our rigid thinking patterns and considered what might be effective, not just what the accepted strategy is.*

<sup>5</sup> If you discuss a particular learner's support needs with any colleagues, make sure that you do that with the learner's consent, or anonymise the situation before you discuss it.

## Social inclusion and mental health

The government's commitment to reducing social exclusion has led to some specific changes in both policy and implementation across all government departments.

In June 2002 the National Institute of Mental Health in England (NIMHE) was launched, as part of the Department of Health NHS Modernisation Agency, to improve the quality of life for people of all ages who experience mental distress. It is doing this by re-designing services, developing the workforce and by changing practice. Underpinning these changes is the recognition that improving the lives of people with mental health difficulties means promoting social inclusion and recovery rather than just treatment. Social inclusion is defined as improved rights of access to the social and economic world, new opportunities and regaining social status. It means having access to work, education, social, cultural and religious groups, friendships and relationships, family and participation in civic life. Recovery in this context means more than 'cure', and is defined as:

*What people experience themselves as they become empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a contributing, positive sense of belonging in their communities.<sup>6</sup>*

In practice, this means that mental health services are being encouraged to rethink and remodel existing services, such as day centres to support service users to take part socially and economically in their local communities, and to access existing community resources. In promoting social inclusion and recovery, NIMHE works beyond the NHS and takes an active role in developing partnerships at a strategic and operational level, nationally and regionally. Adult education can play a crucial role in promoting social inclusion and in recovery. Adult learning and skills providers are some of the key organisations that mental health service providers will, and should, be working with.

<sup>6</sup> NIMHE (June 2005) *Guiding statement on recovery*. National Institute of Mental Health in England at [www.nimhe.org.uk](http://www.nimhe.org.uk)

In June 2004 the Social Exclusion Unit within the Office of the Deputy Prime Minister worked closely with NIMHE to publish its report 'Mental health and social exclusion'.<sup>7</sup> The report seeks to break down the discrimination and stigma experienced by people with mental health difficulties and to challenge the low expectations that many professionals have of people with mental health difficulties. It hopes to raise the expectations and achievements possible for people with mental health difficulties – in employment, education and the community. The report highlights ways to reduce social exclusion among people with mental health difficulties through cross-government departmental work, by making recommendations and setting targets. The report expects the Department for Education and Skills (DfES) to work closely with the Learning and Skills Council (LSC) to, among other things, raise staff awareness in post-16 education of the needs of learners with mental health needs. Specifically, there are targets to increase the number of adults with mental health difficulties achieving Level 2 and equivalent qualifications, and to increase the number of adults on Care Programme Approach<sup>8</sup> accessing mainstream learning opportunities. These will be the levers by which social inclusion, and recovery, will be promoted through adult learning.

Social inclusion is a rights issue, which is why the implementation of the Disability Discrimination Act is so important. Indeed, having rights that ensure you are included in all aspects of society is also crucial to recovery, to having a meaningful and purposeful life, and to knowing you have a future. Adult learning and ensuring that learners' rights are upheld under the Disability Discrimination Act are important factors in promoting social inclusion and recovery. Furthermore, the Disability Discrimination Act and the policy initiatives that promote social inclusion will not only affect those staff in adult learning who have a 'specialist' role in supporting learners with mental health difficulties, but will move beyond them to affect the way that all staff in adult learning and skills provision address the needs of this group of learners. Staff across all sections

<sup>7</sup> Social Exclusion Unit (June 2004). *Mental health and social exclusion*. Office of the Deputy Prime Minister.

<sup>8</sup> Care Programme Approach refers to the duty of local authorities to fulfil their assessment and care-planning role for people with mental health difficulties in the community, and their duty to provide after-care to people who have been sectioned. A section is when a person may be admitted to hospital without their consent, if it is viewed to be in the interests of their own safety, or for the protection of other people.

of adult learning and skills can no longer offer excuses such as 'it is not my job' when it comes to providing opportunities for learners with disabilities, including mental health difficulties. Under the Disability Discrimination Act, and with policy initiatives to promote social inclusion, it is, and will increasingly be, their job.

## **The medical model versus the social model of disability**

A key approach to developing inclusion in education for adults with mental health difficulties is to think about how the work that we do fits into the context of the medical model or the social model of disability.

### **The medical model**

The medical model of disability sees disabled people as the problem: it is the disabled person who needs to be adapted to fit into the world. If it isn't possible for the disabled person to adapt and fit into the world, then one result may be separation, whether that means being shut away in a specialised institution or isolated at home.

The medical model focuses on diagnosis or impairment; that is, on what is 'wrong' with the person and what 'they cannot do'. This can lead to people being seen as deficient, and therefore likely to be treated with pity or fear, or to be patronised. It forces us to have low expectations of what people can achieve. It encourages us to assume that the disabled person will be dependent on us. Focusing on diagnosis or impairment also tends to lead to an emphasis on finding a cure or on management of the condition, which relies on the expertise of other people, usually professionals. Consequently, decisions affecting the lives of people with disabilities are often controlled by professionals who 'know best'. This is not to deny the very necessary role of medical science in keeping people alive, in reducing pain and discomfort or in alleviating symptoms and distress, but it is important not just to reduce people to the sum of their difficulties, as can often happen when we take the 'medical model' approach to disability.

Medical model views are very powerful, and are reinforced through the media, culture, politics and society. They manifest themselves in segregated services, low expectations, enforced dependency and limited opportunities. It is difficult for people with disabilities not to internalise those views, which can lead to the development of low self-esteem and under-achievement. This, of course, further reinforces non-disabled people's assessment of their worth.

The medical model view pervades education, and influences the assumptions we make about learners with disabilities, and how we organise and structure educational opportunities for people with disabilities. Developments in recent years have begun to challenge these assumptions and barriers; the DDA is part of the way in which society is being forced to change its actions towards and thoughts about disabled people.

### **Exercise**

In what way do medical model views affect our assumptions about learners with mental health difficulties, and how might this affect the opportunities that learners with mental health difficulties are offered?

## **The social model**

The social model of disability acknowledges that impairments and chronic illness exist, and that they can pose problems for people, but suggests that the disabilities experienced by people are more often socially constructed, and have little to do with a person's impairment. An impairment refers to a part, or parts of a person's body or mind that is limited in its functioning. An impairment does not make a person any less suitable to participate in society, but disability may prevent them from participating. Disablement is the loss or limitation of opportunities to participate as an equal in society due to physical or social barriers. For example, a person may have a physical impairment that requires them to use a wheelchair. However, they are only disabled when they are confronted by steps to the entrance to a building, or from getting a job because of the attitude of an employer. Similarly, a person with mental health difficulties may be disabled by other people's fears and beliefs that they are dangerous, unpredictable and unable to cope.

The social model view believes that it is society that needs to be adapted and changed (rather than the medical model view which believes that it is the person that needs to adapt and change). The social model of disability therefore focuses on the individual and collective disadvantages experienced by people with disabilities, and suggests that this is due to institutional discrimination akin to racism, sexism and heterosexism.

Challenging this level of discrimination depends on the restructuring of society but also on changing the assumptions and prejudices we have about disabled people. Again, recent developments are contributing to better life chances for disabled people, albeit slowly. The DDA is another important lever in bringing about that change.

### Exercise

In what ways do social model views affect our assumptions about learners with mental health difficulties and the types of provision and opportunities that are available to them?

The following table may help you to think about the differences between the medical model of thinking and the social model of thinking.

<b>Medical model of thinking</b>	<b>Social model of thinking</b>
Person is 'faulty', has something wrong with them.	Person is valued and accepted.
If the person cannot be 'put right' or adapt, the result may include segregation.	Person is included and able to contribute and society must adapt so as not to disable the person.
Person is labelled by their diagnosis or difficulty.	Person is seen as a whole person with strengths, ambitions and abilities, as well as impairments.
Impairment is the focus of attention.	Goals, aspirations and outcomes are the focus of attention.
Segregation and alternative services are offered. The need for therapy is assumed.	Resources made available to 'ordinary' services to support the person.
'Professional' is required to fix the problems of the person. Professional chooses and controls the means to do this.	Person makes choices. Person is empowered. Professional facilitates and supports choices and decisions.
Person is dependent.	Person is independent, or better, interdependent, like everyone else.

## The 'independent living' model

While the social model of disability has brought about many changes in society over the past 30 years, it is not without its limitations. The social model of disability infers that society must reconstruct itself to provide equality of opportunity and rights to people with disabilities. Yet the power to reconstruct society rests within society and is therefore dependent on the goodwill and moral conscience of legislators, organisations and individuals to take it upon themselves to do that. Thus equality of opportunity and rights remains the 'gift' of society to bestow on disabled people. For many people with disabilities the wait for change has been too long, and where changes have been made without involving and consulting disabled people they have not always brought about the changes that disabled people really want and need.

A model for independent living places the power to bring about change in the hands of people with disabilities. The independent living model is not the name of a service or particular type of provision; it is about the empowerment of disabled people and their ability to control their lives.

The social model view stresses the rights of people with disabilities to make their own decisions about the services and opportunities they need and want to participate in society. The provision of direct payments is an example of recent government policy that gives disabled people the opportunity to have greater choice and control over their lives and make their own decisions about how their care is delivered.<sup>9</sup>

The DDA could be used to promote independent living by giving people the power to make those decisions an actuality, and the leverage to force services and organisations to deconstruct the barriers that discriminate against people with disabilities. By December 2006, as part of the Disability Equality Duty (DED), all public-sector authorities will have had to engage actively with those who access their services. The DED will require the public sectors to promote disability equality actively and ensure that disabled people are involved in producing the scheme, in developing action plans and in assessing the impacts of the scheme.

<sup>9</sup> Direct payments are cash payments in lieu of social service provision to individuals who have been assessed as needing services, for example, people who are assessed as being eligible for the Care Programme Approach. Further information can be obtained from [www.dh.gov.uk](http://www.dh.gov.uk)

Of course, most people with disabilities don't want to go round suing organisations; they just want to get on with their lives, like everyone else. What services and organisations, including adult learning and skills providers, must do now is work with disabled learners to reconstruct the provision and opportunities that are available. This may be through the negotiation of individual learning plans that promote achievement and progression, through negotiating the use of additional learning support and other support funds, through consulting and involving learners in developing new opportunities and inclusive services or through whole-organisational change to bring about more respectful, receptive and less disabling environments.

### What is mental health?

Mental health is more than the absence of mental illness and symptoms. There are many definitions of mental health, including:

*the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our sense of our, and others', dignity and worth.*<sup>10</sup>

Mental health is about how we think and feel about ourselves and about others. It affects how we interpret the world. Mental health is about how we cope with life, and how we manage the changes and challenges of everyday life. Mental health is also about our ability to communicate, and to form and sustain relationships. There are many factors that protect our mental health, such as having a close confiding relationship, feeling safe, having opportunities that enable us to fulfil our potential and that give hope for the future, good physical health, being free of pain or discomfort and being free of financial worries.

Our mental health becomes a problem when it begins to have a negative effect on how we feel and think. It can happen to anyone, and it may arise from a temporary period of stress in our lives, such as divorce or bereavement, or it may arise from longer-term situations such as unemployment or social isolation. Everybody shares the same key risk factors, but for some there are additional risk factors, such as racism, discrimination and poverty, being a victim of crime or abuse, or inequalities in service provision or access to support. For some people, mental health problems may develop from an accumulation of problems that make it hard to cope. These key risk factors to mental well-being arise from the social situation in which individuals live. It is also essential to remember that different individuals have different degrees of genetic predisposition to particular types of mental ill-health.

<sup>10</sup> Health Education Authority 1997 quoted by Mentality, [www.mentality.org.uk](http://www.mentality.org.uk)

It can be useful to think about mental health as a continuum. It is something that we all have and our position on that continuum can change over time. Sometimes we may be nearer to one end of the continuum than to the other. Mental health difficulties aren't something that only other people have; we can all relate to mental health problems and could at any time experience more significant difficulties.

Mental health difficulties are very common. Some statistics say that about one in four people in Britain will have a diagnosis of mental illness at some stage of their life.<sup>11</sup> There are two broad types of mental health difficulties, as described below.

- Common mental health problems include anxiety, depression, phobias, obsessive-compulsive disorders and panic disorders. An estimated one in six people in the UK have common mental health problems at any one time.<sup>12</sup>
- Severe and enduring mental health problems include psychotic disorders, such as schizophrenia and bi-polar affective disorders, also known as manic depression. An estimated one in 200 adults will experience a psychotic disorder in any given year. About one in 25 adults has a personality disorder in the UK.<sup>13</sup>

A diagnosis of any particular type of mental health difficulty helps medical staff to assess what treatment is needed and to predict what is likely to happen. It can also be a relief to the person experiencing emotional distress because it enables them to put a name to what they are going through. However, a diagnosis may give a name to the symptoms a person may be experiencing, but it is different from mental well-being. Mental (or emotional) well-being is about satisfaction with life, self-esteem, social connectedness and optimism for the future. It is very subjective.

You may feel that you want to know more about some of the diagnoses listed above. Mind provides very balanced and accessible information on mental health in their *Understanding...* series, which can be accessed from their website at [www.mind.org.uk](http://www.mind.org.uk)

<sup>11</sup> MIND, [www.mind.org.uk](http://www.mind.org.uk)

<sup>12</sup> SEU (June 2004). *Mental health and social exclusion*. Social Exclusion Unit. Office of the Deputy Prime Minister.

<sup>13</sup> SEU (June 2004). *Mental health and social exclusion*. Social Exclusion Unit. Office of the Deputy Prime Minister.

However, understanding different diagnoses has limited uses.

- Each person's experience of mental health difficulties is unique, and people with the same diagnosis may experience it differently.
- Diagnosing mental health difficulties is very difficult, and different doctors may give one person completely different diagnoses.
- You could have a diagnosis of a mental health problem but, because you have an active and fulfilling life and supportive relationships, also have positive mental well-being. For this reason it is important not to make assumptions about how serious a mental health diagnosis is. Many people with common mental health problems say that they are limited by their condition, and about a fifth would say they are disabled by it.<sup>14</sup>
- Diagnosis can also become a label, which can be damaging. A person may become known as a 'schizophrenic' or a 'manic depressive' rather than who they are as a parent, partner, learner or employee. The diagnosis may become the label that leads to social exclusion, which can lead to poor mental well-being.

Most important for those who work in adult education, knowing the diagnosis of a person tells you nothing about them as a learner. It won't help you understand what skills and ability they bring to the learning environment, how they learn best or whether their mental health difficulties will affect their learning. You will only find that out by talking to them as learners.

## **The social context of mental health**

The experience of mental health has a social dimension to it. This means that who we are, where we live and how we live our lives affects our vulnerability to mental health difficulties, what support we get and the opportunity for recovery.

<sup>14</sup> SEU (June 2004). *Mental health and social exclusion*. Social Exclusion Unit. Office of the Deputy Prime Minister.

The following facts are included to raise awareness of the facts about mental health but also to provoke thought and reflection. The widening participation agenda in adult education has brought more and different learners into adult learning and, as a consequence, we need to be sensitive to the wider contexts of learners' lives. The following facts, and many others, are from MIND information and fact sheets.<sup>15</sup>

## Gender

- Studies in the general population suggest that the overall prevalence of mental illness is slightly higher among women than men.
- Women's roles as mothers and carers make them susceptible to poverty, and poverty is associated with mental ill-health. Two thirds of adults living in the poorest households are women.
- Women's mental health is likely to be affected by other factors, such as isolation due to lone parenting and caring responsibilities, and experiences of child sexual abuse, domestic violence, sexual violence and rape.
- There are also protective factors for women, in that they tend to have better social networks and/or confiding relationships than men.
- Physical illness is a major contributory factor in men developing mental ill-health, and men are less likely to seek medical attention than women.
- Unemployment is a major cause of depression and suicide in men. One in seven men who become unemployed will develop depression within 6 months. 75% of suicides in the UK are by men.

<sup>15</sup> Available from [www.mind.org.uk](http://www.mind.org.uk)

## Age

- Psychotic disorders occur in young people from the age of puberty onwards.
- Age and gender are significant factors in prevalence for schizophrenia. One study shows that incidence for men aged 15–24 years is twice that for women, whereas for those between 24–35 years, it is higher for women. This reflects a common late onset of the illness for women.
- Statistics for rates of depression in young people show that ‘at least 5% of teenagers are seriously depressed and at least twice that number show significant distress’ and that ‘in troubled inner city areas with high rates of broken homes, poor community support and raised neighbourhood crime rates, the level of depression may be double that quoted’.
- Self-harm is increasingly common among young people, and more common in girls than boys (11.2% of girls and 3.2% of boys).
- Young offenders have high rates of mental health problems: a diagnosis of a primary mental health disorder can be made in a third of young men aged 16–18 who have been sentenced by a court.
- Young men aged 15–24 have one of the highest rates of suicide – about 13 per 100,000.
- Growing old, while positive for some, may bring susceptibility to mental ill-health for others. Loss of status, loss of income, isolation, physical ill-health, bereavement, as well as ageism itself, can all contribute to mental ill-health. An estimated 10–15% of people over 65 have depression.

## Race and culture

- People from black and minority ethnic communities may be more likely to experience poverty, discrimination and harassment, or be victims of crime, all which have an impact on mental well-being.
- How people from black and minority ethnic communities are diagnosed and treated for mental ill-health differs from their white counterparts. For example, young African Caribbean men are up to ten times more likely to be diagnosed with schizophrenia than their white counterparts. Recent research suggests that although more Black Caribbean people are treated for psychosis, this may not indicate that they are more likely to have such an illness, but that the way they express their symptoms is interpreted in such a way that they are more likely than others to be prescribed treatment for those symptoms.
- Research also shows that more African Caribbean and other Black people with psychosis are admitted to hospital for treatment, and more likely to have been in contact with police or other forensic services. This is despite the fact that they are less likely to show evidence of self-harm than white people, and no more likely to be aggressive to others.
- A further perspective is added to these observations by the fact that African Caribbean men living in the UK are 16 times more likely to experience schizophrenia than those who stayed in the Caribbean.
- Race and cultural background can have an influence on suicidal behaviour; for example, women aged 16–24 of an Asian background have suicide rates three times higher than their white counterparts. Asian women's groups have linked this to cultural pressures and to conservative parental values and traditions that may clash with the wishes and expectations of the young women themselves.
- Prevalence rates for mental ill-health within the Chinese population of Britain are less than 50% of the rates of the white population. This may be because the Chinese culture does not see mind, body and soul as distinct from each other, so when treating mental health problems they treat other aspects of the body thought to be out of alignment. However, it may also be because people do not know what support is available; one study showed that 93% of Chinese people interviewed would use mental health services if they knew what was available.

- Many refugees and asylum-seekers will experience mental health difficulties. They may have fled their country under difficult and stressful circumstances and have suffered from traumatic events such as rape, torture, loss of family and home. The experience of being a refugee or an asylum-seeker can be a difficult and isolating one. They may be worried about being returned to the country where they were persecuted. Once in the UK they may be in poor housing, be unable to work, and may experience racial abuse and harassment. If they are constantly moving, access to services can be complicated by changes of address, lack of interpreting services and unfamiliarity with the system.

## Disability

- Having another disability increases vulnerability to mental ill-health, because people with learning difficulties, physical disabilities or sensory impairment have greater likelihood of being unemployed, living on a low income, having limited life opportunities and restricted choices.
- An estimated 25–40% of people with learning difficulties experience risk factors associated with mental health problems. Approximately 30% of deaf people using British Sign Language have mental health problems.

## Education

- Lack of qualifications and poor experience of initial schooling can lead to limited life opportunities, low-paid employment and increased likelihood of unemployment, which can also be associated with poor mental health.
- People who left school at age 15 or under have higher rates of common mental health problems.

## Employment status

- Over 900,000 adults in England claiming Incapacity Benefit and Severe Disablement Allowance report mental health problems as their primary condition, almost twice as many as in 1995.
- In 2001–02, half a million people believed work-related stress was making them ill.
- Teachers, nurses and managers are the occupational groups most likely to report high levels of stress.

## Environment

- Incidences of mental health difficulties are much higher in urban areas. 20% of young people up to the age of 19 in inner London reported problems such as anorexia and bulimia, sleep disorders, school phobia and depression, compared with 7% in rural areas.
- Risk factors to mental health in rural areas include isolation, lack of suitable or adequate services, lack of transport, boredom, poverty and unemployment.
- Homelessness and housing problems increase a person's chances of physical and mental ill-health. Homeless people have 11 times the frequency of mental health problems, and eight times if accommodated in bed-and-breakfast accommodation or hostels.

As an adult education tutor you may not see yourself as a 'mental health specialist' but you may be working with other groups of learners – young people, people who are unemployed, older learners, women returners or people on managerial courses. Being aware of how social factors can affect mental health may help you to be more sensitive to the experiences and pressures on your learners, and therefore to think about how your teaching practice may address some of those pressures and thereby promote inclusive learning opportunities. These facts also illustrate the importance of providing opportunities for learners to disclose mental health problems at any time.

The facts should also alert you not to take a psychiatric diagnosis, or psychiatric history, at face value, particularly for people from Black and minority ethnic communities. Equally, a lack of psychiatric diagnosis does not mean that the person has not experienced mental distress – it may just mean that they have not been able to access services or get appropriate support.

The value of adult education is that it provides opportunities for people who may not have been able to fulfil their potential in education so far, and it allows adults to improve their life chances. Promoting inclusive learning for adults with mental health problems can support a virtuous circle of improved life chances and positive mental well-being.

## Stigma and discrimination

People with mental health difficulties are among the most discriminated against in society. Discrimination means to treat someone unfairly or to deny them opportunities. Stigma arises from negative stereotypes associated with the symptoms or diagnosis of mental health problems. Stigma and discrimination mean that people with mental health difficulties are prejudiced against in terms of employment, and access to health and other services, and are more often the victims of harassment. In a survey conducted by Mind of 778 people with mental health problems it was found that:

- 34% had been dismissed or forced to resign from jobs
- 69% had been put off applying for jobs for fear of unfair treatment
- 47% had been abused or harassed in public
- 11% had been physically attacked
- 26% had been forced to move home because of harassment
- 50% felt they had been unfairly treated by physical health services
- 33% complained that their doctor had treated them unfairly
- 25% had been turned down by insurance or finance companies because of their mental health difficulties.<sup>16</sup>

Fear of stigma and discrimination can lead to severe loss of confidence, causing people to withdraw from social activities, friendships and from applying for jobs.<sup>17</sup> It also affects an individual's motivation and ability to participate in learning. When rejection and prejudice are commonly experienced, why should someone believe that a learning provider would be any different? We have a responsibility to show that we offer welcoming environments in which to study, that we do not tolerate discrimination or treat any learner unfairly because of a disability.

<sup>16</sup> Read J, Baker S (1996). *Not just sticks and stones*. A survey of the stigma and discrimination experienced by people with mental health problems. MIND.

<sup>17</sup> SEU (June 2004). *Mental health and social exclusion*. Social Exclusion Unit. Office of the Deputy Prime Minister.

The everyday experiences of individuals while they are learning will also affect their ability to remain in learning. One adult and community learning provider who participated in the LSDA action research wrote:

*Everyone feared discrimination by others. Many had experienced discrimination in the past and/or were presently experiencing this. One person had been the victim of hate crime, although she considered that this had been mainly driven by racism. However, knowledge of her mental health had served to reinforce perceptions of her 'differentness' in her immediate locality. The ferocity of this hostility had forced her to move to a new area.*

We need to be aware that learners may be experiencing this level of discrimination while also trying to study. It may make remaining in learning difficult and every support must be given to enable a learner to continue with learning wherever possible.

## Disclosing mental health difficulties

Fear of stigma and discrimination means that people with mental health difficulties have to think very carefully about whether they want to disclose their mental health needs or not.

Some people choose to talk openly about their mental health in the hope of challenging some of the myths and prejudices, as one learner at an adult community college involved in the LSDA action research testified:

*Most people tend to be wary of you. I don't make a secret of it, I tell people. I do it as an example to others. People are frightened of us.*

This is a very brave and admirable stance, but for other people the fear of rejection and discrimination is too powerful, and this may mean that they do not feel able to disclose mental health needs.

In a 1996 survey of people with mental health problems:

- 52% said they had concealed their psychiatric history for fear of losing their job
- 34% said they had been dismissed or forced to resign

- 39% said they had been denied a job
- 16% said they had been threatened with dismissal
- 15% said they had been denied promotion.<sup>18</sup>

A similar survey carried out in 2000 also found that:

- 56% reported discrimination within the family
- 51% reported discrimination from friends
- 47% reported discrimination in the workplace
- 44% reported discrimination from GPs.

The 2000 survey also revealed that as a consequence:

- 74% did not mention mental health difficulties on application forms
- 22% did not tell partners about mental health problems
- 55% did not tell work colleagues
- 42% did not tell friends of their mental health problems.<sup>19</sup>

When you consider these statistics you realise how difficult it can be for a learner with mental health difficulties to tick a 'mental health difficulty' box on an application form. Equally, it is not really very likely that they will feel safe to disclose such difficulties to a complete stranger, particularly during an admissions interview or at the busy time of enrolment. We may know that we will try to treat every applicant who ticks a disability box fairly and that if we know that someone has mental health difficulties we can put in the appropriate support, but how would they know that? As adult learning providers, we have a long way to go in ensuring that learners with mental health needs feel 'safe' to disclose.

<sup>18</sup> Read J, Baker S (1996). *Not just sticks and stones*. A survey of the stigma and discrimination experienced by people with mental health problems. MIND.

<sup>19</sup> De Ponte P (2000). *Pull yourself together!* A survey of the stigma faced by people who experience mental distress, The Mental Health Foundation.

## Recovery

It is important to know, and remember, that people do recover from mental health difficulties. When people apply to do adult learning they may be well on their way to recovery. This may be another reason why they choose not to disclose – would you opt to saddle yourself with a stigmatising label when you are hopeful of leaving the experience of mental health problems behind you? Alternatively, you may be returning to learning in the hope of rebuilding your life while living with ongoing mental health needs.

The evidence shows that:

- about half of those experiencing common mental health difficulties will no longer be affected after 18 months
- of those with a diagnosis of schizophrenia, about a quarter will make a good recovery within 5 years, about two-thirds will experience multiple episodes, while about one tenth will develop severe long-term disabilities
- of those people experiencing bi-polar affective disorder, about a fifth will only have one episode.<sup>20</sup>

These statistics are important because much of our fear of mental illness is because we think it is ‘incurable’, and that once we have mental health difficulties we will be ‘sick’ and ‘disabled’ for the rest of our lives. The following description of being given a diagnosis of mental illness is not uncommon:

*They said I would never get better. I would always be mentally ill. They said I would be in and out of hospitals the rest of my life... I could never be the person I was before my mental illness.*<sup>21</sup>

<sup>20</sup> SEU (June 2004). *Mental health and social exclusion*. Social Exclusion Unit. Office of the Deputy Prime Minister.

<sup>21</sup> Schmook (1994) quoted in Repper J, Perkins R (2003). *Social inclusion and recovery*. Bailliere Tindall.

Yet people can and do recover, and understanding what supports that recovery is very relevant, because adult learning can play an important part in the recovery process. The treatment for any illness is often to go home and wait until the symptoms go away before you resume your life. For many people with mental health difficulties, this would mean a very long wait, perhaps for ever, and in the meantime the life they hoped to resume will have gone. Along the way it is likely they will have lost their job, lost their friends, maybe even have lost their relationship and probably their confidence and self-belief. All this loss while waiting to get over mental health difficulties and get on with life will undoubtedly have an additionally detrimental effect on mental health and well-being. Waiting to 'get better' inevitably leads to a downward vicious cycle of prolonged ill-health and increasing social exclusion. Waiting to 'get better' can lead to loss of income, financial insecurity and poverty, all of which can exacerbate mental ill-health. Claiming benefits while waiting to 'get better' means having to demonstrate and prove how ill you are to get money to live on.

Increasingly, and in response to what people with mental health needs say, mental health service providers are beginning to realise that this approach hasn't worked, so nowadays people experiencing mental health difficulties are being supported to get on with life – to retain jobs, maintain social networks and to make use of all community facilities, including adult education. Returning to learning can be a part of 'getting on with life'.

Recovery in this sense, then, is not about being free of symptoms; it is about a process that enables you to have the life you want. It can be described as follows:

*Everyone who experiences mental health problems faces the challenge of recovery, ie rebuilding a meaningful and valued life. Whether a person's problems are time-limited or ongoing, whether or not their symptoms can be eliminated, they face the task of living with, and growing beyond, what has happened to them.<sup>22</sup>*

<sup>22</sup> Repper J, Perkins R (2003). Social inclusion and recovery. Bailliere Tindall.

The concept of recovery has emerged from the writings of, and from listening to, people who have faced the challenge of life with mental health difficulties. In drawing on these accounts, the recovery journey has been defined as:

*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*<sup>23</sup>

Much of the way in which people experiencing mental health difficulties talk about recovery also has resonance with the way that learners with mental health difficulties describe the impact that learning has on their health and well-being. These quotes are from learners with mental health difficulties who explain what participation in learning has meant to them.

I feel a sense of personal achievement and the class has given me back my self-confidence and self-respect.

I now know I have the right to express opinions, make and refuse requests and give constructive criticism.

I feel I've more right to keep going at something... to do what I want to do... and not be so swamped by other people's needs.

The most enjoyable thing about being at college was meeting new people I feel comfortable with.

The course gave me a sense of purpose in life.

At college I'm allowed to be a person in my own right.<sup>24</sup>

<sup>23</sup> Anthony W (1993) quoted in Repper and Perkins' *Social inclusion and recovery*. Bailliere Tindall.

<sup>24</sup> Learner quotes in Wertheimer A (1997) *Images of possibility*, NIACE.

These comments show that learners feel empowered, with increased confidence and a greater sense of purpose in life, through taking part in learning, which is important to the recovery process. However, it does not imply that tutors have a therapeutic role. Rather, it is access to opportunities, having chances to grow, develop and succeed, acquiring new social networks and friendships and gaining a positive role and purpose in life that promote well-being through adult learning. Access to the same opportunities as everyone else, good teaching and learning and appropriate support are the bases on which recovery and social inclusion are founded in adult learning. Working within adult education we can help people to access opportunities on an individual level, but we can also play a broader role in breaking down the barriers that prohibit such access by implementing anti-discrimination legislation such as the Disability Discrimination Act. The Disability Discrimination Act upholds individuals' rights to find value and purpose in their life through learning.



This section is about how you can support learning for people with mental health difficulties. There are aspects of the Disability Discrimination Act that need to be implemented at this stage, but the most important thing is to start with the learner. We need to place the person experiencing mental health difficulties at the centre of how we support learning. You need to work with the learner to identify what will enable them to access learning, and achieve. You then need to think about how that support fits into the procedures your organisation may have for supporting disclosure of learning difficulties and disabilities, for passing on information, for obtaining additional learning support, for making reasonable adjustments and for risk assessment. In so doing, you will have implemented the requirements of the Disability Discrimination Act for learners with mental health difficulties.

### **Barriers to learning**

People with mental health difficulties can face barriers to accessing learning. Many of the barriers to learning are the same as those faced by most adults returning to learning for the first time, and are unrelated to mental ill-health, particularly if their initial experience of education was not fulfilling or rewarding. For people with mental health difficulties, anxieties about returning to learning may be pronounced, and barriers greater. As we can see from the research evidence, barriers to learning may be personal or emotional, as well as structural or practical.

In the LSDA action research project, two colleges conducted surveys into the main barriers to learning for adults with mental health needs. One college asked 200 mental health services users what they thought were the biggest barriers to accessing learning. Out of the 200 respondents, 145 said that being nervous was the biggest barrier, 118 said that worrying what other people might think of them was a barrier to learning, and 110 said that having to go to college on their own was a barrier to learning. Being able to make friends (100 respondents), bad memories of past education (100), transport (99) and that there would be too much work to do (97) were the next biggest concerns. When asked about the practical barriers to learning, 158 respondents said that they worried about the cost of course fees and cost of materials, 118 said that fear of losing benefits was a barrier to learning and 115 said that the thought of exams were a barrier to learning. A further 118 respondents said that the worry of becoming unwell while at college was also a barrier to accessing learning.<sup>25</sup>

A similar survey conducted by another college showed that nervousness, bad memories of education in the past and worrying what other people would think of them were the three biggest concerns and barriers to learning.<sup>26</sup>

Even if a person has got to the stage of completing an application form, attending an admissions interview or enrolling at the first class, it is likely that they are still experiencing some of those anxieties and trying to overcome those barriers. Cognitive and emotional difficulties are not disabling in themselves; it is the associated discrimination and exclusion that are disabling. When we look at the research evidence conducted by both the colleges and see what people with mental health difficulties felt to be the biggest barriers to learning, we see that the barriers aren't about their mental health but mostly about how they think others will react to their mental health difficulties.

<sup>25</sup> Cornwall College, Project 16 final report, [www.lseducation.org.uk/DDA](http://www.lseducation.org.uk/DDA)

<sup>26</sup> Bolton Community College, Project 16 Final Report, [www.lseducation.org.uk/DDA](http://www.lseducation.org.uk/DDA)

## How do you know a learner has a mental health difficulty?

You may become aware that a learner has a mental health difficulty through a number of means, including the following.

- They have been referred from mental health services. Increasingly, mental health services are supporting their service users to access community resources such as adult education. With support and encouragement from a mental health professional, a learner with mental health difficulties may be referred to you directly, or via a 'specialist' mental health worker within your organisation. If the learner wishes to disclose their mental health need we will consider the implications of this referral route later on. A referral from mental health services might be interpreted as an implied disclosure, but just because someone applies for adult learning with support from a mental health professional does not necessarily mean that they wish to take that 'label' with them into education. They may continue to have support for their mental health outside the learning environment but they may have discussed whether or not to disclose their mental health needs with their support worker and decided to keep their mental health needs private. A referral from mental health services, or the presence of a mental health support worker during an admissions interview, does not constitute a disclosure in the formal sense.
- They have ticked a 'mental health difficulty' box on the application or enrolment form.
- They have declared a mental health difficulty because they are asked about support needs in an admissions interview.

Does your organisation have a policy for disclosure of disabilities and learning difficulties? Are you aware of this and know what the procedures are? Are you aware that once a learner has disclosed a mental health need and has given consent that this information can be passed on to others, that the whole organisation is deemed to know? Does your organisation have procedures to deal with passing on information?<sup>27</sup>

<sup>27</sup> *Disclosure, confidentiality and passing on information. Guidance for Post-16 providers on implementing the Disability discrimination Act Part 4.* (Oct 2003) Learning and Skills Council.

When a learner discloses a mental health need by ticking a box on an application or enrolment form or during an admissions interview you need to make them aware of what the next step will be. You need to let learners know what information about their mental health needs would be useful, why it would be useful and what will happen to that information. Learners need to be in control of that information at all times, and to be informed of the options available to them that will support them in their learning.

A learner may decide that they do not want information about their mental health difficulties to be passed on. This decision has to be respected, though you may wish to document with the learner that they do not wish to have information passed on, and inform the learner that they can change their mind at a later stage should the need for support for learning ever arise. You may wish to reassure the learner that support for learning is not a sign of 'weakness', and that the offer of support is not a reflection of your belief that they cannot cope, but that learning support is available to all learners regardless of level of ability, disability or learning difficulty.

Some learners with mental health needs may not need any additional learning support. Support for learning for the person with mental health needs may involve managing the reactions of others and challenging the discriminatory behaviour of others – staff and other learners.

Having disclosed a mental health difficulty the learner may now want to know what support is available to help them access and succeed in learning.

What do you need to know about a person's mental health to put appropriate support in place?

Before you start to talk to someone about their mental health needs, bear in mind these basic guidelines.

- Don't make any assumptions about them as a learner because they have a mental health need. From Section 2 you will have read that each person's experience of mental health is unique. Their skills, abilities, qualifications and previous experience of learning may have as much impact on their support needs as their mental health difficulties. Experience of being bullied, pressure of exams in previous learning opportunities, literacy, numeracy or language needs may all affect a person's choice of learning opportunities and any support for learning.

- Knowing their mental health diagnosis will not help you at all to understand what support, if any, they will need.
- Medication for mental health difficulties can have side-effects that can be very disabling in terms of learning (memory, concentration, etc). Knowing about the side-effects may be useful, but knowing the type of medication will not.
- Having mental health difficulties and living with the stigma and discrimination associated with mental health difficulties can lead to a loss of confidence and self-belief. This can also be very disabling, and may be what the learner needs support with. Feeling valued and wanted, feeling respected as a learner with abilities, appropriate support, success and achievement will build confidence and self-belief and enable a learner to be independent and require less support. Emotional support for learning is discussed later in this section.
- Most of us experience anxieties about starting new things or meeting new people, or worry about our abilities. For adults whose early experiences of education have not been fulfilling, or for whom life events have knocked their confidence, these anxieties may be more profound. This includes many adults that education providers are encouraging back into learning, as well as adults with mental health difficulties. Some level of anxiety about accessing learning is therefore 'normal', and reassuring learners with mental health difficulties of that fact, and that as an education provider you anticipate it and 'allow' for it, can be helpful.
- Try not to project your own values about learning onto learners with mental health problems, or any learners. Education and academic success may be important to your self-esteem and status but it may have been a source of anxiety or pain for some people, and can lead to worry about failure or unhelpful social comparisons.

Understanding what support a person with mental health needs may, or may not, need in learning can only be achieved by asking them. Only by engaging in a dialogue with the learner can you help them to think through what to expect and what support might be necessary. It will also give you the opportunity to get a more rounded picture of the person as a learner. Again, a few simple guidelines may help you to think about what would be appropriate for the context in which you work. You might want to consider:

- finding somewhere private and confidential to talk
- having enough time available to talk things through without you or the learner feeling rushed, or worrying about the queue of people waiting to be seen
- being relaxed, informal and friendly so that the learner does not feel as if they are being 'interviewed' and judged; in some situations, finding a quiet corner of a canteen or other social area might be appropriate
- trying to avoid interruptions, such as phones ringing, people knocking on the door and so on
- remaining focused on the learning and how you can support the learner to achieve: be careful not to slip into the role of counsellor.

When asking a person how they think their mental health might affect their learning, appreciate that the person is the expert on their own mental health. Their mental health (or the side-effects from any medication they take) may affect:

- memory
- concentration
- stamina
- unshared perceptions – having to balance their internal world with the world that others know
- confidence
- motivation
- physical coordination
- becoming more easily stressed or panicky
- how they cope; they may fluctuate – with good days and bad days.

However, they may not be very familiar with adult learning and the requirements of the course they want to do and, just as you would with any learner, you may need to talk through some of the requirements to ensure that this is the right option for them. This could include:

- number of hours of study per week
- amount of private study and assignments
- early morning starts or late evening finishes
- size of the group
- where they will be studying
- examination or assessment requirements.

Learners may have other anxieties or concerns about what their learning opportunity will be like, such as:

- finding their way around a large building or campus
- the social aspects of the learning – breaks, using the canteen, etc
- what the other learners are like
- additional costs for materials, exam fees, etc
- childcare
- literacy, numeracy or IT skills.

Each learner will be different in how their mental health may, or may not, affect their learning. It goes without saying that you need to be sensitive in the way you ask questions. Be respectful of a person's privacy. Don't just have a tick-list of 'symptoms' or 'difficulties', as this can be offensive. One learner involved in the action research project stated:

*It asks about me as a mental health patient, not as a person. It assumes that I am likely to have certain difficulties or do certain things because of my illness... it's still written down as if that's what they expect me to do.*

The questions you ask must relate to the learning situation, for example, you might say:

*On this course we tend to have about 25–30 people in the group; how would you feel about this?*

or

*You mentioned that you get very nervous; can you tell me what kind of things you think might make you nervous while you are doing this course?*

or

*You mentioned that you have panic attacks. I'm afraid I don't know much about this, so I wonder if you could explain a bit more about that, and help me to understand how it might affect your learning.*

Some anxieties or concerns may easily be overcome with reassurance and support; however, because this may be a new situation for them some learners may discover difficulties they hadn't anticipated. Things may be more difficult on some days than others.

As important as talking about anxieties and difficulties is talking about interests, strengths and abilities. Find out about the learner as a person – are they involved in voluntary work, are they involved in mental health service user groups, how do they spend their time, do they work or what did they work as? Find out why the learner wants to do this course – do they want to get a job, is it for pleasure and interest, to meet other people, to build their confidence or to learn a new skill?

This will enable you to get a more balanced picture of the person as a learner and to see where learning fits in with their life. It will also help you to move away from a 'deficit – they won't be able to do that' – way of looking at the person to a positive 'can do' basis, which is more empowering and makes learning more purposeful.

Talking to learners about what helps them to learn also supports your learning as a tutor. The more we talk to learners about what works for them, the more we begin to understand how learners learn and the better able we are to support that. It also means that we will become more confident in our skills and less anxious about our ability to cope, and this in turn supports our own mental health. Moreover, what works for people with mental health difficulties often works better for everyone, and generally helps to promote mental health and well-being.

## Appropriate support and reasonable adjustments

Once you have spent time talking through any implications of mental health difficulties for learning with the learner, you need to talk about what will support their learning. What do you and the organisation need to do to support that learner to achieve in what they want to learn?

In Section 1 we talked about the social model of disability, in which responsibility for change lies with society rather than the person with the disability. Within education this means that the institution and/or staff have a responsibility to address the barriers to participation that exist, and to provide the necessary support. Under the DDA this is called appropriate support and reasonable adjustments. However, there is a wider role for institutions and staff to play in ensuring that that we create mentally healthy learning and social environments. This is about promoting the mental well-being of all learners, about reducing the chance of people developing mental health problems and ensuring that the environment is as healthy as possible for those who do experience distress. Some of these things might involve making reasonable adjustments for those who need it, but mostly it is about good practice for all – learners and staff alike.

Although some learners may need some additional support for learning, it cannot be stressed enough that the best way to support achievement in learning for people experiencing mental health difficulties is to provide good teaching and learning. This starts with welcoming learners into the learning environment, valuing the contributions they make and encouraging and supporting achievement, as you would for all learners.

Careful initial assessment of a learner's skills is crucial to ensure that they are placed on an appropriate course. On the one hand, it is important not to place a learner on a course that is too difficult. On the other hand, care needs to be taken that mental health difficulties are not equated with being unable to reach a certain level. This could result in a learner being placed on a course that is not challenging enough. Pacing the learning and ensuring early and easy success help to build confidence. Growth in confidence can be matched by incremental increases in challenges.

Under the Disability Discrimination Act education providers have to provide reasonable adjustments for disabled learners. For many learners with mental health difficulties, reasonable adjustments and appropriate support can be very simple and straightforward to put in place.

There may be some reasonable adjustments that will be very specific to the learning situation that you will need to advise the learner about. Other forms of support may be part of your everyday teaching practice, or something that you do for many learners. Reasonable adjustments can take the form of either practical or emotional support. Often these kinds of support overlap, but generally practical support will involve very tangible things that you do to change the way that you teach or support learning. Emotional support may involve the less tangible ways in which you build confidence in learners, encourage and motivate learners and help them to feel welcomed and valued.

## **Practical support may include:**

Planning learning:

- helping the learner to think about what they want to get out of the learning experience and allowing them to set their own targets
- negotiating programmes of work
- agreeing a plan to keep in regular contact with the learner
- breaking large tasks into smaller steps if this is necessary
- support for organising work and for time management
- varying the delivery of your teaching and breaking down the learning into smaller chunks of activity.

Flexible and responsive assessment:

- providing a choice and variety of assessment methods
- providing helpful comments on assignments and giving full comments rather than just ticks if something is right
- suggesting ways in which improvements could be made
- extensions to coursework deadlines.

Arranging support:

- providing impaired performance claims for learners whose ability is impaired through illness and/or disability, and associated difficulties
- special arrangements for examinations – location/size/type of room, extra time, amanuensis
- providing information on sources of financial support or support for childcare
- helping to negotiate leave of absence (if necessary)
- keeping in touch with people while they are away
- support to organise a return to learning
- alternatives or additions to tutorial and peer support (eg through organised telephone contact)
- challenging and dealing with any negative or discriminatory actions of other staff or learners.

Arrangements to help the learner feel comfortable and ensure access to appropriate resources and facilities:

- negotiating seating arrangements so that the learner is comfortable, eg near the door or at the back of the room
- ensure that learners know how to access other facilities – libraries, learning centres, and so on
- note-taking, recording of classes or providing handouts
- equipment to allow the learner to keep in touch with course materials, eg an internet-ready laptop.

## **Emotional support may include:**

At the start of a course:

- take time to settle learners in – spend some time doing gentle ice-breakers so that learners start to get to know one another
- ensure that learners know where other facilities are – canteen, vending machines, toilets, smoking areas
- make sure that learners know why certain information about them is required – benefit details, previous qualifications or employment history

- try to ensure that there is privacy and space so that forms that require personal details can be completed with a degree of privacy
- spend time setting some group ground rules such as respect for diversity within the group, respect for everybody's right to learn, taking in turns to talk, not talking over other people, etc.

During the course:

- think about the social aspects to the learning experience – building in coffee breaks and facilitating inclusion of all group members in social chatting
- get feedback from learners about their learning and the course and make any necessary changes
- ensure that you listen to learners and take into account their views and preferences;
- ensure that learners achieve some success as soon as possible
- give plenty of honest but encouraging feedback
- show where progress is being made
- encourage learners to recognise their own achievements
- never single out any learner for any particular praise because they have a disability
- be friendly and relaxed.

These support strategies are probably the sort of strategies that you would use in your teaching with many different types of learners, and exemplify how good teaching and learning underpin much of the appropriate support for learning required by learners with mental health difficulties. Some learners with mental health difficulties may have specific support needs. For instance, a learner may have phobias or beliefs about certain things that may need managing in the learning environment. Remember that the learner will have strategies for managing those fears or beliefs outside the learning environment, and that you may be able to help adapt them for use in a learning situation. For example, a learner may get very anxious in confined spaces: finding out how they cope at home and in public places may give you ideas as to how that anxiety might be managed in the learning environment. Some learners may experience more disabling effects of mental health difficulties or the side-effects of medication, and may require additional learning support, such as a note-taker or extra tutorial support.

Another important fact to remember is that, for learners with mental health needs, levels of support may vary over time. At the beginning of a course where levels of anxiety may be higher, it is likely that greater support will be required. Getting it right at this stage is important. As confidence in ability and awareness of what is required grow, so support for learning may decrease. Some learners may experience fluctuations in their mental health, and so may require varying levels of support, or even some time away from learning. Learners often say that some days they can do a lot and on others nothing. Staff need to be sensitive and flexible in their response to this. Adjusting levels of support, or supporting a return to learning is crucial for ensuring that learners remain in learning and achieve, while being as independent in their learning as possible.

## Passing on information

At this stage you will have ascertained how a person's mental health may affect their learning and what support for learning will enable them to achieve. Now you need to discuss with the learner who needs to know this information. Under the Disability Discrimination Act, if a learner discloses a learning difficulty or disability to one person, the whole organisation is deemed to know, thereby placing responsibility for managing the process of passing on information to the appropriate people who will be involved in the learning experience of that person within the organisation. In so doing, you also need to comply with the Data Protection Act. In discussing with the learner the passing on of information, you should:

- ensure that the learner is involved at all stages and that you obtain their consent about what information you pass on and to whom
- discuss who needs to know – what other tutors will be involved with the person's learning? Are there other non-teaching staff who may be involved or who could support the learner?
- discuss what they need to know – keep the information that is passed on relevant only to how that person will work with the learner
- keep all information that is passed on free of any stigmatising language or medical jargon
- ensure that all information that is passed on focuses on how to support the learning of the person concerned.

## Risk assessment

Very occasionally, a learner may disclose that there may be a risk, to themselves or to others, in their participation in learning. For example, a learner may disclose that they self-harm when they are stressed or under pressure. Or that they have been, or could in certain situations be, a risk to others. Providers should have risk assessment procedures in place that are designed to support staff, the learner and other learners. Staff should have training in how to carry out risk assessment, or have an identified person with responsibility for risk assessment.

Further guidance on Risk Assessment is available in *I don't want to sue anyone... I just want to get a life*<sup>28</sup> but there are some basic principles on which you need to base your risk assessment procedure. These include the following:

- The learner needs to be aware that a risk assessment is being done, and why.
- The learner needs to be involved at all stages.
- The learner may want to involve a third person or advocate who can support them through the process.
- The risk assessment procedure is about supporting the learner to access and achieve in learning, while ensuring their safety and the safety of other learners and staff.
- The risk assessment procedure should identify what situations could trigger a risk situation in a learning environment and what action will be taken to avoid those triggers; it may be useful to invite mental health professionals to visit the learning environment before a referral is made so that they can assess the environment and help to prepare the learner.
- A risk assessment procedure should define what the risk is, what support is in place and who will deliver it, what will happen should a risk situation occur, and who will have access to the information in the risk assessment.
- Clear, accessible and non-stigmatising language should be used.
- It should be reviewed as appropriate, as situations and circumstances change, and therefore should include an agreed date for review regardless of change or otherwise.

<sup>28</sup> Rose C (2005). *I don't want to sue anyone ... I just want to get a life*. Learning and Skills Development Agency.

Be aware that risk behaviour may arise when learners feel threatened, frustrated or misunderstood. Incidence of risk behaviour may arise as a result of discrimination or insensitivity. Risk assessment is not just about the risk that a learner may present but also about the risks to the learner. A risk assessment therefore needs to consider how we minimise the likelihood of risk situations for the learner. For example, a learner may self-harm as a result of bullying. A risk assessment procedure for that learner would need to ensure that strategies are in place so that the learner could confidently disclose incidences of bullying; the necessary staff were confident in dealing with bullying, and there were appropriate procedures and back-up action to deal with incidences of bullying.

## **Additional financial support for learning**

### **Additional learning support**

Additional learning support is currently available for learners in work-based learning, where resources can be drawn down for learners who have additional learning needs and/or additional social needs. Additional learning needs are described by the LSC as being related to the learner's intrinsic ability. Additional social needs are described by the LSC as related to emotional, behavioural or motivational difficulties. Funding arrangements for additional learning support in work-based learning are currently being reviewed by the LSC.

Within the funding available to colleges and other providers are additional learning support (ALS) funds. Additional learning support is used to fund any additional activities that provide direct learning support to learners. For learners with mental health difficulties this could include funding for a note-taker, additional tutor support, or support in or out of the class. It can include assessment, where this involves specialist or higher-level input than is usually available, or personal counselling where this is necessary for a learner to achieve his or her learning goal. It can also include additional administration where this is in excess of usual requirements.

Within your organisation there will be somebody with a responsibility for coordinating and managing ALS. If you feel that a learner requires ALS you will need to discuss this with that person.

### **Learner support funds**

Colleges and school sixth forms have a limited amount of learner support funds that can be used to fund childcare and transport. At present, learner support funds are not available to learners in work-based learning or in adult and community learning. Learner support funds are available to learners who face financial hardship. Colleges determine their own priority groups and the maximum amount they will award.

### **Adult learner grants**

In some pilot areas of the country, young adults (aged 19 and over and under 31) starting college could be eligible to get a weekly allowance of up to £30. The grant is available to learners on a low income who are studying for a first full-time Level 2 qualification (equivalent to 5 GCSEs) or Level 3 qualification (equivalent to 2 A-levels).

There may be someone in your organisation who can advise you or the learner about sources of funding to support learning. It is important that learners get the right information and advice about financial assistance. Anxiety about costs can be a barrier to participating in learning.

### **Exercise**

Below are some case studies that illustrate the different ways in which mental health difficulties could affect participation in learning.

Imagine that you are meeting a learner for the first time because they are either applying for your course or have turned up for the first lesson. You have discussed why they want to do your course and what they hope to achieve. They have disclosed some mental health difficulties.

Read through these case studies and think about them in relation to the course you teach. Ask yourself the following questions.

- What do you need to discuss with each of these learners to clarify how best you may support their learning?
- What kinds of 'reasonable adjustments' do you think might need to be put in place to support learning in each of the case-study examples?

- Who else in your organisation would you need to pass this information to, with the learner's permission?
- What information would you pass on in each of the case-study examples?

**Learner A** gets very anxious in new situations. Part of this anxiety is a worry that he won't be able to keep up and that he won't be clever enough – when he was a child he had a slight hearing loss that meant he found it hard to hear in class. One particular teacher had bullied him for not understanding instructions and told him he was thick and stupid. He wasn't given any support so he fell further behind, and at secondary school he was put in the bottom class. He still remembers the fear of getting things wrong and of being shown up and humiliated in front of people. Since he has experienced mental health difficulties, this anxiety has become harder to deal with, though he knows that part of the problem is that the worry of not getting it right makes it hard for him to listen, and so he doesn't even hear what he is being asked to do. He has been doing some voluntary work and found that after several weeks he felt more relaxed. He is very keen to get back into learning and to 'make up for lost opportunities', but this anxiety, and memories of past educational experiences, are making it hard for him.

**Learner B** feels that her medication slows her down and that she 'has cotton wool between her ears'. When you ask her to explain this, she explains that at a recent meeting of the service user group she goes to they were discussing an outing they were planning. She found that she struggled to keep up with the conversation because by the time she had thought through what was being said they had moved to another subject. She also explained that since she has gained weight she thinks that people are looking at her, and because she is self-conscious she shies away from social situations. She is discussing her medication with her doctor, and they may change the drugs she is on to see if another type will have fewer side-effects.

**Learner C** gets very panicky and agitated when people are sitting or standing behind her. She says she manages this by sitting with her back to a wall and by avoiding busy places and queues. It also helps to have someone she knows and trusts with her – reassurance and support help her to remain calm. When you ask what she means by ‘panicky and agitated’, she tells you that in the past she has become verbally abusive and has hit out in defence because she has been frightened and thought that people ‘were out to get her’. These feelings are worse when it is dark. She says that there haven’t been any incidents like this for about a year because she tries to avoid trigger situations and to use her coping strategies.

**Learner D** hears voices. When he is tired he finds them more overwhelming and then he finds himself talking back to them. On the other hand there are times when the voices go away, for example when he is really engrossed in an activity such as when he is gardening, when he is working on his computer or when he is listening to music. He knows that other people find it embarrassing when he talks to his voices so he is concerned about how other people will react if he does it in class.

Appendix 1 at the back of this report includes some of the points that may be covered in the case-study discussions.

## Whole-organisation responsibility

As a tutor you have responsibility under the Disability Discrimination Act to ensure that learners with mental health difficulties are supported in their learning. However, no matter what course you teach, it is not your responsibility alone. Learners with learning difficulties and disabilities can only be supported to access and achieve in learning if there is a whole-organisation response to the Disability Discrimination Act. This means that all sections of an educational institution, including marketing, estates management, learning support facilities, senior management, human resources and staff development, and so on, have a responsibility not only to implement the Act but also to ensure that you as a tutor are supported to enable a learner with a disability to achieve in learning. It may be that you are unable to fulfil the requirements of the Act because other people in your organisation have failed to take action. The Act is also anticipatory, so rather than wait and respond to an identified need from a learner, it is necessary to consider what action needs to be taken now and by whom, to ensure that you are able to support the learning of people experiencing mental health difficulties. Bear in mind that much of this action is likely to help all learners.

### Exercise

Think about the course you teach. What would prevent you from implementing the Disability Discrimination Act for learners who experience a mental health difficulty? What action do you need to take, and what support or action do you need other people to take? It may help to complete the following table so that you can see what action needs to be taken.

## Action plan

	I am aware of this in my own organisation.	This does not exist in my organisation (or I have concerns about the way it is handled).	What action needs to be taken?	By whom, and when?
Information to applicants makes it explicit that we welcome applications from learners with disabilities including mental health difficulties.				
Procedures are in place for encouraging and supporting disclosure.				
Procedures are in place for handling disclosure.				
Procedures are in place for passing on information.				
Procedures are in place for handling risk assessment.				
Procedures are in place for making 'reasonable adjustments' that support achievement in learning.				

No one is immune from mental health problems. One in four people experiences some kind of mental health problem during the course of any one year. Mental health difficulties can affect any one of us at any time, particularly if we are experiencing a period of stress, anxiety or self-doubt. These stresses and anxieties may arise from any aspect of our lives, such as our relationships or financial worries, but they can also arise from work. Although adult learning and skills can be an interesting and rewarding area of work, it can also be stressful because of the workload, and changing demands. Whatever the cause of any mental health difficulties, it will undoubtedly affect the way that we do our jobs. It can affect the way we relate to colleagues and learners, and it can affect our judgements and confidence. It is important to seek support.

Working with any group of learners can be fascinating and rewarding, but just like any other group of learners, working with learners with mental health difficulties can bring particular stresses including:

- anxieties about what is meant by mental health difficulties: we may be fearful, doubtful of our ability to cope and worried about doing the wrong thing
- feeling unsupported: that learners are 'dumped' on us without information, without appropriate support for them or us
- feeling 'out of our depth': that we lack the special expertise required or knowledge of diagnoses and medication, etc
- that we may hear things from learners that sadden us: we may have a learner in distress and feel powerless to help in any way
- that learners may have unreal or inappropriate expectations about what help and support we can give them
- unreal or inappropriate expectations of ourselves about what help and support we can give to learners
- 'crises' or 'situations': although these are rare, when they do happen they can leave us feeling shaken, upset, scared, angry, guilty or shocked.

Some of these anxieties may be justified, but some may be unfounded. Some of the anxieties we may have about not being able to cope, not knowing what to expect or feeling isolated and alone, are comparable to the anxieties that many learners, particularly learners with mental health difficulties, may have when they participate in learning. Understanding and acknowledging our own anxieties and concerns help us to empathise with those of others. The important thing to remember is that we have a responsibility to look after our own mental health at work and there are strategies we can use to help ourselves and to get the necessary support we need from others. Again, this is similar to the strategies that we should help learners to adopt in being able to access and remain in learning.

Some strategies for looking after our own mental health follow.

In terms of your own feelings:

- know that it is okay to feel sad, anxious, nervous and embarrassed; the important thing is to deal with those emotions appropriately and professionally
- know that you do not have to struggle alone, and that you cannot know everything and be able to do everything; we all need help and support at times
- know that it is okay to ask questions and to ask for support
- know and value your skills and strengths; what makes you a good tutor is what will enable you to cope: use those skills and abilities.

In relation to your teaching:

- listen to the learner: work out a way with them to resolve any difficulties; listen to what they need and what they think will work; be clear and honest about what you can and cannot do to help and find a workable solution together
- know your boundaries; know what is your job and your remit and where responsibility lies with other people; don't let yourself get over-involved
- always be ethical: know that whatever happens you behaved professionally and fairly; be respectful of others' rights

- reflect on your teaching practice: whether there are things about the way you work that could be changed, adapted or improved, that might help you cope with particular situations or demands – we all need to review and revise our skills
- think about your own development needs: would you feel more confident if you acquired new skills or understanding?

In terms of support and resources:

- know who you can refer to – whether this is your own manager, or an outside agency; know what situations are best dealt with by somebody else, know who that somebody is and how to contact them
- know what procedures, processes and support are in place in your organisation; find out if there are correct ways of dealing with certain situations, such as getting additional learning support, or a risk assessment
- seek out your own support mechanisms, whether with colleagues, managers, counselling services, mentoring or staff development
- know and use other resources that might be available – good practice guides, websites, networking events, conferences and so on
- keep a sense of perspective: for the one learner who may cause you anxiety, there will be many others you will have supported successfully in their learning and achievement.

You may want to think through some of these strategies. What do certain terms, like 'ethical', mean to you in your teaching? You might want to take a proactive approach to some of the strategies; for example, find out about policies and procedures, or resources in anticipation of need, rather than wait until it becomes an urgent need.

You may have developed your own strategies over time, based on your experience, that you can add to the list. If they have worked for you, it may be useful to share them with colleagues.

Many of the strategies that you put in place to support your own, or your colleagues', mental health and well-being, will also help you to support learners with mental health difficulties. For example, developing a risk-assessment policy will not only allay your anxieties about how you work with learners where there is an element of risk, but will also support the learners who require risk assessment. Equally, doing some mental health awareness training to build your confidence in working with learners with mental health difficulties will also improve your ability to support such learners. Looking after your own mental health and well-being and meeting the learning needs of learners with mental health difficulties are two sides of the same coin.

## 5 Further reading and resources

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### Good practice guides and mental health awareness

Aylward N (2002). *The learning needs of young adults with mental health difficulties*. Briefing Paper. Leicester: NYA/NIACE YALPUBS

LSC (November 2005). *'See it my way...'* Reflections of learner experience. Coventry: Learning and Skills Council.

LSDA (2004). *Learners' experiences: A training resource on the DDA*. London: Learning and Skills Development Agency.

Mather J, Atkinson S (2003). *Learning journeys: a handbook for tutors and managers in adult education working with people with mental health difficulties*. Leicester: NIACE.

Maudslay L, Rose C (2003). *Disclosure, passing on of information and confidentiality*. Coventry: Learning and Skills Council.

Mind (2000). *Understanding mental illness*. London: MIND publications.

NIACE/DfES (2003) *New rights to learn: a tutor guide to teaching adults after the Disability Discrimination Act Part 4*. Leicester: NIACE/Department for Education and Skills.

Rose C (2005). 'I don't want to sue anyone... I just want to get a life'; inclusive risk assessment. London: Learning and Skills Development Agency.

SEU (June 2004). *Mental health and social exclusion*. Social Exclusion Unit. London: Office of the Deputy Prime Minister.

Wertheimer Alison (1997). *Images of possibility: creating learning opportunities for adults with mental health difficulties*. Leicester: NIACE.

## Useful organisations and websites

NIACE – this site has reports and publications about learning and adults with mental health difficulties, learning difficulties and disabilities. It also has information about the LSC/NIACE/NIMHE Partnership Project on supporting access to learning for adults with mental health difficulties.

[www.niace.org.uk](http://www.niace.org.uk)

Learning and Skills Network – this site has information on the Disability Discrimination Act

[www.lsneducation.org.uk](http://www.lsneducation.org.uk)

Skill: National Bureau for Students with Disabilities – this site has advice on funding, careers, learning and training opportunities.

[www.skill.org.uk](http://www.skill.org.uk)

MIND – has information on all aspects of mental health including their publications on understanding mental health.

[www.mind.org.uk](http://www.mind.org.uk)

National Institute of Mental Health in England (NIMHE) – has information on all aspects of mental health policy and strategy and mental health awareness. The latest publications are also listed.

[www.nimhe.org.uk](http://www.nimhe.org.uk) and [www.socialinclusion.org.uk](http://www.socialinclusion.org.uk)

Mentality – this site provides information on mental health promotion.

[www.mentality.org.uk](http://www.mentality.org.uk)

## Appendix

Discussion on the case studies could include the following points, though in relation to the course you teach you will probably be able to think of other things as well.

### Learner A

Points to discuss with him could include the following:

- Are there some new situations that make him more anxious than others?
- If talking to you now is a new situation, how is this affecting his concentration?
- What has he learned that can be applied to his learning from other new experiences such as his voluntary work?
- Are there things that help him to feel relaxed and less anxious?
- Are there things that help him to listen and understand, such as reminder notes or visual prompts?

Ideas for reasonable adjustments could include:

- spending time at the beginning of the course ensuring that learners are 'settled in', that they know what is going to be covered by the course, and what is going to happen in each lesson; ensure that learners know where to find things, where to get help and support and what will be expected of them; make sure this information is available to all learners, though you might discreetly ensure that learner A is comfortable with everything
- handouts to read, suggested additional reading, tapes of the lessons or work to practise at home to reinforce learning
- self-directed learning in a learner centre
- varying the delivery of teaching, including visual prompts, small group discussions, etc
- additional tutorial time to go over learning
- ensuring early successes to build confidence
- reassurance and ensuring that learner A recognises his own achievements
- agreeing another meeting to review progress.

Passing on information is only appropriate if he is likely to be taught by other tutors, and only with his consent. Who will pass on information (you or him) and what will be conveyed needs to be discussed. This could involve a statement such as:

*This student thinks he will be very anxious at the beginning of the course. This will affect his ability to listen and take in information. He thinks that with support and reassurance his anxieties will lessen after 5–6 weeks. Support should include...*

### **Learner B**

Points to discuss with her could include the following:

- Is concentrating more difficult with certain tasks, eg in group conversations, in one-to-one conversations, when reading?
- What strategies does she already use to try to concentrate?
- Are some social situations more comfortable for her than others?
- Are her concentration and ability to think better at different times of the day?
- Are her thinking and concentration better at some times than others?

Reasonable adjustments could include:

- handouts, lesson notes to read, tapes of lessons
- studying in a learning centre where she can work at her own pace
- change of teaching delivery – discussions, visual prompts, role plays, etc
- additional tutorial time to go over lessons
- study support on keeping notes
- building breaks into lessons
- additional exam or test time
- review of progress, especially if medication is changed
- consideration given to times of study
- opportunities for her to see the place where she will be learning, or to choose the environment or types of students she will learn with
- buddying or mentoring support, especially for social support.

Passing on information is only appropriate if she is likely to be taught by another tutor, or will access buddying or mentoring support. Information can only be passed on with her consent, and her consent to what that information contains and how it is conveyed. This could include a statement such as:

*This learner takes medication which affects her ability to think and the speed of her responses. The following support has been agreed... This may be reviewed if her medication is changed.*

### **Learner C**

Points to discuss could include the following:

- Ask the learner to tell you about the past incident – how long ago did it happen, did something trigger it, have things changed since then?
- Does the information she provides lead you to think that you need more information or a ‘second opinion’? Ask who else can you talk to.
- How does she manage her mental health condition in carrying out everyday tasks, eg shopping: what are her coping mechanisms?
- How does she think the learning environment will affect her mental health: are there situations that she thinks will be difficult for her?

Reasonable adjustments could include:

- visiting the environment where she will be studying before the start of the course
- time of study to be in daylight hours
- ensuring that she can always sit at the back of the classroom or near the door
- breaks and agreement to leave the room if she begins to feel panicky and agitated
- classroom support
- mentoring or buddying support.

Passing on of information will depend on when the incident took place, the severity of it, and whether the learning environment presents risk situations for that learner. Depending on the information, a risk assessment may need to be completed. Who needs to be told will depend on who is closely involved with the learner. The information conveyed needs to relate to the learning environment.

### **Learner D**

Points to discuss could include the following:

- Is the choice of course likely to keep him engrossed, and therefore less likely to hear voices?
- How does he manage his voices, eg does he wear headphones with music playing, will he prefer to take time out when they are bothering him?
- What does he want to happen if he talks back to his voices in front of his fellow learners? How aware is he that he is talking to his voices?
- How much do his voices affect his concentration? How much might they affect his learning?

Reasonable adjustments could include:

- wearing headphones, if necessary
- taking breaks, if necessary
- agreeing a 'what if' plan, eg does he want the tutor to tell his peers if they show concern about his behaviour?

Passing on information will depend on who else will be involved in his learning. Again, always remember that information can only be passed on with the learner's consent. Discuss with the learner how information will be passed on, and what is passed on, particularly where behaviour may cause concern in others.

Many of the reasonable adjustments made for learners will involve good practice in teaching and learning, and common sense. For some learners you may need to be more creative, but when you discuss with learners their own coping strategies coupled with what support you know can be provided by you or your organisation, the solutions often become apparent.

Be honest in what you offer and don't make promises of support that are inappropriate or not available.







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